Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2012/13

Quality Accounts

Introduction

The provision of safe quality services and experience for patients, staff and the public is central to the work of Maidstone and Tunbridge Wells NHS Trust.

The Health Act 2009 requires all NHS healthcare providers in England to provide an annual report on our Quality Accounts. Within it we aim to highlight the progress we have made against the key priorities as agreed in last year's Quality Accounts, areas of improvement in service delivery for our patients, and highlight those areas that we will be focusing on as priorities for 2013/2014.

As patients, you have a right to expect us to provide high quality services. With the recent publication of the Francis report highlighting the need for an even greater focus on the quality of care that we provide the Trust continues to take determined actions to enhance the care within our services. Through the application of clinical governance we have systems in place to monitor standards and address areas of concern. The aspects of quality delivery fall into the categories of Patient Safety, Clinical Effectiveness and Patient Experience.

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. This year the Department of Health and Monitor have required reporting on further targets so that more comparisons can be made on a National basis. Within Kent and Medway we are also reporting on key issues across the Commissioning groups.

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Part One
Chief Executive's Statement

Welcome to our fourth set of annual Quality Accounts for Maidstone and Tunbridge Wells NHS Trust.

Our hospital continued to see and treat tens of thousands of patients during 2012/13 and at all times our aim has been to do this with the utmost care and compassion.

We have listened closely to our patients about their experience with us during the year. Many patients have been able to comment about the standard of care they received through our daily ward surveys. We were also an early adopter of the new national Friends and Family test.

We are also pleased to have been able to start an MTW public membership scheme. We ended the year with 2,500 public members and as many comments about our services. Our intention is to reach 10,000 members by early next year and create the closest links we have ever had with our local communities as part of our own journey to become a Foundation Trust.

All of these comments have been used and continue to influence the way in which we care for patients and provide our services. They have also influenced our new multi-million pound clinical strategy at Maidstone Hospital, which continues to modernize services, transform wards and enhance our patient experience.

We are working closely with our GP colleagues to ensure the services we provide in our hospitals reflect the care needs of their patients.

Our Quality Accounts show that we did many good things for the majority of our patients last year, but did not consistently meet all of the national standards that are in place, for everyone we saw.

Although the majority of our patients were seen and treated quickly, we failed to meet the A&E four-hour waiting time standard for the whole of the year. While we further reduced hospital-acquired cases of the infection Clostridium difficile during the year, we exceeded and missed the target we had set out to achieve. We also had two cases of MRSA when our target was to have no cases at all.

Both of these areas of care continue to be key priorities for us this year alongside the other equally important priorities that we have set out in our Quality Accounts.

We will continue to closely monitor the clinical priorities in our Quality Accounts throughout the coming year and make our progress publicly available.

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

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

As a result, our priorities for 2013/14 are:

Patient Safety

- Reducing the number of avoidable harms with a focus on:
    - Hospital acquired infections, in particular MRSA, C Difficile, chest infections and urinary tract infections
    - Falls
    - Hospital acquired pressure ulcers
    - Hospital acquired venous thromboembolism

Clinical Effectiveness

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

Patient Experience

- To improve our discharge planning for patients
- 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 or written information

MTW will continue to support its highly skilled staff to help achieve the improvements we have set ourselves, as part of our ongoing commitment to provide safe, high quality care.

The information contained within this report represents an accurate reflection of our organisation's performance in 2012/13 and has been agreed by the MTW Trust Board.

Glenn Douglas
Chief Executive

Part Two
Quality improvement initiatives

How has MTW prioritised its quality improvement initiatives for 2013/14?

Priorities for Improvement

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

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

During the last year we focused on the following priorities:

Patient Safety

- Continuing our focus on reducing the number of avoidable healthcare associated infections
- Prevention of blood clots or venous thromboembolism (VTE)
- Reduce the number of patient falls

Clinical Effectiveness

- Continue our focus on improving care for patients who have had a stroke
- Continue to improve the care we provide for patients who are suffering from dementia
- Improve the management of discharge planning

Patient Experience

- Improve the management and quality of responses to complaints we receive and ensure each is used as an opportunity from which we can learn
- Improve the experience of patients across the organisation through focusing on key areas highlighted as requiring attention in the Inpatient, Outpatient and A&E national surveys

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

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

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

Patient Safety

- Reducing the number of avoidable harms with a focus on:
    - Hospital acquired infections, in particular MRSA, C Difficile, chest infections and urinary tract infections
    - Falls
    - Hospital acquired pressure ulcers
    - Hospital acquired venous thromboembolism

Clinical Effectiveness

- To reduce the length of stay for our patients
- To provide an integrated approach to care with our community colleagues with a specific focus on:
    - Dementia,
    - Discharge planning

Patient Experience

- 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 or written information for patients

Monitoring the progress against these targets is via the governance committee structure to the Trust Board. In addition the Trust meets bimonthly with the commissioners to report on its progress towards meeting all the quality standards that are set.

Over the last year the Trust has revised its operational structures. The Committee reporting structures have been reviewed in line with these changes to ensure robust scrutiny of the quality indicators before they are reported to the Trust Board.

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

During 2012/13 the Trust developed a new Quality Strategy – this is currently being reviewed in line with the Francis recommendations and will be launched in 2013/14.

Patient Safety

Reducing the number of avoidable harms with a focus on:

- Hospital acquired infections, in particular MRSA, C Difficile, chest infections and urinary tract infections
- Hospital acquired venous thromboembolism
- Falls
- Hospital acquired pressure ulcers

Infection Prevention and Control

We have again included the reduction of infection rates for C. difficile and MRSA as a key priority for this year. This is an ongoing focus for us to ensure we meet the challenging targets that are set each year on a Trust by Trust basis. This year we are focussing additionally on healthcare associated chest infections and urinary tract infections (UTI).

Aim/Goal
To reduce our C. difficile cases by 29% and sustain or decrease our low rate of MRSA bacteraemia, maintaining our zero tolerance of avoidable infection.
To decrease the incidence of healthcare associated chest infection and UTI.

Description of Issue and rationale for prioritising
Our rates of C. difficile infection have continued to fall, however, in 2012/13 the Trust did breach the target that it had been set for the year. There has been a reduction in cases of between 4 % and 8% in each of the last three years and by 86% since 2006/7.
Our MRSA bacteraemia rate has plateaued in the last year with two cases again in 2012/13. The rate is down by 97% since 2003/4.

Reduction of hospital acquired Chest infections and UTIs as part of our zero tolerance approach is integral to the reduction of C. difficile cases by reducing antibiotic usage and length of stay amongst the elderly patient population.

As a Trust we have a zero tolerance approach to healthcare associated infection (HCAI) and aim to have no avoidable HCAI.

Identified areas for improvement and progress during 2012/13
We exceeded the trajectory for MRSA by a single case and despite reducing the number of cases seen; we also breached the trajectory for C. difficile infection during the year.

The following actions were taken to support the reduction in HCAI

- Focus on preventing other key infections which may be a precursor to C difficile development e.g. chest infection and urinary tract infections.
- The IV training programme was consolidated and rolled out to all junior doctors and many nurses.
- C. difficile cohort areas were identified at both ends of the Trust to provide specialised care.
- Antibiotic management was improved with the introduction of a 5-day stop supported by training.
- With the opening of the Tunbridge Wells Hospital, infection prevention strategies for single room working were developed
- Deep cleaning programme implemented Trust-wide
- Robust Root Cause Analysis (RCA) process for all cases of C. difficile
- Continued focus on hand hygiene

Initiatives for further action for 2013/14

- Revising the C. difficile action plan including learning from root causes identified as contributing to the infection and trend analysis
- Revising the root cause analysis (RCA) process to ensure further consistency of approach
- Launch a “focus on…” series to make improvements to reduce the risks of chest infection and urinary tract infection, implementing the work of the HCAI task and finish group
- Peer review from a high performing organisation

- Review and benchmarking of antibiotic prescribing and guidance
- Working across the health economy to have a whole system approach to the reduction of C. difficile.

Board Sponsor: Dr Sara Mumford, Director of Infection Prevention and Control
Implementation Lead: Gail Locock, Deputy Director of Infection Prevention and Control
Monitoring: via the Infection Prevention and Control Committee to Quality and Safety Committee.

Venous Thromboembolism (VTE)

We have included venous thromboembolism again this year. Considerable improvements in the prevention and management of VTE have been made in the last year (see section 3), however we need to build upon these improvements to ensure all patients are being appropriately risk assessed and managed accordingly, particularly in view of the latest NICE guidelines published in June 2012 regarding the diagnosis and management of VTE.

Aims/Goals

- To meet national and local goals and monitoring requirements on VTE prevention and investigation
- To ensure all patients identified as at risk of VTE via VTE risk assessment receive appropriate thromboprophylaxis
- To reduce the incidence of hospital acquired VTE
- To learn from the root causes leading to VTE in previous patients to minimise further incidents

Rationale

Targets around VTE have been set nationally and locally and are included within monitoring frameworks including: Commissioning for Quality and Innovation (CQUINs).

- Nationally there is now a target that 95% of adult patients admitted to hospital must have a VTE risk assessment completed on admission.
- The national CQUIN also requires for all patients known to have been diagnosed with VTE to undergo a thorough VTE root cause analysis.
- All potentially preventable hospital acquired VTE and deaths in hospital from VTE to be reported as serious incidents. (All serious incidents are subject to review by a panel of executive and non-executive directors)

Progress and Actions taken in 2012/13

- MTW has been compliant with the national CQUIN goal for VTE that 90% of patients had been risk assessed and managed accordingly since August 2011 and with the local stretch target of 95% since August 2012.
- We have undertaken quarterly audits on VTE prevention using the National Institute for Health and Clinical Excellence (NICE) guidance. Overall this audit has shown that as a trust we have demonstrated an improvement in the prescription of VTE prophylaxis and VTE prevention. It has shown that we were able to meet the local CQUIN goal for an improvement in VTE prevention – 95% in first quarter improving to 98% in last quarter.
- A VTE trust wide action plan has been developed following the setting up of a VTE serious incident sub-panel, which reports in to the main serious incident review panel. This has enabled the actions identified from all root causes of VTE incidents to be amalgamated in one place to optimise the learning. The learning is incorporated into Trust wide VTE training sessions.
- The newly established Thrombosis Committee has been meeting quarterly since September 2012, chaired by a Consultant Haematologist, taking over from the original VTE prevention and implementation group.

New and Ongoing Initiatives for 2013-14

- The new anti-embolism stocking policy will be fully rolled out across the trust, incorporating the nursing care plan, staff competencies and patient information leaflet.
- The intermittent pneumatic compression device policy will be completed and patient information on this will be available.
- A bedside patient information leaflet on VTE and the importance of prevention will be available for all adult in-patients at each bedside.
- A policy for the diagnosis and management of VTE (following on from the latest NICE quality standards) will be produced and rolled out.
- The VTE prevention policy will be revised to reflect the changes/improvements in extended thromboprophylaxis.
- Lower limb plaster of paris patients (out-patients) will be VTE risk assessed and receive thromboprophylaxis where appropriate.
- We will continue to meet the national and local CQUIN targets for VTE prevention and investigation.

Board Sponsor: Paul Sigston, Medical Director
Implementation Lead: Sarah Emberson, Matron for Specialist Medicine
Monitoring: via the Standards Committee to Quality and Safety Committee

Reducing the number of Patient Falls

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

Aim/goal
We aim to reduce the number of falls in the year by 15%. This takes into account the single room environment at the TWH site.

Rationale:
Slips, trips and falls can:

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

Progress and Actions taken in 2012/13

- Trial of electronic alarms, which trigger when patients who are at risk begin to move from their resting position, carried out – and equipment has now been purchased.
- Mobility equipment has all been reviewed to ensure it is fit for purpose.
- Patients at risk of falling are provided with non-slip slipper-socks where it is deemed that this may help to reduce their risk.
- Purchased more low level beds for use by patients at risk of falling
- The toilets and wet rooms on the Maidstone hospital site have been updated to minimise fall risks
- Implemented “Period of Increased Incidence” (PII) following 5 or more falls in the month in one area – this resulted in a detailed investigation and root cause analysis (RCA) with the sharing of leaning following review
- A Falls panel has been set up, attended by an Elderly Care Physician. This reports to the central panel which reviews serious incidents. It was set up to review findings of the investigations and determine whether each case was either avoidable or unavoidable. A trust wide action plan has been developed as a result of these reviews to optimise learning and mitigate risks.
- Developed and implemented a new screening tool for risk assessments – following a policy review this assessment now has to take place within four hours of admission.
- A review of medications which affect the risk of falls has been carried out and an agreed list been ratified.
- Blue has been adopted as a trigger colour to alert staff that a patient is at risk of falling – patients wear blue wrist bands and have blue symbols put on magnetic boards above their beds.

New initiatives for 2013/14

- Trial of link nurse post on Tunbridge Wells Hospital Wards with support from a structured package led by an Elderly Care Physician (audit, teaching etc)
- Review current documentation to enhance compliance and completion by staff
- Implement the Falls Safe project – other exemplar sites who have implemented this project have seen an initial increase in falls as reporting increases, followed by an improvement of up to 25%.
- Wards who have a “Period of increased Incidence” of falls to attend Serious Incident Review Panel to ensure challenge and learning as a focused group

- Introduce an alert system through the use of a Blue Symbol for Falls risk – to be placed on a magnetic board above the patient's bed
- Bid for further equipment in ward areas such as alarms

Board Sponsor: Director of Nursing
Implementation Lead: Siobhan Callanan, Associate Director of Nursing
Monitoring: via Standards Committee to Quality and Safety Committee

Reducing the number of Hospital Acquired Pressure Ulcers

Aim
The priority for the coming year is to reduce 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 and to meet the targets set within the CQUINS targets.

The Trust is aiming to reduce the incidence of category 2 pressure ulcers by 15% and category 3 and 4 by 20%.

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

Initiatives for 2013/14
During 2012/13 the trust has developed a more robust way of collating the number of hospital acquired pressure ulcers of all grades and with the introduction of a Trust-wide action plan there has been a reduction in the number of grade 3 and 4 pressure ulcers.
For 2013/14 there will be a greater focus on grade 2 pressure ulcers:

- All grade 2 pressure ulcers are now subject to a full root cause analysis (previously only carried out for grade 3 & 4) and an action plan developed
- Introduction of "skin bundles" a more holistic approach to ensuring all patients receive the appropriate care to prevent pressure damage
- The introduction of core care plans with respect to pressure ulcers to ensure consistency of evidenced based care delivery
- Partnership working with community colleagues to reduce the number of patients admitted to hospital with pressure ulcers

Board Sponsor: Director of Nursing
Implementation Lead: Joan Bedo, Tissue Viability Clinical Nurse Specialist
Monitoring: via Standards Committee to Quality and Safety Committee

Clinical Effectiveness

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

- Dementia
- Integrated Discharge Planning
- Reducing the length of stay for our patients

Improving Dementia Care

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

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

CQUIN targets 2013 /14:
To assess at least 90% of patients aged 75 and over admitted as an emergency for more than 72 hours to determine whether they have dementia.
To ensure there is sufficient clinical leadership of dementia within provider organisations and appropriate training of staff.
To ensure carers of people with dementia feel adequately supported.

Initiatives in 2012/13
The Trust made the following progress against the targets set for last year:

- Dementia CQUIN screening tool is now fully implemented
- Lead Nurse for Dementia Care in post since December 2012. Medical leads identified for each site
- Dementia pathways completed and implemented to ensure standardised practices across the Trust for the management of these patients from admission to discharge. The pathways are designed to be used in conjunction with other existing pathways of care, policies and procedures relating to the care and management of inpatients.
- Education and Training work-stream developed. E-learning package developed and operational. New leaflet for staff regarding dementia and how to help dementia patients developed
- Dementia Champions identified in ward based areas and have received training re their responsibilities
- Have reduced the prescribing of anti-psychotic drugs for patients with dementia – data collection for this CQUIN is now routinely collected. Anti-psychotic review audit is undertaken quarterly by EQ facilitator.
- Working with Commissioners in piloting within A&E and Crossroads Care West Kent at TWH a plan to assist in the prevention of hospital admissions and also in-reach work for patients with Dementia and their carers.

New Initiatives/ goals for 2013/14

- Completion of pilot of core care plan for patients with cognitive impairment and implementation of this.
- Development of patient / carer information resource leaflet for those admitted with dementia.
- Development of dementia buddy scheme in association with Alzheimer's and Dementia Support Services

- Develop further links with partners such as Crossroads Care West Kent and Alzheimer's Society dementia cafes to help support patients and their carers
- Development of guidance on the management of behaviour that challenges due to dementia or delirium.
- Dementia Awareness Training Strategy – ensuring appropriate training to meet needs of strategy and staff, with clear objectives and learning outcomes.

Board Sponsor – Director of Nursing
Implementation Lead – Liz Champion Lead Nurse for Dementia
Monitoring: via the Dementia Strategy Group to Quality and Safety Committee

Integrated Discharge Planning

Work is currently on-going between the Trust and partnership organisations – social services and commissioners, to ensure that those patients who are medically fit can be discharged into the most appropriate care environment for them. In addition there are specific actions that the Trust is taking to ensure the discharge is planned in an efficient and effective way. With the increased recording of delayed discharges and some targets from last year, although demonstrating improved compliance, not yet fully achieved, we are continuing to focus on discharge planning as a key focus for the coming year.

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.

Initiatives for 2013/14

- Establish a high-level meeting between the Trust and partnership organisations to review patients who are medically fit for discharge, but are delayed within the hospital.
- Weekly meetings to occur on both sites to review all patients with a length of stay greater than 7 days to ensure appropriate actions are being taken.
- Performance regarding delayed discharges to be reported to Trust board monthly.
- Re-evaluate the 7-Day LOS website to see after 6 months of service if any additional changes are needed.
- New discharge lounge to be built at Maidstone that is fit for purpose.
- Development of detailed action plans in partnership with project leads from each organisation aimed at improving the efficiency and effectiveness of services at a wholes system level.
- Develop a robust monitoring system for, for example, referral and treatment criteria, demand management schemes, assessments of the minor injuries units throughput and type of patient, so that early action can be taken if there are problems
- Test new ideas for service integration, for example, Telehealth for patients with respiratory and COPD conditions as part of reducing the presentation of patients with these conditions at A&E

Board Sponsor – Angela Gallagher, Chief Operating officer
Implementation Lead – Shane Morrison-McCabe, Associate Director
Monitoring: Operationally to the Trust management Executive meeting and Quality and Safety Committee

Reducing the Length of Stay

Aim:
To ensure patients have a length of stay that relates to best practice clinical guidelines.

Rationale:
Reducing the length of stay for patients in line with national guidelines is important to ensure we are meeting best practice standards of care. As we are aware these days an increased length of stay can result in additional problems for patients who may be exposed to, for example, infections that may be present in the ward area.

In addition by reducing the length of stay so we will be able to ensure that beds are more readily available to patients who need to be admitted from the accident and emergency department and for operations, thus helping to improve our clinical outcomes.

New initiatives for 2013/14
The Programme is based on recognized key steps and takes forward the work which is already underway:

- Benchmark length of stay performance to identify opportunities for improvement.
- Map processes in order to identify potential delays to patients' discharge. This analysis should focus on identifying bottlenecks, any disruption to the information flow during the patient journey and on patterns of discharge by day, hour and specialty.
- Give patients a planned date for discharge on, or prior to, their admission. This date should be based on protocols for common conditions. Ensure patient, their family or carer, and where necessary social services, are involved in individual discharge planning.
- Ensure a regular decision-making ward round should take place at least once per day, including weekends.
- Discharge patients in the mornings. Criteria-led discharge by nurses and other healthcare professionals to facilitate discharges other than the daily ward round.
- Prevent hospital procedures from holding up discharge ensuring tests and results are readily available together with medicines to take home, transport and social services.
- Ensure that the admissions and discharge processes work seamlessly together. For example, by matching the hour of discharge to the times that beds are required for transfer from A&E can have a significant impact on reducing A&E waiting times.

Executive lead; Angela Gallagher, Chief Operating Officer
Project Lead: Steve Turnbell-Jones
Monitoring Committee: Operationally to Trust Management Executive Meeting and through to the Quality and Safety Committee

Patient experience

- 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 for patients.

Complaints Management

Aim/Goals
Our aim this year is to ensure that all complaints are seen as an opportunity to learn from and that we embed the learning. In addition we aim to ensure complainants receive timely responses which have been fully investigated and address all issues raised.

We also aim to ensure that all responses provided address issues in a timely way and people who have had cause to complain can be assured that actions have been taken to minimise the risk of them happening again.

Targets:
75% compliance with stipulated timescales for responding to complaints.
75% of complainants that respond to our survey score us as 4 or 5 (out of 5) for satisfaction with the service.
CQUIN – achieve a rate of 4.43 complaints per 1000 episodes of care

Activities in 2012/2013
Following on from an independent review of the complaints process in 2011/12:

- Revisions to the complaints handling processes resulting in enhanced quality timeliness in responding to complaints – a reduction in end of year open complaints from 236 to 98
- Reduced the total number of complaints received in 2012/13 by 300 from 2011/12
- Enhanced reporting in relation to learning from complaints feeding into key governance committees
- Implementation of surveys to review the quality of complaints – in doing this we more than exceeded the 10% improvement target that had been set.
- CQC reported compliance with outcome 17 which relates to complaints

Initiatives in 2013/2014

- Implementation of further training re investigation of issues and drafting of complaint responses including using complaints and PALS scenarios in the development of a new Trust wide customer services / OD programme
- Introducing a new system for reviewing and challenging the investigation of serious complaints in conjunction with the patient safety team to ensure robust investigation and learning takes place. (red complaints/incidents panel)
- 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
- Using the internet and new patient newsletter as a means of sharing with patients and the public what actions have been taken in response to the concerns they have raised.
- Implement the recommendations from the Francis report in relation to being more open regarding the complaints we receive and the action we take in response
- Also capturing the learning and action taken from concerns raised through PALS
- Ensure all patients have information about how to raise concerns
- Enhance our practice re early engagement with patients and families

Board Sponsor: Director of Nursing
Implementation Lead: Angela Savage, Complaints & PALS Manager
Monitoring: Quality and Safety Committee

Improving the quality of written information

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

While these developments evolve we also want to ensure that we improve the quality of information in terms of leaflets about conditions and treatments and also the letters that we send out.

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

Rationale:
The national patient survey has highlighted the need for more information in some areas. An internal review has identified the need to improve the quality of some of the information that we provide to patients and the public.

Identified areas for improvement and progress in 2013/14:

- The 'Patient Information and Leaflet Group' (PILG) will work with Directorates to improve their ownership of leaflets and enhance the accuracy and relevance of clinical information
- Ensure leaflets that are easier to read and understand by patients (the PILG editorial group includes patients, clinicians and Communication officers).
- Reduce delays in approving and publishing leaflets
- Ensure a set of core leaflets, relevant to all clinical areas, are readily available to patients and their relatives.
- Health Records Manager and Communications Department to improve the quality, readability and consistency of patient letters.
- Improve the quality and formatting of the web content on the trust's public website to ensure information is written in plain English, relevant, up to date and follows "writing for the web" best practice.
- 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.
- Continue to build up our use of social media to communicate with patients, the public in general and other stakeholders
- Increase our distribution of a quarterly patient newsletter and coverage of patient services and experiences
- Recruiting and communicating with 10,000 public members as part of our bid to become a Foundation Trust.

Board Sponsor – Director of Nursing
Implementation Lead – Head of Quality and Governance
Monitoring: via the Patient Experience and Quality & Safety Committees

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

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

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

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

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

No conditions were applied to the registration.

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

During 2012/13 the Trust provided and/or subcontracted the full range of services for which it is registered.

During 2012/2013 the Maidstone and Tunbridge Wells NHS Trust (MTW) provided and/or sub-contracted 120 NHS services.

MTW has reviewed all the data available to them on the quality of care in these NHS services. These are reviewed formally with the commissioners.

The income generated by the NHS services reviewed in 2012/2013 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2012/2013.

Reviewing Standards

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

- Care Quality Commission – 4 inspections – further details are provided later in the report.
- Annual Cancer Review
- MHRA – research governance inspection in 2012
- Clinical Pathology Accreditation inspections (4 in 2012)
- PEAT (2 visits per year)
- Environment agency
- Information Commissioners
- Kent LINkS – seeking views of patients
- ISO accreditation of portering services
- Pharmacy aseptic units regional quality assurance visits

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

- Care assurance audits
- Internal PEAT reviews
- Hand hygiene audits
- Trust Board member “walkabouts”

The outcomes of these are included within our triangulation process to review clinical areas and identify any where additional support and actions are required to maintain standards.

Reports are scrutinised within identified committees within our governance structure and where necessary action plans are developed and monitored.

Clinical Audit

Another means of ensuring that we are providing services to the required standards is via our clinical audit programme.

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

During 2012/13, MTW participated in 100% of relevant confidential enquiries and 98% of all relevant national clinical audits. The Trust submitted data from just the Maidstone site for the National Adult Diabetes Audit and the Paediatric Diabetes Audit. The software is now fully installed on the Tunbridge Wells site and full participation is expected in 2013/14. During the same period, MTW staff successfully completed 168 clinical audits to action plan stage from 333 started and in progress, which led to improvements in patient note keeping, the quality of letters; clinic organisation and staff training (please see details below).

The Trust did not participate in one audit - the Elective Surgery Audit (part of the national PROMS programme). The Trust did submit data for this audit but it was rejected by the co-ordinating centre as being insufficient in detail. This was due to late changes in the data collection process, implemented by the co-ordinating centre, not fully communicated to the Trust team before data collection.

The national clinical audits and national confidential enquiries that Maidstone & Tunbridge Wells NHS Trust participated in during 2012/13 are shown in Table 1 as follows-

National Clinical Audits for inclusion in Quality Accounts 2013	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2012-13				
Peri and Neonatal				
Neonatal Intensive and Special Care (NNAP)	Y	650	100%	
Perinatal Mortality (MBRRACE-UK)	Y	4 (so far)	100%	Data still being submitted
Children				
Paediatric Inflammatory Bowel Disease. (Round 4)	Y	0	N/A	No cases to submit to date
Child Health (CHR-UK)	Y	1	100%	Ongoing data collection.
Epilepsy 12 (Childhood Epilepsy)	Y	22	100%	
Paediatric Pneumonia	Y	17	74%	
Paediatric Asthma	Y	27	100%	
Paediatric Diabetes (PNDA)	Y	143	60%	Full data submission from Maidstone Partial data

				submission from TW.
Paediatric Intensive Care (PICANet)	N/A			MTW does not provide this service
Acute Care				
Renal Colic (CEM)	Y	77	100%	
National Cardiac Arrest Audit (NCAA)	Y	161	100%	
#Neck of Femur Audit in A&E (CEM)	Y	56	100%	
Adult Critical Care Case Mix Programme (ICNARC) (Round 2)	Y	934	100%	
National Audit of Dementia (NAD)	Y	89	100%	
Adult community acquired pneumonia	Y	69	100%	
Non-invasive ventilation – adults	Y	56	100%	
Sentinel Stroke Audit (SINAP SSNAP)	Y	168 218	100%	
Feverish Children in A&E (CEM)	Y	100	100%	
National Cardiac Rehabilitation Audit	Y	429	100%	
Emergency Laparotomy Audit	Y	No data collection this year.		Trust registered to take part. Data collection to start in 13-14 audit year.
Emergency use of Oxygen	Y	71	100%	
Long Term Conditions				
National Adult Diabetes Audit	Y	25	50%	Partial Data submission Maidstone only.
Inflammatory Bowel Disease (IBD)	Y	4	N/A	Ongoing data collection.
National Parkinson's Disease	Y	84	100%	
BTS Adult Asthma	Y	19	95%	
Asthma Deaths (NRAD)	Y	1	100%	Ongoing data collection
BTS Bronchiectasis	Y	34	100%	
Adult Diabetes Inpatient Audit	Y	87	100%	
Elective Procedures				
Elective surgery (National PROMs Programme)	N	N/A	N/A	Data not collected this year as data collection method had been redesigned to cover all specialties to enable a more robust clinical outcome report.
Coronary angioplasty	Y	290	100%	
Cardiovascular disease				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	377	100%	
Heart failure	Y	417	100%	
Cardiac arrhythmia	Y	154	100%	
Adult Cardiac surgery	N/A			MTW does not provide this service
Carotid interventions	N/A			MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	N/A			MTW does not provide this service
Carotid interventions.	N/A			MTW does not provide this service.
Pulmonary Hypertension	N/A			MTW is not a Specialist PH centre.
Vascular surgery (VSGBI database)	N/A			MTW does not provide this service.
Renal Disease				
Renal Transplantation (NHSBT)	N/A			MTW does not

				provide this service
Renal Registry (UKRR)	N/A			MTW does not provide this service
Cancer				
Lung Cancer (NLCA LUCADA)	Y	204	100%	
Bowel Cancer (NBOCAP)	Y	799	100%	
Head & Neck Cancer (DAHNO)	Y	128	100%	
Oesophago-gastric cancer (NAOCG)	Y	260	100%	
Trauma				
National Hip Fracture Database (NHFD)	Y	379	100%	
Severe Trauma (Trauma Audit & Research Network) TARN	Y	348	100%	
National Joint Registry (NJR)	Y	998	100%	
Psychological conditions				
Prescribing Observatory for Mental Health	N/A			MTW does not provide this service
Schizophrenia	N/A			MTW does not provide this service
Suicide and homicide in mental health (NCISH)	N/A			MTW does not provide this service
Psychological Therapies	N/A			MTW does not provide this service
Blood transfusion				
Audit of blood sampling and labelling (National Comparative Audit of Blood Transfusion)	Y	110	100%	
Cardiothoracic transplant	N/A			MTW does not provide this service
National Confidential Enquiries				
Alcoholic Liver Disease	Y	4	100%	
Subarachnoid Haemorrhage	Y	3	100%	
Tracheostomy Study	Y	8	100%	Organisational Data submitted.

47 National audits were published in 2012/13 with actions taken in 2012/13 to address areas of non or partial compliance. A number of improvements have been made in line with national recommendations, including-

1. **Paediatric Pneumonia** Senior review of antibiotic route on every ward round, with increased use of the oral route. More judicious allocation of IV antibiotic therapy in Community Acquired Pneumonia
2. **CEM Severe sepsis & septic shock** Department handbook has been updated to contain standards on urinary catheterisation and output measurements for staff. New training for nurses has been introduced to improve documentation of observations.
3. **Audit of Consultant Sign off in Emergency Departments 2011** Directive to be disseminated to all A&E staff through Clinical Governance and Junior Doctors training sessions to ensure patients attending should be seen and their case discussed with a senior doctor prior to discharge.
4. **Adult community acquired pneumonia** Chest X-rays to be prioritised by Radiology. A pilot scheme is in place to allow nurses to request chest x-rays in addition to doctors. Doctors are receiving training on compliance with CURB65 scoring and the appropriate use of antibiotics. Any justified deviation from Trust guidelines must be documented in patient notes.
5. **Chronic Obstructive Pulmonary Disease Discharge Audit 2012** Respiratory nurses and doctors attended a cross site education day to increase knowledge around British Thoracic

Society recommendations. A business case has been developed to increase respiratory physiologist hours to allow for increased numbers of spirometry tests that patients require.

6. **National Joint Registry (Hip, knee and ankle replacements**. Patients with metal on metal prosthesis will now receive annual follow ups in line with national recommendation.
7. **National Cardiac Rehabilitation Audit** The Trust is liaising with Kent Community Health for additional funding to support post-discharge rehabilitation programmes and to improve access for additional groups of patients. A business plan is in development to fund home-based exercise courses for patients who are unable to attend sports centres. Patient health education sessions now include Pharmacists, Occupational therapists and psychologists.
8. **Potential Donor Audit (NHS Blood & Transplant)** The Trust critical care unit's Practice Development Nurses and outreach team are establishing and implementing an education strategy for organ donation within the Trust to help build and strengthen relationships with all clinical staff.
9. **Cardiac Arrest Procedures**. A new medical proforma has been introduced to ensure clerking and examination of each patient is explicitly recorded. Life support courses have been introduced for staff which focuses on the early identification of the deteriorating patient. A new formal weekend handover has been instigated to ensure a consultant review is carried out if concerns are identified.

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

The reports of **49** national clinical audits, published in 2011/12 were reviewed by MTW staff, with a number of actions to be in place by 2012/13 to improve patient care. Areas of improvement include-

- Improvements in patient management in ITU and ICU
- Increased communication with patients about their care via new and improved booklets, leaflets, letters and face to face discussions with clinical staff
- Improvements to patient-related documentation to ensure all aspects of care are recorded, linking in with changes and improvements in computer systems used to hold patient information.
- Identification of additional specialist nurses in respiratory, diabetes and stoke care.

Please see Appendix B for full details of progress against each of the reported national audit results 2011/12

A number of service improvements have been made as a result of the **138** local clinical audits completed to action plan stage, across all directorates, in 2012/2013. 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
Critical Care Team	Standardisation of suction units across the trust and intensive training programmes introduced on the use of these units. A designated member of staff has been identified on each ward to carry out daily checks of all suction units as well as resuscitation trolleys. This will ensure that suction units will be readily available for any patient who requires emergency suction.
	The Patient At Risk Score (PAR) is used to identify patients at risk of deterioration and then gives guidance on the appropriate responses and action that should be taken. Additional training and teaching on recognition of the deteriorating patient and emphasise on the importance of fluid balance charting have been set in place.
Sexual Health Team	Changes have been made in the first line antibiotics prescribed for the treatment of Urinary Tract Infections within the GUM department. The new regime will ensure all urinary organisms are isolated and treated.
Obstetrics Team	A new proforma has been introduced to the maternity hand held notes to assist with the management and documentation of 3rd and 4th degree tears.
	Antenatal Clinics have been arranged specifically for the care of mothers with twin pregnancies to provide antenatal and parent-craft information. A Midwife with experience of running twin clinics has been appointed to lead on this. A new trust proforma for the management of twin pregnancies has also been developed. This will ensure that it is documented that mothers are managed and counselled appropriately during the antenatal period
Microbiology	To ensure patients receive all doses of gentamicin at the correct time a sticker has been produced to be put on drug charts to give guidance on timing of doses and when to check levels.
Medical Team	A flow chart that sets out the calculations to be used when prescribing paracetamol particularly with regard to underweight patients has been developed. Patients will now have their weight recorded on the drug chart and the appropriate dose of paracetamol prescribed in every case.
	All wards now have a standardised box for the treatment of diabetic hypoglycaemia which contains intra-muscular and intravenous, as well as oral treatments for the control of hypoglycaemia. This will lead to better management of episodes of hypoglycaemic with improved outcomes for the patient.
Anaesthetic Team	A new Trust Policy has been developed to ensure that all women from menarche to 55 years of age have a pregnancy check in the immediate preoperative period. This will reduce the incidence of women with unknown pregnancies undergoing a general anaesthetic.
	The planning regime of stroke patients' exercise timetables has been changed to include two shorter

Physiotherapy Team	sessions if preferable to a longer session. This takes into account patients who were not medically fit or easily fatigued who would not benefit from one long session.
	A new leaflet has been written for patients to explain post operative exercises following Breast Cancer Surgery. These leaflets are now posted to patients prior to their surgery to ensure they are being informed of the care process that they will receive.
Dietetics Team	New folders to include all aspects of patient nutrition have been developed and will be kept on the ward. They include links to additional patient nutritional information. Patients will have an accurate and relevant nutritional assessment with their requirements identified and acted upon for immediate use.
Radiology Team	A more sensitive and specific test for the identification of Pulmonary Embolism (PE) has been introduced for intermediate risk patients. This will more accurately rule out PE in this group of patients and enable better clinical diagnosis and treatment.
Tissue Viability Team	In order to further reduce the incidence of pressure damage a ward based education programme has been developed. High risk areas such as T&O and Stroke are to be targeted first. All Grade 2 pressure ulcers to have a Route Cause Analysis completed in line with NPSA Zero Tolerance to pressure damage. Skin bundles documentation and assessment tools for the identification of patients at high risk of developing pressure damage to be fully implemented across the trust.
Surgery	Care records for Cancer patients undergoing major abdominal surgery now have prompts ensuring prescribing of extended venous thromboembolism (VTE) prophylaxis and Anti Emetic Stockings on discharge. Training for junior doctors on surgical rotations on the indications and contraindications in this group of patients has been put in place. This to lessen the risk of patients developing VTE following major surgery.
	Following a patient survey in the ENT outpatient department, additional refreshments are now provided for patients. The waiting areas have been reconfigured to allow for easier wheelchair and pushchair access and delays in clinic times are now displayed for patient information.

Nice Guidelines

Every Year the National Institute for Health and Clinical Excellence (NICE) develops a number of guidelines for the NHS to review and implement to enhance practice and the care of patients. As at the end of 2012/13 **859** NICE guidelines had been disseminated to specialty leads throughout the Trust. Of those, **783** (**91.2%**) have been evaluated. **304** (**38.4%**) of the evaluated guidance are relevant to the Trust.

All 94 NICE Clinical Guidelines have been or are planned to be audited to ascertain Trust compliance. To date, 76 guidelines have been audited.

Of the clinical guidelines audited, eight were found to be fully compliant – predominately in the areas of cancer and medicine.

The remaining standards found to be partially compliant have actions identified to make the necessary changes, many are already in place. Many of the actions and changes in practice relate to improving documentation either by including new summary proforma to collect and detail key information or introducing staff education sessions. A number of clinics have either been introduced or existing clinics increased to improve patient care and referral pathways reviewed especially in diabetes and tuberculosis treatment.

The clinical audit team continue to monitor action plan implementation and must ensure all clinical guidelines are audited once according to commissioner guidance.

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

Research

Participation in clinical research

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

During 2012/13, 1581 patients were recruited to research trials at MTW. The majority were placed in national portfolio-led trials spanning all trust directorates (please see split below).

MTW own account recruits = 35
National Portfolio recruits = Cancer studies 399, others 1696
Commercial research recruits = 20

There are presently 169 studies open and recruiting, inclusive of randomised clinical trials, observational studies, MTW investigator led and student projects. Participation in clinical research demonstrates Maidstone & Tunbridge Wells NHS Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During 2012/13, improvements in the diagnosis of women's cancers became standard practice at MTW following the successful completion of own account research. A number of new innovations are currently in development, created by staff following successful research outcomes.

51 new clinical research studies were opened across directorates during 2012/13. Research active services include Oncology, Haematology, Radiotherapy, Rheumatology, Cardiology, Diabetes, Ophthalmology, Stroke Services, Breast Care, General Surgery, Anaesthetics, Orthopaedics, Elderly Care, Endocrinology, Gastroenterology, Respiratory, Paediatrics, Obstetrics and Gynaecology, Radiology, Pathology and Neurology. During 2012-13 MTW recruited to 118 clinical studies (inclusive of the 51 new approved studies). A further 51 studies were closed to recruitment and following-up patients that were recruited in previous years.

337 clinical staff participated in research approved by a research ethics committee during 2012/13. Maidstone and Tunbridge Wells NHS Trust has focused on encouraging non-medical staff to lead innovative research locally and nationally to increase the diversity of research conducted. Clinical staff, with the role of either Principle or Chief Investigator, now includes consultants, senior nursing staff, therapeutic and support service staff.

Since 2008/9, 191 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.

The Kent Oncology Centre Clinical Trials Unit (KOCCTU) at Maidstone Hospital continues to expand its portfolio of cancer trials ensuring that cancer patients have an opportunity to participate in the open trials at the Hospital. Recruitment figures have exceeded those forecasted during 2012-13 and MTW successfully recruited 399 patients against the proposed target of 303. The KOCCTU works in close collaboration with both the National Institute of Health Research specifically under the umbrella of the National Cancer Research Network and the international pharmaceutical industry to ensure that Clinical Trial delivery of innovative treatments can be offered to patients with cancer at different trajectories of their diagnosis and pathway of care.

The expertise of the clinical trials staff, both clinical and non-clinical are able to address the specific challenges and pressures faced by both National Institute of Health Research (NIHR) and industry in successfully delivering cancer clinical trials within the Trust to sustain a portfolio of studies enabling “tomorrow’s treatment today”. All patients are given the opportunity to access a clinical trial during their cancer pathway.

New bids for research funding submitted during 2012/13 include funding applications to look at patient initiated follow up versus hospital led follow up following oesophagus gastric resection for malignancy as a feasibility study. A grant from the British Liver Trust was awarded to a clinical Nurse Educator from Intensive Care for a multi-centre study looking at health care professionals’ knowledge and training around organ and tissue donation and the implications for education. This study became the only nurse-led research to be adopted onto the National Research Portfolio, recruiting participants from across England.

In August 2012, MTW participated in its first MHRA routine Good Clinical Practice (GCP) research inspection. The inspection outcomes were excellent, with the inspectorate finding no critical or major findings. A number of ‘other’ findings were highlighted relating to the completeness of local research policy and procedures and study specific queries. The Trust addressed all findings in-year.

Goals agreed with commissioners

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

In 2012/13 2.5% of the contract value was dependent on achieving the CQUIN targets in line with the CQUIN payment framework. This will be the same for 2013/14, although the targets will have changed.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2012/13, quality improvement and innovation goals were set as indicated in the table below.

	Target	Achieved (local data)
National CQUINS		
% of Adult Inpatients that have a VTE Risk Assessment	**90%**	**95.3%** **(from Aug 12)**
Composite Patient Experience Score (Annual Survey 2012/13):	**90%**	**89.8%**
Involvement in decisions about treatment and care	**90%**	**90%**
Hospital Staff being available to talk about worries/concerns	**90%**	**93%**
Being informed of side effects of medication	**90%**	**78%**
Being informed of who to contact if worried about condition after leaving hospital	**90%**	**90%**
Safety thermometer – submission of monthly data – 50% of wards for quarter 2	**100%**	**100%**
Safer Smarter Care - Submission of Monthly Data - Full year monthly submissions	**100%**	**100%**
Dementia Screening - % Patient Admissions age >=75 who have been screened (April 12 to Mar 13)	**90%**	**98.4%**
Referral for Specialist diagnosis -% Patient Admissions age >=75 who are identified as at risk of Dementia who are referred for specialist diagnosis (April 12 to Mar 13	**90%**	**100%**
Regional CQUINS	**Target (Jan-Dec 2012)***	**Achieved**
Improvement and maintenance of % of patients receiving pathway metrics for key areas:		
Pneumonia with CURB (Apr - Dec 12)*	**83.3%**	**83.9%**
Pneumonia (no CURB) (Jan - Dec 12)	**87.4%**	**92.4%**
Heart Failure (Jan - Dec 12)	**73.2%**	**81.8%**

Hip & Knee Replacements (Jan - Dec 12)	**93.6%**	**98.8%**
Enhanced Recovery: Colorectal, Gynae-Oncology, Hip & Knee Replacements (avg for Dec 12, Jan 13, Feb 13)	**95%**	**95%**
(Improve Performance) % of datasets sent to EQ relating to eligible patients with Acute Kidney Injury (AKI). Target= % of eligible local population	**95%**	**95%**
Improve Patient Outcomes (Readmissions) for Heart Failure- Jan 11 to Mar 12*	**18.35%**	**18.93%**
Improve quality of patient care by engaging in shared learning in the four specific pathways	**Specific events to be attended**	**Attended**
Enhancing Quality (EQ) Data completeness (Jan-Dec 2012)	**95%**	**98%**
% of patients at risk of VTE that were prescribed appropriate prophylaxis – quarterly audit Safe Workforce	**95%**	**96.66%**
Safe Workforce – ward dashboard for workforce and quality indicators	**100% of wards**	**Met**
Long term conditions –whole system approach:		
Participation in the two regional events -(25/4/12) and (4/7/2012)	**Participate in events**	**Met**
Participation in locally agreed projects related to the LTC Programme	**Participate in programme**	**Met**
Psychiatric Liaison:		
Monthly Data collection (from July onwards) for a) pts requiring assessment under the MH Act, b) pts who have self harmed, c) pts with cognitive impairment/dementia	**Collect monthly data**	**Full data collection from November**
Deliver a single point of access and referral process in and out of hours and pathways developed	**Deliver single point of access**	**Met**
KMPT and Trust collaboration including Monthly Data collection (from July onwards) for numbers of ED and ward staff trained	**Monthly data collection**	**Met**
Evidence of Improved outcomes in at least 5 of the 8 indicators by Q4 12/13	**Improve on 5/8 indicators**	**Met**

* Note differing data collection timeframes

You will note that a number of these are linked to the key priorities set for 2012/13.

Similarly we have used these outcomes to help inform our decision on what to make key priorities for 2013/14. We have included the end of year position for the local inpatient survey as well as those published for the 2012 National Survey.

Statements from the CQC

The Care Quality Commission carried out four inspections within the trust in 2013/14:
Dignity and Nutrition Audit – part of a national review
Review of Terminations of Pregnancy Services – part of a national review
One review of each site (two) – part of their annual unannounced round of inspections

The Trust was found to be compliant for the outcomes reviewed in three of the reports – we are awaiting the report of the most recent unannounced inspection.

There are always areas for improvement, however, and we welcome the reports to enable to target areas there the Trust can further improve on.

Actions that we have taken to improve services include:

- Ensuring that information about how to raise a concern is more readily available in the ward areas
- Increased training in relation to the use of resuscitation forms
- Ongoing audits of health records and accuracy of inputting
- Continuing to improve discharge planning arrangements
- Targeting compliance rates for completion of mandatory training

Actions are monitored via the relevant governance committees.

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

Improving data quality at MTW

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

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

During 2012-13 the Trust successfully completed the completeness and validity checks set out as part of the Information Governance Toolkit. This is further confirmed by the results of the Audit Commission's annual Payment by Results audit along with the NHS Information Centre's Secondary Uses Service data quality reports.

The Trust has a Data Quality Steering Group that takes action on data quality issues. Areas identified for improvement during 2013-14 are:-

- Preparation to move to NHS Number as the primary patient identifier used in the Trust
- Implement software that enables Trust systems to be linked to the NHS Spine
- Establish an on-going program of data quality workshops for staff

NHS Number and General Medical Practice Code Validity

Maidstone and Tunbridge Wells NHS Trust submitted records during 2012-2013 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

98.7% for admitted patient care;
99.2% for outpatient care; and
92.1% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;
100% for outpatient care; and
99.9% for accident and emergency care.

Information Governance Toolkit attainment levels

The Trust achieved an 80% satisfactory score against the Information Governance Toolkit Version 10, and achieved 19 of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the Operating Framework for England for 2011/12.

The Trust has a robust Information Governance Management Framework that has been in place throughout the year and significant improvements continue to be made in many areas. An action plan has been developed to address the areas of weakness identified and progress against the action plan is monitored by the Information Governance Committee which is chaired by the Trust Senior Information Risk Owner. The Trust Board is kept fully appraised of Information Governance issues affecting the organisation.

The Trust has worked proactively with the Information Commissioner's Office (ICO) which was asked to undertake a consensual audit in May 2012. As a result of the audit the ICO were able to issue a report providing 'Reasonable Assurance'. The ICO audit report executive summary said arrangements for data protection compliance with regard to governance and controls provide a reasonable assurance that processes and procedures are in place and being adhered to. The audit has identified some scope for improvement in existing arrangements and appropriate action has been agreed to reduce the risk of non-compliance.'

The trust has an action plan in progress to continue to improve its compliance with the IG standards.

Part Three
Review of Quality Performance

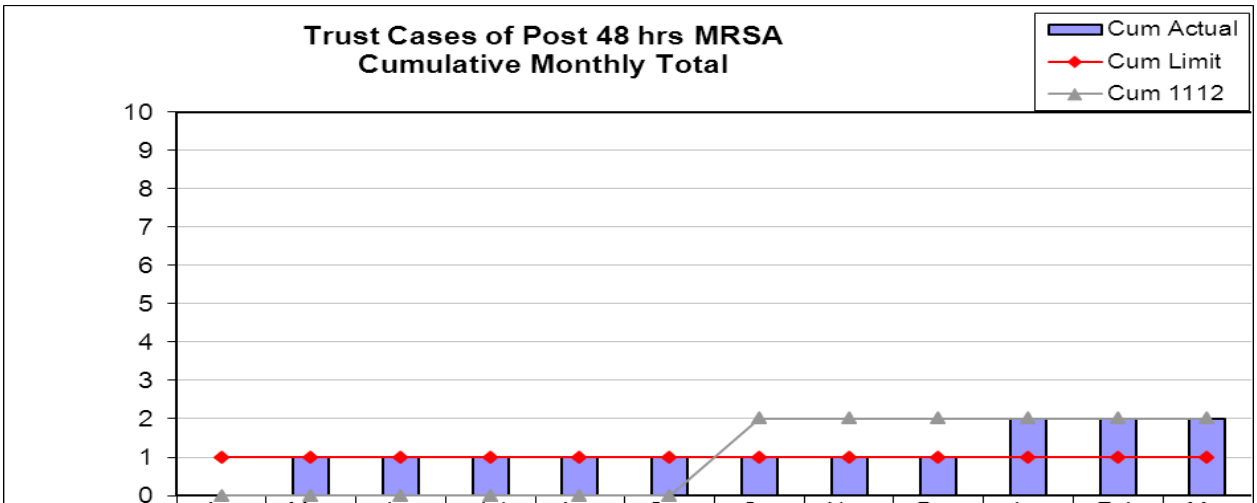
With this section we have reviewed our performance against key priorities that we set for last year and also other areas of quality performance.

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

PATIENT SAFETY
Reducing the number of avoidable healthcare associated infections
See key priorities for 2013/14

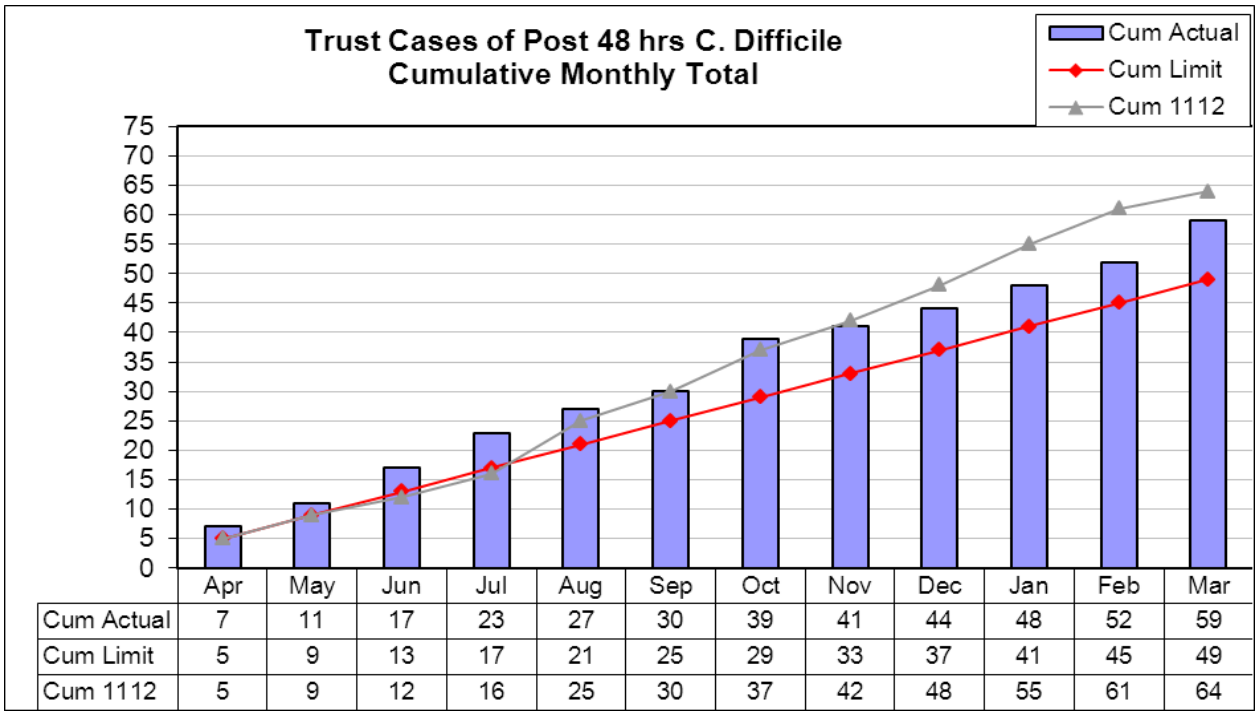
Our rates of C. difficile infection have continued to fall, however, in 2012/13 the Trust did breach the target that it had been set for the year. There has been a reduction in cases in each of the last three years and by 86% since 2006/7.
Our MRSA bacteraemia rate has plateaued in the last year with two cases again in 2012/13. The rate is down by 97% since 2003/4.

Infection Control – MRSA Cases – The Trust did not achieve this standard, with 2 cases of MRSA throughout the year against a maximum limit of 1 case. The number of cases in 2012-13 was the same as 2011-12.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	0	1	1	1	1	1	1	1	1	2	2	2
Cum Limit	1	1	1	1	1	1	1	1	1	1	1	1
Cum 1112	0	0	0	0	0	0	2	2	2	2	2	2

Infection Control – CDifficile Cases – The Trust did not achieve this standard of a maximum of 49 cases for the year. However, the number of CDifficile cases throughout 2012-13 was 5 fewer than the number reported for 2011-12

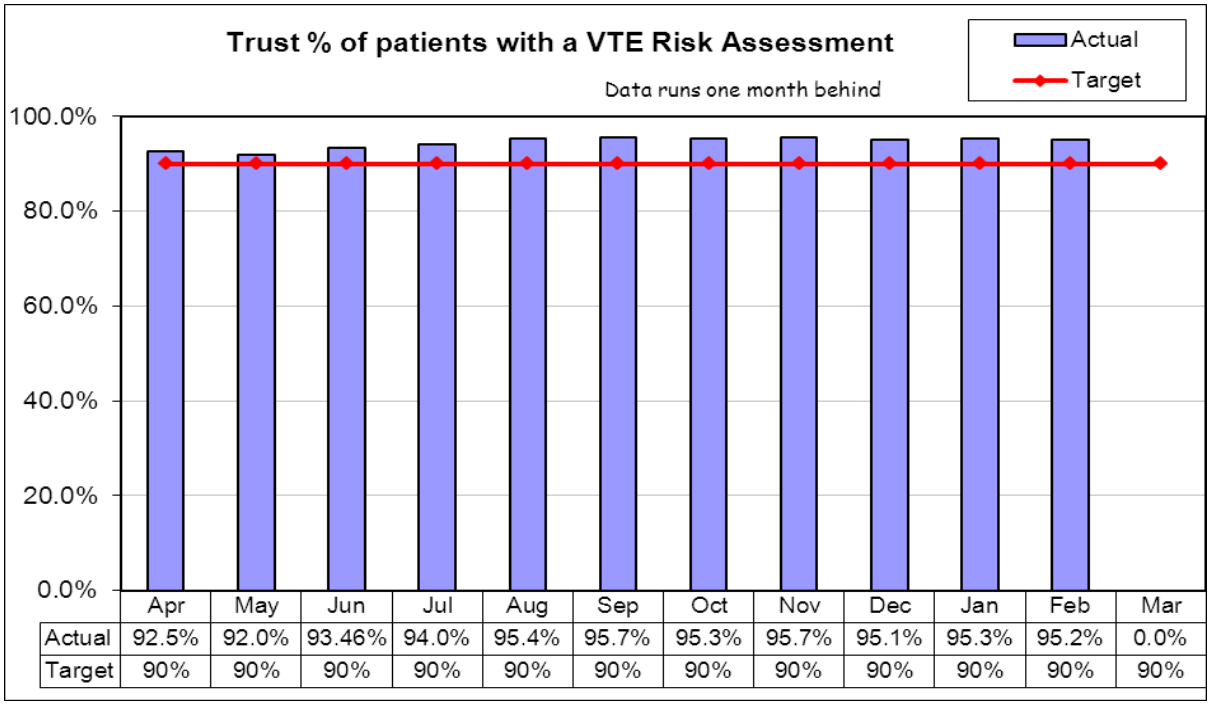


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	7	11	17	23	27	30	39	41	44	48	52	59
Cum Limit	5	9	13	17	21	25	29	33	37	41	45	49
Cum 1112	5	9	12	16	25	30	37	42	48	55	61	64

Prevention of blood clots or venous thromboembolism (VTE)

See key priorities for 2013/14

% Patients VTE Risk Assessment – The Trust is expected to have ensured that 90% of patients were given a VTE Risk Assessment in 2012-13.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	92.5%	92.0%	93.46%	94.0%	95.4%	95.7%	95.3%	95.7%	95.1%	95.3%	95.2%	0.0%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

MTW has been compliant with the national CQUIN goal for VTE that 90% of patients had been risk assessed and managed accordingly since August 2011 and with the local stretch target of 95% since August 2012.

Reducing the number of patient falls

See key priorities for 2013/14.

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

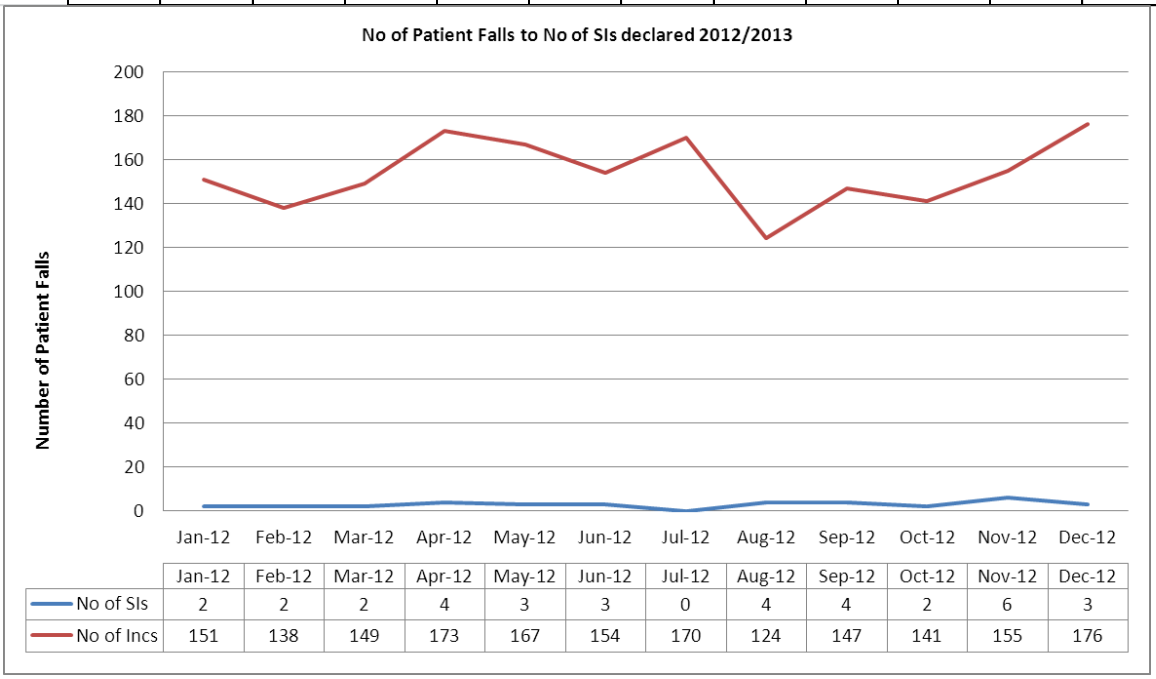
While we have not been able to see the 10% total in reduction that we had hoped for over the last year, part of the root cause analysis is to identify whether the fall was avoidable or unavoidable – we have seen a reduction in the number of avoidable falls.

The Trust has trained staff in falls prevention, introduced risk assessments and a falls car plan, and purchases appropriate aids. It has also been fortunate to receive funding from the League of Friends to purchase safety mats that alert staff when a patient at risk of falls stands up or tries to move from a safe place.

We will continue to build on the work that has been started in order to reduce this harm to patients and you will note that it is a key priority again for 2013/14.

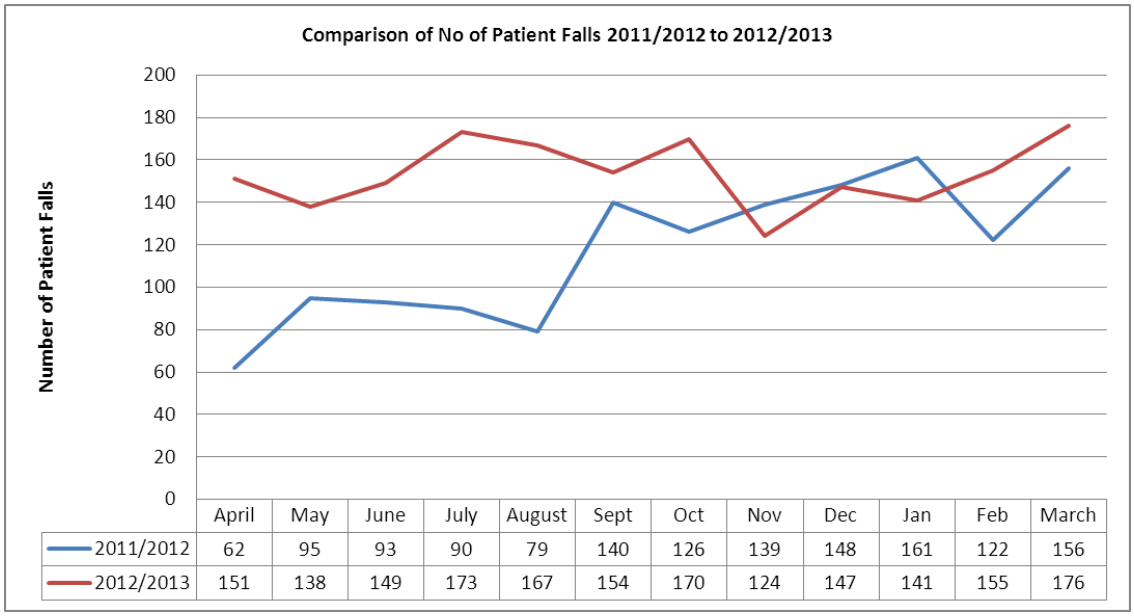
The below is the number of falls reported compared to the number of SIs declared for 2012/2013 – this will be all serious injuries following a fall not just fractures

	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
No of SIs	2	2	2	4	3	3	0	4	4	2	6	3
No of Incs	151	138	149	173	167	154	170	124	147	141	155	176



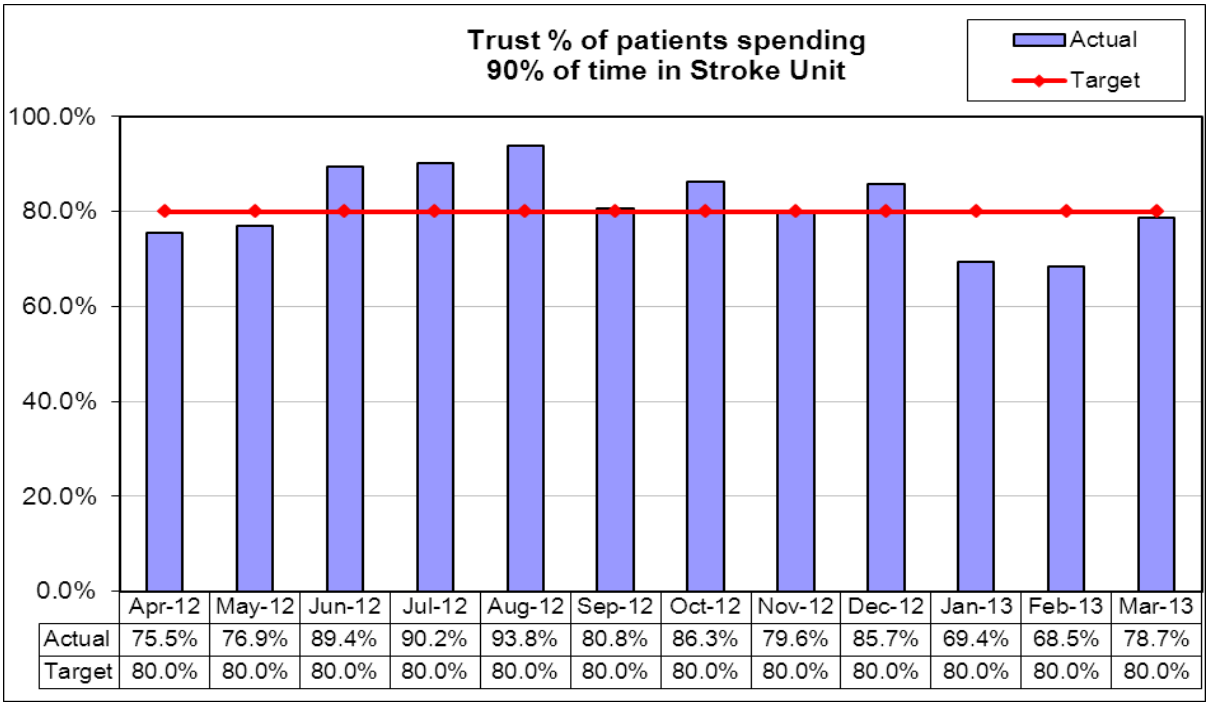
Below is the year on year comparison of the number of patient falls from 2011/12 to 2012/13:

	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
2011/2012	62	95	93	90	79	140	126	139	148	161	122	156
2012/2013	151	138	149	173	167	154	170	124	147	141	155	176

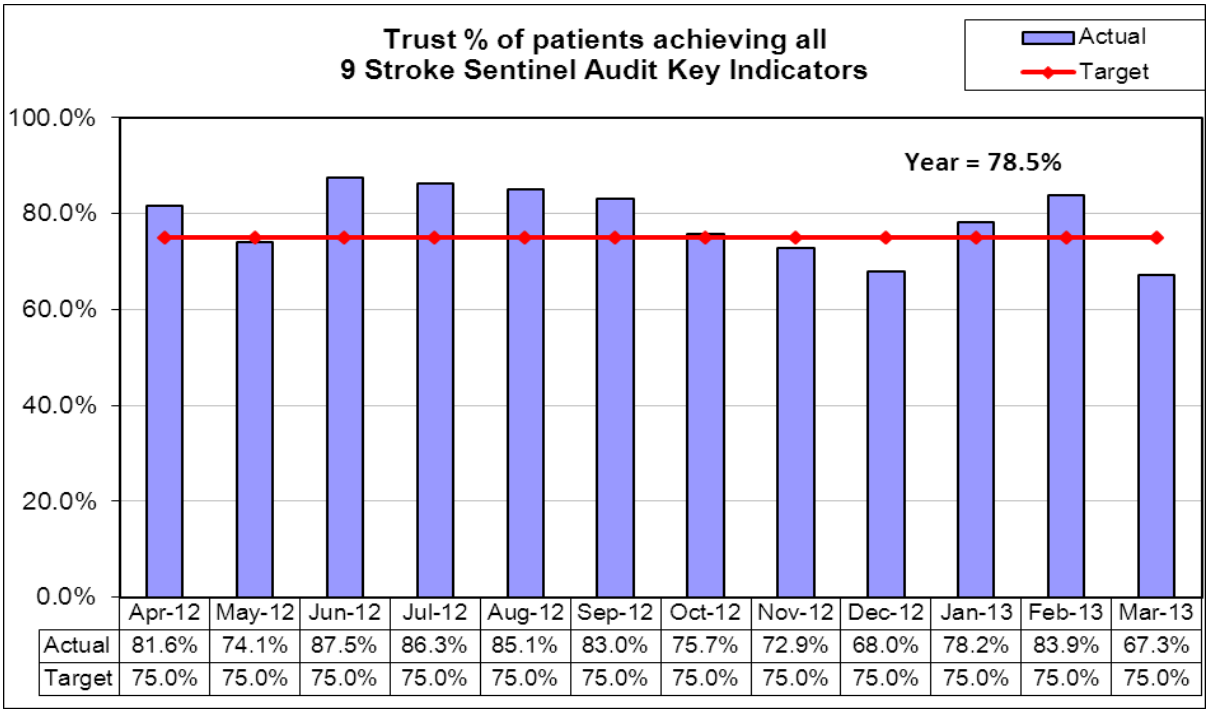


CLINICAL EFFECTIVENESS
Continue our focus on improving care for patients who have had a stroke

Stroke – The Trust did ensure that 80% of stroke patients spent 90% of their time on a dedicated stroke ward in 2012-13.



Stroke Sentinel Audit Indicators – The Trust did ensure that 75% of stroke patients achieved all 9 Key Sentinel Audit Indicators in 2012-13.



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Actual	81.6%	74.1%	87.5%	86.3%	85.1%	83.0%	75.7%	72.9%	68.0%	78.2%	83.9%	67.3%
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

A Clinical Nurse specialist has been appointed for stroke services who works across all Trust stroke services and sites. This has helped the Trust embed stroke pathways and meet standards for stroke care.

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

See Key priorities for 2013/14

The trust made considerable improvements within 2012/13 to ensure patients suffering from dementia receive the appropriate care. To facilitate some of the improvements a Lead nurse for dementia care was appointed.

Actions within the year have been to meet the quality initiatives set nationally and we met the CQUIN targets for this.

There has been a considerable amount of work commenced with community services and charities to help both the patients and their carers. We will continue to build upon this work during 2013/14.

Improving the management of discharge planning

See key priorities for 2013/14

The trust has taken a number of initiatives to improve discharge planning for out patients. This has included closer working with partner organisations in the community to ensure that patients receive appropriate care in the community following discharge. To enhance this multidisciplinary

approach there has also been further training for staff in relation to the required information sharing to facilitate the required care.
There is a county-wide strategic level group to support the multiagency working.

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

We have outlines a number of further actions to be taken in 2013/14 to further improve the process for patients which have been outlined in the key priorities.

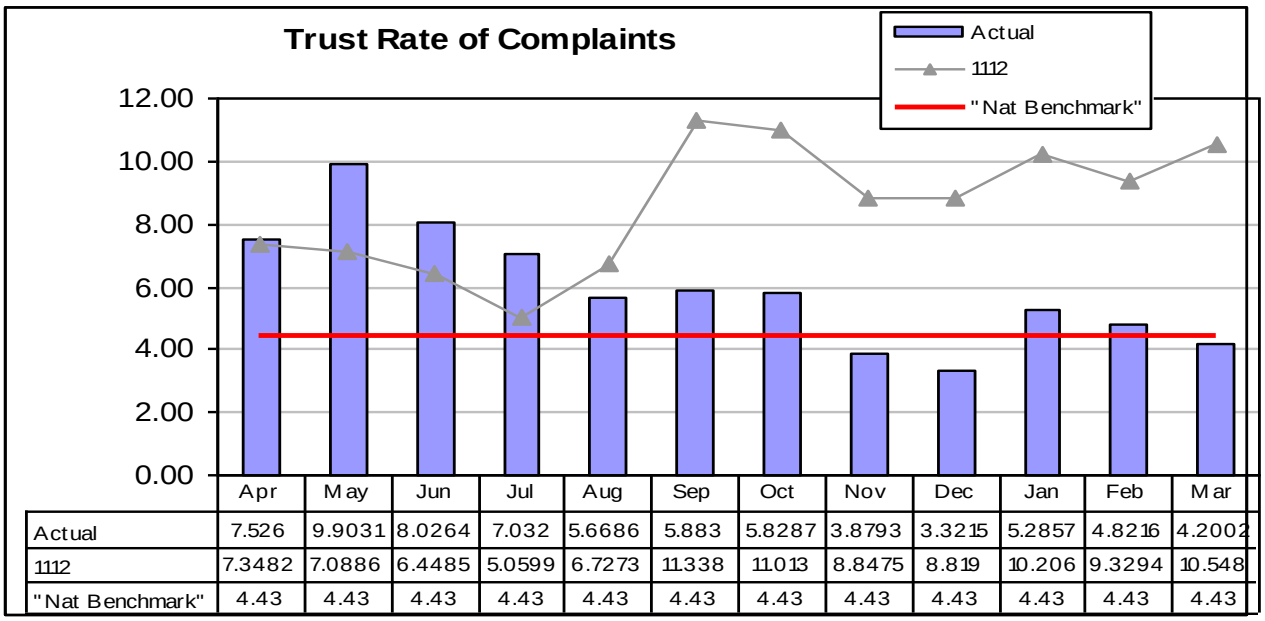
PATIENT EXPERIENCE

Complaints management

See key priorities for 2013/14

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

The complaints handling process has been revised over the last year with the positive impact that we are now managing complaints better. We surveyed a number of complainants over the last year and we have seen the satisfaction rate (Scores of 4 and 5 out of a scale up to 5) increase from 25.7% to 56.7%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	7.526	9.9031	8.0264	7.032	5.6686	5.883	5.8287	3.8793	3.3215	5.2857	4.8216	4.2002
1112	7.3482	7.0886	6.4485	5.0599	6.7273	11.338	11.013	8.8475	8.819	10.206	9.3294	10.548
"Nat Benchmark"	4.43	4.43	4.43	4.43	4.43	4.43	4.43	4.43	4.43	4.43	4.43	4.43

There is an action plan in place to further improve the service and ensure that we optimise the learning from complaints across the organisation.

Patient Surveys

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

- Surveys of patients have been started in the outpatient departments on both sites.

- Two surveys relating to enhancing quality measures for patients undergoing hip and knee surgery and those being treated for heart failure have been introduced.
- The Trust internet page is now able to be accessed by patients to record their opinions in line with the national “friends and family” initiative.
- The trust has also introduced the national friends and family question across all inpatient wards and A&E departments. In 2013/14 this will be reported to the trust Board for scrutiny alongside other survey results.

As stated in last year’s account we also aimed to improve the experience of patients across the organisation through focusing on key areas highlighted as requiring attention in the Inpatient, Outpatient and A&E national surveys. Below are the questions we focused on in each area and this years results are compared with those of the previous year where possible.

MTW Patient Satisfaction Survey - Outpatients Department
This was the first year we had carried out this audit locally in this way – it will now be repeated six monthly.

Focus Questions from Outpatient Survey		MTW Outpatient Departments	
		Yes	No
1	Were the signs to the Outpatient areas clear and easy to read?	97.1%	2.9%
2	Were the clinic rooms and facilities in the waiting area clean?	99.7%	0.3%
3	Was your appointment delayed?	43.3%	56.7%
4	If yes, were you kept informed?	59.7%	40.3%
5	Did the clinical staff in the department introduce themselves?	90.7%	9.3%
6	Did you feel that all our staff was polite and helpful?	99.1%	0.9%
7	Did the doctor/nurse give you time to express your concerns?	99.0%	1.0%
8	Did the doctor/nurse explain your treatment in a way that you understood?	98.9%	1.1%
9	Did you feel you were dealt with in a dignified and private manner?	99.0%	1.0%
10	If the clinician prescribed new medication was this fully explained?	96.2%	3.8%
11	Would you be happy for your friends and family to be treated here?	98.9%	1.2%

The main issue identified from the outpatient survey is regarding late running clinics. This can occur due to many reasons, which may be unavoidable. However, it is within our gift to improve our communication with the patients. Nurses now, not only keep patients informed of late running clinics, but endeavour to have more detail to offer with regard to the reason why and, if/when it will be rectified. The need for this change was due to feedback from patients and a formal procedure has been put in place.

Outpatient departments also act upon both verbal and written requests from patients for improvement to our service throughout the year. Below is a small sample of less noticeable, but equally important, changes made over the last few months:-

- All nurses and reception staff wear a visible name badge – patients felt this was more welcoming.
- Nurses are able to give more detail to the patients when/if clinics are running late.
- Suggestion box available for patients.
- Internal signage to improve location of services within OPD for patients.

- Improved access for wheelchair users and companions.
- Improved access to Information and Guidance leaflets within the OPD's.

National Emergency Department Survey 2012

Focus questions from National Emergency Department Survey		National Emergency Department Survey	
		2012	2008
1	How long did you wait before you first spoke to a nurse or doctor? *(The response is for people that waited less than 60 minutes)*	86.0%	84.1%
2	While you were in the A&E department did a doctor or nurse explain your condition and treatment in a way that you could understand?	87.5%	89.1%
3	If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	82.4%	60.5%
4	While you were in the A&E department how much information about your condition or treatment was given to you?	73.4%	79.0%
5	Do you think the hospital staff did everything they could to help control your pain?	71.5%	79.8%
6	Did a member of staff explain the purpose of the medications you were to take at home in a way that you could understand?	97.7%	90.4%
7	Did a member of staff tell you about medication side effects to watch for?	55.1%	49.5%

Compared to the previous survey undertaken in 2008, we have improved in the following areas:

- The A&E department was clean
- The A&E department toilets were clean
- The patients felt that they were given enough privacy when being examined
- The patients were given enough privacy when discussing their condition with the receptionist

An action plan is in place to address areas for improvement within the A&E departments

National Inpatient Survey 2012

Focus questions from National Inpatient Survey		National Inpatient Survey	
		2012	2011
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	88.9%	86.8%
2	Did you find someone on the hospital staff to talk to about your worries and fears?	44.3%	51.7%
3	Were you given enough privacy when discussing your condition or treatment	97.7%	91.2%
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	36.5%	35.0%
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	65.3%	58.7%

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

There are ongoing actions to improve the services we offer and we welcome the feedback. One of the questions we continue to score poorly on is in relation to patients receiving enough information about medication that they are taking. This is a Kent-wide issue and a county wide working group has been set up to try to address this issue.

The Trust introduced the Family and Friends test into its real-time patient feedback system on 1st July 2012. In the nine months up to 31st March 2013, 4,144 patients were asked if they would recommend the Trust to friends and family. 95.22% of patients surveyed said they would be likely to extremely likely to do so.

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

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

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

- Trust wide action plans are in place and routinely updated for the prevention of falls, pressure ulcers and VTE
- Changes to pathways in A&E for the management of pregnant women admitted who are not registered with a GP
- Management of patients with testicular pain to ensure no delay in review
- New and revised guidelines, for example, Treat and transfer policy
- New guidance for reviewing and reporting results in radiology
- Identified areas for further training
- New patient tracking system for key results within ophthalmology
- Timescales set for referral to and review by specialty teams

Never Events: these are a nationally agreed list serious incidents.
The Trust has had no “never events” to report this year.

Other Quality Monitoring and Improvement Measures

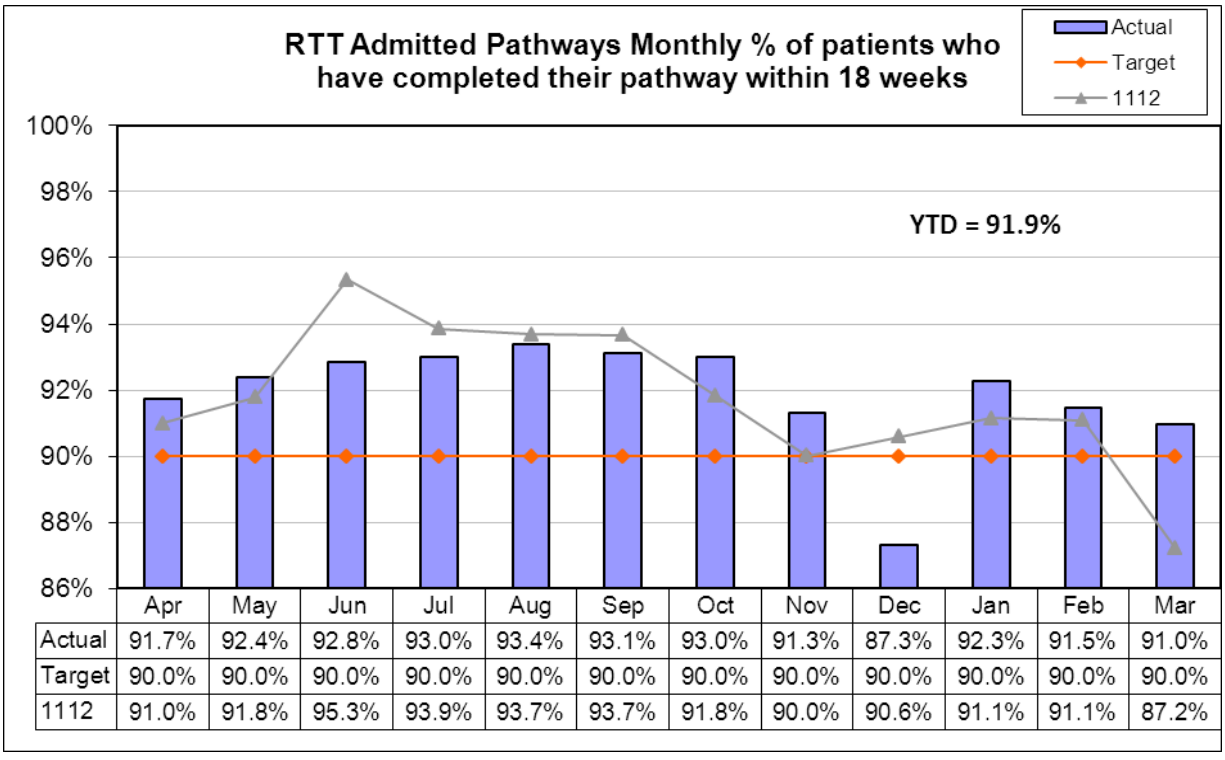
Maidstone and Tunbridge Wells NHS Trust met the majority of national waiting time standards in 2012-13. These are designed to ensure patients are seen appropriately according to their clinical need.

The Trust's overall performance is measured against 70 local and national standards on a monthly basis. These results are shared with commissioners of local health services and are discussed by the Trust Board at its public meetings.

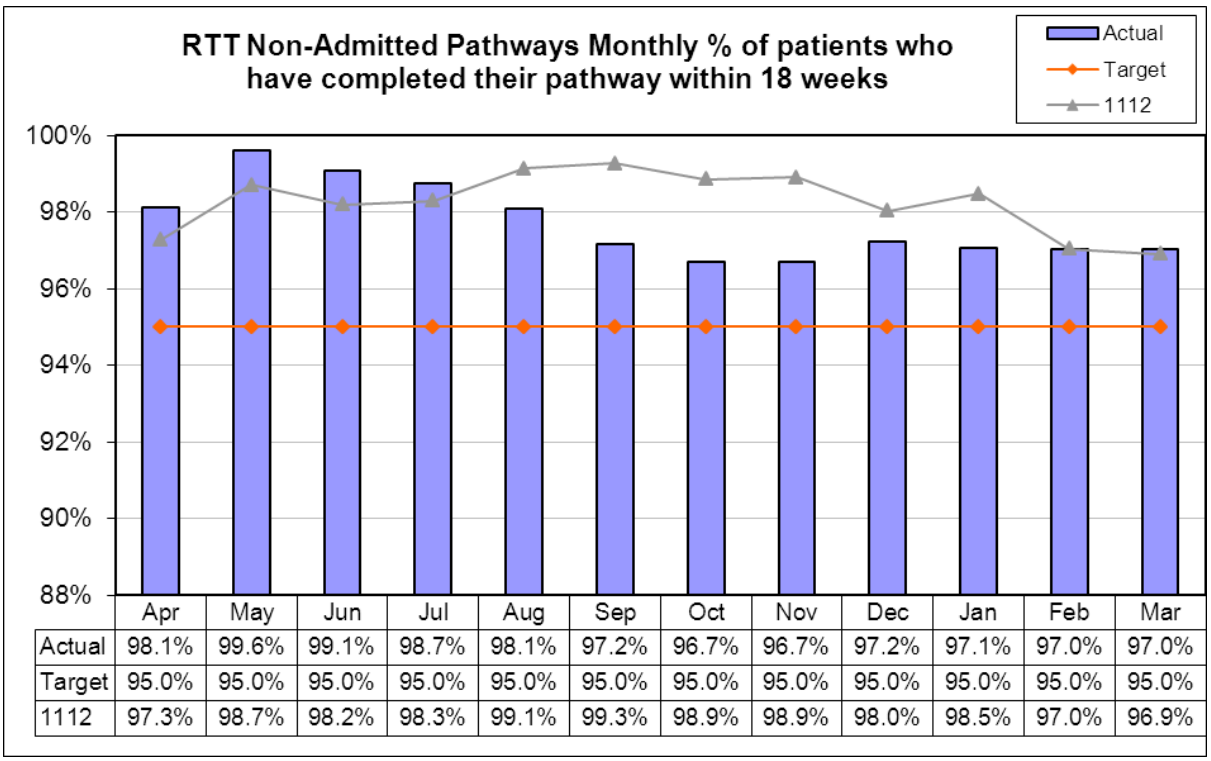
A summary of the Trust's overall performance in all local and national standards for 2012/13 will be available to view on the Trust's website in May 2013 – www.mtw.nhs.uk a summary of the Trust's overall performance for the 11 months up to February 2013 is available on the website now.

The Trust made improvements in care for key conditions such as Stroke and VTE and met all of its CQUIN care indicators. However emergency services remained under pressure for most of the year making it difficult to achieve the four hour target for patients treated in A&E. This is partially due to the high level of patients whose discharge was delayed which reduced the number of beds available to admit patients.

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

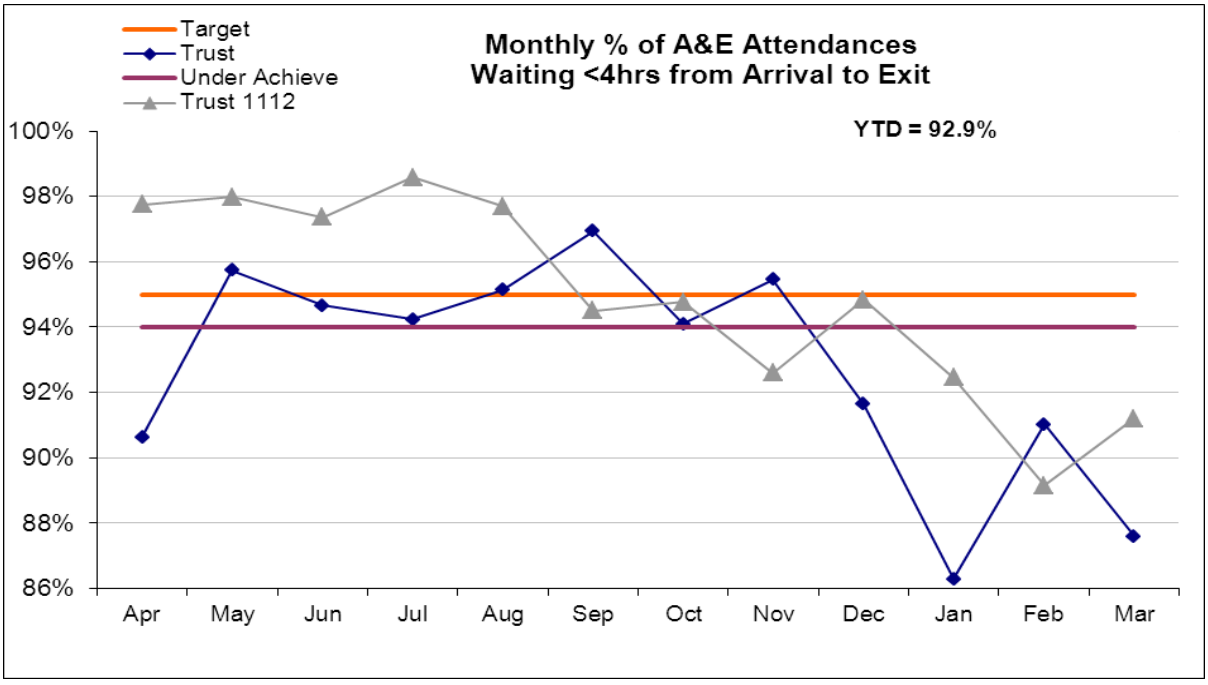


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	91.7%	92.4%	92.8%	93.0%	93.4%	93.1%	93.0%	91.3%	87.3%	92.3%	91.5%	91.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
1112	91.0%	91.8%	95.3%	93.9%	93.7%	93.7%	91.8%	90.0%	90.6%	91.1%	91.1%	87.2%

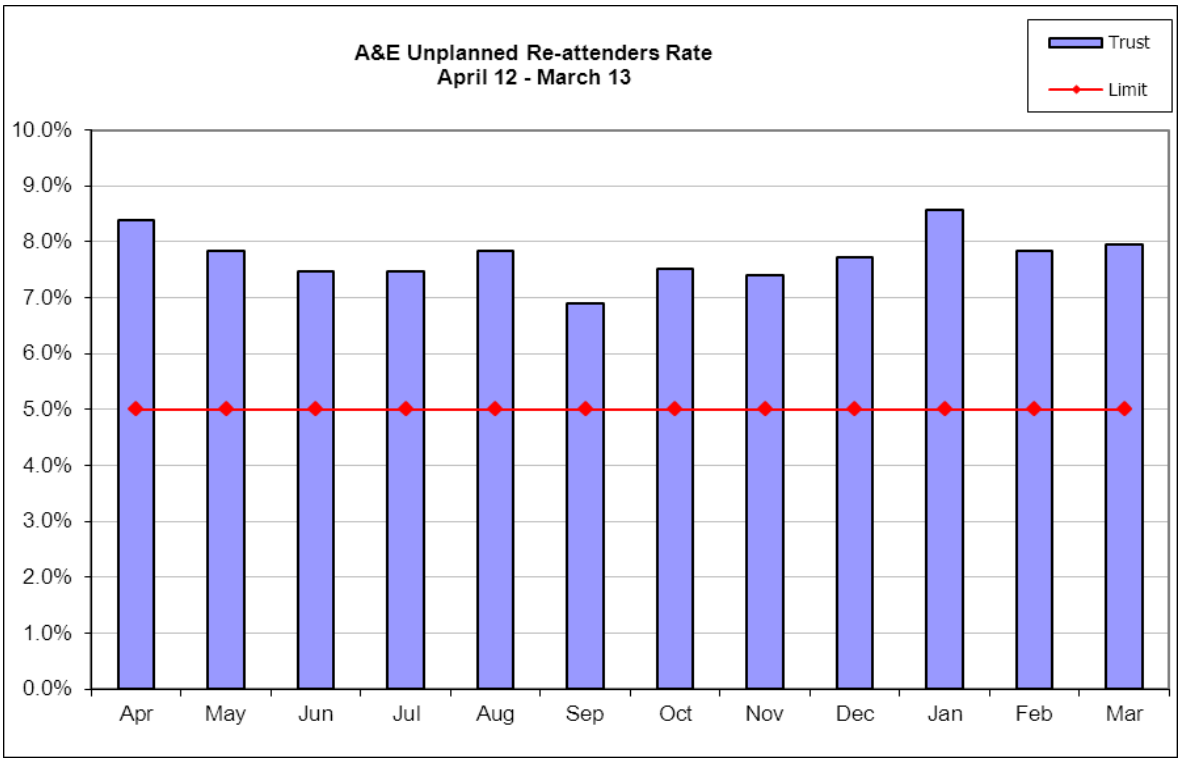


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	98.1%	99.6%	99.1%	98.7%	98.1%	97.2%	96.7%	96.7%	97.2%	97.1%	97.0%	97.0%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
1112	97.3%	98.7%	98.2%	98.3%	99.1%	99.3%	98.9%	98.9%	98.0%	98.5%	97.0%	96.9%

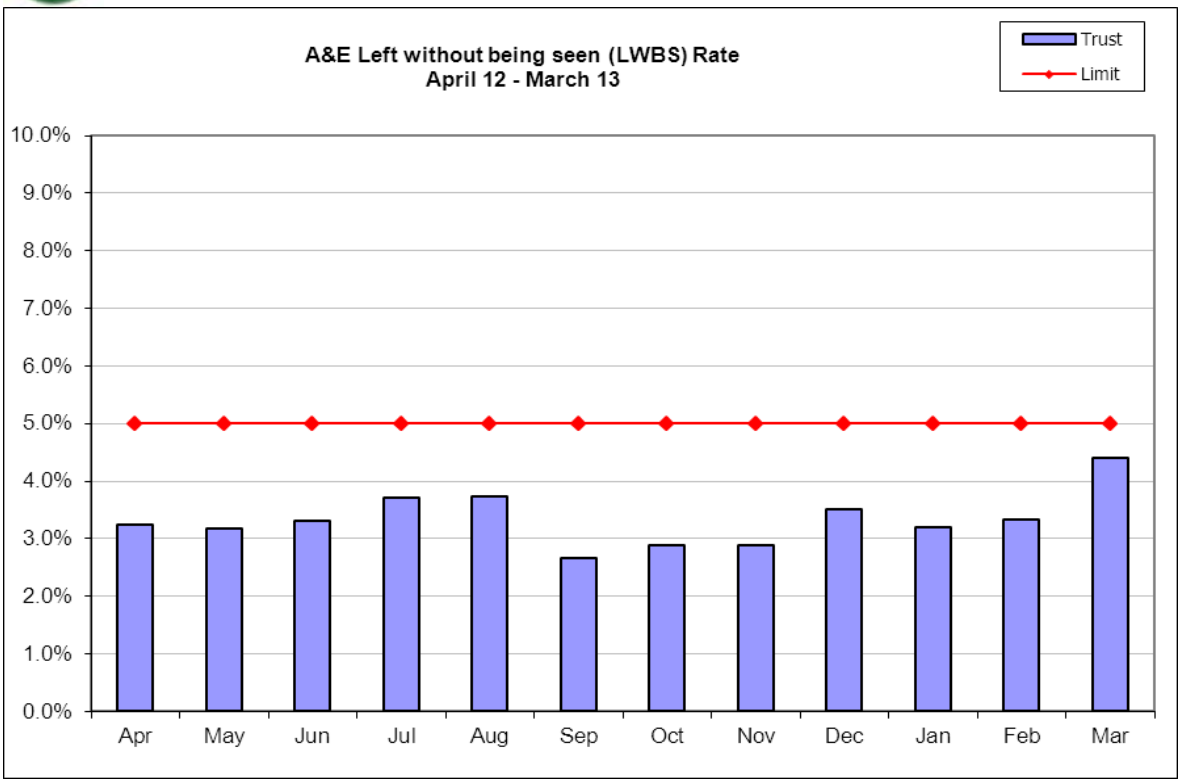
Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2012-13 at 92.9%.



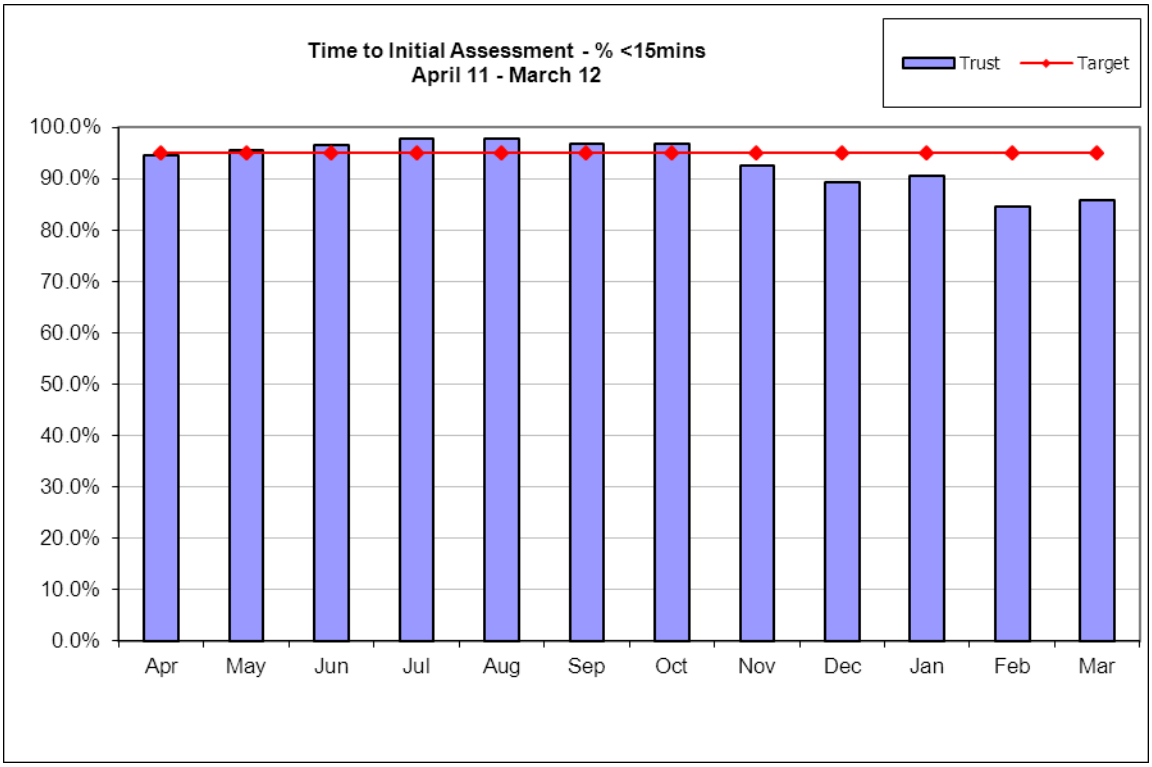
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate.



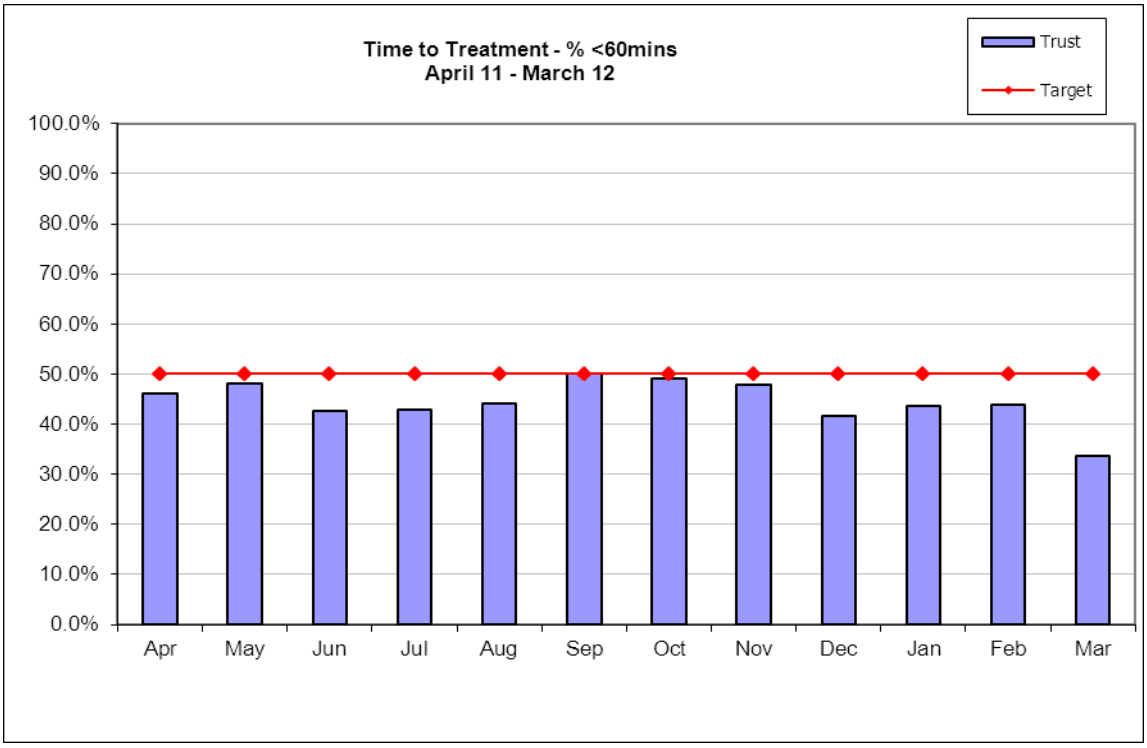
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen.



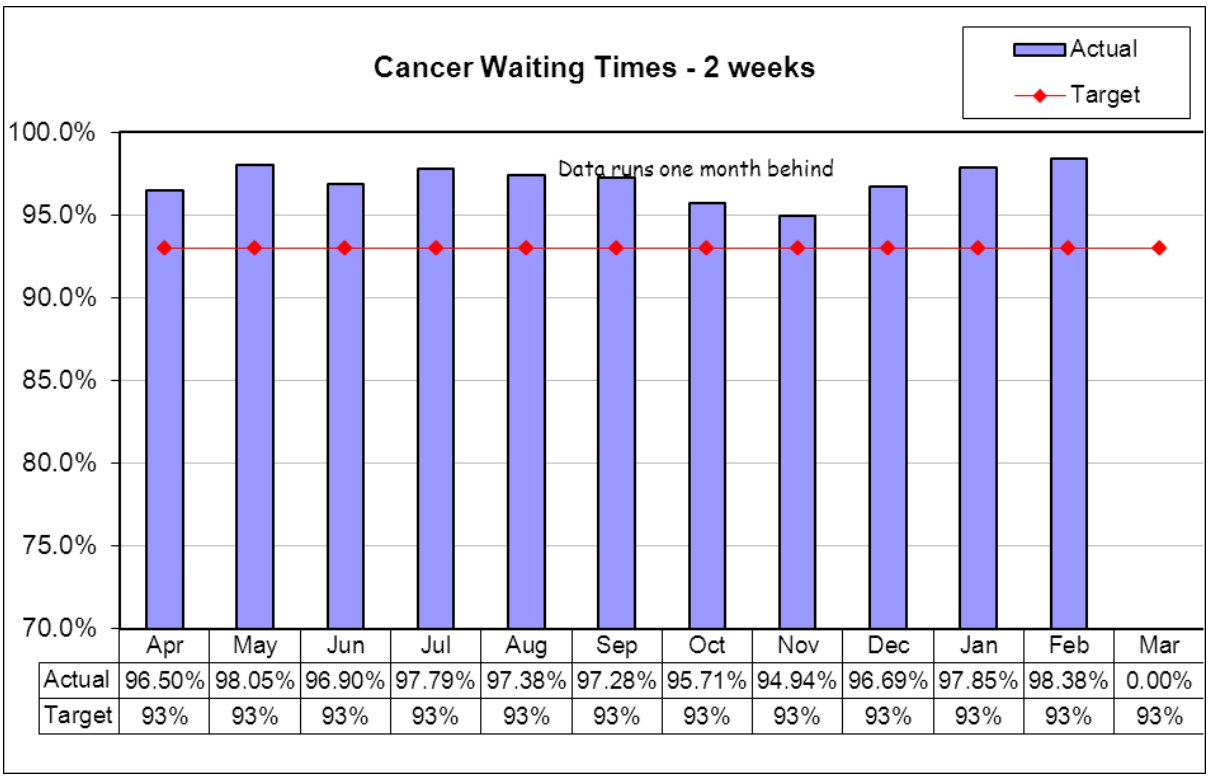
A&E Time to Initial Assessment <15 minutes – The Trust did not achieve this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



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

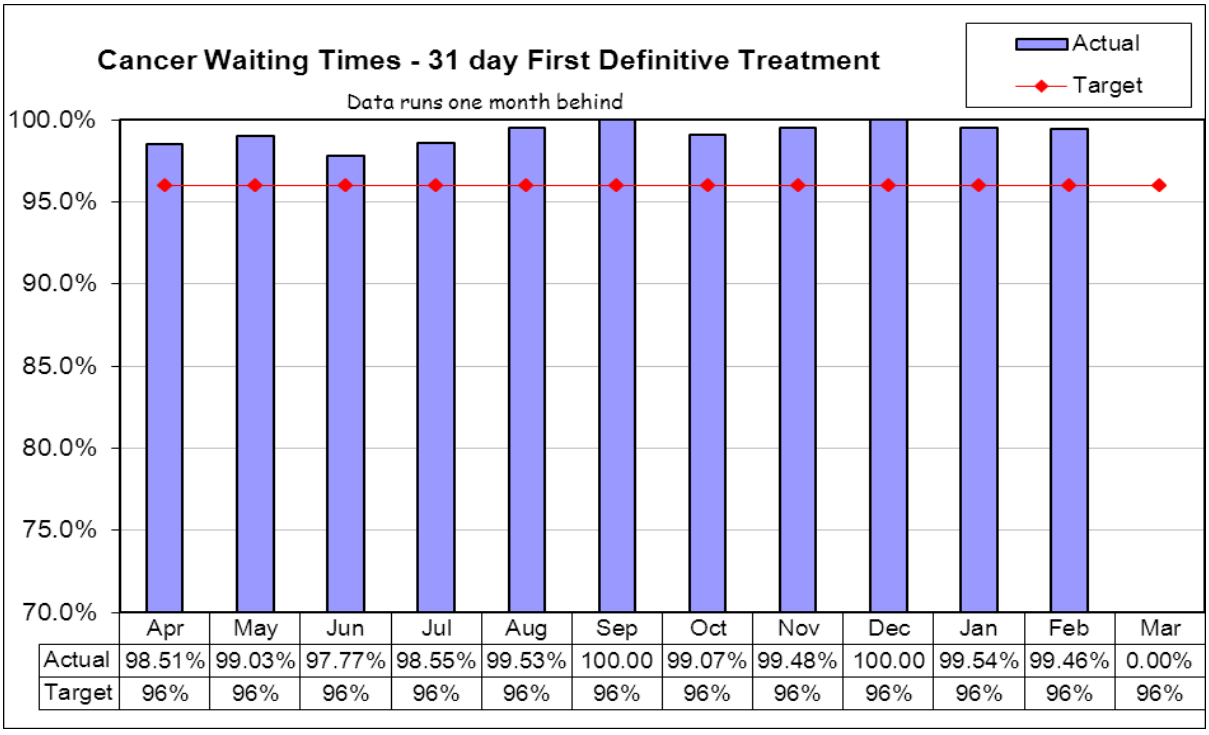


Cancer Waiting Time Targets - 2 weeks from referral – The Trust is expecting to achieve this standard ensuring that 93% of patients with suspected cancer were seen within two weeks.



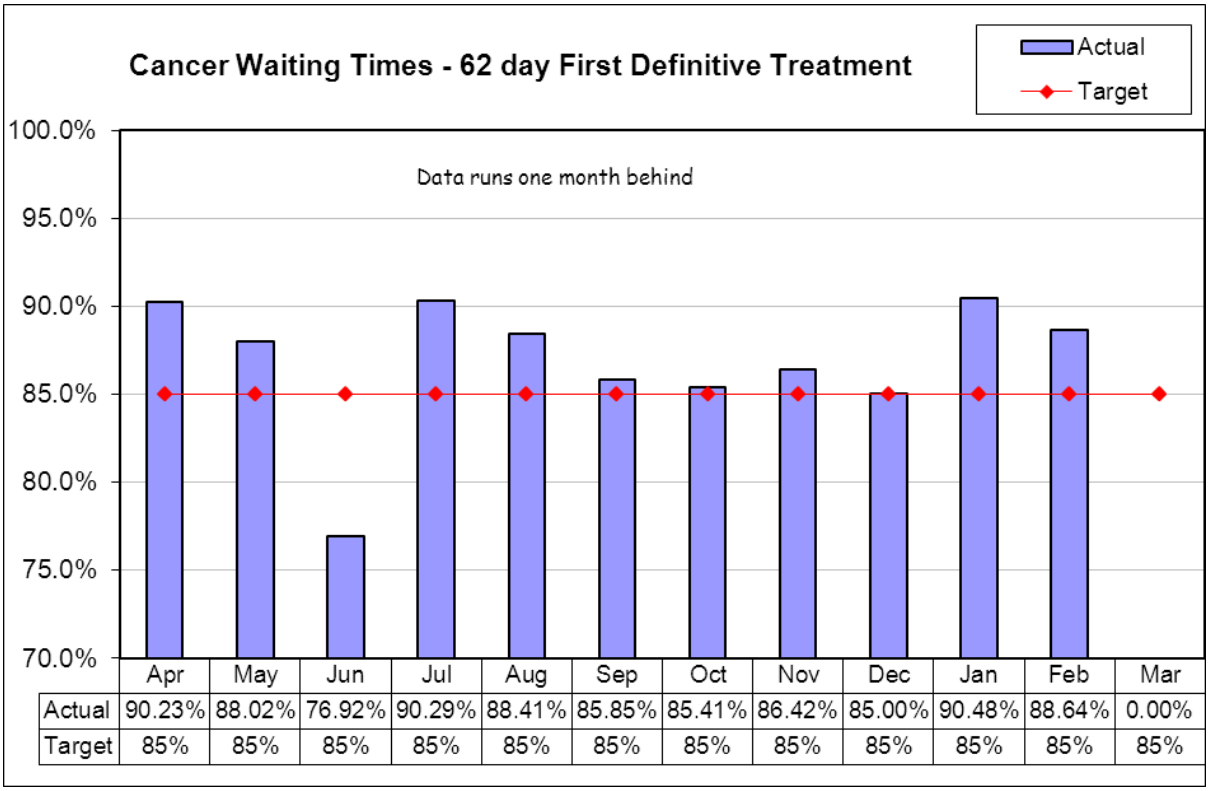
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.50%	98.05%	96.90%	97.79%	97.38%	97.28%	95.71%	94.94%	96.69%	97.85%	98.38%	0.00%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

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



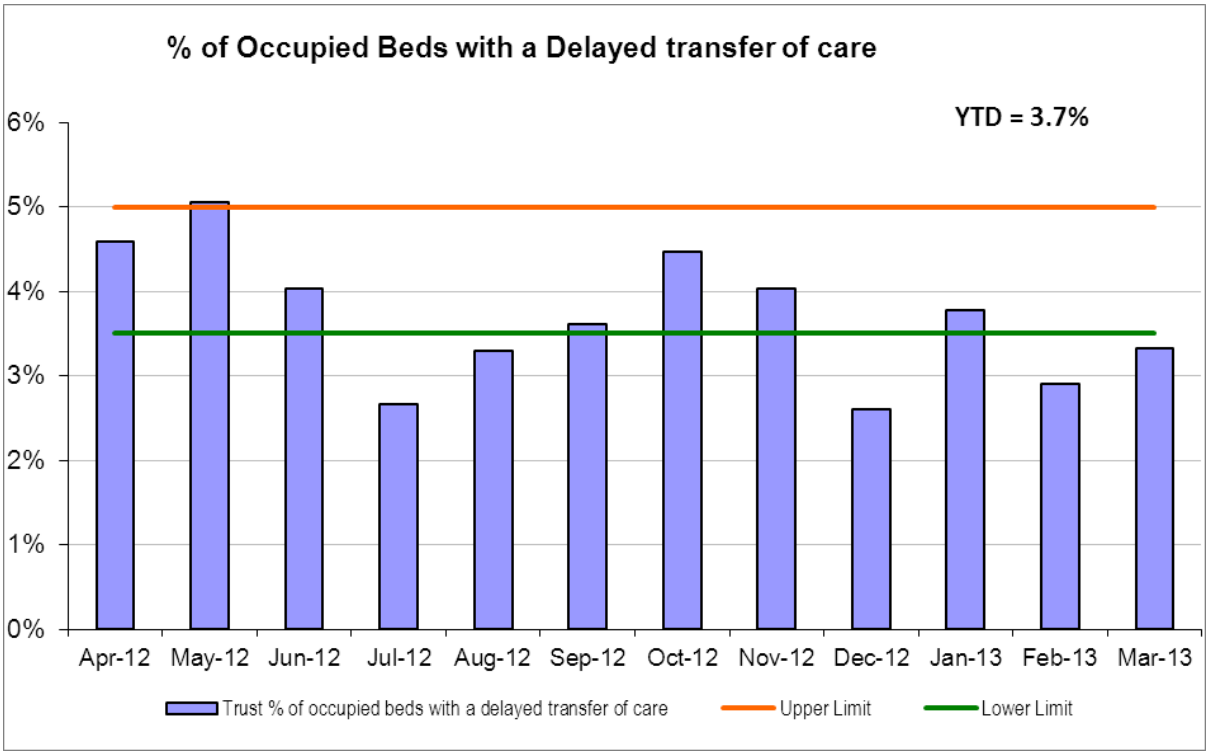
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	98.51%	99.03%	97.77%	98.55%	99.53%	100.00	99.07%	99.48%	100.00	99.54%	99.46%	0.00%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust is expected to achieve this standard ensuring that 85% of patients who needed to start their first definitive treatment within 62 days

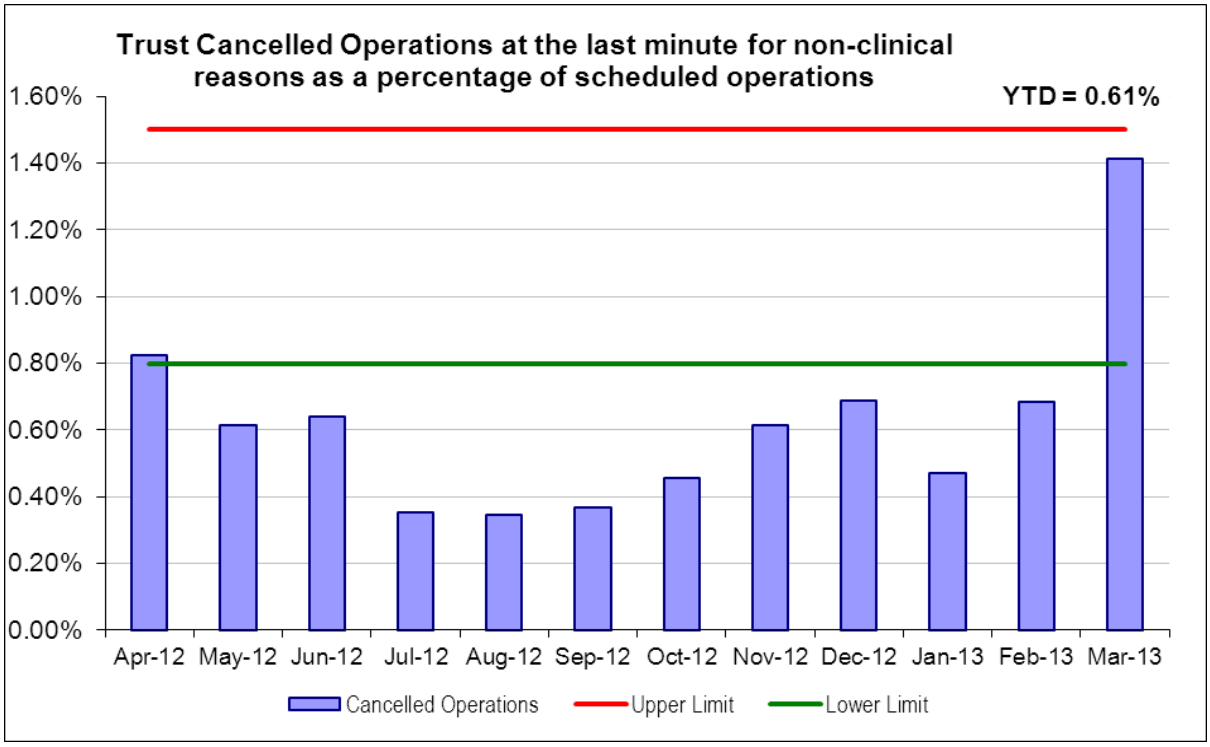


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	90.23%	88.02%	76.92%	90.29%	88.41%	85.85%	85.41%	86.42%	85.00%	90.48%	88.64%	0.00%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

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 3.7%.



Cancelled operations – The Trust achieved the cancelled operations national standard of 0.8% for the fourth 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 (PBR Audit) 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 boards assurance processes. This is over and above the indicators audited as part of the audit of these quality accounts.

The NHS Outcomes framework has 5 domains:

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

Domain	Prescribed data requirements **The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to —**	2011/2012	2012/2013 local and national data	2012/2013 National average
1 & 2	(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.	101.26 Oct 10 to Sept 11	98.2 Oct 11 – Sept 12 *(Better)*	National average is 100
3	the Trust's patient reported outcome measures scores for:			
	i) groin hernia surgery	0.070	0.102	0.085
	ii) varicose vein surgery	N/A	N/A	0.225
	iii) hip replacement surgery	0.428	0.407	0.405
	iv) knee replacement surgery	0.317	0.318	0.299
	during the reporting period *(See below for explanation of reporting data)*			
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.***1**	**Trust** 10.5% **Elective** 5.7% **Non-Elective** 11.8%	**Trust** 10.9% **Elective** 5.7% **Non-Elective** 12.8%	**Elective:** 6.62% **Non-Elective** 13.21% (Q3 12/13 position)
4	The trust's responsiveness to the personal needs of its patients during the reporting period. (Based on the five key questions in the inpatient survey relating to CQUINS)	63.1	66.4	National Aggregate figures TBC
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.	3.62	3.70	3.57 (1 = unlikely to recommend & 5 = likely to recommend)
5	the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	85%	Q1 92.6% Q2 95% Q3 95.4% Q4 95.2% ***2**	93.7 (Dec 2012)
5	the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	26.5	25.8 ***3**	21.8
5	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	0.65% (published data)	1.4%***4** 0.97% (Q1and Q2 published data)	

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

Explanation re PROMS:
A patient reported outcome measure 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 – 67 returns of which 27 reported an improvement on lifestyle following the operation (improvement Health Gain factor of 0.102)
Hip Replacement – 123 returns of which 108 reported an improvement in lifestyle (11.159 factor improvement).
Knee Replacement – 115 returns of which 92 reported an improvement in lifestyle (0.318 factor improvement)
Varicose Vein – insufficient number of questionnaires returned to be able to quantify the data.

In comparison with the National Report (2010/2011 are latest available finalised statistics)
For Groin Hernias – MTW is better than the England average improvements
For Hip Replacement – MTW was slightly better than the England average
For Knee Replacement – MTW was better than the England average
For Varicose Vein – low number of returns so not comparable

Explanation re incidents
The proportion of patient safety incidents which resulted in severe harm or death for 2012/13 was 1.4%. 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 reported to the National Patient Safety Agency (5417).

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 2013 and covering the period of 01/04/12 to 30/09/12 provided a reporting rate of 5.8 incidents reported per 100 admissions for Maidstone and Tunbridge Wells NHS. This placed the Trust within the middle 50% of reporters.

The previous report covering the period of 01/10/11 to 31/03/12 provided MTW with a reporting rate of 4.7 incidents per 100 admissions placing the Trust in the lowest 25% of reporters.

The March 2013 report from the NRLS provided MTW with a reporting rate of 0.9% of incidents leading to severe harm and death. The reporting rate of 'all large acute organisations' in the same report was 0.7%.

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

Mortality data – we continue to review this bi-monthly at the trust's Standards Committee which is chaired by the medical Director.

PROMS - performance is measured monthly. Ongoing work is in place to review the performance in relation to compliance with best practice guidelines. Further work is to be implemented in the coming year, together with the national centre, to review in greater detail, and respond to the patient reports about their outcomes. Some of this is related to a CQUIN target.

We have a rolling programme of audits to ensure 3 key indicators are reviewed every year in relation to C difficile, 18 week referral to treatment and A&E 4 hour waits, in addition to the external auditors have reviewed VTE and incident data.

In addition data in relation to the stroke and dementia care CQUIN targets are subject to monthly revalidation checks internally.

Within 2013/14 we have a process by which we will be using information from the Safety thermometer to cross-check key performance indicators to ensure data quality.

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

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

Additional areas of significant improvement during 2012/13

Radiology Services – The Trust's Radiology teams have increased the number of day-case procedures carried out, resulting in fewer patients requiring an overnight stay in hospital. This has reduced delays in treatment times, reduced the risk of infection and enables patients to go home sooner.

Food and nutrition – The Trust has continued to focus on ensuring patients' food and nutrition needs are adequately met. Red tray and protected meal times continues to be established. New supplies of assisted cutlery and additional aids have also been purchased that are easier for patients to use.

Providing same sex accommodation – The Trust has seen a major improvement in single sex accommodation breaches. The Trust had 14 breaches in the 11 months up to February 2013 (data for March to follow), compared with 1,600 breaches up to same point the previous year. A breach is defined by the admitting of a patient into a bay or sleeping areas shared by patients of the opposite sex. A bay of six beds with five women and one man would be counted as six breaches; the individual `causing' the breach plus those individuals who are subsequently affected. The 14 breaches in 2012/13 were made up of three separate incidents.

Francis Report
The Trust developed a six-point action plan in 2012/13 in response to the Francis Report. The actions have been shared widely with staff and will continue to be implemented during 2013/14. The Trust's actions are:

- To ensure all staff wear name badges at all times
- To use more patient comments to inform service developments
- To make it easier for patients to escalate issues
- To improve the Trust's multi-disciplinary ward rounds
- To provide greater focus on staff behaviour and delivery of the Trust's PRIDE values
- To re-launch the Trust's whistleblowing policy.

Part 4
Appendices A, B and C

Appendix A

National Audits for quality accounts (Not submitted)
Reasons why data not submitted

Elective surgery (National PROMs Programme)	Data not submitted as data collection method had been redesigned to cover all specialties to enable a more robust clinical outcome report. Will participate in 2013/14 audit.

47 National reports were published in 2012/13 with action to be taken in 2012/13

National Annual reports published March 2012 - April 2013	Report Received	
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP)	Y	Staff training sessions have been put in place (nursing and medical) to ensue that babies <28 weeks gestation have their temperature taken within the first hour of birth. A nurse has been identified to check records of all Babies <1501g or gestational age at birth <32 weeks to ensure they have a 1st retinopathy of prematurity screening booked.
Children		
Paediatric Diabetes (PNDA)	Y	Report received February 2013. Action plan being developed.
Childhood Epilepsy (Epilepsy 12)	Y	12 lead ECG to be done for all children with convulsive seizures. A business case has been written and submitted for an Epilepsy Specialist Nurse.
Paediatric Pneumonia	Y	A Senior review of antibiotic route on every ward round with increased use of the oral route. More judicious allocation of IV antibiotic therapy in Community Acquired Pneumonia to be developed.
A&E Medicine		
CEM Severe sepsis & septic shock	Y	Department handbook to be updated to contain standards on urinary catheterisation and output measurements. New training for nurses to improve documentation of observations.
CEM Pain Management in Children	Y	Report received and with Division for action plan development.
Audit of Consultant Sign off in Emergency Departments 2011	Y	Directive to be disseminated to all A&E staff and Jnr. Doctors training sessions to ensure patients attending A&E are seen / discussed with senior doctor prior to their discharge.
Adult community acquired pneumonia	Y	Chest X-rays to be prioritised by Radiology. Pilot scheme is in place to allow nurses to request chest x-rays. Doctors to receive training on compliance with CURB65 scoring and appropriate use of antibiotics. Patients with a high predicted mortality to be discussed with the critical care team.

Emergency use of Oxygen	Y	Report due December 2012. With specialty for action planning.
Non-invasive ventilation – adults	Y	Report Received June 2012. Formal education in place for A&E and general medical junior doctors regarding the investigations required for Acute asthma admissions. Respiratory Nurses to liaise with admitting teams to ensure all patients are referred to the Respiratory team for review. Patients to be reviewed by middle grade or consultants prior to their discharge to check their Preventer inhaler therapy.
Sentinel Stroke Audit (SINAP)	NA	Report due March 2013 (Not available on website)
Adult Asthma	Y	Received February 2013.
BTS Bronchiectasis	Y	Received March 2013. With specialty for Action planning.
Long Term Conditions		
Chronic Obstructive Pulmonary Disease Discharge Audit 2012	Y	Business case being developed to increase respiratory physiologist hours to allow for increased numbers of spirometry tests.
National Adult Diabetes Audit	Y	Although the trust did not submit data for this national audit due to lack of software (Diabeta3), the report and recommendations were reviewed and assessed. The trusts practice was fully compliant with all the recommendations made.
Adult Diabetes Inpatient Audit (NaDIA)	Y	Guidelines for the management of Inpatient hypoglycaemia have been developed and made readily available. Hypo boxes are now in place on all wards to treat patients who develop hypoglycaemic episodes. Blood ketone testing training to be undertaken with current nursing staff.
National Parkinson's Disease	Y	Received June 2012. With specialty for Action planning.
Chronic Pain (National Pain Audit)	Y	(Phase 2+3) Received January 2013. With specialty for action planning.
Elective Procedures		
Coronary Angioplasty	Y	Received September 2012. With specialty for action planning.
National Joint Registry (Hip, knee and ankle replacements.) NJR	Y	Patients with metal on metal prosthesis will now receive annual follow ups.
Adult Critical Care Case Mix Programme (ICNARC) (Round 1)	Y	December 12. With specialty for Action planning.
Cardiovascular Disease		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	Report Received December 2012. Action plan development
National Cardiac Rehabilitation Audit	Y	Liaising with Kent Community Health for additional funding to support post-discharge rehab programmes and to improve access for additional groups of patients. Develop a business plan to fund home-based exercise courses for patients who are unable to attend sports centres. Pharmacists, Occupational therapist and psychologists to be involved inpatient health education sessions.
Cardiac Arrhythmia	Y	December 2012. With specialty for Action planning.
Coronary angioplasty	Y	Received September 2012. Action planning.

Heart Failure Audit	Y	December 2012. With specialty for Action planning.
Cardiac Arrest (National Cardiac Arrest Audit)	Y	Quarterly denominator reports received and reviewed by the trusts Resuscitation Committee and then reported up to Standards Committee.
Cancer		
Bowel Cancer (National Bowel Cancer audit Programme)	Y	November 2012. With specialty for Action planning.
Head & Neck Cancer (DAHNO)	Y	June 2012. With specialty for Action planning.
Lung Cancer (National Lung Cancer Audit)	Y	November 12. With specialty for Action planning.
Oesophago-gastric cancer (NAOCG)	Y	December 2012. With specialty for Action planning.
Trauma		
Severe Trauma (Trauma Audit & Research Network) TARN	Y	October 2012. Report reviewed by specialty. No actions due to small numbers submitted due to staffing issues. A staff member has been appointed to ensure full submission in 12-13 and provide more robust information for MTW.
Hip Fracture (National Hip Fracture Database) (NHFD)	Y	September 2012. With specialty for Action planning.
Heavy Menstrual Bleeding Audit		July 2012. Report disseminated to division. National figures only, not site specific.
Blood transfusion		
'O' Neg blood use "Medical Use of Blood" (National Comparative Audit of Blood Transfusion)	Y	Autumn 2012 Action Planning. Delayed due to lack of staff to review report.
Platelet use "Bedside Transfusion" (National Comparative Audit of Blood Transfusion)	Y	May 2012. Action Planning. Delayed due to lack of staff to review report.
Blood Sampling and Labelling	Y	October 2012 Action Planning. Delayed due to lack of staff to review report.
Potential Donor Audit (NHS Blood & Transplant)	Y	Action taken to link with the critical care unit's Practice Development Nurses and outreach team to establish, implement and evaluate an education strategy for organ donation within the trust and build relationships with clinical staff.
Sexual Health		
National HIV Patient Outcomes Survey: Provision of psychological care and adherence to support.	Y	Received December 2012. With specialty for Action planning.
British Association of Sexual Health and HIV national audit "STI Management Standards".	Y	Received January 2013. With specialty for Action planning.
Patient Surveys		
National Emergency Department Survey	Y	Received December 2012. With the specialty for review and action plan development.
National Cancer Patient Experience Survey	Y	Received August 2012. Report has been circulated across the Directorate and Trust. Report findings have been presented to Cancer Board, Senior Management, and Patient Experience Committee. Action Plan is currently being developed and will then go to Board/Directorate Level for approval.
National Radiotherapy Access Survey	Y	Report currently being reviewed by the Directorate. An action plan will then be developed.

National Radiotherapy Patient Experience Survey	Y	The results of the report were shared with the Directorate. A resume was sent to the Chief Executive for inclusion in the trusts news letter to disseminate results. An action is currently being developed within the Management team.
National Imaging Access survey	NA	Report not yet published.
Confidential Enquiries		
Bariatric Surgery Study	Y	This surgery is not carried out at the trust. The report was reviewed in respect of any patients that may be admitted to the trust as emergency admissions following this type of surgery from other units. Anti Embolism Stockings size XXX are stocked and available when necessary. Imaging modalities available up to 200kg.
Cardiac Arrest Procedures	Y	New medical proforma introduced to ensure clerking and examination is explicitly recorded. Life support courses focus on identification of the deteriorating patient. New formal weekend handover has been instigated which ensures that consultant review is carried out if concerns are identified. Patient At Risk (PAR) scoring is automatically carried out on all patients to identify any patient at increased risk of developing complications. Resuscitation equipment is available on all wards and clinical areas.

Appendix B

The reports of 49 national clinical audits were reviewed by the provider in 2011/2012 and Maidstone and Tunbridge Wells NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit reports published April 2011 - March 2012	Trust action
4th National Audit Project (NAP4) Major complications of airway management in the UK (anaesthetics)	The following changes made. End tidal CO^2 monitoring on ICU for intubation/tracheostomy. To have 1 consultant and another senior anaesthetist present for percutaneous tracheostomy on ICU. Each patient should have a pillow prior to an anaesthetic starting. Emergency cricothyroid sets for theatre (Maidstone) have been purchased
Adult critical care (ICNARC)	The report suggests we perform well compared to similar units. Particular poor performance with relation to delayed discharge from ITU. This relates to overall bed management strategy and has been discussed at divisional level.
Care of the dying in hospital (NCDAH) Liverpool Care Pathway	The use of the LCP within the trust is in line with other organisations nationally. Three areas need action. Provision of written information to support conversations with patients / relatives / carers. Patient Affairs Officer now completes an EDN after death to inform the GP.
National Cardiac Arrest Audit (NCAA)	Report received and presented to Resuscitation Committee 16th April 2012. No action was required as quantative data reported. Will continue to submit data for this national audit.
Elective Surgery (National Proms Programme)	Report received by Division but does not give clinical outcomes for MTW. The PROMS reporting process is now in the process of being changed . The new process to be rolled out across all specialties showing more detailed information on trust activities.
Chronic Pain (National Pain Audit)	Report reviewed by Anaesthetic division January 2012. No actions were deemed necessary. Will continue to submit data for this national audit.
National Potential Donor (NHS Blood & Transplant)	Reviewed by division in March 2012. Report reviews potential missed donors. Following review, no action was required.
National lung cancer audit (NLCA LUCADA)	A business case is to be written and submitted to increase the Lung Cancer Specialist Nurse hours. Aim to improve administration support to make sure that our data is collected and uploaded onto the NICE Audit database. Increase the availability of INFOFLEX passwords to allow more people to input data: This action has been completed. We have introduced the lung cancer staging system on laminated sheets in the MDT to improve documentation.
National audit for head & neck cancer (DAHNO) 2011	Report received and reviewed by division. No action required at this time.
HQIP NATIONAL AUDIT for bowel cancer NBOCAP 2011	Report 2011 with division for review and assessment. Report disseminated December 2011. With specialty for Action planning.
NATIONAL Blood Transfusion audit of the use of platelets -	Trust did not register for this round. Report received and reviewed. No action required.
National Blood Transfusion. O Neg blood use.	Report reviewed. No changes required at this time.
Familial Hypercholesterolaemia (National Clinical audit of the Management of FH)	National Report received and reviewed. Trust has high compliance. No further actions needed.
NATIONAL audit of Services for people with Multiple Sclerosis 2011	Pathway to be formalised for regular therapy input. Review nurse outpatient capacity to enable rapid review in neuro service. Create a specific check list to allow patients to self report.

National audit of Falls and Bone Health in Older People 2010	Report received June 2011. Business case being developed for an Orthogeriatrician. Talks between Trust & PCT taking place to develop a Fracture Liaison Service.
UK National IBD Audit Round 3	Bone protection should be prescribed to all patients who receive corticosteroids. All patients on long term steriod (>3 months) (immunosupression) had their treatment regimes reviewed in line with national clinical guidelines to reduce long-term steriod use and the need for admission.
National audit of Dementia (Care in General Hospitals)	A Dementia Care pathway setting out the acute care and treatment needs of people with dementia at each stage of admission is in development and due to be launched in Spring 2013.Two Senior Consultant Clinicians have been identified to lead on implementation and review of the care pathway. Additional support and protected meal times have been put in place to ensure patients with dementia have their nutritional needs met. Adapted cutlery and aids are available to encourage nutrition / hydration intake. Training workshops for staff are in place to provide basic training on dementia awareness. Staff caring for patients with dementia have a mentorship and appraisal system in place and access to peer support and reflective groups. A business case is being developed for a Dementia Consultant Nurse Specialist post.
National BTS Adult Community Acquired Pneumonia 2010/11	Improve documentation by appropriate use of medical proforma.
National BTS Adult Non-invasive Ventilation (NIV) 2011	National comparative data received November 2011. Local report and action plan completed. Awaiting final version from audit lead.
National Audit of Seizure management in Hospitals (NASH)	Received December 2011. Organisational data received July 2012. Assessment tool and action plan currently being finalised.
CEM - National audit of Renal colic (in adults) in A&E	Extension of Patient Group Directives allowing initiation of analgesia at triage. Changes to IT system to facilitate outpatient referral, in particular to Urology and recording of pain scores.
CEM National audit of fever in children in A&E	Extension of Patient Group Directives allowing initiation of analgesia at triage. Changes to IT system to facilitate recording of observations.
CEM National audit of vital signs in majors in adults	Extension of Patient Group Directives allowing initiation of analgesia at triage. Changes to IT system to facilitate recording of observations.
National BTS Bronchiectasis audit 2011	Report reviewed by Specialty. Awaiting completed action plan from Audit lead.
National BTS Adult asthma audit 2011	2011 report received March 2012. Action plan developed. All Asthmatic patients to be referred to the Respiratory team. Respiratory Nurses to arrange teaching sessions to improve inhaler technique. The junior doctors need to be reminded of the algorithms for treating asthma and the importance of the PEF in determining timely and discharge. Juniors should be encouraged to document the follow up plans and whether or not a written action plan/inhaler technique has been checked on the discharge summary
National BTS Emergency use of Oxygen audit 2011	Respiratory Nurses to provide teaching sessions to clinicians on process for prescribing of oxygen therapy.
National BTS Pleural Procedures audit 2011	National report received December 2011. Awaiting completed action plan from Audit lead.
NATIONAL Sentinel Stroke Audit 2010	Sentinel Stroke (Round 7) National report received June 2011. Business case being developed for an additional Stroke Clinical Nurse Specialist. Patient Key worker system to be implemented. Adjustments to stroke passport to include management plan for incontinence.

National Heart Failure Audit	Compliant with recommendations, will continue to collect and monitor data through the Enhancing Quality Programme and participation in the National Heart Failure audit
National Adult Diabetes Inpatient Audit 2010 (2nd round)	Main objective is to install a functional diabetes database (Diabeta3) to enable full participation in future National Diabetes audits.
National BTS - 1st European Respiratory Society (ERS) COPD Outcomes	European report received December 2011. No hospital specific data. Report with hospital specific information received 18 September 2012. With specialty for Action planning.
National Adult Diabetes Audit 2010 (NaDIA One day audit)	Business case written for additional Inpatient Diabetes Specialist Nurse. Develop guidelines for trainees re Diabetes Inpatient Prescribing. Develop referral criteria for inpatients with diabetes. Update guidelines on management of hypoglycaemia, diabetic ketoacidosis and hyperglycaemia emergencies. Establish a multidisciplinary Diabetes Foot Care Team.
MINAP 2010/11	To Increase the percentage of patients in the TW area with NSTEMI managed on a Cardiac Ward. This has been achieved by moving to TWH with a dedicated cardiac ward.
National Cardiac Rehabilitation Audit - NACR 2009-10	National report received November 2011. Reviewed by Specialty. Business case being developed for training post. Liaising with West Kent PCT re funding for provision of Tai Chi Rehab and Phase III rehabilitation in the community.
CEM National audit of Consultant sign-off in Emergency Departments 2011	Governance and teaching sessions instigated to ensure juniors know how to refer patients for senior review.
National Cardiac Arrhythmia (Cardiac Rhythm) Management 2010	Reviewed by division. No actions required.
National Diabetes Audit - Paediatric	Report received May 2011. Discussions taking place to find a database that is compatible with the national database. An age specification list received from the National Diabetes Audit and disseminated to Clinicians for discussion.
National Paediatric Pneumonia Audit 2010	The management of children with respiratory distress is now included in the induction process for junior doctors. A copy of the printed guideline is available on the ward for reference.
National Audit of Heavy Menstrual Bleeding 2011	National Organisational Data. With specialty for Action planning.
National Neonatal Survey	Report received December 2011. To purchase more screens to have one in each nursery. Work on improved discharge planning with SEND summary to go out with parents at discharge.
BASHH (British Association of Sexual health and HIV) National audit "STI Management Standards" (STIMS)	Report reviewed and key changes have been made. Closer working with microbiology to ensure test results are received in the clinic within 7 working days. An MTW GUM skills mapping proforma has been developed and completed in September 2011. The STI/HIV risk assessment has been added to the current clinic proforma.
National Neonatal Intensive and Special Care Audit 2011 (NNAP)	Report received and disseminated July 2011. A dedicated Consultant has been assigned to the neonatal ward to ensure all babies are seen by a senior member of the neonatal team within 24 hours of admission. The remainder of the recommendations meet national standards.
National Paediatric Asthma Audit (BTS) 2011	A standardised asthma care plan has been produced and e-mailed to all staff involved in the care of these paediatric patients.
Pickers Europe National Adult Outpatient Survey 2011	Main actions identified. Partial booking for follow up appointments and PCO review to incorporate new patient communication process. Reduce the wait in clinic - Keep reception desk updated re clinic delays so that they can inform patients on arrival if requested, keep the patient updated and develop and commence regular internal outpatient survey. Outpatient

	Improvement Group developed to review services provided to this group of patients.
NHFD: National Hip Fracture Database	To continue with the Fast-Track and Hip Fracture Pathway Service reconfiguration. Patients to be admitted to Orthopaedic Care Surgery within 36 hours of admission. Prescribing secondary prevention. Appointment of locum Consultant Orthogeriatrician
National Joint Register: hip and knee replacements	Report received and reviewed by specialty November 2011. No action required.
Coronary Angioplasty	Report received July 2011. Trust protocol being revised to incorporate strategies to achieve 96 hour angioplasty/PCI target. Business case being developed for additional Cardiologist at Maidstone site.
NCEPOD Peri-operative Care Study. (*Knowing the Risk*)	Formalised assessment mortality tool agreed by Directorates. Improved documentation of consultant level discussions around Non-Elective high risk patients. Skills gap identified in Middle Grades regarding invasive monitoring equipment further discussions with Divisions to identify actions required. Delays in receiving cardiologist opinions in cancer patients raised with Clinical Director of Emergency Services. Quicker discharge of patients from HDU to Wards needed to free up HDU beds. Discussion to take place with Bed Managers.
NCEPOD: Surgery in Children Study (*Are we there yet?)*	The anaesthetic bags at the Tunbridge Wells hospital checked to ensure airway and breathing support is included. Family support leaflets are available but will need updating to incorporate all NCEPOD recommendations. Service provision needs to be increased to ensure that sufficient numbers of cases are provided to maintain skill levels within surgical and theatre teams. Named surgeons and anaesthetists needed for dedicated paediatric lists. Pharmacy to be contacted to raise concerns about no dedicated paediatric contact within pharmacy at Tunbridge Wells hospital. PSCPEWS (Paediatric Early Warning Score) chart to be obtained from GOS hospital and used in all areas that care for paediatric patients. 3 different age appropriate charts to be developed

Appendix C

Completed audits against NICE Clinical Guidelines

The following tables show the completed audits against NICE Clinical Guidelines sorted by the compliance status.

Fully

CG	Title	Completion date	Actions and changes in practice
42	Dementia: supporting people with dementia and their carers in health and social care	10/10/2012	All standards met and assurance achieved.
58	Prostate Cancer	22/08/2011	All criteria met in full with 100 % compliance.
60	Surgical management of OME	09/11/2011	All standards met. No actions required
71	Familial hypercholesterolaemia	02/03/2011	The audit provided information on the Trust performance to NICE guidance 2008 and showed that the Trust had a high rate of compliance. No actions to be taken by the Trust.
75	Metastatic spinal cord compression	17/12/2012	Need to identify a process for managing changes to the planning intention for palliatives patients. This to be addressed with the Head of Radiotherapy Physics and Radiotherapy Services Manager.
80	Early and locally advanced breast cancer (replaces TAG107,108,109)	22/11/2011	Monitor services through clinical audits and patient surveys. Continue to develop and maintain services in partnership with other service providers through the local cancer network.
81	Advanced breast cancer (replaces TA30, TA54 and TA62)	22/11/2011	Monitor services through clinical audits and patient surveys. Continue to develop and maintain services in partnership with other service providers through the local cancer network.
126	Stable angina – The management of stable angina	11/01/2013	Treatment of stable angina to be initiated in primary care. Continuation of current management in the secondary sector.

Partially

CG	Title	Completion date	Actions and changes in practice
15	Type 1 diabetes: diagnosis and management of type 1 diabetes in children young people and adults	03/06/2011	Guidelines developed on Diabetes Inpatient Prescribing for trainees at induction. Referral criteria have been developed and discussed amongst Diabetes Specialist Inpatient Nurses and Diabetes Consultants. “Diabetic foot examination” to be included in the new inpatient clerking proforma.

29	The prevention and treatment of pressure ulcers	07/11/2012	Skin bundle first pilot stage completed and the second stage in planning. All grade 2 pressure ulcers to have route cause analysis completed to come in line with NPSA zero tolerance to pressure damage. Education programme currently under development with high risk areas targeted first.
36	Atrial fibrillation: the management of atrial fibrillation	26/07/2011	All patients with (P) AF are anticoagulated within an appropriate time frame after their CVA/TIA. All patients who are seen to need warfarin for AF post stroke should have clear advice as to benefits & complications of warfarin administration +/- risk assessment using CHADS2 VASC. This should be documented in notes.
47	Feverish illness in children: assessment and initial management in children younger than 5 years	20/06/2012	Paediatric vital signs sheet on trial at Maidstone A&E. Teaching sessions on paediatric assessment in the A&E department are in progress. Laminated traffic light system for vital signs to be placed in clinical rooms/cubicles.
48	MI: secondary prevention – Secondary prevention in primary and secondary care for patients following a myocardial infarction	29/01/2013	Cardiology review of all patients diagnosed with MI promoted at local governance sessions. Consultants ensuring that trainees are aware of requirements for clear documentation in notes where there is a deviation from standard secondary prevention drug regimens.
50	Acutely ill patients in hospital	07/03/2013	CSW's alert trained staff to PAR score 1 and above. Trained Nursing Staff made aware of PAR score Algorithm and Trigger actions. Re-audit to be undertaken with larger sample.
54	Urinary tract infection in children: diagnosis treatment and long-term management	13/06/2012	Training of the importance of documentation in the clinical notes included in the departmental induction sessions. A simplified flowchart for imaging guidelines created and made available on the Q:\ drive.
56	Head injury (replaces CG04)	31/03/2012	Continue the practice of use of GCS in all patients presenting with head injury as tool for establishing high/low risk. Improve mean assessment time from 20 minutes to 15 minutes. Improve delays to carrying out and reporting CT scan. This requires action both from A&E and Radiology. Improve co-requesting of imaging for head and C-spine CT when indicated, by development of new Head Injury Proforma.
59	Osteoarthritis (replaces TAG27)	30/01/2013	Patient information leaflet changed and all staff aware. Assessment sheets changed.
63	Diabetes in pregnancy	29/03/2011	Joint diabetes team to develop diabetic pregnancy notes to be used in conjunction with maternity notes. Joint diabetic team to review current patient referral pathways. There is a need for a documentation audit. Patients diagnosed with gestational diabetes to be referred for consultant care.
70	Induction of labour	28/02/2013	Improved training of clinical staff ensuring all members know how to access IUD management protocols and ensure full bloods taken. Post mortem consent is part of the educational training for all trainees. Senior registrars and consultant are available at all times to supervise and educate. Guideline being written for the Trust specifically for the Induction of Labour in stillbirth. Re-audit is not required as Trust is doing well in the standards assessed. Ante-partum and Intrapartum fetal deaths are reviewed as part of the peri-natal morbidity and mortality.
85	Glaucoma	26/07/2011	The most significant area of concern is criteria 20, which suggests all patients should be provided written information about their condition and they should be made aware of the NICE guidance. This was only achieved in 54% of cases, despite the fact that the condition is

			discussed during consultation. Tick box form designed so that all information to be recorded in notes as well as new information leaflet, to be given to patients at first visit. Patients follow-up appointments to be 6 months minimum
86	Coeliac disease	09/07/2012	A re-audit to cover a wider spectrum of patients (e.g. GP referrals and those with negative serology) is to be carried out in 2 years with community services.
88	Low back pain	20/02/2012	GP's alerted to the appropriateness of age limits. Communicate red flag symptoms to radiologists and radiographers who accept referrals.
107	Hypertension in pregnancy	20/06/2012	Use the NICE guidance algorithm to amend the current guideline used in the Trust. Devise a generic plan of care to help ensure compliance. Incorporate key NICE and audit recommendations into pre-eclampsia teaching session at multidisciplinary skills and drills sessions..
109	Transient loss of consciousness in adults and young people	21/05/2012	Feedback to A and E reinforcing the importance of documenting follow-up for these patients. Feedback to A and E regarding the disparity in the quality of documentation between the two sites. Regular audit to ensure the standard is consistent.
117	Tuberculosis	25/10/2011	HIV test to be included by consultant or TB nurse at time of diagnosis. All new patients with possible TB should be directed to Dr Graves & Dr Mankragod. If patients are diagnosed under a different consultant they should be handed to Drs Graves or Mankragod for follow up. Any patient with TB at any site should have a chest x-ray. This should be checked by a chest physician when diagnosis confirmed.
121	Lung cancer - Diagnosing and Staging ONLY	23/05/2012	New lung cancer clinics in place trust wide. Business case for local EBUS service in development.
124	Hip fracture	13/08/2012	Business case submitted to recruit Orthogeriatric consultant. Exeter Trauma Stem now used routinely.
11	Fertility – assessment and treatment for people with fertility problems	14/06/2012	Standard protocol to be followed for investigations to be completed by patients before they attend initial sub fertility appointment (to be done by GP) - If above is followed, patients can have Hycosy at the first/second visit, this frees up several appointments and reduces the waiting time for Hycosy appointments. - Streamline referral for all sub fertility patients.
13	Caesarean section	11/01/2013	Improved documentation of reasons for the CS, risks and complications. The decision for CS not to be made based on a single consultation. A second opinion should be considered from another consultant. Appropriate support services should be available, including midwifery input to explore birth options.
16	Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care	13/06/2012	Safeguarding is included in the training sessions of all the A&E staff. Existing protocols for referral have been amended.
21	Falls: the assessment and prevention of falls in older people	30/03/2013	Falls checklist produced and being used. Information leaflets available for patients. Falls co-ordinator secondment advertised in February. Falls community referral team in place.

27	Referral guidelines for suspected cancer	19/05/2008	60% of patients referred had a normocytic anaemia - only 39% were found to have a microcytic anaemia. Less than 20% had serum ferritin levels performed.
32	Nutrition support in adults: oral nutrition support enteral tube feeding and parenteral nutrition	05/01/2012	Review of red tray policy. Improved accuracy of MUST assessment and care planning. Improved engagement with nutritional link nurses.
35	Parkinson's disease: diagnosis and management in primary and secondary care	04/02/2011	Relevant pharmacy staff informed that Parkinson's medications are frequently out-of-stock on the ward and it currently takes ~1day to acquire stock. Assess the awareness of junior doctors writing up drug charts using a questionnaire.
55	Intrapartum care	08/01/2013	Improve documentation by promoting Obstetric haemorrhage pro-forma during Skills & Drills for doctors & midwives. Clearly document management plan on admission.
65	Perioperative hypothermia (inadvertent)	27/10/2011	4 point action plan to cover most of the needs. 1. Reschedule any elective case with a recorded preoperative temperature of less than 36C to allow re-warming, this can be active or passive. Sarah Turner needs to cascade to senior nurses on surgical wards 2. Use of Bair Hugger or Hot Dog warming devices on ALL patients during their time in theatre 3. Use of Intra-operative temperature monitoring on ALL patients during their time in theatre 4. Use of pre-warmed fluids or, if expected to use large volumes a fluid warmer on ALL patients during their time in theatre
68	Stroke	12/09/2012	Revised stroke proforma to include a section on patient weight on admission. Continue to train junior doctors on the importance of an initial swallow test.
76	Medicines adherence	09/11/2012	Non-medical prescribers informed of the NICE guidance and audit findings. Discussed at pharmacy staff meetings. Included in Standard Operating Procedures where appropriate for ward and dispensary staff.
79	Rheumatoid arthritis (replaces TAG72)	23/06/2011	To publicise the signs and symptoms of RA to patients so that they seek help early. Posters obtained from NRAS and sent to GP surgeries. Consultants encouraged to use the local early arthritis protocol and to record a DAS score at each appointment.
83	Critical illness rehabilitation	17/07/2012	Considering the appointment of a named healthcare professional to co-ordinate rehabilitation care pathways. (Suggested that physiotherapy staff may fill this role). Implement use of short clinical assessment and comprehensive clinical assessment forms. Formally develop and document individualised, structured rehabilitation programme, based on the comprehensive clinical reassessment and the agreed or updated rehabilitation goals for patients at risk of developing physical and non-physical morbidities. Consider the use of a self-directed rehabilitation manual or leaflet for those patients who do not require a comprehensive clinical assessment or an individualised structured rehabilitation programme. Promote information giving to patient and family / carer and documentation of this practice. Ensure patients with continuing rehabilitation needs will receive a functional reassessment by primary or community care at 2 - 3 months after the patient's discharge from critical care.

84	Diarrhoea and vomiting in children under 5	12/06/2012	Formalised a protocol for ORT use, particularly aimed at starting fluid challenge in A&E. Send stool samples in only selected situations. To consider an increased use of nasogastric tubes, when ORT is not tolerated. Using venous gases when canulating, gain measurement of electrolytes & glucose. Use the NICE parent advice leaflets. Use the NICE posters in A&E to improve recognition of signs of dehydrated child.
89	When to suspect child maltreatment	02/08/2011	Pro-forma produced to cover all aspects of assessment, admission & discharge plan. Check list to be added to the hospital notes, completed by staff on the ward throughout the child's admission.
92	Venous thromboembolism - reducing the risk (replaces CG46)	07/11/2012	Results presented at Clinical Governance to ensure that doctors documenting PTWR are all aware of what needs to be documented. To be re-audited in August 2013 once updated medical admissions proforma has been in circulation for a few months.
95	Chest pain of recent onset	22/12/2011	Discussed at Clinical Governance, staff told not to put down MI as cause of death unless indicated by clinical presentation. MINAP report indicates Trust above national average. New 3rd F/T cardiologist appointed. Re-audit not required. MI mortality subject to ongoing surveillance by Dr Foster and as part of MINAP audit.
96	Neuropathic pain - pharmacological management	29/01/2013	The improved speed and efficacy of duloxetine in diabetic neuropathic pain should be emphasised to clinicians. Further, an emphasis on the point that pregabalin can be titrated up to 600mg/day, and currently several patients were sub-optimal in this regard before having medications changed, unless they already had adverse effects which had not been recorded.
103	Delirium	30/06/2012	Patients at risk of delirium should be identified at presentation. The risk factor assessment could be integrated into the pre-existing medical clerking proforma. Patients identified as 'at risk' should be assessed for recent changes in behaviour and if indicators of delirium are present, they should be formally assessed using short CAM tool to make and formally document the diagnosis of delirium. Teaching and training in the use of short CAM will be necessary to implement this guideline successfully A tool/proforma to be developed to facilitate the multidisciplinary intervention as outlined in the guideline to prevent/treat delirium and reassess high risk patients every 24 hours
129	Multiple pregnancy	23/11/2012	Twin clinic to be at both sites. The Trust twin proforma is to be updated.
140	Opioids in palliative care	19/12/2011	Teaching sessions undertaken with junior doctors as they are often expected to prescribe PRN medications in conjunction with LCP. To simplify the use of LCP documentation for junior doctors – place sticker the front of the folders used to store the LCP documents, detailing the location of the prescribing guidelines.

Remaining Clinical Guidelines to be audited.

CG	Audit Title	Lead	Directorate	Audit Start Date	Comments

CG	Audit Title	Lead	Directorate	Audit Start Date	Comments
3	Re-audit :The use of routine pre-operative tests for elective surgery	Phil Blackie/Rob Williams	Critical Care	01/12/2012	Delay by Audit Lead
24	NICE CG 24 - An audit of chemotherapy in poor performance patients with non-small cell lung cancer	Dr Henry Taylor	Cancer and Haematology	07/12/2010	Quality Checking
24	NICE CG24 Network Audit of Small Cell Lung Cancer Patients including Patient Pathways & Outcomes	Dr T Sevitt	Cancer and Haematology	11/10/2010	Data analysis
37	NICE CG37 - Audit of the management of routine postnatal care of women and their babies	Gillian Duffey	Obs, Gynae and Sexual Health	01/07/2012	Registration form Quality Checking
40	NICE CG40 - Audit of outcomes & procedures for TVT & TVTO procedures (Urinary incontinence)	Mr Rowan Connell	Obs, Gynae and Sexual Health	06/06/2011	Chasing for copy of final report - action plan
44	QUALITY ACCOUNT - NICE CG44 - National Audit of Heavy Menstrual Bleeding	Mr Oliver Chappatte	Obs, Gynae and Sexual Health	12/05/2010	Submitted data - awaiting National report
49	NICE CG 49 Faecal incontinence	Mr Danny Lawes	Surgery	01/02/2013	Data collection
62	NICE CG 62 - Antenatal Care	Alison Mendes	Obs, Gynae and Sexual Health	02/07/2012	Delay by Division
64	NICE CG064 - Prophylaxis against infective endocarditis	Dr Bet Mishra	Specialty Medicine	01/11/2012	Report writing
87	NICE CG087 - Type 2 diabetes - the management of type 2 diabetes	Dr Jesse Kumar	Specialty Medicine	09/08/2012	Data collection
94	NICE CG094 - Early Management of Unstable Angina & NSTEMI in patients admitted to TWH only	Dr Derek Harrington	Specialty Medicine	01/11/2012	Data collection
94	NICE CG094 - Early management of Unstable Angina & NSTEMI in patients admitted to Maidstone Hospital only	Dr Bet Mishra	Specialty Medicine	31/01/2013	Data collection
98	NICE CG98 - Audit of the management of Neonatal Jaundice	Dr Bala	Paediatrics	21/11/2012	Data collection
99	NICE CG 99 - Audit of the management of Constipation in children and young people	Dr Bim Bhaduri	Paediatrics	08/03/2013	Data collection
100	NICE CG100 - Alcohol-use disorder: physical complications	Dr Laurence Maiden	Specialty Medicine	01/03/2013	Awaiting information/decision from audit lead
102	NICE CG102; Management of Children & young people with suspected/confirmed Bacterial meningitis & meningococcal septicaemia - Pharmacological criteria	Dr Bala	Paediatrics	02/04/2012	Data collection
102	NICE CG 102 - Management of Children & young people with suspected/confirmed Bacterial meningitis and meningococcal septicaemia; Clinical & Organisational Criteria	Dr Bala	Paediatrics	15/03/2012	Data collection
108	NICE CG108 - Chronic heart failure	Dr Scott Takeda	Specialty Medicine	01/04/2012	Awaiting information/decision from audit lead

CG	Audit Title	Lead	Directorate	Audit Start Date	Comments
110	NICE CG110; Audit of the management of pregnancy and complex social factors	Alison Mendes	Obs, Gynae and Sexual Health	15/10/2012	Not due to start yet
111	NICE CG111 - Nocturnal enuresis - the management of bedwetting in children & young people	Dr Bala	Paediatrics	19/11/2012	Not due to start yet
112	NICE CG112 - Audit of the management of Sedation in children & young people	Dr Bala	Paediatrics	05/08/2013	Not due to start yet
119	NICE CG119 - Diabetic Foot problems - inpatient management	tbc	Specialty Medicine	01/02/2013	Re-audit taken from previous audits action plan
122	NICE CG 122 - Ovarian Cancer Audit	Dr Jyothirmayi & Dr Waters	Cancer and Haematology	14/02/2012	Chasing for copy of final report - action plan
127	NICE CG127 - Hypertension - Clinical management of hypertension in adults	Dr Vinay Bhatia	Specialty Medicine	25/06/2012	Data analysis
130	NICE CG130 Hyperglycaemia in acute coronary syndromes	Dr Dennis Barnes	Specialty Medicine	01/06/2013	Not due to start yet
132	NICE CG132 - Audit of the management of Caesarean Sections	Mr Mark Wilcox	Obs, Gynae and Sexual Health	05/08/2013	Not due to start yet
134	NICE CG134 Anaphylaxis	Dr Tim Bell	Acute and Emergency Medicine	01/08/2013	Not due to start yet
136	NICE CG136 Service user experience in adult mental health (in hospital section only)	Dr Tim Bell	Acute and Emergency Medicine	01/08/2013	Not due to start yet
137	NICE CG137 - Epilepsy in adults	Dr Gerry Saldanha	Specialty Medicine	01/01/2013	Awaiting information/decision from audit lead
137	QUALITY ACCOUNT - NICE CG137 - National Childhood Epilepsy 12	Dr R Gupta	Paediatrics	01/01/2013	Action plan development
144	Audit: Imaging waiting times for diagnosis of deep vein thrombosis	Dr Gough Palmer	Diagnostics, Therapies and Pharmacy	12/09/2012	Data collection
146	NICE CG146 Osteoporosis - fragility fracture	Dr Taher Mahmud	Specialty Medicine	01/06/2013	Not due to start yet
152	NICE CG152 Crohn's Disease	Dr Adam Harris	Specialty Medicine	01/08/2013	Not due to start yet

Part 5
Stakeholder feedback

- **West Kent Clinical Commissioning Group**
- **Independent Auditors' Limited Assurance Report**
- **Statement of directors' responsibilities**
- **HOSC have not provided us with formal commentary but have invited us to attend a meeting to discuss the report.**
- **Kent Healthwatch have not been able to comment formally this year but are working with the trust to develop new ways of collaborating as the organisation develops.**

No changes to the report have been required following review by these stakeholders.

West Kent CCG comments on the 2012/13 Quality Account for Maidstone & Tunbridge Wells NHS Trust (MTW)

As from the 1st April 2013, NHS West Kent Clinical Commissioning Group (CCG) assumed responsibility for commissioning healthcare services across the West Kent region including services form Maidstone and Tunbridge Wells (MTW) NHS Trust and welcomes the publication of this quality account for 2012/2013.

The quality account is robust and clear and highlights best practice and reasons why some targets have not been met. West Kent CCG will be working closely in 2013/14 to support the Trust in meeting its targets and aspirations for excellence in all aspects of patient care.

During 2012/13, C Diff has been a constant challenge despite the efforts of the MTW team. The CCG supports the Trust's proactive approach to reinvigorate and seek external peer review to help address incidence of C Diff.

MTW has struggled with its ability to meet the A & E four hour target for which they achieved 92.9% in 2012/13 against a target of 95%. The A & E also breeched targets for initial assessment and time to treatment targets. The CCG are confident that MTW has identified these breeches as areas for immediate action.

MTW has addressed good practice with regards to mixed sex accommodation which is commendable.

Following the publication of the Francis Report, the Trust has developed an initial action plan in response to recommendations made and the CCG will continue to monitor these.

West Kent CCG is looking forward to working with MTW to ensure that the needs of our population are met. This will involve collaboration at all levels which has already started to reap results.

Dr Steve Beaumont
Chief Nurse
West Kent CCG

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

We are required by the Audit Commission to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

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

- Percentage of patient safety incidents that resulted in severe harm or death (page 56)
- Percentage of patients risk-assessed for venous thromboembolism (VTE) (page 56)

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

Respective responsibilities of Directors and auditors

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

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

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 12/06/2013;
- feedback from Local Healthwatch dated 07/06/2013;
- the Trust's 2012/13 complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholders involved in the sign off of the Quality Account;
- the latest national patient survey dated 16/04/2013;
- the latest national staff survey dated 29/05/2013;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 15/05/2013;
- the annual governance statement dated 29/05/2013
- Care Quality Commission quality and risk profiles dated 31/03/2013; and
- the results of the Payment by Results coding review dated May 2013;

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

This report, including the conclusion, is made solely to the Board of Directors of Maidstone and Tunbridge Wells NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Maidstone and Tunbridge Wells NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the 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 2013:

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

Andy Mack
Senior Statutory Auditor
for and on behalf of GRANT THORNTON UK LLP

Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

Date: 27 June 2013

Statement of directors' responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board

Glenn Douglas
Chief Executive

Date: **26 June 2013**