Maidstone and Tunbridge Wells NHS Trust

Two hospitals One future

# Quality Accounts

## 2010/11

# 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. This is our second Quality Report. 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 2011/2012.

As patients you have a right to expect us to provide high quality services. In recent years there has been a determined drive within the NHS to increase the focus on the quality of care provided. 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.

## Index

Part one

## Chief Executive's Statement

Welcome to Maidstone and Tunbridge Wells NHS Trust's Quality Accounts.

MTW provides a wide range of complex and routine health services to meet people's different health needs.

Our aim is to provide these high quality and innovative health services from hospitals with centres of expertise. Our healthcare professionals strive to be innovative, providing patients with a wide choice of options and treatments that are individual to their needs.

We pride ourselves on our medical and surgical expertise, state of the art diagnostic facilities, our nursing care and the environment in which we care for our patients.

This year MTW is opening the first NHS acute hospital with 100% single en-suite rooms for patients at the Tunbridge Wells Hospital in Pembury.

The Trust is also opening five new centres of expertise in trauma care, planned surgery, orthopaedic surgery, women and children's care and cellular pathology.

All of these developments and other improvements are contributing to a better experience for our patients.

We have established nine key priorities with our stakeholders, including patients and public representatives this year, which we believe will help improve the quality of our services further still.

The key priorities are:

- Continuing to drive down cases of hospital acquired infections, paying particular attention to Clostridium difficile where it has been a side-effect of antibiotic use
- To help our Ward Leaders and teams review the way that key activities are undertaken on wards in order to release time to provide more direct patient care
- Ensuring we meet the needs of patients who have dementia
- Contributing to patients' overall wellbeing by ensuring they receive good nutrition
- Reducing the risk of deep vein thrombosis (venous thromboembolism)
- To improve the quality of care and health outcomes for patients who have had a stroke
- Improvements in Discharge Planning

- To improve the quality of communication and information given to patients and the public

- To deliver same sex accommodation for patients and avoid any breaches

We will continue to monitor what our patients are telling us through our real-time surveys every month and make more of their priorities become our priorities throughout the year.

The information contained within this report represents an accurate reflection of our organisation's performance in 2010/11 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 2011/12?

### Priorities for Improvement

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:

- Reducing the number of avoidable healthcare associated infections
- Reducing the incidence of patient falls
- Improving the care of our stroke patients
- Reducing the number of ward to ward moves for patients
- Improving communication and information given to patients

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

To identify the priorities for this year we have looked at progress against those we identified last year, trends in the complaints we have received and national reports such as the Public Health Service Ombudsman's report published this year, Care and Compassion.

While we have made real progress against last year's priorities we have kept three – preventing hospital acquired infections, the care of patients who have had a stroke and communication, as key areas of focus for 2011/12 to ensure that we continue to improve and embed the learning that has taken place in the last year.

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

## Patient Safety

- Continuing our focus on reducing the number of avoidable healthcare associated infections
- Prevention of blood clots or venous thromboembolism (VTE) – there is a new national target relating to patients who are at risk of VTE receiving treatment to thin the blood (Anticoagulants)
- Ensuring all patients receive their appropriate nutritional requirements

## Clinical Effectiveness

- Ensure greater efficiency of working at ward level through the implementation of the productive ward programme – “releasing time to care”
- Continuing our focus on improving care for patients who have had a stroke
- Improving the care we provide for patients who are suffering from dementia

## Patient Experience

- Continuing our focus on communication and information for patients
- Improving our management of discharge planning
- Reducing the number of breaches we have in relation to delivering same sex accommodation for patients

**There is a robust governance structure for monitoring progress against these indicators to ensure the Trust Board is kept informed and to ensure decisions can be made and corrective action taken if necessary.**

The Trust’s Quality and Safety Committee will receive reports on progress against the key priorities and provide assurance on progress to the Trust Board.

# Patient Safety

**Infection Prevention and Control**

**Venous Thromboembolism (VTE)**

**Patient nutrition**

## Infection Prevention and Control

### Aim/Goal

To reduce our C. difficile rate by 18% and MRSA bacteraemia by 10% in the next year. In 2010/11 the limit set for MRSA bacteraemia cases was 6 – we had 5. In 2011/2012 maximum limit set is 5

### Description of issue and rationale for prioritising

Our rates of C. difficile infection continue to fall year on year. Our MRSA bacteraemia rate has reduced by 67% in the last year and by 91% since 2003/4. As a Trust we have a zero tolerance approach to healthcare associated infection (HCAI).

### Identified areas for improvement and progress during 2010/11

The reduction in MRSA bacteraemia and C difficile infections during the year was supported by the following actions:

- Line-associated and device-associated infections identified in root cause analysis
- During the 2010/11 we have had no line-associated or device-associated MRSA bacteraemia
- Training in line insertion and management
- An IV trainer was appointed who is delivering an extensive programme of training
- Implementation of MRSA action plan including peer review and continuous learning from root cause analysis
- Preventative treatment such as prophylaxis for insertion and removal of lines and devices in MRSA positive patients and the introduction of probiotic for patients on antibiotics
- Introduction of Difficil-S as a cleaning agent for mattresses

### Initiatives for further action in 2011/12

- Further improvement in antibiotic management
- Development of cohort nursing areas at Maidstone and Tunbridge Wells Hospitals
- New infection prevention strategies for nursing patients in single rooms
- Monitoring of the C. difficile action plan including learning from root cause analysis to achieve objective for the year
- Consolidate IV training programme and aseptic no touch technique (ANTT) for venipuncture

**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

## Venous Thromboembolism (VTE)


### Aim/Goal

To comply with the national standards and the Commissioning for Quality and Innovation (CQUIN) VTE measure, that all at risk patients should receive the appropriate anticoagulant therapy following risk assessment.

### Identified Areas for Improvement

Our reported compliance with documenting the VTE Risk Assessment for March 20011 was 43%. Our aim is to achieve 90% compliance with completing risk assessments and administering anticoagulation therapy where appropriate by the end of August 2011.

### Initiatives in 2010/11

During the last year we have implemented various actions to help ensure that we can meet this target, including:

- Introducing a new policy to address the requirements
- New risk assessment forms in place
- Daily monitoring and weekly reporting of compliance re risk assessments
- Introducing a learning package in relation to VTE prevention
- Introducing an audit tool relating to VTE
- Introducing patient information leaflets

In addition to continuing with the initiatives from 2010 / 2011, which were beginning to benefit patients:

### New Initiatives for 2011/12

- A 2nd VTE Nurse Facilitator seconded from 1st April 2011
- Peer review by exemplar sites
- VTE implementation group working to identify and address actions required to improve compliance

**Board Sponsor**: Paul Sigston, Medical Director
**Implementation Lead**: Elaine Cheney, Matron for Medicine
**Monitoring:** via the Standards Committee

# Patient nutrition

**Aim/goal**
All patients to receive their nutritional requirements. This will be supported by their having a nutritional risk assessment undertaken and implemented in accordance with the Malnutrition Universal screening Tool commonly known as MUST.

This is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese.
It also includes management guidelines which can be used to develop a care plan.

- 100% of patients to have a nutritional assessment completed within 24 hours of admission
- From the patient survey questionnaires we can monitor patient satisfaction in relation to:

| | 2010 National Inpatient Survey | March 2011 Local Patient Survey | Aim for National Score in 2011 |
|---|---|---|---|
| The % of patients getting enough assistance to eat | 63% | 90% | 73% |
| The % of patients who rate hospital food as good | 48% | 90% | 58% |

For our national survey scores we are aiming for a 10% improvement in 2011/12.

**Initiatives in 2010/11**

- All patients are identified and given assistance as required by using the Red Tray system
- Introduction of protected meal times
- The Food is medicine Group was established in 2010 in response to an identified need to have a dedicated operational delivery group to support the work and recommendations of the Nutritional Steering Group and national policy

All patients are now assessed on admission and where assistance is required this is noted on both the 'Patient Information Board' and patient's menu card.
Individual meals come from the kitchens on a Red Tray so that patients requiring help can be easily identified. Wards have a local supply of feeding/eating aids such as cutlery with large handles, adapted drinking cups and non-slip place mats.

Regular audit activity indicates significant changes to practice; this has been supported by patient representatives who have visited the wards on a number of occasions. However,

there are still improvements to be made in both the timeliness and consistency of assessment of both nutritional status and assistance requirements. Further work is required to strengthen the support of non-nursing and non-clinical activity on the wards at or around meal times.
Ward Sisters have demonstrated their commitment to Protected Meal Times in a number of ways including early detection of a change in the catering process that impacted on the planned meal delivery times to individual wards.

**New initiatives for 2011/12**

- Meal standard to be introduced across the Trust to strengthen protected meal times, ensure appropriate nutritional assessments are carried out and assistance provided where required. Mealtimes should be supervised by a registered nurse. The standard is being developed in collaboration by the Dieticians and Catering Team via the Food is Medicine Group
- Nursing Nutritional Audit to be carried out

**Board Sponsor:** Flo-Panel Coates, Chief Nurse
**Implementation Lead:** Christine Steele, Matron, Patient Experience
**Monitoring:** via the Nutritional Steering Group

# Clinical Effectiveness

**Greater efficiency – more time to care**

**Stroke Care**

**Dementia Care**


More time to care

# Greater efficiency – more time to care

**Ensure greater efficiency of working at ward level through the introducing the productive ward programme – "releasing time to care"**


**Aim/goal**
Releasing Time to Care - Productive Ward programme is a national initiative designed by the NHS Institute for Innovation and Improvement. The aim of the initiative is to help Ward Leaders and teams review the way that key activities are undertaken on wards in order to release time to provide more direct patient care.

**Initiatives in 2010/11**

- 21 wards across the trust commenced the programme.
- Direct care time has increased from: 32% - 46% on Mercer Ward and 46% to 57% on Ward 7

**New Initiatives for 2011/12**

- All wards to complete the 3 foundation modules for releasing time to care by the end of March 2012
- 80% of wards to have completed at least 50% of the modules by the end of March 2012
- Current target is to increase the direct care time by at least 10% following completion of the foundation modules.

**Board Sponsor:** Flo Panel-Coates, Chief Nurse
**Implementation Lead:** Meral Hart, Productive Ward Lead Nurse
**Monitoring:** via the Standards Committee

# Improving stroke care


## Improving care for patients who have had a stroke

**Aim/goal**
To improve the quality of care and health outcomes for patients who have had a stroke. This will be monitored by improved compliance with the nine core quality indicators in the national sentinel audit.

This was a key priority for us last year and although considerable improvements have been made in the care we now provide for this group of patients it remains a key focus for us.

**Initiatives in 2010/11**

- By the end of the year the trust had achieved 75% compliance with the 9 national targets as set within the Sentinel Audit. These actions have been identified as key to improving outcomes for patients who have had a stroke.
- Expected Date of Discharge (EDD) achieved for stroke patients set within 7 days of admission
- 20% improvement of stroke patients spending 90% of their time in a stroke bed – it is known that outcomes are improved when patients who have had a stroke are cared for in a dedicated unit.
- Maidstone combined stroke unit opened in 2010
- Recruited nurses so that the vacancy factor is now below 8% cross site. Having permanent staff helps to ensure continuity of care and support ward developments.

**New Initiatives for 2011/12**

- A specialist stroke nurse is to be recruited
- 90% of patients to spend 80% of their care episode in a dedicated stroke ward
- To continue to achieve 75% compliance in the 9 key indicators
- Relocation of stroke specific rehabilitation beds at Tonbridge Cottage Hospital – with the move to the Tunbridge Wells Hospital in Pembury, where there will be a dedicated stroke unit for patients in the acute phase of their care. Patients will then be able to move to a dedicated rehabilitation unit in Tonbridge

**Board Sponsor**: Nikki Luffingham, Chief Operating Officer
**Implementation Lead:** Linda Summerfield, Associate Director of Nursing
**Monitoring:** via the Standards Committee

# Dementia Care

**Aim/goal**
To identify those patients with dementia with a view to ensuring that an effective care plan is in place to ensure they receive the best care possible.

Care for patients who have dementia is a key national focus currently and has been a key issue at our Patient Experience Committee.

**Initiatives in 2010/11**

- A new training programme was introduced – exceeded the plan for 10% of our staff to attend specialist training in dementia care in 2010
- The Trust is working with local dementia forums to support and deliver a cohesive multi-disciplinary/multi-agency approach to care for this patient group
- A dementia strategy group, chaired by our Chief Nurse, was started and continues

**New Initiatives for 2011/12**

Maidstone and Tunbridge Wells NHS Trust took part in the national dementia audit and having established a baseline action plan, agreed the following priorities:

- Training strategy – 50% of identified staff to have received some awareness training
- Integrated care pathway for patients with dementia to be developed
- Patient documentation to be improved
- An intranet site to raise awareness regarding dementia care to be introduced
- The Trust has identified a lead practitioner to work with service commissioners regarding more effective liaison for mental health including dementia patients
- An admission avoidance project began in February 2011 and will run for 6 months with input from a commissioner who jointly works for social services and the Primary Care Trust (PCT)
- This year's Enhancing Quality Measures for dementia is the auditing of the appropriate use of antipsychotic drugs.

**Board Sponsor –** Flo Panel-Coates, Chief Nurse
**Implementation Lead –** Jo Hockley, Matron for Older People
**Monitoring:** via the Dementia Strategy Group

# Patient experience

**Discharge planning**

**Improving patient communications**

**Providing same sex accommodation**

# Discharge Planning

**Aim/goal**
Ensure all patients have their discharge from hospital planned to ensure there is a seamless transfer home with appropriate support in place and communication with all relevant parties.

**Initiatives in 2010/11**

- Joint working with community services and social services to help focus

**New Initiatives for 2011/12**

- Ensure electronic discharge notification is rolled out across the organisation
- Revise leaflets for patients and relatives in relation to discharge
- Continued improvements in multiagency working
- Estimated Dates for Discharge to be in place for all patients
- Improved compliance with targets set in the national patient survey:

| | 2010 National Inpatient Survey | Aim for National Score in 2011 |
|---|---|---|
| % compliance with patients feeling involved in decisions about discharge from hospital | 56% | 66% |
| % patients given written information about what they should/should not do after leaving hospital | 65% | 75% |
| % receiving copies of letters sent to GPs | 76% | 86% |
| % Family given enough information re discharge | 38% | 48% |

We are aiming for a 10% improvement in 2011/12.

**Board Sponsor:** Nikki Luffingham, Chief Operating Officer
**Implementation Lead:** Linda Summerfield, Associate Director of Nursing
**Monitoring:** via Divisional Operations Group

## Patient communications

This priority continues from last year – we want to improve the quality of communication and information given to patients and the public.

**Aim / Goal:** To increase patient satisfaction about how they receive communication and information.

**Initiatives in 2010/2011:**

- Sourced new providers for customer care training
- Developed a training programme with Christ Church Canterbury (CCC) University for communication and complaints handling – this is being attended by multidisciplinary groups of staff
- Developed 65 new leaflets for patients during the year for different care areas across the Trust
- Introduced new bedside information folders for patients across the Trust

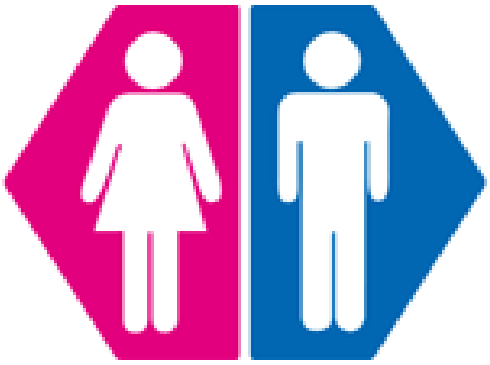
**New Initiatives for 2011/2012:**

- Secured funding for further training days with CCC
- Commencing targeted training for high profile areas and where communication is challenging
- Seeking to improve compliance with national survey questions relating to Communication and information:

| | **Current %** | **Aim %** |
|---|---|---|
| % patients who were involved as much as you wanted to be in decisions about your care and treatment? | 49 | 59 |
| % patients who could find someone on the hospital staff to talk to you about your worries and fears | 35 | 45 |
| % Positive Response to: Were you given enough privacy when discussing your condition or treatment? | 67 | 77 |
| % patients who had been told about medication side effects to watch for when you went home. | 50 | 60 |
| % Patients who were told by hospital staff who to contact if you were worried about your condition or treatment after you left hospital. | 79 | 89 |
| % Patients to whom staff has explained what would be done during the operation or procedure | 68 | 78 |
| % Patients who were told how they could expect to feel after you had the operation or procedure | 52 | 62 |

**Board Sponsor**: Flo Panel Coates, Chief Nurse
**Implementation Lead:** Claire Roberts, Head of Quality and Governance
**Monitoring:** via Quality and Safety Committee

## Same sex accommodation



**Aim / Goal**
Following significant public interest in relation to privacy and dignity in care, the Department of Health gave a commitment that mixed sex accommodation in hospitals would eliminated by March 2011.

The NHS Operating Framework for 2011/12 requires all providers of NHS funded care to confirm whether they are compliant with the national definition *'to eliminate mixed sex accommodation except where it is in the overall best interests of the patient, or reflects their patient choice'*.

The majority of breaches (episodes of non-compliance) occur on our Kent and Sussex site and the Trust is unable to declare full compliance until the New Tunbridge Wells Hospital opens at Pembury, enabling the reconfiguration of services to occur.

- Reduce the number of breaches with respect to delivering same sex accommodation (DSSA) to 0 at Maidstone Hospital

**Initiatives in 2010/2011**

- Particular focus has been given to the management of the Clinical Decisions Unit, Medical Assessment Unit and Trauma and Orthopaedics – which present particular challenges in meeting both clinical need and DSSA requirements
- A GP referral assessment bay has been established on the Medical Assessment Unit which allows the team to better manage the bed stock, ensuring only appropriate patients are subsequently placed in in-patient beds
- Weekly reports are sent to the Divisional Leadership Teams to enable them to plan their elective case loads to better meet DSSA requirements
- All breaches are reported daily via the Site Practitioners and these patients are prioritised for transfer to a speciality gender appropriate bed within 24hrs of the breach occurring

**Initiatives in 2011/2012**

- Tunbridge Wells Hospital at Pembury will be fully operational by the end of September 2011. This site provides care in a 100% single room environment. This will directly benefit all patients who would previously have been treated at the Kent & Sussex Hospital, as well as the majority of trauma and orthopaedics treated at Maidstone Hospital

- Some estates work is also planned for the Clinical Decisions Unit to enable enhanced privacy and single sex accommodation

- The transfer of some services from Maidstone Hospital to Tunbridge Wells Hospital will allow for a review of bed management processes at Maidstone and provide ‘decant’ space to allow for ward refurbishment.

**Board Sponsor:** Flo Panel Coates, Chief Nurse
**Implementation Lead:** John Kennedy, Deputy Director of Nursing
**Monitoring:** Quality and Safety Committee

**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

During 2010/2011 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 120 of these NHS services.

The income generated by the NHS services reviewed in 2010/2011 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2010/2011.

### Clinical Audit

During 2010/2011, 342 clinical audits were carried out in the trust. This was a mixture of national and local audits. 43 national clinical audits and 4 national confidential enquiries covered NHS services that MTW provides.

We participated in 77% of national clinical audits and 100% of national confidential enquiries, which we were eligible to participate in. These are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| **National Clinical Audits for inclusion in Quality Accounts 2011** | | | | ***Comments*** |
|---|---|---|---|---|
| **Recruited patients during 2010 - 11** | ***Participation*** Y, N or NA | ***No of cases submitted*** | ***% cases submitted*** | |
| ***Peri and Neonatal*** | | | | |
| Perinatal mortality (CEMACH) | Y | 27 | 100% | |
| Neonatal Intensive and Special Care (NNAP) | Y | 541 | 100% | |
| ***Children*** | | | | |
| Paediatric pneumonia (British Thoracic Society) | Y | 14 | 100% | |
| Paediatric asthma (British Thoracic Society) | Y | 25 | 63% | 40 cases required from trust. |
| Paediatric fever (College of Emergency Medicine) | Y | 100 | 100% | |
| Diabetes (RCPH National Paediatric Diabetes Audit) | Y | 140 | 100% | |
| ***Adult Care*** | | | | |
| Emergency use of oxygen (British Thoracic Society) | N | 0 | - | Did not register for this year's audit. |

| | | | | |
|---|---|---|---|---|
| | | | | Registered for current year. |
| Adult community acquired pneumonia (British Thoracic Society) | Y | 15 | | Still submitting data. Cut off 31st May. |
| Non invasive ventilation (NIV) - adults (British Thoracic Society) | Y | 50 | 100% | |
| Pleural procedures (British Thoracic Society) | N | 0 | - | Did not register for this audit. Registered for 2011/12 |
| Cardiac Arrest (National Cardiac Arrest Audit) | N | 0 | - | Did not register for this audit. Registered for 2011/12 |
| Vital signs in majors (College of Emergency Medicine) | Y | 100 | 100% | |
| Adult Critical Care (Case Mix programme) | Y | 966 | 100% | |
| Potential donor audit (NHS Blood & Transplant) | Y | 0 | - | Registered but no cases submitted to date |
| ***Long Term Conditions*** | | | | |
| Diabetes (National Adult Diabetes Audit) | N | 0 | 0 | No data submitted this year. Lack of Diabeta 3 means collection and submission not possible. System to be in place next year. |
| Heavy menstrual bleeding (RGOG National Audit of HMB) | Y | 19 | 100% | Data collection started in February 2011 all returned questionnaires submitted to RCOG. Data collection ongoing. |
| Chronic Pain (National Pain Audit) | N | 0 | 0 | No data submitted last year. Registered for 2011/12 |
| Ulcerative colitis and Crohn's disease (National IBD audit) | Y | 18 | 18 to date | 80 entries required. Still submitting data. Data cut off point 31/07/11 |
| Parkinson's Disease (National Parkinson's Audit) | N | 0 | 0 | Did not submit data. Registered for current year. |
| COPD (British Thoracic Society / European audit) | Y | 63 | 63 to date | |
| Adult asthma (British Thoracic Society) | N | 0 | 0 | Did not submit data. Registered for current year. |
| Bronchiectasis (British Thoracic Society) | Y | 10 | 100% | |
| ***Elective Procedures*** | | | | |
| Hip, knee and ankle replacements (National Joint Registry) | Y | 89 | 89 to date | Data collection still ongoing for this year. |
| Elective surgery (National PROMs | Y | 148 | 148 to date | Data collection still |

| | | | | |
|---|---|---|---|---|
| Programme) | | | | ongoing for this year. |
| Coronary angioplasty (NICOR Adult cardiac interventions audit) | Y | 258 | 100% | |
| ***Cardiovascular disease*** | | | | |
| Familial hypercholesterolaemia (National Clinical Audit of Management of FH) | Y | 187 | 100% | |
| Acute Myocardial Infarction and other ACS (MINAP) | Y | 312 | 100% | |
| Heart Failure (Heart Failure Audit) | Y | 427 | 96% | |
| Acute Stroke (SINAP) | N | NA | - | Did not take part in the pilot study. Registered for next round of the audit. |
| Stroke Care (National Sentinel Stoke Audit) | Y | 113 | 94% | |
| ***Renal Disease*** | | | | |
| Renal Colic (College of Emergency Medicine) | Y | 103 | 100% | |
| ***Cancer*** | | | | |
| Lung Cancer (National Lung Cancer Audit) | Y | 193 | 100% | |
| Bowel Cancer (National Bowel Cancer Audit Programme) | Y | 288 | 100% | |
| Head & Neck Cancer (DHANO) | Y | 54 | 100% | |
| ***Trauma*** | | | | |
| Hip Fracture (National Hip Fracture Database) | Y | 310 | 73% | |
| Severe Trauma (Trauma Audit & Research Network) TARN | Y | TBC | - | Trust registered. Numbers and % tbc |
| Falls and non-hip fractures (National falls and Bone Health Audit) | Y | 60 | 50% | Only submitted data from one site. |
| ***Blood transfusion*** | | | | |
| O negative blood use (National comparative audit of blood transfusion) | Y | 40 | 100% | |
| Platelet use (National comparative audit of blood transfusion) | N | 0 | 0 | Trust did not submit data. Trust will register for 2011-12 |
| **National Confidential Enquiries** | | | | |
| Parenteral Nutrition | Y | 51 | 100% | |
| Surgery in the Elderly | Y | 29 | 100% | |
| Cardiac Arrest Audit | Y | 11 | 100% | |
| Peri-Operative Care Audit | Y | 113 | 100% | |
| | | | | |

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

| | |
|---|---|
| NDA: National Diabetes Audit | Diabeta 3 to be installed this year 2011, following ongoing IT problems.<br>Paediatric data submitted. |
| NLCA: Lung Cancer | Fully participating for 2010-11. See data in main table. |
| TARN: severe trauma | Fully participating for 2010-11. See data in main table. |

Eight national audits were published in 2009/10 with action to be taken in 2010/11 –

| | |
|---|---|
| National Diabetes Audit – Fulfilling the requirement for the Diabetes NSF | MTW continue to work with IT for the full implementation of the Diabeta 3 Database. Actions in place to implement Sept 11. |
| National Mastectomy and Breast Reconstruction Audit. (RCN/NCASP) | None needed as Trust met standards Noted by division and presented to Trust Board |
| NCEPOD – For better or Worse? Review of the care of patients who died within 30 days of receiving systemic anti-cancer therapy | None needed as Trust met standards. Noted by division and presented to Trust Board |
| NHS Patient Survey – Adult Inpatient Survey 2008 | Communication and information remains a key issue and remains one of our priorities for 2011-12. |
| Mandatory National Audit: Head & Neck Cancer (DAHNO) | The trust fully participated in this audit and have overcome their data capture problems by closer working with the Kent Cancer Network and more accurate reporting from the INFOFLEX system. |
| Mandatory National Audit: Bowel Cancer (NBOCASP) | Senior consultants have reviewed the 2009 audit report. Continue to submit data. |
| National Mandatory audit: Oesophago-gastric (stomach) cancer (AUGIS/NCASP) | Continue to submit data. No actions were necessary from this report. |
| National audit of the Liverpool Care Pathway Care of the dying (2nd round) | Improve monitoring and measurement of LCP data to mark improvements, Training given to medical and nursing staff in delivery of end of life care and to improve spiritual and psychological care provided to patients and next of kin/carers. In 2011/12 the trust will be participating in round 3 of this audit. |

**The reports of 32 national clinical audits were reviewed by the provider in 2010/2011 and Maidstone and Tunbridge Wells NHS Trust intends to take the following actions to improve the quality of healthcare provided:**

| National Annual reports published March 2010 - March 2011 | Report Received | |
|---|---|---|
| **Peri and Neonatal** | | |
| Perinatal Mortality (CEMACH) | Y | Report received in March 2011**.** Review currently being undertaken and any required actions identified. Action Plan expected by July 2011. |
| **Children** | | |
| Paediatric pneumonia (British Thoracic Society) | Y | Data analysis received from BTS in April. Action plan to be written by June 2011. |
| Paediatric asthma (British Thoracic Society) | Y | Data analysis received in Division in February 2011. Action plan to be written by June 2011. |
| Paediatric Intensive Care (PICANet) | NA | Trust does not provide these services. MTW Special Care Baby Unit operates at Levels 1 and 2. This audit relates to Level 3 Units. MTW Not invited to participate. |
| Audit of Pain in Children within A&E (National CEM) | Y | Report received November 2010.<br>Key Actions: Improvements included introducing electronic software to which includes a mandatory pain score field. Nurses to be trained and accredited to initiate initial prescribing of analgesia. |
| **Adult care** | | |
| Adult Community acquired pneumonia (British Thoracic Society) | Y | Data analysis received September 2010. The Division has reviewed the report and developed an action plan on developing improved training for Doctors in the management of pneumonia. |
| Non Invasive Ventilation (NIV) - adults (British Thoracic Society) | Y | Report received. Data analysis of this pilot study was received in September 2010.This data analysis page concluded with the need for an annual audit of NIV. MTW was not one of the 61 organisations that took part in 2010. MTW has submitted data for the full 2011 audit and awaits the next report. |

| | | |
|---|---|---|
| **Long Term Conditions** | | |
| Diabetes (National Adult Diabetes Audit) | Y | The Diabetes audit report was received in April 2010.<br>Key Actions: to install the Diabeta 3 system across the trust to enable electronic data submission for this national audit project.<br>The trust has registered to take part in the 2011-12 audits. |
| Parkinson's Disease (National Parkinson's Audit) | Y | Data analysis received May 2010. The trust did not participate so has reviewed the data from other trusts to discover if improvements can be made at MTW. Will be participating in the 2011-12 audits. |
| Adult Asthma (British Thoracic Society) | Y | The data analysis for this audit was received in June 2010. The analysis highlighted overarching national concerns with the general management of asthmatics in Outpatient Departments. Therefore learning from this report was limited. The trust is registered and ready to submit data this year. |
| Bronchiectasis (British Thoracic Society) | Y | Analysis received March 2011.<br>Key Actions: a new patient management flow sheet to be introduced. Spirometry and sputum culture to be performed before antibiotics administered. |
| National CEM Asthma in adults and Children (College of Emergency Medicine) | Y | Report received in November 2010<br>Key Actions: asthma proforma modified to provide better recoding of nebuliser treatments; junior doctor clinical handbook reviewed to ensure it includes the latest guidance on treating moderate to severe asthma; peak flow monitors to be available at every triage; the electronic Manchester triage solution implemented. |
| **Elective Procedures** | | |
| Hip, Knee and ankle replacements (National Joint Registry) | Y | Report received in January 2011.<br>Actions include: Conducting a five year follow up of total condylar type knee replacements. Surgeons performing patellofemoral joint replacement aware of the high failure rates associated with this procedure and continue to audit and review of the results of uni-compartmental knee arthroscopy. |
| Elective Surgery (National PROMS Programme) | Y | Reports are published on a monthly basis and reviewed by Pre Assessment staff in the Planned Services Division. |

| | | |
|---|---|---|
| Coronary angioplasty (NICOR Adult Cardiac Interventions audit) | Y | Report received in March 2010 and this was reviewed by our Consultant Cardiologist in the Emergency Services Division. Action plan being developed, planned to be completed by June 2011. |
| **Cardiovascular Disease** | | |
| Familial hypercholesterolemia (National Clinical Audit of mgt of FH Royal College of Physicians) | Y | Report received in November 2010<br>Key Actions: to implement greater use of DNA studies and an increase in nursing support staff within clinics. |
| Acute Myocardial Infarction & other ACS (MINAP) | Y | Report received January 2011. They are in the process of developing an action plan, working with East Kent Hospitals to improve care for MTW patients who are treated at their cardiac centre. |
| Heart Failure (Heart Failure Audit) | Y | Report received January 2011.<br>Key Actions: making improvements to the patient pathway (streamlining), ensuring heart failure specialists are in post to treat patients, auditing heart failure NICE guidelines are during 2011-12 to ensure patients are receiving appropriate medication. |
| Pulmonary Hypertension (Pulmonary Hypertension Audit) | Y | The report was received in September 2010. All patients with pulmonary hypertension presenting to MTW are referred to London for treatment. This benchmarking study was the first national data collection of pulmonary hypertension. The division will use the information to inform their working relationships with the London trusts. |
| **Cancer** | | |
| Head & neck cancer (DHANO) | Y | Report received in January 2011. Currently being reviewed at Cancer Network Group for action plan development by each trust within the network group. Kent wide action plan is planned for completion by August 2011. |
| **Trauma** | | |
| Hip Fracture (National Hip Fracture Database) | Y | Report received January 2011.<br>Key Actions: Ring-fencing of Hip fracture bed, prioritisation of patients on trauma lists, dedicated hip fracture lists and continued audit and surveillance to minimise pressure ulcers. The trust has appointed a dedicated orthogeriatric Consultant. Falls assessment will be promoted with the appointment of the dedicated orthogeriatrician and development of falls clinic. |

| | | |
|---|---|---|
| Severe Trauma (Trauma Audit & Research Network) TARN | N | Trust did not submit data for 2010-11 therefore no report has been received for review. Only 60% of trusts are currently taking part and receiving national reports. The Trust will be participating in the 2011/12 audit. |
| Audit of management of Fracture Neck of Femur within A&E. (National CEM) | Y | Report received November 2010.<br>Reviewed at High Level Exec Committee in Feb 2011. Action plan has been developed. Improvements included introducing electronic software to which includes a mandatory pain score field. Nurses to be trained and accredited to initiate initial prescribing of analgesia. |
| **Blood transfusion** | | |
| O neg blood use (National Comparative Audit of Blood Transfusion) | Y | Report was received in April 2011.<br>The Transfusion Committee will discuss the findings in June 2011 (Next quarterly meeting). |
| Platelet use (National Comparative Audit of Blood Transfusion) | N | The report has not yet been published - delays from NCABT. The trust is registered to take part in 2011-12. |
| National Audit of the use of red cells in neonates and Children (National Comparative Audit of Blood Transfusion) | Y | Report received in June 2010.<br>Key actions: New Guidelines have been written on the use of red blood cells in neonates and children and incorporated into the Trust Transfusion Policy. |
| **Patient Surveys** | | |
| National NHS Inpatient Patient Survey 2010 (Pickers) | Y | Report received February 2011.<br>Key Actions: to address issues associated with patient's dissatisfaction with staff communication, waits for treatment, delayed discharges and noise at night. See also main body of the Quality Accounts re actions relating to survey. |
| National Paediatric Outpatients Survey 2010 (Pickers) | Y | Report received in November 2010.<br>Key Actions: Clearer information letters developed regarding format of outpatient appointments, Guidance documentation written on information for medical staff when providing details of tests required, Training and development sessions around health professional's communication with patients. |

| | | |
|---|---|---|
| National Maternity Survey 2010 (Pickers) | Y | Report received in September 2010.<br>Key Actions: increase choice of birth place (new hospital at Pembury will address this), conduct a follow on maternity questionnaire to seek latest views, increase the number of anti-natal classes available, review facilities in other organisations that provide services to provide post natal care. |
| National Cancer Patient Experience Survey (DoH) | Y | Report received in January 2011.<br>Key Actions: address patient concerns relating to privacy and dignity and communication from staff. Findings mirror patient views in the National Inpatient Survey. |
| **Confidential Enquiries** | | |
| NCEPOD - An age old problem (NCEPOD) | Y | Report received in November 2010.<br>Key Actions: Business case for Orthogeriatrician consultant has been agreed. AKI to be included on local education programmes. Formalist attendance of anaesthetists at T&O meetings. Surgical review of patients to meet 12 hourly target once move to new hospital as 24 hour on call service will be provided. Daily dedicated NCEPOD lists will be implemented once move to new hospital. Move planned in September 2011 |
| NCEPOD - A mixed bag - Parenteral Nutrition (NCEPOD) | Y | Report received in June 2010.<br>Key Actions: Write Policy for Parenteral Nutrition. More surgical input encouraged with a named Surgeon to attend the Nutritional Steering Committee. Local audits have been completed to assess compliance with national results. |

**The reports of 189 local clinical audits were reviewed by the provider in 2010/2011 and actions that Maidstone and Tunbridge Wells NHS Trust has or intends to take to improve the quality of healthcare provided include:**


Radiotherapists identified a need to develop an electronic pathway to ensure **patients plans are ready 24 hours** prior to their appointments. This has been developed and is available for network use via network access


Consultant Urologist purchased a robotic camera holder to assist with Laparoscopic radical prostatectomies as a result of the first round of the audit. The re-audit showed that this has lead to **reduction in operation times**, reductions in blood loss and reduced length of stay in hospital for patients


Anaesthetists identified the need for a **standardised handover chart** to be added to the back of the anaesthetic sheet. This will prompt the verbal handover of all patient information with the transfer of patient from recovery to ward to insure all relevant information is passed on to optimise care for patients


The infection control team audited the cleaning and **disinfecting of flexible endoscopes**. A water level indicator has been fixed to the decontamination sink to ensure accurate measurements and dilution levels of detergents when manually cleaning endoscopes. Additional staff training carried out to ensure staff have retained competency assessments. Staff involved in internal training have undergone a “train the trainer” course


The paediatric team audited the use of **intravenous gentamicin for neonates**. A double checking prompt was instigated and the re-audit showed that this had increased the rate of compliance with recording information within the case notes from 67% to 91%. Formal documentation of delays in preparation is now 95% where previously this information was not recorded at all. Documentation of gentamicin doses administered within 1 hour is now 94% and was previously 2.3%


The Breast Care Nurse specialists have introduced **wrist bands for patients** having axillary node clearance or sentinel lymph node biopsy that is worn on the affected arm to alert staff that no invasive procedure or blood pressure monitoring should be undertaken on this arm. This is to reduce the risk of Lymphoedema following breast surgery. Laminated signs are also put over the patient’s bed with instruction for non-use of the effected arm


The Infection Prevention team have produced a sticker that is placed in the patient’s notes alerting staff of a positive diagnosis of Clostridium difficile. This helps ensure that **patients are easily identified and treated appropriately**


A new pathway has been written in conjunction with the paediatric and A&E teams to **ensure appropriate triaging, assessment and onward referral** when children present in A&E with a temperature of 38 degrees or above.


An audit on the **safe use and management of sharps** has led to the purchase of additional brackets and trays to put sharps bins at a safe level for use. Correct sized bins are available to prevent protruding of sharps from boxes, and one brand system to be in use throughout the trust for consistency and cost reduction.


The Tissue Viability nurse has implemented the use of aqueous cream as a **soap substitute for high risk patients** by working with pharmacy and ward matrons/sisters.


Introduction of a core handover template for the **management of pressure ulcers**. Introduction of a Care Pathway for the management of Grade 3 & 4 pressure ulcers. Review Trusts Pressure Ulcer management guideline/policy. Implement the use of film dressings to heels and heel elevation in Trauma & Orthopaedics.


The Physicians have developed a pro-forma to be completed on the post-take ward round. This will incorporate all the necessary information required to meet the Royal College of Physicians r**ecord keeping standards** and improve the quality and content of documentation.

# Research

## Participation in clinical research

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

## Regulation

The number of patients receiving NHS services provided or sub-contracted by Maidstone and Tunbridge Wells NHS Trust in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 2533.

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.

We were involved in conducting 354 clinical research studies in 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 2010/2011.

There were 84 clinical staff participating in research approved by a research ethics committee at Maidstone and Tunbridge Wells NHS Trust during 2010/2011. These staff participated in research covering 22 of medical specialties.

As well, in the last three years, 40 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates Maidstone and Tunbridge Wells NHS Trust commitment to testing and offering the latest medical treatments and techniques.

Maidstone and Tunbridge Wells NHS Trust is committed to increasing the number of research trials it sponsors, to both widen its scope of research and increase the number of MTW-employed chief investigators. MTW-sponsored projects and proposals, that do not involve a medicinal product, include making improvements in the diagnosis and treatment of breast cancer, improving pain management following hip and knee surgery, treatment of non small cell lung cancer in the elderly and patient verses hospital-led follow up for patients following gastro-oesophageal cancer surgery.

## Goals agreed with commissioners

### Use of the CQUIN payment framework


A proportion of Maidstone and Tunbridge Wells NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between Maidstone and Tunbridge Wells NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2010/11, quality improvement and innovation goals were set as indicated in the table below.

| Indicators with Financial Implications (Based on Year End) | | Year End/Local Survey | | | National Survey 2010 | |
|---|---|---|---|---|---|---|
| | | Plan | Actual | RAG | Actual | RAG |
| **CQUINs** | | | | | | |
| 1 | **% of Adult Inpatients that have a VTE Risk Assessment - runs one month behind** | 90% | 33.8% | | Not applicable | |
| 2 | **% Positive Response to: Were you involved as much as you wanted to be in decisions about your care and treatment?** | 68.29% | 87.0% | Local Survey | 49.00% | 2010 Survey |
| | **% Positive Response to: Did you find someone on the hospital staff to talk to you about your worries and fears?** | 68.29% | 87.00% | Local Survey | 35.00% | 2010 Survey |
| | **% Positive Response to: Were you given enough privacy when discussing your condition or treatment?** | 68.29% | 94.00% | Local Survey | 67.00% | 2010 Survey |
| | **% Positive Response to: Did a member of staff tell about medication side effects to watch for when you went home?** | 68.29% | 60.00% | Local Survey | 50.00% | 2010 Survey |
| | **% Positive Response to: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?** | 68.29% | 68.00% | Local Survey | 79.00% | 2010 Survey |
| 3a | **% All Slips, Trips & Falls per 10,000 admissions - runs one month behind - 7.5% improvement** | 1.65% | 1.17% | | Not applicable | |
| 3b | **% of Falls with Risk Assessment & relevant action completed - 80% or 50% improvement on baseline** | 80% | 85.9% | | Not applicable | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4a | **% of Stroke patients receiving all 9 Key Sentinal Audit Indicators - 75% or 20% improvement on baseline** | 75% | 75.2% | | Not applicable | |
| 4b | **% of Stroke patients with EDD <7 days of admission - 80% or 20% improvement on baseline** | 80% | 93.7% | | Not applicable | |
| 4c | **% of Stroke referral letters sent to next provider at least 24hrs before discharge - 90% or 20% improvement on baseline** | 20% | 26.0% | | Not applicable | |
| 5a | **% of inpatient discharge summaries sent electronically** | 90% | 49.0% | | Not applicable | |
| 5a | **% of outpatient letters sent within 2 weeks of clinic and conforming to revised template** | 85% | 85.0% | | Not applicable | |
| 6a | **Pre-Op Process % Positive Response to: Did a member of staff explain what would be done during the operation or procedure?** | 78% | 88.0% | Local Survey | 68% | 2010 Survey |
| | **Pre-Op Process % Positive Response to: Were you told how you could expect to feel after you had the operation or procedure?** | 62% | 75.0% | Local Survey | 52% | 2010 Survey |
| 6b | **Food & Nutrition % Positive Response to: How would you rate the hospital food?** | 91% | 90% | Local Survey | 48% | 2010 Survey |
| | **Food & Nutrition % Positive Response to: Did you get enough help from staff to eat your meals?** | 89% | 90% | Local Survey | 63% | 2010 Survey |
| 7 | **Referrals to Stop Smoking Service - 1500 in year** | 1500 | 1323 | | Not applicable | |
| 8a | **Diabetes - Audit of Insulin Medication Errors - 24%** | 24% | 15.5% | | Not applicable | |
| 8b | **Diabetes - Audit re: No of inpatients with diabetes who feel that there is usually a meal choice suitable for their diabetes - 25% improvement on baseline** | 52% | 69% | | Not applicable | |
| 9a | **Eligible staff trained in Dementia Awareness - Plan is 70** | 70 | 83 | | Not applicable | |
| 9b | **Attendance at WK Dementia Forum** | 80.0% | 90.0% | | Not applicable | |
| 10 | **Improve Quality of patient care - process milestones for 4 key areas: Myocardial Infarction, Community Acquired Pneumonia, Heart Failure, Hip & Knee Replacements - Sept 2010 onwards** | 85.0% | 85.0% | | Not applicable | |

You will note that a number of these are linked to the key priorities that were set for 2010/11.

Similarly we have used these outcomes to help inform our decision on what to make key priorities for 2011/12. We have included the end of year position for the local inpatient survey as well as those published for the 2010 National Survey.

On reviewing our data we found that we had a corresponding dip in patient satisfaction levels from our local patient surveys that were carried out during the same month as patients who were targeted for the national Survey. Since then (summer 2010) we have been able to see an increase in satisfaction levels reported locally since then.

## Statements from the CQC

Maidstone and Tunbridge Wells NHS Trust is required to register with the Care Quality Commission and is registered to provide the following services:

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

No conditions were applied to the registration.

The Care Quality Commission has not taken enforcement action against Maidstone and Tunbridge Wells NHS Trust during 2010/11

The Trust was part of an integrated inspection of Safeguarding and Looked after Children's Services in Kent – West Kent PCT and providers – undertaken by the Care Quality Commission and Ofsted took place during October of 2010.

The services which were inspected included the Maidstone and Tunbridge Wells NHS Trust, the Dartford and Gravesham NHS Trust, Kent and Medway NHS Partnership and Care Trust and also West Kent Community Health.

**The Inspection Process**

This inspection was conducted alongside the Ofsted-led programme of children's services inspections. These focus on safeguarding and the care of Looked after Children (LAC) within a specific local authority. The two-week inspection process comprised a range of methods for gathering information – document reviews, interviews, focus groups (including where possible with children and young people) and visits – in order to develop a corroborated set of evidence which contributed to the overall framework for the integrated inspection.

The inspection report made 18 recommendations, a number of which were to be the responsibility of all the agencies who had been part of the inspection and some which were specific to particular agencies.

11 of the recommendations were joint, of the remaining 7, 2 were specific to Primary Care Trusts , 4 for all Health Partners and 1 to the Maidstone and Tunbridge Wells NHS Trust (number 13)

Maidstone and Tunbridge Wells Trust has completed an action plan in relation to all recommendations for Health Partner, joint and Trust Specific. This action plan is monitored by a forum chaired by the West Kent lead nurse for Safeguarding. The Trust has appointed into the second post for Safeguarding since the review and is establishing champions for safe guarding children across all its departments.

**The 18 recommendations are as follows:**

**1.** (Joint) Ensure that all partners are equally conversant with the threshold for accessing social care services and provide the appropriate levels of referral information.

**2.** (Joint) Establish clear arrangements for the referral and treatment of young people aged 16-18 requiring a CAMHS service

**3.** (Joint) Ensure that all assessments of looked after children are completed to the standards required by statutory guidance, contain the necessary health and educational information and are included on the child's record.

**4.** (Joint) Improve the quality of case planning and ensure that all relevant professionals are able to participate and contribute to the process.

**5.** West Kent PCT to improve audit and monitoring of LAC needs and outcomes in order to ensure that an equitable and compliant service is in place for children living in Kent.

**6.** (Joint) Establish systematic performance management processes at all levels to improve the quality of practice and management across the partnership.

**7.** Health partners improve audit, monitoring and analysis of safeguarding data to ensure the service is properly resourced and risks identified

**8.** (Joint) Improve the child protection conference process to ensure that professionals are properly prepared and service user confidence is restored.

**9.** (Joint) Ensure that each service subscribes to a suitably independent interpreter service

**10.** (Joint) Ensure that all looked after children can access CAMHS up until 18 years of age

**11.** Health partners engage with locally agreed CAF arrangements to improve understanding of the process monitor referral rates and thresholds

**12.** Ensure that the out of hours GP service includes clear arrangements for safeguarding, including training and supervision of practitioners.

**13.** Complete the strengthening of support arrangements for safeguarding in MTW particularly in A&E.

**14.** (Joint) Review the [safeguarding] workforce and take the necessary steps to address capacity and capability shortfalls.

**15.** (Joint) Develop a multi-disciplinary looked after children strategy and clarify management and leadership roles and accountabilities

**16.** (Joint) Develop a screening tool for substance misuse for use with looked after children and young people

**17.** There is a clear strategy and plan for the health care of all LAC in Kent including annual reporting function to the PCT board and KSCB

**18.** Ensure that developments in ICT for community providers link effectively with partner agencies to improve information flows for children's health and safeguarding

## Improving MTW's data quality

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 2010-11 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 established a Data Quality Steering Group to take action on data quality issues and this has already started to improve data quality. Areas identified for improvement during 2011-12 are:-

- NHS Number Completeness
- A&E Ethnicity data
- Outpatient Referral Source data

**NHS Number and General Medical Practice Code Validity**

Maidstone and Tunbridge Wells NHS Trust submitted records during 2010-2011 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:

97.3% for admitted patient care;
98.6% for out patient care; and
82.7% for accident and emergency care.

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

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

**Information Governance Toolkit attainment levels**

Maidstone and Tunbridge Wells NHS Trust Information Governance Assessment Report overall score for 2010/2011 was 60% and was graded red on the IGT Grading Scheme.

The Trust has developed a detailed action plan, taking account of the identified gaps and weaknesses, for improvements to information governance arrangements within the organisation. The action plan has been reviewed and approved by the Trust Board and submitted to the Strategic Health Authority.

There are four areas where MTW specifically needs to improve:

- Information governance training – we did not meet the 95% target for all staff to be trained by the end of March 2011. E-Learning and face-to-face training is now readily available for staff.
- Informing patients about how their information may be used – to address this MTW now has patient information leaflets, posters and guidelines for staff.
- The transfer of documents that contain patient identifiable information needs to be identified and recorded – this is due to be completed by the end of June 2011 and evaluated by the end of September 2011.
- All assets that hold personal data (all computer equipment) should be protected by encryption – an action plan is in place.

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.

# Patient safety

### Infection control

We achieved our targets for 2010/11

All admissions are screened for MRSA according to Department of Health recommendations. The Trust MRSA screening policy and a notice of compliance are available to the public on the Trust internet site.

Over the last seven years we have reduced MRSA blood stream infections by 60% in our hospitals. For 2010/11 we achieved a 67% reduction in hospital acquired bacteraemia – there were only 7 cases in 2010/11. During 2010/11 we achieved a further reduction of C. difficile infection by 5% in our patients which means that we have seen an 88% reduction in cases since 2005/6. The Trust has an isolation area at Kent and Sussex hospital for C. difficile patients to receive specialist nursing care.

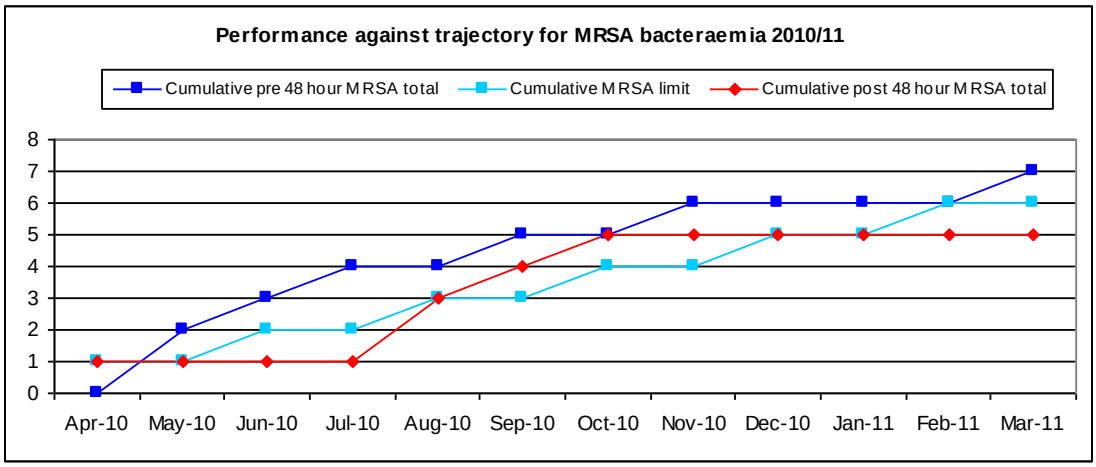
The Trust publishes its MRSA bacteraemia, MSSA bacteraemia, E. coli bacteraemia and C. difficile cases on a weekly basis on the Trust website. To give assurance of the maintenance of high standards of infection prevention and cleaning we have a comprehensive audit programme for infection control. All cases of MRSA bacteraemia or C. difficile are subject to a root cause analysis to ensure learning and best practice is carried forward.

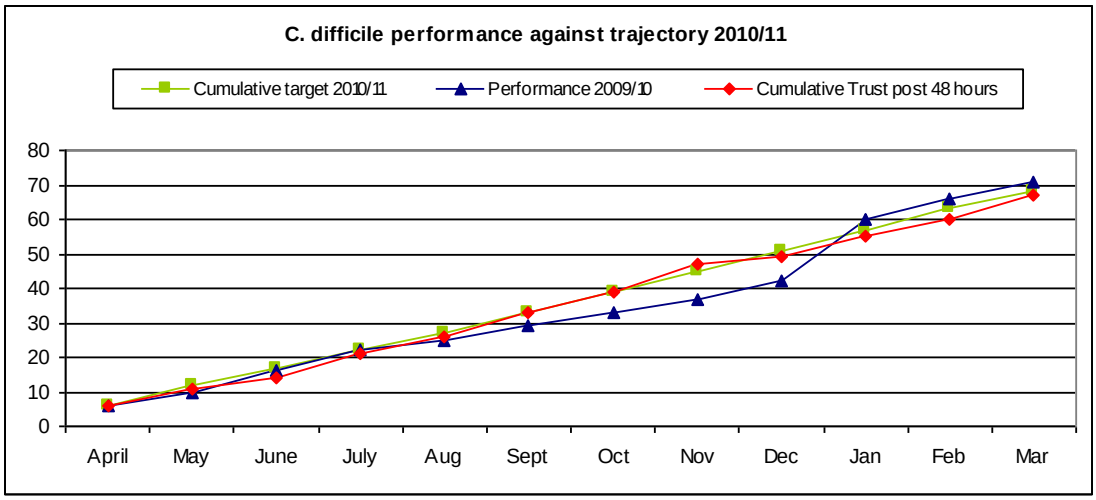
The infection prevention team have a high profile within the Trust and a strong working relationship with operational staff to reduce the impact of challenges such as Norovirus.

The Trust continues to have a zero tolerance approach to avoidable infections and cross infection. We have continued to keep infection prevention and control as one of our key priorities for 2011/12.

**Status to the end of March 2011**

The graphs below indicate the cumulative total number of cases of infection hence the continuing rising number – e.g. total at end of year of 5 cases of MRSA bacteraemia acquired in hospital.




## Patient falls

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. Elderly patients whose general health and confidence is deteriorating may be prone to falls, and this is often a reason for admission to hospital when the patient is beginning not to 'cope' independently in the community.

At Maidstone and Tunbridge Wells NHS Trust this was recognised as a serious concern several years ago and a programme of action put into place to train staff in falls prevention, introduce risk assessments and a falls care plan, and purchase appropriate aids (e.g. low rise beds, Zimmer frames) for patients at risk of falling – following NPSA guidance. For 2010/11 we aimed to reduce falls by 7.5%.

In 2010/11 we incorporated Slips, Trips and Falls training in our Health & Safety Mandatory training update. To date 86.9% of our staff have received this training. Root cause analysis

is carried out for each individual case, and feedback is shared with the clinical areas using posters and formal feedback.

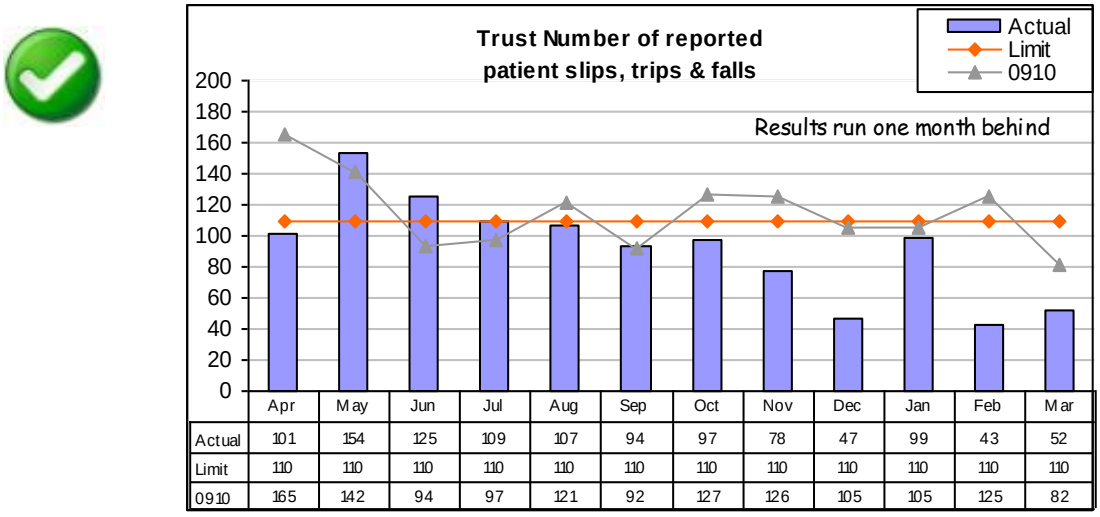
This has had a positive impact and the number of patients who have had falls has been reduced by more than the 7.5% that was set by the Trust which has been assisted by the footwear review for patients identified as being at risk of falling.

A root cause analysis tool has been developed to help identify further learning and E reporting is now in place which will deliver comprehensive live data re falls in clinical areas.

In addition the Trust has streamlined the fractured neck of femur pathway which has improved care for inpatients with a fracture also.

While recognising the good work that has taken place already, a fracture occurring in hospital is potentially an avoidable and life threatening incident for each individual patient and family. Hence, efforts continue with the aim of trying to further reduce numbers. Any patient that sustains a fracture following a fall in hospital is investigated via the Trust's Serious Incident Requiring Investigation (SIRI) process as advised by the NPSA.

Although management of falls has not been included as a key priority as we go forward into 2011/12 this does remain a key focus for us. We continue to monitor falls and determine why they have occurred (root cause analysis) to ensure that the lessons we have learned in the last year have been embedded.

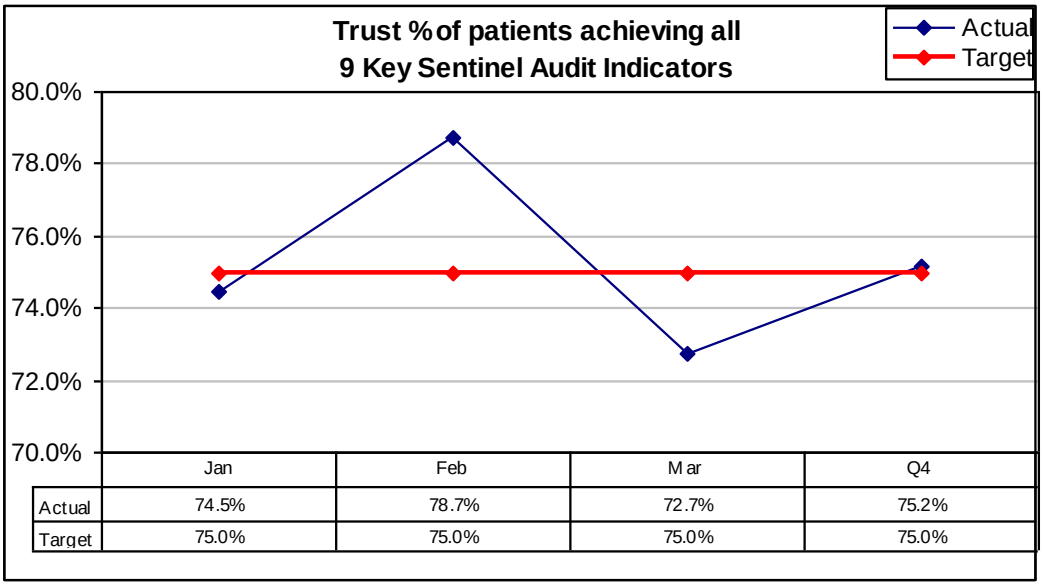



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 101 | 154 | 125 | 109 | 107 | 94 | 97 | 78 | 47 | 99 | 43 | 52 |
| Limit | 110 | 110 | 110 | 110 | 110 | 110 | 110 | 110 | 110 | 110 | 110 | 110 |
| 0910 | 165 | 142 | 94 | 97 | 121 | 92 | 127 | 126 | 105 | 105 | 125 | 82 |

# Clinical Effectiveness

## Caring for stroke patients

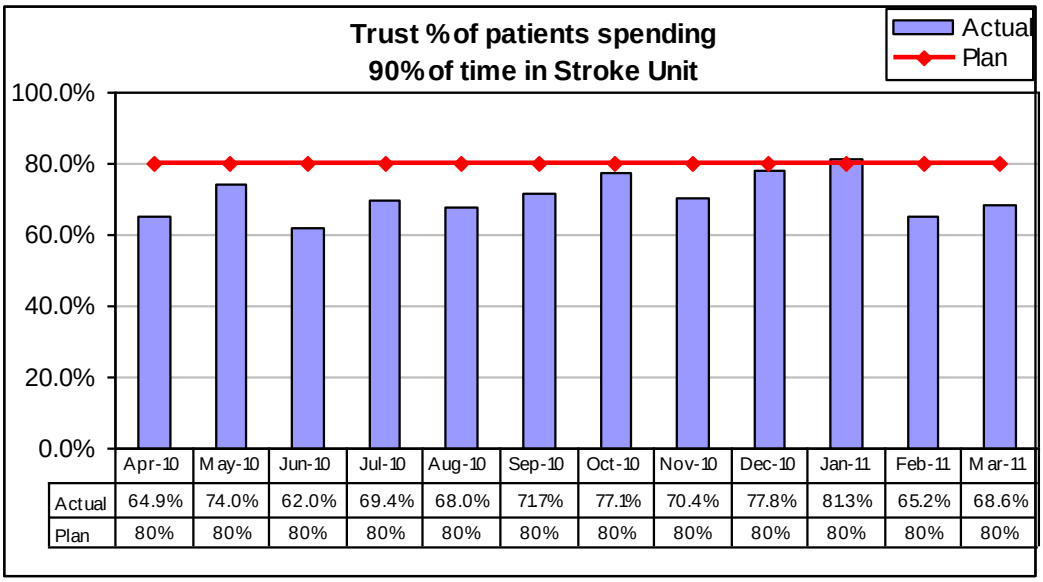
During 2010/11 the trust met the 9 national targets which were monitored within the Sentinel audit:




| | Jan | Feb | Mar | Q4 |
|---|---|---|---|---|
| Actual | 74.5% | 78.7% | 72.7% | 75.2% |
| Target | 75.0% | 75.0% | 75.0% | 75.0% |

An expected date of discharge being set for all stroke patients within 7 days of their admission to hospital was a target which was consistently met and exceeded. The target was 80% and we exceeded 90% in each quarter.

Another improvement to note is the 20% increase (on 2009/10) in stroke patients who spent 90% of their hospital stay in a stroke unit bed rather than a more generic ward. There is evidence patient outcomes improve if they are cared for in a dedicated specialist unit.




| | Apr-10 | May-10 | Jun-10 | Jul-10 | Aug-10 | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 64.9% | 74.0% | 62.0% | 69.4% | 68.0% | 71.7% | 77.1% | 70.4% | 77.8% | 81.3% | 65.2% | 68.6% |
| Plan | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |

You will note that we have included caring for patients who have had strokes within our key priorities for 2011/2012 again. We are keen to ensure that the progress that has been made to date is embedded and that we increase our performance further against the targets in order to ensure that patients are receiving the best possible care.

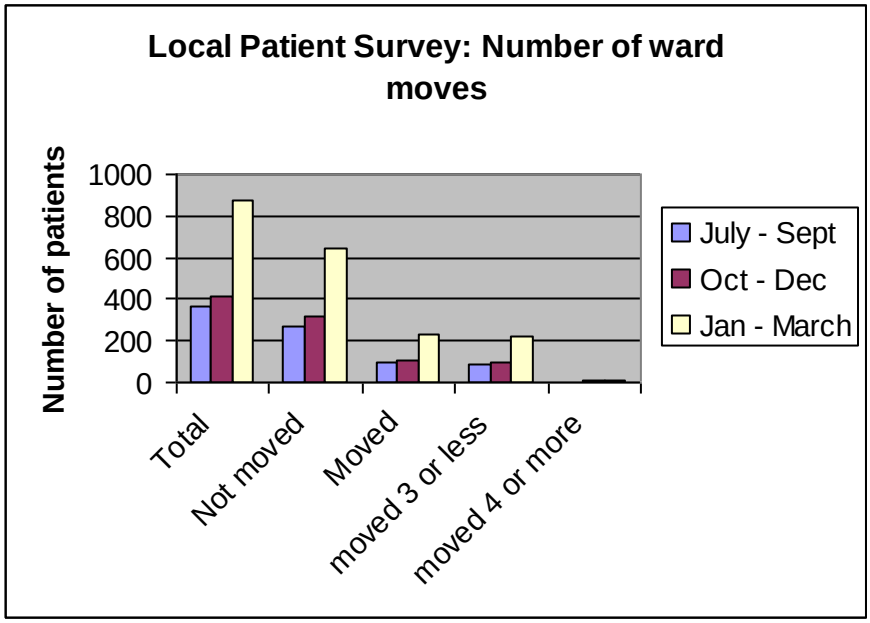
# Patient Experience

## Reducing the number of ward to ward moves for patients

We aimed to ensure patients do not move more than three times (including A&E to MAU/AAU, and MAU/AAU to the ward) unless for clinical care/infection control reasons. Patient move target not fully met for Q4 due, in part to winter pressures.

This is a new issue which was raised by patients through our consultation process and reviewing of complaints. Ward Managers were asked to provide information on the number of moves that their patients experienced. The patient Experience Matrons worked closely with the Associate Directors of Nursing to identify why patients are moved from ward to ward and to put processes in place to reduce this. In supporting the 'Dignity Challenge' patients will be treated as individuals by respecting them and offering a personalised service.

Although not a key priority for 2011/12 this issue remains a key focus to ensure that patients are in the best place to receive optimal clinical care and also to ensure they are being cared for in same sex accommodation.




## Communication and Information

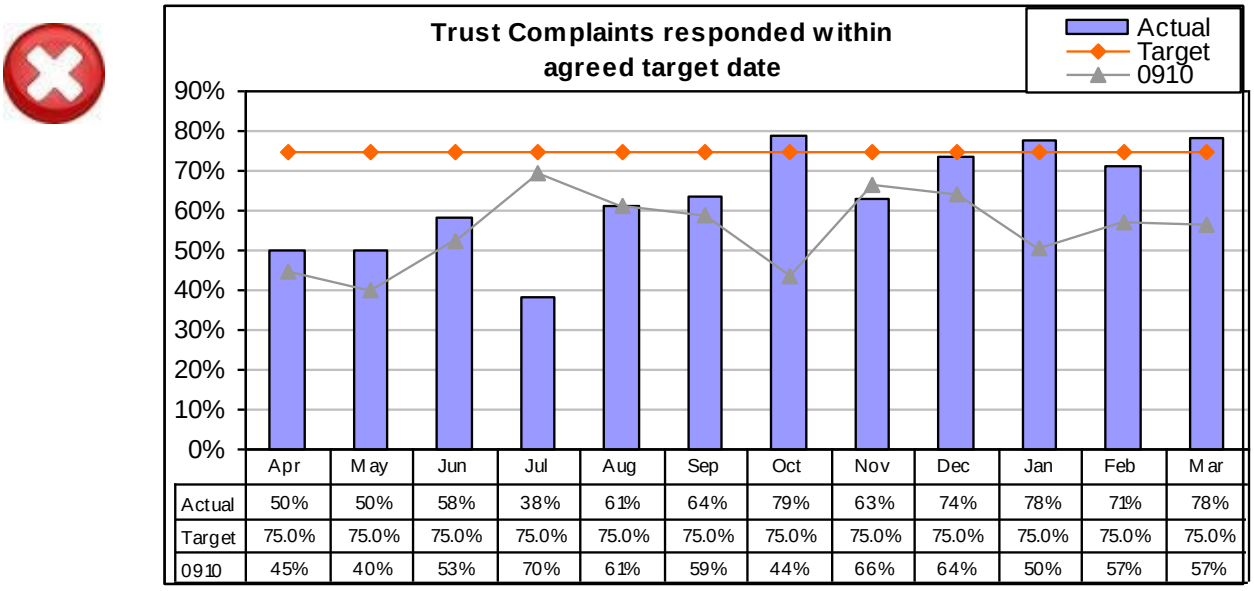
Communication and information remains an important issue for the trust as highlighted within patient surveys, complaints, and Parliamentary and Health Service Ombudsman (PHSO) report and goals were set to confirm that we are moving in the right direction to ensure our patients and visitors needs are met and the information we give to them and communication we have with them is the best it can be.

You will note from part 2 that we have decided to maintain communication as a key priority to be addressed. Although from our local survey results we have seen an improvement in the levels of patient satisfaction, in relation to communication and information there is still room for improvement.

During the last year we have developed a training programme for staff with Christ Church Canterbury University in relation to communication and the management of patient concerns. This has been made available to all front line staff and will be continuing in 2011/2012.

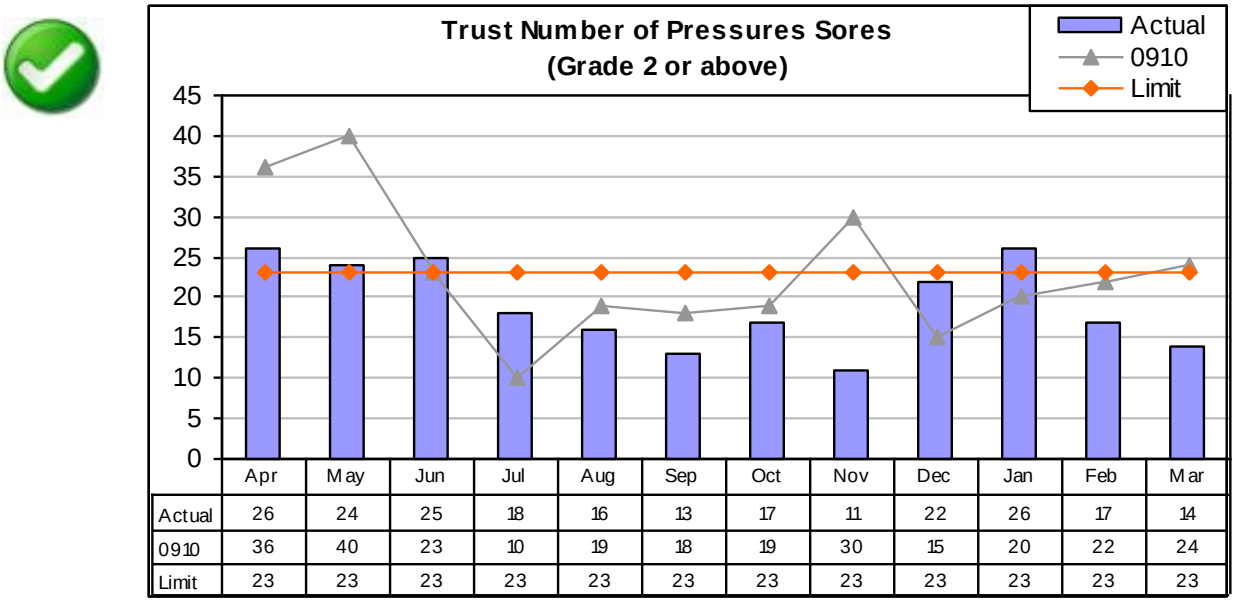
Specific issues of communication and information are being tackled in all areas across the trust where the surveys have highlighted particular concerns, for example in relation to ensuring that patients are told how they can expect to feel post operatively.

**Complaints Management -** There has been an improvement in the Trust responding to complaints within the agreed target date. Complaints are always taken extremely seriously by the Trust and we seek to learn from them all to ensure that when we have got things wrong we put strategies in place to help prevent them going wrong again.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 50% | 50% | 58% | 38% | 61% | 64% | 79% | 63% | 74% | 78% | 71% | 78% |
| 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% |
| 0910 | 45% | 40% | 53% | 70% | 61% | 59% | 44% | 66% | 64% | 50% | 57% | 57% |

**Pressure Ulcers -** Clinically, MTW has seen a reduction in hospital acquired pressure ulcers. MTW's pressure ulcer prevalence audit demonstrated a 4% reduction in 2010. The Trust's hospital acquired prevalence is 8% against a national average of 10%.



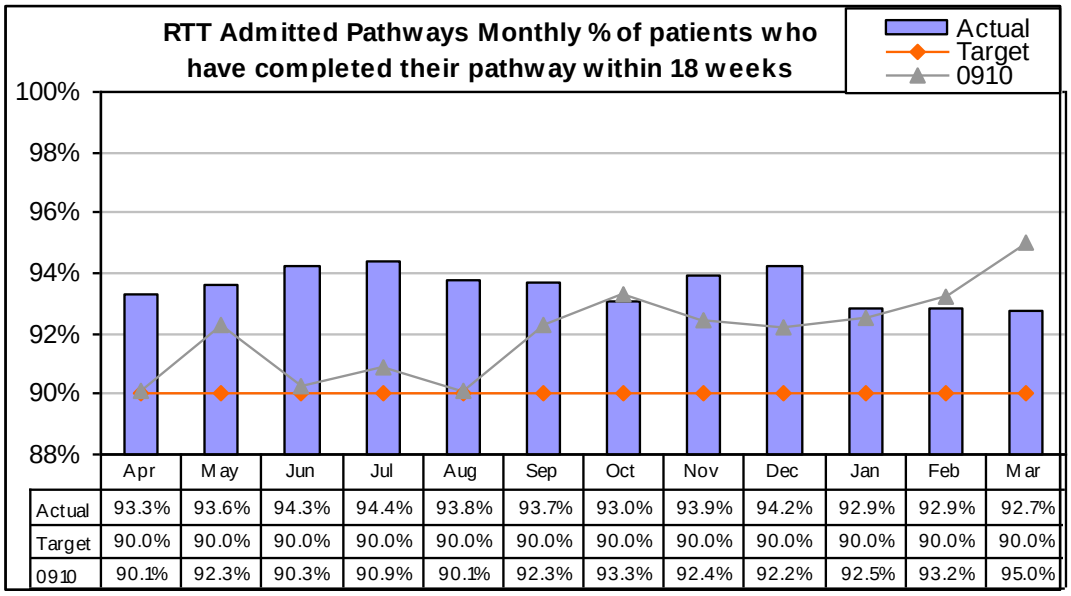

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 26 | 24 | 25 | 18 | 16 | 13 | 17 | 11 | 22 | 26 | 17 | 14 |
| 0910 | 36 | 40 | 23 | 10 | 19 | 18 | 19 | 30 | 15 | 20 | 22 | 24 |
| Limit | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 | 23 |

**During 2010/11** MTW met the vast majority of national waiting time standards. 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 2010/11 is available to view on the Trust's website, in the Board report for May 2011.

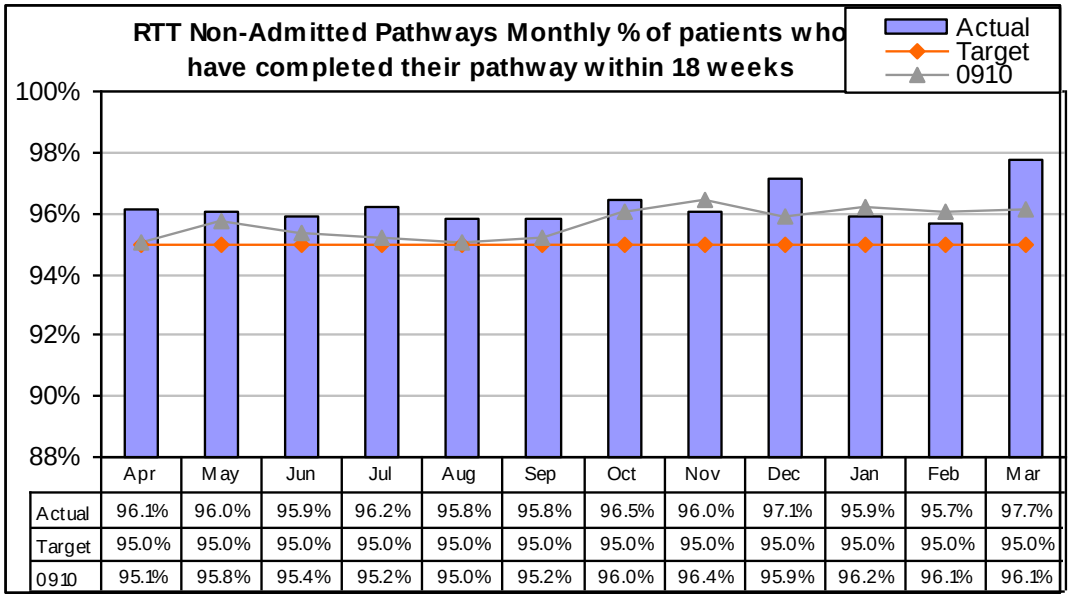
The Trust's performance against key national and local standards in 2010/11 was good with improvements in many areas over 2009-10.

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



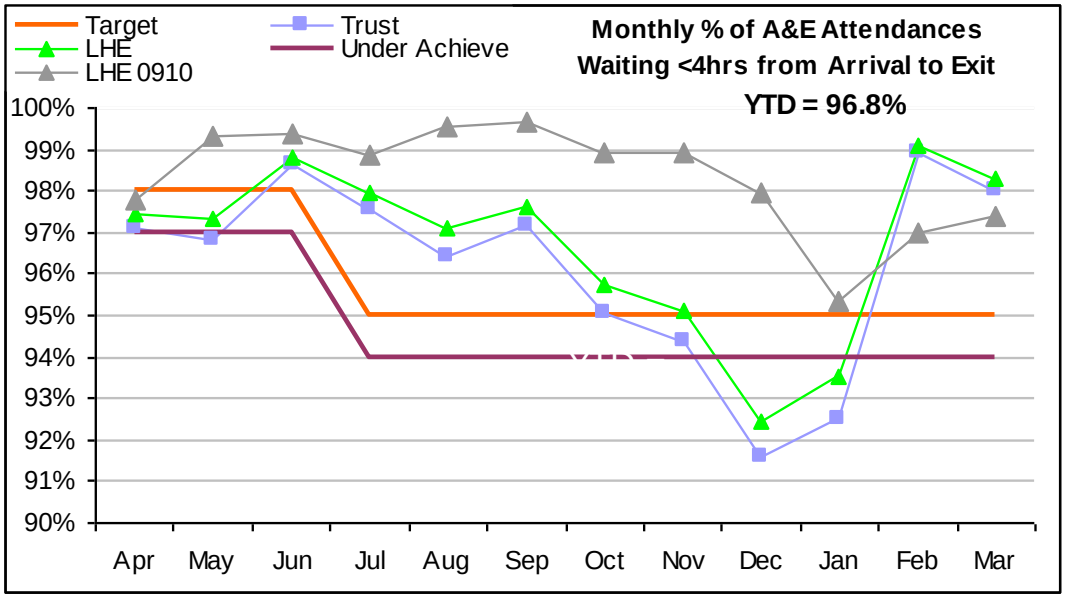

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 93.3% | 93.6% | 94.3% | 94.4% | 93.8% | 93.7% | 93.0% | 93.9% | 94.2% | 92.9% | 92.9% | 92.7% |
| Target | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% |
| 0910 | 90.1% | 92.3% | 90.3% | 90.9% | 90.1% | 92.3% | 93.3% | 92.4% | 92.2% | 92.5% | 93.2% | 95.0% |

(RTT = referral to treatment time)

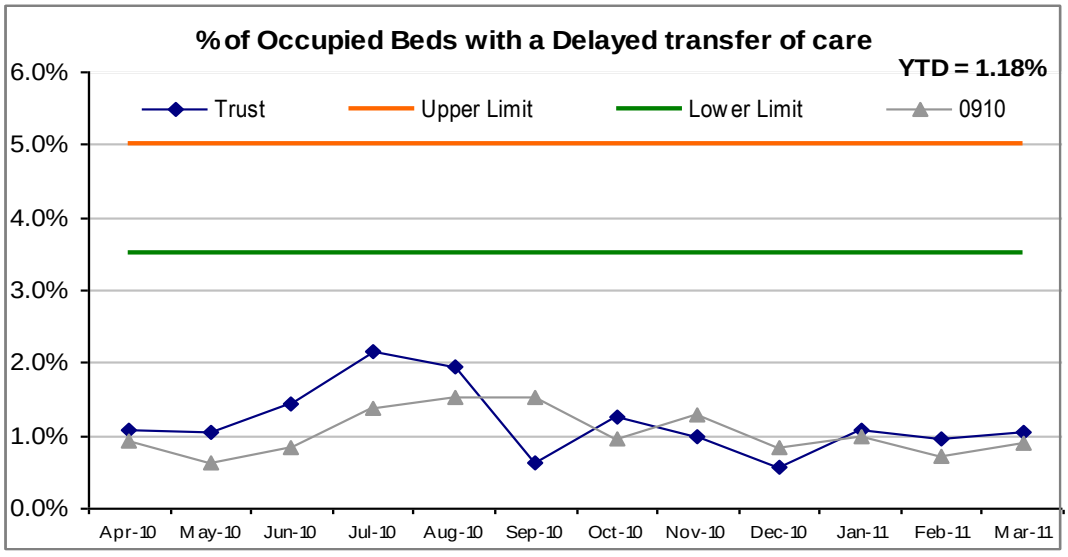



| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 96.1% | 96.0% | 95.9% | 96.2% | 95.8% | 95.8% | 96.5% | 96.0% | 97.1% | 95.9% | 95.7% | 97.7% |
| Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |
| 0910 | 95.1% | 95.8% | 95.4% | 95.2% | 95.0% | 95.2% | 96.0% | 96.4% | 95.9% | 96.2% | 96.1% | 96.1% |

**Emergency 4 hour access** – The Trust saw, treated, admitted or discharged over 95% of patients in its A&E departments in 2010-11, meeting this national standard.

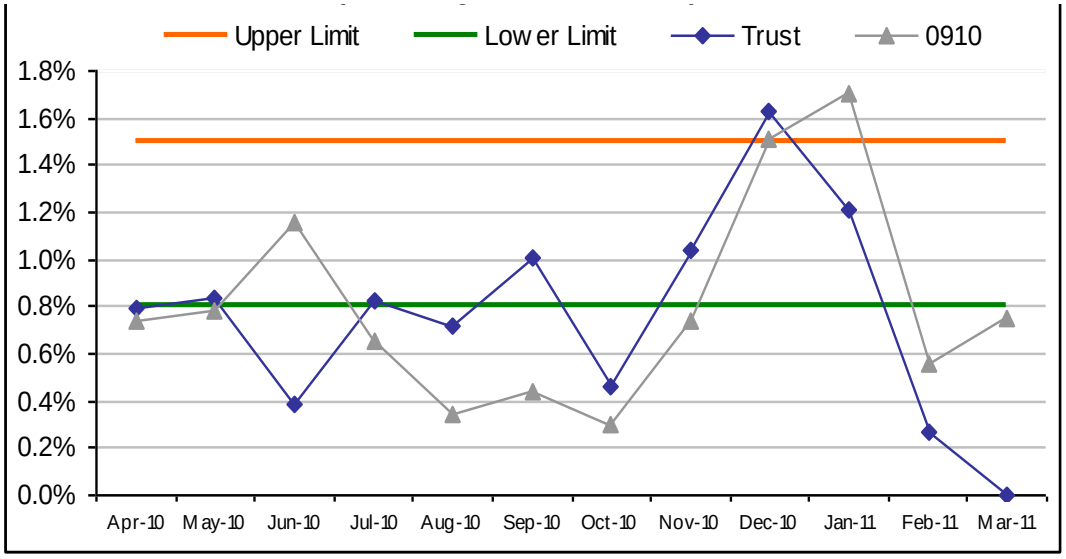



**Delayed transfers of care** – Delayed transfers of care remained well below the national limit of 3.5% at 1.18% throughout the year.

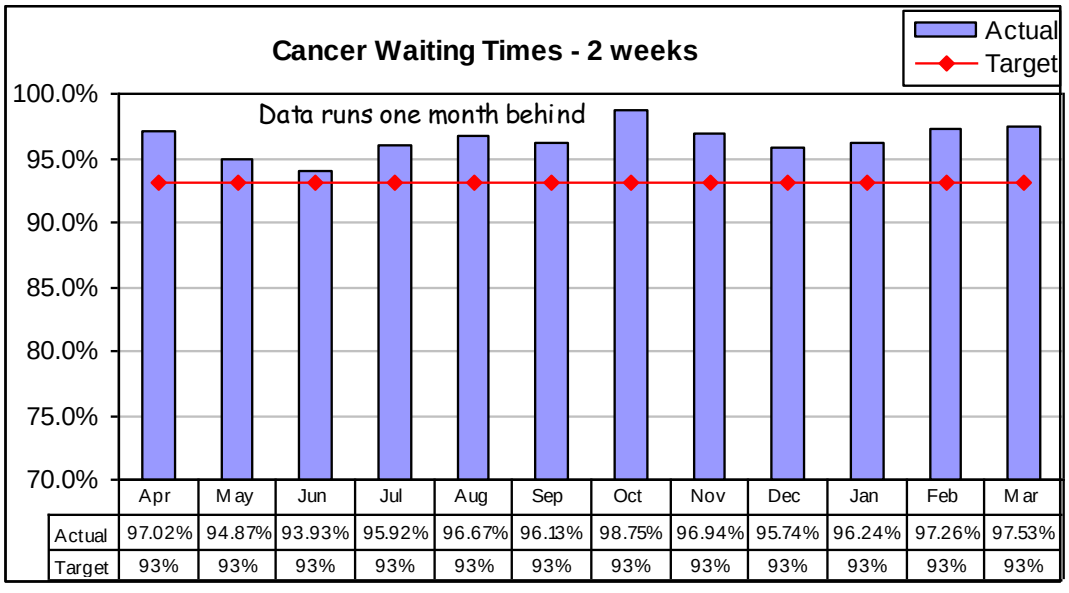



**Genito-Urinary Medicine** – the Trust saw 100% of patients within the 48 hour standard

**Cancelled operations** – for the second year running the Trust met the cancelled operations national standard of 0.8%.

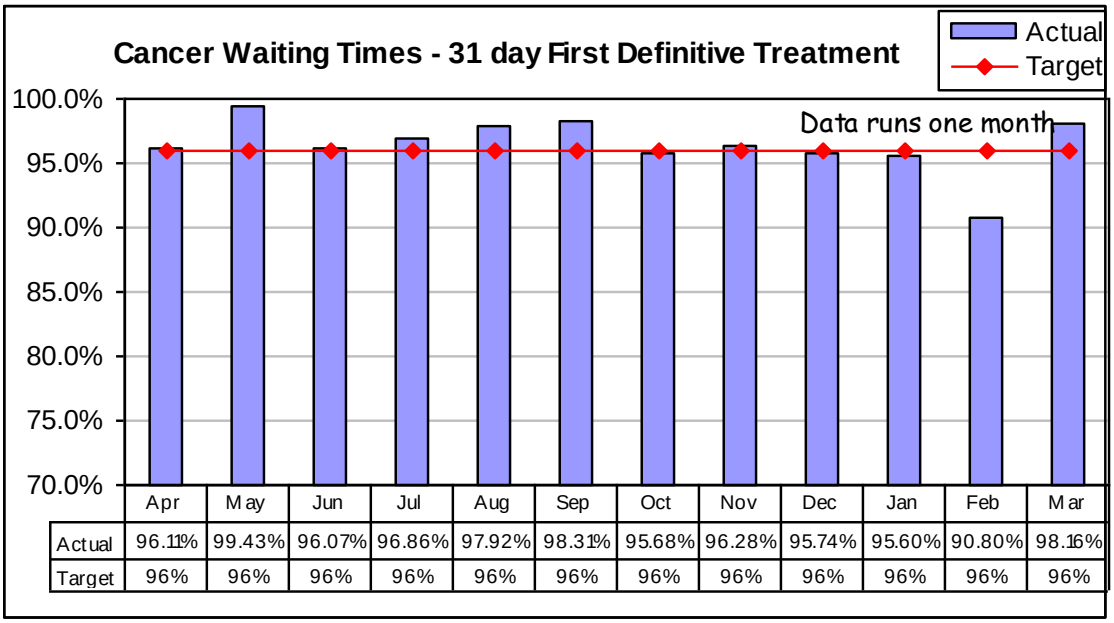



**Cancer Waiting Time Targets** – The Trust ensured 96% of patients with suspected cancer were seen within two weeks, surpassing the national standard of 93%.



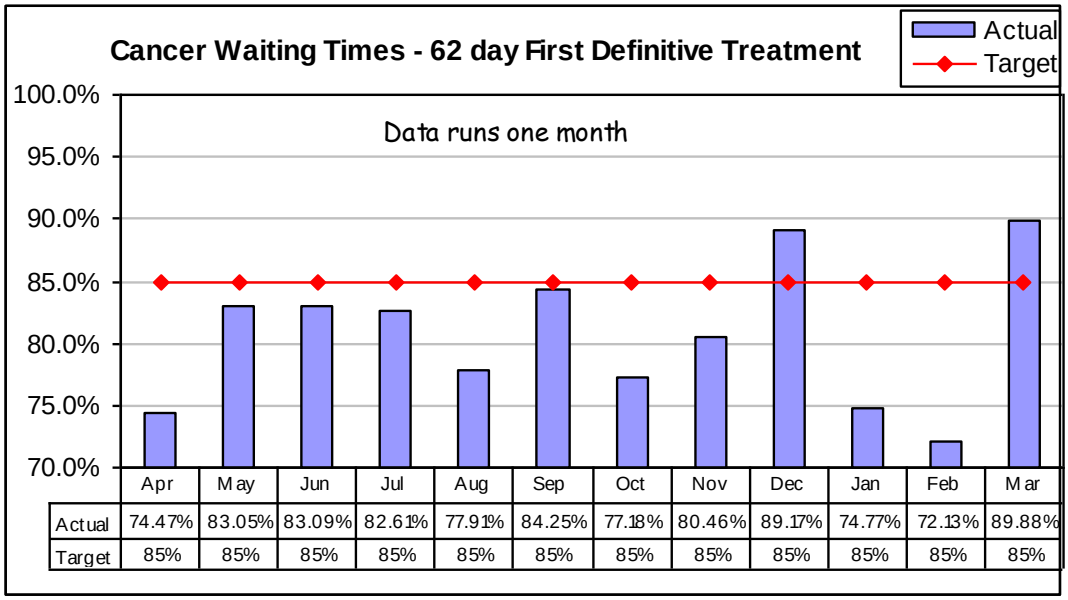

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 97.02% | 94.87% | 93.93% | 95.92% | 96.67% | 96.13% | 98.75% | 96.94% | 95.74% | 96.24% | 97.26% | 97.53% |
| Target | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% | 93% |

**Cancer Waiting Time Targets** – The Trust ensured 96% of patients who needed to start their treatment within 31 days did so, meeting the national standard.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 96.11% | 99.43% | 96.07% | 96.86% | 97.92% | 98.31% | 95.68% | 96.28% | 95.74% | 95.60% | 90.80% | 98.16% |
| Target | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% | 96% |

**Cancer Waiting Time Targets** – the Trust fell slightly behind the national standard for 85% of cancer patients to start their first definitive treatment within 62 days, achieving 80%. We are working with hospitals who refer to the tertiary cancer centre in 2011-12 to ensure all referrals are made in good time.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 74.47% | 83.05% | 83.09% | 82.61% | 77.91% | 84.25% | 77.18% | 80.46% | 89.17% | 74.77% | 72.13% | 89.88% |
| Target | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% | 85% |

## Patient satisfaction Surveys

The Trust ended 2010-11 with a consistently high level of patient experience as shown through its monthly patient satisfaction surveys and audits.

The Trust now surveys over 700 patients a month to gauge levels of satisfaction in four key areas:

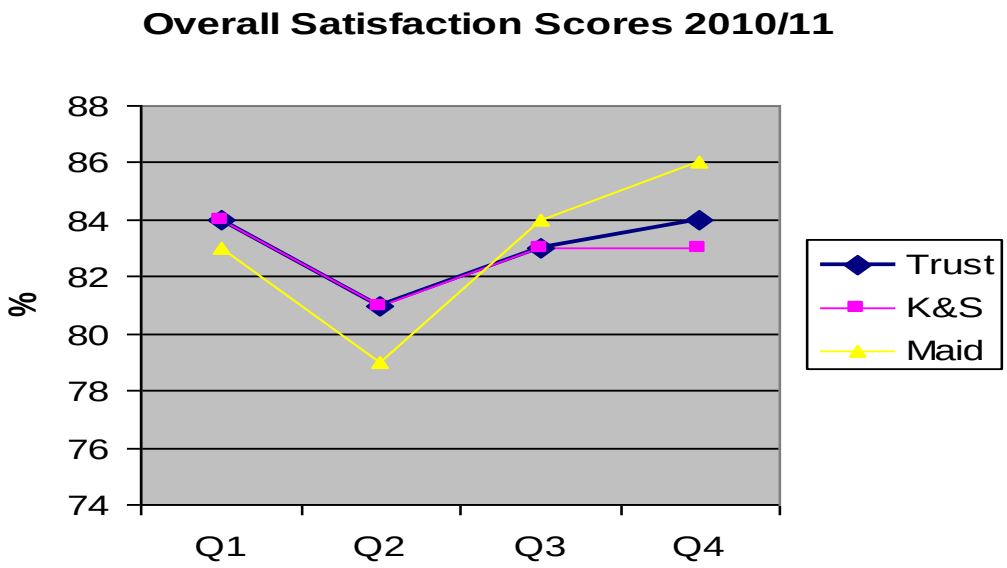
**Patient information and treatment**: this covers aspects such as information regarding medication side-effects, explanation of a procedure, explanation of ward routine and staff having time to listen to concerns.

**Staff Behaviours:** this covers aspects such as staff introducing themselves, response to call bells and requests for assistance.

**Ward Environment:** this covers aspects such as ward cleanliness, calm atmosphere, single sex accommodation and number of ward moves during their stay.

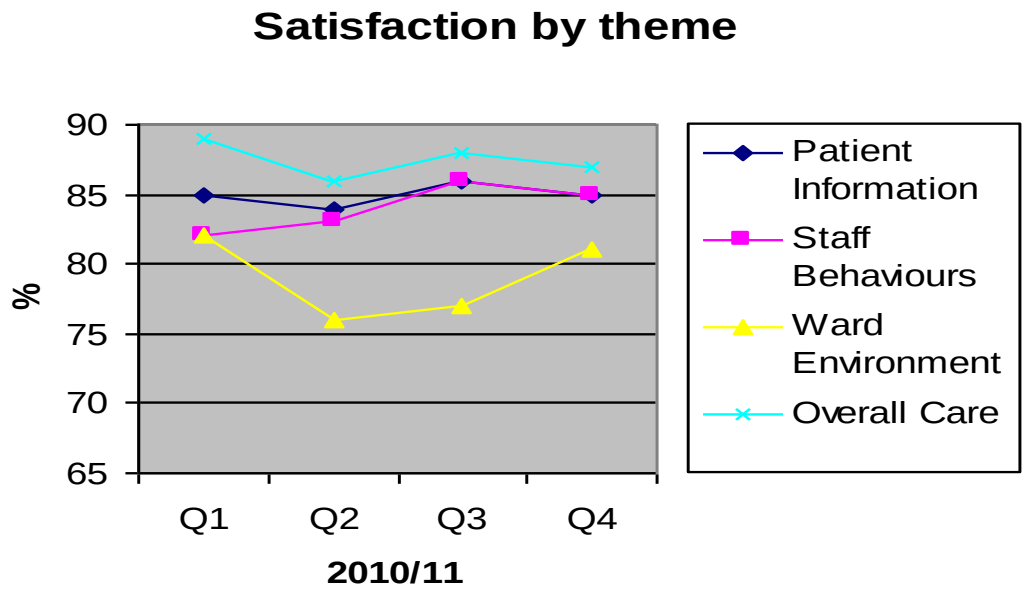
**Satisfaction with overall care:** this asks the patient to rate their overall satisfaction with the care they have received.

The Trust saw a dip in its overall patient experience in the summer of 2010-11. This was mirrored in the national inpatient survey which covered July 2010.




The Trust pinpointed the fall in patient satisfaction to the ward environment. This resulted in a number of initiatives including small scale audits to focus on environmental issues including breaches in mixed sex compliance and patient ward moves.

The Trust saw a steady improvement in the patient experience in the second half of the year as a result of the actions it had taken.




Since January 2011, the Trust has consistently scored well on points such as privacy and dignity, choice of food, help with eating where required and involvement in care.

The patient surveys also helped the Trust highlight a need to improve areas of patient communications and discharge planning. Actions are being developed to improve on these areas and form part of the Trust's Quality Accounts for 2011-12.

Many of the quality care improvements and overall rise in patient satisfaction in 2010-11 were related to:

**Staffing** - The Trust had its lowest vacancy rates for several years across medical, nursing and allied health professionals in 2010-11. This resulted in a decreased reliance in temporary (agency) staff and increased the Trust's ability to provide continuity of care. The Trust is continuing to reduce its agency use in 2011-12.

**Patient Moves** - The Trust's priority will always be to ensure that patients are seen in the most appropriate place to meet their clinical needs. Often this will result in a need to move a patient between wards if their clinical condition changes.

Since August 2010 the Trust has made some significant changes to the way it manages emergency admissions. This included the opening of a GP referral and assessment unit separate from the main A&E Department and introducing a 'way finding nurse' whose role is to ensure that patients are directed to the appropriate urgent care service upon arrival. This may be a referral to the GP Unit, Walk-in Centre or to the main A&E Dept.

The Trust has also worked closely with PCT commissioners to ensure that continuing care arrangements are robust to ensure it is able to safely discharge patients once they no longer require acute hospital care. The Trust has seen reductions in its average length of stay as a result of this. The net effect is to enable MTW to get the patient to the right bed first time from A&E or the Assessment Unit. This work continues in 2011-12.

## MTW's investment in NHS care

At MTW, we recently invested over £30 million in schemes that will help enhance patient care now and in the future.

This sizeable investment contributed to the development of:

- A state of the art cellular pathology centre in West Kent (Maidstone Hospital)
- A new birthing centre (Maidstone Hospital)
- A long list of new replacement medical equipment
- The latest technology in CT scanners – our new SPECT CT scanner (Maidstone Hospital) is faster and exposes patients to less radiation
- Latest equipment and other resources in our new hospital (Tunbridge Wells Hospital)
- Expansion of our breast screening programme with two new digital mammography machines
- Work to keep the environment of our hospitals up to a high standard
- Major refurbishment of one of our stroke units and intensive care unit (both at Maidstone Hospital)

The Trust expects to spend around the same amount of money again this year on other schemes that enhance and improve the patient experience in our hospitals.

## Innovation and expertise

Healthcare professionals at MTW are pioneering and challenge the norm.

Through their vision, innovation and expertise MTW is able to offer new services and treatments to patients.

Here are just a few of our latest services that offer patients new and different choices in the management and treatment of their illnesses.

**Radiofrequency Ablation –** This relatively new technique for treating cancer of the liver, lung or kidneys involves the use of our hi-tech CT scanner at Maidstone.

A fine probe is inserted into the tumour. The probe generates heat inside the tumour which destroys it. The team behind this treatment at MTW has successfully carried out over 40 procedures.

Previously cancer patients had to travel to one of London's big teaching hospitals for this care, but not anymore.

**Wet age related macular degeneration (AMD) –** A new epimacular radiotherapy technique is being used by MTW to treat a common cause of blindness in elderly people.

The normal treatment for AMD involves a series of 7-8 injections a year costing up to £7,000. By comparison, the new surgical procedure, which involves an operation and radiotherapy to treat the diseased part of the eye, entails a one off cost of about £6,000.

The aim of the trial is to permanently halt or slow down the macular degeneration.

**Image-guided RapidArc radiotherapy –** This new technology exposes tumours to precise doses of radiotherapy in a 360 degree circle.

The technology enables cancer doctors to expose the tumour to a more constant exactly calibrated beam of radiation while following its outline with complete accuracy.

Healthy non-cancerous tissue surrounding the tumour is much better protected and patients receive a more effective and faster treatment.

**Chronic Obstructive Pulmonary Disease (COPD) – COPD i**s the second most common cause of emergency admissions to hospital.

MTW has introduced a new scheme called Early Supported Discharge (ESD) which helps people with COPD leave hospital earlier and be cared for at home.
If patients are appropriate for ESD, they are supplied with equipment for use at home such as oxygen and visited by MTW respiratory nurses who carefully assess the patients' needs, and spend time with them explaining how they can best manage their condition.

**Microscopic bubbles –** Pioneering clinicians have developed a revolutionary radiological technique to help detect cancer at MTW by using micro bubbles.

Their breakthrough in diagnostic care will prevent thousands of breast cancer patients in the UK – tens of thousands of women worldwide – from having to have repeat surgery. The test, using tiny bubbles injected into the breast, only takes a few minutes to perform and has transformed the way MTW cares for patients.

Normally, while undergoing surgery to remove breast cancer, surgeons routinely recommend that patients also have an operation to remove glands in their armpit to check if they are cancerous.

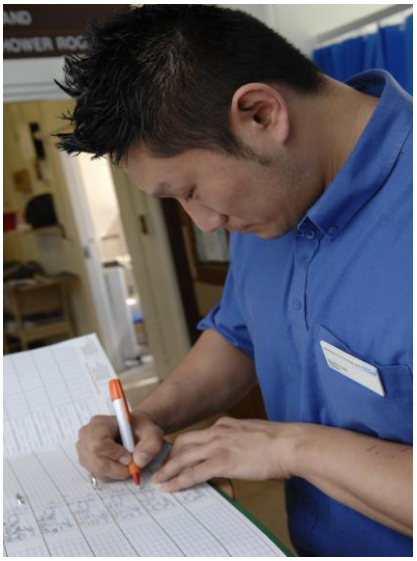
The so called "sentinel lymph node" is the first to be affected if the cancer has spread. It is found during the operation with the aid of a coloured dye and is removed for testing. If the nodes are found to be cancerous a second operation is required to remove all the remaining glands in the armpit.

The procedure, which was pioneered by the specialist breast cancer unit at Maidstone Hospital, allows the sentinel lymph node to be located and tested without surgery.

**Robotic cameras -** MTW experts are also using laparoscopic robotic cameras in prostate surgery which is leading to better outcomes for patients.

**Looking to the future**, the creation of our centres of expertise will help other professionals at MTW sub-specialise and become even more expert in different fields. Our aim is to bring home more of the 35,000 patients a year who travel to London for their care.

## Developing our people



MTW highly values its staff and their invaluable contribution to achieving high standards of care for thousands of patients each year. We believe in great staff providing great care.

The Trust's expenditure on staff learning and education rose by £200,000 from £1.1 million in 2009/10 to £1.3 million in 2010/11. This is a positive move to support staff development and patient care.

The Trust spent approximately £236 on training per member of staff in 2010/11 compared to £209 the previous year.

This investment contributed to the provision of over 320 different types of courses, and over 17,000 training places being taken up by our staff. Our staff also passed over 5,000 courses online.

## MTW's green and sustainable credentials

MTW is working hard to cut its carbon emissions by 12% by 2015. We did well last year, cutting our emissions by 9% - in figures the reduction is from 18,421,883 to 16,710,859 kg of CO2 emissions.

This reduction is mainly from building energy use but there are contributions to this saving from business travel, transport and waste reduction.

The financial savings from this reduction is £339,533 – money that can go into NHS care rather than up the chimney and into the air.

# Part four Stakeholder feedback

NHS West Kent

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Medway Wharf Road
Tonbridge
Kent
TN9 1RE

Telephone: 01732 375200
Fax: 01732 362525

Glenn Douglas
Chief Executive
Maidstone and Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
Kent ME16 9QQ

21 June 2011

Dear Glenn

**Draft statement for inclusion in published document – Quality Account 2010/2011**

NHS West Kent welcomes the publication of Maidstone & Tunbridge Wells NHS Hospitals Trust's Quality Account and the opportunity to comment on its contents. Both organisations are working closely together to ensure that all aspects of service quality – safety, clinical effectiveness and patient experience – consistently meet high standards and focus on continuous improvement.

As far as NHS West Kent is able to comment, the information contained within the Quality Account is accurate. It provides helpful coverage of the strong progress made in many aspects of the quality of patient care whilst acknowledging that there remain challenges.

NHS West Kent has welcomed the proactive engagement over the last year of the Trust to assure and improve the quality of patient care. A range of changes have been made to frontline services and which respond directly to patient feedback and concerns, including the implementation of handheld devices to improve the collection and analysis of patient feedback. Since January 2011, the Trust has consistently scored well on points such as privacy and dignity, choice of food, help with eating where required and involvement in care. They have built on the introduction of "protected mealtimes" over the past year, and will continue to build on delivering same sex accommodation when the new Tunbridge Wells Hospital opens at Pembury.

In terms of Patient Safety, the Trust has achieved a 67% reduction in hospital acquired MRSA bacteraemia, and a further 5% reduction in C. difficile infections, introducing specialist nursing care in an isolation area at Kent and Sussex Hospital. The Trust continues to have a zero tolerance approach to avoidable infections, and the Infection Prevention Team have a strong working relationship with all operational staff. The Trust exceeded their aim to reduce falls by 7.5%, achieving this by incorporating training around Falls Prevention into their Health and Safety mandatory training.

In choosing its quality priorities for the coming year, the Trust has reflected the issues of real concern to patients together with those identified through clinical discussion internally, with NHS West Kent, review of trends in complaints, information from national reports such as the Health Service Ombudsman's report "Care and Compassion", and through extensive consultation with patients and the public. The collaborative process undertaken to develop their quality priorities for 2010 /2011 therefore demonstrates the breadth of local quality discussions and priorities. Building on progress made, the Trust will continue their focus on reducing the number of avoidable healthcare acquired infections, prevent blood clots, improving care for patients who have had a stroke, and the care provided for patients suffering from dementia.

Progress has been seen in the strengthening of internal governance within the Trust to support the quality agenda. Improvements in the investigation of very serious incidents will be built upon over the coming year to ensure more timely closure and demonstration of learning. The Trust has taken a proactive approach to learning from the Health Service Ombudsman's report "Care and Compassion", and together with the opening of the new hospital at Pembury providing state-of-the-art facilities this will significantly improve the quality of patient experience, enhanced by the environment and better facilities for local patients.

The Trust has worked hard to cut their carbon emissions by 9% last year, and will continue to build on this over the coming year with the overall aim to cut its carbon emissions by 12% by 2015, which is commendable.

NHS West Kent looks forward to continuing to work closely with the Nursing and Medical Directors and colleagues at all levels within the Trust to assure the quality of local services and ensure continuous improvement at Maidstone & Tunbridge Wells NHS Hospitals Trust.

Yours sincerely

**Dr. James Thallon**
**Medical Director**

*Your LINk for improving health and social care*
*Your future local HealthWatch*

29 June 2011

# Kent LINk Commentary on Maidstone and Tunbridge Wells NHS Trust Quality Account 2010 / 2011

The Kent LINk would like to thank Maidstone and Tunbridge Wells NHS Trust for the opportunity to comment on their Quality Account prior to publication. The Kent LINk has worked with Canterbury Christ Church University to develop a process for commenting on Quality Accounts and has used a variety of methods to collect data regarding the quality of services provided by Maidstone and Tunbridge Wells NHS Trust, including patient experience questionnaires. Kent LINk Project Development Workers have also engaged with patients at Maidstone and Tunbridge Wells NHS sites to discuss the Trust's priorities for 2011 / 2012.

The LINk has focused on the three aspects of 'quality' as described within the Quality Account and outlined below. LINk participants were also asked to comment on the presentation and layout of the Account. This commentary is based on the responses received by the LINk in relation to the following:

1. Patient Safety
2. Clinical Effectiveness / Effectiveness of Care
3. Patient Experience
4. Quality Account Presentation and Layout
5. Priorities laid out in the Quality Account.

## 1. Patient Safety

The Trust has made positive improvements with regards to C.difficile and MRSA infection rates over the past year and the LINk is encouraged to note the initiatives the Trust has in place for the coming year. The majority of respondents felt safe during their time at Trust hospitals; however, there were a minority who indicated that inpatient wards could feel unsafe. Comments around this issue tended to be related to members of the public being present on wards. The LINk would be keen to see indications of how the Trust will monitor patient safety at the new Pembury Hospital.

During site visits, numerous patients commented that standards of the food provided was poor and indicated that this should be a priority for the Trust. Therefore the LINk was keen to note the inclusion of new initiatives for 2011 / 2012 relating to patient nutrition.

The Trust has made good progress with falls prevention, and has exceeded the target set for reducing the number of falls. The LINk is pleased to note that efforts to reduce the number of falls in Trust hospitals will continue over the coming year.

## 2. Clinical Effectiveness / Effectiveness of Care

The inclusion of stroke care within the priorities laid out by the Trust was positive to see, and the LINk would commend the initiatives planned for 2011 / 2012. However, the LINk notes that there is to be a relocation of stroke specific rehabilitation beds to Tonbridge Cottage Hospital. The LINk would have appreciated some indication from the Trust within the Account as to how the Trust plans to mitigate the loss of a substantial number of beds at Tonbridge Cottage Hospital to Stroke Rehabilitation.

The LINk would like to take this opportunity to commend the Trust for its initiatives for 2011 / 2012 relating to Dementia care, and also to praise the joint working in this area between the Trust, Social Services and the Primary Care Trust.

## 3. Patient Experience

The majority of feedback relating to patient experience was positive, and the Trust clearly has a good programme of patient engagement.

There were only a handful of respondents who reported negative experiences, and these tended to be around discharge planning, communication relating to patient care and lack of communication between staff / departments. The Trust has clear initiatives in place for 2011 / 2012 around these priorities, and the LINk would be hoping to see improvement in patient experience scores in the coming year.

Respondents did also indicate that they had been put in mixed sex accommodation, but the LINk understands that this situation will be partly remedied by the new hospital at Tunbridge Wells.

## 4. Quality Account Presentation and Layout

On the whole the account was well presented, with good size font and appropriate paragraph length. The inclusion of numerous photographs throughout the document was noted as aiding the readability of the document for respondents, as was the inclusion of ‘green tick’ and ‘red cross’ graphics.

The Chief Executive's opening statement sent a positive tone for the Account, and the inclusion of the five key priorities within this opening statement should be considered a good example for all Trusts.

The Trust has clearly demonstrated in Part Two, and throughout the document, that it has engaged with patients and the public throughout the Quality Account process. This should be applauded, as should the Trust's commitment to joint working with the LINk. Throughout the document, priorities and actions were clearly laid out and respondents particularly appreciated the inclusion of named Trust Leads for relevant sections.

The section relating to national clinical audits within the Account could be considered inaccessible to the lay reader, but the LINk was pleased to see the actions relating to these reports laid out in a very well presented manner.

Jargon has been kept to a minimum throughout the document; however, some respondents indicated that a glossary would aid public understanding. In addition, it was noted that an easy read version of the document would be appreciated by some members of the public.

## 5. Priorities laid out in the Quality Account

All of those consulted agreed with the Trust priorities for the coming year relating to patient safety, clinical effectiveness and patient experience. The LINk was pleased to note that the Trust has its lowest staff vacancy rates for several years, and that this has resulted in an improvement of the Trust's ability to provide continuity of care and a decrease in reliance on temporary staff. The LINk would be keen to see this continue, especially in light of the closure of the Kent and Sussex Hospital.

The LINk would like to take this opportunity to thank the Trust for involving the LINk with its priority setting, and for its continued commitment to partnership working throughout the past year. The LINk looks forward to building on this joint working relationship in 2011 / 2012.

--- End ---

# External assurance on the Trust's Quality Account

## Maidstone and Tunbridge Wells NHS Trust

**Audit 2010/11**

**The Audit Commission is a public corporation set up in 1983 to protect the public purse.**

**The Commission appoints auditors to councils, NHS bodies (excluding NHS Foundation trusts), police authorities and other local public services in England, and oversees their work. The auditors we appoint are either Audit Commission employees (our in-house Audit Practice) or one of the private audit firms. Our Audit Practice also audits NHS foundation trusts under separate arrangements.**

**We also help public bodies manage the financial challenges they face by providing authoritative, unbiased, evidence-based analysis and advice.**

# Contents

# Summary of my external assurance on your quality account

### Review of your management arrangements for preparing the quality Account

1 I have now completed my work providing external assurance on your quality account for 2010/11. I have found the Trust has put in place arrangements to satisfy itself the quality account was:

- fairly stated; and
- in accordance with the Department of Health's (DH) requirements.

2 I found arrangements for producing your quality account are good:

- there is a robust corporate framework of management and accountability;
- systems and processes to produce the account are good; and
- the Trust is strengthening arrangements for ensuring its quality account complies with relevant DH regulations and directives.

3 In response to our feedback, the Trust is updating its quality account before submission to reflect more closely the requirements of the DH Toolkit. The key areas for improvement are:

- double-checking the regulations to ensure all aspects have been covered;
- updating information on the Priorities to make them clearer for the lay audience, to explain consistently why each indicator has been chosen and what difference the planned actions will/have made;
- making clearer in the report the links between 2010/11 and 2011/12 Priorities; and
- clarifying how and where the Trust is developing capacity and capability to deliver on its 2011/12 Priorities.

### Testing of performance indicators

4 I tested two performance indicators agreed with the Trust. My testing supports my findings on the review of your management arrangements on the quality account.

Table 1: **Summary of performance indicator testing**

| Indicator | Data relevant and reliable? | Calculated as per definition? | DQ arrangements working consistently? |
|---|---|---|---|
| Clostridium Difficile infections | Yes | Yes | Yes |
| Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers | Yes | Yes | Yes |

5 I made four recommendations to support the Trust improve for 2011/12 and have agreed these with Trust staff. The full action plan is shown at appendix 2.

# Background to the review

## Outline of the Department of Health requirements

6 The health service is facing funding constraints and change. The DH and Monitor have recognised that at such times, there needs to be continued focus on quality and, in particular, the arrangements governing quality within hospitals. While the Care Quality Commission assesses compliance with essential standards, the primary responsibility for maintaining and improving quality remains with trust boards.

7 The Health Act 2009 placed a requirement on NHS bodies to publish prescribed information relevant to the quality of the services they provide. Following the events at Mid Staffordshire NHS Foundation Trust, Monitor reviewed its approach to assessing how effectively the board of applicant trusts ensured good governance of the quality of care they provide. This led to a new framework and approval for evaluating quality governance in applicants. In 2009/10 Monitor started a dry run external assurance of the quality accounts of foundation trusts (FTs). In 2010/11 the external assurance requirement for FTs is included within Monitor's Audit Code for NHS FTs.

8 The DH asked the Audit Commission to arrange for auditors to provide assurance on NHS trusts' 2010/11 quality accounts. The DH is aiming for a consistent approach to quality account assurance for FTs and non-FTs from 2011/12. Therefore for NHS trusts this first year of external assurance will be carried out as a 'dry run'.

9 The DH's external assurance arrangements require me to:

- review your arrangements for satisfying yourself the quality account is fairly stated and follows relevant requirements; and
- test two performance indicators included in the quality account.

10 I am not required to provide any form of opinion on the quality account. However, I report to you my findings and where appropriate recommend focused actions to support the Trust to improve for 2011/12.

## My approach

11 I recognise the challenging timescale the DH presented to your staff to complete the quality account and obtain the required external assurance. I am grateful for the cooperation provided by Trust staff to enable me to complete the review. I have highlighted to the Trust opportunities for improving the quality account for 2011/12 based on my review and the wide knowledge base available from the work of colleagues in the Audit Commission's Audit Practice.

# Detailed findings

## Review of your management arrangements for preparing the quality account

**12** I have reviewed the arrangements you have put in place to satisfy yourselves that the quality account is fairly stated and follows the DH requirements. In considering the adequacy of your arrangements I focused on your:

- governance arrangements;
- systems and processes for producing the quality account;
- use of the DH's Quality Accounts Toolkit 2010/11; and
- approach to enabling Directors to complete the required statements on the quality account.

**13** Table 2 outlines my findings.

Table 2: **Findings of my review of your management arrangements for preparing the quality account**

| Aspect of my review | Findings | Recommendations |
|---|---|---|
| Governance arrangements | Good arrangements are in place. More can be done for operational staff to position the quality account as summarising the Trust's focus on quality. | Yes |
| Systems and processes | Good arrangements are in place although the Trust should ratify and disseminate the new data quality policy as soon as possible. | Yes |
| Use of the Toolkit | The revised quality account is expected to meet all requirements, though timescales did not permit us to review the final document. | No |

| Aspect of my review | Findings | Recommendations |
|---|---|---|
| Directors' statements | You have identified the statements required to support the quality account, and included this in the timetable for signing off the quality accounts. Although Trust governance arrangements mean all information in the quality account has already been reviewed, the Trust should implement a formal process to ensure the Board has evidence of assurance against each point in the disclosures at the time of signing. | Yes |

**Governance**

**14** Quality is the top priority for the Board and the Trust's key objective is to provide safe, quality services and experiences for patients, relatives and the public. The Board and executive team show clear leadership for the quality of information presented in the quality account.

**15** Staff and directors' objectives are mapped back to Trust objectives and assessed through appraisals. Each Executive Director is responsible for at least one aspect of quality services and some, such as the Nursing and Medical directors, are linked to more than one. All directors are focussed on the necessity of having accurate information to inform the delivery of quality services. Quality account arrangements form part of the Trust's established arrangements for delivering quality, and in the main, there are no separate processes.

**16** Responsibility for the quality account is clearly allocated: the Director of Nursing and Medical Director have overall responsibility and they are supported by the Head of Quality and Governance and the Quality Account Steering Group. The group brings together all the key parties involved in producing the quality account to ensure the report is accurate and the Trust's account complies with the DH Toolkit.

**17** Work to ensure appropriate disclosures are made starts at the same time as the need to draft a quality account is raised and time is built in to ensure the disclosures are made. The Board takes assurance that all data in the quality account has previously been ratified through normal Trust governance arrangements. At operational level therefore, the Trust has arrangements to ensure it is able to make the required disclosures in the

Statement of Directors' Responsibilities. However, there is no formal check that all sources of assurance have been utilised and that the Trust has complied with every element in the directors' statement before the Chief Executive and Chair sign the disclosure.

## Recommendation

**R1** Document the sources of assurance for the Directors' Statement, along with the underpinning processes and controls, and formally review these as part of the process of signing off the quality account.

**18** The priorities and targets within the quality account form part of the Trust's overall commitment to delivering quality services to patients and are therefore reviewed as part of day-to-day Trust business. The quality account is seen as a means of summarising and demonstrating that commitment. The contents of the account come from the sources the Trust already has in place to achieve its quality objective. Staff are therefore familiar with the themes and targets contained in the quality account.

**19** At present, the Trust's view is that only the leaders are familiar with the actual quality account, though all staff are focusing on delivering quality for patients. There are arrangements to share the 2010/11 quality account document with staff after it is published, and to complement this with comment in the Chief Executive's weekly newsletter and Director of Nursing's routine update.

## Recommendation

**R2** Develop staff knowledge that the quality account summarises much of the work the Trust is doing to improve the quality of services and acts as a tool to focus attention.

**20** Roles and responsibilities relating to the quality account are clearly understood. The year planner for each governance committee sets out reporting and review roles to avoid duplication and gaps. The account itself sets out how and when each priority will be monitored and measured. The information governance framework sets out the key responsibilities for data quality, and these underpin the account. Each Trust objective, and each quality theme, has an executive lead responsible for both overall delivery and data quality. Trust leads have action plans in place, including audits and reviews, to ensure that data is robust and therefore that judgements on achievements against targets are accurate.

**21** The 2010/11 Head of Internal Audit Opinion gives significant assurance on internal governance controls at the Trust and our own VFM work indicates no areas for concern on governance or internal controls.

### Systems and processes

**22** Policies and procedures for data quality and information governance are in place, and cover all underpinning data requirements for the quality account. A new data quality policy has recently been drafted but has yet to be ratified. It was approved by the Information Governance Steering Group in March 2011, but has yet to receive Board approval.

**23** Policies and procedures are available to, and understood by, relevant staff. Both the new data quality and information governance policies spell out the process to ensure this happens. The draft data quality policy documents roles and responsibilities. It also includes an audit schedule, which sets out how the Trust will check to ensure staff follow procedures as these relate to patient data, though this has yet to begin.

**Recommendation**

**R3** Ratify and disseminate the new data quality policy and underpinning procedures as soon as possible.

**24** There is a data quality steering group, which is a sub-committee of the Board's information governance steering group. This group reviews the quality of data for each division and makes comparisons with national targets and other benchmarks to ensure the quality of data remains good. Divisional directors are required to report back to their divisions on the work of the data quality steering group. The Trust has recently implemented a new process to ensure the data quality steering group can hold divisional directors to account, and this is monitored through the information governance steering group. The data quality steering group can establish task and finish groups to address particular issues although it has not yet had to do this. Reports on data quality go both to the information governance steering group, and to the Board and both receive full reports (rather than exception reporting).

**25** The Trust has arrangements at operational level to ensure policies and procedures comply with the relevant DH regulations and directives, and these define local practices. Mechanisms are in place to check compliance with these policies and procedures, and for reporting results to management as appropriate. However, there is no corporate check to ensure updates are made in a comprehensive or timely way.

**Recommendation**

**R4** Establish arrangements to provide Board assurance that all Trust policies and procedures comply with the relevant DH regulations and directives and are updated in a comprehensive and timely way.

**26** The Trust has appropriate systems and processes in place for collecting, recording and reporting data. These focus on securing data that is accurate, valid, reliable, timely, relevant and complete. The Trust does validity and completeness checks and uses feedback reports from the Secondary User System to drive improvement. The Trust also audits by taking a percentage of case notes and scoring them using the DH template. This process, taken together with the Trust's evidence collation for the 2010/11 Information Governance Toolkit submission, has resulted in the Trust developing an action plan for further improvement, which it is implementing as targets for 2011/12.

**27** Our testing shows the Trust can demonstrate that it has used the appropriate definition and guidance when calculating the performance indicators included in its quality account.

**28** Both the Data Quality and Information Governance policies and procedures show the Trust works on the principle of ‘right first time’ rather than employing extensive data correction and cleansing to produce the information required. The Data Quality policy includes guidance on the need to rectify errors as near to source and as soon as possible. This is embedded in Trust culture through induction and appraisal, and through mandatory completion of information governance training (which includes data quality) for all staff.

**29** The Trust has a framework to review the quality of information in its quality account. It is proportionate to risk and includes robust scrutiny by those charged with governance. The framework operates at a number of levels:

- at corporate level, the quality account document is reviewed by the Director of Nursing and Medical Director, plus the Head of Quality and Governance and the Quality Account Steering Group;
- all executive owners of the individual priorities review the whole document for inconsistencies within the document and with other information known to the division;
- the content and quality of data is reviewed by the Data Quality Steering Group and by Divisional Directors as part of day to day business; and
- corporate Fridays ('back to the floor' days) are used by all directors to check progress against Trust priorities and themes in the quality account as these underpin achievement of the Trust's key objective.

**30** Data used to underpin the quality account is subject to appropriate verification, for example internal audit checks and senior management approval, before being used for reporting.

**31** The Trust has put in place, and trained, the necessary staff to deal with data quality issues. There is training for staff on the policies and procedures underpinning data quality. Induction includes information on policies and procedures generally and there is a focus on 'right first time' for all activities, including data quality.

**Compliance with DH regulations and directives**

**32** The Trust has arrangements to critically assess the external reporting requirements for quality accounts, and it regularly reviews data provision to ensure it aligns to these requirements. This role is primarily carried out by the Director of Nursing and the Director of Corporate Affairs, supported by the Head of Quality and Governance.

**33** All data for external submission is ratified via the governance framework, with data signed off by the relevant Board sub-committee. The Board receives formal documented assurance via these committees. Some data is subject to additional checks, for example the evidence supporting the Information Governance toolkit is reviewed by internal audit and the quality account goes to the Patient Experience Committee (PEC) for review. The PEC includes lay members to ensure the public's concerns are reflected in feedback.

**34** The Trust uses examples of quality accounts from other trusts nationally to drive improvement in the presentation of its own quality account.

**35** The Trust has engaged with key stakeholders, including users of its services, staff and clinical teams, to decide the content and presentation of its quality account. It follows the established process used for its Annual Report. It has developed good relationships with Kent Local Involvement Network, uses local and national feedback on its services and works closely with its PEC to ensure the Priorities reflect those of patients and users. The Trust also seeks feedback from the lead commissioning primary care trust (West Kent), Kent County Council and the Kent Health Overview and Scrutiny Committee.

**36** The Trust's quality account includes positive information on performance, and also acknowledges areas in need of improvement.

**37** The Head of Quality and Governance has corporate responsibility for checking the quality account is in accordance with the relevant DH requirements. She is supported by the Nursing and Medical Directors, who carry out checks from a clinical perspective.

**38** The information contained in the quality account is consistent with the Trust’s description of its quality governance arrangements in its statement on internal control (SIC). Responsibility for the SIC sits with the Chief Executive as overall accountable officer. The Trust executive team review and challenge all documentation and ensure consistency with the SIC. The SIC leads then work with Quality Account Steering Group to do a final check for consistency. Individual leads for the priorities within the quality account also carry out their own checks to ensure there are no inconsistencies between the quality account and other Trust documentation such as board reports, minutes and stakeholder feedback. The final check of the quality account is done by the audit committee, which reviews the draft quality account and is also responsible for signing off the SIC. Should any inconsistencies be identified, there is time built into the process to ensure the Directors' Statement includes the reasons for these.

## Testing of performance indicators

### Objectives

**39** The main objectives of testing two of your performance indicators included in the quality account are to consider whether the Trust is:

- producing relevant and reliable data to underpin the indicators;
- calculating the indicators according to the definition and guidance being used; and
- demonstrating the arrangements for the data quality of these two indicators are working in practice and are consistently applied.

### DH requirements

**40** The DH has specified the testing strategy that I need to follow for the indicators selected. It requires auditors to:

- confirm the definition and guidance used by the Trust to calculate the performance indicator;
- document and walk through the Trust's systems used to produce the performance indicator; and
- undertake substantive testing on the underlying data against six specified data quality dimensions. These are:
  - Accuracy: does the Trust record data correctly and is it in line with the methodology for calculation?
  - Validity: does the Trust produce data that complies with relevant requirements?
  - Reliability: does the Trust collect data using a stable process, consistently over time?
  - Timeliness: does the Trust capture data as close to the associated event as possible and make it available for use within a reasonable time period?
  - Relevance: does all data used to produce the indicator meet eligibility requirements as defined by guidance?
  - Completeness: does the Trust include all relevant information, as specified in the methodology, in the calculation?

### Indicators selected for testing

**41** The DH has not specified the indicators that you are required to include in the quality account. The DH's Quality Accounts Toolkit 2010/11 confirms you are required to report on indicators that support your priorities.

**42** I agreed with the Trust the following two indicators for testing:

- Clostridium Difficile infections; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

### Findings

**43** I have included at appendix 1 my detailed findings from my testing of indicators. I conclude that:

- the system established enables the Trust to capture relevant data and supports its reliability; and
- the Trust's data quality arrangements are consistently working in practice.

**44** My work indicates the Trust's arrangements are satisfactory to meet the six key dimensions of data quality. Therefore I made no recommendations on this area of my review.

# Appendix 1 Detailed findings of performance indicator testing

Table 3: **Findings of performance indicator testing**

| Indicator | Relevant and reliable data? | Calculated as per definition used? | DQ arrangements working in practice and consistently? | Recommendations |
|---|---|---|---|---|
| Clostridium Difficile infections | The system established enables the Trust to capture relevant data and supports its reliability.<br>Twenty cases tested and all found to be supported by relevant and reliable data. | Yes | Twenty cases successfully tested to supporting evidence demonstrating the Trust's DQ arrangements are consistently working in practice. | None. |
| Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers | The system established enables the Trust to capture relevant data and supports its reliability.<br>Twenty cases tested. All cases were reported correctly. However for three cases the waiting time was incorrectly recorded by one day. Target performance was correctly stated as all three cases significantly exceeded the 62 day waiting time (by more than seven days). | Yes | Twenty cases successfully tested to supporting evidence demonstrating the Trust's data quality arrangements are consistently working in practice. | None. |

# Appendix 2 Action plan

| Recommendations | |
|---|---|
| **Recommendation 1** | |
| Document the sources of assurance for the Directors' Statement, along with the underpinning processes and controls, and formally review these as part of the process of signing off the quality account. | |
| **Responsibility** | Flo Panel-Coates, Director of Nursing |
| **Priority** | High |
| **Date** | 1 September 2011 |
| **Comments** | - |
| **Recommendation 2** | |
| Develop staff knowledge that the quality account summarises much of the work the Trust is doing to improve the quality of services and acts as a tool to focus attention. | |
| **Responsibility** | Flo Panel-Coates, Director of Nursing |
| **Priority** | High |
| **Date** | 1 September 2011 |
| **Comments** | - |
| **Recommendation 3** | |
| Ratify and disseminate the new data quality policy and underpinning procedures as soon as possible. | |
| **Responsibility** | Colin Gentile, Director of Finance |
| **Priority** | High |
| **Date** | 1 September 2011 |
| **Comments** | - |
| **Recommendation 4** | |
| Establish arrangements to provide Board assurance that all Trust policies and procedures comply with the relevant DH regulations and directives and are updated in a comprehensive and timely way. | |
| **Responsibility** | Terry Coode, Director of Corporate Affairs |
| **Priority** | High |
| **Date** | 1 September 2011 |
| **Comments** | - |

## STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

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

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, 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
NB: sign and date in any colour ink except black

28.6.11 Date ..... Chairman

28.6.11 Date ..... Chief Executive