Maidstone and Tunbridge Wells NHS Trust

Two hospitals One future

Quality Accounts

2011/12

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 third 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 2012/2013.

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

Index

Part One

Chief Executive's Statement

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

MTW is committed to providing safe patient care and high clinical standards that collectively contribute to a positive experience for the many thousands of people who use our services.

Our overriding aim during 2012/13 is to ensure all of our patients remain well looked after all of the time, and at every stage of their care.

MTW continued to make real progress against many of its priority areas for patients last year. Some of these priorities continue to be at the forefront of our thinking this year. Stroke and dementia care, and infection control, remain three of our ongoing priorities.

To identify other priorities for this year we have listened to patient feedback from our regular patient surveys, analysed trends in our complaints, worked collaboratively with our many stakeholders and taken account of national reports.

As a result, our priorities for 2012/13 are:

Patient Safety

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

Clinical Effectiveness

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

Patient Experience

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

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

The information contained within this report represents an accurate reflection of our organisation's performance in 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 2012/13?

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:

- Continuing to drive down cases of hospital acquired infections, paying particular attention to Clostridium difficile (C. 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

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, national reports and areas highlighted by local and national surveys of our patients.

While we have made real progress against last year's priorities we have continued our focus on a number of the same areas where we feel there is still more that needs to be done to improve the service we offer our patients. These are: preventing hospital acquired infections, preventing avoidable deep vein thrombosis, the care of patients who have had a stroke and those who have dementia, also discharge planning. Many of these continue to be national priorities too and we want to continue to make sustainable improvements.

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)
- Reduce the number of patient falls

Clinical Effectiveness

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

Patient Experience

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

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. This committee then provides assurance on progress to the Trust Board. The Patient Experience Committee is also regularly updated regarding progress.

Patient Safety

Infection Prevention and Control

Venous Thromboembolism (VTE)

Patient falls

Infection Prevention and Control

We have again included the reduction of infection rates for MRSA and C. difficile as a key priority for this year. This remains an important focus for us as we strive to meet the challenging targets that are set on an individual basis for each Trust in England.

Aim/Goal
To reduce our C. difficile rate by 23% and maintain or reduce cases of MRSA bacteraemia, maintaining our zero tolerance of avoidable infection.

Description of Issue and rationale for prioritising
Our rates of C. difficile infection continue to fall year on year. There has been a 4-5% reduction in each of the last three years and by 83% since 2006/7. Our MRSA bacteraemia rate has reduced by 60% in the last year (down to just two cases) and by 97% since 2003/4. As a Trust we have a zero tolerance approach to healthcare associated infection (HCAI) and aim to have no avoidable HCAI.

Identified areas for improvement and progress during 2011/12
We did not exceed the trajectory for MRSA, however, despite reducing the number of cases seen, we breached the trajectory for C. difficile infection during the year.
The following actions were taken to support the reduction in HCAI

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

Initiatives for further action in 2012/13
- Implementation of new laboratory testing guidance for C. difficile
- Implementation of C. difficile action plan including learning from the root causes identified as contributing to the infection and trend analysis to achieve objective for the year

- Introduction of Aseptic No Touch Technique (ANTT) for management of intravascular devices.
- Working across the health economy to review and reduce the use of proton pump inhibitors – medication which can increase the likelihood of a patient being susceptible to C. Difficile.

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

Venous Thromboembolism

We have included the prevention of venous thromboembolism again this year. Considerable improvements in the preventative management of VTE has been made in the last year (see section 3), however we need to build upon these improvements to ensure all patients are being appropriately risk assessed and managed accordingly.

Aims/Goals

- To meet national and local goals and monitoring requirements on VTE prevention
- To ensure all patients identified as at risk of VTE via VTE risk assessment receive appropriate thromboprophylaxis
- To reduce the incidence of hospital acquired VTE

Monitoring Requirements for VTE

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

- Nationally there is a target that 90% of patients admitted to hospital must have a VTE risk assessment completed the local target has been set at 95% by commissioners.
- All potentially preventable hospital acquired VTE and deaths in hospital from VTE to be reported as serious incidents. (All serious incidents are subject to review by a panel of executive and non-executive directors)

Initiatives in 2011-12

- CQUIN goal for VTE that 90% of patients had been risk assessed and managed accordingly was met in August 2011 and continues to be met (8 consecutive months)
- Initiatives to meet CQUIN goal now embedded in clinical practice – these include policy, VTE risk assessment within the Trust prescription chart, system for capturing VTE risk assessments on Patient Centre, cohort list, gateways in theatre and Clinical Decision Unit (CDU)
- Education of clinical staff on VTE prevention via various methods (mandatory update study day, induction programmes, ad hoc sessions, e-learning) continues
- Audit against National Institute for Health and Clinical Excellence (NICE) guidance on VTE prevention was completed & reported – it will be re-audited in 2012-13 to ensure actions taken continue to have the required impact.
- Development of further patient information in relation to VTE prevention is in progress

- Development of use of mechanical thromboprophylaxis (anti-embolism stockings & intermittent pneumatic compression devices) continues – includes staff training, patient information, documentation using care plans, overview of who requires what and for how long

New Initiatives for 2012-13

- Funding approved for 1.6 Band 7 VTE Nurse Facilitator posts
    - 0.8 WTE permanent and post holder in place
    - 0.8 WTE fixed term for 1 year
- VTE Policy Implementation Group to evolve into a Thrombosis Committee which will be led by a senior clinician to oversee all necessary actions to improve services
- Quarterly audit of thromboprophylaxis (60 patients) to be undertaken to review compliance with targets set
- All hospital acquired VTE must now be reported as soon as VTE is diagnosed and investigated in line with Serious Incident Policy

Board Sponsor: Paul Sigston, Medical Director
Implementation Lead: Linda Summerfield, Associate Director of Nursing
Monitoring: via the Standards Committee to Quality and Safety Committee

Reducing the number of Patient Falls

Aim/goal

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

We aim to reduce the number of falls in the year by 10%

Initiatives in 2011/12

- Purchased more low level beds to support patients at risk of falling
- Trial of electronic alarms, which trigger when patients who are at risk begin to move from their resting position, carried out – to be implemented in May 2012
- Implemented "Period of Increased Incidence" following 5 or more falls in the month in one area – this results in a detailed investigation of each fall to ensure any lessons can be learned and shared
- SIRI panel for falls – review of each case outcome declared as avoidable or unavoidable with action plan
- Developed new screening tool for risk assessments
- Elderly care physicians attend Falls Group
- Agreed medication list which affect risk of falls
- Reviewed mobility equipment to ensure fit for purpose
- Raised profile of falls trust-wide

New initiatives for 2012/13

- Amend policy following learning – assessment to take place within 4 hours of admission.
- Link patient care pathway to new Falls Clinic in the community
- Develop integrated falls assessment tool for Multidisciplinary Team to comply with NICE guidelines
- Purchase more low level beds
- Purchase patient alarms following trial period to determine those which are most effective (currently in progress)
- Business case to be submitted to support the provision and appointment of a falls trainer
- Trial the introduction of Link Nurses on TWH wards with support from structured package led by Elderly Care Physician (audit, teaching etc)
- Enhance electronic reporting to incorporate Root Cause Analysis (RCA) templates
- Wards who have a "Period of increased Incidence" of falls to attend Serious Incident Review Panel to ensure challenge and learning as a focused group
- Introduce an alert system through the use of a Blue Symbol for Falls risk – to be placed on a magnetic board above the patient's bed

- Patients at risk of falling to wear a blue name band to alert others who will interact with patient
- Non slip socks to be provided for patients who are at risk of falling

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

Clinical Effectiveness

Stroke Care

Dementia Care

Discharge Planning

Improving stroke care

With the appointment of a dedicated nurse specialist for stroke services and the opening of the rehabilitation services at Tonbridge Cottage hospital, in the last year, considerable improvements have been made. We have not yet met all our targets though and are keen to maintain the focus on improvements in the coming year.

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.

Initiatives in 2011/12

- A specialist stroke nurse was recruited to play a key role in improving the care pathways and outcomes for patients who have had a stroke.
- We did not meet the target that 80% of patients to spend 90% of their care episode in a dedicated stroke ward – work is ongoing to achieve this.
- We did, however, continue to achieve 75% compliance in the 9 key indicators
- During the year a number of stroke specific rehabilitation beds were relocated to Tonbridge Cottage Hospital.

New Initiatives for 2012/13

- To achieve compliance with the target that 80% of patients who have had a stroke should spend 90% of their stay on a dedicated stroke unit.
- For the trust to achieve the target of 60% High risk Transient Ischaemic Attacks (TIAs) patients being seen in the TIA clinic with in 24 hours
- To develop a 6 day service for patients suffering from TIAs by August 2012
- Stroke pathway is to be reviewed, working with social services, to ensure that we can enhance early supported discharge for our patients to reduce the length of stay to optimise care delivery in the most appropriate environment.
- Work towards providing 45 minutes of therapy as deemed appropriate following assessment by therapists
- For both Maidstone and Tunbridge Wells Hospitals to commence data submission to cover 6 months follow up care so that we can monitor more closely the outcomes of care.

Board Sponsor: Angela Gallagher, Acting Chief Operating Officer
Implementation Lead: Amanda Martin**,** Clinical Nurse Specialist for Stroke Services
Monitoring: via the Standards Committee to Quality and Safety Committee

Improving Dementia Care

Care for patients who have dementia remains a key focus for us at our Patient Experience Committee. Various initiatives have been implemented in the last year and have paved the way for further work to improve the care for our patients with dementia. We are therefore keen to maintain this momentum and, in line with consultation results, to keep this as a key priority.

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

Initiatives in 2011/12
The Trust made the following progress against the targets set for last year:

- Training on dementia care awareness developed for staff to attend.
- Ward based dementia care "champions" have been identified to support and progress actions, outcomes and training as required
- A new medical admissions document has been introduced which includes information re patients with dementia
- The care pathway for patients with a fractured hip has been updated to reflect the care of those patients who are also suffering from dementia
- A section on the staff intranet site has been created to raise awareness regarding dementia care
- An admission avoidance project began in February 2011in conjunction with Social Services and primary care providers – report on the impact of this is awaited.
- Enhancing Quality audits have been carried out in the last six months of the year with respect to the appropriate use of antipsychotic drugs – ratification of the results is awaited so that targets can be set for the coming year.

New Initiatives/ goals for 2012/13
- The Trust has identified a lead practitioner to work with service commissioners regarding more effective liaison between mental health services and the acute hospital, including to support dementia patients
- Business case to be developed to fund a dementia specialist nurse
- The Training strategy is to be reviewed to include enhanced dementia care training
- Embed and enhance the role of ward based dementia champions – specifics to be set by specialist nurse once appointed
- Development of a multiagency care pathway by July 2012
- All emergency admission patients over the age of 75 to have dementia screening – CQUIN target of 90% compliance in three consecutive months by year end

Board Sponsor – Flo Panel-Coates, Director of Nursing
Implementation Lead – Linda Summerfield, Associate Director for Nursing
Monitoring: via the Dementia Strategy Group to Quality and Safety Committee

Discharge planning

It can be seen from the graphs in section 3 that there has been an increase in the delayed transfers of care. Work is currently ongoing between the Trust and partnership organisations – social services and commissioners to review this situation to ensure that those patients who are medically fit can be discharged into the most appropriate care environment for them. In addition there are specific actions that the Trust is taking to ensure the discharge is planned in an efficient and effective way. With the increased recording of delayed discharges and some targets from last year, although demonstrating improved compliance, not yet fully achieved, we are continuing to focus on discharge planning as a key focus for the coming year.

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

Initiatives in 2011/12

- Electronic discharge notification systems have been rolled out across the organisation
- Leaflets about discharge have been revised for patients and relatives
- Continued improvements in multi-agency working to benefit patients
- Estimated Dates for Discharge to be in place for all patients within 24 hours of admission – the target of compliance was set at 65% and the trust achieved 67%
- Improved compliance with related questions within the national patient survey.

New Initiatives for 2012/13

- Clear definition of delayed discharge to be agreed by all agencies and policies updated to reflect this – performance re delayed discharges to be reported to Trust board monthly.
- Individual Needs Portrayal assessment training for ward sisters to be rolled out from May 2012, who will then be responsible for review – this will ensure that all patients are appropriately assessed and actions addressed by all agencies prior to discharge
- Relaunch of weekly multidisciplinary meetings to review all patients with a length of stay of greater than 7 days to ensure all appropriate actions are being taken
- Weekly doctors meetings to review patients who are suitable for discharge at the weekends to be led by the Emergency Services Division.
- Relaunch of Discharge Planning Group – to be led by the Acting Chief Operating Officer, to address issues such as: electronic discharge notifications, length of stays, multidisciplinary and multiagency working.

Board Sponsor: Angela Gallagher, Acting Chief Operating Officer
Implementation Lead: Linda Summerfield, Associate Director of Nursing
Monitoring: via Divisional Operations Group

Patient experience

Improving the patient experience with a focus on areas highlighted for improvement within the following national surveys:

- **Inpatient survey**
- **Outpatient survey**
- **A&E survey**

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

Improving the patient experience

This priority expands upon issues highlighted within national surveys that were key priorities last year. This year we are going to focus on key issues highlighted within the national surveys for inpatients, outpatients and A&E services.

Aim / Goal:

- To gain feedback on patient satisfaction to enable improvements to care and overall service to be made in a timely manner.
- To see demonstrable improvements in patient satisfaction with care reflected in the National Patient Surveys, CQUINs and Local Patient Survey.

Initiatives in 2011/2012:

- Local patient survey tablets in place in ward areas
- Number of surveys collected included in weekly nursing Key Performance Indicator (KPI) list.
- Feedback being implemented into Productive Ward Releasing Time to Care indicators
- Quality Rounds implemented at Tunbridge Wells Hospital to patients information and care needs are being met

Last year we focussed specifically on some of the In-patient survey questions relating to communication – details of these are included within Section 3.

New Initiatives for 2012/2013:

- Review of IT hardware support to improve volume of survey returns and expand into outpatient and accident and emergency areas
- Links to be made between Enhancing Quality surveys and local in-patient surveys and to triangulate these with other feedback sources
- Consider web-based (or other media) system for gaining feedback after discharge
- Quality Rounds to be implemented across remaining areas of the organisation
- Quick Reference guide for ward orientation to be implemented across both sites

The following questions have been identified as key indicators from the national surveys:

Focus questions from Inpatients Survey:

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears
3. Were you given enough privacy when discussing your condition or treatment
4. Did a member of staff tell you about medication side-effects to watch for when you went home?

5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital
6. Was the ward routine explained to you when you were admitted (or as soon as practicable after your admission)?

Focus questions from Outpatient Survey:

1. Were the signs to the Outpatient areas clear and easy to read?
2. Were the clinic rooms and facilities in the waiting area clean?
3. Was information regarding waiting times given to you either in person or screen?
4. Did the staff in the department introduce themselves?
5. Did the clinician give you time to express your concerns and listen to them?
6. Did the clinician explain your treatment in a way that you understood?
7. Did you feel you were dealt with in a dignified and private manner?
8. If the clinician prescribed new medication was this fully explained?

Focus questions from Accident and Emergency Survey:

1. How long did you wait before you first spoke to a nurse or doctor?
2. While you were in the A&E department did a doctor or nurse explain your condition and treatment in a way that you could understand?
3. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?
4. While you were in the A&E department how much information about your condition or treatment was given to you?
5. Do you think the hospital staff did everything they could to help control your pain?
6. Did a member of staff explain the purpose of the medications you were to take at home in a way that you could understand?
7. Did a member of staff tell you about medication side effects to watch for?

Board Sponsor: Flo Panel Coates, Director of Nursing
Implementation Lead: Inpatients: John Kennedy, Deputy Director of Nursing
Outpatients: Siobhan Callanan, Associate Director of Nursing
Accident and Emergency: Linda Summerfield, ADN
Monitoring: via Quality and Safety Committee

Complaints Management

Aim/Goals
In the last year we have had an independent review of the complaints process carried out.
An action plan was developed to address the recommendations. Our aim this year is to ensure that all complaints are seen as an opportunity to learn from and that we embed the learning. In addition we aim to ensure complainants receive timely responses which have been fully investigated and address all issues raised.

Initiatives in 2011/2012

- Independent review of the complaints process
- Revisions to the complaints handling processes
- Implementation of surveys to review the quality of complaints

Initiatives in 2012/2013

- Implementation of further training re investigation of issues and drafting of complaint responses
- Implementation of enhanced system to monitor the learning from complaints
- Revision to existing database to enable more efficient statistical reporting so that actions can be targeted on recurring themes and areas of high incidence in a more timely way
- Recruitment of 2 new staff to Patient Advice and Liaison Service (PALS) to determine whether by dealing with calls more quickly can help to ensure local resolution occurs, negating the need for complaints to become formal

Key measures:
- 75% compliance with 25 day response rate
- Attain benchmark of quality review from quarter 4 2011/2012 and improve by 10% by end of 2012/2013

Board Sponsor: Flo Panel Coates, Director of Nursing
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 2011/2012 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 2011/2012 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2010/2011.

Clinical Audit

During 2011/2012, 333 clinical audits were carried out in the trust. This was a mixture of national and local audits. 39 national clinical audits and four national confidential enquiries covered NHS services that MTW provides.

We participated in 92% 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 2012				***Comments***
Recruited patients during 2011-12	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	
Peri and Neonatal				
Neonatal Intensive and Special Care NNAP	Y	630	100%	
Perinatal Mortality (MBRRACE-UK)	Y	39	100%	
Children				
CEM Pain Management in Children	Y	100	100%	
Paediatric Pneumonia	Y	15/16	94%	
Paediatric Asthma	Y	34/20	100%	
Childhood Epilepsy	Y	16/17	99%	
Paediatric Diabetes	Y	102	100%	
Acute Care				
Cardiac Arrest (National Cardiac Arrest Audit)	Y	644	100%	
Adult Critical Care (Case Mix programme)	Y	486	100%	
Potential donor audit (NHS Blood & Transplant)	Y	6	100%	
Emergency use of Oxygen	Y	65	100%	
Adult community acquired pneumonia	N	0	0	

Non-invasive ventilation – adults	Y	23	100%	
Pleural procedures	Y	25	100%	Small numbers so submitted as a Trust.
CEM Severe sepsis & septic shock	Y	100	100%	
NASH national audit of seizure management	Y	30/30	100%	
Long Term Conditions				
Chronic Pain (National Pain Audit)	Y	0	0	Organisational questionnaire submitted only. No clinical cases submitted.
National Adult Diabetes Audit	Y	Approx 40 cases	Unknown	40 cases collected via paper proforma in the absence of Diabeta3. Data to be submitted at next submission point in 2012.
UK IBD – Ulcerative Colitis & Crohn's disease	Y	75/80	94%	
National Parkinson's Disease	Y	84	100%	
BTS Adult Asthma	Y	25	100%	Minimum 20 patients required
BTS Bronchiectasis	Y	23	100%	Minimum 10 patients required
Heavy Menstrual Bleeding	Y	115	100%	
Elective Procedures				
Hip, knee and ankle replacements (National Joint Registry)	Y	462	100%	
Elective surgery (National PROMs Programme)	Y	347	100%	
Coronary angioplasty	Y	319	100%	
Cardiovascular disease				
MINAP	Y	307	100%	
Heart failure	Y	382/480	80%	Still submitting data – within timeframe
SINAP	Y	260	85%	
Cardiac rhythm management / arrhythmia	Y	565	100%	
Renal Disease				
Renal Replacement Therapy	N/A	N/A	N/A	MTW does not provide this service
Renal Transplantation	N/A	N/A	N/A	MTW does not provide this service
Cancer				
Lung Cancer (National Lung Cancer Audit)	Y	194	100%	
Bowel Cancer (National Bowel Cancer audit Programme)	Y	280	100%	
Head & beck Cancer (DAHNO)	Y	113	100%	
Oesophago-gastric cancer (National O-G Cancer Audit)	Y	N/A	N/A	The deadline for the NOGCA submission is Monday 1st October 2012. Data is currently being collected for submission.
Trauma				
Hip Fracture (National Hip Fracture Database)	Y	250	54%	
Severe Trauma (Trauma Audit & Research Network) TARN	Y	3	3%	New person in place to submit data for 2012.

Psychological conditions				
Prescribing in mental health services	N/A	N/A	N/A	MTW does not provide this service
Schizophrenia	N/A	N/A	N/A	MTW does not provide this service
Blood transfusion				
'O' Neg blood use "Medical Use of Blood" (National Comparative Audit of Blood Transfusion)	N	0	0	MTW did not submit cases to this audit
Platelet use "Bedside Transfusion" (National Comparative Audit of Blood Transfusion)	Y	6	100%	
End of Life				
Care of dying in Hospital (NCDAH)	Y	46	100%	
National Confidential Enquiries				
Bariatric Surgery Study	Y	NA	NA	Organisational Data submitted.
Cardiac Arrest Procedures	Y	10/10	100%	Plus organisational data.
Peri-operative Care	Y	8/13	62%	Plus organisational data.
Surgery In Children	Y	NA	NA	Organisational Data submitted.

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

National Audit Medical Use of Blood 2011 (National Comparative audit of blood transfusion)	Following decision re priorities at Standards Committee it was agreed, for capacity reasons, to only submit data for the National Bedside Transfusion Audit this year.
Adult Community Acquired Pneumonia	Late changes made to the data submission criteria. Patient cohort monitored by Enhancing Quality Programme.
Chronic Pain (National Pain Audit)	Organisational data submitted (Phase One of audit). Full participation with all clinical data to be submitted in 2012/13.

30 National audits were published in 2010/11 with action to be taken in 2011/12

National Annual reports published April 2010 – March 2011	Report Received	
Peri and Neonatal		
Perinatal Mortality (CEMACH)	Y	Report received in March 2011**.** Action taken: • Patient access to treatment policy updated in line with recommendations.
Children		
Paediatric pneumonia (British Thoracic Society)	Y	Report Received July 2011. Action taken: • Enhanced training at Induction for junior doctors • All children admitted with pneumonia under the age of 18 months have nasal aspirate taken. • New guidelines issued by the BTS introduced
Paediatric asthma (British Thoracic Society)	Y	Report Received July 2011. Action taken: • BTS guidelines reinforced • Junior doctor handbook developed • Revision of use of routine chest x-ray criteria. • Standardised asthma care plan produced.
Audit of Pain in Children within A&E (National CEM)	Y	Report Received November 2010. Action taken: • Software incorporates pain score and child protection fields. • Patient Group Directions (PGD) now in place for prescribing analgesia.
Adult care		
Adult Community acquired pneumonia (British Thoracic Society)	Y	Report Received September 2010. Action taken: • Training session now built into Trust induction. • 'Management of pneumonia' guidelines available on Trust Intranet.
Non Invasive Ventilation (NIV) - adults (British Thoracic Society)	Y	Report Received July 2010 – Action plan in progress
Long Term Conditions		
Diabetes (National Adult Diabetes Audit)	Y	Report Received April 2010. Action plan in progress
Parkinson's Disease (National Parkinson's Audit)	Y	Report Received May 2010. Action taken: • Report reviewed and no actions required.
Adult Asthma (British Thoracic Society)	Y	Report Received March 2011. Action taken: • Inhaler techniques and prompt follow-up post discharge arranged by Respiratory Nurse and GP.
Bronchiectasis (British Thoracic Society)	Y	Report Received March 2011. Action taken: • Antibiotic administration guidance reviewed • GP training introduced
National CEM Asthma in adults and Children (College of Emergency Medicine)	Y	Report Received November 2010. Action taken: • Single clerking booklet for patients with asthma. • Peak flow monitors now available • Electronic Manchester triage solution implemented.

Elective Procedures		
Hip, Knee and ankle replacements (National Joint Registry)	Y	Report Received October 2011. Action taken: • Joint implants been fully tested and positively rated.
Elective Surgery (National PROMS Programme)	Y	Reports are published on a monthly basis and reviewed by Pre Assessment staff and the ADNS for Planned Services Division See p 59
Coronary angioplasty (NICOR Adult Cardiac Interventions audit)	Y	Report Received July 2010. Action taken: • 96 hour angioplasty target protocol developed • Business case developed for Cardiologist post
Cardiovascular Disease		
Acute Myocardial Infarction & other ACS (MINAP)	Y	Report Received January 2011. Action taken: • Business case developed for Cardiologist post • Acute Coronary Syndromes management protocol updated.
Heart Failure (Heart Failure Audit)	Y	Report Received December 2010. Action taken: • Care delivery monitored through Enhancing Quality Programme and continuing participation in the National Heart Failure audit.
Pulmonary Hypertension (Pulmonary Hypertension Audit)	Y	Report Received September 2010. Action taken: • Division reviewed report to aid understanding of tertiary centre provision
Cancer		
Head & neck cancer (DHANO)	Y	Report Received January 2011. Action plan in progress.
Trauma		
Hip Fracture (National Hip Fracture Database)	Y	Report Received August 2011. Action taken: • Fast-Track and Hip Fracture Pathway service reconfiguration. • Prioritise hip fractures on trauma lists. • Consultant Orthogeriatrician appointed
Severe Trauma (Trauma Audit & Research Network) TARN	Y	No recommendations for MTW.
Audit of management of Fracture Neck of Femur within A&E. (National CEM)	Y	Report Received November 2010. Action taken: • Trust software incorporates pain score • Patient Group Directions (PGD) in place for prescribing analgesia.
Blood transfusion		
O neg blood use (National Comparative Audit of Blood Transfusion)	Y	Report Received April 2011. Action plan in progress.

Platelet use (National Comparative Audit of Blood Transfusion)	Y	Report Received April 2011 - Trust compliant with recommendations no further actions needed.
National Audit of the use of red cells in neonates and Children (National Comparative Audit of Blood Transfusion)	Y	Report Received June 2010. Action taken: • Red blood cell use in neonates and children guidance incorporated intoTrust Transfusion Policy.
Patient Surveys		
National NHS Inpatient Patient Survey 2010 (Pickers)	Y	Report Received February 2011. Action taken: • Patients make outpatient appointments via the choose and book system. • Planned care office telephone patients to make surgery appointment • Admission process explained to patients as part of preadmission clerking • Reduce the amount of patient moves at night.
National Paediatric Outpatients Survey 2010 (Pickers)	Y	Report Received November 2010. Action taken: • Partial booking in place at TWH for specialties within Zone 1 & 2. • Good practice guide for waiting areas and patient information introduced. • High level OPD internal survey introduced
National Maternity Survey 2010 (Pickers)	Y	Report Received September 2010. Action taken: • Maidstone birth centre increased choice of delivery location • Improvement in the quality of food. • Choices website regarding antenatal care
National Cancer Patient Experience Survey (DoH)	Y	Report Received January 2011. Action taken: • Time for patients to ask questions • Ensure patients know how to request time with a doctor, • Privacy monitored via regular survey • Reviewed discharge processes • Awareness raised of treatment protocols relating to medication side effects
Confidential Enquiries		
NCEPOD - An age old problem	Y	Report Received November 2010. Action taken: • Dedicated time on T&O theatre lists for elderly trauma patients • Local audits show compliance with 12 hourly surgical reviews. • Services moved to new hospital to enable 24 hour on call surgical services to be provided.
NCEPOD - A mixed bag - Parenteral Nutrition	Y	Report Received June 2010. Action taken: • Policy for Parenteral Nutrition in place. • Teaching sessions on Neonatal TPN included on medical induction programme.

The reports of 52 national clinical audits were reviewed by the provider in 2011/2012 and Maidstone and Tunbridge Wells NHS Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit reports published April 2011 - March 2012	Trust action
4th National Audit Project (NAP4) Major complications of airway management in the UK (anaesthetics)	Report Received May 2011. Action taken: • End tidal CO2 monitoring on ICU for intubation/tracheostomy • One consultant and a senior anaesthetist present for percutaneous tracheostomy on ICU. • New emergency cricothyroid sets for theatre (Maidstone) introduced.
Adult critical care (ICNARC)	Report Received July 2011 - Action plan in progress.
National Cardiac Arrest Audit (NCAA)	Report Received March 2011 -Action plan in progress.
Elective Surgery (National Proms Programme)	Report Received March 2011 - Action plan in progress.
Chronic Pain (National Pain Audit)	Report Received February 2012 - Action plan in progress.
National Potential Donor (NHS Blood & Transplant)	Report Received August 2011 - Action plan in progress.
NCEPOD: Peri-operative Care Study - Knowing the Risk	Report Received December 2011 - Action plan in progress.
NCEPOD: Surgery in Children Study - Are we there yet?	Report Received October 2011. Action to be taken: • NCEPOD recommendations to be incorporated into family support leaflets • Named surgeons and anaesthetists have dedicated paediatric lists. • Pharmacy reviewing need for dedicated paediatric contact within pharmacy at Tunbridge Wells Hospital. • PSCPEWS (Paediatric Early Warning Score) chart to be introduced in all areas that care for paediatric patients. Three different age appropriate charts to be developed.
NBOCAP 2010 National audit of bowel cancer -	Report Received June 2011. Report reviewed by Division. Trust fully compliant with recommendations.
National lung cancer audit (NLCA LUCADA)	Report Received December 2011 Action plan in progress.
National audit for head & neck cancer 2010 (DAHNO)	Report Received May 2011 - No action required at this time.
NATIONAL AUDIT for lung cancer 2010 (LUCADA)	Report received May 2011- Action plan in progress
HQIP NATIONAL AUDIT for bowel cancer NBOCAP 2011	Report Received November 2011 – Action plan in progress.
NATIONAL Blood Transfusion audit of the use of platelets -	The Trust did not register. Report received and reviewed. No action required.
National Cardiac Interventions (eg angioplasty) 2009/10	Report received July 2011. Action to be taken: • Trust protocol on 96 hour angioplasty/PCI target produced. • Business case developed for additional Cardiologist post.

NATIONAL AUDIT of Services for people with Multiple Sclerosis 2011	Report Received October 2011 – Action plan in progress.
National audit of Falls and Bone Health in Older People 2010	Report Received June 2011. Action to be taken: • Develop a Fracture Liaison Service.
UK National IBD Audit Round 3	Report Received February 2012 – Action plan in progress.
National audit of Dementia (Care in General Hospitals) (	Report Received December 2011- Action plan in progress.
National BTS Adult Community Acquired Pneumonia 2010/11	Report Received December 2011 – Action plan in progress
National BTS Adult Non-invasive Ventilation (NIV) 2011	Report received November 2011 – Action plan in progress
National Audit of Seizure management in Hospitals (NASH) (Nationwide UK Epilesy Audit)	Report received December 2011 – Action plan in progress
CEM - National audit of Renal colic (in adults) in A&E	Report received July 2011. Action taken: • Extension of Patient Group Directives allowing initiation of analgesia at triage actioned. • Changes to IT system to facilitate outpatient referral
CEM National audit of fever in children in A&E	Report received July 2011. Action taken: • Extension of Patient Group Directives allowing initiation of analgesia at triage actioned. • Changes to IT system to facilitate outpatient referral
CEM national audit of vital signs in majors in adults	Report received July 2011. Action taken: • Extension of Patient Group Directives allowing initiation of analgesia at triage actioned. • Changes to IT system to facilitate outpatient referral
National BTS Brochiectasis audit 2010	Report Received April 2011. Action taken: • Bronchiectasis management guidance disseminated to junior doctors and made available on wards. • Respiratory teams education improved
National BTS Bronchiectasis audit 2011	Report Received March 2012 - Action plan in progress.
National BTS Adult asthma audit 2011	Report Received March 2012 - Action plan in progress
National BTS Emergency Oxygen audit 2011	Report Received February 2012. Action to be taken: • Respiratory Nurses to provide teaching to medical staff on prescribing oxygen therapy.
National BTS Pleural Procedures audit 2011	Report Received December 2011 - Action plan in progress
NATIONAL Sentinel Stroke Audit 2010	Report Received June 2011. Action to be taken: • Business case for additional Stroke Clinical Nurse Specialist. • Implement Patient Key worker system • Adjustments to stroke passport to include management plan for incontinence.
National Heart Failure Audit (Apr 10 - Mar 11)	Report Received February 2012. Action taken: • Monitor provision through Enhancing Quality Programme and participation in the National Heart Failure audit.

National Adult Diabetes Inpatient Audit 2010 (2nd round)	Report Received April 2011. Action taken: • Business case written for additional Inpatient Diabetes Specialist Nurse. • Diabetes Inpatient Prescribing guidelines developed • Referral criteria for inpatients with diabetes developed • Updated guidelines on management of hypoglycaemia, diabetic ketoacidosis and hyperglycaemia emergencies. • Multidisciplinary Diabetes Foot Care Team in development
National BTS - 1st European Respiratory Society (ERS) COPD Outcomes	Report Received December 2011 – Action plan in progress
National Adult Diabetes Audit 2009/10	Report Received April 2011. Action to be taken: • Installl diabetes database (Diabeta3)
National BTS Pleural Procedures 2010	Report Received July 2011. Action to be taken: • formal chest drain insertion training programme development • Purchase dedicated respiratory ultra sound machines • Tain respiratory staff to Level 1 thoracic ultrasound insertion to facilitate real-time ultrasound guided insertion.
MINAP 2010/11	Report Received September 2011- Action plan in progress
National BTS Adult Asthma 2010	Report Received March 2012- Action plan in progress
National Cardiac Rehabilitation Audit - NACR 2009-10	Report Received November 2011. Action to be taken: • Liaison with NHS Kent and Medway re funding for provision of Tai Chi Rehab and Phase III rehabilitation in the community
CEM National audit of Consultant sign-off in Emergency Departments 2011	Report Received December 2011 – Action plan in progress
National Cardiac Rhythm Management 2010	Report Received December 2011. Reviewed by Specialty and at Kent & Medway Cardiovascular meeting. No MTW actions required.
National Diabetes Audit - Paediatric	Report Received May 2011 – Action plan in progress
National Paediatric Pneumonia Audit 2010	Received Report July 2011. Action taken: • Management of children with respiratory distress now in the induction for junior doctors. • Printed guideline available on wards for reference.
National Audit of Heavy Menstrual Bleeding 2011	Report Received May 2011- Action plan in progress Final report due 2013.
National Neonatal Survey	Report Received December 2011. Awaiting action plan.
BASHH (British Association of Sexual health and HIV) National audit "STI Management Standards" (STIMS)	Report Received May 2011. Action taken: • Microbiology ensure test results are received in the clinic within 7 working days. • STI/HIV risk assessment added to the current clinic proforma.
National Neonatal Audit Programme - 2010 (NNAP)	Report Received July 2011. Awaiting action plan.

National Paediatric Asthma Audit (BTS) 2011	Report Received February 2012. Action taken: • Standardised asthma care plan has produced
Pickers Europe National Adult Outpatient Survey 2011	Report Received February 2012. Awaiting action plan.
NHFD: National Hip Fracture Database	Report Received August 2011.Action taken: • Fast-Track and Hip Fracture Pathway Service reconfiguration. • Admission to Orthopaedic Care Surgery within 36 hours of admission. • Prescribing secondary prevention. Appointment of locum Consultant Orthogeriatrician
National Joint Register: hip and knee replacements	Report Received November 2011. No action required
NATIONAL PROJECT Re-audit LCP (Liverpool Care Pathway) National care of the dying audit - hospitals 3rd round	Report Received December 2011. Awaiting action plan.

The reports of 138 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:

The Diabetes team has made changes in the insulin prescribing section of the drug chart to incorporate the prescribing options available to clinicians which has resulted in a **reduced error rate in insulin prescribing.**

The Gastroenterology team has introduced a diagnosing Upper Gastro Intestinal (UGI) bleed proforma **to assist the junior doctor to correctly identify UGI bleeds.**

Consultant Surgeons have developed a new post-operative feeding regime for patients who have undergone upper GI resection for cancers. This aims **to reduce the complication rate** of small bowel necrosis which can develop following this procedure.

The Respiratory team has introduced a proforma to include all basic and initial steps in the management of pleural effusions. This has resulted in all patients having appropriate chest drain insertions. A **decreased time between effusion diagnosis and aspiration,** and a **decreased length of stay** for patients.

The Ophthalmology team has designed a tick box proforma to go in the case notes for glaucoma patients to ensure that all **clinical information is recorded**. The quality of **information given to patients has improved** as a new patient information leaflet has been designed and is handed to all patients at their first visit to the department.

The intensive care team has produced a new proforma for documenting patient daily reviews. Re-audit has shown that this has greatly **improved the quality** of recording patient documentation within the Intensive Care Unit (ICU) records.

The maternity team has identified the need for a standardised VTE risk assessment form to be included in new maternity notes at the time of booking. Sections will be included **to ensure that risk assessment is re-assessed within 24 hours of admission**. Weighing scales are also to be made available in the antenatal and postnatal wards so that **accurate doses of** Low Molecular Weight Heparin can be calculated.

The medical team has incorporated the risk assessment for VTE on the drug chart for adult patients and has included a slot on the junior doctor's induction training explaining the importance and process of VTE risk assessment. Acute Assessment Unit (AAU)/A&E Nurses have been asked to remind doctors that the VTE risk assessment must be completed prior to the patient being handed over to the ward.

The Palliative Care Team has identified the need for patients on the end of life pathways to have **adequate opiate dosage.** Teaching sessions have been put in place for junior doctors and stickers have been placed in the front of the patients folders detailing the location of the prescribing guidelines within the patient's case notes.

The HIV team has introduced a New HIV Patient Proforma that is completed when patients attend the outpatient clinics. Re-audit has shown that using the proforma ensures all information is being collected and ensures that baseline tests for this group of patients are being carried out.

The ICU team has implemented a trust wide guideline to ensure that ventilated patients on ICU receive correct mouth care. This **improves patient care** by reducing the risk of ventilator-associated pneumonia.

The Stroke Team have introduced a stroke proforma checklist that has encouraged timely and multidisciplinary working when patients are admitted to the stroke units. The re-audit has shown this has led to improvements in patient outcomes and patient care.

Nice Guidelines:

Every Year NICE develops a number of guidelines for the NHS to review and implement to enhance practice and the care of patients.

NICE Guidance and date audit completed	Actions	Actions Implemented
CG11 - Fertility: assessment and treatment for people with fertility problems **Completed 14/06/10**	A standard pathway to be followed for investigations to be completed by the GP before they attend initial sub fertility appointment. Patients to have Hycosy at first/second visit. Re-audit to be carried out to review changes.	Proforma agreed with GPs for completion accompanying referral ; referral rejected unless received Hycosy at 2nd Visit Re audit 2012
CG13 - Caesarean section (replaced by CG132) **Completed 29/06/11**	Incorporate Caesarean Section pro-forma into Maidstone maternity notes or make more easily available in CDS operating theatre. The Vaginal Birth After Caesarean clinic is already in place. NICE guidelines indicate it is important to offer women counselling for VBAC, however, maternal wishes should be followed. Further investigation should be undertaken to assess if the women who declined VBAC, also declined the VBAC clinic, but this was not in the scope of this audit. Re-audit in 6 months	Pro forma included in all maternity records Name of VBAC clinic replaced by " Birth Options Clinics " to try to improve uptake by women in place Re audit 2012
CG15 - Type 1 diabetes: diagnosis and management of type 1 diabetes in children young people and adults **Completed 03/06/11**	1.To have a full-time In-patient Diabetes Specialist Nurse based at the Tunbridge Wells Hospital 2.To develop referral criteria for in-patient diabetes opinion (via Think Glucose) 3.To improve the inpatient management of hypoglycaemia 4.To improve in-patient diabetic foot care 5.To develop Diabetes Inpatient prescribing guidelines 6.To improve the management of diabetic ketoacidosis and hyperglycaemic emergencies	Referral criteria have been developed and discussed amongst Diabetes Specialist Inpatient Nurses and Diabetes Consultants. Audit presented at Clinical Governance meeting and recommended adoption of national guidelines. Division to develop guidelines based on national guidelines adapted for local use. "Diabetic foot examination" to be included in the new inpatient clerking proforma.
CG20 - The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care **Completed 15/12/09**	Avoid EEG if no clinical diagnosis of epilepsy. EEG preferably after the 2nd seizure, after 1st episode in selected cases. Routine EEG should be the first EEG. Request form should be completed in all aspects with adequate clinical details. As far as possible, originator to request in writing. All children with convulsive seizure or collapse to have 12 lead ECG and QTc interval calculated. All children to have an EEG within 4 weeks of request.	Ongoing referral pathway in place Registered with Royal College Paediatric and Child Health for inclusion in the Epilepsy 12 project. Standards covered by this local audit will be incorporated in the National audit. National Report due May 2012.
CG21 - Falls: the assessment and prevention of falls in older people **Completed 25/10/11**	Introduce a 10 point falls checklist to be added to the patient notes. This will cover some of the key areas in this audit and also other aspects of falls assessment, such as continence, not covered in this audit. Doctors and nurses can use this to check a thorough falls assessment has been performed on their patients. The checklist will be trialled on the medical/orthogeriatric ward at TWH and, if successful, expand it throughout the medical division. This will also require the production of Falls information leaflets to give to patients and investment in equipment to assess vision.	10 point checklist added to notes. Trialling checklist on wards. Patients who are admitted to MTW, division currently been re-auditing, to see if the implementation of a falls Proforma has improved the assessment of these patients.
CG29 - The prevention and treatment of pressure ulcers **Completed 04/04/11**	MUST training relating to the nutritional assessment and needs of patients to be enhanced. Adaption of Waterlow risk assessment. Staff training on completion of revised Waterlow risk assessment. Re-audit due April 2012.	Training programme with ward dieticians underway.
CG32 - Nutrition support in adults: oral nutrition support enteral tube feeding and parenteral nutrition **Completed 05/01/12**	Distribute report. Present to nutrition steering group, TPN reduction through education, Nutritional support team, guidelines have been revised (March 2012). All staff email sent out (April 2012) regarding the use of TPN and the need for appropriate guidance before it is prescribed.	Action plan to be developed in discussion with the Dietetic team and nutritional support lead

CG35 - Parkinson's disease: diagnosis and management in primary and secondary care **Completed 04/02/11**	1) Ensure better access to Parkinson's disease medications on the wards. In particular on weekends when pharmacy is not open it may be worthwhile having 1 or 2 wards that always have stock of common Parkinson's medications such as sinemet and madopar. Staff should be made aware of where to find out-of-hours stock of medication and the importance of seeking it out as soon as possible. 2) Assess staff awareness of the importance of giving Parkinson's medications on time. If staff are not aware of the importance it may be that they did not pursue out-of-stock medications as rapidly as they could have. 3) Make doctors and nurses aware that certain patients should be allowed to self-medicate in order to continue to take their medications at their specific times rather than waiting for the nurse drug round. This should be documented in the medical notes and also on the drug chart 'additional instructions' so that nursing staff and pharmacists are aware. 4) It would be useful to review more casenotes as this was a small sample size.	Actions Completed Re-audit due to start May 2012.
CG36 - Atrial fibrillation: the management of atrial fibrillation **Completed 26/07/11**	In patients with AF permanent AF a risk–benefit assessment should be performed and discussed with all patients/family to inform the decision whether or not to give antithrombotic therapy by June 2011	Action completed Presented at Stroke Network 4months ago Re-audit planned for July 2012
CG40 - Urinary incontinence: the management of urinary incontinence in women (replaces TAG56) **Completed 26/08/11**	Organisational issues: Lack of formal staff training on promoting continence care. Bladder Bowel Care: Poor documentation and use of diaries / quality of life indicators needs resolving.	
CG47 - Feverish illness in children: assessment and initial management in children younger than 5 years **Completed 09/11/11**	Paediatric teaching for healthcare professionals introduced. Paediatric care pathway has been re-written. Present this audit to A&E. Re-audit	Paediatric care pathway completed September 2011 Re audit completed and presented at clinical governance February 2011
CG50 - Acutely ill patients in hospital **Completed 26/07/11**	It is hoped that the new observation chart that has boxes to record PAR scores for conscious levels and urine output will improve the accuracy of the PAR score documentation. The new chart also requires the nurse to initial when they have undertaken the task	
CG54 - Urinary tract infection in children: diagnosis treatment and long-term management **Completed 21/05/10**	Re-audit at an appropriate date	Re-audit started in July 2011. Chasing division for final report and action plans

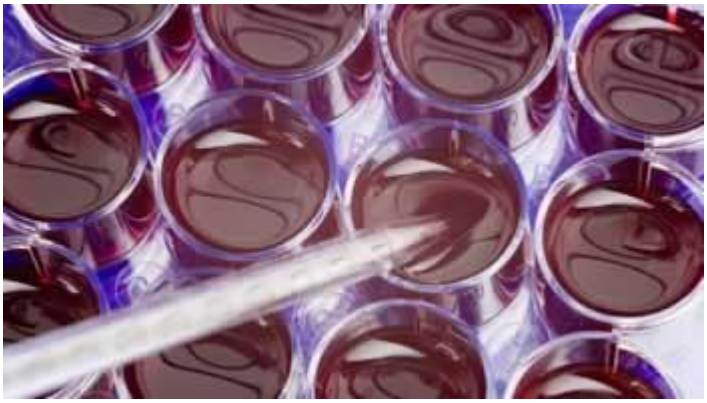
NICE Guidance and date audit completed	Actions	Actions Implemented
CG55 - Intrapartum care **Completed 02/08/11**	Heighten / Promote awareness regarding the required standards via the maternity newsletter, midwifery team meetings, CTG meetings and Obstetric Skills Drills. Design a stamp/sticker for use to improve compliance. Re-audit after the implementation of the above in about 6-12 months.	Weekly teaching sessions in place Sticker designed and in place Pro forma included in new notes Skills drills in place with monitoring of attendance Re-audit has been added to 2012/2013 programme. Due to start May 2012.

CG58 - Prostate Cancer **Completed 22/08/11**	EKHT to alert consultants of the need to fully inform patients at diagnosis of the illness and treatments.	There is a leaflet explaining the illness and treatment and this should be given to 100% of the patients.
CG59 – Osteoarthritis **Completed 28/10/10**	Need additional staff / clinic time to meet standards. Unable to change at present.	Staff are in the process of being recruited. Local policy in place which provides better qualitative data than NICE guidance. Re-audit on the 2012/12 programme.
CG60 - Surgical management of OME **Completed 09/11/11**	None required	
CG63 - Diabetes in pregnancy **Completed 29/03/11**	Improved documentation of diabetic care within maternity notes. Provision of pre-pregnancy counselling. Review referral pathway to ensure early referral to diabetic clinic. Documentation of postnatal arrangements to be encouraged. Patients diagnosed with gestational diabetes to be referred for consultant care. Re-audit in 12 months to assess implementation of recommendations from 2011 audit.	Uptake of pre pregnancy counselling remains poor
CG65 - Perioperative hypothermia (inadvertant) **Completed 27/10/11**	Presentation and discussion occurred to take place within Division Governance Committee and policy to be reviewed.	Re-audit due to start in August 2012.
CG68 - Stroke. **Completed 21/02/12**	Improve documentation Initial swallow assessment on admission Better assessment of Mood Rehabilitation goals set by MDT Aspirin commenced within 24 - 48 hours - Alternative route (rectal) Adequate skilled staff for the unit Stroke admission proforma / checklist Re-audit to evaluate change	Training has commenced and is ongoing /No stroke Proforma checklist at present .Still under review to be discussed at the next Stroke meeting Re-audit in planning stages planned for October 2012
CG71 - Familial hypercholesterolaemia **Completed 02/03/12**	No actions required	
CG75 - Metastatic spinal cord compression **Completed 03/08/11**	Develop local guideline and include on the intranet, Tutor to include the topic in future F1/F2 teaching programmes	Action completed
CG76 - Medicines adherence **Completed 01/12/11**	1. To raise awareness of HCPs of disabilities of patients which might impair or prevent patients from talking about their medicines 2. Raise awareness amongst HCPs to explain how medicines might help patients and be more open to discuss the pros and con	Action plan forwarded to Audit department Action plan completed and being implemented within pharmacy.
CG79 - Rheumatoid arthritis (replaces TAG72) **Completed 23/06/11**	1. Education of patients about the signs and symptoms of arthritis so that they seek help early in the disease process. 2. Education of GPs regarding the importance of early referral to secondary care, if possible with the patient having had the necessary investigations so that treatment can be started soonest. 3. Education of consultants to remember to record a DAS so that monitoring of disease activity and response to treatment can be evaluated. 4. Have a consistent department protocol so that all staff know the likely hierarchy of drugs and the escalation thereof.	GP education commenced but dependent on GP participation. No poster provided although NRAS booklets are provided. Consultants written to by Dr Batley re ensuring use local protocol and DAS score

	5. Is it helpful to have an early arthritis proforma for all consultations, so that nothing is missed? (we do have one of these)	
CG80 - Early and locally advanced breast cancer (replaces TAG107,108,109) **Completed 22/11/11**	Continue to monitor services through clinical audit and patient surveys Continue to develop and maintain services in partnership with other providers through the local cancer network	Actions completed
CG81 - Advanced breast cancer (replaces TA30, TA54 and TA62) **Completed 22/11/11**	Continue to monitor services through clinical audit and patient surveys Continue to develop and maintain services in partnership with other providers through the local cancer network	Actions completed
CG85 – Glaucoma **Completed 26/07/11**	Design tick box form so that all information to be recorded in notes Design new information leaflet, to be given to patients at first visit Patients follow-up appointments to be 6 months minimum Re-audit in July 2012	Actions completed
CG88 - Low back pain **Completed 20/02/12**	To liaise with GPs to improve referral rates and quality of information To standardise work instructions for investigation criteria in the medical imaging dept	Re-audit started January 2012
CG89 - When to suspect child maltreatment **Completed 02/08/11**	Check list added to the hospital notes which will be completed by staff on the ward throughout the child's admission. The child will not be discharged before this form is completed. Produce the pro-forma.	Form agreed and in use (August 2011) Parent / carer section encouraged Re-audit due to start june 2012
CG92 - Venous thromboembolism - reducing the risk (replaces CG46) **Completed 26/09/11**	Immediate considerations 1.Admission risk assessment to be completed by junior doctor at time of clerking. 2.Risk assessment within 24 hours to be completed at time of post take ward round. 3.Update VTE risk assessment form to reflect following: 4.VTE form to be filed in end of bed folder, ideally alongside, but detached from the drug chart. 5.Ward nurses to enquire about completion of VTE form PRIOR to accepting a patient on to the ward. 6.AAU/A&E nurses to remind doctors to complete VTE risk assessment before a patient is handed over to ward. 7.All new doctors joining trust should be educated about the importance of VTE risk assessment at time of their induction. 8.Publicity under 'stop press' on home page of staff intranet to provide education and to remind junior doctors and ward staff to ensure forms are completed. 9.When referring to other specialties, A&E doctors should consider themselves as the 'admitting doctor' and conduct the initial admission risk assessment. Long term considerations 10.Develop an electronic risk assessment form linked to patient centre that automatically prompts the doctor to complete the risk assessment online, before a patient can be 'transferred' from AAU/A&E to a peripheral ward. 11.Written information for patients and next-of-kins to read so that an informed decision can be made to receive treatment.	Next print run of prescription chart due in April 2012 Leaflets have been submitted but still not gone through PILG .Although small pilot underway VTE training commenced as part of mandatory study day Completed .Information disseminated. Re-audits due to commence in April 2012 with revised methodology and incorporating requirements from NHS Kent and Medway. Each Division is to take responsibility for their VTE programme working with respective audit facilitator.

CG95 - Chest pain of recent onset **Completed 22/12/11**	1) To review Trust-wide guidance on the death certification of patients who die where Troponin levels are elevated but the clinical presentation does not suggest a primary coronary event. 2) To improve consultant and cardiology input for patients admitted actual with suspected AMI 3) To improve access to echocardiography and diagnostic coronary angiography for patients admitted with suspected AMI	1 Discussed at clinical Governance Staff told not to put down MI cause of death unless indicated by clinical presentation. 2. MINAP report –indicate that Trust above national average 3 New Consultant appointed.
CG103 – Delirium **Completed 14/01/11**	Education of staff to ensure the tool is at the forefront of their minds when clerking patients with signs of delirium. Posters giving information around identification & diagnosis of delirium would be useful in A&E, AAU and on all wards.	Commenced educating junior and senior Doctors about the diagnostic criteria, causes and management of delirium as well as using a screening tool routinely. Consultant has arranged for the new version of our Medical Admissions Proforma to incorporate the screening tool when it is next printed. Delirium poster being printed for all clinical areas in the Trust both sites that might see Delirium patients.
CG117 – Tuberculosis **Completed 25/10/11**	HIV blood test should be included in the baseline bloods taken by Respiratory consultant/nurse at the time of diagnosis. Respiratory consultant will be responsible for insuring a chest x-ray is performed on all patients with a diagnosis of TB at any site	Actions completed.

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 2011/2012 that were recruited during that period to participate in research approved by a research ethics committee was 1581. Research participants were split as follows:

MTW own account recruits = 423
National Portfolio recruits = 1,146
Commercial research recruits = 12

Participation in clinical research demonstrates Maidstone & Tunbridge Wells NHS Trust's 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. Staff both host and attend regular research events held at the Trust. During 2011/12, staff have organised events looking at advancing research locally in surgery, rheumatology, paediatric care and ophthalmology.

MTW was involved in conducting 308 clinical research studies across all four divisions. Research active services include Oncology, Haematology, Radiotherapy, Rheumatology, Cardiology, Diabetes, Ophthalmology, Stroke Services, Breast Care, General Surgery, Anaesthetics, Orthopaedics, Elderly Care, Endocrinology, Gastroenterology, Respiratory, Paediatrics, Obstetrics and Gynaecology, Radiology, Pathology and Neurology.

There are currently 276 clinical staff participating in research approved by a research ethics committee at Maidstone and Tunbridge Wells NHS Trust. During 2011/12, Maidstone and Tunbridge Wells NHS Trust has focused on encouraging non-medical staff to lead innovative research locally and nationally to increase the diversity of research conducted. Clinical staff, with the role of either Principal or Chief Investigator, now includes consultants, senior nursing staff, therapies and support service staff.

In the period 2008/9 to 2011/12, 181 research papers were published either solely by research staff at Maidstone and Tunbridge Wells NHS Trust or by Maidstone and Tunbridge Wells NHS Trust staff working as part of a research team. Maidstone and Tunbridge Wells NHS Trust's engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques to patients. MTW staff are actively involved in participating in national portfolio research studies co-ordinated by the National Institute for Health Research Comprehensive Local Research Network.

Many own account research projects have led to improvements and changes in the care delivered to our patients. Most notably during 2011/12, the gynaecology research team published their work looking at sentinel node detection in women with cervical and vulval cancers. The breast care team at Maidstone now offer sentinel node detection (Microbubbles) as standard NHS care for women following their research into sentinel node detection in breast cancer treatment.

The Kent Oncology Centre Clinical Trials Unit at Maidstone Hospital works in close collaboration with both the National Institute of Health Research specifically under the umbrella of the National Cancer Research Network and the international pharmaceutical industry to ensure that Clinical Trial delivery of innovative treatments can be offered to patients with cancer at different trajectories of their diagnosis and pathway of care.

The expertise of the clinical trials staff, both clinical and non clinical are able to address the specific challenges and pressures faced by both NIHR and industry in successfully delivering cancer clinical trials within the Trust to sustain a portfolio of studies enabling "tomorrow's treatment today". All patients are given the opportunity to access a clinical trial during their cancer pathway.

There are presently 57 open and recruiting trials inclusive of randomised clinical trials and observational studies. This number is mirrored for those trials in follow up.

Maidstone and Tunbridge Wells NHS Trust staff who have successfully completed research that leads to changes in patient care share this knowledge and expertise through training events held at the new Trust Academic Centre. Training is provided for Trust staff and health care professionals from further afield.

New bids for research funding submitted during 2011/12 include funding applications to look at the impact of isometric exercise post cancer surgery, working in collaboration with the Christ Church College University, Canterbury Kent and how to increase collaborative working between acute and community pharmacy to improve services for local patients. Maidstone & Tunbridge Wells NHS Trust will receive notification in the summer of 2012 if successful.

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 which has now become standard practice. Other projects include looking at the genetic

make up of anal cancers and if the genetic make up of the cancer can influence how they respond to chemotherapy and introduction of a pre- and post operative exercise programme in Oesophageal Cancer patients.

Goals agreed with commissioners

Use of the CQUIN payment framework

A proportion of Maidstone and Tunbridge Wells NHS Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals in line with the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2011/12, quality improvement and innovation goals were set as indicated in the table below.

CQUINS 2011/12			Year End				2011/12 Year End			
		Baseline	Plan	Local Data Actual	Var	RAG	Plan	National Actual	Var	RAG
CQUINs										
National CQUINS										
1	**% of Adult Inpatients that have a VTE Risk Assessment - runs one month behind**		90%	85.0%	-5.0%		90%	85.0%	-5.0%	Q1 & Q2 Failure
2	**Composite Patient Experience Score (Annual Survey 2011/12):**	64.8%	90.0%	89.6%	-0.4%		65.0%	63.1%		
	Involvement in Decisions about treatment/care	89.0%	90.0%	89.0%	0.0%		65.0%	68.3%		
	Hospital Staff being available to talk about worries/concerns	91.0%	90.0%	92.0%	1.0%		65.0%	57.1%		
	Privacy when discussing condition/treatment	96.0%	90.0%	96.0%	0.0%		65.0%	81.4%		
	Being informed of side effects of medication	78.0%	90.0%	81.0%	3.0%		65.0%	42.0%		
	Being informed of who to contact if worried about condition after leaving hospital	86.0%	90.0%	90.0%	4.0%		65.0%	66.8%		
Regional CQUIN										
1	**Improve Performance % of patients receiving pathway metrics for 4 key areas:**			Jan-Dec 11	Dec 2011			Jan-Dec 11		

	Acute Myocardial Infarction (AMI) (Jan - Dec 11) - Baseline Jul - Dec 2010	93.19%	95.0 %	96.5%	98%	3.0%		95.00 %	96.53%	1.5%	
	Pneumonia (Jan - Dec 11) - Baseline Jul - Dec 2010	44.33%	76.2 %	79.0%	87.1 %	10.9 %		76.24 %	79.00%	2.8%	
	Heart Failure (Jan - Dec 11) - Baseline Jul - Dec 2010 - Partial Payment for 64.10% or above	61.70%	65.7 %	70.4%	88.5 %	22.8 %		65.70 %	70.44%	4.7%	
	Hip & Knee Replacements (Jan - Dec 11) - Baseline Jul - Dec 2010 *	77.80%	85.6 %	89.6%	99.3 %	13.7 %		85.61 %	89.56%	4.0%	
3	**Improve Patient Outcomes (Mortality) for Pneumonia - Jan 11 to Mar 12**	37.61%	Achieved Indicator					Achieved Indicator			
	Improve Patient Outcomes (Readmissions) for Heart Failure- Jan 11 to Mar 12	20.16%	Achieved Indicator					Achieved Indicator			
4	**Improve quality of patient care by engaging in shared learning in the four specific pathways**	Apr 11 to Mar 12	Attending Events	Meeting Thresholds				Attending Events	Meeting Thresholds		
5	**Data Completeness**		95.0%	95.0%		0.0%		95.0%	95.0%	0.0%	
Local CQUINs											
3a	**Effective Discharge - % of all admitted pts who have an EDD <24hrs - Partial payment if above 25%**		65%	67%				65%	67%	-2.5%	
3b	**Effective Discharge - Average Length of Stay**	7.2	7.0	6.7		0.3		7.0	6.7	0.3	

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

Similarly we have used these outcomes to help inform our decision on what to make key priorities for 2012/13. We have included the end of year position for the local inpatient survey as well as those published for the 2011 National Survey.

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
- Family Planning
- 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 visited the Trust twice in 2011/12 – firstly in May 2011 and subsequently in January 2012.
Following the May visit some suggestions for improvement were made in relation to staff training, changes to care planning documentation and ongoing monitoring for transfers of care with the opening of the new hospital – these issues have all been actioned.
In January, after visiting the Trust's Accident and Emergency Department the CQC required improvements in the care and safety of patients and staffing levels within the department. Immediate action was taken to address the deficits highlighted. The CQC made a follow up visit to the Trust in April 2012 – the publication of this report is awaited.

Key actions that we have taken to address the areas of concern:

- Enhanced staffing levels at all levels within the department
- Escalation policy reinforced for use in times when the area is very busy to increase support as required
- Hourly rounds introduced to ensure all patients are seen at least hourly and kept updated re progress, care needs and ensure their nutritional needs are met
- New vending machines for drinks and snacks installed
- Targets set for timely review by specialist teams – escalation process implemented if these are not met

A&E performance against national targets are included later in this section.

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 2011-12 the Trust successfully completed the completeness and validity checks set out as part of the Information Governance Toolkit. This is further confirmed by the results of the Audit Commission's annual Payment by Results audit along with the NHS Information Centre's Secondary Uses Service data quality reports.

The Trust has a Data Quality Steering Group that takes action on data quality issues. Areas identified for improvement during 2012-13 are:-

- NHS Number Completeness
- Software upgrades to improve data flows to Commissions and the Department of Health
- Outpatient Referral Source data

NHS Number and General Medical Practice Code Validity

Maidstone and Tunbridge Wells NHS Trust submitted records during 2011-2012 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:

97.1% for admitted patient care;
98.7% for out patient care; and
87.6% 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

The Trust achieved a 74% score against the Information Governance Toolkit Version 9, and achieved a minimum of level 2 against all the requirements of the Toolkit as required by the Operating Framework for England for 2011/12. The Trust has established a robust Information Governance Management Framework that has been in place throughout the year and significant improvements have been made in many areas. An action plan has been developed to address the areas of weakness identified. The Trust Board is kept fully appraised of Information Governance issues affecting the organisation.

The Trust is also working proactively with the Information Commissioner's Office which was asked to undertake a consensual audit in May 2012. At the time of writing the outcomes of the audit are not known but any recommendations made will be utilised to develop further action plans for Information Governance improvements.

Part Three

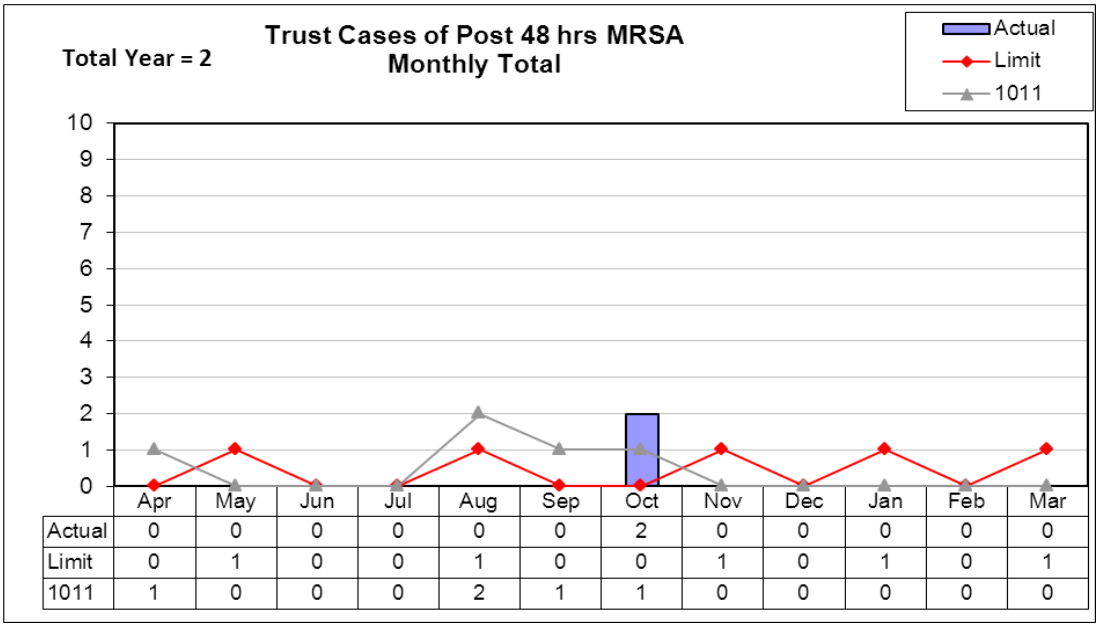
Review of Quality Performance

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

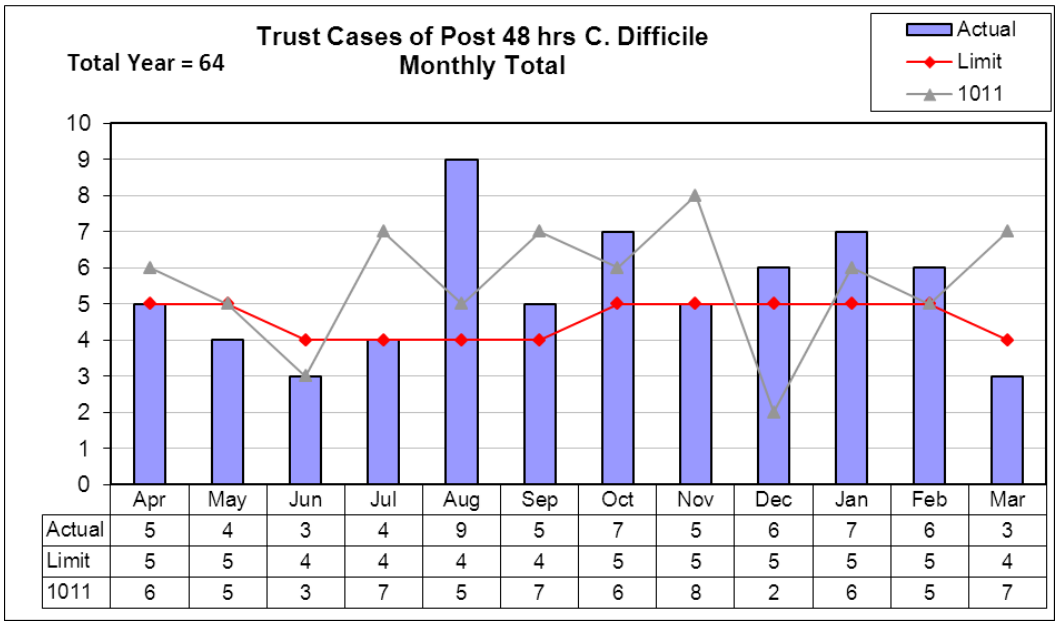
Infection control – see part 2 for additional information within key priorities section

Infection Control – MRSA Cases – The Trust achieved this standard, with 2 cases of MRSA throughout the year against a maximum limit of 5 cases.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	0	0	0	0	0	0	2	0	0	0	0	0
Limit	0	1	0	0	1	0	0	1	0	1	0	1
1011	1	0	0	0	2	1	1	0	0	0	0	0

Infection Control – C. Difficile Cases – The Trust did not achieve this standard of a maximum of 55 cases for the year. However, the number of C. Difficile cases throughout 2011-12 was fewer than the number reported for 2010-11

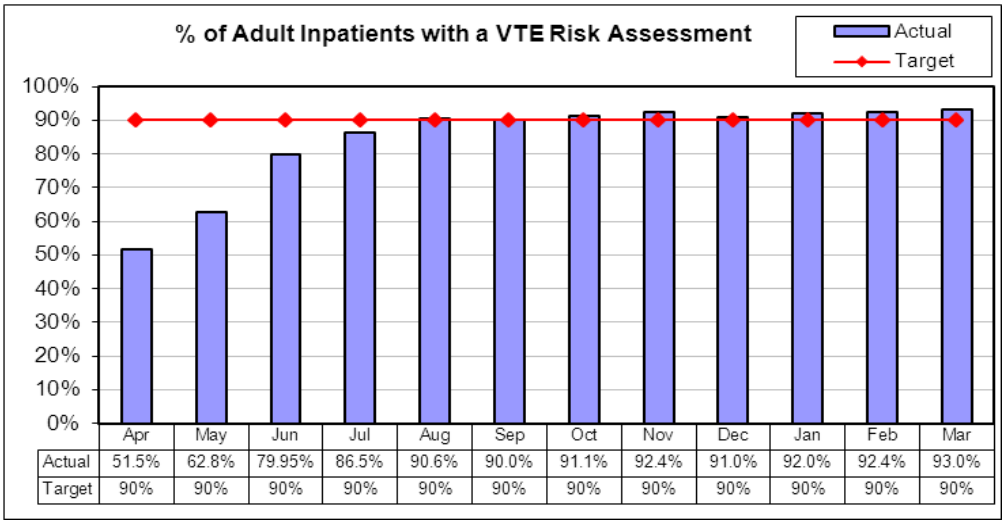


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	5	4	3	4	9	5	7	5	6	7	6	3
Limit	5	5	4	4	4	4	5	5	5	5	5	4
1011	6	5	3	7	5	7	6	8	2	6	5	7

Nationally there were 7670 cases of C. difficile in all Trusts across England of which 64 cases were within MTW. To make comparisons between the trusts it is necessary to compare the number of cases to the number of bed days. The Health Protection Agency will be producing this comparison data for 2011/2012 in the autumn.

Prevention of VTE

- MTW has continued to achieve the VTE CQUIN goal for 8 consecutive months, achieving the highest % so far in March of 93.05%
- VTE Prevention Group last met in February 2012 and work is now in progress to evolve into a Thrombosis Committee
- Root Cause Analysis (RCA) of known cases of VTE commenced in Oct 2011 and is ongoing. Current retrospective system to be replaced by a prospective system using Datix e-reporting of all hospital acquired VTE.
- Development of further patient information on VTE continues
- Action plan for improving practice in relation to mechanical thromboprophylaxis developed and commencing implementation
- Education of clinical staff is ongoing via various methods



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	51.5%	62.8%	79.95%	86.5%	90.6%	90.0%	91.1%	92.4%	91.0%	92.0%	92.4%	93.0%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

From national statistics: VTE Risk Assessment Data Collection, July to September 2011

The fifth set of quarterly statistics on Venous Thromboembolism (VTE) Risk Assessment in England, produced by the Department of Health were released in December 2011.

The key results for data collected on the number and proportion of VTE Risk Assessments carried out on adult admissions to NHS funded acute care were that:
Of the 3.3m adult patients admitted to NHS funded acute care between July and September 2011 88% of these received a VTE risk assessment on admission, an increase compared to Q1 2011-12 (84%).

In September 2011, 209 providers (out of 256 providers who submitted data), reported that at least 90% of adult admissions were risk assessed for VTE, compared to 131 in June 2011, and 18 in July 2010.

Ensuring Patients receive appropriate nutritional requirements

During the last year considerable progress has been made towards ensuring that our patients receive the appropriate nutritional requirements. Improvements have also been demonstrated within out local and National survey results:

	2010 National Inpatient Survey	March 2011 Local Patient Survey	2011 National Inpatient Survey
The % of patients getting enough assistance to eat	63%	90%	76.9%
The % of patients who rate hospital food as good	48%	90%	50.1% 84.2% (if including fair

To facilitate the improvements various initiatives were implemented during the year:

- Meal standard was endorsed across the Trust to strengthen protected meal times, ensure appropriate nutritional assessments are carried out and assistance provided where required.
- Introduction of the 'meals module –Productive Ward'
- Weekly review of MUST scores implemented by and led by Dietetics Team
- Nutrition Action Plan in place following audit, led by the Food as Medicine Group with oversight by the Nutritional Steering Group.
- Quality Assurance inspections –particularly focusing on Nutrition, in place with plan to ensure that all wards are visited though the course of the year.
- Engagement and active participation of patient representatives and Non-Executive Directors in the Quality Assurance visits.

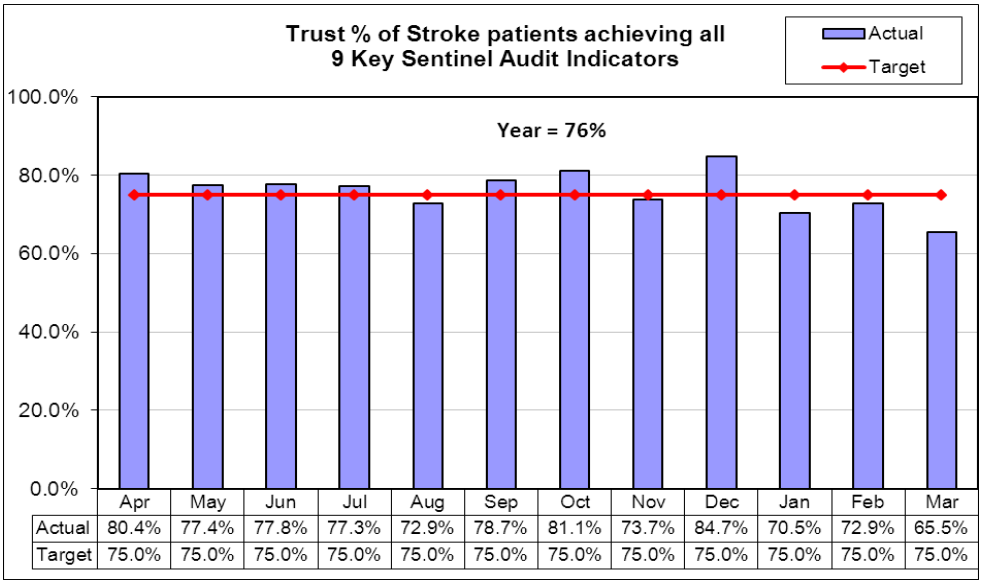
Clinical Effectiveness

Improving the care we provide for patients who have had a stroke

- Stroke nurse recruited for one year
- 90% target not achieved by year end.
- 9 key indicators compliance achieved

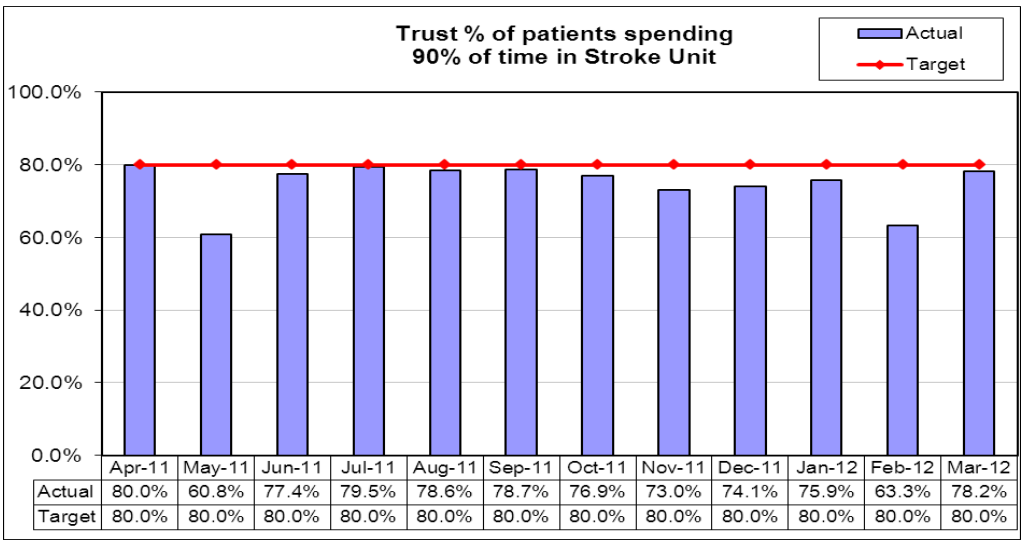
Dedicated stroke units at Tunbridge Wells and Tonbridge are now established.

Stroke Sentinel Audit Indicators – The Trust did ensure that 75% of stroke patients achieved all 9 Key Sentinel Audit Indicators in 2011-12.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	80.4%	77.4%	77.8%	77.3%	72.9%	78.7%	81.1%	73.7%	84.7%	70.5%	72.9%	65.5%
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%

Stroke – The Trust did not ensure that 80% of stroke patients spent 90% of their time on a dedicated stroke ward in 2011-12.



	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Actual	80.0%	60.8%	77.4%	79.5%	78.6%	78.7%	76.9%	73.0%	74.1%	75.9%	63.3%	78.2%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Improving the care we provide for patients with dementia

Steps taken in the last year to address improvements in caring for patients with dementia are highlighted in section two and include:

- Training on dementia care awareness developed for staff to attend.
- Ward based dementia care "champions" have been identified to support and progress actions, outcomes and training as required
- A new medical admissions document has been introduced which includes information re patients with dementia
- The care pathway for patients with a fractured hip has been updated to reflect the care of those patients who are also suffering from dementia

Ensure greater efficiency of working

Thirty-six clinical areas have now signed up to Releasing Time To Care programme. Baseline 'direct care time' given by nurses and midwives is between 13% and 58%; with an overall Trust position of 51%.

To date the programme has focused on all inpatient areas completing the foundation modules of the Well Organised Ward, Knowing How We Are Doing and Patient Status at a Glance. Upon completion of the foundation modules, staff have been encouraged to undertake a module that supports a Trust-wide initiative. All wards have been encouraged to undertake the Medicine and Meal Modules with an aim to reduce medicine errors and endorse Protected Mealtime and nutritional care. Other clinical areas such as ITU, Neonatal units, Short Stay Day Surgery unit, Women's and Children's wards will be undertaking the Handover module

The institute for Innovation and Improvement has set out a series of questions and prompts to guide through first impressions of a ward. It is believed that first impressions and follow through of key questions can establish how well a ward is functioning and a unique perspective to understanding the quality of care that is being delivered. The '15 Steps Challenge' has been designed to support the Productive Ward programme and help wards to understand how they are doing from a patient's perspective. All clinical areas undertaking the Productive Ward programme will be signed up to meeting the '15 Steps Challenge', with first assessments taking place at the end of March 2012

We will be continuing to roll out the different module is the coming year with the aim to:

- Establishing baseline 'direct care time within at Tunbridge Wells Site
- Increase the direct care time by at least 10% following completion of the foundation modules.
- All wards to have completed all relevant process modules and have standardised processes and practice, with methods of auditing to ensure sustainability.
- All clinical areas undertaking the Releasing Time to Care programme signed up to meeting the '15 Steps Challenge' and audited
- All clinical areas within the releasing time to care programme to feedback actions in response to patient views and key outcome measures; promoting a culture of caring about communicating with, and listening to, our patients.
- Establish long term sustainability of concept and application of releasing time to care improvements.

Patient Experience

Communication and Information

See full section re Patient Satisfaction Surveys below.

Improving the management of discharge planning

The Trust performance against the indicators set in the National Survey for Discharge Planning is broadly comparable with the national average but we are keen to demonstrate improvements in this area and have kept discharge planning as a key priority for the coming year.

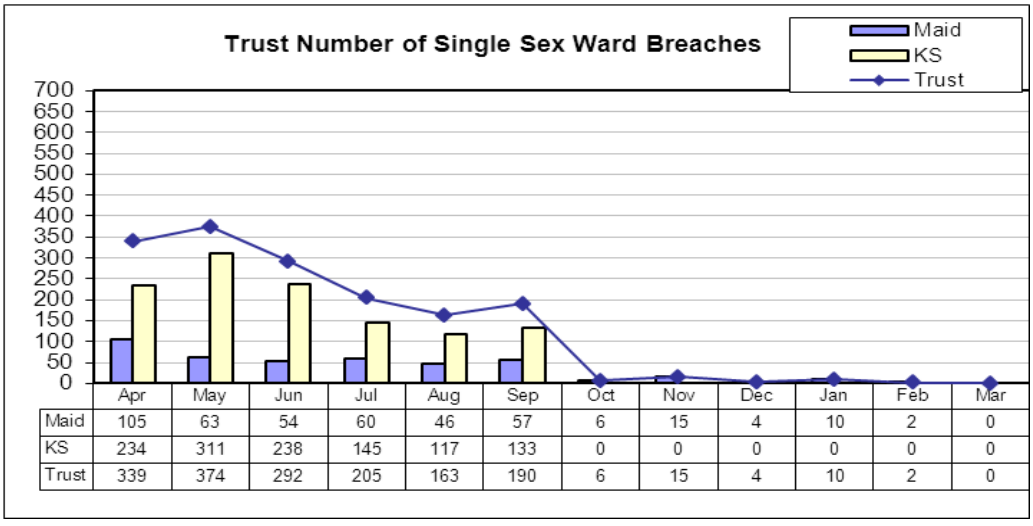
There has been an improvement in the implementation of electronic discharge notification from to 67% in the last year. By using electronic discharge notifications we are able to ensure that GPs are aware of what treatment their patients have had in a more timely way and also to speed up such processes on the discharge planning pathway as the dispensing of medications that patients need to take home.

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 continued in 2011-12.

Reducing the number of breaches we have in relation to delivering same sex accommodation for patients

Eliminating mixed sex accommodation remains a challenging area for MTW, however, with the opening of the Tunbridge Wells Hospital the Trust can focus on the Maidstone site. Any further design changes at Maidstone Hospital in the coming year will ensure we continue to make improvements with respect to Delivering Same Sex Accommodation (DSSA).
There were no incidents of DSSA breaches in March 2012.

Single Sex Ward Breaches



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Maid	105	63	54	60	46	57	6	15	4	10	2	0
KS	234	311	238	145	117	133	0	0	0	0	0	0
Trust	339	374	292	205	163	190	6	15	4	10	2	0

Looking at other performance indicators which enable us to SEE (safety, effectiveness and experience) Quality:

Patient Falls

Although not a key priority within the Quality Accounts for last year the trust has maintained an ongoing focus on falls. Within the last year a number of actions have been taken to minimise the risk of patient's falling. These have included:

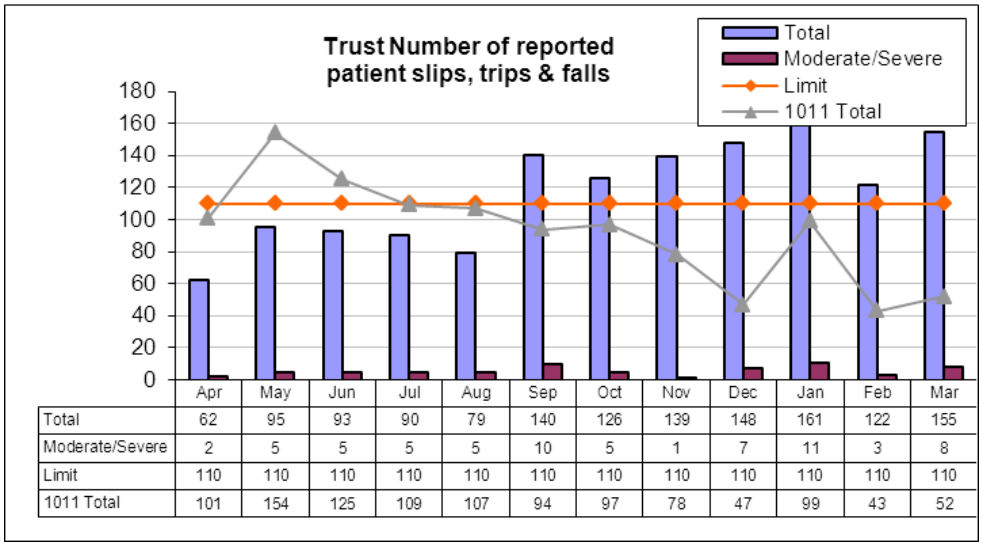
- Purchased more low level beds
- Implemented a "Period of increased incidence" focus on wards following 5 or more falls in the month – this results in a detailed root cause analysis (RCA) on each fall, review of training records and sharing of learning across the organisation
- We have set up a serious incident review panel specifically for falls. At the panel we review the outcome of the investigation of each case and ensure an action plan is in place to address any areas of learning identified.
- Developed new screening tool to help ensure that patients at risk of falling receive appropriate help
- An elderly care physician is now a member of the Falls Group
- Agreed medication list which affects the risk of falls
- Reviewed mobility equipment to ensure fit for purpose

The Trust has seen an increase in falls since September; this coincides with the opening of the new hospital and the introduction of the single room environment. Initiatives to understand and reduce occurrences are ongoing. Work to date has included:

- Review of shift pattern – twilight
- Increase in staff numbers in key areas
- Introduction of quality rounds

The number of falls at TWH has evened out to that of the Maidstone site.

Falls



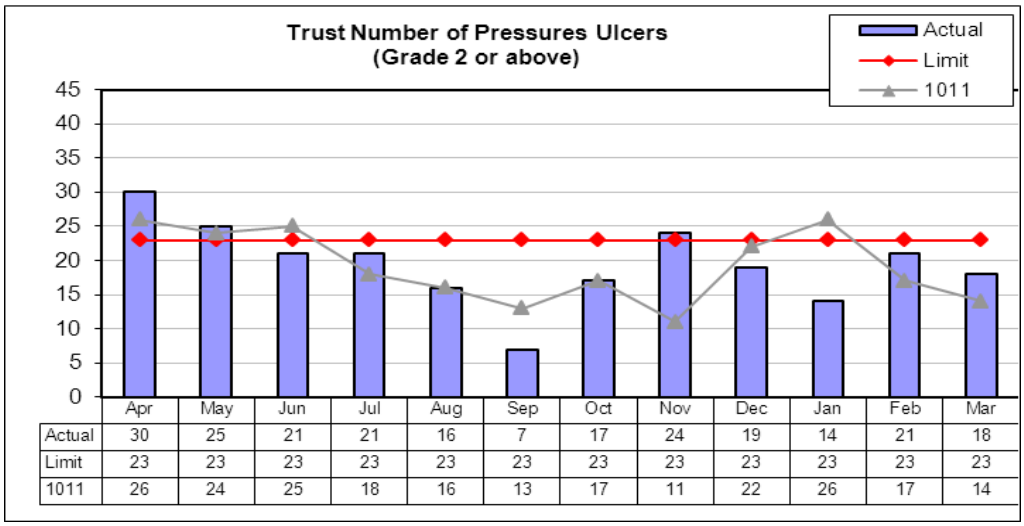
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	62	95	93	90	79	140	126	139	148	161	122	155
Moderate/Severe	2	5	5	5	5	10	5	1	7	11	3	8
Limit	110	110	110	110	110	110	110	110	110	110	110	110
1011 Total	101	154	125	109	107	94	97	78	47	99	43	52

Actions to be taken this year are highlighted within the focus on falls as a key priority within section 2.

Pressure Ulcers -

MTW continues to improve on last year's 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%.
The key area of improvement has been in the reduction of hospital acquired Grade 3 and 4 pressure ulcers.

Pressure Ulcers



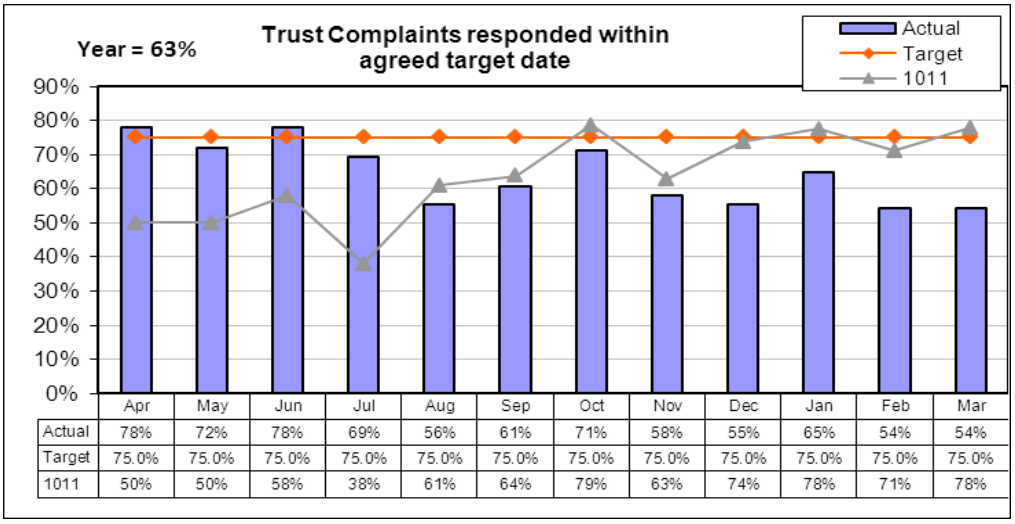
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	30	25	21	21	16	7	17	24	19	14	21	18
Limit	23	23	23	23	23	23	23	23	23	23	23	23
1011	26	24	25	18	16	13	17	11	22	26	17	14

All hospital acquired pressure ulcers are subject to a root cause analysis and presentation to a Pressure Ulcer Review panel chaired by the Deputy Director of Nursing. Prevalence audits are now conducted twice a year instead of annually. During the prevalence audit every single in-patient is reviewed by the audit team rather than wards self-reporting.
There is a core Trust-wide prevention action plan in place which is monitored bi-monthly via the Serious Incidents Requiring Investigation (SIRI) panel. The action plan is formally reviewed every 6 months in partnership with the NHS Kent and Medway.

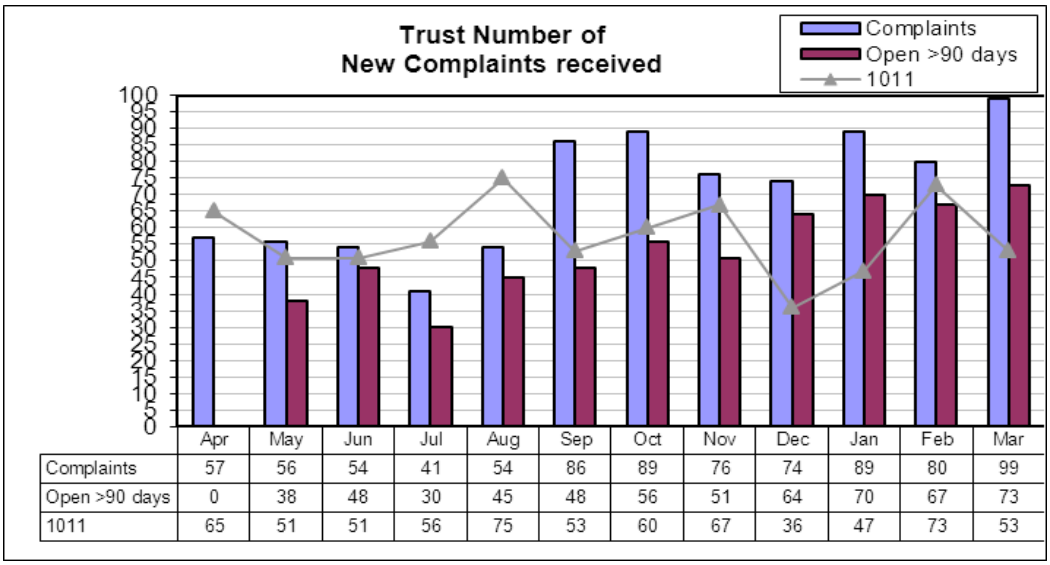
Complaints Management –

While it will be noted that the compliance with responding to patients within an agreed target date has fallen over the year, this needs to be looked at in line with the number of complaints coming into the hospital, which has seen an increase in the last six months. The increase in numbers is under constant review so that action can be targeted in the appropriate areas.
Following a review of the management of complaints throughout the trust there is a robust action plan in place to help us address areas for improvement.
From trend analysis the top five themes of complaints relate to: communication, attitude, clinical care and delays in appointments.
We have identified the management of complaints as a key priority for the coming year. The initiatives to be taken to improve this service are highlighted in section two under the key priorities.

Complaints



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	78%	72%	78%	69%	56%	61%	71%	58%	55%	65%	54%	54%
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%
1011	50%	50%	58%	38%	61%	64%	79%	63%	74%	78%	71%	78%



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complaints	57	56	54	41	54	86	89	76	74	89	80	99
Open >90 days	0	38	48	30	45	48	56	51	64	70	67	73
1011	65	51	51	56	75	53	60	67	36	47	73	53

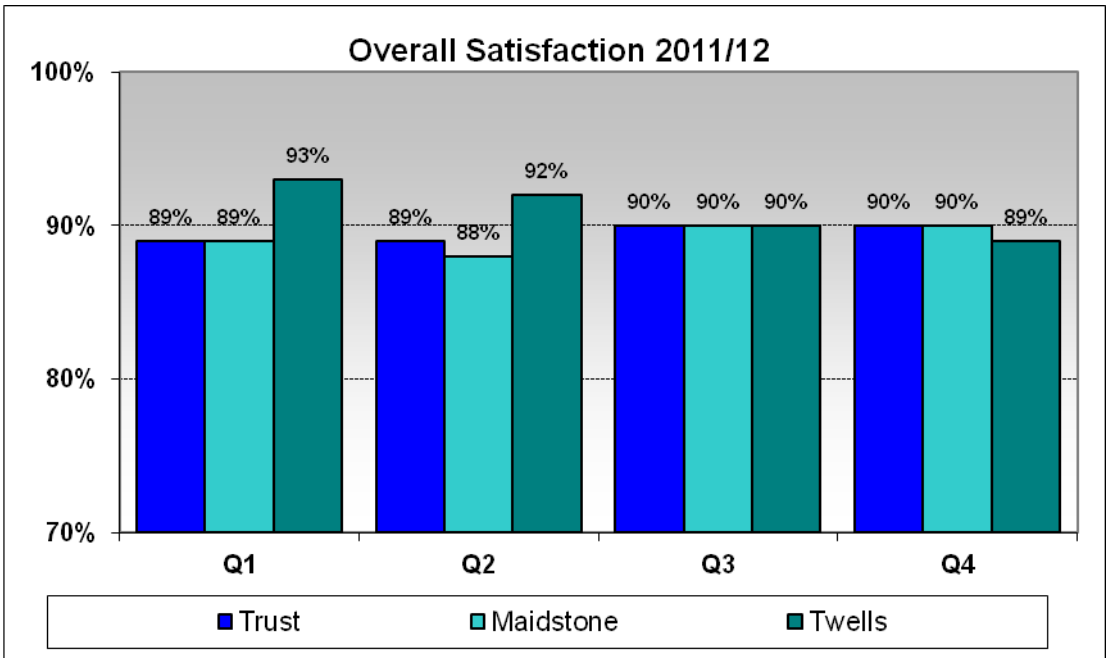
Patient satisfaction Surveys

The Trust has ended 2011-12 with encouragingly high levels of positive patient experience, in spite of a year of massive change, as indicated through its monthly patient satisfaction surveys and audits.

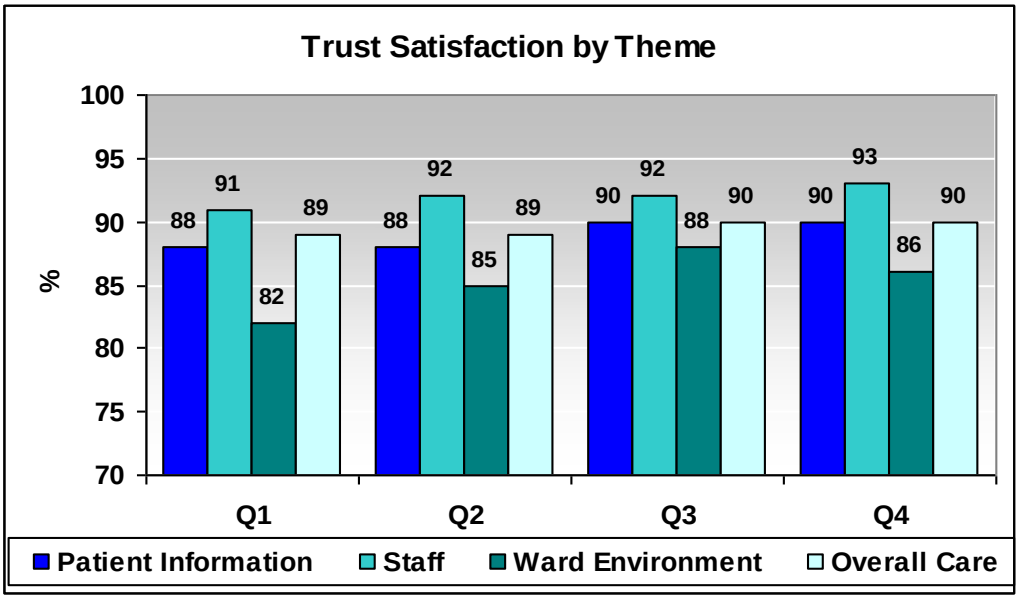
The Trust now surveys an average of over 450 patients a month to gauge levels of satisfaction in four key areas:

- **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.

Trust overall satisfaction maintained consistency through the opening of the new hospital as well as the addition of the Stroke Rehabilitation unit at Tonbridge Cottage Hospital and changes to services offered at Maidstone.



The Trust pinpointed areas for focus particularly in the area of ward environment. This has resulted in a series of ward focused care assurance audits, conducted by the Corporate Nursing team, assisted by directorate matrons and members of the MTW Patient Experience Committee.



The Trust continues to score well in areas of ward cleanliness, privacy and dignity as well as patient confidence in doctors and nursing staff.

Within the operating framework there are specific questions that we are required to report on:

(Q 41) Were you involved as much as you wanted to be in the decisions about your care and treatment?

Year end aggregated score is 88.92%. Performance month on month has been relatively static.

In the national patient survey we scored worse than last year in this area.

(Q 44) Did you find someone on the hospital staff to talk to about your worries and fears?

Performance is again relatively static with year end score 91.83%. At local survey level this score has never dipped below 90%, with consistent performance across both sites.

In the national patient survey we scored slightly better than last year in this area.

(Q 46) Were you given enough privacy when discussing your condition or treatment?

The Trust has scored consistently well on this on local survey data across all sites, with the impact of single rooms at Tunbridge Wells having minimal overall impact on this score. This would indicate that staff at Maidstone are cognisant of the environmental challenges and take appropriate and effective steps to ensure privacy when discussing condition and treatments with their patients.

In the national patient survey we scored significantly better than last year in this area.

(Q 65) Did a member of staff tell you about medication side effects to watch for when you went home?

The area of explaining the side effects of medication to patients in a manner that they both understand and recall has remained a challenge. The local patient survey results suggest marked improvements at the time of data capture. The current method of

canvassing our patients does not allow for how they may feel about the information they have been given once they have left the hospital.
In the national patient survey we scored the same as last year in this area, but lower than national comparator group in the 2011 survey.

(Q 70) Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
Informing patients who to contact if they were worried once they have left the hospital has proved to be a similar challenge. We have struggled to get above 90% consistently in the local patient survey.
In the national patient survey we have scored significantly worse than last year.

Comparison between the national patient survey for 2010/11 and 2011/12 indicates that we have

- Worse on two indicators (41 & 70)
- Stayed the same on one indicator (65)
- Marginal improvement on one indicator (44)
- Significant improvement on one indicator (46)

From the staff survey we are able to report the following:
Percentage of staff who would recommend MTW to friends or family needing care:
Results from the staff survey is actually scored as a scale summary score, calculated by converting staff responses to particular questions into scores with the minimum score is always 1 and the maximum score is 5.

2011 Trust Staff Survey Score: 3.61
2011 National Average for Acute Trusts 3.50

The 2011 Trust score represents a third successive year-on-year improvement in performance against this key measure and is a result of all the hard work that has been put in place in recent years to turn around the organisation and improve performance. A new Human Resources (HR) Framework and Organisation Development (OD) strategy is being developed to continue to improve the organisation as a place to work and one key strand will be a focus on customer care.

Listening and responding to patients
Feedback from patients takes place in many ways including local feedback at ward or department level, local patient surveys, PALS, and Complaints.

Key elements from feedback is themed and reviewed on a regular basis. These themes are reviewed at the Complaints, Litigation, Incidents and PALs (CLIP) meeting which has representation from the Divisions. The themes are subject to higher level review and scrutiny at the Clinical Governance Overview Group (CGOG).

Some examples of changes made as a result of feedback include:

- Review of patient information and literature
- Review of condiments and revision of ward stock levels of food
- Review of menus at Maidstone Hospital
- Review and investment in walking aide stock at ward level
- Purchase of clocks for single rooms at TWH
- Move from cups to mugs for hot drink provision

Safeguarding our Patients

Safeguarding Children
The trust has an established Safeguarding Committee for Children which reports into the Quality and Safety Committee.

There are three key aspects to ensuring that MTW meets its statutory obligations in discharging it's obligations to safeguard children who use services:

- That there is 24 hour advice for all staff who have concerns in relation to children , this is met by expert advice provided by the named nurse, named doctor and nurse for safeguarding and out of hours by the consultant paediatrician on call. 2012 has seen the retirement of the named nurse and resignation of the nurse for safeguarding. Both posts have been appointed to.

- Daily review of all attendances by children to our Accident and Emergency departments, ensuring that histories given are consistent with the injury / condition with which the child presents. Also ensuring that attendances are communicated to appropriate partner agencies, school nursing, general practitioner and when relevant social services. This daily review has been completed for 2011/12 and continues to be provided.

- Delivery of the approved training strategy with regard to level one and level two training specific to safeguarding children for staff working within the trust. Training has been delivered throughout the year at both levels at induction programmes, mandatory updates and at other sessions as requested. Both level one and level two training can also be accessed on line. Compliance with training as per the strategy is reviewed bi monthly at the Trust Safeguarding Children committee.

In addition to the points above, the Trust has been represented on external partner agency forums to ensure communication and participation in the health economy agenda for safeguarding children.

Safeguarding Adults

The Trust has an established Safeguarding Adults Committee with multi-agency representation, which reports into the Quality and Safety Committee.

Over the last year, the core Trust Policy has been reviewed to reflect changes in raising alerts of concern, making reasonable adjustments to provide individualised care, introduction of the ‘This is Me’ booklet and more recently DH guidance in relation to early identification potential radicalisation of vulnerable people (both patients and staff) via the PREVENT framework.

The committee monitors the number of alerts raised and the time taken to investigate and close cases and ensures learning is disseminated as appropriate.

Core mandatory training is monitored and content is check to ensure it is in line with the learning outcomes stated by Kent County Council. The Trust is currently above trajectory for compliance with level 1 safeguarding adults training.

Increased awareness of the Mental Capacity Act has been noted and work in this area continues. Dementia awareness workshops have been run with positive feedback from staff. The last year has also seen the development and implementation of an E-Learning package for End of Life Care.

The Trust works closely with Social Services, County Council colleagues and primary care colleagues to develop safeguarding strategies, work collaboratively to manage concerns and to share learning and best practice.

Learning from Incidents

Learning from incidents is key to improving services for our patients. We believe that an open the reporting culture is essential and encourage supporting so that we can investigate and take remedial action when necessary.

In 2011/2012:

- 7708 incidents reported from 1/4/2011 to 31/3/12.
- 80.5% (6209) were patient safety related incidents.
- 2% (127) of which were serious or death related.

The number of reported incidents has increased since e-reporting came in from 1 April 2011 by just over 10%. The number of serious and death outcomes has reduced

Learning from other incidents:
Some of the many actions that have come out of our investigation of incidents have resulted in the following action being taken to avoid related problems recurring:

- Failure to diagnose a subarachnoid haemorrhage has led to provision of top tips for locums as well as educational teaching of the subject.
- Following investigation into C-Difficile infections we reviewed and reiterated the antibiotic prophylaxis protocols.
- A delay in diagnosing cancer has led to backup processes ensuring that the cancer services multidisciplinary team receive all results. An operational manual for secretaries has also been devised to ensure any temporary staff are aware of procedures for handling results.
- Following other delays in diagnosis a confirmed pathway for responding to follow-up letters has been introduced and an agreed unified approach to terminology to avoid confusion.
- Medication error – the Trust antibiotic protocol is now laminated and placed in all anaesthetic rooms. All antibiotics are to be prescribed by surgeon pre-operatively.
- MRSA bacteraemia – following analysis of the cause of the bacteraemia additional training for staff in taking swabs for screening and blood for culture and cannulation for paediatric doctors. A new blood culture audit form specific to paediatrics.

Never Events:
These are serious incidents that should never happen and are usually due to process/system failures. Three never events occurred during 2011/2012. These related to:
Two incidents of the wrong implant/prosthesis and one retained foreign object post-operation.

Learning and changes in practice:

- The WHO and instrument check lists were not followed. All staff were issued with further guidance and in one case disciplinary procedures instigated.
- The packaging of + and – lenses were so similar that further errors could occur. The manufacturer was contacted regarding this and is looking at changing this. In addition the theatres have rearranged their stock locations into + and – areas so confusion should not occur.
- Additional checking processes introduced to double check all lenses before being inserted.

All three cases were discussed at the specialty governance meetings

National Indicators

There are a variety of National indicators highlighted within the Outcomes Framework that each Trust is required to report on – these include issues such as infection rates, VTE and patient experience that we have already mentioned. Other indicators include:

Preventing people from dying prematurely
The latest Summary Hospital Level mortality indicator (SHMI) data released 24th April 2012 shows that our trust has a marginally higher (worse) mortality figure than the national average. This figure is 1.01, suggesting a 1% increased rate, which is well within the “expected” level.

Within 2011/12, 0.7% of our patients who were admitted were coded as requiring palliative care.
13.4% of the patients who died within the trust were coded as receiving palliative care at the time, this compares with 16.4% nationally.

Of note, a previous national comparison had shown a figure of 1.04, when SHMI was launched and this improvement is mirrored in the data we use to oversee our outcomes (Dr Foster), which has shown a decrease in mortality in Q3 and Q4 of the last financial year.

It is too early to comment if the reconfiguration of our trust services has contributed to this change, but we are actively monitoring this data.

Mortality reports are discussed at our Standards and Quality and Safety Committees and reported to the Trust Board.

Helping people to recover from episodes of ill health or following injury

Patient Related Outcome Measures (PROMs)

This section of the Outcomes Framework looks at a number of issues including Patient Related Outcome Measures (PROMs).

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

From the four surgical procedures for which PROMs data is captured, the findings were:
Groin Hernia – 94 returns of which 43 reported an improvement on lifestyle following the operation (improvement Health Gain factor of 0.166)
Hip Replacement – 160 returns of which 147 reported an improvement in lifestyle (0.258 factor improvement).
Knee Replacement – 145 returns of which 118 reported an improvement in lifestyle (0.187 factor improvement)
Varicose Vein – insufficient number of questionnaires returned to be able to quantify the data.

In comparison with the National Report (2009/2010 are latest available statistics)
For Groin Hernias – MTW is not as good as the England average improvements
For Hip Replacement – MTW was better than England
For Knee Replacement – MTW was better than England
For Varicose Vein – low number of returns so not comparable

Emergency readmissions to hospital within 28 days of discharge
The national data shows an average readmission rate of 11.15%, within Kent, this figure is 11.61% and our trust shows a figure of 12.05%. It appears that some of our internal data may have duplicate data entries, with moving wards or hospitals; therefore it has been difficult to identify the areas of higher readmission. Further work is being done to identify "unexpected" readmissions, rather than planned readmissions, which occur commonly in our specialties. We will continue to monitor this and findings will be reported through our Standards Committee to the Quality and Safety Committee.

During 2011/12 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 2011-12 will be available to view on the Trust's website in May 2012 – www.mtw.nhs.uk A summary of the Trust's overall performance for the 11 months up to February 2012 is available on the website now.

The transfer of services into a brand new all single room hospital during the year has affected the emergency pathways for all specialties, resulting in an underperformance against the key targets. However, with the exception of A&E performance, the other access targets for elective services have been met. A major success since the move has been the achievement of the DSSA standards across both hospital sites.

There have been some challenges too. The number of transfers of care between sites has increased as a result of service reconfiguration and the new clinical strategy.

Any patients who come to A&E at Maidstone who are assessed as needing trauma or surgical care are transferred to TWH for their care. Orthopaedic patients who need trauma surgery at TWH but have a Maidstone place of residence will return to a ward at Maidstone for rehabilitation on or around the third day post-op, or when they are deemed stable.

We also have circumstances when medical patients who are in Maidstone Hospital develop surgical problems and need to be transferred to TWH, directly to a ward.

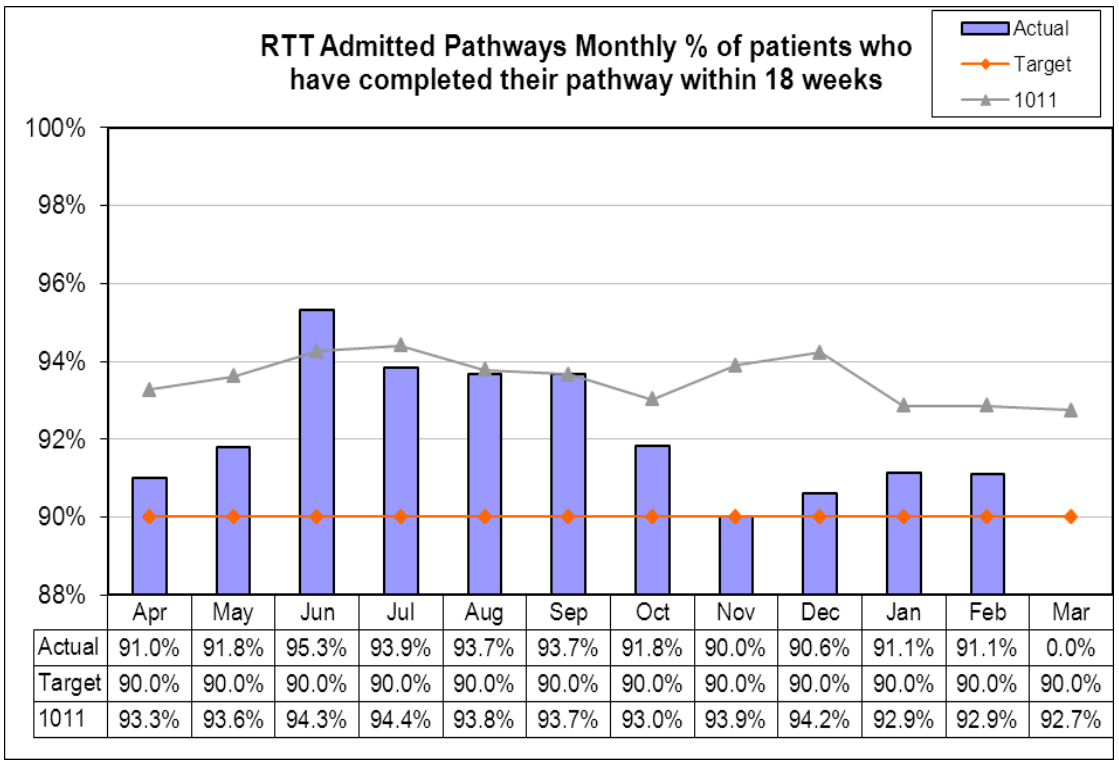
Patients who have had a stroke and are admitted to acute stroke unit at TWH will be transferred to Tonbridge Cottage Hospital if they need ongoing rehabilitation. It should be remembered that some patients are discharged home directly from the acute unit.

There are also circumstances when one of the sites is under pressure that they may need to be diverted to the other site. If patients with a postcode for the other site are treated within the A&E department we assess and treat them, then transfer them back to a ward at Maidstone once they are stable.

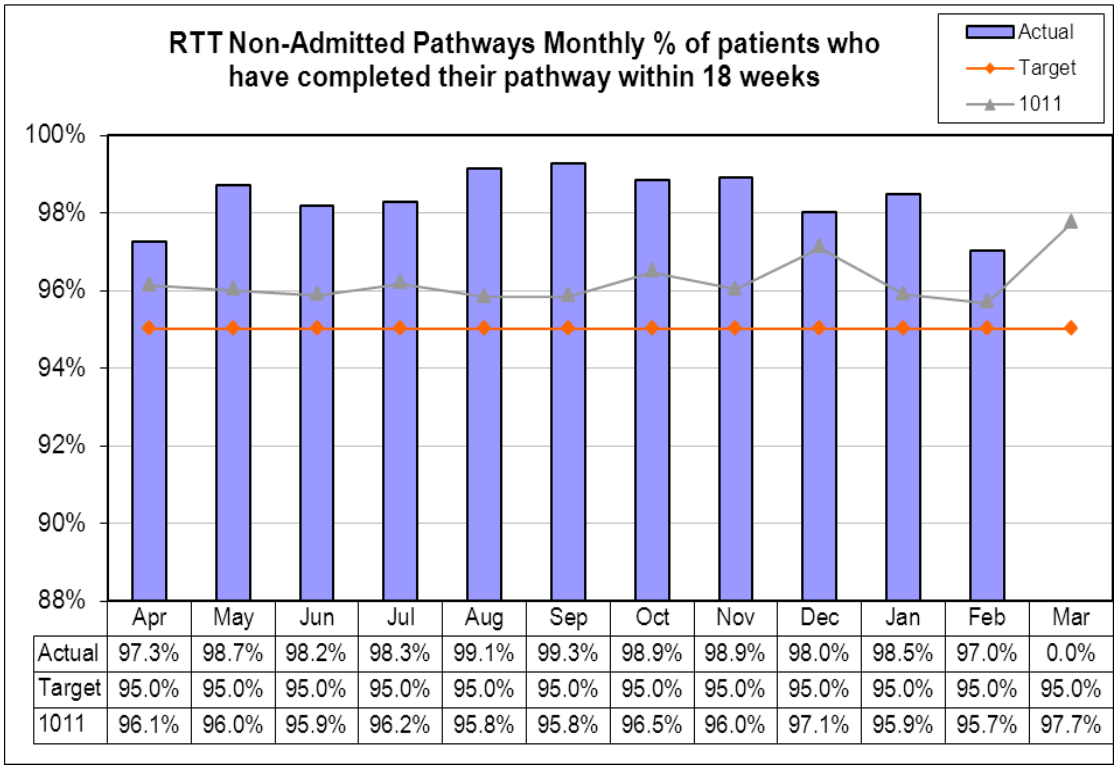
There are robust policies in place to support the transfer, and treat and transfer of patients.

Early evidence shows that the Trust's performance against key national and local standards in 2011-12 was good with the Trust being rated as performing under the NHS Performance Regime for most of the year.

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.

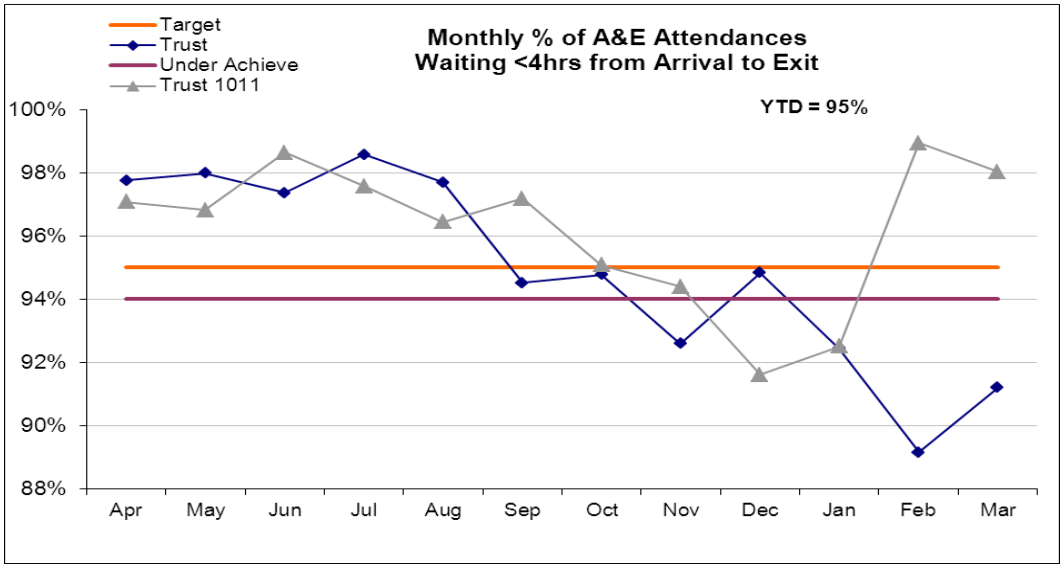


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	91.0%	91.8%	95.3%	93.9%	93.7%	93.7%	91.8%	90.0%	90.6%	91.1%	91.1%	0.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
1011	93.3%	93.6%	94.3%	94.4%	93.8%	93.7%	93.0%	93.9%	94.2%	92.9%	92.9%	92.7%

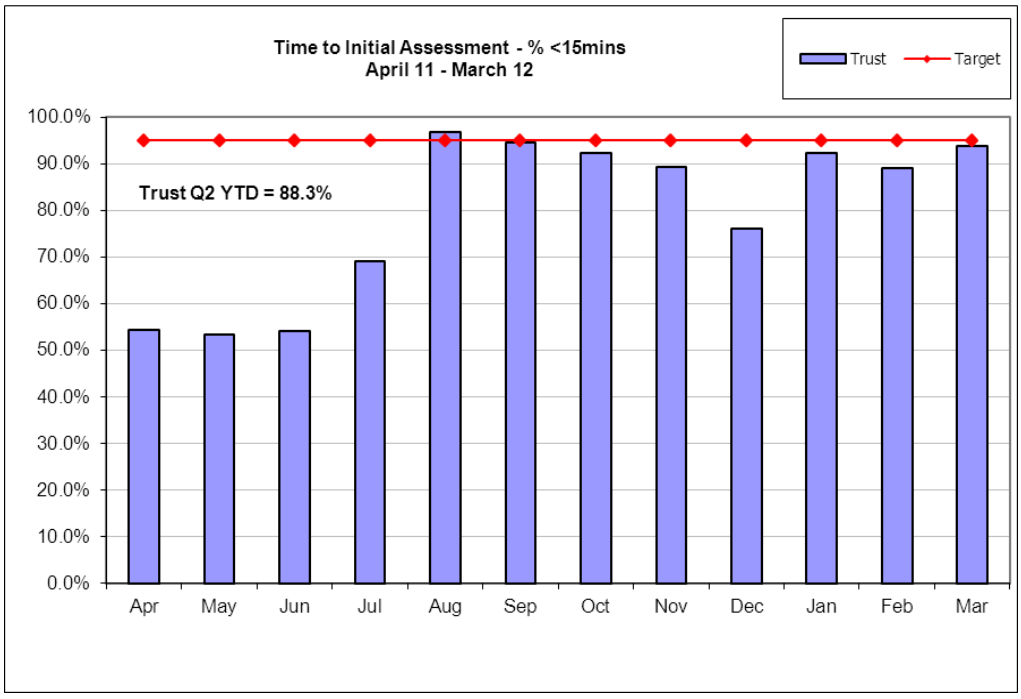


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.3%	98.7%	98.2%	98.3%	99.1%	99.3%	98.9%	98.9%	98.0%	98.5%	97.0%	0.0%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
1011	96.1%	96.0%	95.9%	96.2%	95.8%	95.8%	96.5%	96.0%	97.1%	95.9%	95.7%	97.7%

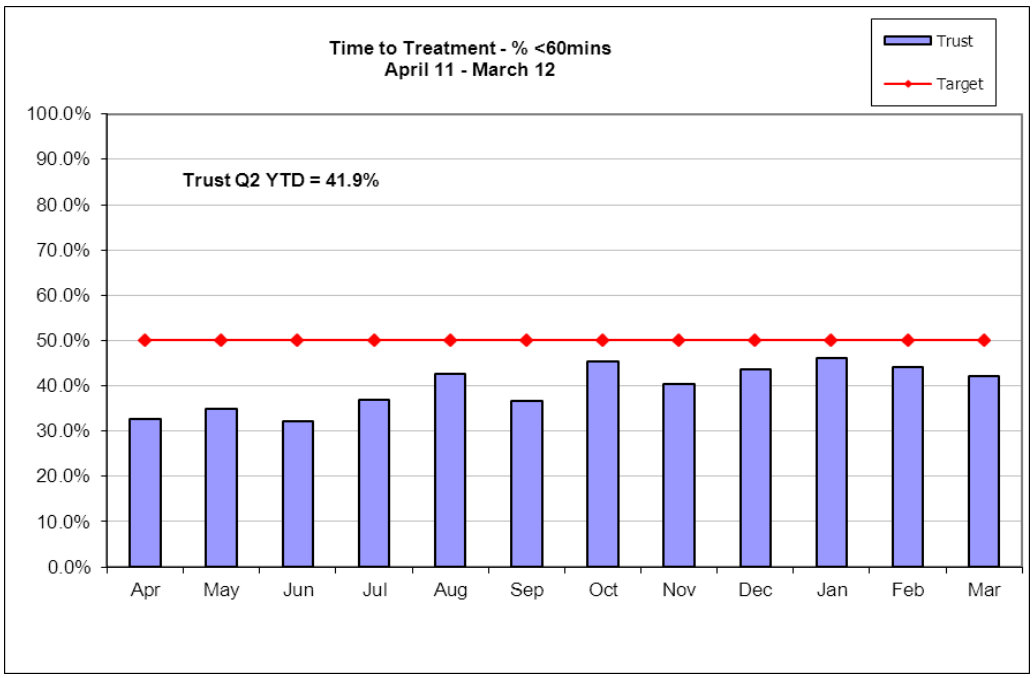
Emergency 4 hour access – The Trust will achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2011-12.



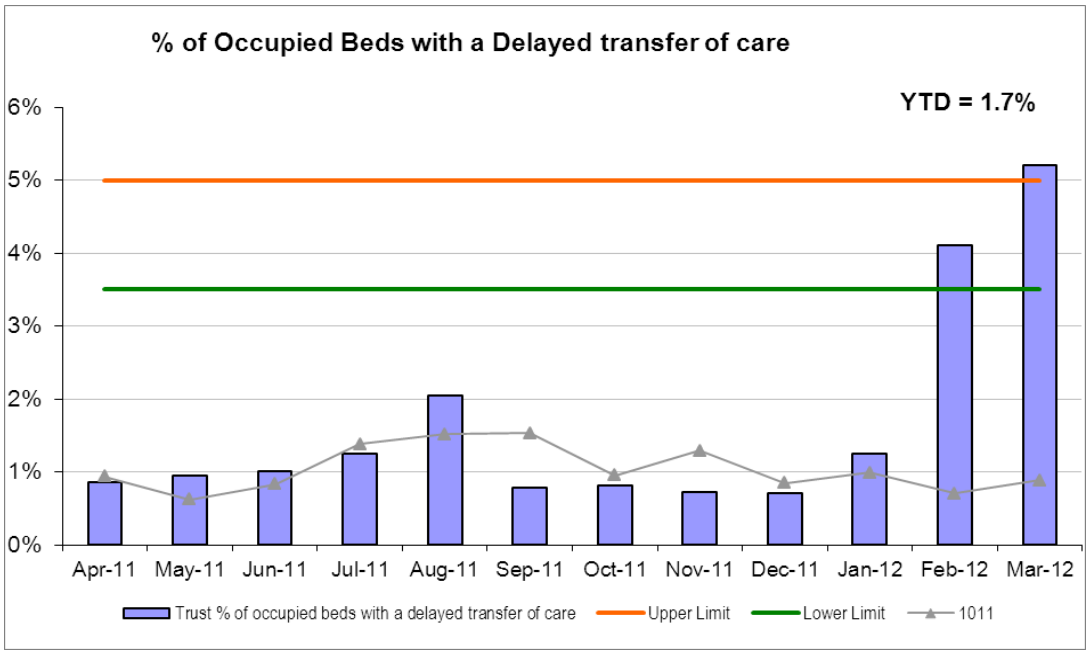
A&E Time to Initial Assessment <15 minutes – The Trust will not achieve this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



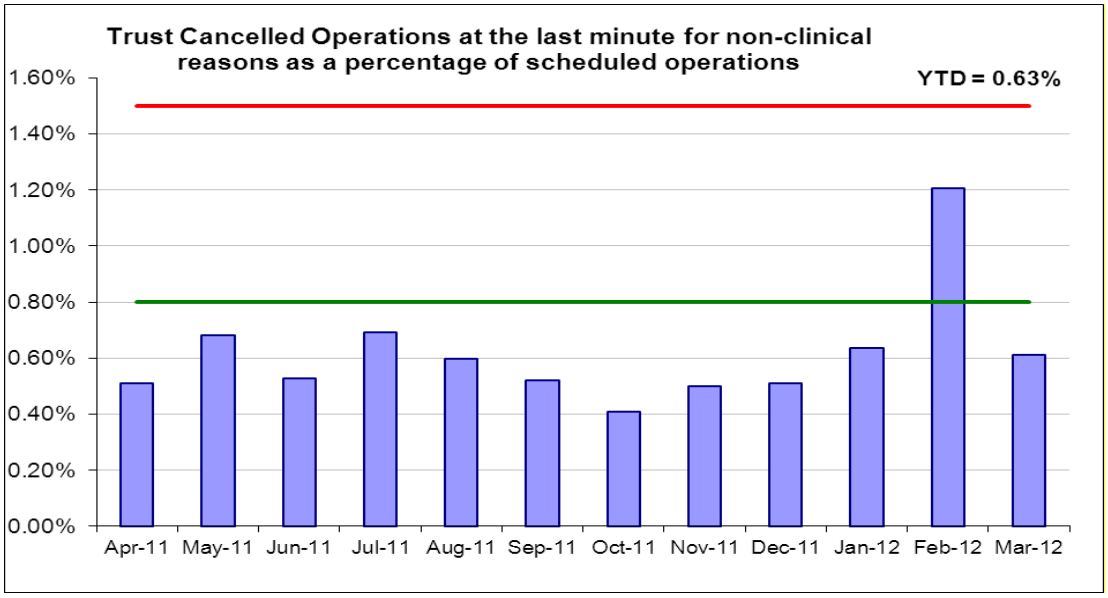
A&E Time to Treatment <60 minutes – The Trust will not achieve this standard of 50% of patients arriving in its A&E Departments being treated within 60 minutes of arrival.



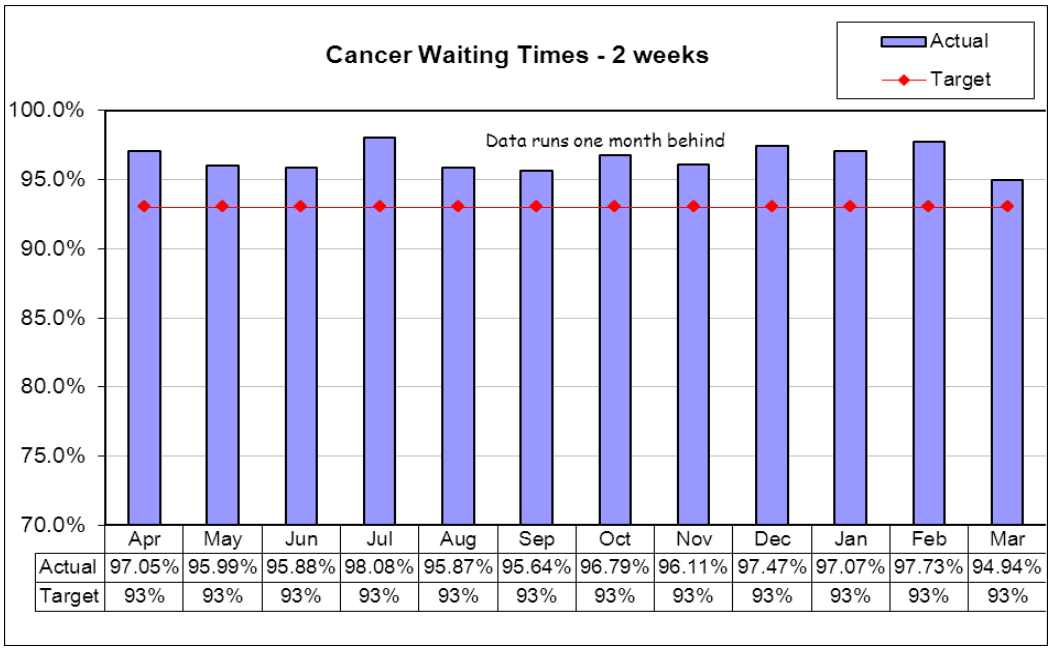
Delayed transfers of care – The Trust will achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year.



Cancelled operations – The Trust will achieve the cancelled operations national standard of 0.8% for the third year running.

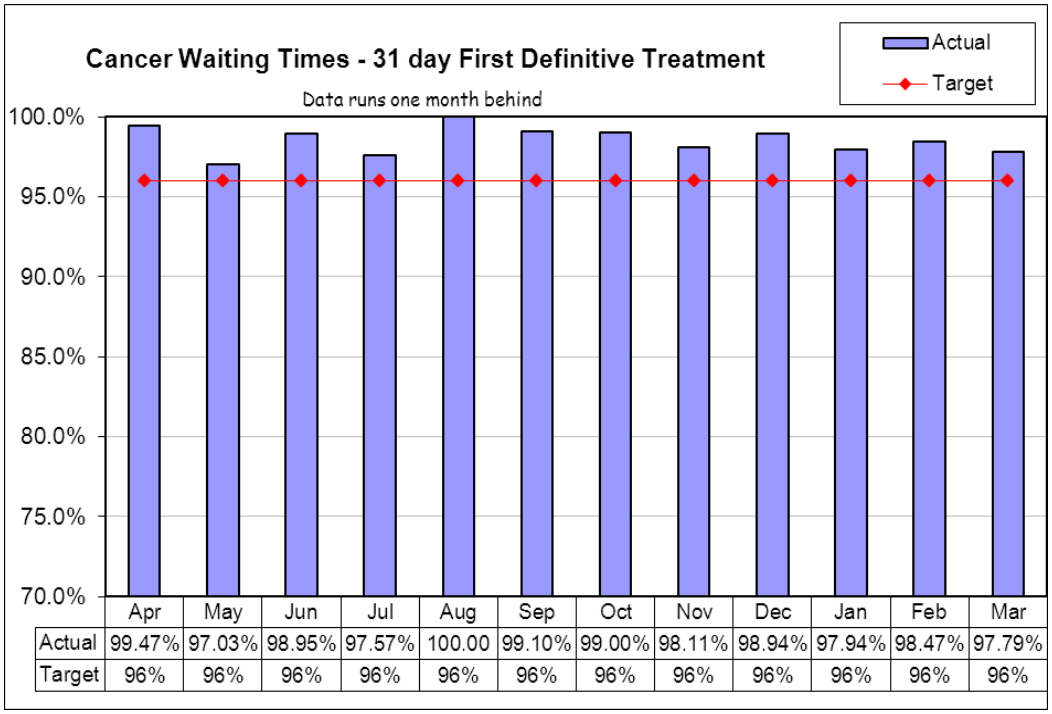


Cancer Waiting Time Target 2 weeks to initial appointment – The Trust will achieve this standard ensuring that 93% of patients with suspected cancer were seen within two weeks.



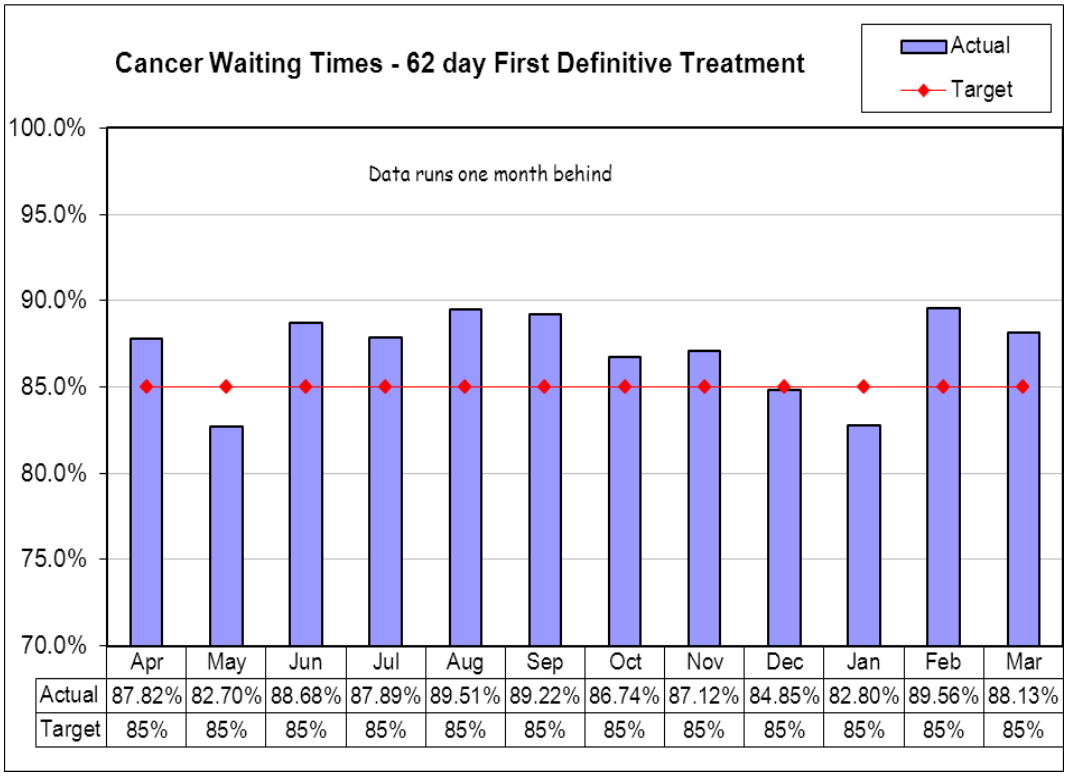
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.05%	95.99%	95.88%	98.08%	95.87%	95.64%	96.79%	96.11%	97.47%	97.07%	97.73%	94.94%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Cancer Waiting Time Target 31 days to treatment – The Trust will achieve this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	99.47%	97.03%	98.95%	97.57%	100.00	99.10%	99.00%	98.11%	98.94%	97.94%	98.47%	97.79%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Waiting Time Target 62 days to treatment – The Trust will achieve this standard ensuring that 85% of patients who needed to start their first definitive treatment within 62 days did so.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	87.82%	82.70%	88.68%	87.89%	89.51%	89.22%	86.74%	87.12%	84.85%	82.80%	89.56%	88.13%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Part Four
Stakeholder feedback

Feedback received from LINk - attached

Feedback received from NHS Kent and Medway - attached

HOSC have not provided up with commentary but have invited us to attend a meeting to discuss the report.

As a result of stakeholder feedback the following changes have been made:

The Kent LINk kindly provided suggestions re the reformatting of some of the graphs to make them more understandable which we have implemented.

In addition they also suggested that some of the terminology required further information as a result of which the document has been updated with more explanation of terms used.

We are grateful to them for this help and support.