Appendix 1

NHS
Medway
NHS Foundation Trust

Quality Account

2022/23

Best of care
Best of people

Quality Report Contents

Part 1: Chief Executive's Foreword

As a provider of healthcare services to the local community, the Trust is committed to delivering safe, effective, and compassionate care to all patients. This Quality Account provides an opportunity to reflect on our achievements over the past year and to set out our priorities for the coming year aligned to our Patient First Strategy.

We have worked hard to engage with our patients, staff, and stakeholders to ensure that we are delivering high-quality services that meet the needs of our local population. Our focus on quality improvement is at the heart of everything we do, and we are constantly striving to improve the care we provide.

Since our last Quality Account was produced, the Trust, and NHS as a whole, has seen a period of significant pressure with high demand for our services, and the ongoing challenge of discharging medically fit patients continuing to have an impact. Our staff have worked hard to manage those challenges and ensure that safe care can be provided consistently.

Through our innovative Patient First programme we continue to see improvements to the care we provide, and I'm pleased to say that, despite the pressures, we have seen some excellent performance against statutory targets such as cancer waiting times. We were also pleased to launch our new Acute Medical Model at the Trust. This initiative is supported by NHSEngland and brings a new model to the Trust for patients with an acute medical need. Following the introduction of the model, we saw an immediate improvement in ambulance handover times.

We continue to expand the rollout of Patient First across the organisation, with more and more colleagues getting involved, and beginning to make a difference.

As a Trust we are proud of our participation in national clinical audits and research, ensuring that we continue to be at the forefront of innovation across healthcare and implementing evidence-based treatments and models of care which improve outcomes for patients. We are one of the leading Trusts in Kent, Surrey and Sussex for patients participating in research studies and have been recognised at national and international levels. By taking part in research, we offer our patients new and up-to-date treatments.

We were delighted to see the hard work of our urgent and emergency care colleagues recognised by the CQC in June 2022. The CQC noted significant improvements since its previous inspection in December 2020 and rated the service as 'Good' overall. The service had previously been rated as 'Inadequate'.

Making care more accessible for our patients remains a key focus for the Trust and this year we were proud to open our new Frailty Unit in Sheppey which provides care closer to home for this group of patients who live in Swale. We have also introduced a number of new initiatives to improve the patient experience, including the new dandelion scheme to promote dignity, respect and compassion.

We continue to learn from the experiences of our staff and we receive feedback in a number of ways including monthly pulse surveys and the national staff survey. Following the last staff survey we have introduced a range of initiatives including new staff networks, culture café and a new annual appraisal process which now includes a staff wellbeing check.

While we have seen progress towards our quality priorities, we recognise that there is still much to do to ensure we are delivering the best of care every day.

This Quality Account sets out our ambitious plans for the future as we continue in our aim to deliver compassionate, high quality and effective services which meet the needs of our community.

Jayne Black

Chief Executive

1.1 Performance Overview: Introduction to the Quality Account 2022/23

NHS Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012, and the National Health Service (Quality Account) Regulations 2010, to produce an annual document detailing information in relation to the quality of services provided to local communities, any achievements and/or improvements made and any areas where further improvements may be required for each financial year. The Quality Account is therefore a key mechanism to enhance the Trust's accountability to the public and its commissioners, providing demonstrable evidence of measures undertaken in improving the quality of the Trust's services, and what further improvement is required. Quality accounts are therefore both retrospective and forward looking.

As part of the development of the Quality Account all Foundation Trusts are required to identify measurable priorities that are mapped against the three Darzi headings of Safe, Effective and Patient Experience.

The purpose of the account is to:

- promote quality improvement across the NHS
- increase public accountability
- allow the Trust to review the quality of care provided through its services
- demonstrate what improvements are planned
- respond and involve external stakeholders to gain their feedback including patients and the public.

Operational performance at Medway NHS Foundation Trust is measured against its existing strategic objectives and improvement plan, which sets out the key quality elements of areas where focus on quality care delivery will be made.

The Trust's overall vision is to continually improve our service and provide the 'Best of Care through the Best of People'. We have made a commitment that by 2028, our ambition is to deliver outstanding care outcomes through exceptional people and be a leading partner within the integrated system of health and social care, providing patient experience without boundaries.

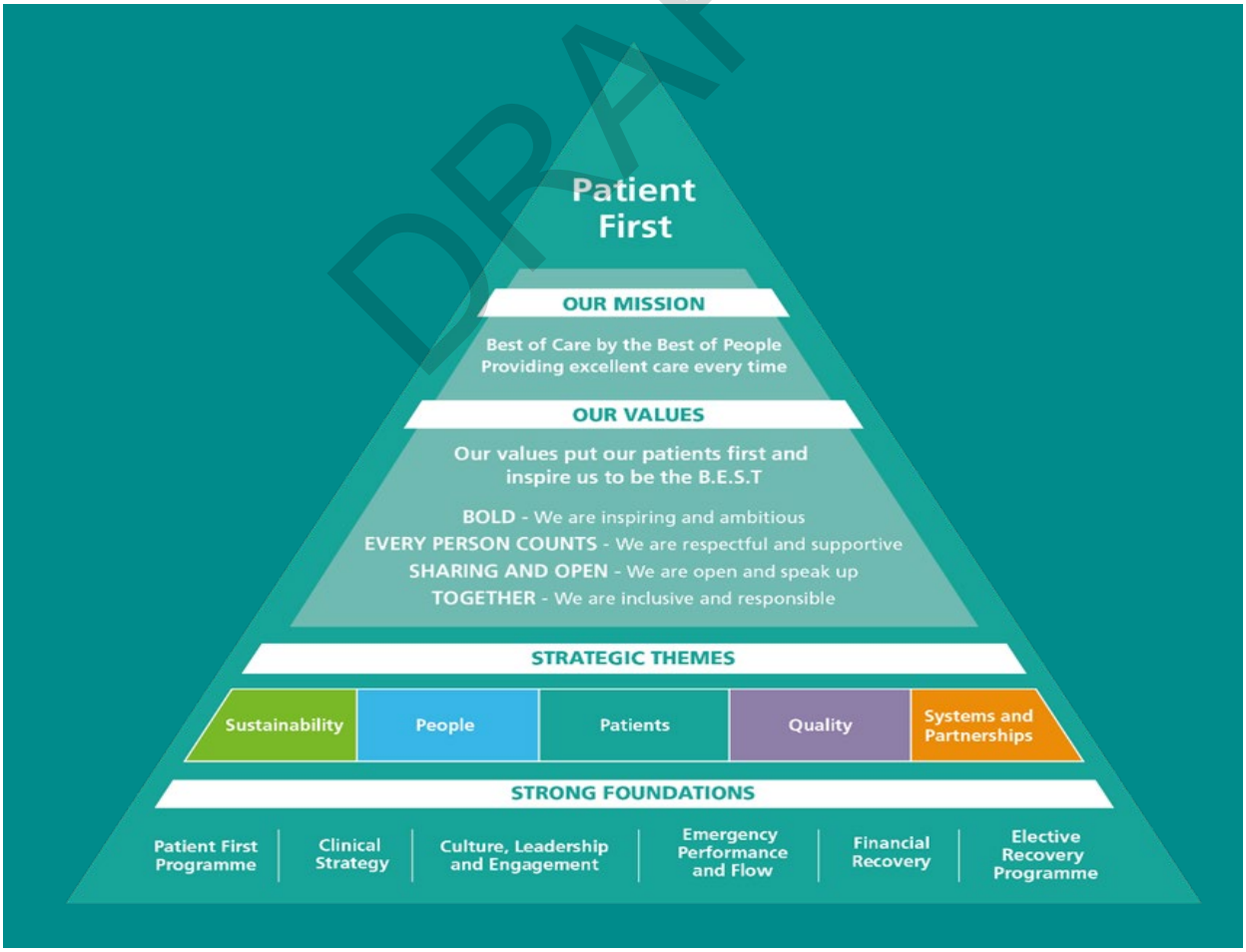
At Medway, the delivery of a high quality care service provision has always been placed at the heart of decisions taken by the Board. Our quality priorities are also a call to action for everyone to make a difference and be part of the Medway quality improvement journey. Our priorities have been mapped against the Trust's Patient First Strategy to ensure alignment with patient safety, clinical effectiveness and overall patient experience as well as initiatives at national and regional level; this forms an important part of its implementation. It is both ambitious and aspirational by design.

Medway NHS Foundation Trust will continue to follow any advice and guidance put forward from NHS England to ensure patients continue to receive high quality care. For the completion of this quality account, NHS England has confirmed that NHS providers are no longer expected to obtain assurance from their external auditors in the preparation of their quality account /quality report, however the trust has undertaken its own internal review to provide assurance that the required elements have been met (See Annex 2).

Part 2: Priorities for Improvement and Statements of Assurance from the Trust Board

2.1 PRIORITIES FOR IMPROVEMENT 2023/24

The quality of the care that we provide and the safety of our patients are the top priorities for the Trust. Our vision, to deliver our true north of 'Patient First' gives us the direction to achieve an organisational culture that empowers our staff to take the initiative and make lasting changes that benefit patients accessing our services and the community at large. Aligned to our ambitious Patient First strategy are our 2023/24 quality priorities that are a building block to a longer-term approach to transform the way we deliver our services for the better. Patient First is a process of continuous improvement that gives frontline staff the freedom to identify opportunities for positive, sustainable change and the skills to make it happen. Patient First is a programme based on standardisation, system redesign and ongoing development of care pathways, built on a philosophy of incremental and continuous improvement led by front-line staff empowered to initiate and lead positive change.



The Medway NHS Foundation Trust Board recognises that the foundation of excellent care delivery lies in the skill, enthusiasm and innovation our staff teams bring to their individual roles. Through our staff we have set out to achieve five quality priorities over the next 12 months that are strongly aligned with the Trust's Quality Strategy and mission statement to provide the best of care by the best of people, providing excellent care every time. Our 2023/24 quality priorities have been developed in collaboration with our patients and our staff and represent the highest priority areas for the population that we serve. They have also been endorsed by both our external and internal stakeholders including the Kent and Medway Integrated Commissioning Board and Governors.

As part of our development of the Trust's 2023/24 quality priorities, a members' event was held on 8 February 2023 to engage our governors, staff and patient group representatives on progress with the last year's (2022/2023) quality strategy and to discuss the quality priorities for the upcoming year (2023/2024). This successful event enabled our stakeholders to pose questions and gain understanding on our Patient First Programme, which displays the organisation's

- vision, strategy and values,
- embedded improvement methodology in operational delivery
- integrated performance management and improvement system ensuring that the patient is at the heart of everything we do
- themes gained on the day were used to support the development of and reach agreements on the priorities as highlighted below.

Quality Priorities 2023-24

Domain	No	Description	How we will measure success
Safe Reducing harm and creating a culture of safety	1	Excellent quality of care and ensuring no patient comes to harm	50% reduction in avoidable 2222 calls. A shift in avoidable 2222 calls with the majority being for peri-arrest as opposed to cardiac arrest.
	2	Improve patient outcomes through having lowest possible quartile mortality rate	An improvement in the depth of coding audits. Return to expected ranges for SHMI and HSMR.
Effective	3	Developing systems and processes to support the organisation on its journey to excellence by achieving 92%	Reduction in the number of patients waiting longer than 40 weeks on the RTT pathway.

Quality Priorities 2023-24			
Domain	No	Description	How we will measure success
Evidence-based and best practice		of patients being seen or treated within 18 weeks for RTT	
	4	Improve timely access to patient records by digitalising patient records (EPR). To achieve 95% of patients treated within 4 hours in emergency care	Increase in the number of patients treated within 4 hours within emergency care
Patient Experience Best experiences of care for our patients, families and carers	**5**	Provide outstanding and compassionate care for our patients every time	95% FFT- Patient experience recommend rate. 95% of patients surveyed say that they were treated with privacy, dignity, respect and compassion

Patient Safety Incident Response Framework (PSIRF)	In addition to the Trust's 2023/24 quality priorities Medway FT is committed to fully implementing the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety known as PSIRF. This is a fundamental shift in how the organisation will respond to patient safety incidents for learning and improvement and will require Trustwide commitment.
Learning from Patient Safety Events (LFPSE)	In accordance with the requirements of the NHS's patient safety strategy Medway FT will also transition to the new national NHS service for the recording and analysis of patient safety events that occur in healthcare – known as LFPSE. The switch to recording patient safety events using LFPSE will help to identify areas for improvement and improve learning for the organisation.

2.2 PROGRESS AGAINST OUR 2022/23 QUALITY ACCOUNT PRIORITIES

Progress with our 2022/23 quality priorities has seen some areas of success, for example, we have achieved high reporting of no harm and low harm incidents which demonstrates that the trust has an open and transparent culture and has only a small proportion of incidents (<1%) that result in significant harm to patients, and some areas that need continued focus and improvement, for example, early recognition of deteriorating patients, which is why we will be taking this priority forward into the next financial year.

Quality Priorities 2022-23

Domain	No	Description	Achievement
Safe Reducing harm and creating a culture of safety	1	95% of incidents reported are no and low harm	

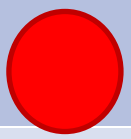
Across the year the Trust achieved 99.0% of incidents being reported as no and low harm, an improvement from the previous year where we achieved 98.5%.

The Trust has worked to revise its internal incident reporting system which has enabled improved functionality and better capturing of the details surrounding incidents. A daily review has been initiated whereby every incident reported is checked for quality and accuracy and immediately escalated where appropriate. This ensures better consistency of which incidents result in no and low harm, and also enables a shorter time between the incident being reported and learning and improvement being captured and implemented.

Part of this improvement work has also involved creating an open and transparent culture of incident reporting for the benefit of learning and improvement. The Trust has also improved its feedback processes following an incident being reported, which has improved the sharing of learning and provided greater reassurance to those involved that the incident is sufficiently reviewed and improvements are made as a result.

The Trust has plans to further increase the proportion of no and low incidents as a total of all incidents, and these will be incorporated into the implementation of the new national Patient Safety and Incident Response Framework (PSIRF) in late 2023.

Quality Priorities 2022-23

Domain	No	Description	Achievement
Safe Reducing harm and creating a culture of safety	**2**	50% reduction of cardiac arrest calls (2222)	

The total number of avoidable 2222 calls reported this year was 83, an increase from 42 the previous year. For the first half of the year (April-September) the average monthly avoidable call rate was 7.3 compared to the second half (October-March) (when interventions were in place) where the average monthly avoidable rate was 6.5, suggesting the improvement measures are beginning to have a positive effect.

Through a process of collaborative A3 meetings between our resuscitation, outreach, emergency, and acute medical multidisciplinary teams, a root cause analysis identified our primary causes as failure to recognise, failure to escalate, and gaps in clinical planning. This was triangulated with both quantitative and qualitative data to ensure validity and target interventions

During this time we set-up weekly huddles attended by clinicians and executives to review performance and drive continuous improvement, supported by more detailed A3 meetings with wider groups of frontline teams.

Using a Quality Improvement methology we process mapped and undertook an audit of the responses to high national early warning scores (NEWS), undertook a qualitative thematic analysis of incident reports, and performed a root cause analysis to triangulate causes of avoidable 2222 calls.

To eliminate some human factors delays in escalation, we modified our existing EPR system to display a tracking board of patients with a high NEWS score so that our outreach team could directly monitor this, and then could “trigger” and treat unwell patients early.

With 15% of ambulance handover delays taking over 30mins we introduced the acute medical model which prioritises ambulance handovers, enables rapid transfer of acute medical patients from the ED to wards, and promotes early consultant reviews.

In addition, we launched an initiative called “Call 4 Concern,” which encourages patients and relatives to activate an outreach review when they feel a patient’s clinical condition has declined or is

Quality Priorities 2022-23			
Domain	No	Description	Achievement
		declining. We are continuing to co-produce this service with patients, service users, and relatives. This service has already shown success in escalating deteriorating patients early when used in other trusts as it recognises service users as assets (a core principle of co-production), and utilises their knowledge, skills, and time to help identify deteriorating patients. We have also developed a safety culture of continuous improvement by introducing annual NEWS training and ward based, twice daily safety huddles, discussing high NEWS patients and their escalation status. This has resulted in frontline, staff led changes, including ward safety huddles, electronic track and trigger of high NEWS, patient co-produced “Call 4 Concern”, and an acute medical model reducing delayed ambulance handovers from 15% to 4%.	

Quality Priorities 2022-23

Domain	No	Description	Achievement
Effective Evidence-based and best practice	**3**	Reduction in the number of patients waiting longer than 40 weeks on the RTT pathway.	

The total number of patients waiting over 40 weeks from referral to treatment in 2022/23 was 2,726; an increase from 1,663 in the previous year.

The Trust executive has made the reduction in patients waiting over 40 weeks a key business objective as part of the Patient First programme. This has included weekly performance meetings with the divisional leadership teams and the chief operating officer with the support of the Trust's transformation team. As a result there have been significant improvements in waiting times for first outpatient appointments in most specialities.

Although many specialities have seen a reduction in both first appointment and treatment waiting times, the total number of patients waiting over 40 weeks has unfortunately increased. This is largely a result of capacity versus demand on the services (ENT, and Rheumatology) and diagnostic capacity in Endoscopy (Gastroenterology, Colorectal/General Surgery).

Improvement plans are underway to address the individual challenges in these services in 2023/24 and weekly performance meetings will continue with support from the Trust's transformation team.

Quality Priorities 2022-23

Domain	No	Description	Achievement
Effective Evidence-based and best practice	4	Increase in the number of patients treated within four hours within the emergency care department	

The average compliance with the Emergency Care four hour performance in 2022/23 was 66.9%, a reduction against the 75.5% achieved the previous year. This is largely due to the challenged performance in the first six months of the year.

Four hour performance stabilised in January and then achieved consistent incremental improvements thereafter.

There has been significant work undertaken to achieve this improvement and ensure it is both sustainable and incremental. We have achieved de-escalation of our PAHU attendance unit, our Discharge Lounge, and our Frailty Assessment unit as escalation wards, in addition to redesigning and relaunching our CDU pathway. All of this enables improved flow throughout the department, ensuring patients are seen in the right place, by the right person, first time.

April 2023 saw the highest average four hour performance total for more than 12 months at 76% and May performance indicates even further improvement at over 78% putting us regularly in the top 5 performers in the region. Further improvement work will continue over 2023 and include the redesign of our mental health pathways, a deep-dive focus on full utilisation of our streaming pathways, and a renewed focus on our Type 3 pathways.

Quality Priorities 2022-23

Domain	No	Description	Achievement
Patient Experience Best experiences of care for our patients, families and carers	5	95% FFT- Patient experience recommend rate	

Friends and family feedback is a trust priority as part of the true north domains and as a breakthrough objective. As such, focused work to hear the patient voice has been driven by the Patient First methodology, launched at Medway during 2022. The way in which data was collated and utilised changed in October 2022. The new system now allows easier processing of issues, themes and trends from patients and creation of improvement action plans in clinical areas.

The average FFT recommend rate in 2022/23 was 82.7%, which was a reduction from the 84.2% achieved the previous year, however there has been an increase in the recommend rate to 86.5% in the last five months of the year (November-March).

In order to further improve the response and recommend rate the Trust has implemented a new software system called 'Gather' to better capture and analyse patient feedback. This has allowed the clinical teams to hear the patient voice and dig deeper into the issues that may concern them whilst in our care. Each area then focuses upon quality improvement projects to address the issues that have been reflected by patients in their feedback.

Other areas of improvement the organisation is working on are ensuring consistent information sharing with patients who are waiting longer than expected in assessment areas and reducing noise at night for patients in open ward areas, again based on feedback received from patients who were disturbed by lighting and other noise during their stay.

Up until now, this way of collecting and focussing on the detail of feedback was not available, consequently we were not able to fully achieve our target recommend rate. There will be further projects to improve areas of care based on patient feedback in real time over the coming year.

Quality Priorities 2022-23

Domain	No	Description	Achievement
Patient Experience Best experiences of care for our patients, families and carers	6	95% of patients surveyed say that they were treated with privacy, dignity, respect and compassion	

Unfortunately the data collated from the friends and family test feedback in 2022/23 has been captured in a different way meaning that a direct comparison with previous years cannot be made. However, the data shows that between September and March 2022/23 over 95% of patients said they were treated with privacy, dignity, respect and compassion.

Sept	Oct	Nov	Dec	Jan	Feb	Mar	April
98%	97%	96%	96%	97%	96%	96%	96%

Over the next 12 months, the organisation is committed to improving patient experience of privacy and dignity whilst under our care with a number of focussed improvement projects.

Promoting independence and mobility for frail and elderly patients by rolling out the end PJ paralysis project being one of them. This initiative aims to ensure patients are out of bed, dressed in their own clothes and moving every day. A pilot has commenced in our frailty wards with plans to roll this out to other areas of the Hospital over the coming 12 months.

The Trust has also recently employed a Namaste Practitioner; as the first in the country, this initiative provides patient centred, holistic care to patients at the end of life and who are living with Dementia. Early indicators suggest not only a large demand for this service but also that it is having a positive outcome for patients.

 Indicates that we met our objectives for the year

 Indicates that we made good progress , but did not quite reach our objective

 Indicates we did not meet our objective and further work is required and will be undertaken

2.3 ACHIEVEMENTS IN QUALITY

- In August 2022, the Trust was awarded a National Joint Registry (NJR) Quality Data Provider for the third consecutive year.
- The NJR Quality Data Provider scheme has been devised to offer hospitals public recognition for achieving excellence in supporting patient safety standards through compliance with the mandatory NJR data submission quality audit process.

- The Cancer Services Team was named South East regional winner at the NHS Parliamentary Awards 2022 in the 'Excellence in Healthcare' category.
- The team won the award after being nominated by a local MP following significant improvements which saw the Trust achieve the national standard in four key areas of cancer care in December 2021.

- Learning Disability Liaison Nurse Eloise Brett was presented with a Cavell Star Award for promoting equality in healthcare and ensuring a positive experience for patients.
- Eloise was nominated for overseeing initiatives to help improve patient outcomes while they spend time in hospital, including the launch of a new 'one stop shop' service at the Trust for patients with learning disabilities and autism who require medical procedures under a general anaesthetic.
- This allows patients to have a combination of important treatments such as dental and podiatry work, and endoscopies or colonoscopies, while they are sedated, and following a best interest decision. Usually these procedures are completed while a patient is awake, but for people with learning disabilities and autism they can be traumatic and overwhelming.

- The Trust's NHS Staff Survey 2022 response rate was 40 per cent meaning more than 1,800 members of staff took the time to complete the survey.
- The survey results showed improvements in five out of the seven People Promise themes: We are compassionate and inclusive; We each have a voice that counts; We are safe and healthy; We are always learning and We are a team.

2.4 STATEMENTS OF ASSURANCE 2022/23

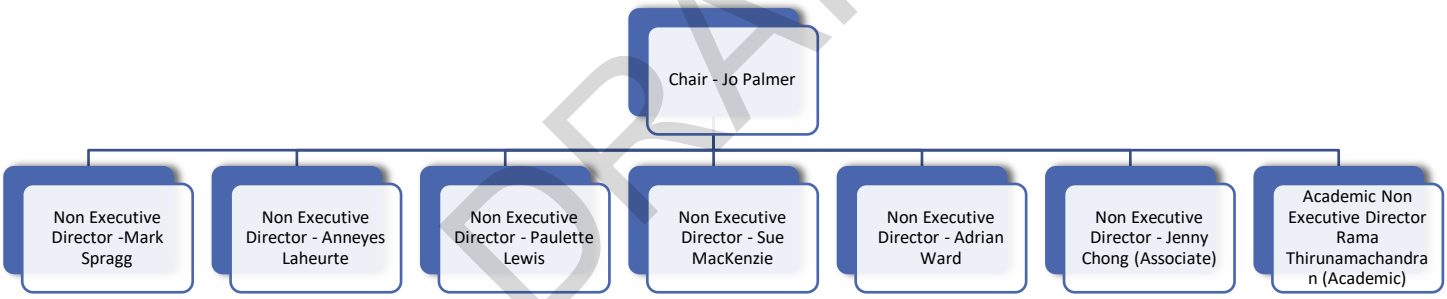
2.4.1 REVIEW OF OUR SERVICES

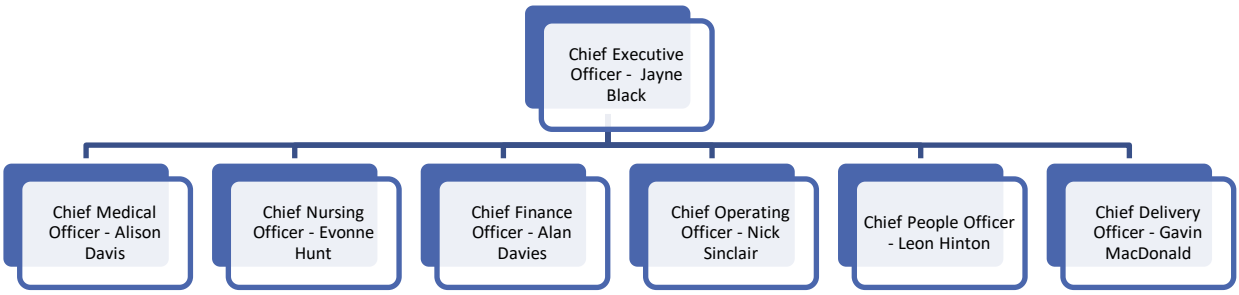
During 2022/23, Medway NHS Foundation Trust provided and/or sub-contracted 46 relevant health services, to the people of Medway and Swale.

Activity 2022/23	Q1	Q2	Q3	Q4	TOTAL
Outpatient Appointments	90,686	92,347	90,296	86,556	**359,885**
Total Discharges - Elective & Non-Elective	13,141	14,222	13,922	13,304	**54,589**
Total Discharges - Daycase & Regular Day Attenders	8,113	7,881	8,462	8,253	**32,709**
Total Deliveries (Confinements)	1,068	1,169	1,203	1,107	**4,547**
Babies Born (includes multiple births)	1,082	1,190	1,225	1,123	**4,620**
Home Births	33	25	31	26	**115**
Emergency Attendances - Type 1	23,178	26,377	25,160	26,204	**100,919**
Emergency Attendances - Type 3	18,374	19,099	19,975	19,861	**77,309**

Activity 2022/23	Q1	Q2	Q3	Q4	TOTAL
Emergency Admissions	3,742	4,124	4,086	3,477	**15,429**
Ambulance Arrivals	8,236	8,975	8,605	8,579	**34,395**
Occupied Bed Days (G&A)	45,307	43,652	43,840	45,320	**178,119**
Beds Open (G&A)	48,669	48,626	48,071	49,282	**194,648**
Bed Occupancy % (G&A)	93.1%	89.8%	91.2%	92.0%	**91.5%**
Beds Occupancy % (Critical Care)	57.5%	54.9%	66.5%	65.0%	**60.9%**

2.4.2 BOARD STRUCTURE





2.4.3 PARTICIPATION IN NATIONAL CLINICAL AUDITS (NCA) AND NATIONAL CONFIDENTIAL ENQUIRIES INTO PATIENT OUTCOME AND DEATH (NCEPOD)

The Trust's participation in National Clinical Audits and National Confidential Enquiries into Patient Outcome and Death enables us to benchmark the quality of the services that we provide against other NHS Trusts. It also highlights best practice in providing high quality patient care and drives continuous improvement across our services.

During 2022/23 the Trust participated in 46 out of 47 national clinical audits, achieving 98% participation in eligible audits as set out in the HQIP National Clinical Audit and Patient Outcomes Programme Directory. The list of national clinical audits, number or registered cases and percentage submitted for each audit are detailed in Annex 3 (page 64). Some areas have been marked as 'in progress' which means that the data is still being collated for the 2022/23 reporting period. Annex 3 also contains a summary of some of the key audit achievements and planned actions for improvement.

2.4.4 LOCAL AUDITS

Clinical audit drives improvement through a cycle of service reviews against recognised standards and then provides a baseline for implementing change as required. We also use audit to benchmark our care against local and national guidelines so we can put resources into areas requiring improvement; this is part of our commitment to ensuring best treatment and care for our patients.

Local clinical audits are selected on the basis of various priorities and requirements including annual audit cycles, commissioning requirements, emerging incident themes, risks or complaints, trust priorities and many others.

The table below shows that in 2022/23 the number of registered local audits increased by 15% however the number of audits that were seen through to completion has decreased.

Year 2021/22	Year 2022/23	Projects Completed 2021/22	Projects Completed 22/23	Projects Outstanding 2021/22	Projects Outstanding 22/23
200	**231**	**156**	**80**	**6**	**148**

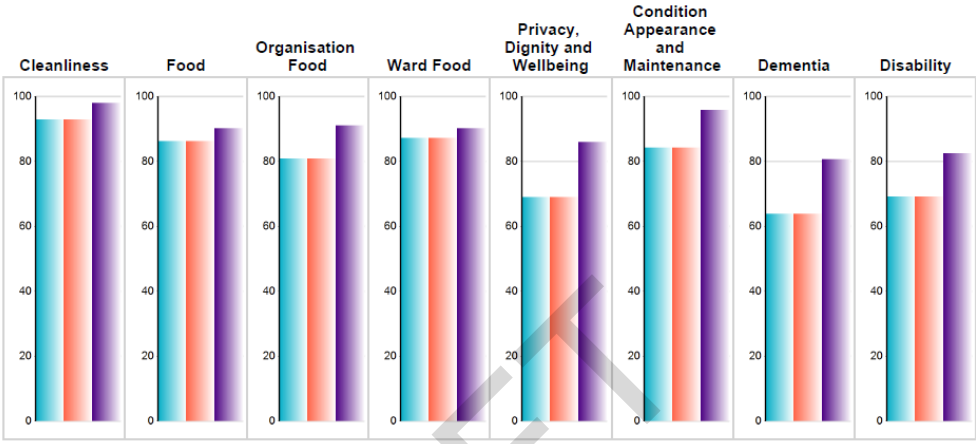
2021 – 36 abandoned or rejected for various reasons ***2022/23 – 3 abandoned or rejected for various reasons***

2.4.5 PATIENT LED ASSESSMENT IN THE CARE ENVIRONMENT (PLACE) AUDIT

The Trust undertook its annual PLACE assessment in October 2022.

The table below depicts the PLACE audit compliance score: 93% Cleanliness, 86% Food, 81% Organisation Food, 87% Ward Food, 69% Privacy, Dignity & Wellbeing, 84% Condition & Appearance, 64% Dementia and 69% Disability.

MEDWAY MARITIME HOSPITAL- Collection: 2022



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	1881.0000	514.0000	76.0000	438.0000	375.3333	834.0000	532.0000	420.0000
Available Score (Actual)	2024.0000	596.0000	94.0000	502.0000	544.0000	990.0000	834.0000	608.0000
Site Score	92.93%	86.24%	80.85%	87.25%	69.00%	84.24%	63.79%	69.08%
Organisation Average	92.93%	86.24%	80.85%	87.25%	69.00%	84.24%	63.79%	69.08%
National Average	98.01%	90.23%	91.03%	90.26%	86.08%	95.79%	80.60%	82.49%

Following the results of the 2022 PLACE audit the Trust has established a PLACE group that meets fortnightly and is attended by the service leads for each of the eight domains. This group has been established to focus on, and drive forward improvements where we are performing below the national average. Progress on this improvement work will be overseen by the Patient Experience team via the Chief Nursing Officer.

2.4.6 PARTICIPATION IN CLINICAL RESEARCH

The Trust has committed to undertaking research as a driver for improving the quality of care and patient experience and is actively involved in research supported by the National Institute for Health and Care Research (NIHR). Furthermore, our Research and Innovation (R&I) strategy is heavily linked to specialty priorities agreed by the Department of Health (DoH) and NIHR. During 2022/23 the capacity of clinical services to support research delivery has remained challenged due to national workforce and workload issues as services continue to recover from the challenges brought about by the COVID-19 pandemic. This however has not discouraged

services engaging in research activity and has led to a year end position of 4,852 participants recruited, exceeding our recruitment target of 3,110.

The comparative data below shows the National Institute for Health and Care Research (NIHR) requirement target and the actual recruitment figures for Medway NHS Foundation Trust and shows that the Trust continues to exceed its recruitment targets.

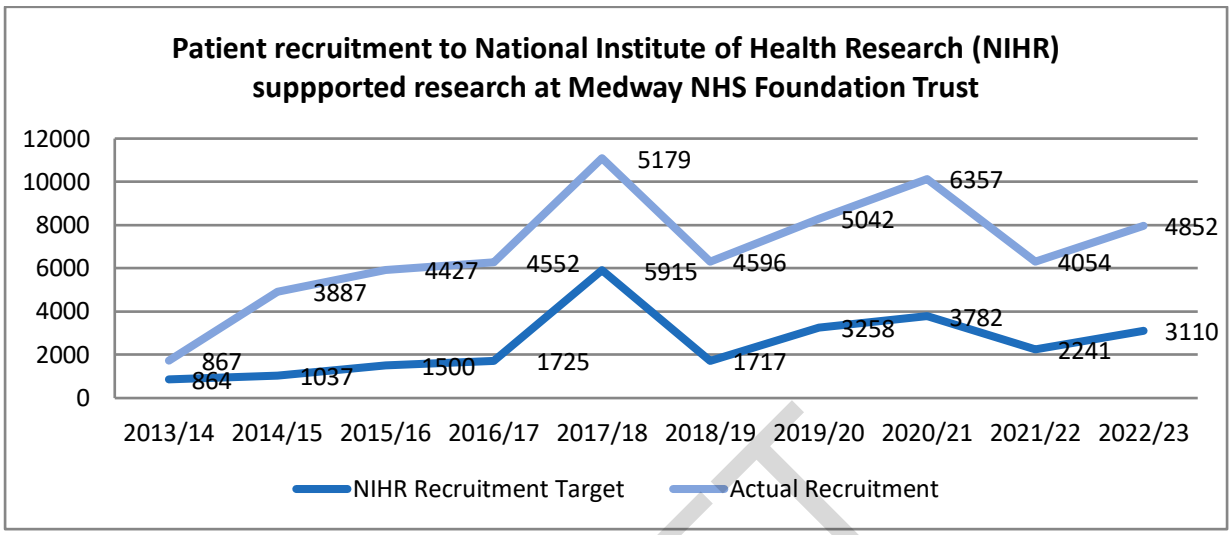


Chart1. the annual recruitment target and the actual number of patients recruited into the NIHR adopted studies between 1 April 2013 and 31 March 2023.

In 2022/23 Medway Foundation Trust was the third highest performing organisation in terms of participant recruitment to clinical trials in the Kent, Surrey and Sussex region.

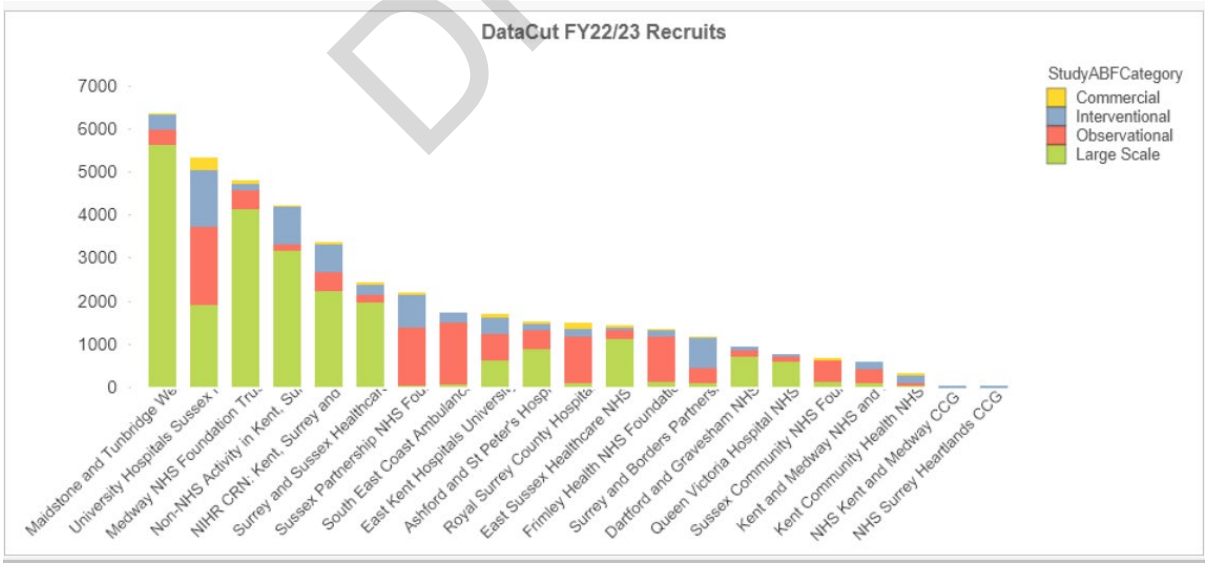


Chart.2. Medway NHS Foundation Trust performance compared to other Trust across Kent Surrey and Sussex Local Clinical Research Network.

Trust staff are able to keep abreast of the latest treatment possibilities through active participation in many different types of research, which has led to successful patient outcomes.

For the period 2022/23, there were a total of 111 research studies conducted at the Trust, including staff undertaking MSc final year dissertations. For the same period, the Trust took part in 72 NIHR supported studies, including eleven cancer specialty studies.

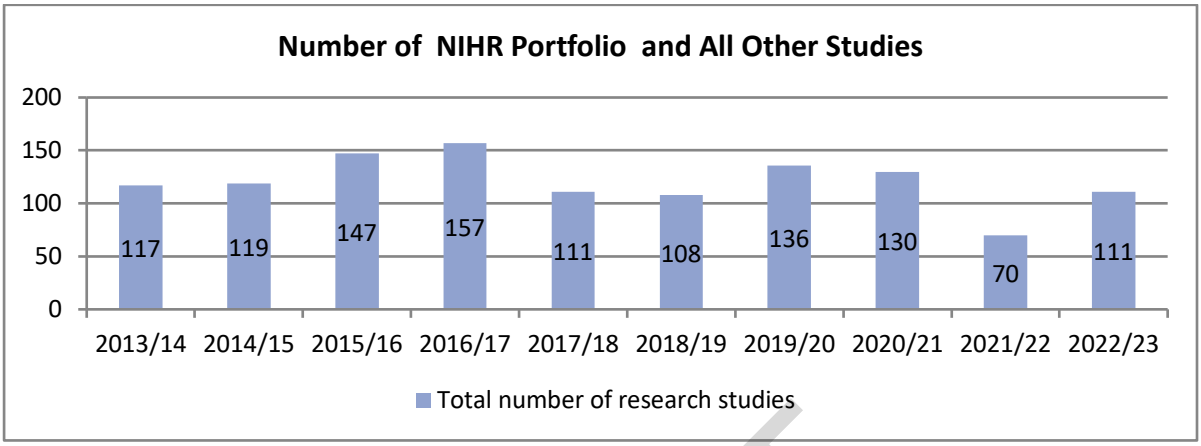


Chart.3. the number of studies that Medway NHS Foundation Trust participated in between 1 April 2013 and 31 March 2023.

Conducting research requires commitment from staff and this commitment is evidenced by the number of clinical staff participating in research across various fields. There were approximately 182 clinical staff participating in research approved by the Health Research Authority at the Trust between 1 April 2020 and 31 March 2023 resulting in over 56 publications in peer reviewed journals.

Staff participating in research cover 22 disease specialties, including studies looking into urgent Public Health research such as COVID-19 studies.

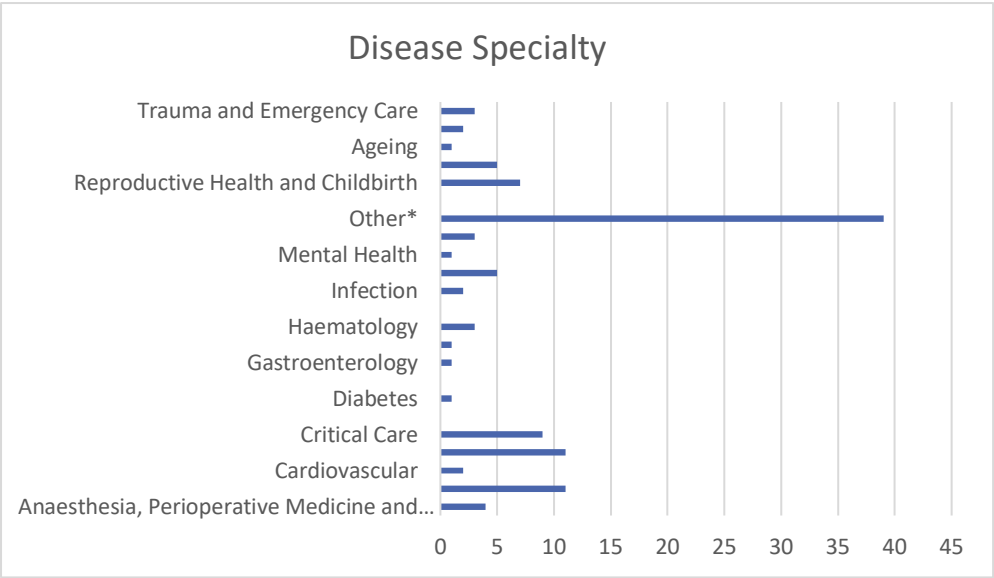
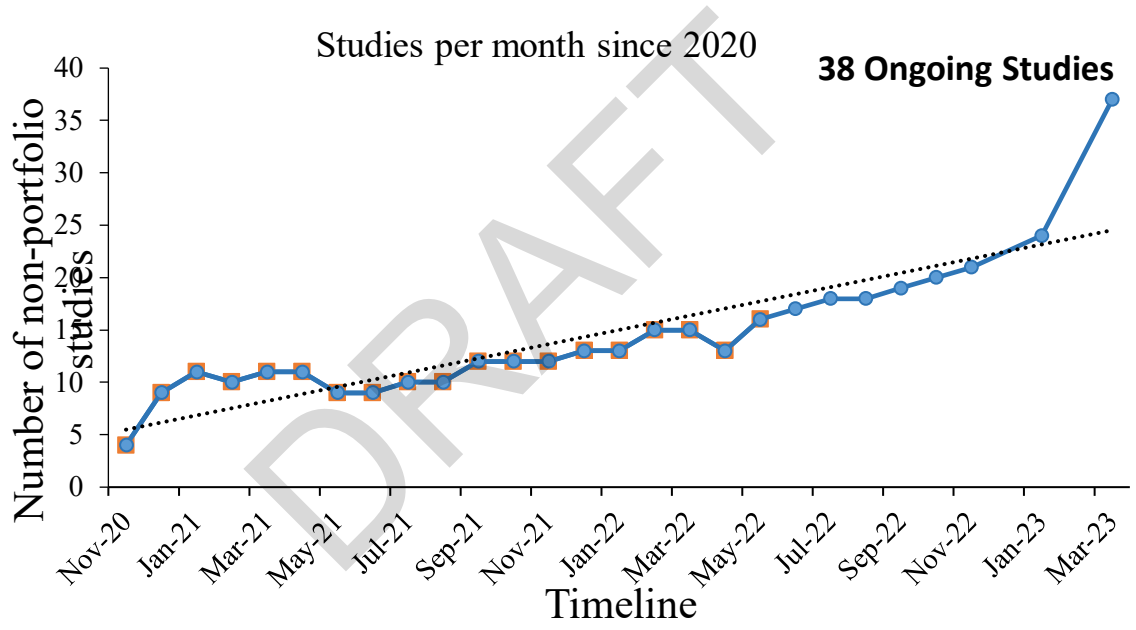


Chart 4 Number of Studies Conducted Per Disease Speciality at Medway NHS Foundation Trust during 01 April 2020-31 March 2023

***Studies outside of clinical speciality for example educational studies or research into overall patient experience.**

The COVID-19 pandemic brought new challenges but also created new opportunities for clinical research where there is keen interest shown by staff to participate in the majority of leading global trials. Being able to offer up-to-date, novel treatments to the patient is at the forefront of the Trust agenda. A good example is the RECOVERY Trial which focused to identify treatments that may be beneficial for adults hospitalised with confirmed COVID-19. Baricitinib and Dexamethasone is now used as standard care, Tocilizumab is also used as standard of care in highly inflamed patients.

With the ambition of becoming a 'University Trust', Medway has established a portfolio of its own research (so-called 'home grown') in collaboration with local universities. In the last three years we have registered 38 ongoing 'home grown' studies.



Number of Home grown since 2020.

2.4.7 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

Whilst there was no conditional financial incentivisation to achieving the CQUIN targets in 2022/23 Medway NHS Foundation Trust remained committed to achieving the scheme's targets for achieving improvements in the quality of services and delivering on new and improved patterns of care. The table below details the quarterly performance with the 2022/23 CQUIN scheme.

CQUIN Description	Min CQUIN Target	Max CQUIN Target	Qrt 1 % CQUIN Compliance	Qrt 2 % CQUIN Compliance	Qrt 3 % CQUIN Compliance	Qrt 4 % CQUIN Compliance	Status
CCG1 Flu vaccinations for frontline healthcare workers	70%	90%	N/A	N/A	N/A	N/A	
CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+	40%	60%	33%	20%	16%	20%	
CCG3 Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	20%	60%	81%	81%	86%	91%	
CCG4 Compliance with timed diagnostic pathways for cancer services	55%	65%	0%	0%	2%	0.99%	
CCG5 Treatment of community acquired pneumonia in line with BTS care bundle	45%	70%	7%	6%	7%	8%	
CCG6 Anaemia screening and treatment for all patients undergoing major elective surgery	45%	60%	94%	93%	89%	81%	
CCG7 Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	0.50%	1.50%	1.60%	3.05%	2.74%	2.67%	
CCG8 Supporting Patients to drink, eat and mobilise after surgery	60%	70%	40%	33%	37%	33%	
CCG9 Cirrhosis and fibrosis tests for alcohol dependent patients	20%	35%	0%	0%	4.0%	8%	

CQUIN Met Target	No data received	Did not meet Target

Where the Trust was not able to meet the CQUIN target for the year a review was undertaken and areas of improvement identified and initiatied.

CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+

- Based on the results of CQUIN CCG2, targeted local audits are being undertaken in Elderly Care and Acute Medicine where diagnosing and prescribing have been identified as areas for improvement. The Trust also plans

to undertake a review of medical staff knowledge and understanding of antibiotic prescribing and will develop educational resources pending the results of this review.

CCG4: Compliance with timed diagnostic pathways for Cancer services

- In 2022/23 changes were made by NHS England on the content of what was to be collected. This made identification of exclusions challenging and the ability to accurately obtain data for CQUIN CCG4 complex.
- In order to improve the accuracy of data capture for this CQUIN the Cancer services team at Medway FT have initiated discussions with the Medway Cancer Alliance and are working with the Business Intelligence team to identify possible solutions.

CCG5: Treatment of community acquired pneumonia in line with BTS care bundle

- The Trust recognises the need to improve compliance with the BTS care bundle for the treatment of community acquired pneumonia and has identified four actions that it will take that will help with achieving this target:

1. Training and education for staff to ensure that the CURB score is captured
2. Engage specifically with the Emergency Department to maximise education around pneumonia
3. Undertake a review of how EPMA in EPR can support with antibiotic documentation
4. Design a solution to add the CURB score to EPR

CCG8: Supporting patients to drink, eat and mobilise after surgery

- The improvement work for CQUIN CCG8 will continue into 2023/24 and part of this programme of work will be to include accurate capturing of mobilisation after surgery on EPR.

CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients

- Whilst the Trust was unable to meet the CQUIN target for CCG9 in 2022/23 it has been able to clearly identify a number of key areas for improvement:

1. All liver function tests to incorporate AST and GTT as part of the testing
2. The Hepatology service will update the current alcohol pathway to include risk stratification for fibrosis in the ‘at risk’ patient population.
3. Teaching for F1/F2 and registrar level doctors and provide updates to the department educational meeting
4. Wide reaching communication cascades to provide updates about changes in current clinical practice

2.4.8 CARE QUALITY COMMISSION: URGENT AND EMERGENCY CARE RATED GOOD

The hard work of our urgent and emergency care colleagues was recognised by the CQC in June 2022. The CQC noted significant improvements since their previous inspection in December 2020 and rated the service as 'Good' overall. The service had previously been rated as 'Inadequate'.

In the report, inspectors commended staff for managing infection control risks, assessing risks to patients, and acting upon them. They praised the way care was planned to meet the needs of local people and the individual needs of patients. They also reported that staff felt respected, valued and supported and that they were focused on the needs of patients receiving care.

TRUST MATERNITY SERVICES RATED 'GOOD'

In 2022/23, our Maternity services were inspected by the Care Quality Commission (CQC) as part of a national maternity inspection programme. The programme aimed to provide an up-to-date view of the quality of hospital maternity care across the country, and a better understanding of what is working well to support learning and improvement at a local and national level. The inspection focused on the domains of Safe and Well Led only. The final inspection report was published in April 2023 and rated the Trust as Good for both the Safe and Well-Led domains and issued no requirement notices.

Despite recent improvements in care as recognised by the CQC, the overall rating for the trust remains 'requires improvement'. However, the trust is continuing to push forward with its ambitious improvement plan to achieve an overall rating of good from the CQC across all services and all CQC domains.

Rating for Medway Maritime Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement → ← Jul 2021	Requires Improvement → ← Jul 2021	Good ↑ Jul 2021	Requires Improvement ↑ Jul 2021	Requires Improvement ↑ Jul 2021	Requires Improvement ↑ Jul 2021
Services for children and young people	Good ↑ Jul 2021	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Good → ← Jul 2021	Requires Improvement → ← Jul 2021
Critical care	Good Apr 2020	Good Apr 2020	Outstanding Apr 2020	Good Apr 2020	Outstanding Apr 2020	Outstanding Apr 2020
End of life care	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020	Good Apr 2020
Maternity and gynaecology	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Requires improvement Apr 2020	Good Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020	Requires improvement Apr 2020
Urgent and emergency services	Requires improvement Apr 2020	Good Apr 2020	Good Apr 2020	Requires improvement Apr 2020	Good Apr 2020	Requires improvement Apr 2020
Diagnostic imaging	Requires improvement Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018
Outpatients	Good Jul 2018	Not rated	Good Jul 2018	Requires improvement Jul 2018	Requires improvement Jul 2018	Good Jul 2018
Overall	Requires Improvement → ← Jul 2021	Requires Improvement → ← Jul 2021	Good → ← Jul 2021	Requires Improvement → ← Jul 2021	Requires Improvement → ← Jul 2021	Requires Improvement → ← Jul 2021

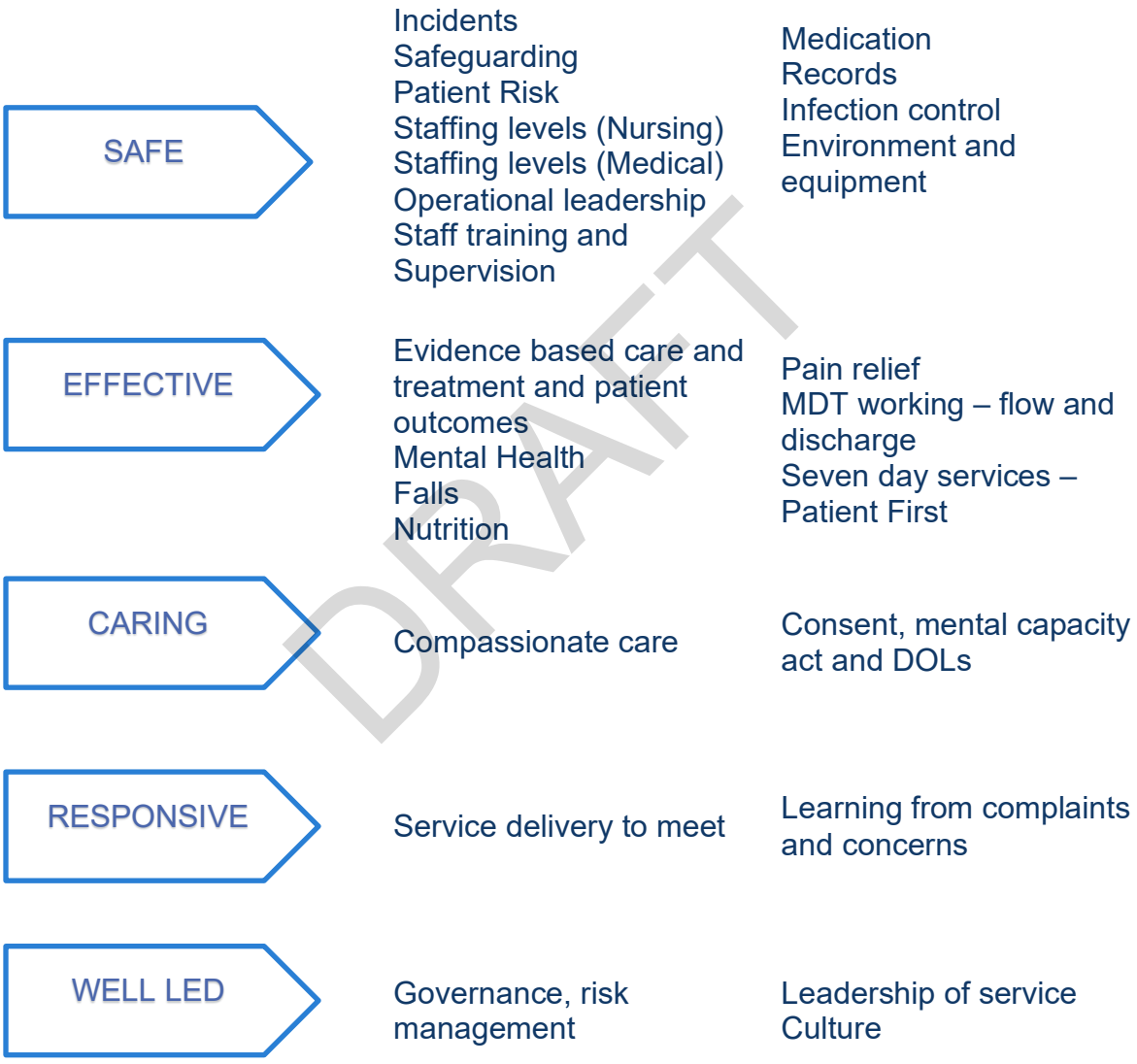
The trust aims to achieve a Good rating across all services and in all domains by:

- Strengthening its internal assurance by relaunching a programme of Internal Assurance Visits focused on identifying and improving all areas assessed as requiring improvement. The approach is based on the continuous improvement principle of standardisation, recognising, sharing and consistently applying best practice in the interests of patient care.
- Improving access to data by further rolling out the data collection system ''Gthr' which will enable staff to access real time data on the Trust's performance against important indicators thus supporting the trust's mission to provide excellent care every time.
- Transforming the way we deliver joined up patient care by continuing to introduce Electronic Patient Records (EPR) throughout the hospital as we move to a fully digitised organisation.
- Embedding the findings from external governance reviews to strengthen the Trust's assurance and accountability framework.

2.4.9 INTERNAL QUALITY ASSURANCE PROGRAMME

In 2022 the Trust approved a programme of Internal Assurance Visits (IAVs) as part of a rolling internal quality assurance programme to assess the core services as defined by the Care Quality Commission (CQC) and set the foundations for developing a ward accreditation scheme.

The purpose of the quality assurance visits is to assure that all fundamental standards are being complied with. These visits also improve local service provision, understanding and offer opportunities to discuss service developments. On visiting a ward or department for an internal assurance visit the panel are looking for the following Key Lines of Enquiry (KLoE):



The internal assurance visits have received positive feedback from staff as a mechanism through which change and improvement can be expedited. The trust uses the intelligence it gathers to shine a light on areas of excellence and also areas that require additional support and resource.

2.4.10 REPORTING TO SECONDARY USES SERVICE (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

The Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics and these have been included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number, was:

- 99.9% for admitted patient care
- 99.9% for outpatient care
- 99.2% for accident and emergency care

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care

2.4.11 INFORMATION GOVERNANCE TOOLKIT (IGT)

The Data Security and Protection Toolkit enables the Trust to measure its compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

In 2022/23, our Information Governance Assessment submission met most of the conditions, and an action plan produced to guarantee all requirements are met going forward.

An independent audit report is generated for the Toolkit each year, and is due to take place in April 2023. Last year, for this submission we have been rated as Amber/Green.

Medway NHS Foundation Trust's full response for 2022/23 has yet to be submitted as the deadline is 30 June 2023.

2.4.12 CLINICAL CODING

The Trust undertakes an annual clinical coding data quality audit to determine how accurately our coded clinical data reflects documented diagnoses and procedures in the patient record.

	2022/23	Previous year (2021/22)
Primary diagnosis	90.24%	88.50%
Secondary diagnosis	81.34%	83.76%
Primary procedure	90.77%	95.77%
Secondary procedure	93.75%	86.12%

It should be noted that that activity audited this year is different to the previous, so the figures are not directly comparable:

- The figures for primary diagnosis meet the standard 90% attainment level outlined in Data Security and Protection Toolkit Standard One Data Quality.
- The figures for secondary diagnoses meet the standard 80% attainment level outlined in Data Security and Protection Toolkit Standard One Data Quality.
- The figures for primary procedure meets the standard 90% attainment level outlined in Data Security and Protection Toolkit Standard One Data Quality.
- The figures for secondary procedures exceeds the 80% attainment level and meets the upper 90% attainment level outlined in Data Security and Protection Toolkit Standard One Data Quality.

In 2022/23, the results show that Clinical Coding met three and exceeded one of the four attainment level metrics. The full report including conclusions and recommendations for continued improvement will be available from June 2023.

2.4.13 DATA QUALITY

High quality information leads to improved decision making, which in turn results in better patient care, wellbeing and safety. We continued to focus on improving the quality of our performance data, and the Trust is taking the following actions to improve data quality:

- Ensuring automated data flows become essential
- Investigating the implementation of two-way PTS (Patient Tracking Solution) within our PAS/EPR System
- Raising awareness of poor data quality and focusing attention on areas which need support
- Continuation of a Data Assurance Committee with key lines of investigation and escalation.

2.4.14 LEARNING FROM DEATHS

The Trust is committed to learning and this includes learning from when patients die within our care or shortly after receiving hospital treatment. As a result the trust has established a Structured Judgement Review (SJR) panel that is a multidisciplinary, multi-professional panel consisting of patient safety leads from medicine, nursing, governance, end of life care, and resuscitation. The panel averages 4 SJRs each week and together, review the care the patient received during their last admission, judging each phase of care and whether the patient achieved excellent, good, adequate or poor care.

The cases presented for SJR review are primarily highlighted by the Medical Examiner during scrutiny, although referrals for SJR can be received from any clinical team with concerns around the care of a patient. There are also a random selection of cases reviewed for quality assurance purposes and any cases that have been highlighted from specialty mortality and morbidity meetings.

Deaths which occurred in 2022/23

During 2022/23, 1,605 Medway NHS Foundation Trust adult patients died; this comprised the following number of deaths, which occurred in each quarter of stated reporting period. This compares with 1317 adult deaths reported in 2021/22.

	Qrt.1	Qrt.2	Qrt.3	Qrt4.	Total 2022/23
Total number of deaths (adult)	381	346	453	425	1,605

Between April 2022 and March 2023, 151 structured judgement reviews were completed. 48% of cases were rated to have received good or excellent care for overall assessment with positive learning identified; Good care for complex patients, good communication with families, good timely end of life care and good documentation on decision making.

	Qrt.1	Qrt.2	Qrt.3	Qrt4.	Total 2022/23
Number of structured judgement reviews carried out	37	32	42	40	151

105 cases were identified for further review to identify any additional learning or problems in care.

The number of deaths in each quarter for which a structured judgement review required a further review was:

	Qrt.1	Qrt.2	Qrt.3	Qrt4.	Total 2022/23
Number of further reviews required	24	26	29	26	105

Since April 2022, six deaths were identified as being more likely to have been caused as a result of failings in care representing 0.4 per cent of the patient deaths during the reporting period.

	Qrt.1	Qrt.2	Qrt.3	Qrt4.	Total 2022/23
Number of deaths more likely than not to have been due to failings in care	1	3	1	1	6
Percentage of all deaths	0.3	0.9	0.2	0.2	0.4

Clinicians reviewing cases are asked, in their opinion, whether the patient was more likely than not to have died due to failings in care. Of the six cases judged as deaths due to failings in care, four of these are being investigated as Serious Incidents (SIs), one case is undergoing a High Level Investigation and one case has had the level of harm downgraded after a rapid review and was closed.

The Trust has identified areas of learning from structured judgement reviews and has taken actions to address these gaps.

Key learning and action points are:

- Since the introduction of electronic patient records (EPR) copy and paste issues were reported by the Medical Examiner Office and noted as a theme during SJR reviews. Copy and Paste on EPR meant that medical reviews were repetitive and not updated with current findings, making it challenging to review a patient's pathway during their final admission. This issue was escalated to the EPR board and the issue was further addressed with the specialities via a presentation from clinical coding around the pitfalls of copy and paste.
- Failure to escalate increasing NEWS scores and failure to document NEWS scores accurately was noted as a theme during SJR reviews and is recognised as part of Trust's Patient First Breakthrough Objective of improved recognition of a deteriorating patient, reducing the number of avoidable cardiac arrest calls and for Medway to be in the top 25% for low mortality rates during the week and at the weekend. Mandatory NEWS training and ensuring appropriate escalation of elevating scores are amongst some of the actions underway to improve this.
- Long waits in the Emergency Department, bed occupancy and capacity issues, along with ambulance delays were accentuated during certain periods throughtout the year. All SJRs that had identified these issues as problems in the care of the patient were highlighted to the Director of Operations as part of ongoing initiatives to improve patient flow and patient discharge times.

- Key themes identified from cases which were highlighted as having problems in care included; poor documentation, failure to review, failure to escalate, poor communication and copy and paste on electronic patient records (EPR). These cases were flagged for further review and fed back to the relevant specialty lead to discuss cases at their speciality Mortality and Morbidity (M&M) meetings.

A recent review of the Structured Judgement Review process has identified a need to provide up to date training for current reviewers and for new reviewers interested in becoming an SJR reviewer. Currently, the Trust reviews 10% of deaths through the SJR process. Systems for improved data capturing from reviews have been introduced to support a more robust process of learning from deaths and to support enabling the Trust to increase its SJRs to nearer 15-20% of deaths.

2.4.15 HEALTH AND SAFETY EXECUTIVE INCIDENTS

There were no health and safety incidents investigated by the Health and Safety Executive during 2022/23.

RIDDOR reportable incidents

There were 22 notifiable incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) in 2022/23, down from 28 in 2021/22. There were no notifiable incidents relating to the public.

A reportable incident is work related and results in a death, a specific type of injury or results in a staff member being incapacitated for over seven consecutive days. The Trust must also report certain specified injuries to members of the public on Trust grounds.

The RIDDOR incident by type reported in 2022/23 were:

Type of RIDDOR incident	2021	2022
Slips, trips and falls	6	6
Physical Assault	6	5
Moving and handling	8	3
Struck by	6	3
Accidental release of substance	2	2
Exposure to hazardous substances	0	1
Other	0	2
Total	28	22

Key Health and Safety Trends /Themes

Violence and Aggression

Violence and aggression continues to be an issue, particularly within our unplanned division.

Learning point: The Trust is providing prevention and management of violence and aggression (PMVA) training to staff, and has recruited additional staff to the security team. The Security, Violence and Aggression Group monitors all violence and aggression incidents at the Trust.

Moving and Handling

Moving and handling injuries are a high-risk area within health care. The trust has seen a 27% decrease in moving and handling incidents with 19 incidents, down from 26 incidents last year, of which three were RIDDOR reportable.

Learning point: The Trust continues to work to reduce moving and handling incidents, ensuring that risk assessments are suitable and sufficient, and that training is tailored to staff groups.

Staff Slips, Trips and Falls

Slips trips and falls (staff) has seen a sharp increase since last year, with 38 incidents reported this year, compared to incidents 22 last year, an increase of 78%, with six meeting RIDDOR criteria.

Learning point: Key areas to focus on in the working environment are: good housekeeping to ensure trip hazards are removed from corridors and work areas, damage to flooring is reported, and repairs implemented quickly, chair castor selection to ensure they are correct for the type of flooring they are used on.

2.4.16 REPORTING AGAINST CORE INDICATORS

2.4.16.1 SUMMARY HOSPITAL LEVEL MORTALITY INDICATOR

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

The expected number of deaths is calculated from statistical models derived to estimate the risk of mortality based on the characteristics of the patients (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender and method of admission to hospital).

The SHMI has been consistently within the ‘as expected’ range for the majority of 2022/23, and only recently within the ‘higher than expected’ range. The 10 diagnosis groups included in the SHMI are the diagnosis groups most indicative of Trust performance. The nature of these groups is such that they are often higher risk with higher patient activity. The Trust is within the ‘as expected’ band for all ten of these diagnosis groups.

Reporting Period	SHMI	Observed	Expected	Banding	Palliative care coded (%)
Apr 2021 – Mar 2022	1.05	1580	1506.87	As Expected	47.0
May 2021 – Apr 2022	1.05	1584	1508.67	As Expected	46.0
Jun 2021– May 2022	1.07	1607	1501.38	As Expected	45.0
Jul 2021 – Jun 2022	1.09	1637	1508.41	As Expected	43.0
Aug 2021 – Jul 2022	1.10	1640	1492.09	As Expected	43.0
Sept 2021 – Aug 2022	1.12	1661	1487.57	As Expected	42.0
Oct 2021 – Sep 2022	1.11	1650	1483.16	As Expected	42.0
Nov 2021 – Oct 2022	1.13	1645	1461.80	Higher than Expected	42.0

2.4.16.2 HOSPITAL STANDARDISED MORTALITY RATIO

The Hospital Standardised Mortality Ratio (HSMR) is a calculation used to monitor death rates in a Trust. The indicator is produced and published monthly, three months in arrears. The data is published nationally by Dr Foster, Telstra Health UK. It is the ratio of the observed number of in hospital deaths to the expected number of in hospital deaths (multiplied by 100) for 56 diagnosis groups (which give rise to 80% of in hospital deaths). The national benchmark for the HSMR is 100 – meaning that the number of expected deaths and the number of observed deaths are exactly the same.

Reporting Period	HSMR	Crude rate %	Expected rate %	Banding
Mar 2021 – Feb 2022	95.8	3.61%	3.77%	As expected
Apr 2020 – Mar 2022	95.4	3.59%	3.76%	As expected
May 2020 – Apr 2022	99.7	3.71%	3.72%	As expected
Jun 2020 – May 2022	103.5	3.80%	3.67%	As expected

Reporting Period	HSMR	Crude rate %	Expected rate %	Banding
Jul 2020 – Jun 2022	106.0	3.90%	3.68%	As expected
Aug 2021 – Jul 2022	110.2	4.06%	3.68%	Higher than expected
Sept 2021 – Aug 2022	112.1	4.10%	3.66%	Higher than expected
Oct 2021 – Sept 2022	113.6	4.10%	3.61%	Higher than expected
Nov 2021 – Oct 2022	114.7	4.15%	3.62%	Higher than expected
Dec 2021 – Nov 2022	115.5	4.12%	3.57%	Higher than expected

The Trust's HSMR for December 2021 to November 2022 was 115.5 and 'higher than expected'. The Trust has been in the 'higher than expected' banding since August 2021. The Trust has taken a proactive approach to monitoring outliers and focusing deep dives to understand the potential contributing factors to the rise in HSMR. There are a number of potential drivers that are causing the rise in HSMR. For these reasons, the Trust is actively looking at a number of different areas of improvement. One area of focus has been the downward trend in the expected death rate which could be due to the quality of documentation issues and palliative care coding, both of which will affect the calculated mortality risk of a patient and therefore have an impact on the expected rate.

Diagnosis groups that have alerted consistently over recent months are being monitored and undergoing deep dives. It is important to note that the rise in HSMR is not indicative of quality of care. To date, all clinical reviews undertaken have not revealed any failings in care or that the deaths under the diagnosis groups were avoidable deaths.

For the most recent reporting period of December 2021 to November 2022, Dr Foster highlighted the following diagnosis groups as being outliers.

- Acute Bronchitis
- Acute Cerebrovascular Disease
- Chronic Obstructive Pulmonary Disease
- Gastrointestinal Haemorrhage
- Other perinatal conditions
- Pneumonia
- Urinary Tract Infections
- Other infections including parasitic

- Other nutritional, endocrine and metabolic disorders
- Short gestation, low birth weight and fetal growth retardation.

Other perinatal conditions and short gestation, low birth weight diagnosis groups are monitored via the well-established Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) programme, as well as through the National Neonatal Audit Programme. Dr Foster have confirmed that HSMR is not a good measure of performance and risk for this cohort and advise that crude numbers are reviewed rather than focus on outlier status.

Cases from these outlier groups have been selected for deep dive reviews, and are reported to the Trust Mortality and Morbidity Surveillance Group for monitoring and identifying any improvements.

The Trust considers that this data is as described for the following reasons:

- The data is extracted directly from Dr Foster's Mortality data for English NHS acute trusts' documents. Dr Foster is an independent, established and recognised source of data nationally
- The data is reviewed regularly through the Trust's Mortality and Morbidity Surveillance Group.

The Trust has taken the following action to improve these indicators, and consequently the quality of its services:

- The Trust Mortality and Morbidity Surveillance Group monitors the HSMR and SHMI and undertakes necessary actions to review and identify areas for improvement
- A weekly Structured Judgement Review Panel reviews all cases that trigger a review and cases are escalated appropriately and promptly.
- An additional 10% of reviews of Structured Judgement Reviews is being targeted by consultant led Quality and Patient safety Leads.
- The drive to improve documentation and capture of comorbidities and palliative care for clinical coding is ongoing. Presentations on the importance of wording and documentation have been delivered to specialty teams and presentations to Junior Doctors will be facilitated throughout the year.
- All specialties hold regular mortality and morbidity meetings and undertake a number of mortality reviews to identify learning points and actions for improvement.
- Every specialty will be working to ensuring accuracy of mortality data with coders.

2.4.16.3 PATIENT REPORTED OUTCOME MEASURES (PROMS) (EQ-5D INDEX SCORE)

PROMs use a standardised tool as a measure of health outcomes. It is applicable to a wide range of health conditions and treatments and provides a simple descriptive profile and a single index value for health status.

Type of surgery	Sample time frame	% improved	Trust adjusted health gain	National average health gain	National highest	National lowest
Groin hernia*	Not applicable					
Varicose veins*	Not applicable					
Hip Replacement (primary)	Apr 2019 – Mar 2020	92.7%	0.527	0.468	0.536	0.330
	Apr 2020 – Mar 2021	83.3%	0.44	-	0.54	0.40
Knee replacement (primary)	Apr 2019 – Mar 2020	82.5%	0.322	0.342	0.421	0.243
	Apr 2020 – Mar 2021	58.3%	0.27	-	0.39	0.20

** Oct 2017 - NHS England has taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.*

A higher score indicates better health and/or greater improvement in function following an operation. We consider any data received as described because it is extracted directly from NHS Digital, which is an established and recognised source of data nationally

The Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Ensuring that there is a robust, consistent and sustainable process in place for making sure that all patients are provided with the opportunity to complete the initial survey pre-procedure
- Ensuring that compliance with the above process is monitored within the appropriate directorates and areas for improvement are identified, acted upon and tested.
- Continuing to make timely PROMS data submission.

2.4.16.4 28 DAY READMISSIONS

28 day Readmissions	2021-22 (FY)			2022-23 (up to Jan-23)		
	0-15	16 and over	Total	0-15	16 and over	Total
Discharge	12,084	68,807	80,891	6,743	40,333	47,076
28 day readmissions	1,257	7,405	8,662	698	3,741	4,439
28 day readmission rate	10.4%	10.8%	10.7%	10.4%	9.3%	9.4%

Reducing 28 day readmissions to hospital is an important national indicator across the NHS. Improved discharge processes are key to ensuring patients are discharged to the right place and at the appropriate time in order to prevent the costly effects of re-admitting patients.

The Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Ensuring that the Business Intelligence Team validates all readmissions data internally
- Ensuring that the data is monitored on a monthly basis at both divisional and Trust level.

2.4.17 THE FRIENDS AND FAMILY TEST (RESPONSIVENESS)

The Friends and Family Test (FFT) is a nationally recognised tool to seek patient and family feedback in regards to their recent experiences of care. This facilitates patient voice and opinion, and allows the organisation to change practice based on recommendations that are provided by them.

The Trust considers that this data is as described for the following reason: the data has been extracted directly from the NHS England, which is an established and recognised source of data nationally.

Friends and family feedback is a trust priority as part of the true north domains and as a breakthrough objective. As such, focussed work to hear the patient voice has been driven by the patient first methodology, launched at Medway during 2022. The way in which data was collated and utilised changed in October 2022. The new system now allows easier processing of issues, themes and trends from patients and creation of improvement action plans in clinical areas.

Friends and Family Test	2021-22				2022-23				
	A and E	**Inpatient**	**Outpatient**	**Maternity**	**A and E**	**Inpatient**	**Outpatient**	**Maternity**	**A and E**
Response rate	14.2%	19.7%	7.4%	14.2%	7.1%	16.6%	8.7%	53.6%	14.2%
% would recommend	71.4%	81.3%	89.1%	100%	73.7%	85.5%	91.7%	95.1%	71.4%

** Data as at March-23*

The Trust has taken the following actions to improve this indicator by:

- Exploring alternative suppliers to offer a fresh approach in 2023
- Exploring the possibility of maternity services becoming digital, which would mitigate the postnatal delay with uploading data.
- Focused weekly meetings with each division to highlight specific areas requiring improvement and establishing actions in response to responses.

2.4.18 RESPONSIVENESS TO THE PERSONAL NEEDS OF OUR PATIENTS

This data is collated from the national care quality commission survey on friends and family test feedback.

Medway Performance 2019/20	Medway Performance 2020/21	Medway Performance 2021/22	Medway Performance 2022/23	National Average Performance 2022/23	Highest Performing Trust Performance 2022/23	Lowest Performing Trust Performance 2022/23
84%	**89%**	**86%**				

2.4.19 VOLUNTEERS

The Trust currently has 125 active volunteers who give their time to assist patients, visitors and staff.

Volunteers carry out many valuable roles across the Trust this includes:

- Hospital Wards and Departments
- Reception areas and Guides
- Administration and clerical roles
- Chaplaincy
- Assisting with patient mealtimes and beverages
- Gardening
- Pets as Therapy
- Pharmacy
- Emergency Department.

Due to the pandemic our volunteer numbers have significantly reduced. However, we are welcoming our volunteers back and recruiting new volunteers to increase our volunteer team.

All our Volunteers are Covid Risk Assessed, Enhanced DBS checks, Occupational Health Assessment/Clearance and references are taken up.

Volunteers give their time and support in order to enhance the quality of life for patients and visitors whilst supporting members of staff.

Volunteering is a great way of giving something back to your local community.

2.4.20 VENOUS THROMBOEMBOLISM

VTE assessments	2021-22	2022-23 (Feb-23)
Our Trust	94.5%	71.3%
National average	-	-
Best performing trust	-	-
Worst performing trust	-	-
2020/21 to date, data not available as national submission has been suspended *Data up to and including February 2023		

The Trust considers the data presented is as described because it has been extracted directly from NHS Digital, which is an established and recognised source of data nationally, and all data is subjected to internal validation.

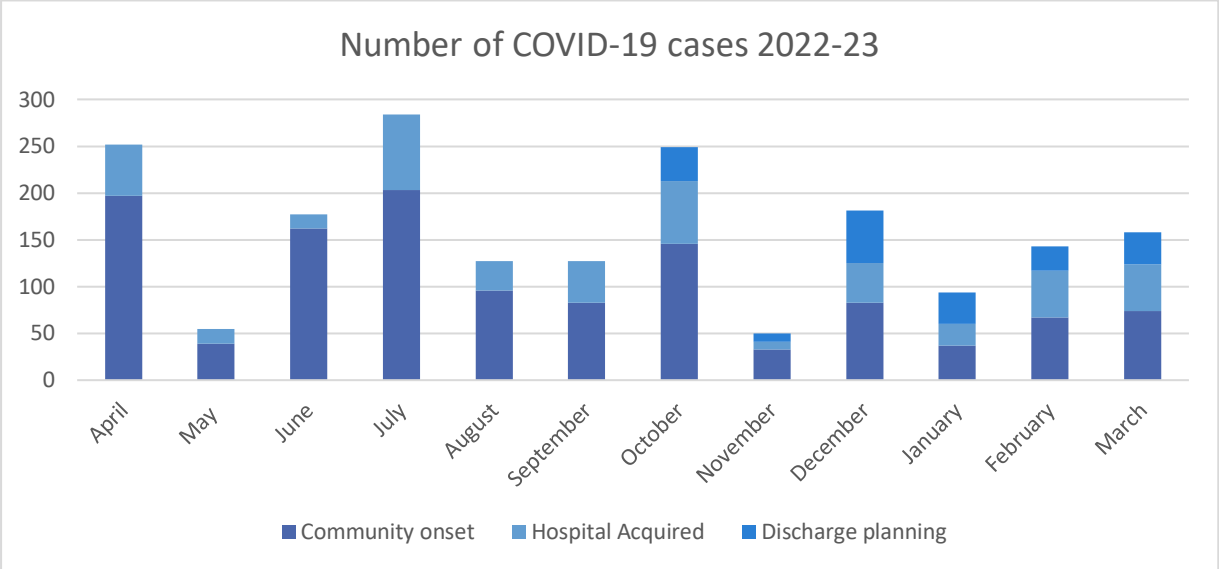
The Trust has taken the following actions, to improve this indicator, and so the quality of its services, by:

- Supporting colleagues through transition from paper to electronic prescribing and risk assessment
- Supporting ward clerks to maintain logging of VTE risk assessment data,
- Regularly reporting VTE data at governance level so that awareness across the Trust is consistent
- Using Patient First A3 Methodology to improve VTE risk assessment compliance and data logging.

2.4.21 COVID-19

Infection Control COVID 19	2020-21	2021-22	2022-23
Total number of COVID admissions	1963	710	1220
Total COVID cases	N/A	1186	1853
Total number of deaths with COVID in part 1	571	96	170
Total number of HAIs	NA	224	650
Total number of outbreaks	17	22	22

Changes to the management of COVID came into force from April 2022 following the publication of the “Living with COVID” White Paper by the government in February 2022. Following these changes the Trust was able to stop the need for COVID wards and has managed using side rooms and bays at times of surges. The last ward being used for COVID ceased in November 2022.



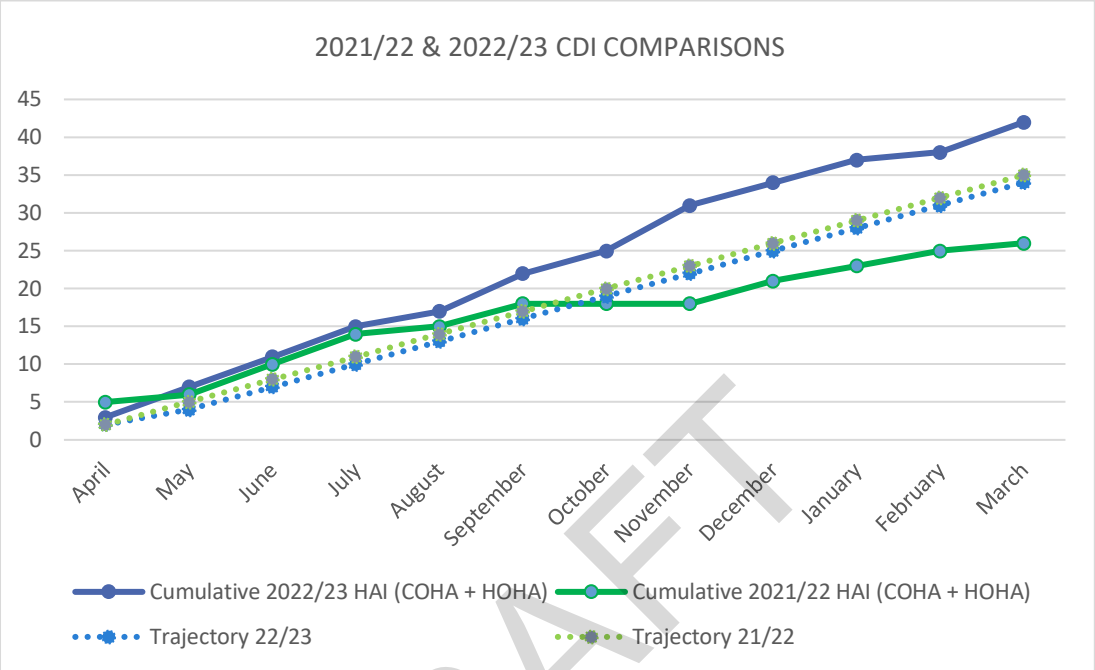
The table shows the number of cases per month and demonstrates peaks in April, July and October for positive results. Following on from the pause in asymptomatic testing an additional parameter for discharge planning was added. This is because many patients who tested positive for discharge to a care facility had been in the Trust longer than 8 days which is when a COVID-19 infection can probably be hospital acquired; however they were asymptomatic and had not been tested on admission.

During this time the Trust had periods of extreme pressure with an increase in hospital admissions. It is important to note that due to challenges with capacity at certain times, covid positive patients were unable to be moved out of a bay into a side room or covid positive bay within an hour as per trust policy and resultantly remained in the bay for longer. This has been linked to the cause of 14 out of 22 COVID-19 outbreaks. Other causes have been linked to an increase in community cases and the extension of visiting. There has been no identified link of transmission between staff and patients.

The IPC team reviewed all Hospital acquired cases (both probable and definite) and outbreaks using a root cause analysis methodology and continue to implement any learning that comes from these investigations.

2.4.22 C-DIFF

In 2022/23 the trust reported a total of 42 cases of C.difficile. This equates to a rate of 25.8 cases per 100,000 occupied bed days. A post infection review (PIR) is undertaken for all Trust apportioned C.difficile infections which identified that in four cases the onset of infection was avoidable.



In order to reduce the number of C.difficile cases the Trust has taken the following actions:

- Working to ensure antimicrobial stewardship remains a top priority
- Continue to hold C.difficile PIR's as a panel to insure learning is understood for any lapses of care
- Monthly data driven discussions
- Commode cleaning competencies for all staff
- Trust wide commode audits to support plan for a single style commode
- Review of cleaning products and trial undertaken including potential for sporicidal wipes to improve commode cleanliness in September 2022. Business case under development.
- Diarrhoea assessment tool developed and launched on 3 April 2023
- Link practitioner session on stool chart, stool assessment and documentation.

2.4.23 PATIENT SAFETY INCIDENTS RESULTING IN SEVERE HARM OR DEATH AS REPORTED TO THE NATIONAL REPORTING AND LEARNING SYSTEM

The Trust encourages all healthcare professionals to report incidents as soon as they occur to ensure timely investigation and outcomes, which are shared to support learning that is reflective of a positive safety culture.

The Trust uses nationally reported and verified data from the National Reporting and Learning System (NRLS) to benchmark its reporting culture against other like performing NHS Trusts. The data shows all incidents reported by Medway for the period April 2021 to March 2022; our incident-reporting rate for this period was 28.8 incidents per 1000 bed days against the national average of 57.5 incidents per 1000 bed days. Medway NHS Foundation Trust individual incident reporting data is made available by the NRLS every six months and the Trust has been shown to have a low reporting level for the acute non-specialist trust cohort.

Medway NHS Foundation Trust considers that this data is as described in that

- The Trust uses an electronic reporting system DATIX which is used to report nationally and verified data to the National Reporting and Learning System (NRLS)
- The serious incident data has been extracted directly from the Strategic Executive Information System (StEIS) which is an established and recognised source of data nationally
- The Trust has a fortnightly Serious Incidents Review Group (SIRG) and weekly Incident Review Group (IRG), chaired by the Director of Integrated Governance, Quality and Patient Safety and the Medical Director for Patient Safety and Quality, which explore in detail those incidents that fall within the scope of the terms of reference of the panel.

The table below shows the total number of reported patient safety incidents (PSI) during the period April 2021 to March 2022 and represents the latest nationally published data.

Total number of reported PSIs

Patient safety incidents	April 18 – Sep 18	Oct 18 – Mar 19	April 19- Sep 20	Oct 19- March 20	April 20- March 21	April 21- March 22
Total reported incidents	2288	2297	2173	1271	3169	4563
Rate per 1000 bed days	**27.2**	**26.8**	**26.3**	**15.7**	**27.2**	**28.8**
National average (acute non-specialist)	44.5	46.0	49.8	50.7	58.4	57.5
Highest reporting rate	107.4	95.94	103.8	110.2	118.7	205.5

Lowest reporting rate	13.1	16.9	26.3	15.7	27.2	23.7

The table below presents a summary update of the total number of PSIs which resulted in severe harm or death that were reported across the trust from April 2018 to March 2022.

Number of PSIs resulting in severe harm or death

Patient safety incidents	April 18 – Sep 18	Oct 18 – Mar 19	April 19- Sep 20	Oct 19- March 20	April 20 – March 21	April 21– March 22
Incidents causing severe harm or death	20	42	26	19	56	41
% incidents causing severe harm or death	0.90%	1.80%	1.20%	1.50%	1.70%	0.9%
National average (acute non-specialist)	0.30%	0.40%	0.30%	0.30%	0.40%	0.40%
Highest reporting rate	1.20%	1.80%	1.60%	1.50%	2.80%	1.7%
Lowest reporting rate	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

The Trust intends to take the following actions to improve this data, and so the quality of its service by:

- Ongoing scrutiny of quality of the serious incident reports, including revision of Trust templates to national standards
- Revision of the Incident Management Policy to incorporate risk assessing and a more systems based approach in line with the introduction of the Patient Safety Incident Response Framework (PSIRF)
- Continue to educate staff on the importance of improving the reporting of incidents and near misses to support a positive safety culture for our patients
- Revision of the incident management system to provide improved feedback to reporters of incidents and an easier to use system to encourage reporting
- Introducing a dedicated Patient Safety Improvement Team to facilitate and embed Trust-wide learning from incidents and near-misses

Data for April 2022 to March 2023 has not been published at the time of writing this account.

2.4.24 SERIOUS INCIDENTS

The Trust investigates all patient safety incidents, reported on our incident reporting system, DATIX. Incidents that are deemed serious incidents or never events undergo robust investigation, which involves root cause analysis (a systematic investigation that looks beyond the people concerned to understand underlying causes and environmental context in which the incident happened).

The Trust reported 97 (101 in 2021/22) serious incidents to Kent and Medway ICB from April 2022 to March 2023 via StEIS (Strategic Executive Information System - supports

the monitoring of investigations between NHS providers and commissioners). An additional two incidents were reported to StEIS, however, following investigation these were downgraded and not recorded as SIs.

The following themes from serious incidents are:

Serious Incidents Themes	No.
Abuse/alleged abuse of adult patient by staff	1
Adverse media coverage or public concern about the organisation or the wider NHS	1
Apparent/actual/suspected self-inflicted harm meeting SI criteria	1
Blood product/transfusion incident meeting SI criteria	1
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	4
Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus neonate and infant)	4
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	5
Medical equipment/devices/disposables incident meeting SI criteria	4
Medication incident meeting SI criteria	4
Pending Review	2
Pressure ulcer meeting SI criteria	8
Radiation incident (including exposure when scanning) meeting SI criteria	2
Slips/trips/falls meeting SI criteria	20
Sub-optimal care of the deteriorating patient meeting SI criteria	18
Surgical/invasive procedure incident meeting SI criteria	5
Treatment delay meeting SI criteria	17
Total	97

The four most reported serious incident themes which have been reviewed are:

Serious Incidents Themes	
Slips/Trips/Falls meeting the serious incident criteria	The Trust reported 20 serious incidents within this category. The most common falls reported were falls resulting in a fracture, with a fractured neck of femur the most common.

	Other fractures reported include a fall to head injury and fall to fractured humerus.
Sub-optimal care of the deteriorating patient meeting SI criteria	18 serious incidents were reported in this criteria. The most common incidents for this category were failure to escalate a deteriorating patient.
Treatment delay meeting SI criteria	17 incidents were reported in this criteria. This included incidents relating to missed diagnosis of fractures and cancerous lesion's.

The Trust is committed to being open and honest with our patients. Undertaking Duty of Candour is a legal requirement for all safety incidents recorded as causing moderate harm, severe harm or death where we will formally apologise to the patient and/or family involved and undertake an investigation into their care.

We will feedback in writing the findings of our review and any actions we are taking to prevent a similar incident from happening again. In 2022/23 formal Duty of Candour was applied to 138 of our reported incidents.

2.4.25 NEVER EVENTS

The Trust has reported three never events between April 2022 and March 2023.

One never event was reported in April 2022 for a Retained Swab. The second never event reported by the trust was in August 2022 for a misplaced NG tube, and the third never event reported by the trust was in September 2022 for a wrong sized prosthesis inplant. All investigations are now complete and the learning is outlined below:

The trust has taken some important learning from the retained swab never event including:

- Importance of the same two persons undertaking the swab count prior to and after speculum examination.
- Importance of documentation of swab count in and out.
- Inappropriate to use small non-Raytec swabs for speculum examination.
- There was no current departmental policy formalising expected practice around swab counts at the time of vaginal examination in clinic or emergency gynaecology settings.

There was also important learning which came from the misplaced NG tube incident including:

- Compliance with LocSSIPs – essential to go through each step of recommended checklist.

- Misrecognition of Nasogastric tube position due to gap in education and training for correctly identifying nasogastric tube position.

The most recent never event was reported in September for the use of a wrong sized prosthesis which highlighted the following key learning:

- Distractions to be removed from theatre environment when completing checks.
- Work to continue with theatre teams on building psychological safety and encouraging staff to feel safe to challenge, creating a no blame supportive culture for learning and improve communication within the team.
- Prosthesis training to include differences between sizes commonly used in different procedures.
- National Joint registry form with all stickers and boxes are now checked by all staff before skin closure for compatibility.

All incidents have been submitted to the ICB and have now been closed

2.4.26 NRLS EXPLORER TOOL

The publication of this year's explorer tool is delayed for testing the new annual format. The explorer tool will be released as soon as testing had been completed, and this webpage will be updated on release.

3. Other Quality Information

3.1 EMERGENCY DEPARTMENT (ED) PERFORMANCE

Overall patient attendances from April 2022 to March 2023 are 143,780 compared to 138,139 same period last year, an increase of 4%.

The organisation has seen fluctuating but sustained pressure via increased attendances, acuity, workforce pressures and delayed discharge combined with industrial action across staffing groups, reduction in community capacity increasing our length of stay, and numbers of patients within our acute beds that are medically fit for discharge. Across the 12 month period our four-hour non-admitted percentage has decreased by 8.92% to 73.72% and our four-hour admitted has decreased by 0.51% to 2.81%. Significant improvements have been made in the last quarter despite this being our most pressured time of year, improving from 64.7% for non-admitted four-hour performance to 77.05%, and from 4.11% to 5.71% for admitted performance. During this same period we also almost fully eradicated ambulance handover delays over 60 minutes, reducing from 782 Nov-Feb in 2021/22, to 60 between Nov-Feb 2022/23. We were previously a significant outlier for our difficulties in offloading ambulances, and are now consistently one of the best performers in the region.

The Emergency Care Intensive Support Team has recently re-visited our Emergency Department and fed back that without exception all conversations were extremely positive, and they were pleased to see the positive feedback regarding leadership from the top of the organisation down, that the team felt listened to and supported by the whole organisation, and that system wide relationships had significantly improved, having a significant positive effect on patient and staff experience.

Current developments include a trust-wide corporate project, focusing on the full patient journey from admission at the front door, to either supported discharge or to a home environment. This has supported the significant improvement seen in the 4 hour non-admitted performance in the last quarter, and is now moving to a focus on 12 hour ‘length of stay’ within ED, supported by planned improvements to the mental health pathway, the alternatives to ED ‘A-TED’ work streams, and HARIS work-streams looking at in-reach, hot clinics and frailty flow.

SEVEN DAY SERVICES

The Seven Day Hospital Services (7DS) Programme is a nationally driven quality improvement initiative and supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS Trusts in England.

There are 10 standards in total and the Trust has been working on four standards as highlighted within the quality improvement initiative priorities from NHS England.

Achievements to date include:

- **Standard two: Time to consultant review**: The Trust is committed to early consultant review. Acute medical consultants, frailty and specialist medicine consultants have been allocated to emergency medicine department, acute medical, frailty, cardiology and respiratory inpatient wards at the weekend. This has seen a significant improvement in early senior decisions and reduction in avoidable cardiac arrests. There is also an increase in weekend discharges.
- **Standard five: Diagnostics:** Access to diagnostic tests both biochemistry and imaging and therapies support is available over weekends and will continue to form part of the Trust's Patient First strategy to reduce length of stay.
- **Standard six: Consultant directed interventions:** Using the Patient First approach there will be a standardisation of morning ward rounds and morning and afternoon board rounds over weekends to ensure that interventions are consultant directed. There is weekend acute medical, frailty, cardiology respiratory and general medicine inpatient ward rounds and board rounds at the weekend. Furthermore cardiology gastroenterology respiratory and general medical consultants are on call twenty four seven/365 days
- **Standard eight: Ongoing review in high dependency areas:** Due to the impact of Covid a dedicated respiratory ward for high dependency patients has been created. High dependency cardiac patients are also managed on a dedicated ward. These dedicated wards have seven day speciality input. Work is ongoing to create dedicated high dependency wards for other subspecialties. ITU, HDU and neonatal services continue to have seven day consultant support.

Implementation of the seven day service will continue and this will be included in the Trust's Patient First programme.

3.2 MAXIMUM TIME OF 18 WEEKS FROM POINT OF REFERRAL TO TREATMENT (RTT) IN AGGREGATE – PATIENTS ON AN INCOMPLETE PATHWAY.

RTT Incomplete Pathway %	2020-21	2021-22	2022-23 (Feb-22)
Our Trust	64.55%	61.5%	61.5%
National average	-	70.2%	-
Best performing trust	-	100%	-
Worst performing trust	-	38.3%	-

** Data up to February 2022 only*

The trust considers that this data is as described for the following reasons.

- Data is taken direct from the internal source clinical system(s). Validation will occur by the appropriate service (in addition to the Central Data Assurance Team, where relevant) and once complete, is signed off and submitted nationally together with reported internally via dashboards and the IQPR

The Trust has taken the following actions, to improve this indicator, and so the quality of its services, by:

- Increasing the utilisation of current systems
- Increasing operating theatre efficiency and capacity
- Improving the management of GP referrals through advice and guidance and triage
- Creating additional virtual outpatient capacity by introducing a virtual hub
- Working with system partners and using the independent sector for insourcing and outsourcing capacity

3.3 MAXIMUM SIX-WEEK WAIT FOR DIAGNOSTIC PROCEDURES

6-Week Diagnostic Wait	2020-21	2021-22	2022-23
Our Trust	81.6%	75.85%	
National average	61.78%	-	
Best performing trust	100.00%	100.00%	
Worst performing trust	8.86%	59.57%	

The Trust considers that this data is as described for the following reasons:

- Data is taken direct from the internal source clinical system(s). Validation will occur by the appropriate service (in addition to the central Data Assurance team, where relevant) and once done, is signed off and submitted nationally together with reported internally via dashboards and the IQPR

The Trust has taken the following actions, to improve this indicator and so the quality of its services, by:

- Using the independent sector to support insourcing and outsourcing capacity for a number of diagnostic modalities
- Additional imaging capacity from two mobile MRI scanner units

3.4 FRACTURED NECK OF FEMUR PATHWAY

The accelerated fractured neck of femur pathway was re-introduced in August 2022, following a period of suspension due to COVID-19. The pathway is initiated in the community by the SECamb staff and continues in the hospital by using the fast-track transfer to the ring-fenced beds on Pembroke ward. The pathway includes guidance on pain management, bloods tests, lab and radiological investigations and then during day time hours the orthogeriatricians receive notifications to review patients. By using this pathway we aim to achieve the best possible care for older, frail patients, avoiding the need to wait in ED, and maximising effective pain relief and prompt pre-operative management.

3.5 NATIONAL NHS STAFF SURVEY

The NHS staff survey is a vital measure of the Trust's level of staff engagement, how staff are feeling, their morale and their experiences of working here. This is used by the Trust to listen and adapt to make improvements. The survey is conducted annually and compared against other NHS acute organisations and also against the Trust's own results from the previous year. This provides not only an opportunity to learn from our staff, but also how we compare to the national picture.

Since 2022, the Trust has improved in five of the seven themes; we are compassionate and inclusive; we each have a voice that counts; we are safe and healthy; we are always learning and we are a team. The Trust's People Strategy retains culture as a key delivery programme for the future. By continuing the embedding of our culture improvement programme in tandem with our staff survey action planning and implementation, values-based recruitment and continuous improvement methodologies – the Trust is committed to improving our staff experience which, in turn, will improve patient experience.

This year's Staff Survey response rate was 40 per cent, which is unchanged from 2021.

The survey is aligned with the seven People Promise elements and in itself is critical to the promise that we each have a voice that counts. Employee voice is a fundamental enabler for employee engagement. Alignment of the survey with the People Promise elements began in 2021 and continued into 2022 offering a two-year trend. This year eligibility was extended to active, in-house, bank only workers (staff

who do not have a substantive or fixed term contract with the organisation). This is the first national data collection for bank only staff.

The Staff Engagement score for 2022 was 6.6 which has increased by 0.1 since 2021. Our target as a Trust (our True North breakthrough objective) is to improve our staff engagement score to the upper quartile of national results by 2025, which is currently a score of 6.9. This score is made up of three elements; motivation (which scored 7.0), involvement (which scored 6.8) and advocacy (which scored 6.1). The motivation and involvement scores are equal to the national average however the advocacy score falls below the national average by 0.5 points.

The national benchmarking results show the progress we have made towards our Patient First breakthrough objective of reaching the upper quartile for staff engagement by 2025. In 2022 our national ranking for this metric improved by 18 points from 112th to 94th and marks two consecutive years of progression.

The Staff Morale score was 5.6 for 2022 and has similarly improved by 0.1 since 2021.

The theme indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. Scores for each indicator together with that of the survey benchmarking group (acute) are presented below.

People Promise	2021 score	2021 respondents	2022 score	2022 National Average	2022 respondents
We are compassionate and inclusive	6.9	1839	7.0	7.2	1826
We are recognised and rewarded	5.7	1832	5.6	5.7	1817
We each have a voice that counts	6.4	1816	6.5	6.6	1803
We are safe and healthy	5.6	1818	5.7	5.9	1812
We are always learning	5.4	1736	5.5	5.4	1747
We work flexibly	5.9	1813	5.9	6.0	1804
We are a team	6.4	1829	6.6	6.6	1816
Staff Engagement	6.5	1843	6.6	6.8	1826
Morale	5.5	1842	5.6	5.7	1826

3.6 COMPLAINTS/ COMPLIMENTS

The Trust welcomes and actively seeks patient and visitor feedback. This can include concerns, complaints, compliments and suggestions for service improvement.

This means we want to work in partnership with our staff, patients, their families and carers and system partners to seek opportunities to improve the quality of the care and services we provide.

All feedback is assessed and entered onto a computerised system. All concerns are triaged to identify the most appropriate method of handling and it is the Trust's ambition for complainants to have their concerns resolved as swiftly as possible, by offering a formal or informal method of resolution.

While handling concerns and providing resolution, the Trust has a focused approach to learning and improvement for patient care and services across the organisation. We focus on identifying opportunities and barriers for effective complaint handling, strengthening and improving systems and processes, and embracing the ethos of improvement and learning across the Trust.

A new Patient Complaint and Feedback Management Policy was introduced in October 2022 which references the Patient First Strategy which has been developed to help the Trust ensure that we deliver the best of care for our patients and to support our staff to be the best of people.

The new policy outlines the Trust's commitment to early resolution and actively listening to the people who use our services, their families and carers to understand what matters to and is important to them.

In line with the new policy, the Trust changed the way complaints are handled by introducing a centralised complaint handling model which ensures that complaints are managed from start to finish by one team. This provides oversight of each complaint handling stage which is supported by a collaborative approach from teams and departments across the organisation. The Trust recognises that a large number of legacy complaints were open at the point of re-centralisation.

In addition to complaints and concerns, the Trust recognises that many compliments are received across the organisation but are not registered for reporting purposes. The Patient Experience Team are exploring additional opportunities to receive and record compliments across the Trust to maximise the opportunity to capture and share compliments as examples of good practice and patient satisfaction.

118 compliments were registered across the Trust and shared with named staff members, teams and departments whose care has been highlighted for recognition.

In accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, this part of the report sets out analysis of the nature and number of complaints in Medway NHS Foundation Trust during 2022/23.

Between 1 April 2022 and 31 March 2023 the Trust registered 481 complaints, averaging around 40 per month. This is a reduction of 1% when compared to the same reporting period in the preceding year. The information below details themes of complaints for this reporting period.

Complaint Themes	
Admission, discharge and transfer arrangements	25
Aids and appliances, equipment, premises, access	6
All aspects of clinical treatment	291
Appointments, delay/cancellation (outpatient incl. long waits in Emergency Dept.)	31
Appointments, delay/cancellation (inpatient)	5
Attitude of staff	49
Communication/information to patients	37
Consent to treatment	3
Information relating to other organisations	1
Privacy and Dignity	4
Patient status, discrimination	1
Other	4
Patients' property and expenses	9
Personal records (incl. medical and/or complaints)	10
Results	5
Total	481

Every complaint is assessed and managed individually, although issues raised may be similar to others; we recognise the circumstances and experiences are often different for the individual concerned. It is important to remember that not all formal complaints are as a result the Trust failing to provide a good quality service. For example, a

complainant may not be happy with the service provided because they consider their needs are different to what the Trust has assessed them as needing or can offer.

Complaints are categorised according to severity and complexity in a BAR rating system (Blue, Amber, Red). Thirteen complaints were categorised as red complaints (most severe/complex), which is a reduction of 1.4%, and 468 were categorised as amber and blue complaints.

- 96% of all complaints were acknowledged within 3 working days.
- In relation to the Trust's key performance indicator for responding to complaints, on average, 23% of complaints were closed on time.
- At the end of March the Trust had 205 complaints open, 78% of which had breached the Trust's target response time.

In response to complaints received about clinical care and treatment the following improvement measures have been introduced:

Clinical Care:

- To support patients in hospital who usually have domiciliary ventilation at home and require it to continue in hospital and require support to do this, the Respiratory Team are exploring the benefit of producing guidelines to support staff and patients, which will be particularly beneficial out of hours when there is no access to the domiciliary ventilation service.
- A separate nodule multi-disciplinary team meeting has been introduced to ensure diagnosis of lung cancers and potential lung cancer is made in a timely manner. Previously these cases had been included in the general lung multidisciplinary team meeting which was constrained by the number of cases and time pressures.
- A 'faster diagnosis nurse' has been recruited as part of the lung multidisciplinary team.
- Administration time has been incorporated into consultant job plans to ensure multi-disciplinary actions are completed and to prevent delays in patient treatment and referrals.
- A GAU (gynaecology assessment unit) pathway is now available for patients requiring specialist gynaecology care and treatment.
- An additional junior doctor has been sourced overnight to support the Surgical Team and to reduce delays with patients requiring clinical review.
- A pathway has been introduced for escalation of patients who have been reviewed by the Acute Response Team (ART) who may require critical care escalation.
- A new audit meeting has been established to improve communication between the Acute Response Team (ART), Surgeons and Nursing.
- Changes have been made in the way the respiratory team work; ensuring that every action from the Radiology Meeting or Multi-disciplinary Team meeting has

a named consultant responsible which will reduce the risk of actions being missed.

Nursing Care:

- A mouth-care project has been launched which includes both theoretical and face to face training, aligned to the Royal Marsden guidelines.
- A continence working group has been set up to raise awareness of continence, dignity and supportive measures for patients
- Learning Disability training sessions have been introduced by the Learning Disability Team
- The Enhanced Care Team have rolled out a Dementia and Delirium training programme across the organisation.
- Dementia and Delirium audits now form part of routine nursing audits in regard to compliance with the butterfly scheme and 'This is me'. The audit scores form part of the scoring system for the Trust's Ward Accreditation Scheme which recognises excellence in care
- The maternity team have launched Personalised Care Plans and are working with expectant mothers and families to agree a joint approach to safe and effective personalised care.
- The maternity education team have developed a training programme specifically tailored for Maternity Health Care Assistants.
- The Emergency Department is undertaking a review of the process for updating relatives of patients when a patients is transferred to a ward
- Emergency Department staff will now prioritise patients with cancer, who are undergoing treatment and are immunosuppressed and have a 'red card' which entitles them to rapid access.

3.7 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN COMPLAINTS

Between 1 April 2022 and 31 March 2023 15 complaints were assessed by the Parliamentary and Health Service Ombudsman (PHSO). This compares with 14 cases in 2021/22.

- One complaint was returned for further local resolution and this has since been resolved to the complainants satisfaction
- Two complaints were closed with no further investigation
- One complaint was assessed and closed with no further action necessary
- One complaint was investigated and closed with no further action necessary.

The Ombudsman is currently investigating one case, and ten cases are currently being assessed.

3.8 PATIENT ADVICE AND LIAISON SERVICE (PALS)

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters to patients and their families and provides a 'much needed point of contact for patients, their families and their carers' (NHS.UK 2018).

Early and proactive resolution is key to de-escalating issues and providing remedy for patients and their families resulting in a good outcome. This approach reflects the Parliamentary and Health Service guidelines which promotes welcoming complaints in a positive way and recognising them as valuable insight for organisations, supporting patients and families with a thorough and fair approach that accurately reflects the experiences of everyone involved and promotes a learning culture by supporting organisations to see complaints as opportunities to improve services.

Patients and their families can contact PALS by telephone, email or visit in person. Additionally, contact can be made via a 'Have Your Say' form on the Trust website.

The Patient Advice and Liaison Service (PALS) registered 5161 enquiries in 2022/23. This is significantly higher than the 4,602 concerns registered in the previous year and demonstrates a more efficient approach to registering and handling concerns with the ambition to provide remedy and resolution at the earliest stage.

The PALS team works collaboratively with teams, wards, departments and individual staff to highlight and help resolve concerns and enquiries as swiftly as possible. It requires a well informed and pro-active PALS team along with a responsive approach from staff to address concerns swiftly and effectively. The information below details themes of PALS concerns for this reporting period.

PALS Themes	
Admission, discharge and transfer arrangements	200
Aids and appliances, equipment, premises, access	60
All aspects of clinical treatment	918
Appointments, delay/cancellation (outpatient incl. long wait in ED) (Urology, Colorectal, Trauma & Orthopaedics, Neurology and Gastroenterology received the most enquiries)	1332
Appointments, delay/cancellation (inpatient)	101
Attitude of staff	254
Complaint handling	6
Communication/information to patients	1197
Compliments	118
Consent to treatment	4

Failure to follow agreed procedure	3
Hotel services	23
Information relating to other organisations	33
Mortuary and post mortem arrangements	20
Other	194
Patients' privacy and dignity	8
Patients' property and expenses	81
Patients' status, discrimination	1
Personal records (incl. medical and/or complaints)	233
Results	364
Transport (ambulances/other)	11
Total	5161

Annex 1: Statement from Commissioners, Local Healthwatch Organisations and Overview and Scrutiny Committees

STATEMENT FROM THE LEAD GOVERNOR ON THE QUALITY ACCOUNT

STATEMENT FROM KENT AND MEDWAY INTEGRATED CARE BOARD (ICB)

STATEMENT FROM MEDWAY HEALTHWATCH

Healthwatch Medway act as a community watchdog for healthcare services, ensuring that the voice of the community is heard, their concerns addressed, and improvements made to enhance the quality of care provided. We serve as an independent voice representing the interests and concerns of Medway residents. We monitor and evaluate the quality of healthcare services in Medway, including assessing accessibility, effectiveness, safety, and patient experiences. We work with healthcare providers, policymakers, and regulators, to influence positive changes that address the community's needs.

We sincerely appreciate Medway NHS Foundation Trust for sharing the Quality Account Report with us. We value Medway NHS Foundation Trust's dedication to promoting quality healthcare and commend your Patient First methodology and the new Patient Complaint and Feedback Management Policy. Our attendance at the regularly held Patient Experience Group meetings highlights the ongoing and evolving efforts to provide a safe, caring, and effective environment for our community. During these meetings, patient experiences are shared first-hand, directly from the patients themselves, with support from the Patient Experience Team to facilitate their participation. These real-life examples contribute to the promotion of the Patient First approach.

Understanding the importance of a collaborative approach in driving positive change, we are eager to work in partnership with Medway NHS Foundation Trust to address the healthcare priorities outlined in the quality account. As a dedicated advocate for healthcare consumers, Healthwatch Medway is committed to actively supporting improvement initiatives and facilitating meaningful community engagement.

Therefore, we extend our full support to Medway NHS Foundation Trust in their efforts to address these priorities. Our team is prepared to contribute our expertise, resources, and community insights to the collaborative process. We eagerly participate in improvement initiatives and welcome collaboration with Medway NHS Foundation Trust to develop and implement strategies that enhance the quality of care provided. Our objective is to foster a responsive, patient-centred, and continuously improving healthcare system.

Please consider Healthwatch Medway as a committed partner in your endeavours. We thank you for your continued commitment to collaboration as we strive to deliver the highest possible standards of healthcare for the people of Medway.

Yours sincerely,

Ms. Emma Sue Willows
Strategy and Intelligence Lead
Healthwatch Medway

STATEMENT FROM MEDWAY COUNCIL'S HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

STATEMENT OF ADJUSTMENT FOLLOWING RECEIPT OF WRITTEN STATEMENTS REQUIRED BY SECTION 5(1) (D) OF THE NATIONAL HEALTH SERVICE (QUALITY ACCOUNT) REGULATIONS 2010

Annex 2: Statement of Director's Responsible For the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2022/23 and supporting guidance Detailed requirements for quality reports 2022/23
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2022 to March 2023
    - papers relating to quality reported to the board over the period April 2022 to March 2023
    - feedback from commissioners dated 7 June 2022
    - feedback from governors 21 June 2022
    - the trust's 2022-23 complaints report for the period April 2022 to March 2023 published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2022/23 national patient survey results – currently unpublished
    - the 2022/23 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment NHS providers are not needed for this quality account.
    - CQC inspection report dated April 2023
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the board:

…… **Dated:** Thursday, 30 June 2022

Jo Palmer

Chair of Medway NHS Foundation Trust

Chief Executive Date 30th June 2022

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF MEDWAY NHS FOUNDATION TRUST ON THE QUALITY REPORT

There is no requirement for a foundation trust to commission external assurance on its quality report for 2022/23, however the trust has undertaken its own internal review to provide assurance that the required elements have been met.

Description	Areas applicable to Medway NHS Foundation Trust	National Average	Outcome/ Performance	Supporting commentary explaining variation	Referenced page on report
(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	Summary Hospital-level Mortality Indicator (SHMI)	Expected 1461.80 No data available	Observed 1645 42 %	The Trust is within the 'as expected' band for all ten of these diagnosis groups	Page 30
The trust's patient reported outcome measures scores for:	Not applicable			Not applicable	Page 34

Description	Areas applicable to Medway NHS Foundation Trust	National Average	Outcome/ Performance	Supporting commentary explaining variation	Referenced page on report
(i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery and (iv) knee replacement surgery during the reporting period.	Not applicable	Not applicable NA 0.47 0.34	Not applicable N/A 0.53 0.32	N/A The Trust is reliant on feedback from patients in relation to the results of their surgery.	
The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	28 Day Readmissions	No data available	10.4% 9.3%		Page 35

Description	Areas applicable to Medway NHS Foundation Trust	National Average	Outcome/ Performance	Supporting commentary explaining variation	Referenced page on report
The trust's responsiveness to the personal needs of its patients during the reporting period.	Friends and Family Test	No data available	86%		Page 37
Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)	Friends and Family Test	Not available			Page 36
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.				2020/21 to date, data not available as national submission has been suspended *Data up to and	Page 38

Description	Areas applicable to Medway NHS Foundation Trust	National Average	Outcome/ Performance	Supporting commentary explaining variation	Referenced page on report
				including February 2023	
The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	Aged 2 and above	No data available	25.8 cases per 100,000 occupied bed days		Page 39
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	All areas	57.5 incidents per 1000 bed days	28.8 incidents per 1000 bed days		Page 40

Annex 3 – National and Local Clinical Audit participation

National Audit	Data Collection Completed	Number of Cases submitted	Status
Breast (and Cosmetic) Implant Registry	Y	10	Completed 100%
Care of Older People	Y	0	In progress
Case Mix Programme (CMP) part of Intensive Care National Audit & Research Centre (ICNARC)	Y		Completed 100%
Child Health Clinical Outcome Review Programme - Testicular Torsion	Y		In progress
Child Health Clinical Outcome Review Programme -Transition from child to adult health services	Y		Completed 100%
Cleft Registry & Audit Network (CRANE)	Y		Completed 100%
Medical and Surgical Clinical Outcome Review Programme - Community Acquired Pneumonia (CAP)	Y	8	In progress
Medical and Surgical Clinical Outcome Review Programme - Crohn's Disease	Y	6	Completed 100%
Medical and Surgical Clinical Outcome Review Programme – Endometriosis	Y		In progress
Epilepsy 12: National Clinical Audit of Seizures and Epilepsise for Children and Young people (Cohort 5) - Clinical audit	Y	2	Completed 100%
Epilepsy 12: National Clinical Audit of Seizures and Epilepsise for Children and Young people (Cohort 5) - Organisational audit	Y		Completed 100%

National Audit	Data Collection Completed	Number of Cases submitted	Status
Medical and Surgical Clinical Outcome Review Programme - Epilepsy in adults	Y		Completed 100%
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Services (FLS)	Y		Ongoing
Falls and Fragility Fractures Audit Programme (FFFAP) - National audit of Inpatient Falls	Y		Completed 100%
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD)	Y	1470	Ongoing
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database (NHFD) - Facilities Audit	Y		Completed 100%
Female Genital Mutilation (FGM)	Y	16	Completed 100%
Infection Prevention & Control v3	Y	264	Ongoing
Learning Disabilities Mortality Review Programme (LeDeR) Previously known as Learning Disabilities Mortality Review Programme	Y	11	Completed 100%
Major Trauma Audit (TARN)	Y	218	Ongoing
Maternal, Newborn and Infant Outcome Review Programme	Y		Completed 100%
Maternal, Newborn and Infant Outcome Review Programme - MBRRACE-UK Perinatal Mortality Surveillance	Y		Completed 100%
Maternal, Newborn and Infant Outcome Review Programme - Perinatal confidential enquiries	Y		Completed 100%
Emergency Medicine QIPs - Mental Health (Self-Harm) v2	Y		In progress
NAP7: Perioperative Cardiac Arrest	Y	3	Completed 100%

National Audit	Data Collection Completed	Number of Cases submitted	Status
National Adult Diabetes Audit	Y		Completed 100%
National Adult Diabetes Audit - National Diabetes Core Audit	Y		Ongoing
National Adult Diabetes Audit (NDA) 2022 National Pregnancy in Diabetes Audit	Y	74	Completed 100%
National Adult Diabetes Audit (NDA) 2023 National Diabetes Footcare Audit	Y	101	In progress
National Asthma and COPD Audit Programme (NACAP)	Y	676	Completed 100%
National Audit of Breast Cancer in Older People (NABCOP)	Y		Ongoing
National Audit of Care at the End of Life (NACEL) - Round 4	Y	82	Completed 100%
National Audit of Dementia Round 5	Y	30	Completed 100%
National Cardiac Arrest Audit (NCAA) part of Intensive Care National Audit & Research Centre (ICNARC)	Y		Completed 100%
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management	Y		Completed 100%
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Y	324	Ongoing
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions	Y		Ongoing
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Y		Ongoing 80%

National Audit	Data Collection Completed	Number of Cases submitted	Status
National Early Inflammatory Arthritis Audit (NEIAA)	Y		Completed 100%
National Emergency Laparotomy Audit (NELA) Year 9	Y	1494	Ongoing
National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit	Y	233	Ongoing
National Gastro-Intestinal Cancer Audit Programme (GICAP) - National Oesophago-Gastric Cancer Audit (NOGCA)	Y	44	Completed 100%
National Joint Registry (NJR) - Elbow replacement and revision	Y		Completed 100%
National Joint Registry (NJR) - Hip replacement and revision	Y		Completed 100%
National Joint Registry (NJR) - Knees replacement and revision	Y		Completed 100%
National Joint Registry (NJR) - Shoulder replacement and revision	Y		Completed 100%
National Lung Cancer Audit (NLCA)	Y	269	Completed 100%
National Maternity and Perinatal Audit (NMPA)	Y		Completed 100%
National Neonatal Audit Programme (NNAP)	Y		Ongoing
National Paediatric Diabetes Audit (NPDA)	Y		Ongoing
National Post Colonoscopy Colorectal Cancer Audit	Y		Completed 100%
National Respiratory Support Audit	Y		In progress
Elective Surgery - National PROMs Programme	Y		Completed 100%
National Prostate Cancer Audit (NPCA)	Y		Ongoing
National Vascular Registry (NVR)	Y		Ongoing

National Audit	Data Collection Completed	Number of Cases submitted	Status
Paediatric Asthma Secondary Care (NACAP)	Y	18	Ongoing
Emergency Medicine QIPs - Pain in Children	Y	203	Completed 100%
Perioperative Quality Improvement Programme (PQIP)	Y		Ongoing
RCEM consultants sign off	N	0	Did not participate
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y		Ongoing
Society for Acute Medicine's Benchmarking Audit 2022 (SAMBA)	Y	67	Completed 100%
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery. (MITRE)	Y		Ongoing
UK Parkinson's Audit	Y	20	Completed 100%
UK wide Acute Upper Gastrointestinal Bleeding Audit	Y	44	Completed 100%

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participation	Percentage of required number of cases submitted
Transition from child to adult health services	Y	Completed 100% 5
Epilepsy in adults	Y	Completed 100%
Community Acquired Pneumonia (CAP)	Y	Completed 100% 4
Crohns	Y	Completed 100%

		6
Testicular Torsion	Y	In progress 5/6
Endometriosis	Y	In progress

Examples of actions to improve the quality of healthcare provided	RAG
National Neonatal Audit Programme (NNAP) Thermoregulation care bundle created. Support continuous temperature monitoring. Datix all cases outside the normothermic range. Monthly Update on governance board. Implement Respiratory care bundle. Extend LISA surfactant delivery to Labour ward. Aim to get BFI stage 1 accreditation to promote breast feeding. To ensure all high risk patients have been offered a 2 year ND follow up. **National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)** Every person to receive an early and accurate diagnosis based on a guideline-defined approach and a plan for their care - completion of personal asthma action plans. Care to be provided to people with asthma and COPD within the recommended timeframe after hospital admission, to support optimal outcomes – referrals to respiratory level. **National Falls and Fragility Fractures Audit programme (FFFAP)** All in-patients receive a MFRA regardless of ward. All elements of high quality MFRA are included on the electronic patient record risk assessment and associated care plans linked to activities of daily living to address risks identified. Flat lifting equipment is available at all sites. MFT completed the VFSA sprint audit 2021. CNS attends national webinars to support knowledge sharing and learning for the Osteoporosis unit. **2021.107N - Upper gastrointestinal bleed management -** Gastroenterology dept Increased awareness about the use of electronic referral for upper gastrointestinal endoscopy for emergency GI bleeds. The use of the pathway for managing patients for upper GI bleed in the emergency as well as the medical assessment units. Poor filling of the upper GI bleed electronic referrals for endoscopy. **Actions** Patients presenting with upper GI bleed ideally should have endoscopy within 24hrs of presentation - patients to be offered the option of endoscopy when they present; Proper documentation on the online referral for patients	

Examples of actions to improve the quality of healthcare provided	RAG
presenting with upper GI bleed; Patients with GBS score 0 should have OGD as outpatient basis - already implemented; Posters to be put in the emergency department as well as the medical assessment units and gastroenterology ward to remind colleagues on guidelines for managing upper GI bleed - already implemented; Upper GI bleed care pathway available in ED - already implemented. **2122.040 – Screening for secondary hypertension** – Acute Medicine department Significant reduction in the number of patient unnecessarily screened (comparing this second cycle to the first cycle) leading to improved patient care. If this is maintained this will also lead to reduced costs. **2122.102 -Screening, Assessment, and Intervention for Sarcopenia in acute elderly care wards: SARC-F Nutritional assessment in elderly care: a MUST! –** Elderly care dept MUST completion is timely (99% compliance with nutrition screening in 24hrs). 90% of patients had correct care plan implemented. 82% of patients at high risk of malnutrition received individualized dietitian input during admission. **Actions** Ongoing staff training and audits using gthr tool to identify areas of improvement and target ward based training for MUST; QI project with abbott to implement into RACE clinic +/- ward settings if able; Frailty nutrition protocol to be implemented for all patients.who meet the criteria. **2122.204 - Management of patients with acute sickle cell crises at** MMH – Haematology dept The majority of sickle cell patients are being appropriately referred to medics and discussed with haematology. Insight gained into the current management of an acute sickle cell pain crisis in the Emergency Department. Personalised sickle cell care plans are not being used in the majority of patients (61%). There is a failure to objectively assess pain in an acute sickle cell crisis in a timely manner. Patients are not being regularly assessed for pain every 30 mins until pain is controlled. **Actions** The Green book guidance on Sickle Cell Disease should be updated to reflect the trust guidelines and incorporate the Acute Pain Management Flowchart; ED nursing and medical staff should receive training on Sickle Cell Disease periodically - liaise with Emergency department seniors regarding bi-annually teaching for clinical staff; Foundation Trainees should receive annual teaching on the Management of patients with acute sickle cell crises at MMH - liaise with Foundation Director, Sally Bamborough regarding annual teaching for F1s and F2s; Sickle Cell Care Plans should be easily accessible on EPR - Discuss with the EPR team regarding the uploading.	  

Examples of actions to improve the quality of healthcare provided	RAG
2223.017 - Accuracy of prescribing on drug charts using the drug charts tool (2nd cycle) – Gastroenterology dept Generally, our interventions were effective in generating a positive change. Those worth mentioning are - antibiotics - we received positive results in antibiotics legibility, indication, and signature; VTE prophylaxis - the interventions were successful in causing a positive effect with an increase in signature, weight adjustment and VTE prophylaxis prescription of 18%, 16% and 5%, respectively. Antibiotics - the 3rd day review declined over the period. Still room for betterment; especially in the antibiotics and VTE prophylaxis portion of the drug chart. **2021.111N - To study the concordance rate between pre-op axillary USS and post-op SLNB results in invasive breast cancer patients –** Breast Surgery Dept Results showed that axillary USS and SLNB is in concordance (75%) with national guidelines. However, there is a low concordance in Triple positive breast cancer, will require MRI. Actions include: Additional information about lymph nodes in reporting the USS to be reviewed and discussed in the MDT 2. Look at MRI breast for all invasive lobular breast cancers **Actions** Additional information about lymph nodes in reporting the USS to be reviewed and discussed in the MDT 2. Look at MRI breast for all invasive lobular breast cancers **2021.171N - Anorexia Nervosa Care and Management in the Paediatric Ward – Paediatric dept** More than 61% of staff feel there is good dietician input during the week. However, there is a lack of support during the weekend. Only 13.9 rated that they were familiar with managing children with anorexia nervosa and Inadequate CAHMS support during the week. 100% of colleagues believe they need training in managing patients with anorexia nervosa. At their self-defined level, <20% of HCPs at Medway are not confident in caring for a child with an eating disorder(s). Recommendations: Educational seminar for doctors on MARZIPAN guidelines, poster to be created on eating disorders, Recruit a Specialist Eating Disorder Nurse and education teaching sessions to be given to doctors on eating disorders **Actions** Educational seminar for doctors on MARZIPAN guidelines; Poster to be created on eating disorders; Recruit a Specialist Eating Disorder Nurse; Education teaching sessions to be given to doctors on eating disorders. **2122.060 - Introduction of video consultations in Surgical hot clinics** – General Surgery dept Based on patients feedback 40% would prefer a video consolation over a telephone consolation. Patients that were not in favour of a video consolation gave clear reasons for their resistance which is to be addressed. There is an	   

Examples of actions to improve the quality of healthcare provided	RAG
Insufficient timescale to successfully implement improvements and carry out second survey during my employment at the trust. Project may require continuation by current SHOs. Recommendation is for patients to be introduced to video consolations for surgical hot clinics. Re-audit in October 22 **Actions** Patients to be introduced to video consolations for surgical hot clinics; Re-audit in three months	
2122.128 - Compliance of laxatives prescription for opioid induced constipation in patients with hip fractures (2nd cycle) – T&O dept The re-audit showed that 60% of patients opened their bowels within the 3 days with triple laxative therapy (30%). Laxatives were prescribed within 24 hours of admission of constipation (approx 90%), adherence to guidelines has improved (80%). Key concerns: the size of the Ortho booklet if recommended advice was to be incorporated and the Inclusion criteria for the study- only orthogeris patient's included.	
2122.185 - Uric acid and Calcium levels in suspected renal colic patients (3rd cycle) – Urology dept A marginal increase in the number of patients correctly investigated, 8.3% to 11% had both Calcium and Uric acid measured. Still only 11% of patients are being correctly investigated. **Actions** Targeted teaching session for SAU nurses who take bloods for patients referred with renal colic to encourage them to include Uric acid and Calcium on routine bloods for all suspected renal colic patients; Educate all new Urology doctors regarding measuring serum Uric Acid and Calcium in stone patients during all inductions; Posters in the triage room and doctors office in SAU; Re-assess in Autumn / Winter for 4th cycle following intervention to see if greater success.	
2223.040 - Compliance with Neuroprotective Measures in Head Injured Patients on ICU (2nd cycle) – Critical Care dept Results show that they are fully compliant with potassium targets and hypoxaemia avoidance. Glucose levels and MAP targets were compliant in all instances however, outliers were identified during admission and appropriate actions were taken. No recommendations required	
2223.068 - Pilot study for tracheostomy tea-trolley teaching: basic emergency care for blocked tracheostomy – critical care dept Improvement in confidence levels in junior doctor practice as first responder to a tracheostomy emergency post intervention of low fidelity teaching session with simulation. 90% of trainees had an increase in confidence after receiving the training. Concerns: Current cohort of non-airway doctors often have very	

Examples of actions to improve the quality of healthcare provided	
little knowledge thus confidence in managing tracheostomy emergencies and tracheostomised patients are cared for both in ITU and HDU settings, where sometimes at least one unit will have no airway trained staff unless calling for help from anaesthetist colleagues. Recommendations for further training sessions have been put into place. **Actions** Liaise with ICM college tutor in charge of induction to propose inclusion of this, with document created for guideline on suggested inclusion points for delivering this teaching. 2. Emergency tracheostomy management teaching box to be created to include simulation equipment, feedback forms, bedhead signs and emergency algorithms 3. Liaison with MMH simulation staff for ongoing dialogue regarding future inductions to borrow equipment for this teaching.	

GLOSSARY

Acronym	Meaning
ASSKING	Assess Risk, Skin assessment and skin care, Surface selection and use, Keep patients moving, Incontinence assessment and care, Nutrition and hydration assessment/support, Giving information
CCG	Clinical Commissioning Group
C-DIFF	Clostridium difficile
CNST	Clinical Negligence Scheme for Trusts
CO	Carbon monoxide
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRASH	CRASH Bundle C= call bell, R= Review medication, A= Appropriate equipment, S = shoes (appropriate footwear), H= Hypotension (postural)
DATIX	National Risk Management and reporting system
DQ	Data Quality
E. coli	Escherichia coli
ED	Emergency Department
EOLC	End of Life Care
FFT	Friends and Family Test
FGR	Fetal growth restriction
GRAM	Gram-negative bloodstream infections
HSMR	Hospital Standardised Mortality Ratio
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
LeDER	Learning Disabilities Mortality Review Programme
MRSA	Methicillin-Resistant Staphylococcus Aureus
NCAA	National Cardiac Arrest Audit
NELA	National Emergency Laparotomy Audit
NHS	National Health Service
NHSI	National Health Service Improvement
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PHSO	Parliamentary and Health Service Ombudsman
PPE	Personal Protective Equipment
PROM	Patient Reported Outcome Measures
PST	Patient Safety Team

Acronym	Meaning
QIP	Quality improvement project
RADG	Resuscitation and Acute Deterioration Group
RTT	Referred to Treatment
SATOD	Smoking at time of delivery
SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
StEIS	Strategic Executive Information System
SUS	Secondary Uses service
UTI	Urinary tract infection
VTE	Venous thromboembolism

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