Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2016/17

Quality Accounts

Providing safe, high quality health services and a good overall experience for our patients, staff and the public is at the centre of everything we do at Maidstone and Tunbridge Wells NHS Trust (MTW).

The Health Act 2009 requires all NHS healthcare providers in England to provide an annual report to reflect on standards of care and set priorities for improvement. These are called Quality Accounts.

Our Quality Accounts for 2016/17 highlight the progress we have made against key priorities for the year to improve services for our patients and present those areas that we will be focusing on as priorities for 2017/18.

We believe patients have a fundamental right to receive the very best care. This should be provided to them in the most appropriate setting, by teams of highly skilled and expert healthcare professionals who care passionately about the care they provide. We believe we have continued to make strong progress at MTW in providing patients the highest standards of care.

There are a number of national targets set each year by the Department of Health and locally, against which we monitor the quality of the services we provide. Through these Quality Accounts we aim to provide you with information on how effective our services are, how they are measured and where we aim to make improvements.

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Part One
Chief Executive's Statement

Glenn Douglas

Welcome to our Quality Accounts for 2016/17 which provides a picture of patient care at Maidstone and Tunbridge Wells NHS Trust and sets out our quality priorities for the year ahead.

Demand for NHS hospital-based care reached unprecedented levels in West Kent and north East Sussex during 2016/17.

Our teams of highly skilled healthcare professionals at Maidstone and Tunbridge Wells hospitals provided over 800,000 episodes of care for our patients last year – that's around 50,000 more instances where patients required our help compared to the previous year.

We believe that the demand for our services will continue to grow for the foreseeable future and that is why we are working closely with our partners in health and social care, alongside our patients and the public, to create a Kent and Medway-wide health and social care plan to meet people's changing health needs.

We have an aging and increasingly elderly population and are seeing many more patients over the age of 65 being admitted to our hospitals in an emergency with complex care needs. More often than not, these patients require prolonged periods of hospitalisation and on-going care in the community. This is the `new norm' for the NHS locally and our quality priorities for the year ahead continue to build on our service improvements - from a patient safety, experience and clinical effectiveness perspective - for this important group of patients.

One of our priorities this year is to help more of our older patients retain their much-valued independence and return home after their hospital stay. This is important to them and it's important to us.

The growth in emergency hospital attendances, admissions and length of stay has had a clear impact on our ability to meet some of our waiting time standards all of the time. You will see from our Quality Accounts that we have not always consistently managed to see some of our emergency and elective patients as quickly as we would want to. Our quality priorities for 2017/18 continue to build upon our ongoing work to improve these areas of care.

At the same time we have maintained or improved key areas of patient safety during 2016/17. This is a testament to the efforts of our hardworking staff who have continued to put the safety of our patients first. There is still more we can do to improve the safety of our patients this year, and every year. Our Quality Accounts set out our priority areas to continue our patient safety improvements in an open and transparent way, based very much on an ethos of acknowledging when things have gone wrong, learning from our errors and sharing best practice.

While we will continue to look at every opportunity to enhance the care and experience that all of our patients have, 2016/17 was also a bumper year for babies. We delivered more babies than ever before last year and are delighted to see an increase in our birth rates at both Maidstone and Crowborough Birth Centres. We are one of few Trusts in the country to provide women with a full range of birth choices and are nationally piloting a birth choices project for the NHS.

The information contained within this report represents an accurate reflection of our organisation's performance in 2016/17 and has been agreed by the MTW Trust Board.

Thank you for taking the time to read our Quality Accounts. If you have any comments or suggestions for our Trust, you can contact us in the following ways:

Follow us on Twitter: www.twitter.com/mtwnhs
Join us on Facebook: www.facebook.com/mymtwhealthcare
Become a member of our Trust: www.mtw.nhs.uk/mymtw

Glenn Douglas
Chief Executive

Part Two
Quality improvement initiatives

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

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

We have chosen three quality improvement priorities in 2017/18 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The quality priorities have been reviewed and agreed by the members of the Patient Experience committee, which include patient representatives and representatives from Healthwatch Kent.

Quality Improvement Priorities 2017/18

NHS Improving Quality

Patient Safety
To create reliable processes that will build a supportive environment to reduce avoidable harm.
Key objectives will include:

- We will demonstrate that we have embedded a safety culture within all departments undertaking invasive procedures with compliance with the WHO surgical safety methodology.
- We will improve the reporting of medication errors within the Trust and reduce the number of inappropriate omissions of doses of medication.
- We will reduce our observed rates of mortality to be in line with expected rates according to speciality.
- We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
- We will improve the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.

Patient Experience
To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback.
Key objectives will include:

- Implementation of the revised Friends & Family methodology to provide a more targeted focus on 5 questions relating to the patient's overall experience.
- To achieve consistent monthly response rates to the Friends and family test.
- To work with external partners such as Healthwatch, NHSI, CQC and the CCG to identify key themes of good practice and emerging issues that may give cause for concern. Activities may

include engagement with compliance Assurance, formal and informal PLACE assessments, engagement with service improvement initiatives and patient experience improvement groups
- Develop a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).

Clinical Effectiveness

To improve the management of patient flow.

Key Objectives will include:

- Avoiding unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend our emergency departments.
- Work with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
- Improved access to ring-fenced beds for Stroke and fractured neck of femur patients.
- Development of pathways that will support the timely discharge of patients

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

Our newly refurbished phlebotomy room at Maidstone Hospital in Main Outpatient's Clinic 3.

Patient Safety

Maidstone and Tunbridge Wells NHS Trust is committed to the creation of an open and honest approach to patient safety which relies on both our staff feeling empowered to report incidents and raise concerns and our patients being welcomed to let us know when the care they receive falls short of expectations.

The evidence and information that is gathered from our incident reporting system, complaints, Patient Advice & Liaison service (PALs), inquests, legal claims, mortality reviews and clinical audit are all fundamental to the triangulation of key themes and trends which are then used to disseminate learning. Through this approach we aim to inspire our teams towards making a sustained and positive approach that ultimately improves the safety of our patient care.

Aim/goal

To ensure that all actions that we said we would undertake as a result of learning from incidents and complaints, as indicated in our action plans, have been undertaken and ensure that the learning from these has been disseminated and embedded into practice.

Description of Issue and rationale for prioritising

Embedding a positive and strong patient safety culture takes sustained time and effort to ensure that staff feel safe to raise concerns, empowered to make a difference and have faith that a fair and consistent approach will be taken when fault is discovered. Developing this culture relies on trust and a continuous approach to the developments we are making. In an effort to maintain the momentum of change we have chosen to continue with the dissemination of learning as a key priority for the coming year.

Identified areas for improvement and progress during 2016/17

The following actions were taken in 2016/17

- A central database is now in place that supports the patient safety team with the monitoring of actions previously identified and agreed at the Learning and Improvement committee (SI panel) for all serious incidents reported.
- The Trust's Internal Assurance Inspection process has, as part of their intelligence gathering process, identified actions that were previously agreed. Evidence for these actions were then investigated and collated during the course of these inspections. During 8 separate inspections we were able to evidence staff awareness and find evidence of practical actions being undertaken.
- The Governance Gazette has been published monthly and regularly features case studies to support shared learning.
- Launch of the Patient Safety Calendar in September 2016 with key safety initiatives identified and supported on a monthly basis. These have included communication, infection control, falls, pressure sores, medicines optimisation, Venous Thromboembolism (VTE) and incident reporting.
- Learning from Falls has also been evident with several safety initiatives undertaken this year, including falls as a safety calendar theme for the month of November 2016 and more recently the 'take 5' approach to patient assessment. We have also been successful in achieving our aim to reduce the number of patient falls this year to less than 6.2 per 1,000 occupied bed days achieving 6.07.
- Governance presentation to Directorates and Junior medical staff, on the importance of incident reporting and key learning themes that have been identified, given during the months of February and March 2017.

Initiatives for further action for 2017/18

Key objectives will include:

- We will demonstrate that we have embedded a safety culture within all departments undertaking invasive procedures with compliance with the WHO surgical safety methodology.
  - Agree a programme of audits on WHO compliance to all areas undertaking invasive procedures and monitoring of compliance.
  - Promotion of 'Human Factors' training and methodology.
- We will improve the reporting of medication errors within the Trust and reduce the number of inappropriate omissions of doses of medications.
  - Monthly reporting of medication safety incidents and raised awareness through Governance meetings and Medicines Safety News.
- We will reduce our observed mortality rates to be in line with expected rates according to speciality.
  - By the end of March 2018 every in hospital death will have been reviewed (in line with prevailing guidance)
- We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
  - Through the work of the Sepsis Committee we aim to achieve the National CQUIN. This will be monitored monthly through the CQUIN Board and reported to the Patient Experience Committee.
- We will improve the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.
  - The work of the National Maternity Safety Improvement plans will be reported through the Maternity Board and the Key Performance Indicators (KPI's) will be monitored to inform their progress.

Executive lead: Claire O'Brien, Interim Chief Nurse
Board Sponsor: Claire O'Brien, Interim Chief Nurse
Implementation lead: Wendy Glazier, Associate Director Quality Governance
Monitoring: Trust Clinical Governance Committee

Patient Experience

NHS England publicise that good care is linked to positive outcomes for the patient and is also associated with high levels of staff satisfaction, however they also acknowledge the inconsistencies experienced by different patient groups. There is also an anxiety that those least likely to complain or speak out will experience the poorest care. Our 'Values' are therefore crucial in this objective to improve our patients' experience.

P– Patient First; We always put the patient first and at the centre of what we do.
R– Respect; We respect and value our patients, visitors and each other.
I – Innovate; We take every opportunity to improve service delivery.
D– Delivery; We aim to deliver high standards of quality and efficiency in everything we do.
E– Excellence; We take every opportunity to enhance our reputation and aim for excellence.

Aim/goal

To progress improvements made in capturing patient feedback which is essential for the assessment of our services and to help us make the necessary changes and improvements where necessary.

Description of Issue and rationale for prioritising

Service user feedback is one of the vital elements essential for improving and benchmarking the quality of care provided. It also provides an opportunity for services to reflect on their care, celebrate positive feedback and consider where and how to make local improvements.

This organisation relies on several methods of feedback both internal and external and will proactively work with all providers of data and information that relates to our service users to help apprise us of improvements that are required.

Identified areas for improvement and progress during 2016/17

The following actions were taken in 2016/17

- A task and finish group was established and a new contract engaged with 'Iwantgreatcare' to re-establish a process to consistently gather and display patient feedback.
- The Internal Assurance Inspections were also instrumental in ensuring that each area visited was displaying their feedback and able to demonstrate their local themes and trends.
- Achievement for Friends & Family for 2016/17 is:-
  (See Part 3, p39 for further detail)

Response Rate:

	Achieved	Plan	Benchmark
Maternity Services	26.6%	25.0%	24.0%
In-Patient Services	23.3%	25.0%	25.7%
Accident & Emergency	15.5%	15.0%	12.7%

Positive score – would recommend the service:

	Achieved	Plan	Benchmark
Maternity Services	93.6%	95.0%	95.6%
In-Patient Services	95.5%	95.0%	95.8%
Accident & Emergency	90.7%	87.0%	85.5%

- Each Directorate reports monthly to the Trust Clinical Governance Committee their plaudits and positive feedback. These are then shared with our Communications team to ensure that good practice and initiatives are publicised to promote learning throughout the organisation.
- Our new contract with 'Iwantgreatcare' has the capacity to extract personal feedback which staff can utilise during their appraisals and practice development plans.
- Healthwatch Kent have supported us with an Enter and View visit to our Outpatient departments in September 2016 and have remained instrumental in gaining external feedback. Formal reports are now being received on a quarterly basis, whilst informal communication occurs as necessary.

Patient Experience 2017/18

Key objectives will include:

- Implementation of the revised Friends and Family Test methodology to provide a more targeted focus on 5 questions relating to the patient's overall experience.
- To achieve consistent monthly response rates to the Friends and Family Test.
- To work with external partners such as Healthwatch, NHSI, CQC and CCG to identify key themes of good practice and emerging issues that may give cause for concern. Activities may include engagement with compliance Assurance, formal and informal PLACE assessments, engagement with service improvement initiatives and patient experience improvement groups
- Develop a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).

Executive lead: Claire O'Brien, Interim Chief Nurse
Board Sponsor: Claire O'Brien, Interim Chief Nurse
Implementation lead: John Kennedy, Deputy Chief Nurse
Monitoring: Patient Experience Committee

Clinical Effectiveness

The Organisation is committed to the improvement of patient flow throughout the organisation by means of monitoring and benchmarking of patient data which supports the ethos of our patients' entitlement to the right care the first time in the most appropriate environment for their presenting condition.

Aim/goal

To deliver safe and effective care for patients by which-ever pathway of care best meets those needs. These options should include a variety of ambulatory pathways, onward referral to other provider organisations who are better able to meet their care needs and for those who are admitted in ensuring the minimum length of stay possible. This will include the on-going work around the reduction in bed occupancy rates, achieving the A&E 4 hour standard and achievement of the Stroke and Neck of Femur indicators which are priorities for service users, commissioners and this organisation.

Providing safe effective care

Description of Issue and rationale for prioritising

Safe and effective care for our patients remains at the heart of this organisation's objectives. For us to be able to deliver this there is a requirement to ensure good patient flow and the availability of specialist inpatient beds when needed.

Identified areas of improvement and progress during 2016/17

The following actions were taken in 2016/17

- Full implementation of **S**enior review, **A**nticipate, **F**low, **E**arly discharges, **R**eact to delays & waits (SAFER) Discharge Bundle.
- Improved accessibility to a stroke ring-fenced bed on both sites.
- Achievement of 80% of stroke patients spending at least 90% of their stay on a dedicated stroke ward.
- In support of right care, right place we have reviewed our bed stock for each clinical speciality. This has resulted in the re-opening of the Maidstone Orthopaedic Unit for elective orthopaedics. Whatman Ward and Ward 20 have been designated as medically fit wards for those patients awaiting onward care. Gynaecology ward has become Ward 33 to care for all surgical female patients.
- Flexible use of inpatient capacity to manage non elective patient flow during periods of increased demand.
- The reallocation of our previous Clinical Decision unit in the A&E Department to become the Rapid Assessment Triage to support the prompt assessment of all patients arriving by ambulance.
- Development of ambulatory pathways of care model in both Trauma & Orthopaedics and Gynaecology.

Initiatives for further action for 2017/18

Key Objectives will include:

- Avoiding unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend our emergency departments.
    - Increase of specialities available on the ambulatory pathway model.
    - Development of frailty units on both the Tunbridge Wells and Maidstone hospital sites.

- Work with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
  - As part of the national CQUIN we aim to improve the pathways of care for patients with mental health needs by reducing the frequency of these attendances by 20%.
- Improved access to ring-fenced beds for Stroke and fractured neck of femur patients.
  - We will work with the speciality leads for both Stroke and Hip Fracture pathways of care to make sustained improvements in the national key performance indicators for each speciality and improve the standards of care.
- Development of pathways that will support the timely discharge of patients.
  - To work in partnership with our Community Trust and Social care partners to develop alternative models of care for our patients.
  - To improve the percentage of non-elective patients over 65 who return to their original place of residence by 2.5%.

Executive lead: Angela Gallagher, Chief Operating Officer
Board Sponsor: Angela Gallagher, Chief Operating Officer
Implementation lead: Lynn Gray, Director of Operations for Urgent Care
Monitoring: LOS Steering Group

Fergus was born three weeks early on 1 February 2016. Diagnosed with Down's Syndrome, his health took a turn for the worse one week after his birth. Here is his family's story …

"On the evening of Saturday 6 February, I noticed that Fergus had become unresponsive and I was struggling to rouse him. He was beginning to feel cool and I couldn't obtain a reading on the thermometer when trying to take his temperature. Recognising that there was a serious problem, and fearing the worst, we rushed him straight to A&E at Tunbridge Wells Hospital."

On arrival, specialist doctors immediately began to examine and treat Fergus. Once he was stabilised, ventilated, had an IV line in and was wrapped in an insulation blanket, Fergus was taken to theatre for x-rays. It was established that there was fluid on his left lung, which explained his difficulty breathing – in essence, Fergus was drowning. Fergus' condition was so serious it was decided to transfer him to the specialist children's hospital, Evelina, in London, where he was admitted to their intensive care unit. Following a scan of his heart, a drain was inserted into Fergus' left lung to commence draining of the fluid and lines were inserted into him to administer medication required to improve his vital signs.

Thankfully, Fergus started to improve, however a subsequent CAT scan indicated a build-up of air in the pleural space around the lung. Urgent treatment ensued to remove the air and stabilise his lung function. "The next target was to get Fergus off the ventilator and breathing independently. This took five days with Fergus initially doing well, but due to his slow progress, he was put on continuous positive air pressure (CPAP) to help support his breathing and enable this to continue." However, the cardiology team involved in Fergus' care found that his VSD (hole in his heart) was now considered to be of moderate size. So, on the day Fergus turned five weeks old he had open heart surgery.

Two weeks after the operation and the cardiology team signed him off and he was handed over to the respiratory team and transferred from the Paediatric Intensive Care Unit (PICU) to the High Dependency Unit (HDU) at the Evelina. Ten days later the family finally got the all clear and Fergus was discharged from hospital. The two-month ordeal was nearing an end and Fergus was coming home!

"We are eternally grateful to everyone who helped with Fergus during what was a really difficult time. We received nothing but the most caring, selfless and professional lifesaving NHS treatment – and it all started over a weekend. If it weren't for the amazing staff on duty that weekend, he would not have survived.

"The wonderful staff at the Evelina London Children's Hospital treated him and nursed him back to health, but the fast and thoughtful actions of the staff at Pembury Hospital undoubtedly saved his life."

They added: "When we look back now and think of all that the teams did for us, we feel so humbled and grateful. We were powerless and had to put our trust in the doctors. It was hard, but their expertise, knowledge and overall unfailing dedication and care saved our son."

For further patient experiences visit-
https://www.mtw.nhs.uk/?s=patient+first

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

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

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

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

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites).
- Diagnostic and screening procedures (at both hospital sites).
- Family planning services (at both hospital sites).
- Maternity and midwifery services (at both hospital sites plus the Crowborough Birth Centre, which was added to the Trust's CQC registration in April 2016).
- Surgical procedures (at both hospital sites).
- Termination of pregnancies (at Tunbridge Wells Hospital only).
- Treatment of disease, disorder or injury (at both hospital sites).

No conditions were applied to the registration.

The Nominated Individual for the Trust's Registration is Claire O'Brien, Interim Chief Nurse (Avey Bhatia was the Trust's Chief Nurse and the nominated individual until February 2017).

During 2016/17 the Trust provided and/or subcontracted acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, Kent County council and NHS England. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or sub-contracting of, NHS services.

Reviewing standards

To ensure that we are providing services to the required standards the Trust supported a number of reviews of its services during 2016/17, undertaken by external organisations such as:

- General Medical Council (GMC) Trainee survey – 22nd March-11th May 2016
- Pearson Standards Verifier Visits – 4th April, 15th & 22nd June, 2016 and 31st January, 10th February, 2017
- NHS Protect Audit, Standard 24 – May 2016
- National Cancer Peer review – CUP- May 2016
- National Cancer Peer review – Anal – May 2016
- Kings Medical School Visit – 2nd June 2016
- Antenatal and Newborn Screening Quality Assurance visit – 14th June 2016
- Quality Surveillance – Acute Oncology – June 2016
- Quality Surveillance – Brain – June 2016
- Quality Surveillance – Urology –June 2016
- Quality Surveillance – Head and Neck – June 2016
- Quality Surveillance – Breast – June 2016
- Quality Surveillance – Colorectal – June 2016
- Quality Surveillance – Lung– June 2016

- Environment Agency (Radioactive substances regulation) – Tunbridge Wells hospital - 7th July 2016
- South East London, Kent & Medway review –Trauma services – 7th September 2016
- Healthwatch Kent – Enter and View of both outpatient departments – 28-29th September 2016
- Environment Agency (Radioactive substances regulation) –Maidstone hospital - 12th October 2016
- Quality Surveillance – Adult Chemotherapy – October 2016
- Southeast Coast Critical Care Network Visit – 21st October, 2016
- Counter Terrorism security advisers (CTSA's)- Pathology – 8th November 2016
- CHKS (ISO 9001:2008, CQC Peer Review) – February 2017
- Quality Surveillance – Paediatric – February 2017
- Counter Terrorism security advisers (CTSA's)- Radiology – 1st February 2017

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

- Internal assurance inspections (CQC style) with participation from our patient representatives
- Internal PLACE reviews
- Infection Control including hand hygiene audits
- Trust Board member "walkabouts"

The outcomes of these are included within our triangulation process to review clinical areas and identify any areas where additional support and actions are required to maintain standards. Reports are scrutinised in the identified committees within our governance structure and where necessary action plans are developed and monitored accordingly.

Hand hygiene audits to check service quality

"The rooms at the hospital were also fantastic. The en-suite bathrooms really helped and the whole set-up gave me privacy and dignity. It's kept spotlessly clean and the attention to infection control is superb. I can't fault a thing and I would say to anyone who finds themselves in the awful position of needing to be admitted to hospital that this is the place you want to be."

For further Patient experiences visit- https://www.mtw.nhs.uk/?s=patient+first

Clinical Audit

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

During 2016/17, MTW participated in 100% of relevant confidential enquiries and 98% of all relevant national clinical audits (1 not submitted to – Ophthalmology). During the same period, MTW staff successfully completed **199** clinical audits (local and national) to action plan stage of the expected **371** audits on the programme to be undertaken. The remaining audits are at various stages of completeness and will be closely monitored through to completion.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2016/17 are presented as follows-

National Clinical Audits for inclusion in Quality Accounts 2016/17	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2016/17 (Any period during 01/04/2016 to 31/03/2017)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	TWH: 500 MAID: 513	100%	
Emergency Laparotomy Audit (NELA)	Y	122		Data collection ongoing.
NAP 6 Perioperative anaphylaxis	Y	3	100%	
Severe Sepsis and Septic Shock (care in Emergency Department)	Y	MGH: 50 TWH: 50	100%	
Society for acute medicine's benchmarking audit (SAMBA16)	Y	MGH: 33 TWH: 18	100%	
Moderate & Acute Severe Asthma – adult and paediatric (Care in emergency departments)	Y	MGH: 50 TWH: 50	100%	
Neurosurgical National Audit Programme	N/A			MTW does not provide this service
National Vascular Registry	N/A			MTW does not provide this service
Severe Trauma (Trauma Audit & Research Network) TARN	Y	545	99%	Data collection ongoing. Awaiting case notes.
National Complicated Diverticulitis Audit (CAD)	N/A			MTW does not provide this service
National Joint Registry (NJR)	Y	MTW: 506 (Knee: 213 Hip: 293)	100%	
Consultant Sign off (Care in the Emergency Department)	Y	MGH: 50 TWH: 50	100%	
BAUs Urology Audits: Radical prostatectomy audit	Y			Data collection ongoing
BAUs Urology Audits: Female Stress urinary incontinence audit	N/A			MTW does not provide this service
BAUs Urology Audits: Cystectomy	Y			Data collection ongoing
BAUs Urology Audits: Nephrectomy Audit	Y			Data collection ongoing
BAUs Urology Audits: Percutaneous Nephrolithotomy (PCNI)	Y			Data collection ongoing

National Clinical Audits for inclusion in Quality Accounts 2016/17	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
BAUs Urology Audits: Urethroplasty Audit	N/A			MTW does not provide this service
ANS and BCN standards for intraoperative monitoring for spinal deformity surgery	N/A			MTW does not provide this service
Breast and cosmetic implant registry (BCIR)	N/A			Breast team will be doing this audit in 2017/18. N/A for 2016/17
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) – Audit of red cell and platelet transfusion in adult haematology patients	Y	39	100%	
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	N/A			Data being collected 2017/18. Currently being collected
Audit of Patient Blood Management in Scheduled Surgery – Re-audit September 2016	Y	28	100%	
Serious Hazards of Transfusion (SHOT) UK. National haem vigilance scheme	N/A			
Cancer				
Lung Cancer (NLCA)	Y	1377	100%	
Bowel Cancer (NBOCAP)	Y	Patient: 310 Tumour: 310 Surgery: 238 Pathology: 173 Chemotherapy: 141		Final date for submission 15/05/17. Data collection ongoing
National Prostate Cancer Audit (NPCA)	Y	Diagnosis: 408 Symptoms: 419 Treatment: 547	100%	
Oesophago-gastric cancer (NAOCG)	Y	Patient: 116 HGD: 6 Tumour: 110 Chemo/Radio:75	100%	
Head and Neck Cancer 2015 (DAHNO)	Y	Patient: 80 Baseline A: 32 Baseline B: 80 Follow up: 0 Non-surgery: 68		
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	TWH:216 MGH: 207	100%	Data collection still open and data being submitted
Heart failure	Y	TWH: 224 MGH: 254	100%	Data collection still open and data being submitted
Coronary angioplasty/ National audit of PCI	Y	MTW: 279	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	MTW: 446	100%	Data collection still open and data being submitted
National Cardiac Arrest Audit (NCAA) 661	Y	TWH: 122 MGH: 105	100%	Data collection still open and data being submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Y	1.Pulmonary rehabilitation**:** 77 2.Secondary care**:** 0	100%	1.Data submitted 2.Data collection only opened Feb 17 data being submitted
Adult Cardiac surgery	N/A			MTW does not provide

National Clinical Audits for inclusion in Quality Accounts 2016/17	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
				this service
Congenital heart disease (Paediatric and Adult cardiac surgery)	N/A			MTW does not provide this service
Pulmonary Hypertension	N/A			MTW does not provide this service.
Long Term Conditions				
Adult Asthma (BTS)	Y	MGH: 18 TWH: 10	100%	
National Adult Diabetes Inpatient Audit (NaDIA) 572	Y	MGH: 54 TWH: 64	100%	
National Diabetes Foot care Audit 622	N/A			Trust patient data currently submitted by the Community Podiatry Team. Will be brought back in house for 2017-18
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MGH: 1 TWH: 0		Amalgamated old web portal with new on-line registry.
UK Cystic Fibrosis Registry (Adults + Paediatrics)	N/A			MTW does not provide this service
Renal Replacement Therapy (Renal Registry)	N/A			MTW does not provide this service
Endocrine and Thyroid National Audit	Y	MTW: 108	100%	
National Core Diabetes Audit (NDA)	Y	MTW: 3657	100%	
Chronic Kidney disease in Primary Care	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Prescribing antipsychotics for people with dementia	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Monitoring of patients prescribed lithium	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Rapid tranquilisation	N/A			MTW does not provide this service
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP)	N/A N/A Y	1.Inpatient Fall (NAIF) 2.Fracture Liaison Service Database organisational data 3. National Hip Fracture Database 563		1. No data collection in 2016-17 2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted
National Audit of Dementia	Y	1.Organisational 2.Clinical data MGH: 50 TWH: 50	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	1. Organisational 2. Clinical Data MGH: 322 TWH: 345	100%	1. Organisational data submitted 2. Data collection still open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein		Hip: 393 Knee: 403 Groin: 433 Varicose: 0	100%	
National Ophthalmology Audit	N			Registered to

National Clinical Audits for inclusion in Quality Accounts 2016/17	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
				participate. Still awaiting software link from Royal College to upload data.
Smoking Cessation	Y	MGH: 50 TWH: 46	96%	Some notes unavailable
Learning Disability Mortality Review Programme (LeDeR)	N/A			Staged introduction across England
Mental Health				
Prescribing Observatory for Mental Health (POMH-UK)	N/A			MTW does not provide this service
Suicide and homicide and sudden unexplained death	N/A			MTW does not provide this service
Women's and Children's Health				
Neonatal Intensive and Special Care (NNAP) 67	Y	MTW: 669	100%	
MBRRACE-UK; National surveillance and confidential enquiries into maternal deaths	Y	MTW: 0	100%	At present none of our patients fulfil the criteria requirements.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	Stillbirth: 16 Neonatal: 1 Extended Perinatal:17	100%	
MBRRACE-UK; Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	N/A			MTW does not provide this service
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) 495	Y	Stillbirth: 22 Neonatal: 3 Extended Perinatal: 3 Intrapartum: 8	100%	
Paediatric Inflammatory Bowel Disease	Y	TWH: 0		At present none of our patients fulfil the criteria requirements.
National Maternity and Perinatal Audit (NMPA)	Y	11,659	100%	Organisational survey data also submitted
Paediatric Intensive Care (PICANet)	N/A			MTW does not provide this service
National Pregnancy in Diabetes Audit	Y	MTW: 16	100%	
Paediatric Pneumonia	Y	MTW: 36	100%	Data submission still open.
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 131 MGH: 114	100%	
Paediatric Asthma (BTS)	Y	MTW: 27	100%	
National Confidential Enquiries				
Non Invasive Ventilation	Y	2	50%	
Heart Failure	Y	N/A	N/A	Patient data submitted to NCEPOD waiting for patient selection process for peer review.
Cancer in Children, Teens and Young Adults	Y	N/A	N/A	Patient data submitted to NCEPOD waiting for patient selection process for peer review.
Child Health Clinical Outcome Review Programme: Chronic Neuro-disability	Y	5	50%	Data collection still ongoing
Child Health Clinical Outcome Review Programme: Young Peoples Mental Health	Y	3	43%	Data collection still ongoing

41 national audits were published in 2016/2017 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including:-

Trauma & Audit Research Network (TARN)

Rehabilitation Prescriptions have now been developed and implemented; these put in place a package of on-going post-op rehabilitation for a maximum 4 weeks and allow patients to return to their own home, as opposed to temporary accommodation or community hospitals, enabling earlier discharge from hospital and treatment in a more comfortable environment. Highlighting the process of expediting patients to CT scan has led to a substantial improvement in patients with head injuries being scanned within the 60 minutes recommended in the NICE guidance, this enables a quicker diagnosis and where applicable, prompt transfer to King's College Hospital for specialist treatment.

Emergency Laparotomy Audit (NELA)

We have introduced an emergency laparotomy pathway comprised of 6 evidence based steps to improve care for these patients. This involves screening of patients using PAR scoring, lactate measurement and calculation of pre-operative risk; sepsis screening with early antibiotics where indicated; theatre within 6 hours of a decision to operate; goal directed fluid therapy in theatre, critical care for all patients postoperatively and consultant delivered care. Compliance with the bundle has steadily improved and there has been a significant reduction in mortality which sits comfortably below the national average (7.2% vs 11.1%).

MBRRACE-UK Saving Lives, Improving Mothers Care; Surveillance of Maternal Deaths 2012-2014

The Trust has invested in an outreach team which is now available 24/7. The maternity service has an excellent relationship with the outreach team and they review the HDU patients as a priority so that each woman is risk assessed to see if it is appropriate to continue care onsite. If the woman needs to be transferred to a tertiary unit, this will always be to a London Hospital which has obstetric services which would comply with the principle "one transfer to definitive care".

British Thoracic Society (BTS); National Paediatric Asthma Management 2015

Ongoing audit reviews demonstrate that the care of children with acute asthma continues to be efficient and effective; with initial assessments being performed on all asthma patients; and the provision of $Beta_2$ agonists being used as the first line treatment. Mild - moderate asthma patients, all receive salbutamol via MDI and spacer. Severe asthma patients (oxygen Saturation level <92%) all receive nebulisers. These interventions form part of the best treatment guidance advocated by the British Thoracic Society.

National Pregnancy in Diabetes Audit (NPID) 2015

The Midwifery Diabetic Team have improved early communication regarding specialist support by producing a clear pathway and implementing the diabetes in pregnancy pathway once pregnancy is disclosed by the woman to her GP. All women are seen within 1 week at the combined antenatal diabetic clinic and commence the pathway of 2 weekly visits once pregnancy disclosed. Women who have been identified to be part of the pathway benefit from being closely monitored which has the potential for reducing lasting effects on the baby. Women who attend for their diabetes appointments and are of childbearing age are offered family planning advice. MTW maintains a high level of research based practice.

Please see Appendix A for full details of progress against each of the reported national audit results 2016/17

Service Improvements

A number of improvements have been made as a result of the 147 completed local clinical audits, across all Directorates, in 2016/17, 51 of these were local re-audits. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through a systematic review against explicit criteria. Improvements include:

Actions taken following local audits	Trust Actions
Palliative Care Team	The decision to make a DNACPR order for a patient is an important and often challenging one. These results demonstrate evidence in improvement in a number of areas since the last audit in 2015, in particular the accurate use of patient identifiers and the number of records that include documentation of a conversation with the patient's next of kin. The audit also shows evidence of continued good practice in both completion of the section on clinical information regarding the reason resuscitation would not be appropriate and in obtaining an authorising signature. Cross boundary working has also positively progressed, with a rise in the presence of DNACPR forms brought in by patients from the community.
Tissue Viability	Pressure ulcers are a complex health problem arising from many interrelated factors. Prevention and treatment are paramount to ensure patient comfort and care. Actions from the previous round of the audit include: A Trust-wide education campaign to reduce the overall numbers of moisture associated skin lesions. Working with individual wards to raise knowledge of pressure damage prevention and treatment. A rapid review process of all category 2 ulcers by the Tissue Viability Service is in place. These actions have led to a sustained and continued improving picture in the reduction of pressure damage.
Infection Control Team	The Infection Prevention team developed a sticker to be placed in the patient notes on diagnosis of CDT (Clostridium Difficile associated diarrhoea) enabling a more consistent approach for the management of patients. This has been well evaluated as it is easy to see when in situ. If a patient is diagnosed over the weekend the sticker would be placed in the notes the next working day. This raises awareness to other health professionals. The audit shows that the care pathway is strongly embedded into everyday practice.
Ophthalmology	Actions from the previous round of this audit include the department hiring a clerk to call patients two weeks prior to surgery to confirm the patients' attendance and elicit any concerns. A TCI letter specifically reminded patients to stop their anti-platelet drugs as instructed at pre-assessment clinics. If patients cancel when contacted then this allows sufficient time to re-book another patient therefore reducing costs and optimising theatre time efficiency. Our results show a significant improvement in the rate of theatre cancellations and the new measures have consequently reduced costs and optimised theatre time efficiency. This is also beneficial to patients who can be slotted into any cancellations reducing their waiting times.
Paediatrics	Delay in treatment of children with suspected neutropenic sepsis can cause rapid deterioration and can potentially cause overwhelming sepsis and death. As a result of the last audit an Oncology Admission Proforma was introduced and has shown to have improved clinical response to a febrile oncology child as Medical and Nursing response times have improved and the percentage of antibiotics given within 1 hour has increased.
Cardiology	The cardiology team have introduced a new online request form which helps the clinicians (requesting the echo) to mention the appropriate indication by triaging the echo request according to British Society of Echocardiography (BSE) criteria. Since then the number of inappropriate referrals has significantly reduced. This has led to improvement in patient care now that we are prioritising and categorising all the echo's – this enables us to identify the truly urgent scans without any delay.
Respiratory	Audits were carried out into the management of Pleural effusions. Following these audits a proforma was introduced which included all the initial steps in the management of pleural effusions according to BTS guidelines. Junior

Actions taken following local audits	Trust Actions
	doctor education is carried out at every rotation in the use of this proforma and in the use of ultrasound guided aspiration. A new ultrasound machine is now available on the Respiratory wards. This ensures identification of a diagnosis swiftly and logically, to minimise unnecessary invasive investigations and minimise hospital stay.
General Surgery	Our previous audit found that only 32% of Barrett's Oesophagus cases with endoscopic diagnosis had a Prague classification. In our re-audit of the Barrett's specific list, we found that 100% had an appropriate classification therefore meeting our audit standard. In order for correct surveillance pathways to be allocated to patients, the diagnostic criterion needs to be met. In our first audit we highlighted a lack of defining Prague criteria at endoscopy and a suboptimal result in terms of quandrantic biopsies being taken (when the clinician was able). We can now demonstrate that the use of a Barrett's specific list will allow these standards to be met. This then allows the clinicians to make appropriate decisions with their patients regarding follow up

Enhancing Quality and Enhanced Recovery Programme

Clinical teams across Kent, Surrey & Sussex (KSS) agreed a number of key clinical interventions that should happen when a patient has been admitted across a number of clinical pathways as part of the Enhancing Quality (EQ) and Enhanced Recovery Programmes (ERP). The Enhancing Quality pathways include Community Acquired Pneumonia, Heart failure, Chronic Obstructive Pulmonary Disorder (COPD) and Fractured Neck of Femur. For each of these pathways there are a number of performance measures to attain that demonstrate compliance of the key quality indicators. These quality measures pulled together are regarded collectively as a 'care bundle'. It has been clinically proven that delivery of the full 'care bundle' improves the patients' outcomes.

Enhancing Quality
Community Acquired Pneumonia (CAP)
MTW performance is in line with KSS regional average for the Community Acquired Pneumonia Pathway; with key outcomes reported for mortality having decreased over the 6 years reported by 5% from 23% to 18% and also 30-day readmissions significantly below the regional average. Length of stay varies between 8 and 11.4 days which has been consistently in line with the regional average.

Heart failure
The measures selected for Heart Failure are aligned to the National Heart Failure Audit and support greater compliance with NICE guidelines and quality standards. Throughout the course of the heart failure programme, MTW's performance for Length of Stay (LOS) and 30-day readmissions are in line with the regional average. The rates of Heart Failure Admissions range from 5.6 to 10.2 (per 1,000 Trust admissions); which is below average for heart failure admissions as a proportion of total Trust admissions. The Appropriate Care Sore performance score measures, the percentage of patients who receive the full care bundle. MTW performed above the regional average at 93%. Mortality rate for MTW heart failure patients has risen to 17%, this is reported as the highest in the region.

Chronic Obstructive Pulmonary Disorder (COPD).
MTW performance since implementation of the programme has been significantly above the regional average in this pathway, with approximately 75% of patients receiving the full 'care bundle'. In hospital mortality rates vary between 1.5% and 6%. MTW mortality is average for the region. Average length of stay is dispersed varying between 4 and 7.5 days which is longer than average, however the 30 day re-admission rates are below the regional average

Fractured Neck of Femur
The best practice tariff (BPT) for hip fracture came into effect in April 2010, meeting the commitment to High Quality Care for All, Lord Darzi's NHS Next Stage Review report. Meeting the BPT offers a financial incentive to improve care. The best practice measures have been selected in line with British Geriatrics Society (BGS) and National Institute for Health and Clinical Excellence (NICE) guidelines and are designed to ensure the patient recovers as quickly and as fully as possible. Compliance against standards are recorded on the National Hip Fracture Database (NHFD).

Maidstone and Tunbridge Wells NHS Trust is one of the busier hospitals with a higher number of hip fracture patients then most of the other participating hospitals within the region. NHFD monitoring compliance outcomes indicate MTW mortality rate, readmission rate and length of stay as average for the region.

TARN – The Trauma Audit and Research Network
TARN was established in 1988 after a number of recommendations were made for improvement in the care of trauma patients. Data is collected in order to monitor and compare Trauma Management in and between participating hospitals. Observations and interventions from the time of the accident, pre-hospital care, Emergency Department, ITU, imaging and operations are submitted together with diagnosis, past medical history and rehabilitation details. Participation is mandatory to maintain our status as a Level 2 trauma unit.

The Maidstone and Tunbridge Wells NHS Trust submit approximately 500 trauma patients per year to TARN, which is above regional numbers of 200 – 300 patients submitted. TARN use coding information to assess how many injuries meet TARN criteria for each hospital, and then report the number of expected submissions in comparison to the number received as a percentage. Submissions from Tunbridge Wells are now at 73%. Tunbridge Wells has led on the inclusion of Rehabilitation Prescriptions in TARN submissions, one of the only Trauma Units in the country to be undertaking this remit.

Emergency Laparotomy
The Emergency Laparotomy Collaborative (ELC) is led by the Kent, Surrey & Sussex Academic Health Science Network (KSS AHSN) with an aim to provide support in improving emergency laparotomy care and also to deliver quality improvement training. The Care Quality Score (CQS) performance score identifies the number of measures passed by each patient. MTW CQS performance was above average for the region. Admission rates across the region range between 0.7 to 3.4 admissions per 1,000 Trust admissions. MTW admissions are below average. Average length of stay is dispersed across Trusts and varies from 14 to 24 days, with MTW demonstrating an average of 20 days.

Enhanced Recovery Programmes (ERP)
Enhancing Recovery includes three elective pathways; Colorectal, Gynaecology and Orthopaedics. The aim for these pathways is to improve outcomes including reduced length of stay and readmission rates. All ERP Pathways have the following measures in common; pre-operative assessment; planning and preparation before admission; reducing the physical stress of the operation (by using minimally invasive techniques and preventing hyperthermia); a structured approach to immediate post-operative and peri-operative management (including pain relief, postoperative nutrition and early mobilisation). Making patients active in their own recovery and planning means that the patients are better prepared to cope when they are back at home. Care Bundles when performed consistently and fully, have been clinically proven to improve patient outcomes.

The enhanced recovery project team continued its focus on increasing the numbers of patients going through each of the pathways and reviewed and reported each care programme monthly via

the Trust Clinical Governance committee. This work continued until December 2016 when the national data collection process ceased.

Orthopaedics
The Appropriate Care Score (ACS) performance measures the percentage of patients who receive the full care bundle. MTW has historically performed in line with the regional average but performance has been variable over the last 12 reported months. Admission rates have ranged from 5.9 to 15.1 orthopaedic admissions per 1,000 Trust admissions, which can be explained by the periods of increased non-elective flow. MTW orthopaedic admissions are below average for the region. Length of stay for orthopaedic patients is largely consistent across Trusts with a regional average of 4.2 days.

Gynaecology
MTW ACS performance score measures have been consistently above the regional average throughout the course of the programme, although 2016 has seen considerable variation throughout the year with lower than average outcome noted for those receiving the full care bundle. MTW's rate of admission was above average for the region. Length of stay has decreased over the course of the programme by 1 day and is now an average of 3 days.

Colorectal
The ACS performance score measures the percentage of patients who receive the full care bundle. There is considerable variation between Trusts in performance over the last 12 months. MTW performance has historically been consistent with the regional average at 60% but has declined in recent months. Colorectal admission rates have remained consistent across Trusts, however MTW saw slightly higher than average admissions in the reported period at 2.5 admissions per 1,000 Trust admissions. MTW's length of stay was the highest in the region at 11.5 days.

NICE Guidelines

Every year the National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. NICE's role is to improve outcomes for people using the NHS by producing evidence based guidance and advice and monitor compliance through set quality standards and performance metrics.

MTW review all published guidelines produced by NICE to identify those which are relevant to the care we provide to our patients. Clinical audits are then undertaken on those guidelines identified as being relevant to assess the Trust's compliance. These clinical audits focus on a number of key quality standards; that are designed to drive measurable service improvement to enhance practice and the care of patients. At the end of 2016/17 there have been **1204** NICE guidance documents disseminated to the specialty leads throughout the Trust. Of those, **1164** (**96.7%**) have been evaluated. **430** (**36.9%**) of the evaluated guidance are relevant to the Trust. The breakdown is shown in the table below.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (NICE CGs)	**253**	**223**	**102**
Interventional procedures (NICE IPGs)	**515**	**487**	**74**
Technology Appraisals (NICE TAs)	**436**	**387**	**159**
Totals	**1204**	**1097**	**335**

Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2016/17.

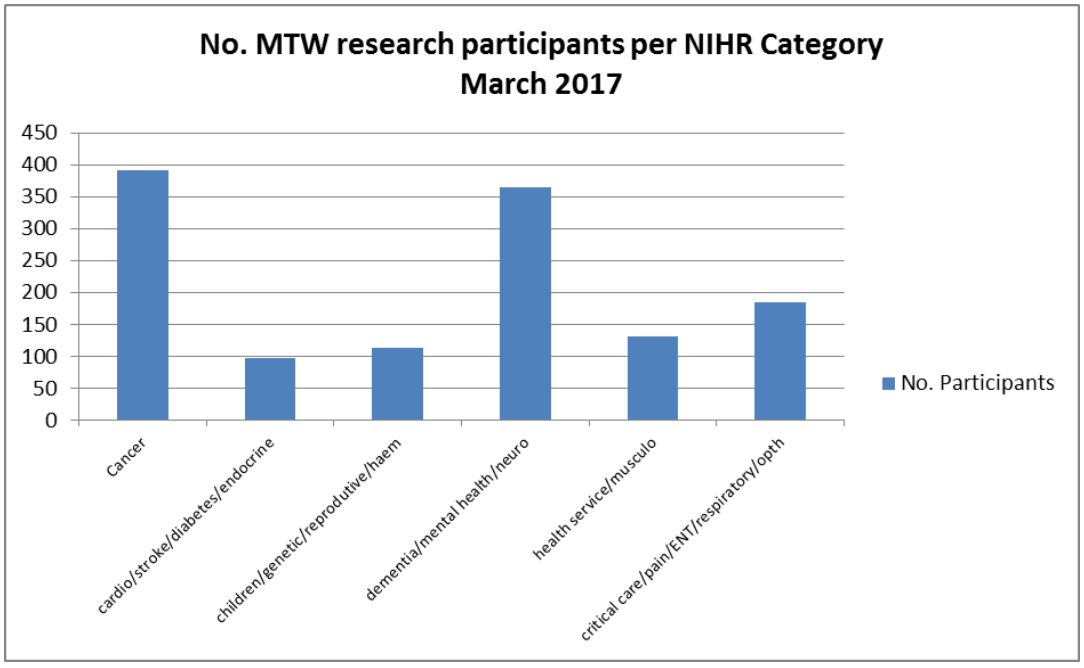
Research

Participation in clinical research

Maidstone and Tunbridge Wells NHS Trust (MTW) understands the importance of being a research active organisation. Not only is it a central requirement within the NHS Constitution, it is also a patient priority.

Participation in clinical research means patients can get access to new treatments, interventions and medicines and investment in research can mean better, more cost effective patient care.

In 2016/17 MTW played a key part in delivering the national research agenda by recruiting 1171 patients to studies that required a review by the National Research Ethics Service (NRES) from a total of 1535 people recruited to trials. MTW met its recruitment target of 1250 people, as set by the Kent, Surrey and Sussex Clinical Research Network (KSSCRN). Successful recruitment during the year was as a result of a full complement of delivery staff in all research teams and an improved, speedier expression of interest process to secure large recruiting studies early.



Recruitment by NIHR specialty grouping

The highest recruiting research areas in MTW during 2016/17 were oncology and mental health as they both ran high recruiting studies – DETECT-1 and the Self Declaration of Compassion Survey.

Trust Clinical Lead for Research and Development

During 2016, Maidstone and Tunbridge Wells NHS Trust successfully appointed a new Trust Lead for Research and Development, Mr Alastair Henderson, Consultant Urological Surgeon. Alastair took up the role in July 2016 and has already been instrumental in promoting research both within and outside the organisation. He is Principle Investigator for the urology study, DETECT 1, the second largest recruiting study at MTW during 2016/17.

Mr Alastair Henderson
Trust Lead for Research & Development

Patient Public Involvement

The Research and Development Department believes patients and their carers' and relatives should be partners in research activity. During 2016, MTW's patients played a central part in research set up and delivery. The Elective Peri-Operative Isometric Exercise Programme (EPOP) surgical study (looked at designing an exercise regime to boost post-operative recovery) methodology and resulting exercise programme was developed by patients and clinicians working together. MTW also supported the National Institute of Health Research National Patient Survey, seeking the experiences of patients who have joined our trials. The results of this survey will be available in early May, 2017 and will inform how studies are delivered in the future.

"The trial at Maidstone Hospital was actually a very good experience. I was monitored very carefully and very frequently, which was time consuming but also helpful and reassuring. It was also very interesting to be part of a clinical trial and to feel like I was contributing to the development of medicines, and potentially helping people in the future."

For further patient's experiences visit-
https://www.mtw.nhs.uk/?s=patient+first

In January 2017, the Research and Development Manager and Research Patient Representatives from Maidstone and Tunbridge Wells NHS Trust and Kent Community Health Foundation Trust delivered a Patient and Public Involvement (PPI) workshop to staff across Kent and Medway. The workshop was part of a conference held at the University of Kent, developed and delivered by research staff from NHS organisations across Kent and Medway. The purpose of the workshop was to discuss cross-organisation working to promote PPI in research. Ideas from this workshop are shaping how the Trust works with their peers to that the needs of our patients remain central to the research that we undertake.

A Diverse Research Delivery Team.

During 2016/17 the research and delivery team has grown to meet increasing recruitment and diversity of studies. The research team has been boosted by the addition of an ophthalmic research practitioner who is medically trained. This Research Practitioner has a dual role by supporting the delivery of ophthalmic trials and preparing an MTW research project for adoption onto the National Portfolio of studies. A number of MTW nurses have also joined the research team, on a part time basis, to gain more knowledge and practical research experience. The research nurse role compliments our Trust's many nursing roles perfectly.

Research governance has been further strengthened by a junior governance officer joining the research governance team. This role has helped to expedite the set-up of trials across the organisation.

Research Nurse Wendy Milligan, Governance Officer Clare Calvert and Research Practitioner Dr Meriam Islam

Within oncology research, each tumour group now has a dedicated team of research nurses and a dedicated Clinical Trial Administrator to facilitate an efficient commencement and effective delivery of new trials. The new Haematology Lead Research Nurse, which was historically a dedicated oncology research role, has now been expanded to work across oncology and non-oncology research and has a team of delivery staff to support this.

The increase in delivery staff has enabled more patients to be recruited to studies at the Tunbridge Wells Hospital, particularly in haematology, critical care, trauma and orthopaedics and breast cancer. Increasing the number of studies opened at The Tunbridge Wells Hospital is a strategic aim for the forthcoming year.

Awarding excellence in research

The National Institute of Health Research awarded 10 consultants at Maidstone and Tunbridge Wells NHS Trust extra funding during 2016 for exceeding recruitment to trials, across a range of specialties. This additional funding has supported additional research nurse hours thereby increasing recruitment to trials and allowed a number of delivery staff to attend research conferences and participate in research training.

Goals agreed with commissioners

CQUINS

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

In 2016/17 2.5% of the contract value was dependent on achieving the CQUIN targets for CCGs and 2.0% was for NHS England in line with the CQUIN payment framework.

Within the commissioning payment framework for 2016/17 quality improvement and innovation goals were set as indicated in the table below.

CQUINs	Target	*Achieved (local data)	RAG Rating
National CQUINs (CCGs)			
Introduction of health and wellbeing initiatives; Physical Activities, Fast-Track Physio, Mental Health Initiatives such as Stress Management	Evidence of 3 initiatives promoted	100%	Green
Healthy Food for NHS Staff, visitors and patients; banning of a) price promotions b) advertising c) banning from checkouts of sugary drinks and foods (HFSS) d) Ensuring availability of healthy options	Delivery of four outcomes agreed with CCG	80%	Amber
Improving the uptake of flu vaccinations for frontline medical staff	65-74.9%= 80% >75%=100%	66.6%=80%	Amber
Timely identification and treatment for sepsis in emergency departments; percentage of eligible patients screened for sepsis.	90%	100%	Green
Sepsis ;% of eligible emergency patients with SEPSIS given intravenous antibiotics <60mins	Q1 = 65%, Q2 = 70%, Q3 = 75%, Q4 = 80%	Q1=71.4%, Q2=72.9%,Q3 =78.3%,Q4= 89%	Green
Timely identification and treatment for sepsis in acute inpatient settings; percentage of eligible patients screened for sepsis	Q1 establish baseline; Q2=55%;Q3=65 %Q4=70%	Q1 achieved; Q2=63.1%;Q3 =72.2%; Q4=77%	Green
Sepsis; 0% of eligible inpatients with SEPSIS given intravenous antibiotics <60mins	Q1 establish baseline; Q2=50%;Q3=55 %Q4=60%	Q1 failed; Q2=90%Q3=1 00%;Q4=100 %	Amber
SEPSIS % of eligible emergency patients or Acute Inpatients with SEPSIS reviewed <3 days	90%	100%	Green
Reduction in antibiotic consumption per 1000 admissions 1) total antibiotic consumption 2) Total consumption of carbapenem 3) total consumption of piperacillin-tazobactam	Reduction of 1% against baseline	100%	Green
Empiric review of antibiotic prescriptions	Q1 establish process; Q2=50%;Q3=75 %Q4=90%	Q1 achieved; Q2=72%Q3=8 5%;Q4=91%	Green
	Target		

CQUINs	Target	*Achieved (local data)	RAG Rating
Local CQUINs (CCGs)			
Medication Safety Thermometer; increased reporting of organisation medication errors and embed systems of learning from these errors and improving practice	100% of audits completed on 10 wards & demonstrate 2 areas of improvement	92%	Amber
Stroke Early Supported Discharge (ESD); to be supporting a fully functioning multi-disciplinary ESD team which has 7 day service coverage and has both quality and length of stay improvements for patients and carers; 10% reduction in LOS from 1516 baseline by Quarter 4 - Full Year; Carer Survey and Patient Experience Surveys carried out; Care Plan Audit Undertaken	20.2 LOS & audits submitted	100%	Green
Patient Flow; improving patient flow by using microsystems and a quality improvement programme; 4 microsystems identified in 4 wards and booklets submitted as evidence	16 microsystems evidenced	100%	Green
Domestic Abuse; Develop Training, Introduce a system to identify and flag on systems those who may be abused or other vulnerable patients, Introduce DASH Risk Assessment in A&E, Set up Domestic Abuse Champions, be involved in Kent Domestic Abuse Health Subgroup.	Identification of Eligible Patients	100%	Green
ED Hour to Access; arrival time in ED to contact with decision making clinician <60 mins	Q1 establish process; Q2=50%;Q3=55 %Q4=60%	100%	Green
NHS England CQUINs	**Target**		
Enhanced Supportive Care (ESC) Access for Advanced Cancer Patients; Audit of % of patients referred to Supportive Care Team out of total number of new diagnosis of incurable disease, Clinical Champion Nominated and engagement with National Peer Group	Establish process & audit	100%	Green
Clinical Utilisation Review (CUR) Installation and implementation; reduction in inappropriate hospital utilisation; Quarterly Reports on Progress and Delays pre go live, Quarterly data output reports post go live	Establish process and rollout of system	100%	Green
Activation System for Patients with Long Term Conditions (LTC's)- Chronic Obstructive Pulmonary Disease (COPD) and Irritable Bowel Syndrome (IBD) 1). Planning & Set Up - Year 1. 2). Team Building. 3). Elicitation of Activation information via the PAM. 4). Analysis & response	300 questionnaires	100%	Green
Adult Critical Care Timely Discharge; to reduce delayed discharges from Intensive Care to ward level care by improving bed management in ward based care, thus removing delays and improving flow. 30% reduction over the year in >24hr delayed discharges from Critical Care. 2014/15 baseline	30% reduction	50%	Amber

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2016/17, including what we have achieved and what has challenged us.

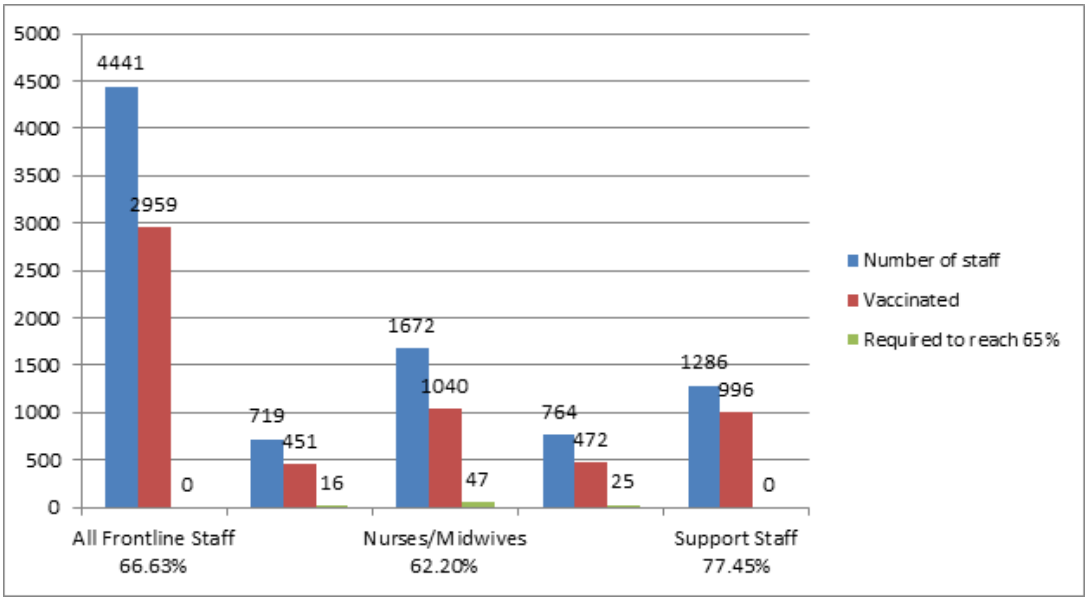
National CQUINs:
The Trust successfully achieved the National CQUIN to ensure the appropriate identification and management of patients, who attended Accident & Emergency or were later diagnosed with SEPSIS as an inpatient, with the exception of Quarter 1 for the identification of Sepsis in the inpatient category. This was due to a failure to identify any inpatients in the random sample which did not meet national guidance, hereafter we strengthened the processes and consistently achieved the stretch targets set. This work has been achieved through the co-ordination and multi-disciplinary team working of the SEPSIS committee and the enthusiasm of our staff. This agenda has ensured that the pathways and protocols for Sepsis have been reviewed and the introduction of a SEPSIS sticker to support our medical and nursing teams in its prompt treatment whilst improving patient outcomes.

"The one piece of advice I have for others is to be aware of the symptoms of sepsis. I knew nothing about it before this happened to me but the reality is, it kills more people than a lot of more widely understood illnesses. I am very keen to raise awareness of sepsis wherever I can – the more people who are aware of the condition, the more lives may be saved."

"I would like to take this opportunity to thank everyone involved in my care, but particular thanks must go to the paramedics, doctors and nurses that worked tirelessly to treat me, because they quite literally saved my life."

For further patient's experiences visit-
https://www.mtw.nhs.uk/?s=patient+first

Ensuring that our frontline staff were immunised for flu this year was particularly challenging as the maximum we'd previously achieved was 45% in 2015/16. The efforts made in collaboration with our Communications team helped to raise some competitive spirit within our workforce and thereby ensuring that 66.6% of our frontline staff were immunised for flu. This was a tremendous achievement with the additional benefits of reducing sickness and protecting and caring for our patients at the same time.



Frontline Staff Immunised for Flu Sept-Dec 2016

Local CQUINs:

The Trust has also made significant improvements in the number of patients seen by a decision-making clinician within 60 minutes of arrival in the Emergency Department exceeding the national target of 50% at 60.02% for the year. This was a target that we had failed to achieve last year so

this year our Emergency department team introduced several initiatives to ensure our patients were promptly seen and treated. These initiatives included a revised rapid assessment model and a review of the staffing model to complement the rising demand for emergency care at peak times and days of the week, all of which supported us in this achievement.

The Stroke Early Supported Discharge (ESD) Teams have worked successfully in collaboration with the Stroke Multidisciplinary Team in ensuring safe and effective discharge of our patients. This has been evidenced through our improvements in reducing the Length of Stay for Stroke Patients by 10% to an average 19.52 days and through the patient and carer's experience surveys that were undertaken. We also undertook an audit of the health and social care plan and made subsequent improvements to this document which we are confident will benefit our patient's further.

We have also worked collaboratively with West Kent CCG in regard to 'Improving Patient Flow' within four of our wards, two at Tunbridge Wells and two at Maidstone hospital. The CCG provided microsystem coaches to work with each multidisciplinary team to identify four areas of improvement that they each felt would benefit our patients and make further efficiencies in their pathways of care, these have included the establishment of 'Board Rounds' to expedite actions that will make the greatest impact on that patient's care, improving transfer times to the Discharge lounge on the day of discharge, improving pre-operative nutrition and improving communication between teams and specialities. Both the Trust and our Commissioners were complimentary of the benefits achieved through this collaboration and the insight that this gave them. This has also established firm grounds for future projects together to improve patient care.

NHS England CQUINs:

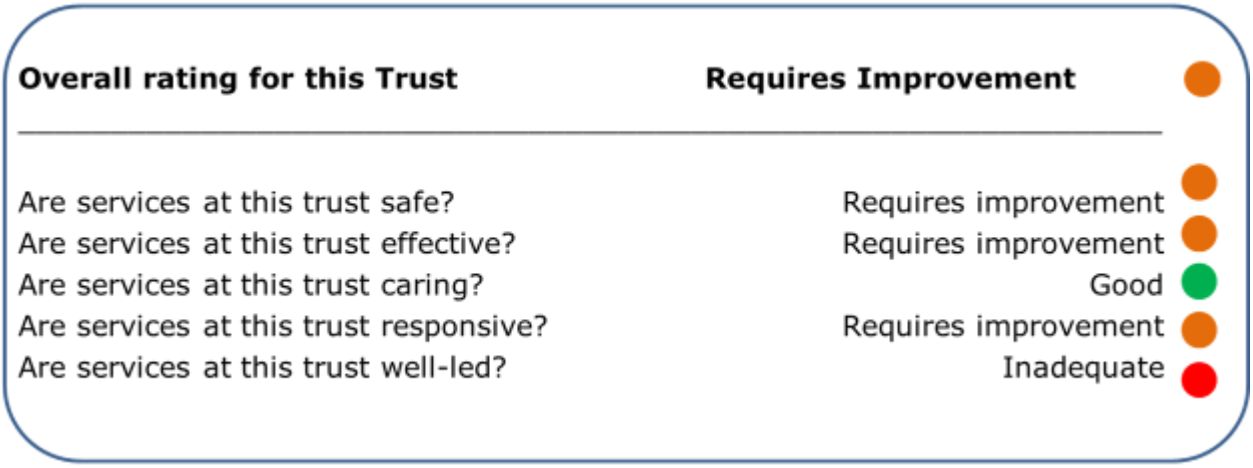
The Trust successfully achieved all of the NHS England CQUINs with the exception of the reduction in length of stay of less than 24hrs in Adult critical Care. This CQUIN concentrated on the Trust's ability to discharge medically fit patients to an acute ward within 24hrs. Due to a spike in activity in the summer of 2016, the Trust did not achieve the milestones set in Quarter 1 & 2, however we successfully achieved the milestones set in Quarter 3 & 4 and showed a remarkable improvement across the year, which also improved our effectiveness in patient flow and patient experience.

The CUR CQUIN has proved to be difficult to manage due to the prolonged delay in the installation of our new Patient administration system. However a decision was made in Q3 to install CUR onto the existing system and thanks to the great efforts made by our staff we were able to ensure that CUR was implemented across 400 beds by the end of March 2016.

Staff encountered numerous information technology (IT) issues in submitting the data to NHS England for the Long-term Conditions (LTC) CQUIN. However not only has the Trust met the milestone of 300 questionnaires for the LTC of Chronic Obstructive Pulmonary disease (COPD) and Irritable Bowel Disease (IBD), but it has met all other aspects of the CQUIN to the satisfaction of NHS England.

Statements from the CQC

The Trust was inspected in October 2014 with the report published January 2015.
Overall the rating for the Trust was 'Requires Improvement'



The CQC inspection findings concluded with 1 enforcement notice and 18 compliance actions. The Trust welcomed the report and considered its findings to be fair. A Quality Improvement Plan was developed and progress was monitored at Board.

The enforcement notice relating to annual water sampling for legionella was responded to immediately with actions undertaken to address the issue and ensure governance is now in place to prevent the risk of re-occurrence. The CQC visited Maidstone hospital on 30th June 2015 to review evidence submitted in practice and the enforcement notice was lifted by the CQC In September 2015.

There have been a number of substantial improvements since the report was published. These include:

- The appointment of a dedicated Staff engagement and Equality lead.
- New provider of Translation services is in place.
- Consultant working patterns in ITU are fully compliant to ICU standards and include twice daily ward rounds every day.
- Critical Care outreach service is in place 24/7.
- A revised governance committee structure was implemented with a clear ward to board communication/ escalation process.
- Paediatric Early Warning system is utilised in paediatric services including paediatric A&E.
- Water hygiene management is now fully compliant with statutory requirements with robust governance and management in place.
- Shower and toileting facilities are in place for our patients in ITU.
- Review of the functionality of both Clinical Decision units in A&E so that privacy & dignity standards now meet compliance.

The Quality Improvement Plan was finally accepted and closed at Trust Board in May 2016, however ongoing work in terms of CQC preparedness and internal scrutiny via the Trust Internal Assurance inspections remains as part of our day to day business and is monitored through the Trust's Quality Committee.

Improving data quality at MTW

Maidstone and Tunbridge Wells NHS Trust is committed to providing services of the highest quality.

Specifically, MTW needs to ensure its information is:

- Consistently captured;
- Recorded accurately;
- Securely shared within the boundaries of the law.

High quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

The Trust develops a workplan for the Data Quality Steering Group annually which is influenced by national and contractual data quality standards as well as local initiatives for targeted improvements.

Recommendations and remedial actions are discussed and forwarded to appropriate areas.

Areas identified for improvement during 2016/17 were:-

- the use of the NHS Number within the Trust as the primary identifier
- Continue an on-going program of data quality workshops for staff based on targeted areas for improvement.

NHS Number and General Medical Practice Code Validity
Data quality is also monitored for each submission the Trust is required to make throughout the year to NHS Digital, Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient‘s valid NHS number was (as at Month 11):
  99.1% (98.9% 15/16) for Admitted Patient Care;
  99.3% (98.4% 15/16) for Outpatient Care; and
  97.1% (96.0% 15/16) for Accident and Emergency Care.

The Trust has developed a data quality dashboard to assist service managers and clinicians.

Information Governance Toolkit

The Information Governance Toolkit is a performance tool produced by the NHS Digital (formerly the Health and Social Care Information Centre). It draws together the legal rules and central guidance related to Information Governance. The Trust achieved a score of 74% (72% in 2015/16) satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 14, and achieved 10 (8 in 2015/16) of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the Operating Framework for England for 2011/12.

The Trust reviews its Information Governance Management Framework on an annual basis. This is to ensure that all the information the Trust holds is managed, handled, used and disclosed in accordance with the law and best practice. An action plan is developed each year to address the areas of weakness identified and progress against the action plan is monitored by the Information Governance Committee which is chaired by the Trust Data Protection Officer. The Trust Board is kept fully apprised of Information Governance issues affecting the organisation.

The Trust has an action plan in progress to continue to improve its compliance with the Information Governance standards.

Clinical Coding

Maidstone and Tunbridge Wells NHS Trust employs a team of appropriately qualified staff to code patient care episodes and associated clinical data. This coding it independently audited to ensure that the coding reflects the patient's diagnosis and treatment.

In 2016/17 a **Clinical Coding audit and process review** was undertaken by Maxwell Stanley Ltd on behalf of MTW which was released in March 2017. The audit scored the Trust at Level 3 using the IG Toolkit's scoring mechanism. The recommendations within the audit report have been fed into an action plan to address the issues identified.

Attainment Levels	
0	Work has begun to develop the policies, procedures and/or processes that are necessary to become compliant
1	Work has begun to develop the policies, procedures and/or processes that are necessary to become compliant
2	there are approved and implemented IG policies and procedures in place that have been made available to all relevant staff
3	staff compliance and the effectiveness of the policies and procedures is monitored and assured

Errors may occur when a clinical coder translates the written information provided by a clinician regarding a patient's diagnosis and treatment into standard codes. These codes are nationally and internationally recognised and are used by healthcare professionals and researchers to check on the outcomes of a patient's diagnosis and treatment and compare it to other patients and organisations in other parts of the country and abroad.

Part Three

Results and Achievements for the 2016/17 improvement initiatives

Patient Safety

Aim/Goal

To improve the dissemination of learning from serious incidents and complaints to drive improvement across the organisation

Action	Update
Introduce a central database to monitor all actions agreed following Serious Incidents reported to Learning and Improvement committee (SI panel) ○ Monitor SI action plans monthly at the Learning and Improvement Committee (SI Panel) via exception report ○ Ensure 90% actions are completed within designated timeframes and 100% actions completed within 1 year of a Serious Incident or Red Complaint.	• *The Patient Safety team have developed and implemented a new monitoring database, with all new action plans being directly entered, upon agreement at the Learning & Improvement panel. The process of adding action plans that remain open is almost complete* ○ *Action plans that are overdue are escalated within the relevant Directorate to the Directorate leads and the AD for Quality Governance* ○ *The database that has been developed to support our actions plans currently does not include complaints, nor does it have the ability to statistically validate completion dates. This action therefore has not been achieved.* *Manual extraction of our data currently reports Serious Incidents to have reached a 42% completion rate for those actions that have reached their completion target dates. However the Complaints data is currently reporting 14.3% for entire action plans rather than individual actions which may have increased compliance.*
Actions agreed as a result of Serious Incidents and Complaints to be tested in practice through the internal assurance review programme and executive / non-executive walkabout. ○ Testing in practice for all SI's and Red Complaints from previous 12 months to be included in internal assurance and included within the internal assurance review reports (100%)	• *Patient Safety and Complaints teams provide information to the Inspection teams in regard to Actions that have previously been agreed for the area being visited to develop Key lines of Enquiry (KLOE's)* • *Eight internal Assurance Inspections have been undertaken this year and compliance with the Directorates previously agreed action plans have been positively tested in terms of staff knowledge or in actions demonstrated, these are then captured in the Directorate reports and reported to the Trust Clinical Governance Committee.*
Improvements as a result of learning from all	• *Governance Gazette is published monthly with*

Action	Update
Serious Incidents and Red Complaints to be shared in a staff monthly newsletter and on the intranet and website (100% where disclosable)	*each edition dedicating a section to learning from complaints and serious incidents.* • *Use of Chief Executives Newsletter to communicate key themes* • *Annual Complaints report published on Trust website* • *Governance presentations at Directorate Clinical Governance*
Improvements to in-hospital falls prevention with a reduction in falls rates to a target of less than 6.2 per 1,000 occupied bed-days by end of March 2017	• *Establishment of the Falls Task & Finish Group chaired by the Chief Nurse* • *Policy & Procedure for Falls was reviewed and revised* • *Terms of reference for Slips, Trips and Falls group was reviewed* • *The Period of increase Incidence (PII) monitoring framework for falls was revised* • *Threshold for falls number on each ward/unit was set* • *Monthly falls data by ward sent out to all ward managers* • *Falls dashboard established.* • *Nursing assessment documents for falls prevention have been reviewed.* • *Screen saver with falls prevention message instigated* • *The cumulative position for 2016/17 was 6.07 per 1,000 occupied bed days against a plan of 6.2 therefore objective delivered. (Further detail can be found on p53)*
Improvements as a result of learning from the review of in-hospital mortalities ○ By end of March 2017, 75% of all in hospital mortalities (excluding A&E only admissions) to be reviewed and submitted to the central database ○ Learning identified via individual mortality review process to be collated and reported at each Mortality Surveillance Group meeting from August 2016 onwards. This learning to be fed back to departments via Directorate Clinical Governance meetings.	• *Establishment of the Mortality Surveillance Group (MSG) and mortality review process.* • *Establishment of data reporting tool and monthly Directorate Reports produced* • *Deep dive into fractured neck of femurs undertaken with Directorate and Dr Foster to further understand anomalies in SHMI/HSMR data for MTW.* • *Submission of Mortality review data and learning identified has been formally recorded in the minutes of the MSG. In addition a six monthly review of learning was presented to the MSG and to the Trust Clinical Governance Committee for onward discussion at Directorate Clinical Governance Meetings.* • *Year-end percentage achieved for hospital mortality reviews undertaken is 43% against our plan of 75%. This action was not achieved but sustained improvement has been evidenced.* ○ *Quarter 1 = 29.67%* ○ *Quarter 2 = 50.67%* ○ *Quarter 3 = 60.67%* ○ *Quarter 4 = 31.0% (data collection ongoing)*

Patient Experience

Aim/goal

To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback

Action	Update
Friends & Family results to be clearly and consistently displayed within departments including actions and improvements as a result of qualitative feedback ○ Set up a task and finish group by September 2016 to re-establish a process to consistently gather and display patient feedback. ○ 85% of areas will display their FFT positive response rates and their actions to support improvements by March 2017 ○ By March 2017 the Trust will achieve 25% response rates in FFT in all adult inpatient and Maternity Services and 15% response rate for Accident & Emergency services.	• *The Friends & Family project group has been established and continues to lead the organisational approach to embedding the friends & family test into practice. The membership of this group includes a member of Healthwatch in addition to Trust staff.* • *Results over the last year have shown an inconsistency in response rates; whilst this can be largely attributable to increased operational pressures we acknowledge that further work is required.* • *There has been a renewed focus within the project team to reenergise the teams in practice as an opportunity to engage feedback from our patients.* • *'How we are doing' boards can be evidenced in each Ward/Department however ensuring that the FFT data remains current has been a challenge identified by the Quality Assurance Inspections.* • *Monthly agenda item for Nurse Education & Learning Forum (NELF)- ward managers are presenting their FFT to share learning and best practice and importantly to share the positive feedback that so many of our patients provide.* • *We achieved 26.6% for Maternity & 23.3% for Inpatients – objective partly met; A&E achieved 15.5% - objective met.* • *Implementation of our new contract with 'iwantgreatcare' has also supported a renewed focus and they have supported the organisation to undertake a case study on successes within our emergency departments which will then be shared across directorates to promote learning.*
Positive feedback / plaudits to be gathered and shared in a more robust way with staff to ensure good practices are acknowledged and become drivers for improvement ○ Implementation of a new system which enables staff to upload plaudits and positive feedback.	• *A section for feedback/plaudits is integrated within the Directorate reports which report initially to the Clinical Governance Committee.* • *Collaboration with the Communications team ensures that these are also publicised in the CEO's weekly update.* • *The 'iwantgreatcare' database also has a facility that enables us to extract individual feedback for our staff who can then use this as supportive evidence for their appraisals and revalidation.*
Working with Healthwatch Kent, consider and implement different ways of listening to staff	• *Patient representatives from Healthwatch continue to support the Trust in a number of patient focussed initiatives.*

Action	Update
and service users to drive improvements (such as listening events, better use of social media and technology) ○ The Trust will engage with Healthwatch to undertake at least one listening event per quarter and continue to facilitate and respond to 'Enter and View' visits at least twice per year.	• *They have also supported us on our Internal Assurance Inspections.* • *In September an 'Enter & View' visit was undertaken in our Outpatient department.* • *Healthwatch have also commenced a review of the discharge experience of our patients.*

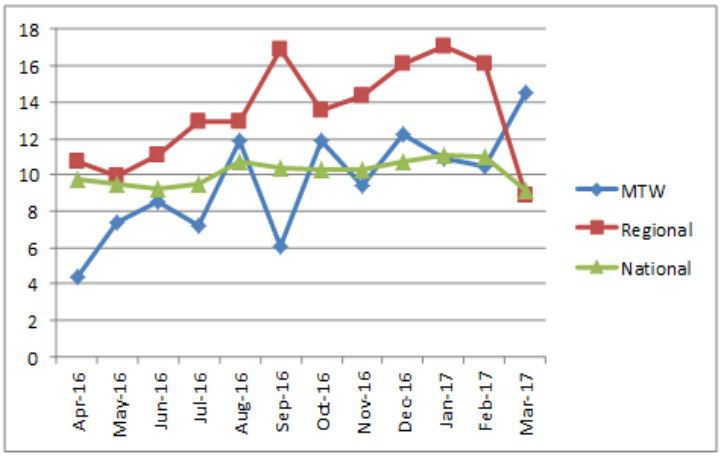
Clinical Effectiveness

Aim/Goal

To deliver safe and effective inpatient care with the minimum length of stay possible. This will include the on-going work around the reduction in bed occupancy rates, the reduction in transfers from Intensive Care Unit after 8pm, achieving the A&E 4 hour standard and achievement of the Stroke indicators which are priorities for service users, commissioner and the Trust.

Action	Update
Sustained reduction in length of stay achieved through (but not exclusively) the full implementation of SAFER Discharge Bundle. To achieve the outputs and timeframes agreed at the Timely Effective Safe (TES) Steering Group.	• *7.83 days reported for the Non-elective Length of Stay for Mar-17 against the Trust phased target of 6.8 days. For the year the average LOS was 7.72 days.* • *The Elective LOS is 2.97 days for March discharges against the phased target of 3.2. 3.29 for the year* • *Percentage delayed of occupied bed-days fell back from 7.11% in Feb to 6.17% in March (lowest level since June 16)* • *Full year attendances are 4.2% higher than last year, and A&E admissions 17.6% higher. Mar type 1 attendances were 4.7% down on last March.* • *Therefore despite higher attendances and admissions, LOS has remained stable from the previous year* • *Implementation of SAFER bundle across all wards – roll out over all medical and surgical wards on 2 sites over 18 weeks from March 16* • *Ongoing work to continue to implement SAFER through focus groups with junior doctors, weekly meetings with nursing staff, clinical governance sessions with Medical Director. Audit of SAFER on wards to identify gaps. Led by Clinical Lead CD for Diagnostics/ Infection Control* • *SOPs in place for Board rounds and criteria led discharges* • *Executive sponsor and Clinical lead, robust governance structure* • *Link into CCG A&E Delivery Board chaired by MTW Deputy Chief Executive* • *Home First pathway 1 rolled out to a number of Maidstone wards, working with Local Referral Unit (LRU)* • *Introduction of Clinical Utilisation Review (CUR) to identify patients which do not qualify for the acute sector*

Action	Update
	• *Electronic Discharge Notification (EDN) task and finish group led by CD for Diagnostics to simplify EDN process to be trialled early 2017* • *A&E performance for year-end was 87.1% (see p54 for further details).* • *We have also made significant improvements to our delays for patients waiting for transfer out of ITU during Quarter's 3 & 4 but failed to deliver the required reduction in Q1 & 2 (NHS England CQUIN).* • *Reduction in LOS for Stroke patients in Quarter 4 by 10% to achieve an average of 19.52 days (Local CQUIN)*

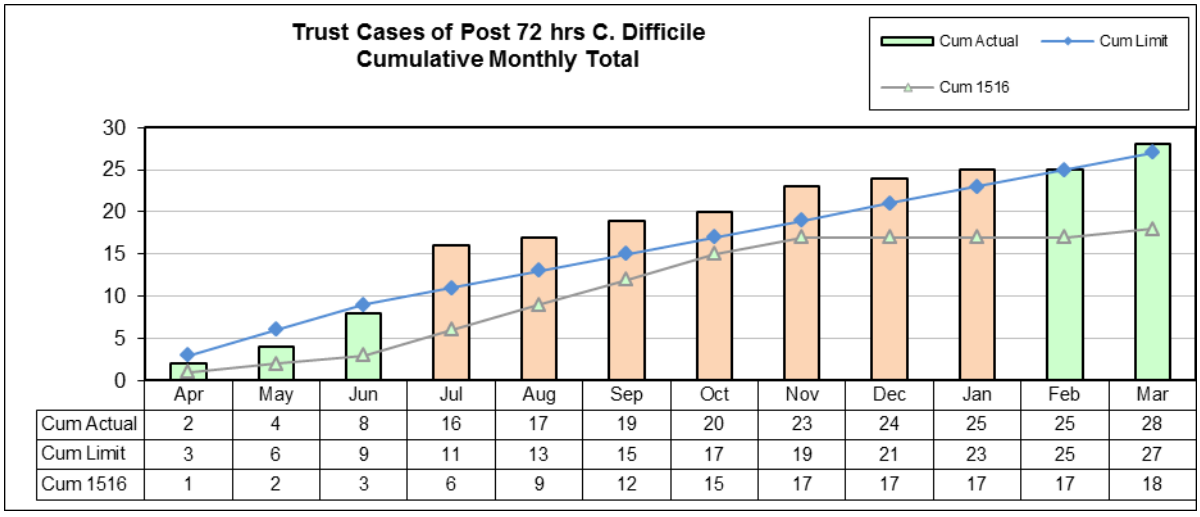
Sustain one ring-fenced bed for Stroke patients at Maidstone at all times and two on the TWH site (90% by March 2017). Sustain one ring-fenced bed on W31 at TWH for fractured neck of femur patients at all times (90% by March 2017).	• *The availability of ring fenced beds for Stroke and fractured neck of femur are reported at each site meeting. If ring fenced beds are not available, this becomes a priority for the Clinical Site team to achieve before the next site meeting.*
	• *The Sentinel Stroke National Audit Programme (SSNAP) also records the timeliness of admission to a Stroke Unit.* ***% patients direct admission to Stroke Unit <4hrs-60% target***
	  ○ *Trust 54.2% (↑5.7% 2015/16)*
	  ○ *TWH 50.1% (↑9.1% 2015/16)*
	  ○ *MGH 58.4% (↑3.6% 2015/16)*
	• *The National Hip Fracture Database (NHFD) has also started monitoring the time to Ward for Fractured Neck of Femur patients, although we are unable to define an achievement percentage it is evident that we did not achieve the 90% target. However in comparison to the regional and national averages, it is evident that as an organisation we continue to perform well as demonstrated in the graph below. (Data entry for March for all organisations is not currently complete).*
	 
	Average Time To Orthopaedic Ward 2016/17

Embed new ambulatory pathways on Acute Medical Unit (AMU) at Tunbridge Wells Hospital to achieve a 10% reduction (minimum) from March 2016 baseline in admitted patients from the medical take each day. The target is to be achieved by March 2017.	• *Ambulatory pathways across all specialties* • *T&O cellulitis ambulatory pathways set up* • *Embedding of surgical ambulatory pathways/ SAU* • *Escalation during winter months continues to be a barrier to full implementation* • *Medical ambulatory pathways being introduced gradually but escalation remains a problem.*

Action	Update
	• *Improved ED handover to specialties* • *Key stakeholders in fortnightly ED recovery task and finish group identifying actions to meet A&E standard and reduce admissions. ED recovery task and finish group reports into TES (Timely Effective Safe) Steering Group. Robust governance.* • *Due to the 4.2% increase in attendances that we experienced we were unable to achieve the planned reduction in patients admitted.*

Review of Quality Performance

Infection Control – Clostridium Difficile cases – The Trust did not achieve this standard with 28 cases against a maximum of 27 cases for the year equating to a rate of 10.5 CDifficile Case per 100,000 occupied bed days

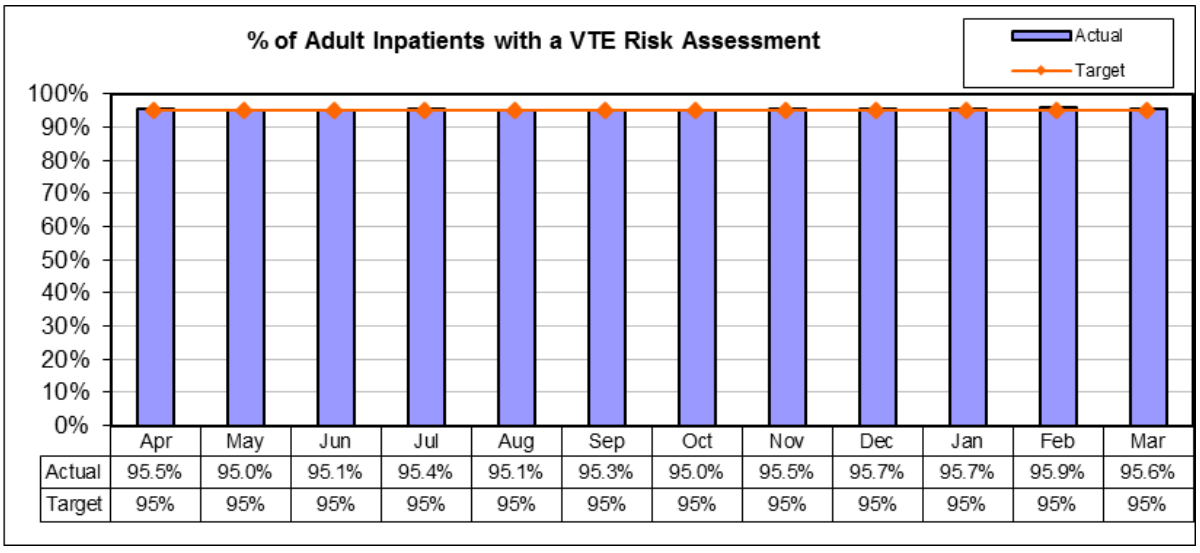


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	2	4	8	16	17	19	20	23	24	25	25	28
Cum Limit	3	6	9	11	13	15	17	19	21	23	25	27
Cum 1516	1	2	3	6	9	12	15	17	17	17	17	18

Infection Control – MRSA Bacteraemia cases – The Trust under-achieved the standard, with 1 case of avoidable post 48 hr MRSA bacteraemia through the year against a Trust standard of zero avoidable.

Prevention of blood clots or venous thromboembolism (VTE)

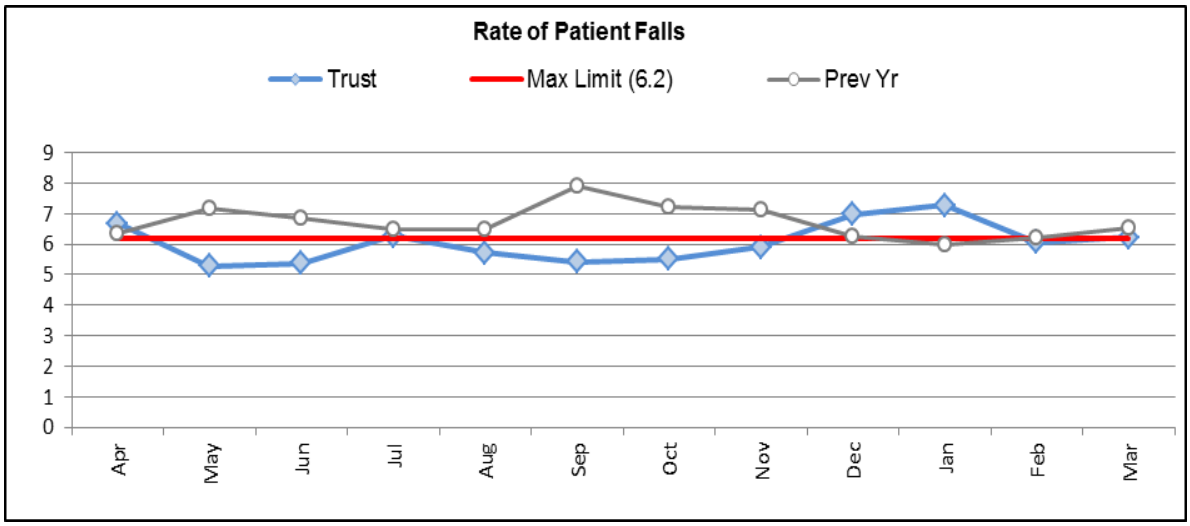
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2016-17.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	95.5%	95.0%	95.1%	95.4%	95.1%	95.3%	95.0%	95.5%	95.7%	95.7%	95.9%	95.6%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

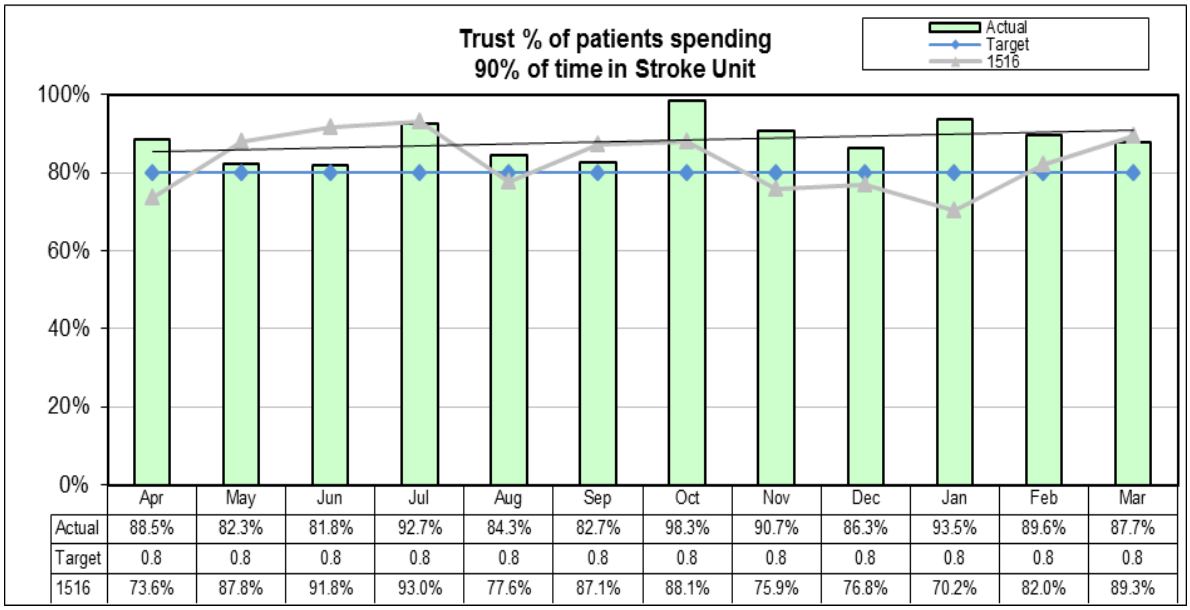
Reducing the number of patient falls

Rate of Falls – The Trust's rate of Falls per 1,000 Occupied Bed days is below the Trust maximum limit of 6.2 at 6.07 for the year (6.69 for the previous year). The number of falls reported in 2016/17 was 1613 (7 fewer than the previous year).



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

80% of patients spending 90% of time on the Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2016-17 at 82.4%.

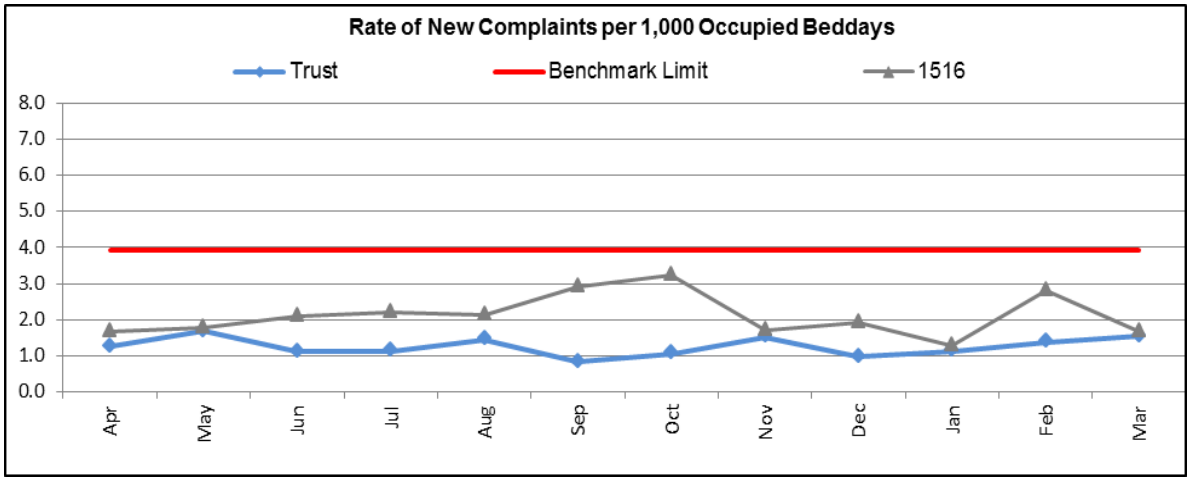


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	88.5%	82.3%	81.8%	92.7%	84.3%	82.7%	98.3%	90.7%	86.3%	93.5%	89.6%	87.7%
Target	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8	0.8
1516	73.6%	87.8%	91.8%	93.0%	77.6%	87.1%	88.1%	75.9%	76.8%	70.2%	82.0%	89.3%

PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 episodes is below the expected range of between 1.32 and 3.92 at 1.25 for the year (4.06 for the previous year). The number of new complaints received in 2016/17 is a 35% reduction (-178) from the previous year.



Complaints report summary

(Regulation 18 of the Local Authority, Social Services and NHS Complaints (England Regulations 2009). Presented and discussed at MTW Quality Committee in July 2016.

The Trust has a statutory duty to investigate and respond to complaints in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (the regulations). This statutory obligation is further supported by the Trust's values – PRIDE – which highlight the importance of being customer focused and striving for continuous improvement. Whilst complaints are often considered to have a negative connotation, we recognise that they are also valued methods of feedback and can highlight shortfalls in current practice or policy. This feedback is essential in helping us to improve the quality of our services and the way in which we engage with our patients and their visitors**.** This includes being open and honest and saying sorry when it is required.

> As you will note from the opening and closing paragraphs of my original complaint, all that was sought was an acceptance by the Trust that certain care fell below an appropriate standard; an apology; and some reassurance that the Trust would perhaps learn from the experience. I believe that as a result of your efforts and this response, all three of these objectives have been achieved. …..in view of the above and in agreement with my siblings, I confirm that your response and apology bring this complaint to a satisfactory conclusion.
>
> Complainant

During 2016/17 we received 332 new complaints compared to 510 during 2015/16. The rate of complaints per 1,000 occupied bed-days was 1.25 for the year (lowest/highest decile

range of 1.32 to 3.92). It is our aim to investigate and provide a full response to all formal complaints within an agreed timeframe of either 25 or 60 working days of the complaint being received, depending on the severity of the complaint. We responded to 69% of complaints within the agreed timescale against a target of 75%. Although we have seen some improvements in performance on a monthly basis we have been unable to consistently sustain this. We are confident in our complaints handling approach; however recruitment challenges have negatively impacted upon this performance standard that we know to be achievable. We remain optimistic that we can meet these standards in 2017/18.

The central complaints team provide regular reports on the learning and service improvements arising from complaints. These are submitted to the Clinical Governance Committee on a monthly basis and examples of the learning from complaints are also reported to the Patient Experience Committee and Quality Committee on a quarterly basis. Case studies and key messages from complaints are regularly included in the Trust's Governance Gazette which is produced monthly.

Patient Surveys

NHS Surveys
Focused on patients' experience

National Patient Surveys

During 2016 the Trust undertook three National Surveys. Although they are led by Picker Europe and the CQC we have been undertaking these in house. The surveys were the following:

- Emergency Department Survey.
- Children and Young Persons Survey.
- Adult Inpatient Survey.

The Emergency Department survey runs bi-annually and was previously run in 2014. The Inpatient Survey is run on an annual basis. The Children and Young Persons Survey was a further survey added to the NHS Patient experience survey programme. This survey is still in the data collection stage.

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

Adult Inpatient Survey 2016

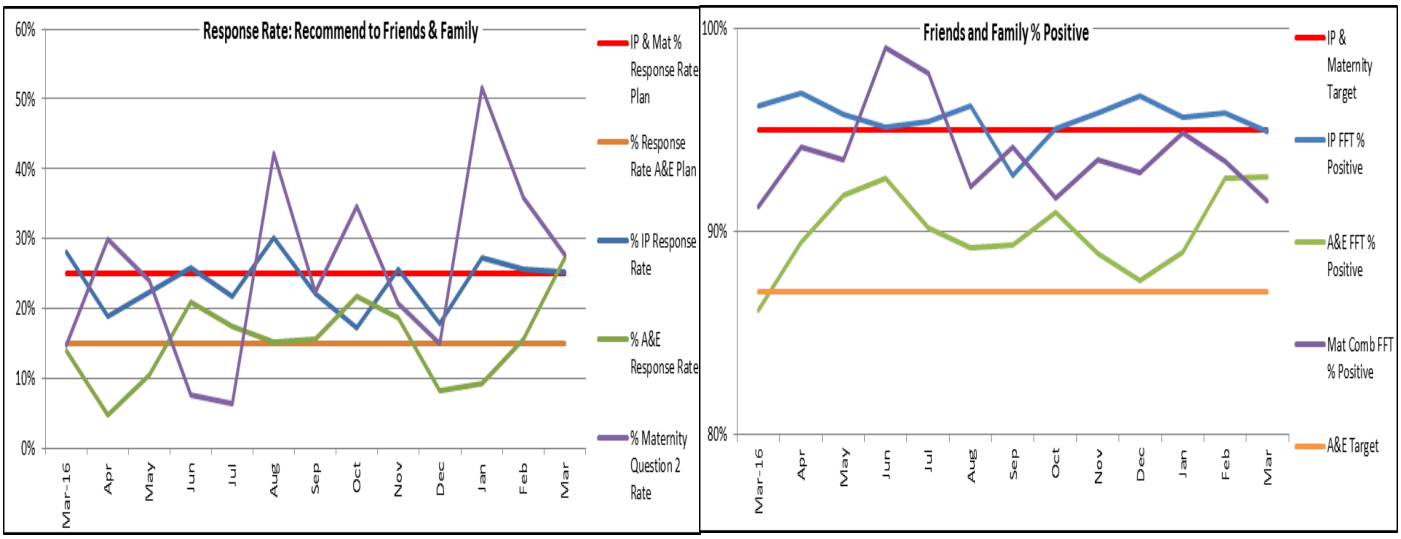
Focus questions from National Inpatient Survey		National Inpatient Survey	
		2016	2015
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.0%	91.7%
2	Did you find someone on the hospital staff to talk to about your worries and fears?	47.7%	46.9%
3	Were you given enough privacy when discussing your condition or treatment	92.8%	95.8%
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	39.4%	39.3%
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	66.3%	69.1%

Friends and Family

The inpatient and A&E positive response rates (95.5%, 90.7% respectively) have exceeded the Trust Plan indicating that patients would recommend the Trust to their Friends and Family. However the Inpatient positive response rate narrowly missed the national benchmark of 95.8% at 95.5%. Maternity did not meet either the Trust target of 95% and the national benchmark of 95.6% at 93.6%.

Maternity and A&E response rates however both exceeded the planned Trust rate and the national benchmarks at 26.6% and 15.5% respectively, whereas the Inpatient response rate did not achieve either at 23.3%.

MTW Friends and Family scoring



Staff Survey 2016

This section outlines our most recent staff survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that the Trust provides equal opportunities for career progressions or promotion) for the Workforce Race Equality Standard.

KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
This is reported at 25% which is a 3% increase from the 2015 survey findings and is the same as the National 2016 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 25% (2015 findings – 21%) (National average for acute Trusts – 24%)
BME 21% (2015 findings – 25%) (National average for acute Trusts – 27%)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
This is reported at 90% which is a 4% increase from the 2015 survey findings and is 3% higher than the National 2016 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 89% (2015 findings – 89%) (National average for acute Trusts – 88%)
BME 91% (2015 findings – 71%) (National average for acute Trusts – 76%)

The Trust appointed a new Head of Staff Engagement and Equality in April 2016 who has gone on to implement a new translation service providing a one stop shop for all translation services

including written translation, face to face, British Sign Language, Deaf/Blind services. The telephone translation service is available 24 hours a day, 7 days a week, 365 days a year.

The Workforce Race Equality Standard (WRES) and Equality Delivery System (EDS2) have been completed and published and the Trust has obtained Level 2 Disability Confident Employer status which replaced the Positive about Disability “Two Ticks” scheme in July 2016. A Cultural Diversity Network has been set up to celebrate the diverse cultural backgrounds of Trust staff, to provide support and career development advice and guidance and drive forward the WRES action plan.

Working with Stonewall the Trust are Diversity Champions and the Stonewall Workplace Equality Index completed in September 2016 demonstrates an increased score from 2015. Transgender Awareness Workshops delivered internally have been well attended and a Transgender Policy to support staff undergoing gender transition has been written. An LGBT survey, created in collaboration with Great Ormond Street Hospital to assess how members of our LGBT community are treated at the Trust was undertaken in January 2017. As a result of this, an LGBT Network Group will launch at the beginning of May.

The Trust’s intranet and website have dedicated Equality & Diversity areas and bespoke Diversity training sessions have been delivered to Trust staff.

The year ahead will see the launch of a Disability Network Group, the review of mandatory Equality & Diversity training and the update of the Equality & Diversity Policy. Workforce Equality Data needs to be improved to ensure that information we report on the protected characteristics of the Equality Act is a true representation of our workforce and role models for those characteristics need to be identified at senior levels of the organisation.

Learning from Serious Incidents / Never Events

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

All serious incidents are assigned a lead investigator or reviewer independent of the area where the event occurred and undergo a root cause analysis using recognised investigative tools. Action plans are developed to share learning across the organisation to prevent a similar event occurring. All serious incidents and never events are reported to an executive led panel to ensure a robust investigation has been undertaken and all learning outcomes identified.

The Trust declared 115 serious incidents in 2016/2017 compared to 99 the previous year.

Of these 115 Serious Incidents, following a robust investigation it was identified there was no significant learning for the Trust and all appropriate actions were already in place for 15 of these. These cases were discussed with our Commissioners who agreed with our findings and that these cases no longer met the Serious Incident criteria and these were subsequently downgraded by them bringing our total incidents reported down to 100 during 2016/17.

Actions and learning from serious incidents are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2016/2017 learning and actions included:-

- Review/introduction of the WHO safety checklist for interventional procedures in the Cardiac Catheter Lab and Radiology
- Improved patient information and discharge advice for those undergoing Gastrostomy tube placement and Colposcopy
- Revised Doctor handbooks to ensure awareness of procedures within the Trust and sign posting to key departments and policies/guidelines
- The process in theatres has been reviewed to ensure all staff working in the area are aware of their roles and responsibilities during the WHO safety checklist and “time out” process
- Individualised induction information for temporary staff ensuring they are aware of our expectations of the care they provide.
- Amendment of our Critical Medications guidelines and posters identifying what these medications are and the effects of not receiving them
- Enhanced care guidance and risk assessments in particular for those with a high risk of falls – we have reduced our falls rate to 6.07 per 1,000 bed days against a threshold of 6.2 which we had set to achieve.
- We have improved feedback and shared learning from incidents – this includes teaching sessions with junior doctors, sharing monthly reports with new starters and all trainees, monthly safety moments with a different theme and attendance at Directorate Clinical Governance sessions.

Never Events

There were 4 Never Events during 2016/2017, a full root cause analysis was undertaken and presented to the Executive led panel and findings shared with NHS Improvement to ensure wider learning.

The first Never Event was identified in July 2016 when during an emergency surgical operation a central line was inadvertently inserted into the right carotid artery instead of the right internal jugular vein. The line had been inserted during the surgery due to the patient’s clinical condition.

During the procedure the ultrasound device used to check the positioning, had failed. Following the procedure it was evident that the patient had developed severe weakness in their left arm and leg and was diagnosed with a stroke as a result of this error. The patient was subsequently transferred to a specialist unit for vascular surgery. The patient is undergoing extensive rehabilitation as a result of this error. Actions taken as a result included the dissemination of details of the incident with key points of learning. The Trust guidance for Central line insertion was updated.

The second Never Event identified in August 2016 related to a patient that had the wrong side knee component inserted. Although this does not appear to have had a discernible effect on the patient it was identified that the standard checking process was not implemented by all staff involved in the procedure. Actions implemented include the introduction of an implant collection form for all primary hip and knee replacements. The Standard Operating Procedure has also been amended to highlight each individual's responsibilities during surgical procedures. This event also included personal reflection and learning for the individuals present during the surgery.

The third Never Event identified in November 2016 occurred when a patient underwent one procedure as per their consent and healthcare records but following this the surgeon undertook a further procedure which they had not consented to which has had an indeterminate impact on their plans for the future and caused psychological distress. It was identified that the surgeon did not fully participate in the "Time out" and was therefore not clear on the order of the list. Staff present also did not challenge a procedure being undertaken that had not been consented for. Actions taken have included the sole reliance on the electronic theatre list on the theatreman IT system, to ensure that this will now be the only available list to be referred to. There was also a lack of verification with the patient's consent form and no challenge was made when an additional piece of equipment was requested—the WHO checklist has been amended to make it explicit that the procedure the patient has consented for is read aloud by the operating surgeon and this is then written on the whiteboard within theatres as a visual confirmation.

The fourth Never Event identified in February 2017 relates to a mis-placed Nasogastric Tube, this incident remains under investigation.

Duty of Candour

From April 1st 2015 all registered providers were required to meet the new Regulation 20: Duty of Candour. The aim of this regulation is to ensure that providers are open and transparent with people who use services and other "relevant persons" (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

During 2016/17 we have demonstrated an increased compliance with the 3 elements of meeting duty of candour for patients involved in a serious incident. During 2016/17 our database can evidence that 3% of our patients have no evidence of a verbal apology being given to them compared to 12% the previous year. In addition 3% of patients involved in a Serious Incident did not receive an initial duty of candour letter in 2016/17 compared to 27% the previous year. Communicating the outcome of the investigation to the relevant person has also showed improved compliance with 55% of the 75% required in 2016/17 already completed with the remaining 20% still open and under investigation. This is compared to 63% compliance against a figure of 90% the previous year. There is on-going education with departmental managers with all initial letters being reviewed by the central team in terms of quality and compliance and to ensure there is an identified person and relevant address to aid communication of the outcome. The central team are also concentrating on moderate incidents to improve compliance and this requirement will continue in 2017/18.

‘Sign up to Safety’ Safety Improvement Plan

MTW developed and agreed safety pledges in 2015 and developed a Safety Improvement plan that was rolled out during 2015/16 with a completion delivery date predicted as 2018/19.

The following safety improvement domains were identified and remain a focused improvement as the result of a review of the data from legal services over claims against MTW through the NHS Litigation Authority data in the preceding 5 years, a review of the trends and themes from Serious Incidents and feedback from the CQC: Handover / communication, fetal assessment and identification of deviations from the norm (CTG interpretation), Patient decision making and informed consent & In patient falls. These claims are from the ‘*low value, high volume’* (Failure / delay diagnosis; Failure to obtain informed consent), *‘high value, high volume’* (Handover communication, Failure to monitoring or respond to abnormal fetal heart rate, obstetric)

These safety improvement domains form the heart of this organisation’s Safety Improvement Plan:

- To improve communication during the handover process
- To improve the effectiveness of identifying and act upon deviations from normal during labour and birth
- To improve the quality of patient involvement in decision making and standards of obtaining informed consent
- To reduce the number of In Patient Falls

The Safety Improvement plan follows the Plan, Do, Study, Act (PDSA) 90 day cycle supported by the NHS England Sign up to Safety Campaign.

Progress made against agreed improvements during 2016/17 include:-

Improve communication during the hand over process:

- ✓ The organisation has invested in ‘Nerve-centre’, which is an IT based solution for monitoring of our patients and enables the use of early warning triggers to enhance the escalation of deteriorating patients.
- ✓ The establishment of integrated discharge teams aligned to wards who facilitate timely intervention and exchange of information within the multi-professional team.
- ✓ Establishment of 'board' rounds to enhance decision making within the team for daily care planning and review of progress on care pathways.

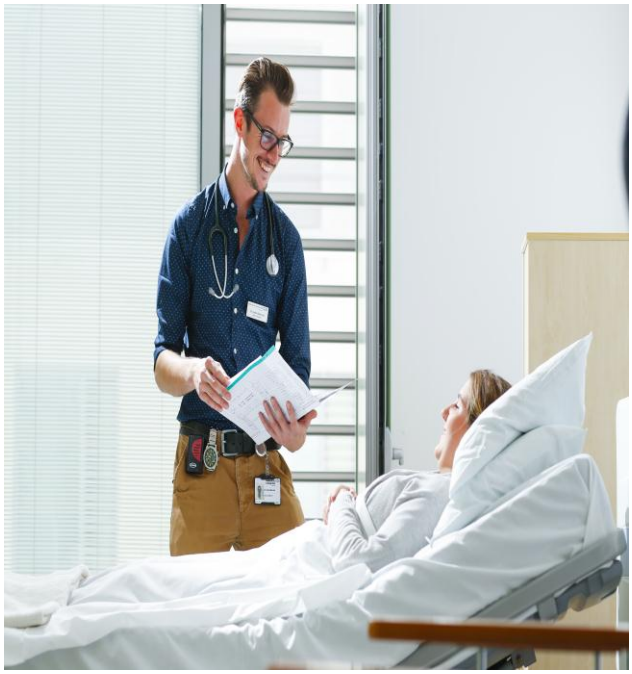
To improve the effectiveness of identifying and act on deviations from normal during labour and birth:-

- ✓ Implementation of a revised mandatory annual training programme using the PROMPT method of training: **PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining. PROMPT training helps develop the technical skills required in an emergency and also the non-technical skills, such as effective communication, calling for help effectively, team working, making the best use of the resources available, and delegation.
- ✓ In addition to the mandatory PROMPT training, the Trust provides access to High Fidelity Simulation Training for Obstetricians, Midwives, Anaesthetists and Theatre Practitioners.
- ✓ Increase in the number of consultants in Anaesthetics since 2012 with a trend towards a service that is increasingly consultant-delivered rather than simply consultant-led.
- ✓ The Trust now has increased Consultant cover in the maternity unit and increased Consultant Anaesthetist cover with one specifically designated to provide cover for the

elective caesarean section list and a further Consultant Anaesthetist on duty for the Delivery Suite who has no other duties and is therefore available to attend emergencies.

To improve the quality of patient involvement in decision making and standards of obtaining informed consent:-

- ✓ Significant work has been undertaken within elective surgery to improve the consent process, including the implementation of a robust and timely availability of translation services.
- ✓ Further work is required for Urgent Care, End of Life Care and Medicines Management.
- ✓ The end of life steering group is looking at a number of initiatives to improve communication between patients and their families.
- ✓ A medications user group has also been established to improve patient involvement and engagement with strategies to understand and manage understanding of their medication regimes.
- ✓ The medicines information database (MAPS) has been fully implemented; this enables personalised production of medicines information at ward level.



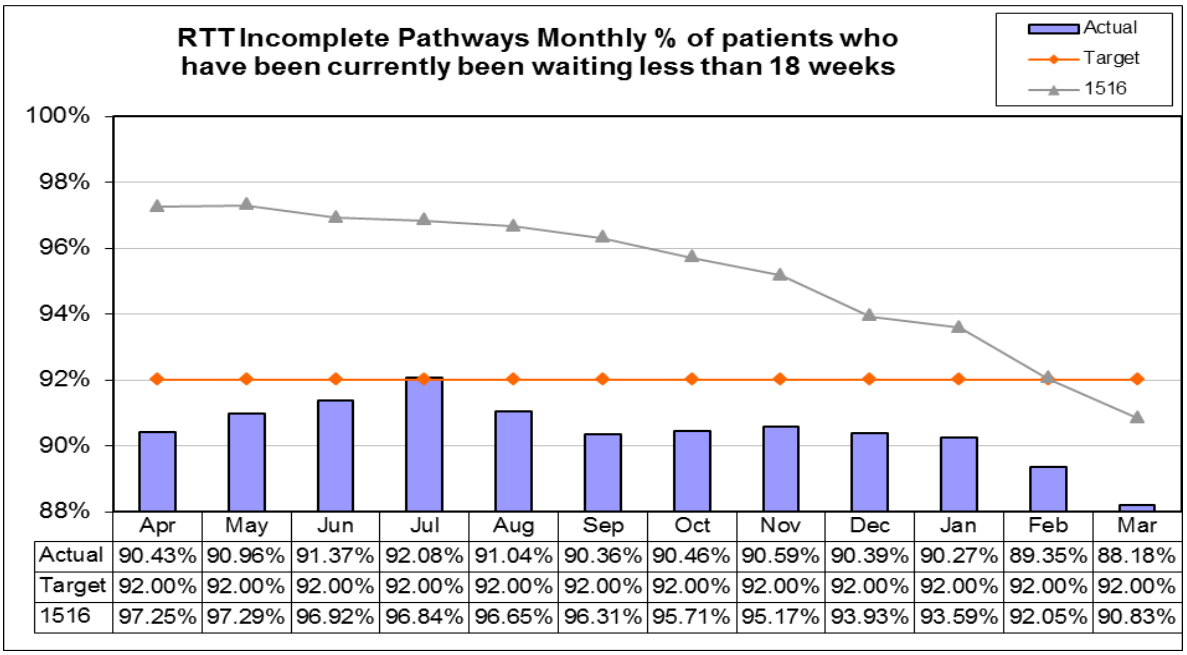
To reduce the number of patient falls:-

Significant work has been undertaken to reduce the number of falls culminating in a year end falls rate of 6.07 per 1,000 occupied bed days against an aim of 6.2. This was achieved through:-

- ✓ Establishment of the Falls Task & Finish Group which was chaired by the Chief Nurse.
- ✓ Terms of reference for Slips, Trips and Falls group was reviewed
- ✓ The Period of increase Incidence (PII) monitoring framework for falls was revised
- ✓ Threshold for falls number on each ward/unit was set and monitored by the Chief Nurse
- ✓ Monthly falls data by ward sent out to all ward managers
- ✓ Falls dashboard established.
- ✓ Nursing assessment documents for falls prevention have been reviewed.
- ✓ Safety Calendar Month of November focused on Falls Prevention
- ✓ Screen saver with falls prevention message instigated

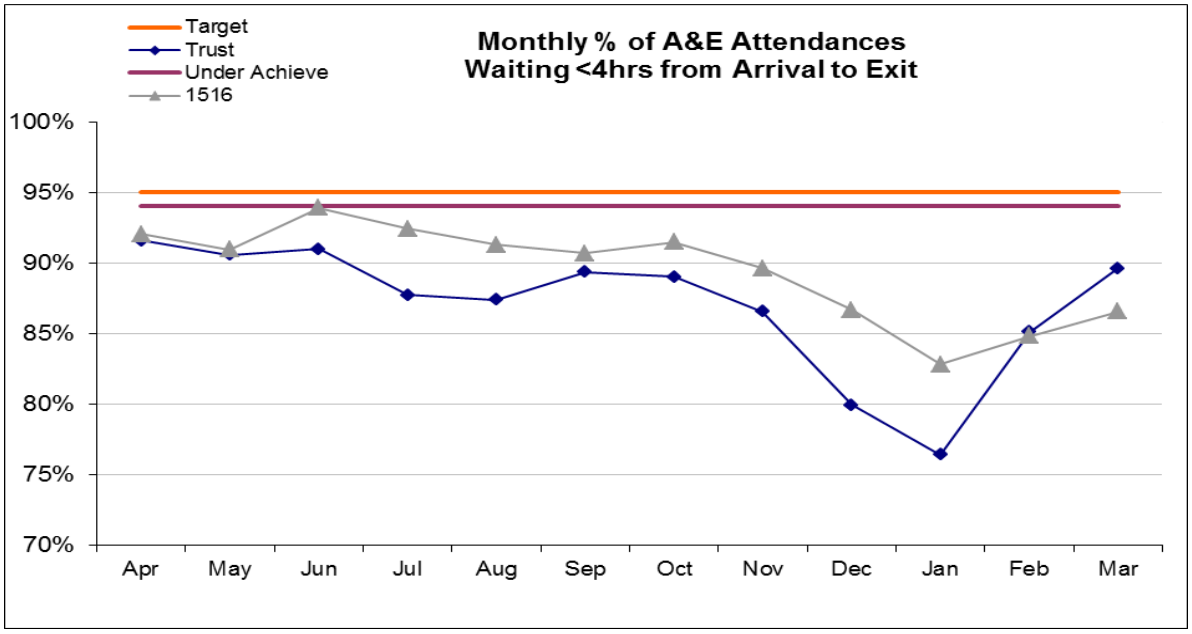
Other Quality Monitoring and Improvement Measures

18 weeks standard – The Trust did not achieve this standard at an aggregate Trust level of at least 92% of patients on an Incomplete Pathway had been waiting less than 18 weeks.

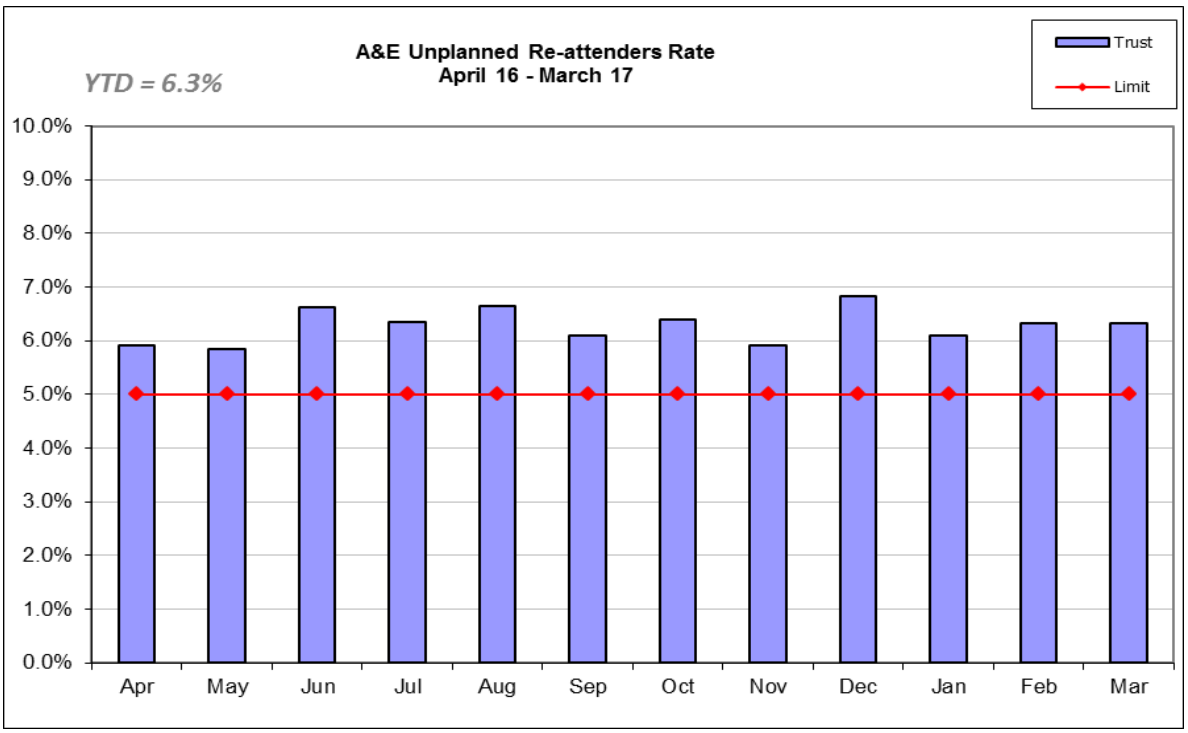


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	90.43%	90.96%	91.37%	92.08%	91.04%	90.36%	90.46%	90.59%	90.39%	90.27%	89.35%	88.18%
Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
1516	97.25%	97.29%	96.92%	96.84%	96.65%	96.31%	95.71%	95.17%	93.93%	93.59%	92.05%	90.83%

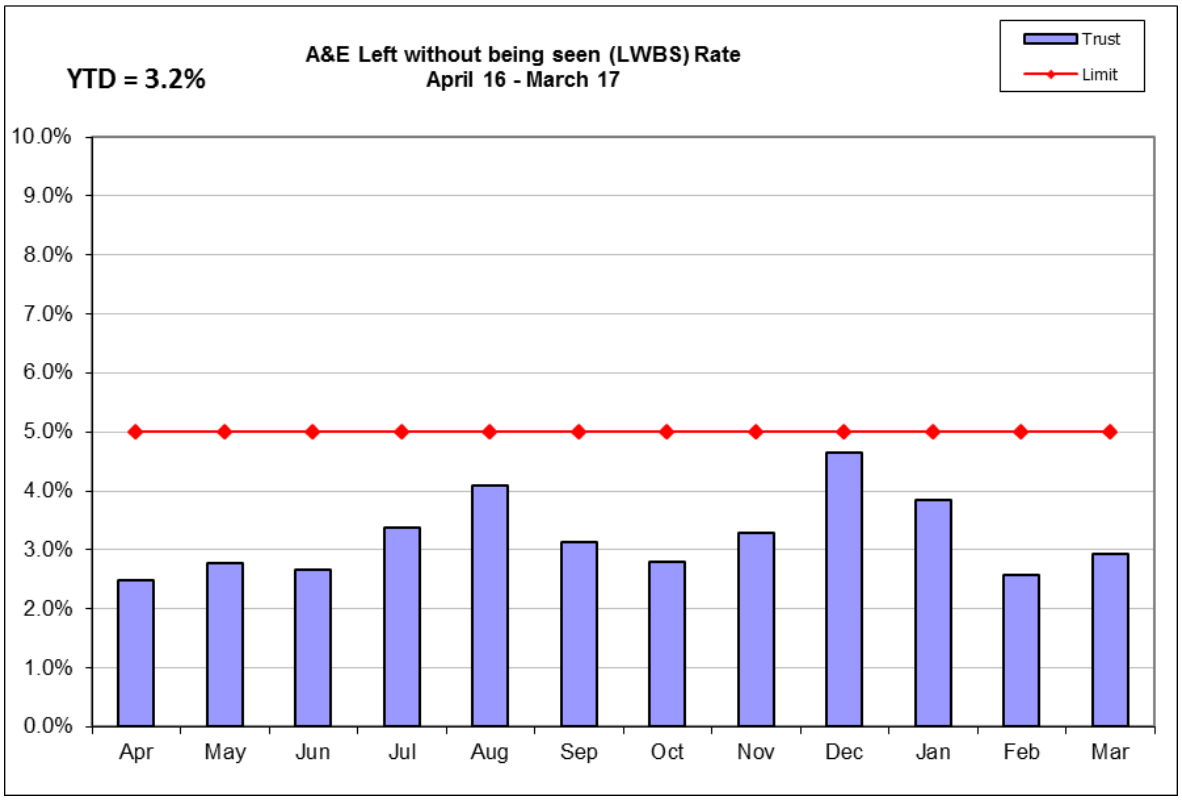
Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2016-17 at 87.1%.



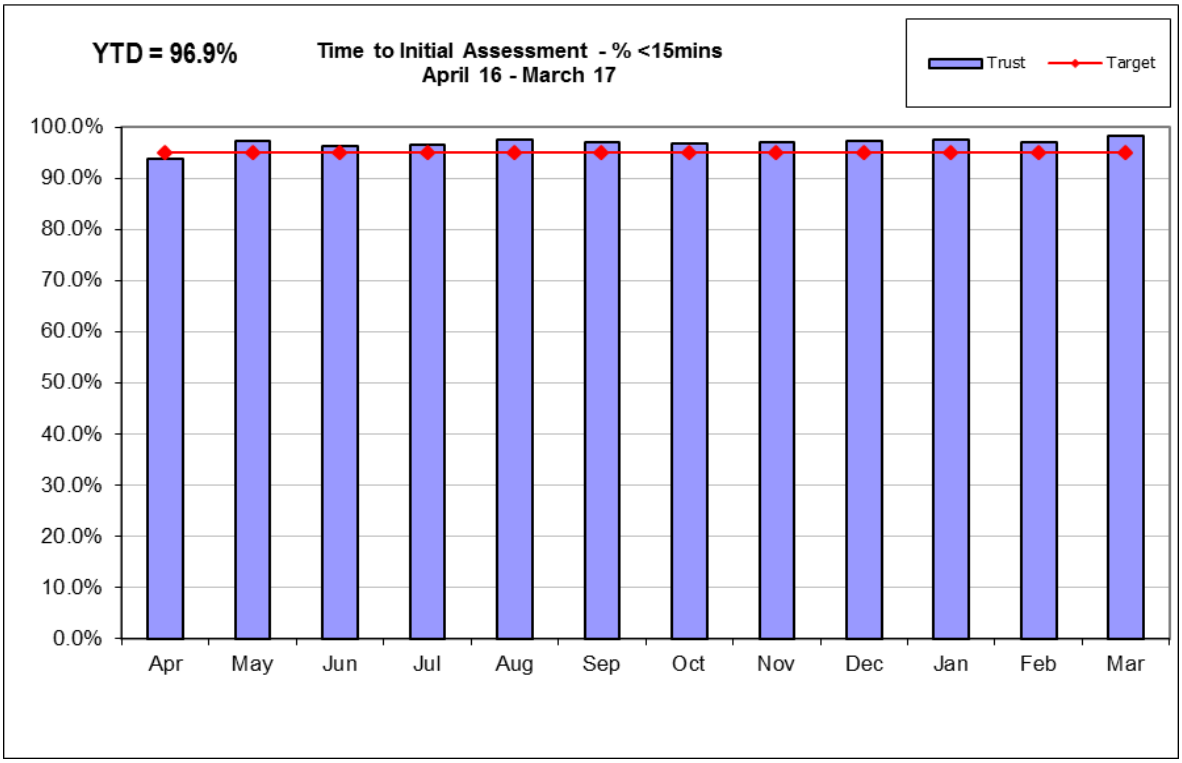
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 6.3%.



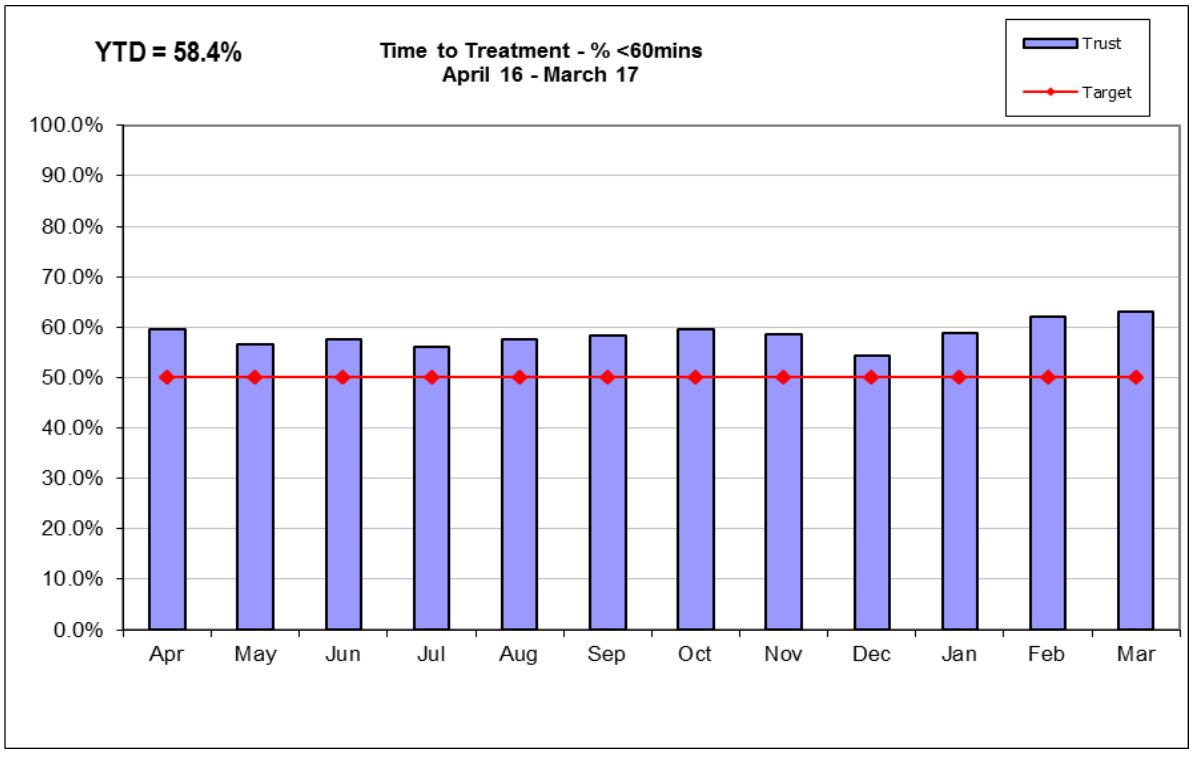
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen.



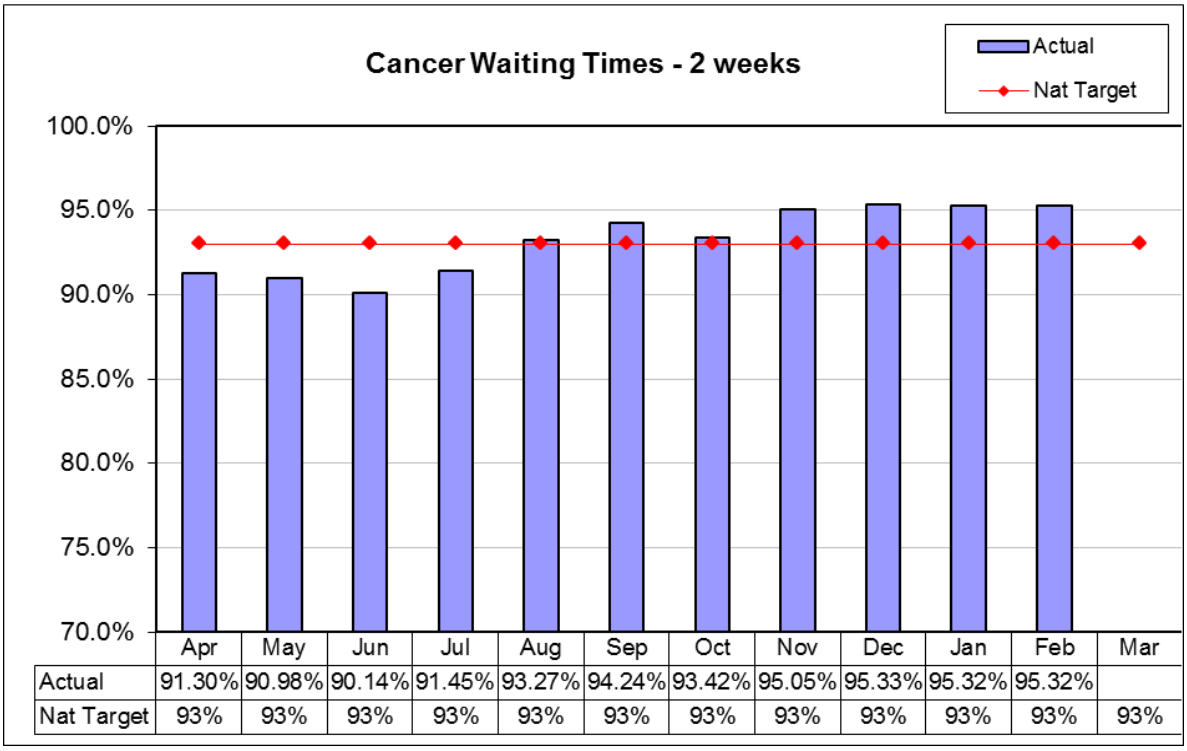
A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 58.4%. This is a 7% improvement on last year.

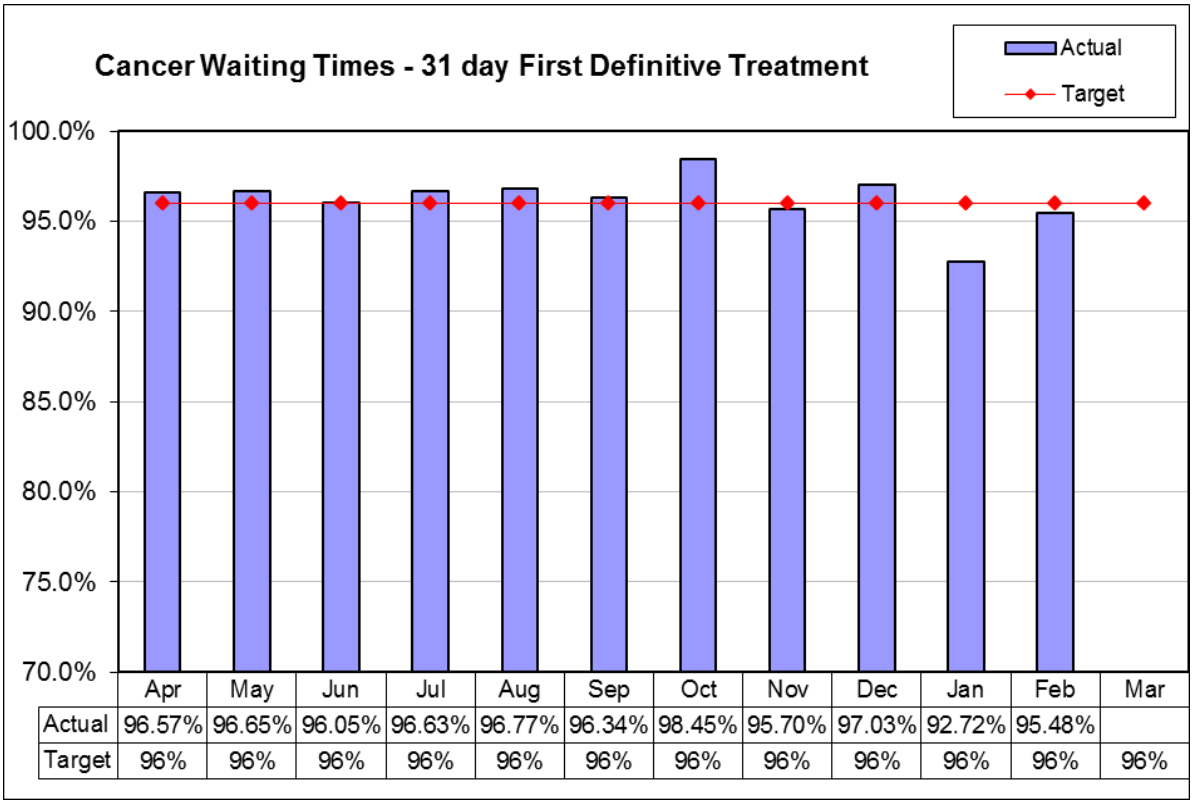


Cancer Waiting Time Targets - 2 weeks from referral – The Trust achieved this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



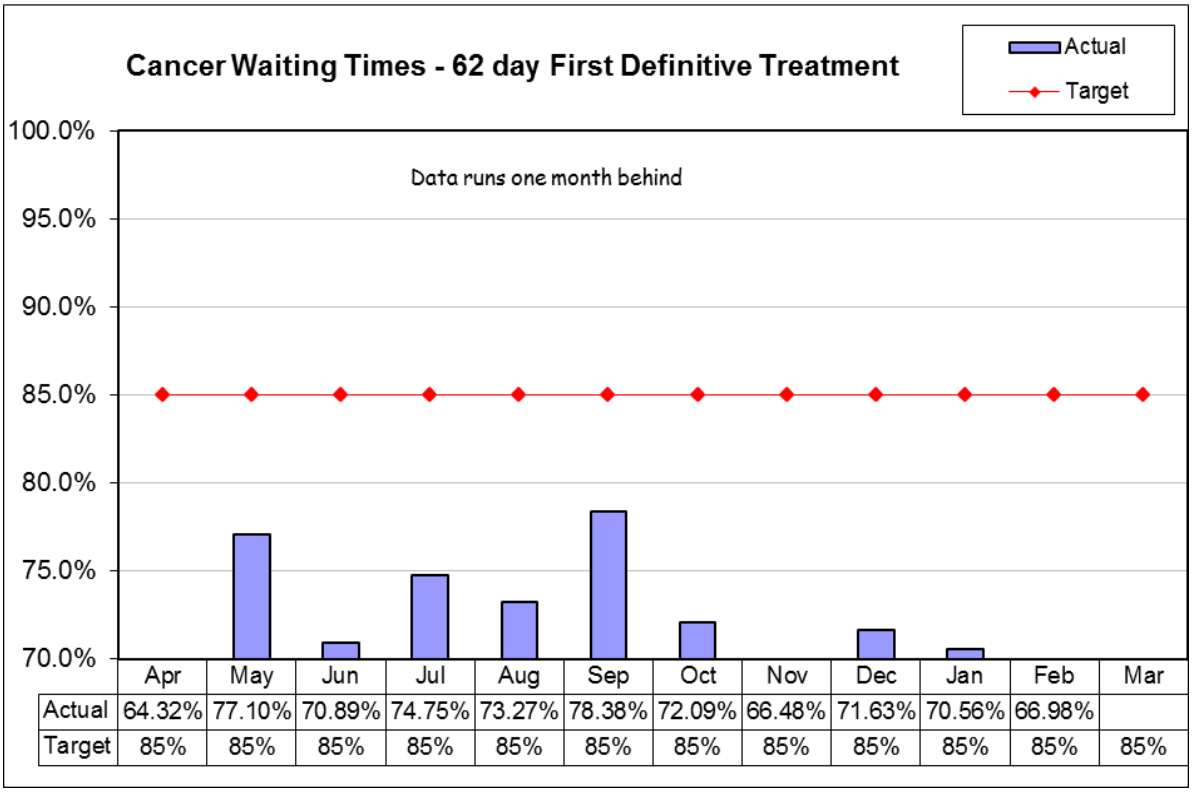
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	91.30%	90.98%	90.14%	91.45%	93.27%	94.24%	93.42%	95.05%	95.33%	95.32%	95.32%	
Nat Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

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



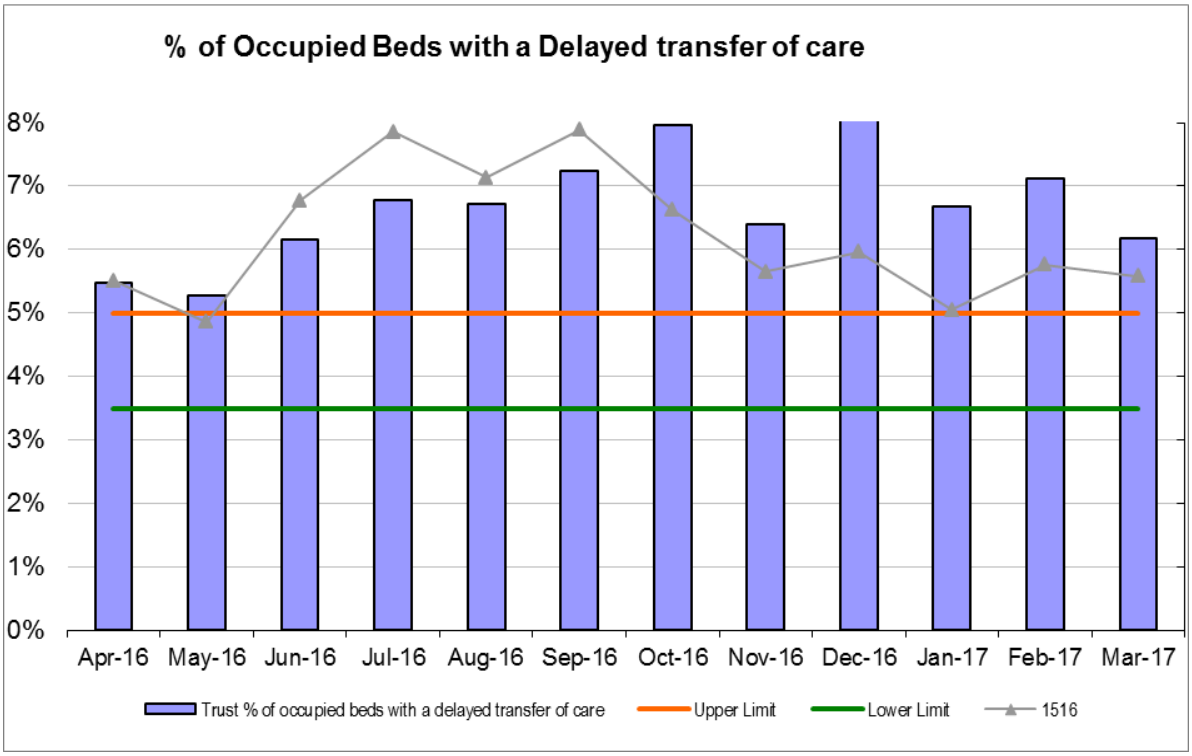
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.57%	96.65%	96.05%	96.63%	96.77%	96.34%	98.45%	95.70%	97.03%	92.72%	95.48%	
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days doing so (expected 69%)

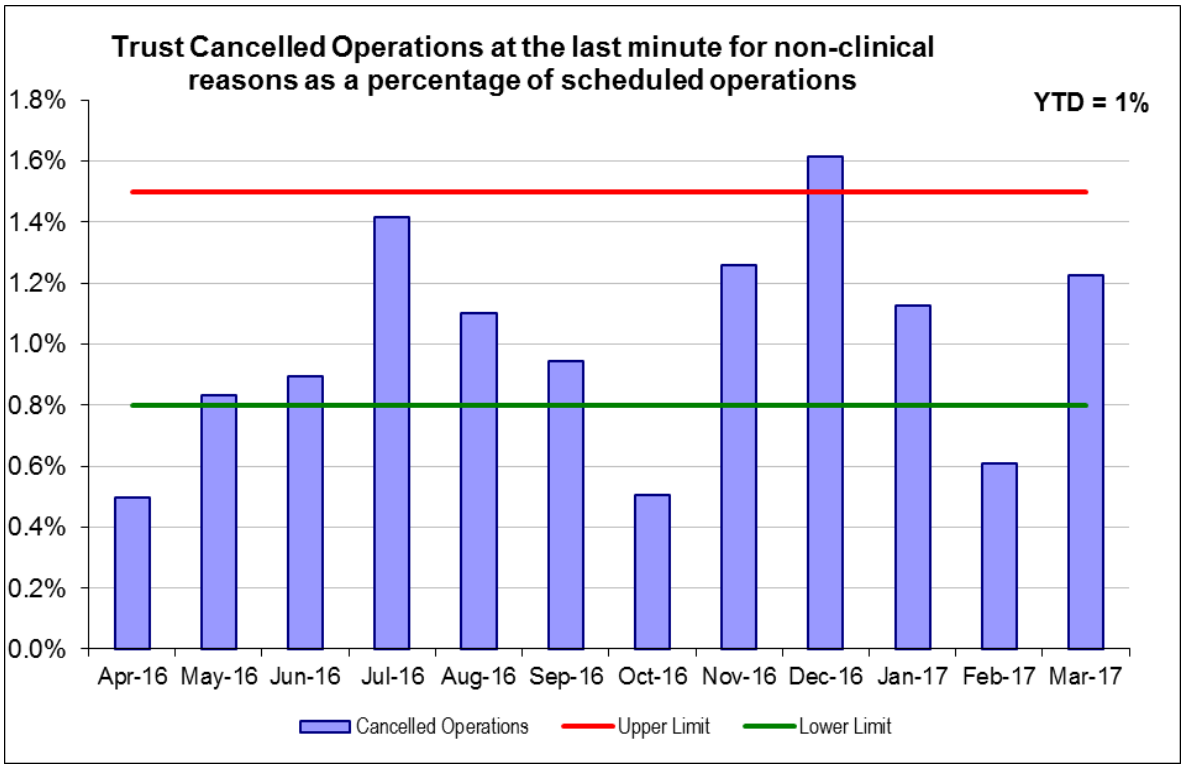


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	64.32%	77.10%	70.89%	74.75%	73.27%	78.38%	72.09%	66.48%	71.63%	70.56%	66.98%	
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

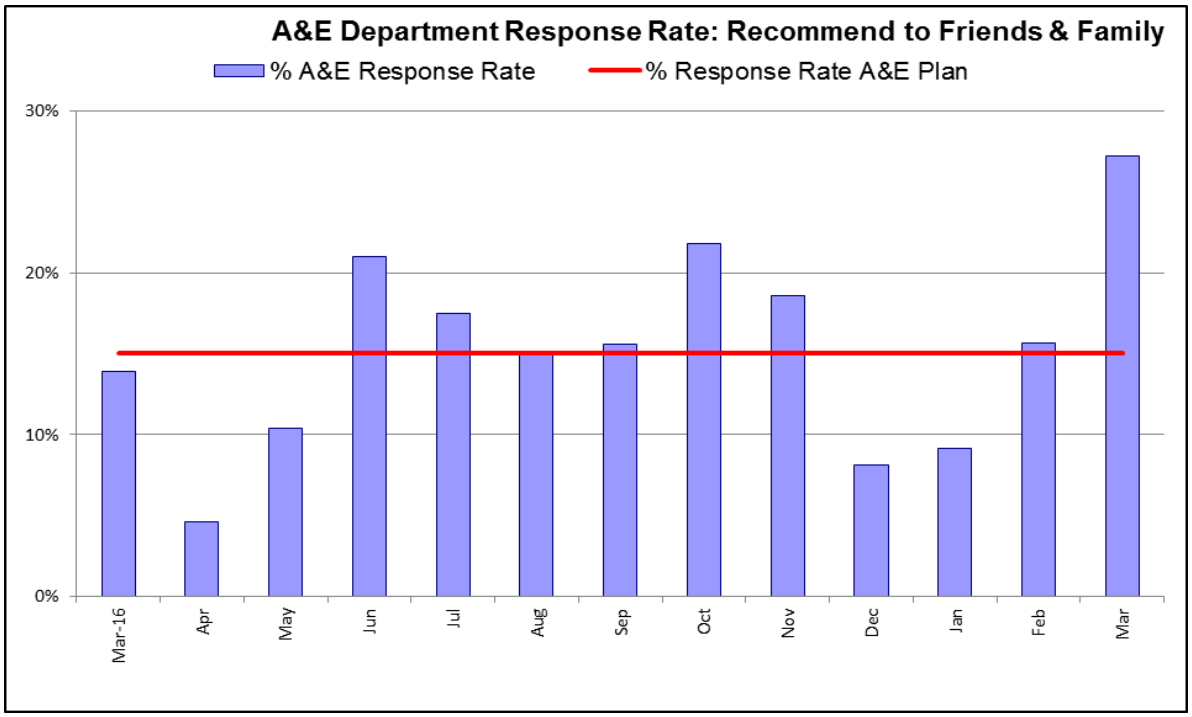
Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 6.67%.



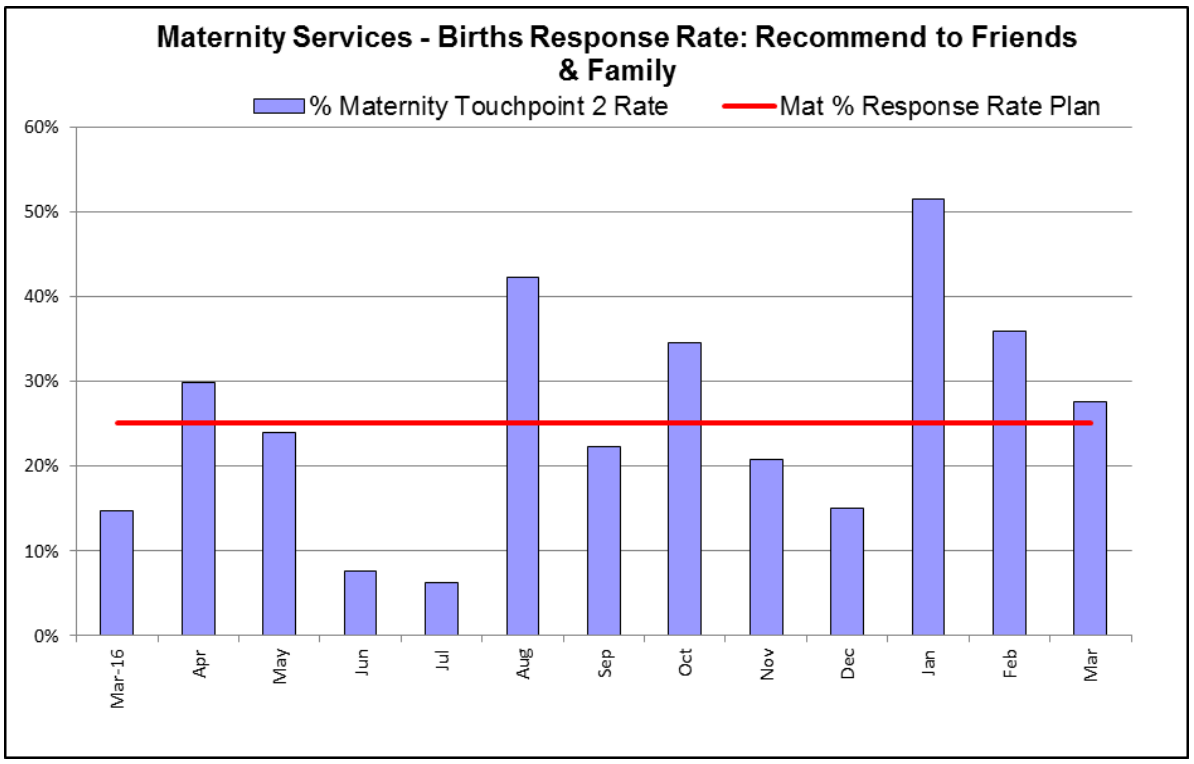
Cancelled operations – The Trust did not achieve this standard with 1% of operations cancelled at the last minute against the national maximum limit of 0.8%.



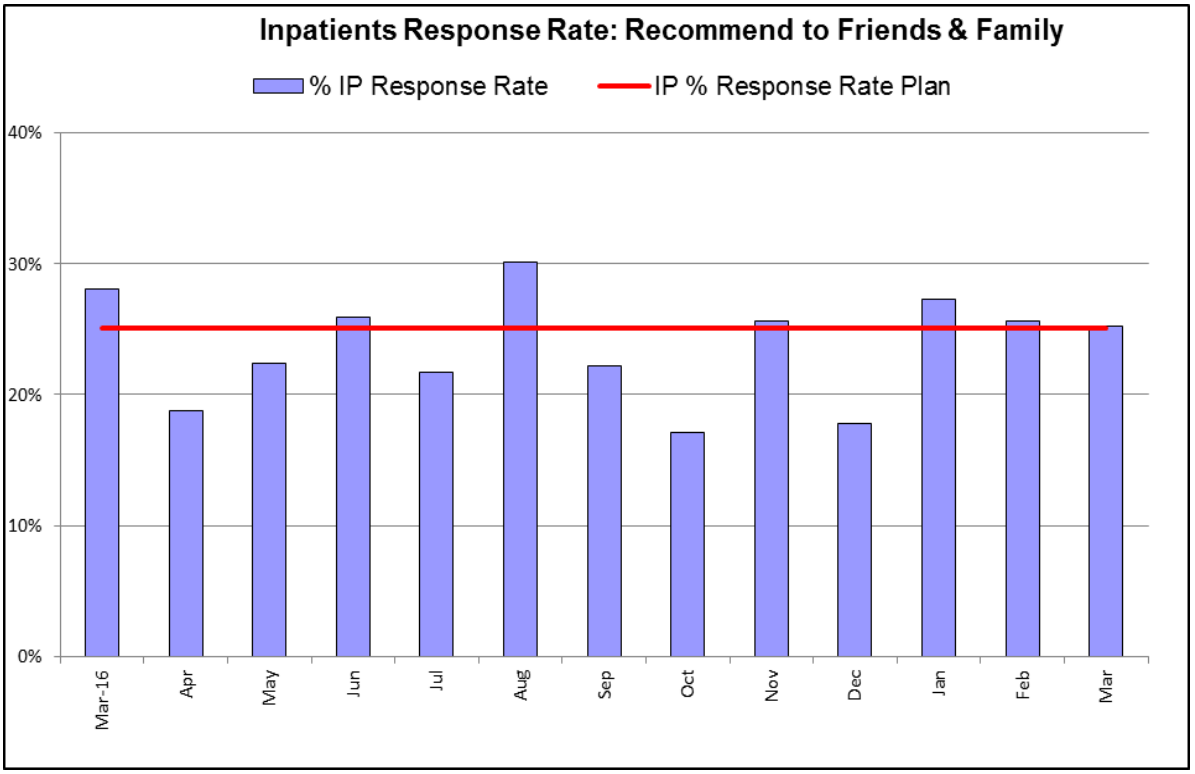
Friends and Family Test Response Rate A&E- The Trust achieved the target of 15% response rate for the Friends and Family Test given to patients in the A&E Departments at 15.5%. Of the responses received 90.7% were positive



Friends and Family Test Response Rate Maternity- The Trust achieved the target of 25% response rate for the Friends and Family Test given to patients after giving birth at 26.6%. Of all the responses received for patients accessing Maternity Services 93.6% were positive



Friends and Family Test Response Rate A&E- The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients at 23.3%. Of the responses received 95.5% were positive



National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.

Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:-

The Trust has achieved level 2 for the Information Governance Toolkit. As part of this process audits of clinical coding and non-clinical coding have been undertaken as well as completing the "completeness and validity checks".

In addition three key indicators are selected and audited each year as part of the Trust's assurance processes. This is over and above the indicators audited as part of the audit of these Quality Accounts.

The NHS Outcomes framework has 5 domains:

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

Domain	**Prescribed data requirements** **The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —**	**2016/17 local and national data**	**2015/16 local and national data**	**National average**
1 & 2	(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	1.0762 (Band 2 – "As Expected" Oct 2015 – Sept 2016	1.026 (Band 2 – "As Expected" Jul 2014 – Jun 2015	100
3	PROMS			
	i) groin hernia surgery ii) varicose vein surgery iii) hip replacement surgery iv) knee replacement surgery during the reporting period (*See below for explanation of reporting data)*	0.074 No data available 0.442 0.337 (Apr 15-Mar 16)	0.084 N/A 0.464 0.320 (Apr 14-Mar 15)	0.088 N/A 0.438 0.320 (Apr 15-Mar 16)
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of	**Trust** 10.9% **Elective** 5.1%	**Trust** 10.7% **Elective** 5.4%	(Q1 13/14 position) **Elective:** 6.81%

Domain	Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —	2016/17 local and national data	2015/16 local and national data	National average
	the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.***1**	**Non-Elective** 11.7%	**Non-Elective** 11.4%	**Non-Elective** 14.10%
4	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	82.2	83.1	79 (2015/16)
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.4%***2**	95.3%	96.0% (Jan 2015)
5	The rate per 100,000 bed days of cases of C. Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.	10.5 ***3**	7.4	15.5
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	7716 77 (0.99%)	6902 80(1.15%)	

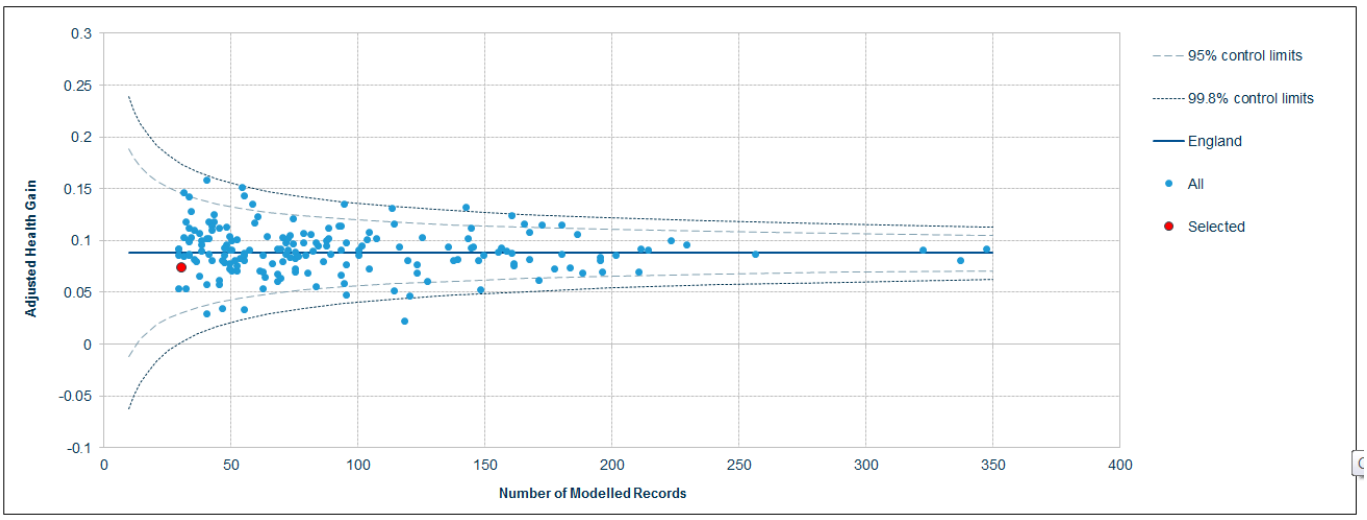
*1 Local and national data is based on 30 day re-admission.
*2 Q4 not yet published so taken from local data.
*3 Figure based on local data as national data not published at time of report. National denominator figure derived from HES data, local denominator derived from KH03 return.

Patient Reported Outcome Measures (PROMs)

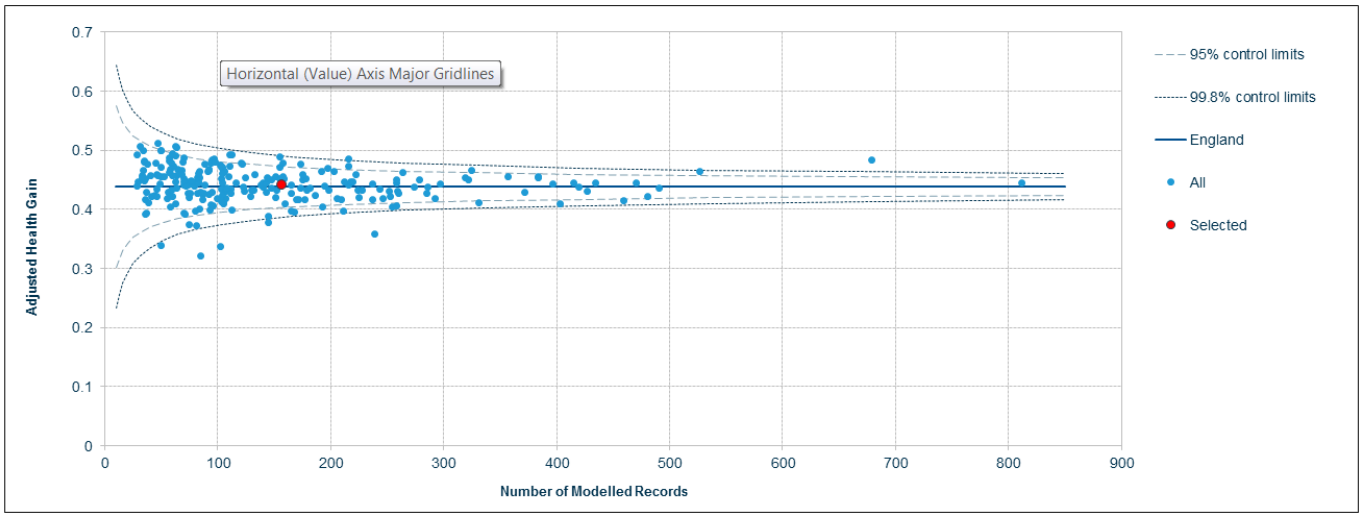
The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. Data is collected in the form of a patient questionnaire. This helps to measure and improves the quality of care.

There are four surgical procedures for which PROMs data is captured: Groin hernia, Hip replacement, Knee replacement and Varicose veins. Results are uploaded on the Health and Social Care Information Centre (HSCIC) from which the graphs below are provided. Data published in February 2017 (based on April 2015 to March 2016) shows all 3 surgical procedures showing an improvement in health gain following an operation (note that there was insufficient data for varicose veins surgery)

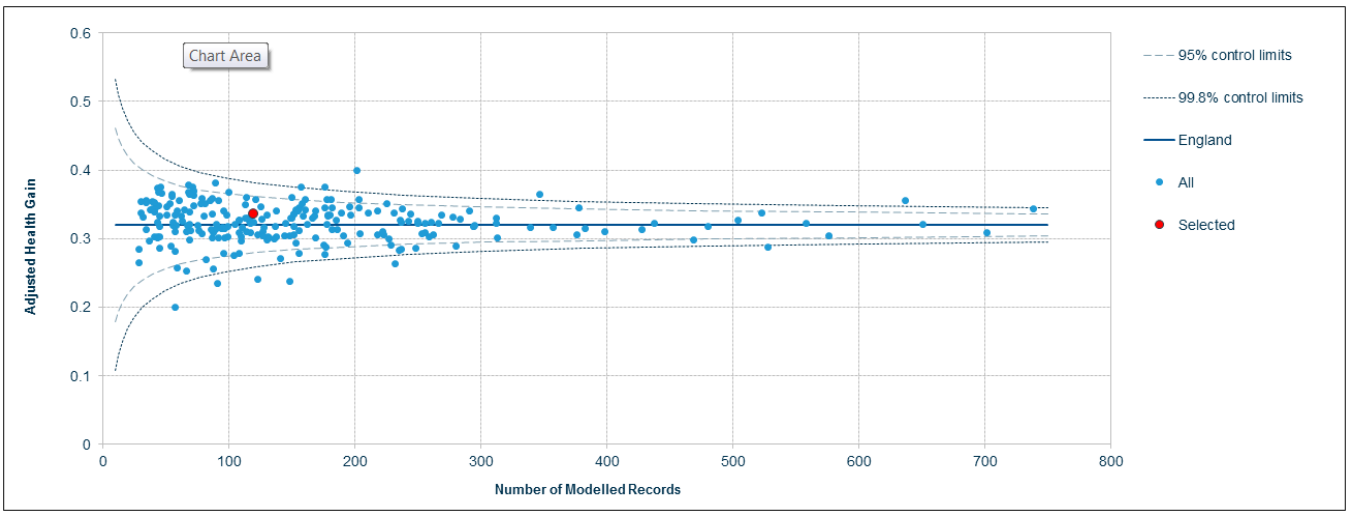
Groin Hernia – 31 returns of which 17 reported an improvement in health following the procedure.



Hip Replacement – 157 returns of which 140 reported an improvement in health following the procedure.



Knee Replacement – 120 returns of which 100 reported an improvement in health following the procedure.



Patient Safety Incidents

The proportion of patient safety incidents which resulted in severe harm or death for 2016/17 was 0.99% (1.15% 2015/16). This is calculated by dividing the number of serious and catastrophic incidents reported by Maidstone and Tunbridge Wells NHS by the total number of patient safety incidents 7716 (6902 for 2015/16).

How performance compares with the national average for this indicator where the data is available and meaningful:-

The latest report from the National Reporting and Learning System (NRLS), which was published in March 2016 and covers the period of 01/04/16 to 30/09/16, provided a reporting rate of 26.23 compared to 26.02 the same time last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% of reporters and a position we continue to improve upon.

Improving performance

Maidstone and Tunbridge Wells NHS Trust also have several Divisional and Trust-Wide clinical operational groups which monitor the organisations key performance indicators. These clinical meetings ensure that indicators can be monitored and performance improved but also supports and enables our staff to have cross-directorate discussions and to share learning and overcome concerns. These meetings include:-

The Trust Mortality Surveillance Group; established in its current format in January 2016. This meets monthly to review all hospital related mortality data, identify trends and share learning. Following recent guidance from the National Quality Board in March 2017 and the CQC (Learning, Candour and accountability Report, December 2016) the Group is currently reviewing their aims and objectives to ensure these recommendations are met over the coming year. The Group reports bi-monthly into the Trust's Clinical Governance Committee and in addition supplementary reports have been submitted to the Quality committee and Trust Board. The chair of this Group is the Medical Director.

Serious incidents pertaining to severe harm and death are investigated using Root Cause Analysis methodology and are monitored via an executive-led panel which meets monthly. This group reviews all serious incident investigations and considers the root causes of incidents to identify learning and ensure that actions can be put in place to mitigate the risk of recurrence of similar events. The learning is disseminated across the Trust through the Directorate and Trust clinical governance committees.

Maidstone and Tunbridge Wells NHS Trust meets the statutory requirement of having in place an Infection Prevention and Control Committee (IPCC), which is chaired by the Executive Lead for Infection Prevention and Control. In addition the Trust has a named Director for Infection Prevention and Control (DIPC) who also attends the Trust Board meetings. The IPCC sets the standards and monitors compliance against key infection prevention measures including those for Clostridium Difficile and MRSA. The IPCC receives Directorate reports and monitors their compliance via a monthly audit programme including standards for commode cleaning, hand hygiene, infection prevention training and Periods of Increased Incidence (PII). PII is an audit framework specifically used to check infection prevention standards in wards and departments where there may be concerns about practice, notably relating to any diagnosis of a Clostridium Difficile infection.

Each Division is required to undertake a regular Executive Performance review. These meetings monitor compliance through the Divisional dashboards. In particular Urgent Care have responsibility for the Accident & Emergency four-hour access standard and Planned Care

responsibility for the 18 week referral to treatment access standard. The Director of Operations and the Clinical Directors of these Divisions also work in collaboration with our commissioning teams to address non-compliance and to look at the implications of the wider health economy to ensure that our patient's needs are met.

Scrutiny

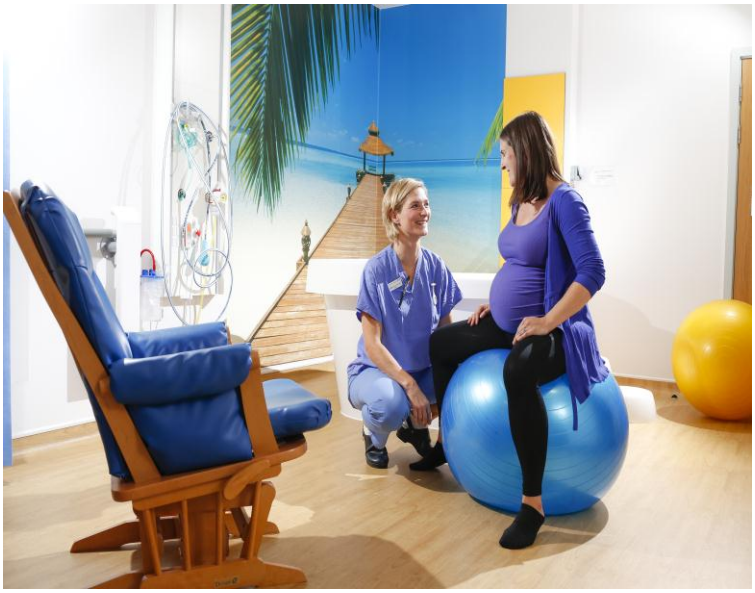
Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees, Trust Management Executive and the Quality Committee.

Additional areas of significant improvement during 2016/17

This section will provide a summary update on further initiatives that were undertaken during the past year:

Maternity
It has been a busy, but exciting time for our Maternity services during the past year. We were delighted with the recent results of an independent review by NHS England which rated our Maternity services as having the lowest stillbirth and neonatal death rates in the whole country. We have also seen a 4% rise in the number of women choosing to have their baby at MTW, reflecting the good reputation of our services held by women and their families living locally.

There have been many different initiatives to improve our service throughout the year. We have achieved a 3% increase in the number of women with a straightforward pregnancy giving birth in an out of hospital setting, which is known to improve clinical outcomes for this group of women and also helps capacity issues at Tunbridge wells hospital. Maidstone Birth Centre has had a 20% increase in births throughout the year, Crowborough Birth centre, (which came under MTW management in April 2016), has seen a rise of 28% and Homebirths continues to be a popular choice for women. 13% of all births at MTW are now taking place in an out of hospital setting and we hope to see this increase further as more women understand the advantages of this model of care for women at low risk of complications.



There have also been numerous initiatives to improve care for women with a more complicated pregnancy, such as midwifery led antenatal clinics working in tandem with obstetricians to improve continuity of care, the 'Gap and Grow' antenatal program to improve the detection of babies at risk of growth problems in pregnancy, introducing 'out of hospital induction of labour' for appropriate women and the implementation of an enhanced recovery program for women having for women having an elective caesarean birth facilitating early discharge from hospital.

Two maternity initiatives from the past year have achieved national recognition by becoming finalists at national awards; The 'Kangaroo care at elective caesarean birth' project (HSJ Awards) and the MTW Better Births initiative (RCM awards) are examples of initiatives that have been highly rated by users of our service and demonstrate improvements in clinical outcomes.

During the year ahead we will continue to focus on improving our service in relation to safety, choice and continuity of care in line with the aims of the National Maternity Review.

Cancer Services
Thanks to the collaborative working between the Trust and Macmillan we have been able to support the expansion of the Colorectal Cancer Clinical Nurse Specialist team which has been instrumental in developing and implementing the “Straight to Test” pathway of care to facilitate an earlier diagnosis for our patients and streamline their journey. This also seeks to make further improvements with our cancer waiting targets.

A three month evaluation was undertaken at the Kent Oncology Centre’s chemotherapy day unit to trial an air tight sealing disposal system for cytotoxic waste management. This seeks to improve safety in the disposal and potentially reduces the amount of evaporated chemotherapy exposure for our patients and staff. This will also improve our environmental footprint. This will now be rolled out across the directorate.

We also undertook a trial and set-up an ambulatory haematology day unit. The intention was to ensure patients receive the right care in the right place at the right time and did not have to be unnecessarily admitted to an acute bed, thereby supporting our patients to spend as much time as possible in their home environments. With the implementation of the Ring fenced bed for our dedicated haematology in patient ward alongside ambulatory care this will also positively affect our hospitals length of stay and maximise our bed availability.

Neonatal
Our Neonatal team have taken advantage of the benefits of technology, for our new Mothers who are in the High dependency or Intensive care units and physically unable to visit their babies in the Neonatal unit, through the use of ‘facetime’ on IPads donated by previous parents. This helps to lessen their anxiety and supports that important interaction between a mother and her baby.

In addition we are supporting the Unicef Baby Friendly Initiative standards and are working towards Level 2 accreditation having identified 2 breast feeding leads and started staff training days. Our neonatal team also have regular BLISS (for babies born premature or sick) meetings which are attended also by a parent representative, work will be ongoing this year to continue to improve and reach the required standard required for accreditation.

The Trust Website has also been updated to support the parents of neonatal babies, and during the course of this year we appointed a Bereavement lead for parents whose baby has died. This service has also addressed the shortfall that we had previously identified for those parents who have had a baby at Tunbridge Wells hospital but who later dies in an out of area hospital.

End of Life Care (EoLC)
Several initiatives have been undertaken to improve EoLC within the Trust during 2016-2017. The Trust have mandated EoLC training for all registered clinical staff working within adult inpatient and emergency services on a three-yearly basis. Clinicians have the option of completing their training via the bespoke EoLC E-Learning package, developed within the Trust, or attending one of the mandatory training sessions. In addition, each adult ward has a named EoLC Palliative Care Clinical Nurse Specialist (CNS) to identify specific palliative and EoLC training needs and an identified "Ward Champion".

A survey of our bereaved relatives’ experience of care within MTW was undertaken between September 2016 until March 2017 to bench mark EoLC care and inform future service development. The first 100 completed surveys returned have now been analysed. Results identified that 83% of respondents rated the care for their relatives and friends in the last few days of life as good or excellent and 91% felt that that the patients were treated with dignity and respect. This will now be an ongoing Trust survey.

Following MTW's disappointing results from The National Care of the Dying Audit (2015) the audit was repeated internally by the EoLC and Palliative Care Team during 2016 using a more representative sample. Preliminary findings are favourable and have shown an improvement in all but one of the five indicators.

The individualised Care Plan for the Dying Patient documentation has been revised in consultation with clinicians and piloted on two wards and will be re-launched within the Trust in June 2017.

Review of Bed Capacity and speciality allocation to support the increased demand for admissions

During the course of the year we have reviewed our bed capacity based on the needs of our patients and as a result we have made every effort to redistribute our beds to meet the changing demand of our patients and thereby improve pathways of care for both planned and unplanned admissions by supporting the right care in the right place.

The Maidstone Orthopaedic Unit has transferred back to Orthopaedics to support the timely admission of orthopaedic patients waiting for elective procedures. We have also changed the criteria for admission to the Gynaecology ward which has since been renamed Ward 33 and now cares for female general surgical patients in addition to gynaecology patients. In addition three beds from the post-natal ward have been reallocated to Ward 33 increasing the general bed stock by three beds. The Private Patients Unit has also seen the conversion of three of its outpatient rooms back to patient bedrooms and 20 rooms on this unit have now been allocated to General Medicine from surgery. The Cardiac catheter (Cath) Lab recovery unit at Tunbridge Wells hospital has become the new home of the Surgical Assessment Unit. Cath lab patients will now be recovered in the pain room which has been redesigned to take three recliner chairs. In addition three of the rooms in the Coronary Care Unit have also been altered to accommodate 2 trolleys each, for Cath Lab recovery patients. These changes ensure that cardiac interventional surgery is not impeded due to the escalation of patients into these recovery beds whilst also ensuring that the surgical flow of patients from A&E can be assured of prompt assessment. In addition these changes have collectively meant that the Short Stay Surgical Unit can now open as a dedicated 23 hour stay day surgery unit, with an admissions lounge for elective patients. Interventional radiology patients are also being accommodated here, therefore ensuring prompt treatment.

In addition we have more recently reviewed those patients who are awaiting social care arrangements, who are deemed to be medically fit but who still require nursing care, and through this review of patient needs we have been able to reallocate our resources more efficiently with the creation of two medically fit wards. These are - Ward 20 at the Tunbridge Wells hospital and Whatman Ward at Maidstone hospital. These wards are also supported by activity co-ordinators and members of our Discharge team thereby ensuring that we can promote a more homely environment until arrangements can be made to support them out of hospital.

Our paediatric patients have also seen improvements with the longer opening hours of the Woodland Assessment unit and the conversion of some of Hedgehog's utility rooms into bedrooms; this has helped to reduce the number of out of area transfers due to a lack of capacity during periods of increased admissions.

We are confident that these considered reviews and redistribution of bed stock and resource has helped us as an organisation to make essential improvements in both the quality and effectiveness of our patients' treatment and care and also supported their timely discharge home by getting it right the first time.

Part Four
Appendices A, B and C

Appendix A

41 National reports were published where the topic under review was relevant to the Trust in 2016/17 with action to be taken in 2016/17

National Report Published April 2016 to March 2017	*Report received*	Date report due
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**Summary report received for July 2016 for 2015/16 data.** Local reports with national comparative data. Reviewed and reported to the Trust's Resuscitation Committee. Data continues to be submitted to this audit however we have no current concerns identified.
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	**Y**	**Report received June 2016.** Annual ICNARC Report for 1 April 2016 to 31 March 2016 was presented and discussed. Generally results were very encouraging for both Units when benchmarked against similar Units. Excellent SMR for both Units. Areas of concern were delayed admissions at TWH, delayed discharges on both sites. A business case to increase the dependency at TWH to 8 should improve delayed admissions considerably. High levels of high risk sepsis admissions on both sites were thought to be due to the case mix the Units see i.e. Emergency abdominal surgery at TWH and Haem/Oncology at Maidstone.
Emergency Laparotomy Audit (NELA)	**Y**	**5 July 2016** Report received and disseminated to team for review and assessment. Audit results regularly reviewed and assessed at clinical sessions. The Trust is in the top performing Trusts.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	**27 July 2016 (Orthopaedic Injuries) / 29 December 2016 (Head & Spinal Injuries) March 2017 (Thoracic and Abdominal Injuries)** These are reviewed by the Clinical Lead for Trauma and discussed at Trauma Board. Any areas of underperformance are highlighted and actions for improvement identified. A report highlighted a lower than average percentage of patients with head injuries getting to CT scanning within 60 minutes of admission. Prioritising these patients for CT has led to improved results.
National Joint Registry (NJR)	**Y**	**Report received November 2016.** Annual NJR Report for 1 January to 31 December 2015. The report shows overall great compliance of 99% for the Trust. Our Trust is not an outlier.
Smoking Cessation	**Y**	**Comparative data received 7 December 2016.** The Trust is partially compliant. Patients are appropriately referred to Smoking Cessation Services. Need to ensure doctors are aware of the availability of Nicotine replacement Therapy and prescribe as necessary.
Vital Signs in children (care in the emergency department)	**Y**	**National report received 31 May 2016.** Site specific reports received June 2016. Both sites performed well in the taking and recording of vital signs with 97% compliance. Results for Maidstone were slightly better than TWH but this should show an improvement with the opening of a specific Paediatric ED.

National Report Published April 2016 to March 2017	*Report received*	Date report due
VTE Risk in lower limb immobilisation (care in emergency department)	**Y**	**National report received 31 May 2016;** site specific reports received June 2016. Both sites performed well Maidstone 97% and TWH 100%. Need to ensure there is evidence that patient information leaflets are being given to all patients.
HQIP National SAMBA 16 (Society for Acute Medicine Benchmarking Audit)	**Y**	**September 2016. Report received Jan 2017 with specialty for assessment.** The Trust is partially compliant. Trust-wide education to take place to ensure all patients admitted to AMU have an Early Warning Score (EWS) measured upon arrival at AMU and reviewed by a competent decision make within 4 hours.
Procedural sedation in Adults (Care in emergency department)	**Y**	**National report received 31 May 2016**; site specific reports received June 2016. The Trust is partially compliant. Implementation of new sedation proforma to ensure all relevant observations are taken and recorded.
UK Cystic Fibrosis Registry (Paediatric and Adult)	**N/A**	The Trust does not provide this service
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	**N/A**	The Trust does not provide this service
Use of Emergency Oxygen (BTS)	**Y**	**Report received May 2016.** Trust is partially compliant. Respiratory Clinical Nurse Specialists to continue drug prescription chart for all patients requiring emergency oxygen. Implementation of Nerve Centre database to allow for target parameters to be entered for each patient. Explore purchasing of ear SpO2 probes to ensure appropriate monitoring equipment is available in all clinical areas.
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**Y**	**Report received August 2016.** Haematological patients are high blood users and those with chronic BMF receive more blood than those with reversible BMF. Single unit red cell transfusions are uncommon and prophylactic single unit platelet transfusions would almost certainly be increased if counts were performed prior to transfusions of further units. Local hospital guidelines are frequently discrepant with national guidelines and contribute to inappropriate transfusion practice. Compliance is similar across all levels of care.
Use of blood in lower GI bleeding	**Y**	**Report received May 2016** with the speciality awaiting assessment completion
Audit of patient blood management in scheduled surgery	**Y**	**Report received January 2017.** Patient Blood management has not been integrated in surgical practice within the Trust. The Trust performs below national average on delivering the recommendations within PBM in surgical patients. The results are being discussed and managed at a Trust-wide level and there is a re-audit on the 2017/18 programme.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**N/A**	No report available this year
Cancers		
National Cancer Diagnosis Audit	**N/A**	Primary Care Audit only
Lung Cancer (NLCA)	**Y**	**National Report received 25 January 2017.** With speciality for assessment, assessment should be completed by end April 2017

National Report Published April 2016 to March 2017	*Report received*	Date report due
Bowel Cancer (NBOCAP)	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017
Head & Neck Cancer (DAHNO)	**N/A**	**February 2017 –** No report from DAHNO yet.
National Prostate Cancer Audit	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017
Oesophago-gastric cancer (NAOCG)	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017
Urology		
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	**N/A**	**No report available**
BAUS Urology Audits: Radical Prostatectomy Audit	**N/A**	**No report available**
BAUS Urology Audits: Cystectomy	**N/A**	**No report available**
BAUS Urology Audits: Nephrectomy Audit	**N/A**	**No report available**
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**N/A**	**No report available**
BAUS Urology Audits: Urethrolasty audit	**N/A**	The Trust does not provide this service
National Ophthalmology Audit	**Y**	**National report received May 2016** and reviewed by specialty**.** Plan to enter data for next round of the audit.
Chronic Kidney Disease in Primary Care	**N/A**	Primary Care Only
Renal Replacement Therapy (Renal Registry)	**N/A**	The Trust does not provide this service
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15 data (202)	**Y**	**National report received 30 January 2017.** With Specialty for assessment. Should be available by mid-May.
Heart failure Audit 2014-15	**Y**	**National report received August 2016.** Performance at both sites is above national average. Both hospitals have a designated Heart Failure Nurse Service for inpatients, excellent echocardiogram services, cardiologist support for inpatient referrals and regular multi-disciplinary heart failure meetings.
National Cardiac Arrest Audit (NCAA) 661	**Y**	**National report received June 2016** There were no abnormal variants regarding age, sex or location. The Trusts survival to discharge rate is better than the predicted figures for similar hospitals.
Cardiac Rhythm Management (CRM) 2014-15	**Y**	**National report received 3 August 2016.** Overall performance on both sites was good with particularly good data on physiological (dual chamber) pacing for SSS. CRT and ICD implant rates are in line with national performance.
Coronary angioplasty/ National audit of PCI 2014	**Y**	**National report received 1 April 2016.** Radial access to be established as default access route for PCI, compliance increases year on year. Data completeness to be improved for patient diabetic status and renal function.
Adult Cardiac surgery	**N/A**	The Trust does not provide this service
Congenital heart disease (Adult cardiac surgery)	**N/A**	The Trust does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	**N/A**	The Trust does not provide this service
Pulmonary Hypertension	**N/A**	The Trust does not provide this service
National Vascular Registry	**N/A**	The Trust does not provide this service
National Pregnancy in Diabetes Audit 171	**Y**	**National report received 1 November 2016.**

National Report Published April 2016 to March 2017	*Report received*	Date report due
		Our numbers were too small to be included in some of the analysis of this report. MTW were better than National and Regional results for Glucose Control, along with Folic acid supplement prior to pregnancy. However, we were lower with our Antenatal Care. MTW are to continue regular contact with local GP's and maintain the leaflets in the surgeries. Consider development of a preconception clinic.
National diabetes inpatient audit (NaDIA) 2016	**Y**	**National report received 8 March 2017.** With specialty for assessment
National Core Diabetes Audit (NDA) 2015-16 (573)	**Y**	**Report published 31 January 2017**. Downloaded April 2017, report missed due to double reporting by NDA. Currently with specialty for assessment.
Inflammatory Bowel Disease (IBD) Programme – IBD registry 2015-16	**Y**	**National report received 23 September 2016**, The Trust partially compliant. IBD specialist nurses now in place to assist with ensuring patients are followed up within appropriate timescale.
Rheumatoid and early inflammatory arthritis (NCAREIA) 2015-16	**Y**	**National report received 24 July 2016.** Overall the Trust is partially compliant. Poor GP referrals make it difficult to triage patients into appropriate ESYN (early synovitis) clinics. GP referral database (DORIS) is available but not always used. Additional clinic capacity required to ensure patients are seen within 3 weeks of referral. Advice line available for direct access to department. 24 hour answer phone service with calls returned within 48 hours.
Neurosurgical National Audit Programme	**N/A**	**Trust does not provide this service**
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	**N/A**	**1. Inpatient Falls (NAIF) No report this year**
	N/A	**2. Fracture Liaison Service** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture Database Report due 3 September 2016.** Received and discussed within the team. An Ortho-Geriatrician has been appointed to enable joint care of patients with Orthopaedic Consultants on admission. Designated #NOF nurse to measure time taken for patient to be taken to theatre to identify areas where this patient journey can be shortened.
Sentinel Stroke National Audit Programme (SSNAP)	**Y**	**National report received October 2016** with specialty for assessment. Should be available by end May
UK Parkinson's	**Y**	**National report received August 2016.** The Trust is partially compliant. Need to allocate more time in clinics to allow for discussions re excessive daytime sleepiness and driving and anticipatory care planning to be had and documented. Need to be more aware of the management of bone health particularly in patients that have had a fall.
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	**Y**	**National Report received January 2017** MTW are to review the promotion of the PROMS questionnaires to patients in the pre-operative setting and reviewing the data that is being collected internally
Mental Health		

National Report Published April 2016 to March 2017	*Report received*	Date report due
Prescribing Observatory for Mental Health (POMH)	**N/A**	The Trust does not provide this service
Suicide and homicide in mental health (NCISH)	**N/A**	The Trust does not provide this service
Prescribing Observatory for Mental Health (POMH-UK): Prescribing anti psychotics for people with dementia	**N/A**	The Trust does not provide this service
Prescribing Observatory for Mental Health (POMH-UK): Monitoring of patients prescribed lithium	**N/A**	The Trust does not provide this service
Women & Children		
MBRRACE-UK; National Surveillance of perinatal deaths (Late foetal losses) 581	**Y**	**Report received May 2016** Each Cause of Death is checked by the Bereavement Midwives or Maternity Clinical Risk Manager before signing off. It's also discussed at Risk meeting if no post mortem performed.
MBRRACE-UK; National Surveillance and confidential enquiries into maternal deaths 719	**Y**	**Report received 7 December 2016** Plan to extend the Emergency Gynaecology Assessment Unit to 12 hours a day. A business case has been in place for the last 3 years for scanning at the weekend, but due to the financial situation this hasn't happened.
MBRRACE-UK; Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	N/A	The Trust does not provide this service
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme) 414	**Y**	**Report received September 2016.** Biological therapies are safe. Treatment rates for UC have increased substantially in the past year. Meeting with Pharmacy to switch patients already on Remicade to Biosimilars. New starters to only be prescribed Biosimilars.
National Paediatric Diabetes Audit (NPDA) 2015 64	**Y**	**Report received June 2016** A total of 119 children were included. Overall the Trust was higher on a number of treatment regimens and met the criteria best practice for children with adjusted percentage HbA1c .The remaining criteria indicates the Trust outcomes were slightly lower than the National average, remedial actions have been put in place to support improving outcomes.
Neonatal Intensive and Special Care (NNAP) 2015 90	**Y**	**Report received September 2016** Trust performance is in line with national figures. Need to list all babies<35 weeks and check whether steroids given on a monthly basis. Baby Friendly training starts April 2017 to be Baby Friendly Initiative compliant at Level 2 for all Neonatal Unit staff. Encourage all Dr's and NNU nursing staff and night staff to complete information on Badger information system.
Paediatric Asthma 65	**Y**	**Report received March 2016** The Trust is largely compliant with the national standards. More of our patients are given steroids and antibiotics than the national average Asthma awareness training sessions to be set up and new guidelines and information to be uploaded to intranet.
Paediatric Intensive Care (PICANet)	**NA**	
Confidential Enquiries		
NCEPOD: Acute Pancreatitis (Treat the Cause)	**Y**	**Report received 7 July 2016.** Trust mainly compliant with recommendations. A Business Case for more dedicated theatre lists (hot lists) is

National Report Published April 2016 to March 2017	*Report received*	Date report due
		being discussed to enable more timely access to theatres. Planning to reinstate the system of GP referral letter post-discharge advising of the need to refer patient to support services (Alcohol Support Services) as this service is provided by another Trust and will require referral by the patients GP.
NCEPOD: Treat as One (Adult Mental health in Acute hospitals)	**Y**	**Report received 26 January 2017** Report received and distributed. With specialty for assessment.

Appendix B

Updated actions on reports received during March 2015 to April 2016. These were awaiting review or had previously been reviewed and action plans developed. These reports have been reviewed and the table below shows which actions have been completed and implemented or where reviews are still outstanding.

National Report Published April 2015 to March 2016	*Report received*	
Acute Care		
National Cardiac Arrest Audit (NCAA)	Yes	The Trust continues to have a better than predicted survival to discharge rate for patients who have an in hospital cardiac arrest. To continue with training programmes.
Adult Critical Care Case Mix Programme (ICNARC) (Round 2) (CMP)	Yes	Report April 2015 Will continue to submit data and review the quarterly reports.
Emergency Laparotomy Audit (NELA)	Yes	Clinical report received. October 2015.Surgeons are completing the pre-POSSUM booking process passes and the consultant surgeons attendances are in line with the national average. Mortality rates continue to be better than national average.
Severe Trauma (Trauma Audit & Research Network) TARN	Yes	Themed reports published 3 times per year. Rehab prescription developed in conjunction with TARN database.
National Joint Registry (NJR)	Yes	Report received September 2015. With specialty for assessment. This was superseded by the next years report.
Adult Community Acquired Pneumonia	Yes	Report received December 2015. Continued education for frontline staff in the need for prompt chest x-ray request. Ongoing programme to ensure PGD for antibiotic prescribing, now in place for A&E and AMU nursing staff to ensure prompt administration of first dose antibiotics. Continued education of doctors in the need for combined antibiotic prescribing for patients with moderate or high severity CAP (CURB65 score 305).
Fitting child (care in emergency departments)	Yes	Report received June 2015. The Trust is partially compliant. Introduction of Paediatric ED and consultant Paediatrician for assessment of fitting children. Need to ensure blood glucose is taken as part of the initial assessment and documented in the patient's clinical record.
HQIP National SAMBA 15 (Society for Acute Medicine Benchmarking Audit)	Yes	Report received October 2015. Training programme to ensure patients should have an Early Warning Score documented and they are seen within 4 hours of arrival by a competent decision maker.
Mental health (care in emergency departments)	Yes	Report received June 2015. Mental health risk assessment proforma (SMART tool) successfully introduced. Mental Health awareness now embedded into A&E induction teaching programme.
Blood transfusion		
(National Comparative Audit of Blood Transfusion Programme) National comparative audit of blood transfusion of patient information and consent 2014	Yes	Consent for transfusion is poorly delivered and documented. The Trust performs below national average on delivering information to patients regarding the risks and alternatives on blood transfusion, and is worse at documenting it. Rationale is better documented however 100% compliance is now required for which we fall short.
Audit of patient blood management in scheduled surgery	Yes	Patient Blood Management (PBM) has not been integrated in surgical practice within this Trust. The Trust performs below national average on delivering

National Report Published April 2015 to March 2016	*Report received*	
		the recommendations within PBM in surgical practice. The timely identification and management of preoperative anaemia is lacking, as is identifying patients at increased surgical risk and thus there is a need to urgently address this. PBM intra-operative strategies need to be looked at and implemented and blood usage was often inappropriate and there is a need for the Trust to introduce a single unit transfusion policy with clearly defined transfusion triggers.
National Comparative Audit of blood transfusions: use of Anti-D 2012	Yes	Report received October 2015 and with specialty for final updates on assessment and action plan. Due for completion May 2017
Cancer		
Lung Cancer (NLCA)	Yes	Report received December 2015. With specialty for assessment. This was superseded by the next years report.
Bowel Cancer (NBOCAP)	Yes	The colorectal department is achieving consistently excellent clinical outcomes with mortality rates well below the regional and national average in one of the busiest departments in the country. There are no areas of clinical care identified within the audit where the department is an outlier.
Head & Neck Cancer (DAHNO)	Yes	Report received December 2015 and with specialty for review and action plan development
National Prostate Cancer Audit	Yes	This National Prostate Cancer Audit reports outcomes for patients diagnosed with Prostate Cancer in England between 2010 and 2013. Most of the results are presented by Cancer Network with some Trust specific data for patients diagnosed between 1 April 2014 and 31 July 2014. The Kent and Medway results show good data completeness (6th best in England), a low rate of potentially inappropriate radical treatment in cases of low risk prostate cancer (and by inference an acceptance of the role for active surveillance in these cases), an appropriate use of radical RT in cases of locally advanced prostate cancer, a low length of stay post radical prostatectomy with a low readmission rate.
Oesophago-gastric cancer (NAOCG)	Yes	Overall, the mortality from this surgery in the Trust was within the national expected figures: year and year survival figures were 80% and 50% (compared to ~75% and ~45% from the AUGIS data for national mortality). A review of other surgery carried out by the Trust assured the Trust Board that patients are receiving high quality and safe care. Patients requiring Oesphagectomy and Gastrectomy are receiving the majority of their care locally, but the major operation now takes place in Guys and St. Thomas's Hospital in collaboration with MTW's clinical cancer teams.
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15	N/A	National report received January 2017. This is now reported in the 2016/17 Quality Accounts Report.
Heart failure 2013-14	Yes	National report received November 2015. Performance at both sites is above the national average. Both hospitals have a designated Heart Failure Nurse Service for inpatients, excellent echocardiogram services, cardiologist support for inpatient referrals and regular multi-disciplinary heart

National Report Published April 2015 to March 2016	*Report received*	
		failure meetings
Cardiac Rhythm Management (CRM) 2014-15	N/A	National report received August 2016. This is now reported in the 2016/17 Quality Accounts Report.
Coronary angioplasty/ National audit of PCI 2014	N/A	National report received August 2016. This is now reported in the 2016/17 Quality Accounts Report.
Adult Cardiac surgery	NA	MTW does not provide this service
Congenital heart disease (Paediatric cardiac surgery)	NA	MTW does not provide this service
Pulmonary Hypertension	NA	MTW is not a Specialist PH centre.
National Vascular Registry	NA	MTW does not provide this service.
Long Term Conditions		
National (Adult) Diabetes Audit (NDA)	Yes	Report received February 2016. There are encouraging trends of improvement in blood pressure control for people with type 1 and type 2 Diabetes and glucose control for type 1 Diabetes. People aged under 40 are much less likely to receive their care processes and those under 65 are less likely to achieve their treatment targets
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Yes	National report received September 2015. IBD specialist nurses now recruited to assist with 3- and 12- month follow-up appointments, submission of patient data onto the IBD Biologics database and PROM forms completed.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – PULMONARY REHABILITATION	Yes	National Report received October 2015. Discussion has taken place with the CCG to obtain funding / staffing and extend the rehabilitation programme to include MRC2 patients as long as they have functional limitations due to breathlessness.
HQIP National Diabetes Footcare audit	Yes	Report published March 2016. The Trust is fully compliant. All patients are advised to check their feet regularly. Prompt referral to the podiatrist if any concerns about feet present. All patients admitted with diabetic foot problems are referred to diabetes foot MDT for review within 24 hours.
Rheumatoid and early inflammatory arthritis	Yes	Report received January 2016. Overall the Trust is partially compliant. Poor GP referrals make it difficult to triage patients into appropriate ESYN (early synovitis) clinics. GP referral database (DORIS) is available but not always used. Additional clinic capacity required to ensure patients are seen within 3 weeks of referral. Advice line available for direct access to department. 24 hour answer phone service with calls returned within 48 hours.
National Audit of Intermediate Care	NA	The Audit is not applicable to the Trust.
Chronic Kidney Disease in Primary Care	NA	MTW does not provide this service
Renal Replacement Therapy (Renal Registry)	NA	MTW does not provide this service
Older People		
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	Yes	1. Falls- Report received November 2015. The Trust performed very well in the organisational aspects of this audit. Ongoing education to ensure lying and standing blood pressure is performed as soon as practicable and appropriate actions taken if there is a substantial drop in blood pressure on standing.
	N/A	2. Falls Liaison Service
	Yes	3. National Hip Fracture Database- Report reviewed by department. Business plan for a second Ortho Geriatrician in place, interviews to take place.
Older people (care in emergency departments)	Yes	Report received June 2015. Overall the results from this audit are good. The one fundamental standard, 'that all patients over the age of 75 have at least one Early Warning Score' has already been addressed with the implementation of the Rapid assessments

National Report Published April 2015 to March 2016	*Report received*	
		areas at both sites.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received January 2016 and with specialty for review and action plan development.
UK Parkinson's	N/A	National report received August 2016. This is now reported in the 2016/17 Quality Accounts Report.
Other		
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Yes	National Report received January 2017. MTW are to review the promotion of the PROMS questionnaires to patients in the pre-operative setting and reviewing the data that is being collected internally.
Mental Health		
Prescribing Observatory for Mental Health (POMH)	NA	MTW does not provide this service
Suicide and homicide in mental health (NCISH)	NA	MTW does not provide this service
Women's and Children's Health		
MBRRACE-UK; Perinatal Mortality Surveillance report; UK Perinatal Deaths for Births in 2013	Yes	Report received October 2015. All notes are reviewed at multidisciplinary mortality meetings. Learning identified and discussed at Risk Meeting, Clinical Governance Community Midwives team leaders meeting, Maternity Risk update. GAP (Growth Analysis Protocol) Project being implemented. Interpreters for Non English speaking patients. Kick Count being promoted by Community Midwives. This was the first time that many clinicians had used the Cause of Death & Associated Conditions (CODAC) system of death classification. In order to ensure accurate, consistent reporting it's recommended that the coding of the cause of death is undertaken by small local multidisciplinary teams. Cause of death to be checked by Bereavement Midwives or Maternity Clinical Risk Manager following post mortem/ all test reviewed. Continue processes and pathways already in place as now fully compliant
MBRRACE-UK; Perinatal Confidential Enquiry; Congenital Diaphragmatic Hernia (CDH)	N/A	MTW does not provide this service
MBRRACE-UK; Perinatal Confidential Enquiry; Antepartum stillbirth in term normally formed infants 2014	Yes	Report received November 2015. Growth should be monitored from 24 weeks by measurement of the symphysis fundal height and plotting the measure on a growth chart. Growth Analysis protocol being implemented from April 2016. GAP is now in place, with staff trained and aware of the policy.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Yes	Report received September 2015. Education programme has been developed on the use of the Infliximab pro-forma that is filled out when patients come to the ward. All new patient starters have a chest Xray, T-Spot and appropriate bloods prior to starting biologics. Guidelines followed. All Patients that start Biologics are followed up within 3 months of commencing Biologics and seen by the Nurse Specialist at each infusion to document Progress. PCDAI used to score patients progress. Steroids are always used as a last resort in patients with Crohn's disease.
National Paediatric Diabetes Audit (NPDA) 2014	Yes	Report received March2015. This was superseded by the next years report as the Assessment of Compliance for 2014 was never completed.
National Pregnancy in Diabetes Audit (NPID) 2014	Yes	Report received November 2015. Further liaising with primary care teams/GP surgeries regarding

National Report Published April 2015 to March 2016	*Report received*	
		promotion of pre-conception care. Investigate the possibility of offering a pre-conception clinic facility within the maternity unit at MTW. Look at the possibility of creating a pre-conception advice page on the Trust website. Parts of the population are not accessing the care prior to pregnancy and this needs the primary carers to become involved. Encourage primary carers to use the available posters in the surgeries to improve uptake of pre-conception care.
Neonatal Intensive and Special Care (NNAP) 2014	Yes	Report received December 2015. New E3 Euroking maternity system downloads data direct to Badger interface. Badger training now included on new Drs induction programme by NNU staff
Paediatric Intensive Care (PICANet)	NA	MTW does not provide this service
National Confidential Enquiries		
Sepsis Study: 'Just Say Sepsis'	Yes	Report published November 2015. The Trust has a protocol that has been ratified and is available on Q-Pulse. Shortfall was identified in training of F2's and Registrars on the management of sepsis. Training slots to be arranged with clinical tutors. The outreach team carry out mandatory training on sepsis and there is an e-learning package available. Standardised sepsis proforma developed to aid the identification, coding and treatment of sepsis are in use and available across the Trust. A&E has a triage process using PAR scoring to identify patients with suspected sepsis. Nerve Centre is also used to identify these patients and ensure appropriate treatment pathways are followed. The Trust undertakes training on the management of Severe Sepsis and Infection control. A training package is included on the Trust mandatory training programme on antimicrobial policies and prescribing. The Trust provides rehabilitation in critical care and a 3 day follow up service on the wards but no formal post discharge follow-up is available due to limited resources. Patients who die with sepsis are discussed at M&M meetings, Autopsies are only done following a Coroner's opinion.
Gastrointestinal Haemorrhage Study: 'Managing the flow'	Yes	Report received July 2015 A Task and Finish Group has been set up to review service provisions in line with the recommendations of this national report. New pathway to be developed between Lower GI and Upper GI consultants to ensure continuity of care. A care pathway is to be developed to incorporate all elements of assessment, escalation of care, documentation and network arrangements. To establish the role of an on-call consultant who will be responsible for major GI bleeds to enable assessment within one hour of the diagnosis of a major bleed. A service to enable 24/7 access to an OGD within the optimal 24 hours is to be set up.

Appendix C

Summary of local audits undertaken during 2016/17 against NICE Guidelines

Audits of NICE Guidelines are an ongoing process of implementing change and measuring improvement until full compliance is achieved. The following table shows compliance against NICE Guidelines following local Trust audit and details the actions put in place to improve practice when partial or non-compliance was found. Changes will be implemented and a re-audit will be undertaken to identify whether these have led to improvements in practice.

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

CG/NG = Clinical Guidelines TA = Technology appraisal IPG = Interventional Procedures
Guidance QS = Quality Standard PH = Public Health MPG = Medicines Practice Guidelines

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
NICE CG132: Audit on Timing of Administration of Antibiotics for Caesarean Section	Fully compliant	No actions required as standards met.
NICE CG156: An audit of Perinatal Risks & Outcomes in	Partially compliant	Antenatal counselling regarding risks associated with an IVF pregnancy requires improvement. A leaflet is to be developed to be given in Gynaecology/Fertility clinics and used for counselling in Antenatal Clinics. All other standards were met.
NICE CG134: IVF Pregnancy Anaphylaxis	Partially compliant	The standards were not met on documentation of timings and advice given. We will monitor this as part of our regular departmental audits on documentation. All other standards were met.
NICE IPG 344: Assessment of departmental compliance with BSG Guidelines on Endoscopic classification and surveillance inpatients with Barrett's Oesophagus	Not compliant	Barrett's specific lists are now in place. Prague criteria should be stated for all endoscopic diagnoses. Quadrantic biopsies should be the minimum standard taken in patients with endoscopic diagnosis of Barrett's Oesophagus. BSG protocol, in addition to patient's preference and performance status, should be used to inform choices regarding endoscopic surveillance.
NICE CG144 & TA287: Diagnosis, management and follow-up of patients with PE (pulmonary emboli) at TWH	Partially compliant	Wells scores are inadequately utilised and documented in notes. Patients with unprovoked PEs, did not all have CT scans. PE proforma has been designed for junior doctors to complete and insert into clinical notes as guidance for investigating unprovoked PEs to include information for follow-up. eDNs to have automated proforma to provide more information for GPs follow-up
NICE CG144: Unprovoked pulmonary embolism follow-up	Partially compliant	Follow up of unprovoked PEs has to be carefully considered as it may be the first sign of a sinister pathology. All routine investigations are carried out, gender specific tests are not always done. A change has been made to the eDN to ensure follow up decision is always recorded and GP notified. A proforma has been created to list all investigations and management plans required.
NICE CG94: GRACE scoring in Acute Coronary Syndrome (ACS) Is it being assessed/done?	Not compliant	Assessment of future risk stratification of ACS is not always being carried out. Teaching sessions for staff working in A&E have been arranged. Cardiology team to calculate and document a GRACE score on initial assessment with all patients.
NICE TA249: Atrial fibrillation - dabigatran etexilate	Not compliant	Documentation of the process and reasoning behind the drugs prescription is poor and should be improved. Dabigatran is now rarely used in AF prophylaxis. Alternative drugs, Rivaroxaban and Apixaban are now widely used. Re-audit of documentation of discussion with

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
		patients on the risks vs benefit with regards to this anticoagulant.
NICE CG 32: Re-audit: Use of the MUST screening for malnutrition at Maidstone and Tunbridge Wells NHS Trust 2016	Not compliant	Implemented actions: Increased MUST training. Update of MUST e-learning tool. Redevelopment of MUST tool to include action plan. Improvements shown since the last audit but still not reaching the required standard. Plans to include MUST in mandatory training for CSW's and RNs. The correct MUST tool to be used, contact the ward clerks to ensure correct ordering code is used.
NICE CG130: Hyperglycaemia in acute coronary syndrome (ACS)	Not compliant	Training for A&E clerking medical doctors / cardiology nurses of the importance of having blood glucose taken on admission. To consider including blood glucose as standard protocol for patients presenting with chest pain.
NICE QS63: Delirium: Re-audit	Partially compliant	Actions implemented: An additional clock was made available on Chaucer ward. Several teaching sessions were carried out to ensure doctors are aware of the need to carry out AMTS score for appropriate patients, act upon the score findings as necessary and communicate results to the GP. Education to ensure all doctors understand when to complete an AMTS. A new information leaflet for patients, family and carers is available and has been circulated to all staff. New junior doctor intakes are aware of the need to communicate results to GPs to enable further input from the community as necessary.
NICE QS90: Urinary tract infections in in-patients over 65 years	Partially compliant	The Trust is performing well in three areas. Less well in three others. Raise awareness of the over-diagnosis of UTIs and that the diagnosis should not be made on the basis of just a positive urine dip or urine culture. An Elderly Care liaison service commenced in October 2016, which may reduce the number of inappropriate diagnoses of UTI in medical admissions.
NICE CG169: Acute Kidney Injury and its management in Medical Patients (Re-audit)	Not compliant	Following the last round of the audit an AKI Care Pathway has been introduced. Improvements shown but standards not yet fully met. Doctors made aware of the need for clearer documentation of urinalysis and the need for USS of renal tract when assessing AKI patients.
NICE CG74: An audit of the use of antimicrobial prophylaxis for orthopaedic surgery at MTW NHS Trust	Partially compliant	Audit identified the need for both clarity and for post-surgical doses to be written up with clear 'post-induction' times. Clarification of terminology with a defined range of acceptable times could be of great use within the guidelines.
NICE CG92: Extended VTE prophylaxis in oncology patients undergoing major abdominal surgery: an audit in a district general hospital (T/Wells)	Not compliant	When patients are discharged from hospital LMWH is often not added to the TTO. To document '28 days of LMWH' in the post-operative instructions on the operation note. Review possibility of changing eDN software so the completing doctor actively considers the need for extended VTE prophylaxis
NICE MPG2: Re-audit of the use of PGDs for Sexual Health conditions in the hub GUM Clinic at MTW	Partially compliant	Template to aid documentation has been created and is in use. The audit demonstrated good PGD practices in the GUM clinic.
NICE CG124: Are we meeting the gold standard of care with regards to mobilisation of patients day one post repair of fractured NOF?	Partially compliant	Pain and anxiety were primarily the reasons why patients failed to mobilise in medically fit patients. A new Fracture NOF pathway has been developed to prompt appropriate analgesia. Education of nursing staff regarding MDT communication for referrals to physiotherapy, pain management and medical review where necessary.
NICE CG 179: Prevalence Audit March 2016	Partially compliant	Root cause analysis for all hospital acquired pressure damage is continuing and forms the basis for the serious incident review for hospital acquired category 3 and 4 pressure ulceration. The Trust will adopt a zero tolerance to moisture lesions. Education of all staff including Allied Health professionals will continue to be a priority to accurately recognise pressure ulcers and deliver

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
		appropriate care. Ward based teaching will continue. Wards achieving zero prevalence will be published as good news events. A Trust-wide Action plan on prevention is in place.
NICE CG161: Audit: Compliance with the MTW NHS Trust 'Falls medication review stickers'	Not compliant	Falls Group Nurse to emphasise to the clerking ward staff the importance of attaching a yellow falls sticker onto a falls patient's drug chart. CSW/nurses/pharmacists to check the sticker for signature and date, if absent, they should remind the medical team to review. Falls Group Committee to emphasis to ward staff that a falls stickers must be placed on all patients aged 65 or older, regardless whether they have been admitted with a fall, so that their medications are reviewed and possibility of future falls reduced. Pharmacy team to pay particular attention to medicines that increase patients' risk of falls when reviewing medications, especially those patients admitted with a fall.
NICE CG 154: Early Pregnancy Assessment Clinic (EPAC) Performance Audit	Fully compliant	Consultant sessions presence in EPAC have increased due to additional weekly consultant sessions. All standards met so no actions required.
NICE CG140: Audit: Use of buprenorphine patches at Maidstone & Tunbridge Wells Hospital.	Not compliant	Pharmacy staff training on the use of when Butrans patches are appropriate to be prescribed will allow them to challenge prescriptions more.
NICE CG44: Re-audit of Intra-operative Novasure Failure Rate	Partially compliant	Following the previous audit a training session from the "Novasure" representative was undertaken for all clinical staff and this has reduced the risk of failure during the procedure. Medical staff to be made aware that all patients have USS organised before Novasure procedure. Another training session by "Novasure" representatives re trouble-shooting if cavity assessment fails; tips and techniques to overcome this.
NICE IPG156: Does breast papilloma follow-up at MTW breast unit detect any malignancies?	Fully compliant	Standards were met and no actions need to be taken
NICE CG37: Re-audit of the management of routine postnatal care of women and their babies	Partially compliant	Improvements demonstrated. Further re-audit to be carried out to assess whether the new E3 computer system resolves the problems with documentation in Postnatal care
NICE CG190: Management of delay in labour using Syntocinon	Partially compliant	A standardised document has been developed for use in vaginal examination timing and whether awaiting regular contractions before planning four hour examination.
NICE PH3: Audit of Prevention of Sexually transmitted infections & under 18 conceptions (Criteria 1-8 only Sexual Health)	Partially compliant	An Outreach team has been created and is currently in practice that focuses on change in behaviour of our patients. A 1:1 referral pathway within integrated sexual health for vulnerable groups clinics is now in place
NICE IPG 391: An audit on referral of patients with acute severe respiratory failure for extracorporeal membrane oxygenation (ECMO)	Fully compliant	An on line referral system will now allow direct access to referrals for auditing purposes.
NICE TA375: Biologic Therapy for Rheumatoid Arthritis	Partially compliant	There is a need to improve the area of provision of therapy within a reasonable range of time. Introduce a flowchart representing a graded procedure by which Biologics are prescribed and delivered to the patients in a more organized and timely manner, to ensure all appropriate data is recorded; one form to be completed for each patient.

Part Five

Stakeholder feedback

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

West Kent Clinical Commissioning Group comments on the 2016/17 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

We welcome the Quality Accounts for Maidstone and Tunbridge Wells NHS Trust (MTW). MTW is the main provider of acute NHS services for the population in West Kent. As a CCG we work collaboratively with the staff at MTW with the shared aim of improving the quality and safety of the health care that we commission.

Patient Safety
Learning from incidents and embedding change is essential. We look at how MTW intends to learn and share from serious incidents as part of our incident closure process, identifying themes and trends to help identify areas for greater scrutiny. It is pleasing to note the incidents of falls has declined and that work continues to reduce these further. It was disappointing for all concerned that the Trust exceeded the maximum number of cases of C-Diff this year by one. The CCG continue to support the embedding of a safety culture within the Trust and applaud their open and honest approach.

Patient Experience
Listening to feedback from patients and their relatives is essential to enable improvements to care. Also, compliments need to be welcomed and conveyed to staff. The CCG is pleased to see that the Trust is committed to improving the response rates from the Friends and Family Test. Moreover, the Trust‘s commitment to include service user engagement will compliment other patient feedback mechanisms such as complaints and PALS.

Clinical Effectiveness
Effective patient flow is conducive to improved patient care and outcomes. We are working with all stakeholders to support MTW in reducing the length of stay and facilitating effective discharge. We are pleased to see that the Trust has worked hard to ensure that the patient is in the appropriate area for their care. The Trust‘s achievement in and commitment to improving ambulatory care is welcome.

Paula Wilkins
Chief Nurse
West Kent CCG

5th May, 2017.

Health Overview and Scrutiny Committee – Kent County Council comments on the 2016/17 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Draft Quality Accounts were submitted to the Kent Overview and Scrutiny Committee, Kent County Council. The Chairman, Mike Angell who responded:-

Thank you for the copy of Maidstone and Tunbridge Wells NHS Trust Quality Accounts 2016/17. The Kent HOSC will not be providing a statement this year as the Committee has not been reconstituted following the election on 4 May; it will be reconstituted on 25 May which is after the deadline for comments.

The Committee looks forward to receiving future copies of the Quality Accounts.

Received on the 9th May, 2017.

Healthwatch Kent comments on the 2016/17 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Maidstone and Tunbridge Wells NHS Trust Quality Account Response

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.
For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).
As Healthwatch Kent has experienced cuts in resources along with everyone else, this year we have not been able to look at the report in detail.
However, we would like to support the Trust with a comment which reflects some of the work we have undertaken together in the past year.
We have seen that Maidstone and Tunbridge Wells values and understands our statutory role as a "critical friend". Some of our involvement with the Trust this year has included:

- Using our formal powers to Enter & View Outpatients services at both hospitals and talk to patients about their experience. Many of our recommendations following that visit have now been implemented including improved signage and layout.
- We are currently visiting both hospitals, care homes and people's homes to gather feedback from patients about their experience of being discharged from hospital.
- Being an active member of the Patient Experience Committee and supporting the group's development.
- Meeting regularly with the Chief Nurse to keep up to date with Trust activity
- Holding regular information stands at both Maidstone and Tunbridge Wells Hospitals, to talk directly to patients and hear their experiences of services.
- We have reviewed the Trust's engagement activities and encouraged the Trust to commit resource to engaging and involving local communities more in their work.
- Our volunteers regularly review patient leaflets.

We look forward to our continuing work with the Trust throughout the upcoming year.

Healthwatch Kent
15th May, 2017.

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

We are required to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

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

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

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

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account. Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2016 to June 2017
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from Commissioners dated 5th May 2017;
- feedback from Local Healthwatch organisations dated 15th May 2017;
- feedback from Overview and Scrutiny Committee dated 9th May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated May 2017;
- the latest national patient survey dated 26th May 2016;
- the latest local patient survey dated March 2017;
- the latest national staff survey dated 10th March 2017;
- the latest local staff survey dated March 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 25/04/2017;
- the annual governance statement dated 25/5/2017; and
- any other relevant information included in our review.

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

This report, including the conclusion, is made solely to the Board of Directors of Maidstone and Tunbridge Wells NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Maidstone and Tunbridge Wells NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicators tested back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary.
Furthermore, the nature and methods used to determine such information, as well as the measurement

criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

In addition, the scope of our limited assurance work has not included governance over quality or non- mandated indicators which have been determined locally by Maidstone and Tunbridge Wells NHS Trust.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

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

Grant Thornton UK LLP

Grant Thornton
UK LLP 2nd Floor
St Johns House
Haslett Avenue
West Crawley
RH10 1HS
29 June 2017

Statement of Directors' responsibilities in respect of the Quality Accounts

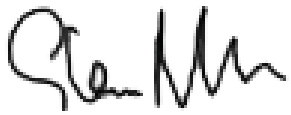
The directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality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

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

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

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

By order of the Board



Date: 28/06/17