Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2015/16

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 2015/16 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 2016/17.

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 2015/16 which is an overview of the work we have undertaken to improve our patient experience and wellbeing.

We have continued to place our patients at the centre of everything we do during 2015/16 and I am proud to represent, through this report, the efforts of our dedicated teams of healthcare professionals.

As a Trust, it is our aim to become even more sensitive to the individual and collective needs of our patients. We are achieving this by being open and honest about our weaknesses, learning from our errors, and sharing best practice.

We were pleased to be rated `good' for openness and transparency during the year as part of a national review of the way hospitals learn from errors and improve patient care. We can and will do more to achieve the top rating of excellent.

We measure patient care in many ways as an organisation. This report sets out our performance against a number of national standards, for instance, and while we have met many of these we have struggled to achieve some for the reasons outlined below. While these are all important, and command our utmost attention, our Trust Board has been humbled, at times shamed, but ultimately inspired by the powerful stories our patients and their relatives have chosen to share with us, in person, at our public board meetings.

As a learning organisation, we have focused heavily on improving our clinical governance processes during 2015/16 and we will continue to do so in 2016/17 by looking at our human as well as our technological systems that measure our patient experience, and help us improve care outcomes.
From a human perspective, we have focused heavily on reviewing and improving the way we individually and collectively report and learn from incidents by embedding better processes for our staff to follow.
We have also introduced new technology at the frontline of patient care to protect our patients. We have invested heavily in new systems to help us better monitor patient vital signs in real-time, to provide earlier intervention for deteriorating patients. This is improving outcomes.

Our Quality Accounts also reflect upon our efforts to improve other aspects of patient safety including a major focus on falls prevention. We are committed to making further progress and improvements in this area during 2016/17. Other quality improvement initiatives that we have set out for 2016/17, focus heavily on further improving our patient experience monitoring systems, learning from patients and other organisations and showing our actions, sharing our successes, and reducing length of stay.

We know from experience that with commitment and focus, MTW can be among the best providers of healthcare. During 2015/16 we had the lowest rate of hospital-acquired Clostridium

difficile of all acute hospitals in the South of England and were among the best performing hospitals in the country. We will continue to do more to protect patients from avoidable infections. Other challenges require the combined efforts of every organisation and partner involved in health and social care.

Around 96,000 people were admitted to our hospitals in Maidstone and Tunbridge Wells for both urgent medical and surgical care and planned procedures in 2015/16. Sitting behind these figures are over 460,000 outpatient appointments, 340,000 images, and two million pathology tests.

137,000 A&E attendances – 8,000 more than the previous year

Our A&E departments saw over 137,000 people in 2015/16 which is 8,000 more patients than the previous year. In the last three years A&E attendances have risen by 10%. If you look back further, we are now seeing over 20,000 more A&E attendances a year than we did when our first Quality Accounts were published in 2009/10.

At the same time, we carried out 13,000 more planned procedures last year than we did in 2009/10.

One of single biggest challenges we faced in 2015/16 was patient flow and length of stay. Too many patients had their discharge from hospital delayed because of long waits for their ongoing care needs to be met. This reduced the number of beds available for patients coming into our hospitals for planned or emergency care and affected our ability to see all of our patients in a timely way. This also had an adverse impact on our finances, which are important part of maintaining patient care.

We opened a new acute medical unit at Tunbridge Wells Hospital towards the end of the year to help fast-track urgent medical care for patients coming through A&E. This will have a positive impact on patient care in 2016/17. We also providing more care in the community to help patients with chronic conditions better manage their health and avoid hospitalisation.
Patient flow through our hospitals is an on-going challenge, however, that we are unable to resolve alone. We are continuing to work closely with our partners on the improvements we all need to be part of during 2016/17.

By continuing to listen to our patients, our staff, and working closely with our stakeholders, we believe we can continue to make further care improvements for our patients in the year ahead. The information contained within this report represents an accurate reflection of our organisation's performance in 2015/16 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 priorities in 2016/17 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 representative from Healthwatch Kent.

Quality Improvement Priorities 2016/17

NHS Improving Quality

Patient Safety
To improve the dissemination of learning from serious incidents and complaints to drive improvement across the organisation.
Key objectives will include:

- Central database to monitor all agreed actions agreed following Serious Incidents and Complaints reported to Learning and Improvement committee (SI panel)
- 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.
- Improvements as a result of learning from Serious Incidents and Complaints to be shared in a staff monthly newsletter and on the intranet and website
- Improvements as a result of learning from the review of in-hospital mortalities.

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:

- Friends & Family results to be clearly and consistently displayed within departments including actions and improvements as a result of qualitative feedback
- 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.

- Working with Healthwatch partner, consider and implement different ways of listening to staff and service users to drive improvements (such as listening events, better use of social media and technology)

Clinical Effectiveness
To improve the management of patient flow.
Key objectives will include:

- Sustained reduction in length of stay achieved through (but not exclusively) the full implementation of SAFER Discharge Bundle
- Sustaining ring-fenced beds for Stroke and Trauma and Orthopaedic patients
- Embedding the new pathway on AMU at Tunbridge Wells Hospital to further improve ambulatory care

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 new ambulatory medical care ward at Tunbridge Wells Hospital opened at the beginning of 2016 following an investment of £3 million.

Patient Safety

The organisation is committed to improve the reporting of incidents and the learning from them, together with the learning from complaints and claims in order to make sustained improvements to the services and care we deliver.


17 mtw Governance Gazette

Why do you need to report it??

In this issue

CLINICAL AUDIT COMPETITION 2016

Report It

sharing best practice with our staff

Aim/goal

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

Description of Issue and rationale for prioritising

Developing and improving care and as a result of lessons learnt from incidents, complaints and claims is at the heart of good governance. To maintain the momentum of change and sustain improvements already made the organisation wishes to continue this area of work as a priority. The organisation also recognises that cultural change takes time and continued prioritisation will enable these structural and process changes to influence and drive learning as a continual cycle of improvement.

Identified areas for improvement and progress during 2015/16

The following actions were undertaken in 2015/16

- The establishment of a triangulation group called CLIPA that brought together information and learning from complaints, legal services, incidents, PALS and audit. This group reports into Trust Clinical Governance Committee and shares learning via staff communication.
- The Incident reporting system (DATIX) was upgraded and reporting pages were streamlined and made more readily available for staff to use (via apps)
- We ran a patient safety culture conference in the summer of 2015 with multidisciplinary attendance
- A WHO accredited patient safety education course has been running since January 2015 available for all staff
- The Governance Gazette, a staff newsletter published monthly, has featured regular case studies for shared learning

Initiatives for further action for 2016/17

- Introduce a central database to monitor all agreed 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.
- 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%)

- Improvements as a result of learning from all Serious Incidents and Red Complaints to be shared in a staff monthly newsletter and on the intranet and website (100% where disclosable)
- Improvements to in-hospital falls prevention with a reduction in falls rates to a target of less 6.2 per occupied bed-days by end of March 2017
- 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.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Avey Bhatia, Chief Nurse
Implementation lead: Jenny Davidson, Assc Director Quality Governance
Monitoring: Trust Clinical Governance Committee

Patient Experience

Aim/goal

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

Description of Issue and rationale for prioritising

Service user feedback is an important source of information to drive local improvements. Review of trends can indicate whether a service needs change or can indicate if a planned change has had the desired or expected outcome.

Identified areas for improvement and progress during 2015/16

Full implementation of FFT across all areas including children's services, out-patients and day care areas such as endoscopy.
Increased response rates across all areas.
Achievement on FFT for 2015/16 is (see p42/43 for further information):

Response Rate:

	Achieved	Plan	Benchmark
Maternity Services	19.8%	15.0%	23.4%
In-Patient Services	25.3%	30.1%	25.1%
Accident & Emergency	13.1%	20.0%	13.1%

Positive score – would recommend the service:

	Achieved	Plan	Benchmark
Maternity Services	94.7%	95.0%	95.5%
In-Patient Services	96.4%	95.0%	95.7%
Accident & Emergency	88.4%	87.0%	86.9%

Initiatives for further action for 2016/17

- 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 The 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 and Emergency services.

- 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.

- Working with Healthwatch Kent, consider and implement different ways of listening to staff 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.

Executive lead: Avey Bhatia, Chief Nurse
Board Sponsor: Avey Bhatia, Chief Nurse
Implementation lead: Claire O'Brian, Deputy Chief Nurse
Monitoring: Patient Experience Committee

Clinical Effectiveness

The Trust is committed to ensuring effective patient flows throughout the inpatient areas to allow patients to receive the right care at the right time in the most appropriate environment for their condition.

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, commissioners and the Trust

providing safe and effective care for patients

Description of Issue and rationale for prioritising

Safe and effective care for patients remains at the heart of the Trust's objectives. In order to deliver this, there is a requirement to ensure good patient flow and availability of specialist inpatient beds when needed.

Identified areas of improvement and progress during 2015/16

- New ward opened at Tunbridge Wells Hospital in March 2016
- Implementation of Integrated Discharge Team
- Flexible use of inpatient capacity to manage non elective patient flow
- Implementation of **S**enior review, **A**nticipate, **F**low, **E**arly discharges, **R**eact to delays & waits (SAFER) Discharge Bundle
- Achievement of 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

Initiatives for further action for 2016/17

- 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 **T**imely **E**ffective **S**afe (TES) Steering Group.
- 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).
- 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.

Executive lead: Angela Gallagher
Board Sponsor: Angela Gallagher
Implementation lead: Lynn Gray
Monitoring: LOS Steering Group

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) (this Regulated Activity was added during 2015/16)
- Diagnostic and screening procedures (at both hospital sites)
- Family planning services (at both hospital sites)
- Maternity and midwifery services (at both hospital sites)
- 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 Avey Bhatia, Chief Nurse.

During 2015/16 the Trust provided and/or subcontracted the full range of services for which it is registered (during 2015/16 the Trust provided and/or sub-contracted 101 NHS services). All the data available on the quality of care in these NHS services has been formally reviewed (with commissioners).

The income generated by the NHS services reviewed in 2015/16 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 2015/16, undertaken by external organisations such as:

- NHS England – Framework of Quality Assurance (independent verification) – 2nd June 2015.
- NHS England – Local supervising group (statutory supervision of midwives) – 21st September 2015.
- NHS England peer review –Trauma services – 24th September 2015.
- Environment Agency (Radioactive substances regulation) – 14th July 2015.
- Counter terrorism security advisers (CTSA's) – April and October 2015.
- UKAS accreditation (clinical pathology accreditation (CPA/ISO 15189) – Histology and cytology – June 2015
- UKAS accreditation (clinical pathology accreditation (CPA/ISO 15189) – Blood sciences – August 2015
- UKAS accreditation (clinical pathology accreditation (CPA/ISO 15189) – Histopathology EQA scheme – Octobert 2015
- Medicines and Healthcare Products regulatory Agency (MHRA) – Transfusion – 5th October 2015.
- Health and Safety Executive (HSE) – Inspection of CL3 Laboratories – 14th September 2015.

- Kent police – counter terrorism crime and security Act annual inspection – September 2015.
- Standards Verifier for the Pearson's group (Diplomas in clinical healthcare support) – July and December 2015.
- Skills for Health (Quality improvement manager) – 10th June 2015.
- National cancer peer reviews – Haematology peer review – May 2015.
- National cancer peer reviews – Internal Validation – June 2015.
- National cancer peer reviews – Urology – 29th July 2015.
- CHKS (ISO 9001, CQC Peer review) – January 2016.
- ISO Accreditation 90001:2008 – EME services – 17th April 2015.
- NHS Protect (Qualitative assessment) – 17th August 2015.
- External audit as part of the Trust application to be ISO14001 registered (Estates) – June 2015.
- Pharmacy aseptic unit's regional quality assessments –May, November and December 2015.
- Patient led Assessments of the Care Environment (PLACE) – April and May 2015.
- Health Education Kent Surry and Sussex (HEKSS) Ophthalmology programme review – April and November 2015.
- Health Education Kent Surry and Sussex (HEKSS) Ophthalmology programme review – April 2015.
- General Medical council – Trainee and trainer survey – May 2015.
- Audit Commission – statutory audit of charitable funds – October 2015.
- Audit Commission – statutory audit of annual accounts – June 2015.

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

- Internal assurance reviews (CQC style)
- 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 anywhere additional support and actions are required to maintain standards. Reports are scrutinised within identified committees within our governance structure and where necessary action plans are developed and monitored.

Hand hygiene audits to check service quality

Clinical Audit

This section of the Quality Account 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 2015/16, MTW participated in 100% of relevant confidential enquiries and 100% of all relevant national clinical audits. During the same period, MTW staff successfully completed 149 clinical audits (local and national) of the expected 311 audits due to be completed (the audit programme had a total of 443 audits but not all were expected to complete within the timeframe). Whilst the majority of audits were undertaken and presented by staff at local meetings the Trust define a fully completed audit as being undertaken, presented with a written report and an action plan in place, submitted to the central audit team. A completeness exercise continues to assist staff to ensure all aspects of their audit have been fully completed and submitted as required.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2015/16 are shown as follows-

National Clinical Audits for inclusion in Quality Accounts 2015/16	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2015/16 (Any period during 01/04/2015 to 31/03/2016)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	489 (M) 613 (TW)	100%	
Emergency Laparotomy Audit (NELA)	Y	176	93.8%	Audit requirement 80% of relevant cases.
NAP 6 Perioperative anaphylaxis	Y	3	100%	Data collection still open and data being submitted
Use of Emergency oxygen (BTS)	Y	26	100%	
Procedural Sedation in Adults (CEM)	Y	66	100%	
Vital Signs in Children (CEM)	Y	100	100%	
VTE risk in lower limb immobilisation (CEM)	Y	100	100%	
Non-invasive Ventilation (BTS)	NA			No data collection in 2015/16
Severe Trauma (Trauma Audit & Research Network) TARN	Y	390	55.2%	Data input ongoing.
National Complicated Diverticulitis Audit (CAD)	NA			Audit not applicable to the Trust.
National Joint Registry (NJR)	Y	748	98%	
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) - National Audit of Patient Blood Management in Scheduled Surgery 2015	Y	28	100%	
National Audit of the use of blood in Lower GI bleeding 2015	Y	11	100%	
National Comparative Audit of Red Cell and Platelet Transfusion in Adult Haematology patient 2016	Y	45	100%	

National Clinical Audits for inclusion in Quality Accounts 2015/16	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Cancer				
Lung Cancer (NLCA)	Y	264		Data collection still open and data being submitted.
Bowel Cancer (NBOCAP)	Y	272		Data collection still open and data being submitted.
National Prostate Cancer Audit	Y	383		Data collection still open and data being submitted.
Oesophago-gastric cancer (NAOCG)	Y	138		Data collection still open and data being submitted.
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	355	100%	Data collection still open and data being submitted.
Heart failure	Y	360	100%	Data collection still open and data being submitted.
Coronary angioplasty/ National audit of PCI	Y	263	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	550	100%	
National Cardiac Arrest Audit (NCAA)	Y	26 (TW) 106 (M)	100%	Data collection still open and data being submitted
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 does not provide this service
National Vascular Registry	NA			MTW does not provide this service.
Long Term Conditions				
Adult Asthma (BTS)	NA			No data collection in 2015/16
National (Adult) Diabetes Audit (NDA)	Y	3657	100%	
National Adult Diabetes Inpatient Audit (NaDIA)	Y	113	100%	
National Diabetes Footcare Audit	Y	33		Data collection still open and data being submitted
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Y	80		
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	COPD = 109 Rehab = 23	100%	
Rheumatoid and early inflammatory arthritis	Y	50		
National Audit of Intermediate Care	NA			Audit 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				

National Clinical Audits for inclusion in Quality Accounts 2015/16	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	1. Y 2. NA 3. Y	1. Falls = 30 2. Fracture Liaison Service Database 3. National Hip Fracture Database = 485	1. 100% 2. N/A 3. 100%	2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted.
UK Parkinson's audit	Y	130	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	1. Organisational Audit 2. Clinical Audit – 1198	1. N/A 2. 100%	1. Organisational data not collected this year 2. Data collection still open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	Hip: 259 Knee: 284 Groin: 320 Varicose: 15		
National Ophthalmology audit	Y			Registered to participate. Still awaiting software link from Royal College to enable data entry.
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				
Neonatal Intensive and Special Care (NNAP)	Y	708	100%	All data submitted.
MBRRACE-UK; Perinatal Mortality Surveillance report; UK Perinatal Deaths for Births in 2013	Y	Stillbirth = 20 Neonatal = 1 Extended Perinatal = 21	100%	
MBRRACE-UK; Perinatal Confidential Enquiry; Congenital Diaphragmatic Hernia (CDH)	N/A			MTW is not a Level 3 Neonatal Unit
MBRRACE-UK; Perinatal Confidential Enquiry; Intrapartum stillbirths & Intrapartum related Neonatal deaths 2015	Y			Data collection still open and data being submitted.
MBRRACE-UK; Perinatal Confidential Enquiry; Antepartum stillbirth in term normally formed infants 2014	Y	Baby = 85 Woman = 85	100%	
MBRRACE-UK; Saving Lives, Improving Mother's Care	Y	0		No cases to report as no patients fitted this criteria
MBRRACE-UK; Maternal Saving Lives, Women with severe epilepsy	Y			Data collection still open and data being submitted.
MBRRACE-UK; Saving Lives, Women with artificial heart valves	N/A			MTW does not provide this service
Paediatric Inflammatory Bowel Disease. (Round 4) (IBD Programme)	Y	0	100%	MTW did not have any relevant cases during this round.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Y	0	100%	MTW did not have any relevant cases during this round.

National Clinical Audits for inclusion in Quality Accounts 2015/16	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
National Paediatric Diabetes Audit (NPDA)	Y	TWH = 742 MGH = 839	100%	Data submitted, awaiting National report due May 2016
Paediatric Asthma (BTS)	Y	MTW = 27	100%	
UK Cystic Fibrosis Paediatric Registry	N/A			MTW does not provide this service
National Confidential Enquiries				
Adult Mental Health	Y	8	80%	Data collection still open and data being submitted.
Acute Pancreatitis	Y	8	100%	
Sepsis	Y	6	100%	
Gastrointestinal Haemorrhage	Y	8	100%	
Child Health Clinical Outcome Review Programme: Mental Health Conditions in Young People	Y	46 patient data submitted for selection	100%	Prospective data collection still open and data being submitted.

37 national audits were published in 2015/2016 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including-

1. **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 up to 4 weeks and allows 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.
2. **Emergency Laparotomy Audit (NELA)**
   A system has been set up to ensure that Surgeons complete the pre-POSSUM predicted mortality tool before patients are accepted by theatres. This is to make sure that patients are admitted to the appropriate level of post-operative care on leaving theatres.
3. **Adult Community Acquired pneumonia.**
   A programme of continued education has been put in place for antibiotic prescribing in A&E and AMU nursing staff. This is to enable prompt administration of the first dose of antibiotics and chest x-rays requests when patients are admitted via A&E. Early treatment should produce better patient outcomes and reduce hospital length of stay.
4. **Mental Health (Care in Emergency Departments)**
   A mental health risk assessment proforma (SMART tool) has successfully been introduced and training on its use has been embedded into the A&E induction teaching programme which has input from the Consultant Liaison Psychiatrist. This tool aids clinical assessment and risk stratification and streamlines the referral pathway in a standardised way.
5. **Inflammatory Bowel Disease (IBD) programme – Biologic Therapy only.**
   Additional IBD Nurse Specialists have been appointed to increase capacity and enable 3 and 12 month follow-up appointments to be offered. This will enable regular monitoring of treatment progression.
6. **MBRRACE-UK Perinatal Confidential Enquiry programme**
   A Growth Analysis Protocol has been implemented from April 2016 which monitors growth from 24 weeks gestation by measuring the symphysis fundal height and plotting the measurements on a growth chart used for plotting fundal height and estimated fetal weight. This will aid early identification of fetal growth restriction which is associated with stillbirth, neonatal death and perinatal morbidity.
7. **NCEPOD – Sepsis Study**

A training package has been developed to be included on the trust mandatory training programme covering antimicrobial policies and prescribing, review and administration of antimicrobials. The trust Sepsis Group is working with the clinical coders to improve the accuracy of coding for patients diagnosed with sepsis. This will make it easier to identify patients for clinical audit, national reporting and shared learning.

Please see Appendix A for full details of progress against each of the reported national audit results 2015/16

Service Improvements

A number of service improvements have been made as a result of the **118** completed local clinical audits, across all Directorates, in 2015/16. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through the systematic review of the care they provide against explicit criteria. Improvements include:

Actions taken following local audits	Trust Actions
Radiology	GP's refer patients for lower limb ultrasound scan when deep vein thrombosis (DVT) is suspected. New practices were implemented for focused scanning of the proximal part of the lower limb. Doppler flow is not performed for these particular referrals and other causes of leg swelling, for instance, muscle tears are not offered. This has shortened the scanning time from 20 minutes down to 10 minutes per patient so that double the numbers of daily time slots are now available. Re-audit shows that there is a substantial improvement with more GP referred patients being scanned within the recommended time frames.
Radiology	Where a diagnosis of bone or soft tissue sarcoma is suspected, the reporting radiologist/ radiographer should attach the sarcoma reporting pre-set to the radiological report to raise the possibility of a sarcoma diagnosis in this rare rumour. Once diagnosed these patients should then be referred to the London sarcoma service. A reminder letter was sent to all radiologists/reporting radiographers/ sonographers that the pre-set exists and when it should be used. A re-audit was completed which led to the standard being met in all cases. There was no delay in referral to the appropriate sarcoma service therefore no delay in treatment.
Emergency and Medical Services – Elderly Care.	Low impact or fragility fractures are very common in people aged over 65. They include fractures of the hip, pubic rami, wrist and humerus. The Trust has employed Orthogeriatricians to improve care of patient admitted with hip fractures to aid the identification of osteoporosis and allow interventional treatment to potentially prevent further fractures. A Community Falls Service (run by Kent Community Health NHS Trust) has also been created. Patients presenting to the Emergency Departments at Maidstone and Tunbridge Wells NHS Trust with other fractures will be referred to the Falls Service for an osteoporosis assessment.
Midwifery	This audit of High risk twin pregnancies resulted in the Specialist Multiple Pregnancy Clinics being been introduced on both sides of the Trust. These new clinics review women who

Actions taken following local audits	Trust Actions
	were previously being seen for antenatal care as well as capturing newly referred women to the service. Re-audit results show there has been an improvement across all parameters. The care package includes: Early scanning and regular scanning programmes for MC and DC twins. Discussion and documentation of birth options. An agreed plan for the mode of delivery. Provision of twin specific information and support. Full blood count taken at 20-24 weeks as well as at 28/40 weeks. Aspirin is given if clinically indicated.
Surgery	Cancer patients have a sevenfold increased risk of developing VTE. For patients undergoing major abdominal surgery the risk of fatal VTE is double the baseline risk. Additional training was provided by the VTE nurse practitioner for junior doctors on the prevention of possible DVTs. Results show that there has been further improvement to patient care, chemical thromboprophylaxis is prescribed and administered in 100% of patients audited across both sites. The prescription of Anti-embolism stockings (AES) to reduce the risk of blood clots forming in the patients legs has also improved by 25% to 87% which suggests that our measures to improve prescription of AES were effective.
Anaesthetics	A new obstetric anaesthetic chart for caesarean section was developed and has substantially improved the overall quality of documentation for this group of patients. Tick boxes made recording of documentation easier, quicker and standardised the recording of information. The inclusion of the massive obstetric haemorrhage protocol on the anaesthetic chart has received really positive feedback The results were also made into a poster for presentation at the Royal College of Anaesthetists College Tutor meeting
Anaesthetics	Discontinuing medications peri-operatively may lead to adverse outcomes and the rate of non-surgical complications increases when patients do not receive certain regular medicines. Following the findings of the initial audit, the predominant reason for patients not receiving essential medications was because patients were perceived to be nil by mouth peri-operatively. A poster was produced to show which medications patients should receive prior to surgery and which should be omitted. A copy was put in surgical wards and a copy was placed onto all drugs trollies making it clearly visible whenever nurses did their drugs rounds. The re-audit has shown the proportion of medicines not given because patients were nil by mouth has considerably reduced suggesting that the key message of our educational campaign has been effective.
Acute Medicine	An audit of the Management of hypokalaemia (electrolyte abnormality) led to additional teaching sessions and distribution of Guidelines for Potassium replacement therapy on all wards, and informing staff of availability on Q-Pulse. Re-audit shows improvements in the management of hypokalaemia. Further action is required to update the trust guideline to allow for variations in acceptable treatment modalities for each severity cohort incorporating evidence-based guidelines such as cardiac monitoring.

Enhancing Quality and Enhanced Recovery Programme

Clinical teams across Kent Surrey Sussex (KSS) have agreed a number of key clinical interventions that should happen when a patient has been admitted across several pathways as part of the Enhancing Quality and Enhanced Recovery Programmes. For each pathway there are a number of performance measures to attain. These measures pulled together are regarded collectively as a 'care bundle'. Patients who receive the full 'care bundle' it has been clinical proven to improve patient outcome. Enhancing Quality pathways include Community Acquired Pneumonia, Heart Failure and Chronic Obstructive Pulmonary Disorder (COPD). Enhancing Recovery Programme includes three pathways; Orthopaedic, Gynaecology and Colorectal.

Enhancing Quality
Community Acquired Pneumonia
There have been several modifications to the Pneumonia pathway. The pathway was revised to bring it up to date with the latest clinical evidence. MTW performance is in line with KSS average for the Community Acquired Pneumonia Pathway; outcomes are mortality and 30-day readmission significantly below the regional average. Length of stay (LOS), however, is significantly higher than the KSS average.

Heart failure
The measures selected for Heart Failure were revised in April 2015, to align to the National Heart Failure Audit and support greater compliance with NICE guidelines and quality standards. MTW performance has been shown to be significantly above regional average with key outcomes mortality, Length of Stay (LOS) and 30-day readmission in line with regional average.

Chronic Obstructive Pulmonary Disorder (COPD).
The COPD pathway has been running since October 2014. MTW performance since implementation has been significantly above the regional average for KSS in this pathway, with approximately 75% of patients now receiving the full 'care bundle'. The pathway concerns the bundle of care provided at discharge and therefore 30-day readmission rate is the key outcome measure. MTW has the lowest rate of readmission and with all other measures in line with the regional average.

Enhanced Recovery Programmes
Enhancing Recovery Programme includes three pathways; Orthopaedic, Gynaecology and Colorectal surgery. All enhanced recovery 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, structured approach to post-operative care. MTW adopted the care bundles swiftly, and has consistently performed at and above regional averages for each procedure care pathways. With orthopaedic and gynaecology both continuing to attain around 90% and above. Colorectal surgery is showing considerable improvement and is currently trending at regional average. Within all care pathways improvements have been seen in ensuring patients are given written and verbal explanation of their role in their recovery and discharge advice.

NICE Guidelines

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 trusts 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. As at the end of 2015/16 there were **1107** published NICE guidance. Of those, **1007** (**91%**) have been evaluated. **337** (**33%**) 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)	232	199	102
Interventional procedures (NICE IPGs)	490	463	79
Technology appraisals (NICE TAs)	385	345	156
Totals	1107	1007	337

Audits of NICE Guidelines are an ongoing process of implementing change and measuring improvement until full compliance is achieved.

Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2015/16.

Research

Participation in clinical research

Maidstone and Tunbridge Wells NHS Trust 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. A June 2012 poll commissioned by the NIHR Clinical Research Network showed that 82% of the public think that it is important for the NHS to offer opportunities to take part in healthcare research

Participation in clinical research means patients get access to new treatments, interventions and medicines, and investment in research means better, more cost-effective patient care. In 2015/16, Maidstone and Tunbridge Wells NHS Trust played a key part in delivering the national research agenda despite the Trust recruiting only 500 patients to trials during the year against the NIHR requirement of 1250.

Patient Recruitment Leaders

MTW research teams achieved a number of UK and European 'firsts' during 2015, most notably the Rheumatology Research Team, led by Dr Mike Batley, being the first research team in the country to recruit a patient to an important trial involving rheumatoid arthritis patients. The breast cancer research team were the top recruiting team in the country for the Manta breast cancer study and second highest in Eurpoe. The ophthalmic research team Led by Mr Luke Membery won a highest recruiter award from the Moorfields hospital in 2015 and has put MTW in the top five of organisations for patient recruitment to ophthalmic trials.

2015 saw the development of the new Respiratory Research Team at Maidstone Hospital. The team, consisting of a new Lead Research Nurse and Research Associate recruited 18 patients to their first national portfolio study called Laser, looking at patients with allergic asthma. The team recruited the highest number of patients in the country.

Trust-Led Studies

The Trust has successfully delivered the first year of a three year study called BPOP (previously the BETTER study), working alongside researchers in local academic institutions and collegues from East Kent hospital. The study is the biggest study to be sponsored by MTW to date and is aiming to develop a pre and post exercise routine to improve outcomes for patients following abdominal surgery for cancer. The Surgical Research Team, led by Mr Haythm Ali, has enlisted the help from a number of MTW patients to design a new exercise regime with support from sports science experts.

The Surgical Research Team was successful in achieving National Portfolio status for the EPOP study late in 2015, increasing the study's recognition across the Clinical Research Network.

Patient and Public Support

In the summer of 2015, MTW recruited a second Patient Research Ambassador, Judith Strutt. Judith has a special interest in diabetes, so is supporting the development of more studies in this area. Judith also supports diabetic patients who are participating in trials and who may wish to know more about joining a trial. It is anticipated that the trust will recruit many more specialist Patient Research Ambassadors year on year.

Judith Strutt – Patient Research Ambassador for Diabetes.

Increasing Patient Recruitment to Trials

The trust secured a number of high recruiting studies during 2015 to help deliver the increasing patient recruitment target for 2016/17 of 1455 patients. A number of registry studies have been opened in surgery, rheumatology, cardiology, haematology and hepatology, and studies looking at innovative ways of supporting patients in the community using technology.

New Look Research and Development Team

The central research and development department underwent a re-structure at the end of the financial year to free up existing staff to provide closer support to large recruiting national portfolio studies. This focus will help the trust to recruit a higher number of patients to trials, year on year, which in turn will help to deliver the NIHR annual recruitment target. The post holders also support hospital staff to develop their own 'in-house' research studies in preparation for inclusion onto the NIHR National Portfolio of studies. www.ukctg.nihr.ac.uk.

Denise Day, Research Governance Co-ordinator (centre) with new CTAs Kevin Bishop and Aimee Williams

The central governance team was also boosted by the recruitment to two new Clinical Trial Administrators to help support the growing number of trust research studies. The new central team provide support to clinical staff involved in research and have freed up the work of the oncology research team considerably to focus on patient recruitment.

Goals agreed with commissioners

CQUINS

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

In 2015/16 2.5% of the contract value was dependent on achieving the CQUIN targets for CCGs and 2.4% was for NHS England in line with the CQUIN payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at www.mtw.nhs.uk

Within the commissioning payment framework for 2014/15 quality improvement and innovation goals were set as indicated in the table below.

CQUINs	Target	*Achieved (local data)	RAG Rating
National CQUINs (CCGs)			
The percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of the four key items	**90%**	94.7%	Green
The total number of patients presenting to emergency departments who met the criteria of the local protocol and were screened for sepsis.	**90%**	100%	Green
The number of patients who present to emergency departments with severe sepsis, and who received intravenous antibiotics within 1 hour of presenting:	**90%**	**73.5%**	Red
The proportion of patients aged 75 years and over screened for Dementia following an episode of emergency, unplanned care to hospital	**90%**	**98.7%**	Green
The proportion of those identified as potentially having dementia or delirium who are appropriately assessed	**90%**	**100%**	Green
To ensure that appropriate dementia training is available to staff through a locally determined training programme.	**90%**	**97%**	Green
To ensure that carers of people with dementia and delirium feel adequately supported	**20%**	**48%**	Green
Local CQUINs (CCGs)	**Target**	**Achieved**	
UEC - % of patients treated <60mins of arrival in A&E - 60% Target is Quarter 4 only	**60%**	**52%**	Red
Medication Safety Thermometer - Agreed new number of wards audited per month ie Q2 100% of patients on 4 Wards, Q3 100% of patients on 8 Wards, Q4 100% of patients on 10 Wards	**68%**	**Did not achieve Quarter 2 or Quarter 3**	Red
Stroke - Setting up Early Supported Discharge Teams at both sites – 10% reduction in length of stay by Quarter 4	**17.25**	**18.97**	Red
Implementation of HOUDINI Screening Tool for Catheter Associated Urinary Tract Infections (CAUTI) & Audits undertaken	**Implement, Audits Undertaken**	**Achieved**	Green
Reduction in CAUTI rate in Quarter 4 - 10% reduction from	**6.3%**	**3.0%**	

CQUINs	Target	*Achieved (local data)	RAG Rating
baseline			Green
NHS England CQUINs	**Target**	**Achieved**	
Clinical Utilisation Review - Installation and Implementation of software	**Implement**	**Implemented**	Green
Clinical Utilisation Review Installation – Review Impact	**Review**	**Not achieved**	Red
Clinical Utilisation Review - Reporting	**Report**	**Not achieved**	Red
Management of Oral Formulation of Systemic Anticancer Therapy (SACT) - 30% reduction from baseline in Oral SACT issued to patients but not taken by patients	**100%**	**100%**	Green
Oncotype DX: Eligible patients receiving a NICE DG10 compliant test with provision of monitoring data	**Eligible Patients**	**Achieved**	Green
Neonatal Unit Admissions - For all babies who are admitted to a neonatal unit for medical care at term a thorough and joint clinical review is undertaken	**95%**	**100%**	Green
Hepatitis C Networks - Year 1 - National Model of Specialised Hepatitis C Networks - developing a working group, map patient pathways and produce a plan to improve partnership working.	**Implement**	**Achieved**	Green

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2015/16, including what we achieved and what challenged us.

National CQUINs:

The Trust successfully achieved the National CQUINs ensuring appropriate management after discharge for patients with AKI. More patients with dementia and delirium were identified early and supported to help them manage their condition and have a more positive experience with health and social care services. The Trust established a local protocol and ensured that appropriate emergency patients were screened for Sepsis. The Trust made significant progress in initiating intravenous antibiotics for those patients who have severe sepsis, red flag sepsis or septic shock within 60 minutes of presentation but for some patients this fell just outside the 60 minute timescale. The Trust will continue to embed this CQUIN in 2016/17 to further improve outcomes and patient experience.

Local CQUINs:

The Trust 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 51.4% for the year. However, the Trust failed to deliver the stretch target of 60% for Quarter 4 (52%) and this will remain an area of focus for next year.

The Trust developed a process for performing monthly audits of drug charts from relevant clinical areas and uploading this data to the national database, however this process was not fully implemented until November. This is now fully implemented within the Trust and the Trust will

continue to embed this CQUIN in 2016/17 continuing monthly audits and disseminating learning from themes linked to improvement opportunities.

Early Supported Discharge Teams attached to the Stroke Multidisciplinary Team have been successfully set up at both sites. The Trust made an improvement in reducing the Length of Stay for Stroke Patients but due to the slippage in the opening of the new ward at Tunbridge Wells and transferring Stroke patients from Tonbridge Cottage Hospital to Tunbridge Wells failed to achieve the 10% reduction. The Trust will continue to embed this CQUIN in 2016/17 to ensure a reduction in length of stay for stroke patients.

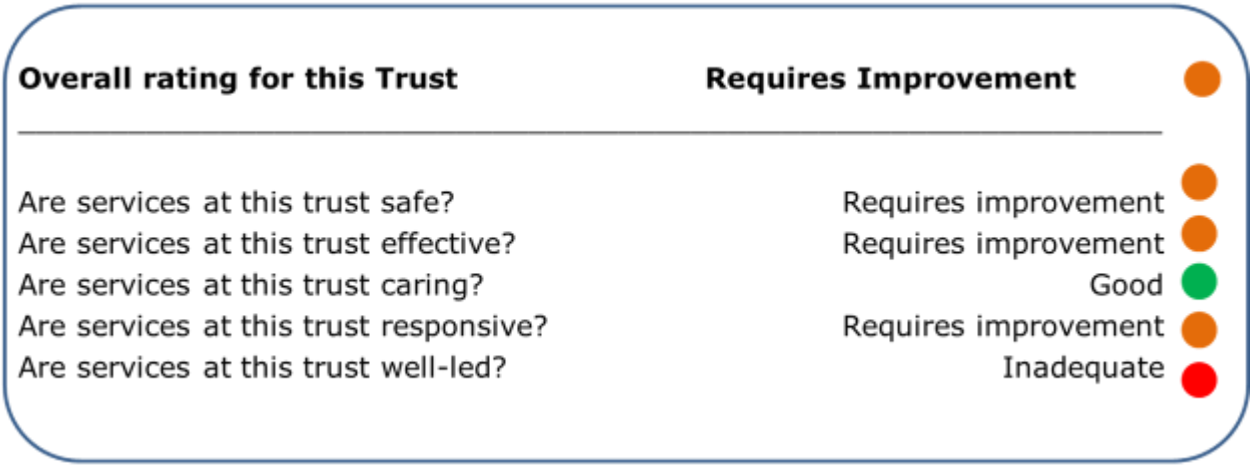
The Trust successfully implemented the HOUDINI Screening Tool for Catheter Associated Urinary Tract Infections (CAUTI) and audits were undertaken. The Trust exceeded the required 10% reduction in the CAUTI rate.

NHS England CQUINs:

The Trust successfully achieved all of the NHS England CQUINs with the exception of the Clinical Utilisation Review. This CQUIN was in three parts and due to the initial slippage in the installation and implementation of software was unable to achieve the review and reporting parts of the CQUIN. The Trust will continue to embed this CQUIN in 2016/17.

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 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 over the 12months since the report was published. These include:

- A dedicated Staff engagement and Equality lead has been appointed
- Translation services have been fully reviewed and a new provider has been identified
- Consultant working patterns in ITU have been revised and are now compliant to ICU standards. This means there are twice daily ward rounds every day of the week.
- Critical Care outreach service implemented 24/7
- A full governance review has resulted in a revised governance committee structure for the Trust and a clear ward to board communication/ escalation process
- Paediatric Early Warning system has been implemented in paediatric services including paediatric A&E
- Water hygiene management is now fully compliant with statutory requirements with robust governance and management in place
- Consideration for privacy and dignity of patients in ITU regarding toilet facilities has been met

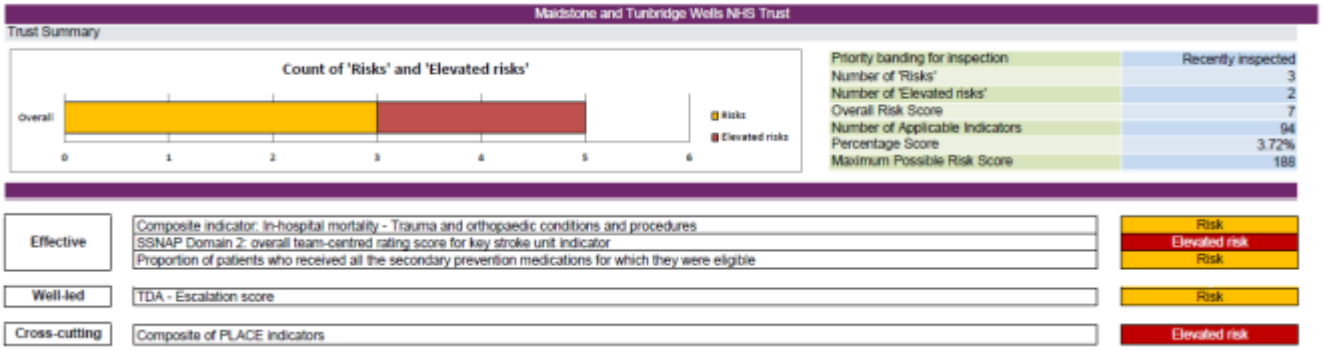
The monthly Quality Improvement Plan reports are published on our staff intranet and shared with commissioners and the CQC.

Intelligent Monitoring:

The CQC developed a new model for monitoring a range of key indicators about NHS acute and specialist hospitals in 2013. These indicators relate to the five key questions asked of all services. The indicators were used to raise questions about the quality of care. They will not be used on their own to make judgements. Judgements will always be based on the result of an inspection, which will take into account Intelligent Monitoring analysis alongside local information from the public, the Trust and other organisations.

Trusts are given a risk rating between 1 and 6, with Band 1 being the highest priority rating (or greatest risk) and 6 being the lowest priority (or lowest risk).

The rating was revised approximately every quarter. The last report (at the time of writing these Accounts) was published in May 2015 and the profile is given below. A banding was not given as the Trust had been recently inspected. However a percentage score of 3.72 % corresponds to a banding of 4.



No further reports have been issued or published on the CQC Website.

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.

During 2015/16 the Trust successfully completed the completeness and validity checks set out as part of the Information Governance Toolkit. The Trust uses the results of these checks to inform the workplan for the Data Quality Steering Group whose remit is to monitor performance against data quality standards. Recommendations and remedial actions are discussed and forwarded to appropriate areas.

Areas identified for improvement during 2015/16 were:-

- the use of the NHS Number within in 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 the Health and Social Care Information Centre, Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient‘s valid NHS number was:
  98.9% for admitted patient care;
  98.4% for outpatient care; and
  96.0% 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 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 72% satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 13, and achieved 8 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 2015/16 a **Clinical Coding audit and process review** was undertaken by CHKS Ltd on behalf of MTW which was released in February 2016. The audit resulted in eight recommendations and the Trust has developed an action plan to address the issues identified.

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

Update on improvement initiatives 2015/16

Patient Safety

To improve the system of incident reporting and learning lessons from incidents, complaints and claims

Aim/goal
To make the process of reporting incidents quicker, easier and more accessible for all staff
To engage all staff groups to report incidents
To improve the current system of sharing the learning from incidents, complaints and claims

Action	Update
Incident reporting process to be developed to be easier, quicker and more accessible for all staff	*Datix improvement group established, DATIX upgrade completed March 2015. Reporting page reviewed and process now quicker and easier. DATIX app currently been rolled out on tablets and iPhone for improved access*
To develop a programme of staff engagement events identifying and engaging staff groups who currently are low reporters of incidents	*Clinical Governance Roadshow week undertaken in November 2015. This included patient safety awareness and how to report incidents. Associate Director Quality Governance attended Directorate Clinical Governance meetings to update staff*
To publish a summary of learning from every serious incident in our Governance newsletter	*Learning from SI's published in Governance Gazette,*
To implement a methodology for triangulating lessons from incidents, complaints and claims more effectively in order to identify overarching themes and organisational learning	*Complaints, Legal, Incidents, PALS, Audit (CLIPA) weekly meeting re-established in September 2015. Data on emerging themes and trends reviewed. Monthly report for Trust Clinical Governance Committee*
To review the current communication pathways for lessons learnt from incidents, complaints and claims and, with the informatics and communication teams consider and implement more effective ways to get messages of learning to staff and the public.	*Improvements made to information on the Trust intranet, input into communication team to provide learning, themes and trends via their forums and communication pathways (such as Glenn's newsletter)*

To improve the patient safety culture within the organisation to ensure the organisations and all staff are responsive to learning

Aim/goal

To engage all staff in developing a 'just' culture that is understood, practiced and owned by everyone

Action	Update
To implement an engagement campaign called 'Step up to Safety' with the aim of raising awareness and engaging staff sign up to a 'just' culture	*Clinical Governance Roadshow week undertaken in November 2015. This included patient safety awareness and a challenge to staff to share how they provide safe and quality care on a day to day basis. Leaflet disseminated to staff. Associate Director Quality Governance attended Directorate Clinical Governance meetings to update staff*
To host a patient safety culture focussed conference for MTW staff	*Conference hosted on 3rd July 2015 with over 60 attendees and positive feedback*
To engage staff is making a patient safety film that is then used to educate staff on the importance of 'just' culture and accountability.	*Financial constraints have prevented the completion of a tender process to fund an external company to produce a film. Alternatives are under consideration*

To improve patient flow through the Trust

Aim/goal

To have effective flow throughout the hospital, that enables patients to be cared for in the right environment by the right staff at the right time.

Action	Update
50% reduction in delayed transfers of care from MTW in the next 12 months	*The DTOC rate since November has ranged from 3.9% to 6.1%. Around 50% of these are related to waiting for Nursing Homes. Care Home availability continues to be a significant issue for the health economy as a whole as similar DTOC levels are experienced in the Community Hospitals, reducing patient flow from the acute sites.* *West Kent is recognised as an outlier for DTOC and as a result, a visit was undertaken in February by Ian Wilson, national expert, and his recommendations are being reviewed by health and social care partners.*
Review of wards at MTW to improve efficiency and flow through ward location and co-adjacencies	*Service redesign continues to be reviewed. The Trust has joined the National Programme for Ambulatory Emergency Care (AEC) with the expectation that up to 20% of the medical take can be treated on ambulatory pathways.*
Creation of additional capacity at the Tunbridge Wells Hospital (30-39 bed unit)	*The new Acute Medical Unit is due to opened in March 2016 with the addition of 38 bed spaces.*

To improve the quality of Stroke care

Aim/goal

The Trust intends to continue work on the improvements the stroke service by ensuring access to a stroke bed within 4hrs of attendance to Emergency Department, ensuring a CT (computerised tomography) scan within an hour of arrival at the hospital and the provision of a 7 day Transient Ischaemic Attack (TIA) service. These will have significant impact on the safety of patients requiring stroke care.

Action	Update
Ensure that patients are admitted to stoke bed within 4 hours of arrival, with a measure of MTW achieving a position in the upper quartile of Sentinel Stroke National Audit programme[1] (SSNAP) national data set.	*From Oct – Dec data* *TWH:37.9% - SSNAP level E* *MDGH:55.1%- SSNAP level D* *National: 59.8% - SSNAP level D*
Ensure that a CT scan is performed in under an hour of arrival, with a measure of MTW achieving a position in the upper quartile of SSNAP national data set.	*TWH: 59.3% - SSNAP level A* *MDGH: 57.1%- SSNAP level A* *National: 48.2% SSNAP level A*
Provision of a high risk TIA service 7 days /week (daytime)	*Currently a 5 day service remains operational. Strategic and directorate discussions regarding ability to provide a 7 day service taking place.*

Patient Experience

Meeting the needs of our clients with due regard to their cultural and linguistic backgrounds

Aim/goal

To meet the needs of all clients with due regard for their cultural and linguistic background.
To ensure our services meet these needs effectively by undertaking a review of the linguistic translation services and improving the service

Action	Update
Recruitment of an Equality and Diversity lead for the Trust	*Staff Engagement and Equality lead recruited who will lead on Equality and Diversity (commenced in post April 2016)*
Implement the tender process for linguistic translation and adopt an efficient system that meets patients and service needs	*Tender process completed and new provision of linguistic translation implemented June 2016 with new provider*
Implement a staff flag project, where staff who speak other languages wear a flag of this country on their name badge	*This will be part of the work plan for the Staff Engagement and Equality lead over the coming year*

[1] The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence-based standards, and national and local benchmarks. Building on 15 years of experience delivering the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP), SSNAP is pioneering a new model of healthcare quality improvement through near real-time data collection, analysis and reporting on the quality and outcomes of stroke care.

Development of an Equality and Diversity awareness programme for all staff	*An awareness programme is in place* *Staff Engagement and Equality lead will review this programme in the coming months and recommend improvements, as necessary*
Development of a MTW Equality and Diversity strategy	*This forms part of the Workforce Strategy that was approved by the Trust Board in September 2016*

Fully implement Friends and Family Test for Outpatient Services and improve learning and action taken in response to Friends and Family test

Aim/goal

The aim is to expand the friends and family test to service users at all MTW outpatient departments and use this information to improve learning and implement improvements.

Action	Update March 2016
Include outpatient services in overall Friends and Family report	*Fully implemented.*
Establish a robust feedback loop where learning and improvements can be identified and changes implemented	*Feedback loop has been developed to enable with further work to continue this work to enable change and improvement planned in the coming year*
Triangulate results with themes from incidents and complaints, identify areas of good practice and where development should be focussed	*Dependent on the above. Intention is to stay with I Want Great Care. Revised service will enable benchmarking and trend analysis*
Ensure results, learning and changes are publically displayed in outpatient areas and kept up to date and improve response rates	*In progress; detailed analysis is dependent on supplier and support transcribing free text from out-patient returns (OP is an automated telephone service).*

The ensure meaningful patient and public involvement in all service improvements

Aim/goal

The aim is to undertake a review of current patient and public involvement processes, identify effective practice, identify areas for improvement and implement a cohesive approach and strategy.

Action	Update
Review of all patient and public involvement activities in the Trust including all local and national patient experience surveys to identify good practice and areas for development.	*Engagement with HealthWatch Kent strengthened. Regular meetings with HWK to identify trends and themes.* *HealthWatch have a designated representative on the Patient Experience Committee, undertake a number of 'enter and view' visits and have been involved in the planning of the new ward at Tunbridge Wells Hospital.*
Include service user representation at meetings where service improvement is on the agenda.	*Process in place. Recent examples include stroke strategy consultation and new ward development programme at TWH – plus as above.*
Conclude review of Patient Experience Committee.	*Review completed. Refined core committee membership to enable it to provide an 'assurance' function.*
Focus on Children Services feedback.	*FFT includes parents, children and young people.*

	Patient Stories are heard at Public Trust Board

Ensure clinical governance frameworks and processes throughout the Trust and at speciality level are effective

Aim/goal

To undertake an organisational review of Ward to Board clinical governance framework, processes and culture in order to identify effective practice and areas of improvement. To implement changes where required and measure improvements.

Action	Update
An external supported review of organisational clinical governance to identify good governance and culture, identify areas for improvement and implement new governance framework within the organisation.	*External governance review that included cultural element completed August 2015 with full report*
Establishment of a consistent organisational governance framework that supports effective Directorate level clinical governance.	*External governance review completed and committee structure amended.* *Clinical Governance framework developed with clear ward to board flow and clarity over reporting and support for Directorate clinical governance*
Establishment of a system of intelligent monitoring that will enable more effective measurement of quality and safety.	*Internal assurance process developed in relation to CQC domains. Pilot commenced April 2016*

Review and improve the effectiveness of Morbidity and Mortality meetings and reviews

Aim/goal

The aim is to further develop our existing mortality review process and demonstrate how this process can lead to care and service improvements through openness and shared learning

Action	Update
Review of current governance process against new CQC Well – led Domain	*Included in the external governance review completed August 2015*
In collaboration with Directorate leads and external partners agree an improved mortality review process that is documented as a standard operating procedure	*Establishment of revised Mortality review process and Trust Mortality Surveillance group January 2016.*
Review membership of the Trust Mortality Review Group to ensure representation within and external to the organisation	*Trust Mortality Surveillance group has membership in line with NHS England recommendations. The Clinical Commissioning Group is a member of the Trust Mortality Surveillance Group.*
With data analysts and informatics department, consider ways of automating the Mortality Review process that would make for a more timely and efficient process	*Support from Health Informatics department established. Automated mortality review process considered but not currently achievable due to changes to central patient data systems, however this will be consider & included in longer term plans*
With data analysts, consider and implement a triangulation system to ensure the data is being	*Triangulation system established in revised Mortality review process with data reported March 2016*

used more effectively in proactive risk management	*onwards*
Publication of summary reports on the intranet to demonstrate transparency and ensure shared learning across the organisation	*This will commence once data flow is established through the new Mortality review process. Expected May / June 2016. The Clinical Commissioning Group is a member of the Trust Mortality Surveillance Group.*

To ensure that systems and processes as well as, support for our staff is in place to discharge our responsibility to be honest, open and truthful in all dealings with patients and the public.

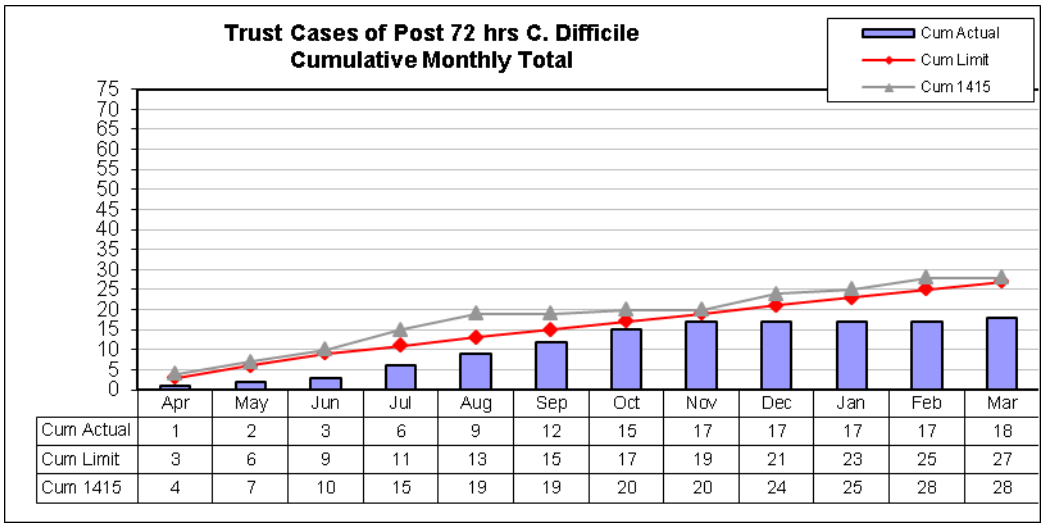
Aim/goal

The aim is to ensure all systems and processes follow the requirements and the essence of the statutory duty of candour.
To implement a support system for staff to discharge their responsibilities to be honest, open and truthful in al dealings with patients and public

Action	Update March 2016
To update the 'Being Open' Policy to include the Duty of Candour requirements	*Policy reviewed and Duty of Candour requirements explicit*
To further extend the training programme in place for all staff	*Training continues as part of the wider patient safety training program*
To further develop resources to assist and support staff when undertaking duty of candour in the clinical setting	*Patient Safety manager commenced in post September 2015 and further staff recruitment achieved. The better resourced patient safety team will be able to provide improved support and guidance for clinical staff as well as maintain a central database for assurance*
Along with the 'Cultural change' programme and 'Step up to Safety' campaign, implement a strategy to further embed the 'Honest and open' culture	*Quality strategy has been integrated into the Trust Clinical Strategy as Quality and culture underlies all future improvements.*
Develop a more robust support process for patients, relatives / carers and staff who have been affected by an incident that causes harm	*Included in the revised 'Being Open' policy and included in the revised 'Serious Incident' policy. Planning with Human resources to implement improved staff support when traumatic event occur.*
To implement an internal assurance process to provide continuous evidence of meeting the statutory requirements	*Audit undertaken on Duty of Candour requirements shows an improving trend. Further work is being undertaken and another audit is planned for later in 2016.*

Review of Quality Performance

Infection Control – C.Difficile Cases – The Trust exceeded this standard with 18 cases against a maximum of 27 cases for the year. The number of CDifficile cases throughout 2015-16 was 9 fewer than the number reported for 2014-15 – 36% reduction

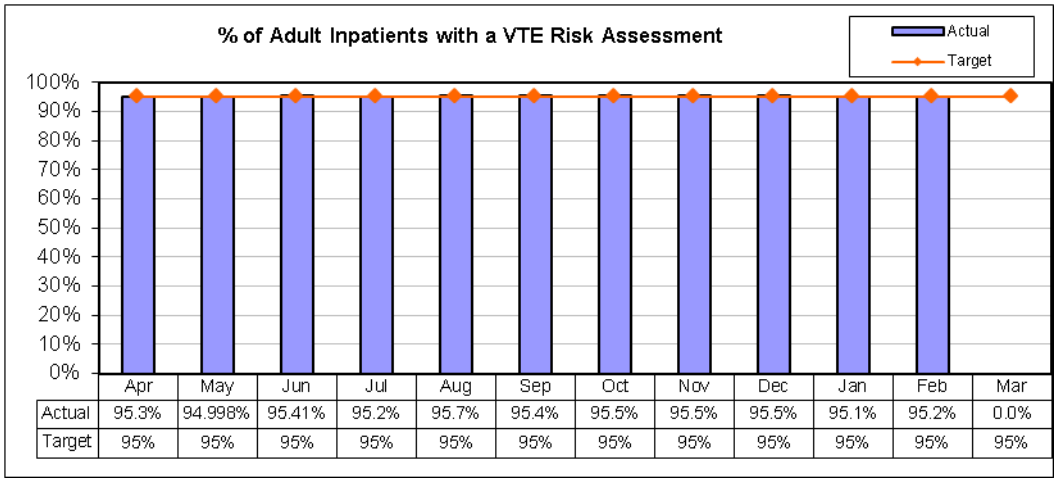


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	1	2	3	6	9	12	15	17	17	17	17	18
Cum Limit	3	6	9	11	13	15	17	19	21	23	25	27
Cum 1415	4	7	10	15	19	19	20	20	24	25	28	28

Infection Control – MRSA 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)

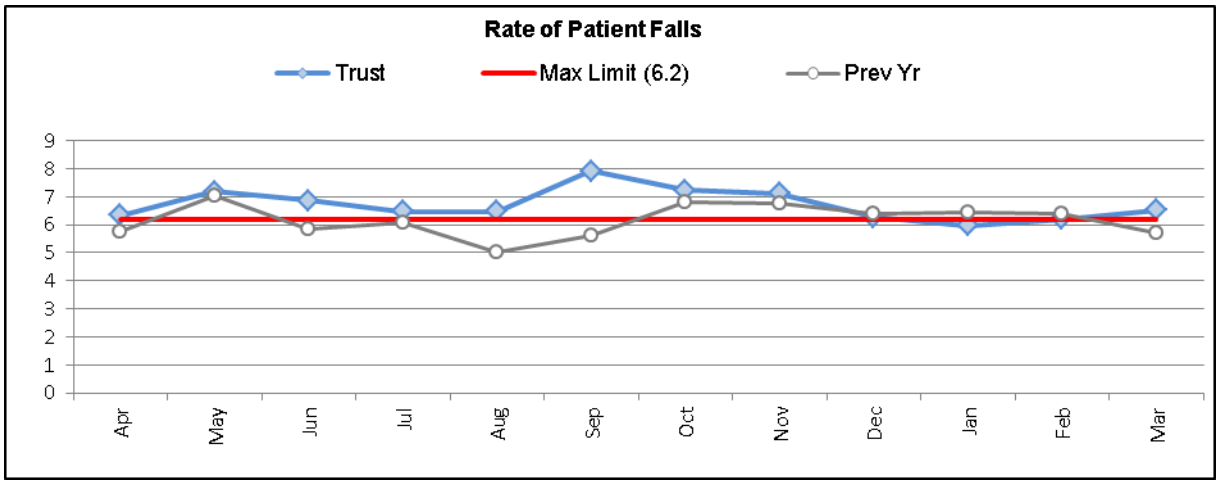
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2015-16.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	95.3%	94.998%	95.41%	95.2%	95.7%	95.4%	95.5%	95.5%	95.5%	95.1%	95.2%	0.0%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Reducing the number of patient falls

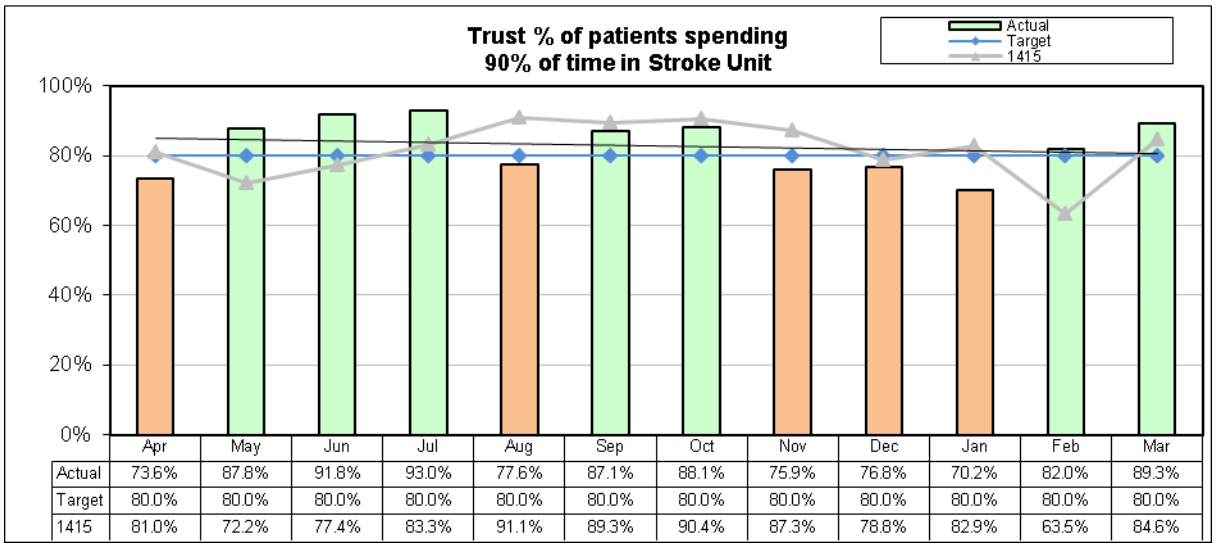
Rate of Falls – The Trust's rate of Falls per 1,000 Occupied Beddays is above the Trust internal improvement target of 6.2 at 6.69 for the year (6.16 for the previous year)



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

Also see update summary in part 3

80% of patients spending 90% of time on in Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2015-16 at 82.4%.

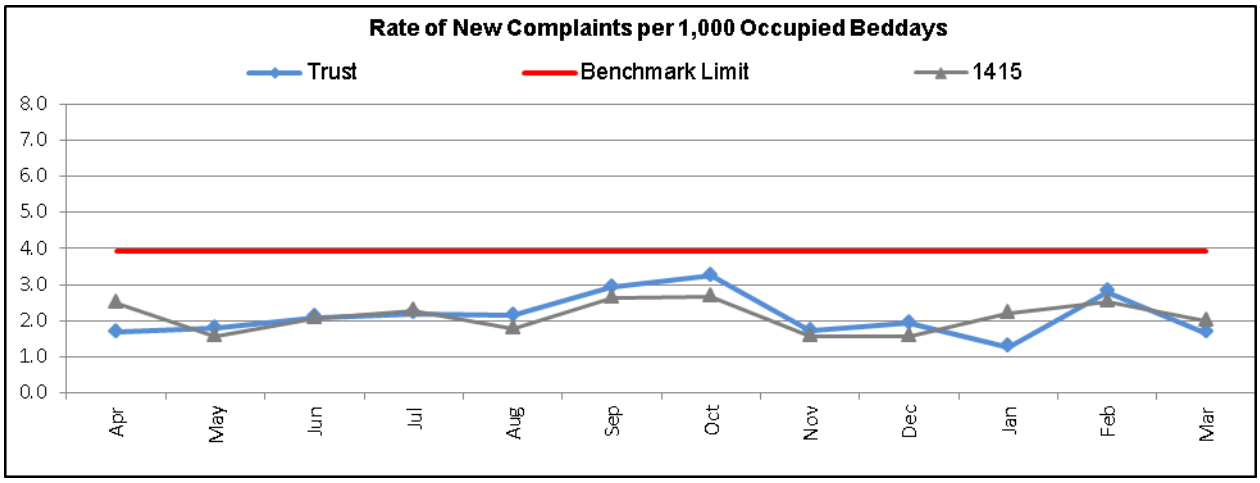


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	73.6%	87.8%	91.8%	93.0%	77.6%	87.1%	88.1%	75.9%	76.8%	70.2%	82.0%	89.3%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
1415	81.0%	72.2%	77.4%	83.3%	91.1%	89.3%	90.4%	87.3%	78.8%	82.9%	63.5%	84.6%

PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 episodes is below the national benchmark of 6.26 at 2.11 for the year (4.08 for the previous year). The number of new complaints received in 2015-16 is a 5.8% increase (+28) 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 8th July 2015

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. While 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**.**

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 regular basis and examples of the learning from complaints are also reported to the Patient Experience Committee. Case studies and key messages from complaints are regularly included in the Trust's Governance Gazette, produced monthly.

Patient Surveys

National Patient Surveys

During 2015 the Trust undertook two National Surveys. Although they are led by Picker Europe and the CQC we have been undertaking these in house. The surveys were the following:

- Women's Experience of Maternity Services
- Adult Inpatient Survey

The Maternity Department survey runs bi-annually and was previously run in 2013. The Inpatient Survey is run on an annual basis.

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 2015

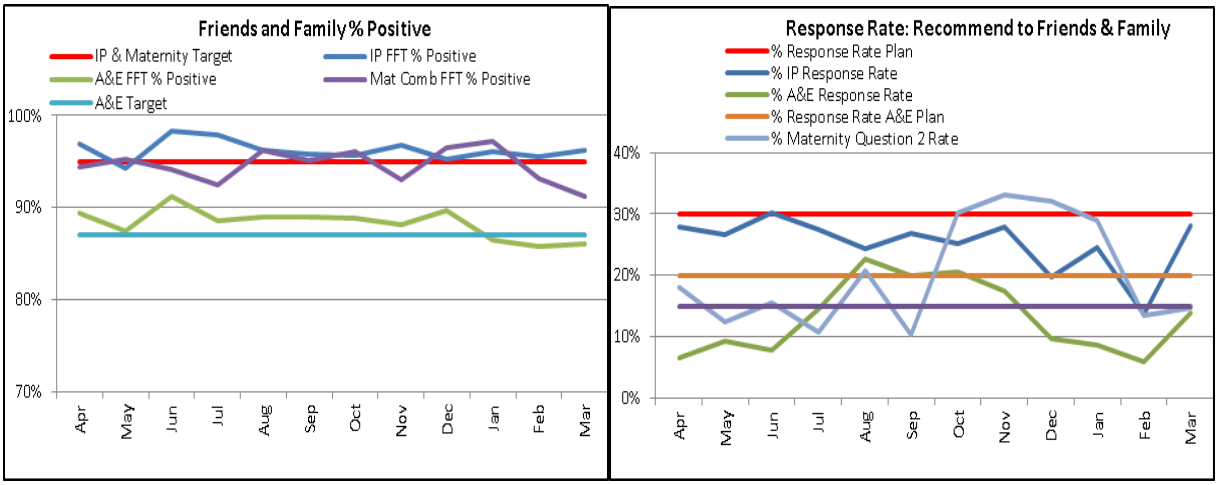
Focus questions from National Inpatient Survey		National Inpatient Survey	
		2015	2014
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.7%	87.5
2	Did you find someone on the hospital staff to talk to about your worries and fears?	46.9%	47.3
3	Were you given enough privacy when discussing your condition or treatment	95.8%	95.6
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	39.3%	42.0
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	69.1%	71.4

Friends and Family

The Inpatient and A&E positive response rates (96.4%, 88.4% respectively) have exceeded the Trust Plan and national benchmarks indicating that patients would recommend the Trust to their Friends and Family.
The Maternity positive response rate is just below the 95% target at 94.7%

Inpatient and A&E response rates have not met the planned Trust rate, but have exceeded the national benchmarks. Maternity response rate is above the 15% Trust target.

MTW Friends and Family scoring



Staff Survey 2015

This section outlines our most recent staff survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (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 22% which is a 1% decrease from the 2014 survey findings and is 4% lower than the National 2015 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 21% (2014 findings – 23%) (National average for acute Trusts – 25%)
BME 25% (2014 findings – 23%) (National average for acute Trusts – 28%)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
This is reported at 86% which is a 1% decrease from the 2014 survey findings and is 1% lower than the National 2015 average for acute Trusts

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 89% (2014 findings – 90%) (National average for acute Trusts – 89%)
BME 71% (2014 findings – 78%) (National average for acute Trusts – 75%)

With the appointment of the new Staff engagement and Equality lead, the Trust plans to review the current Equality and Diversity approach and develop an up to date Equality and Diversity awareness programme for all staff. We will be working with a partner Trust to create a plan for delivering department/staff group specific training. Further, the Trust will be working with Stonewall to complete the Equality Index for 2016, we will utilise their materials to deliver appropriate training for the support of LGBT staff, set up an LGBT staff network and provide a mentoring scheme for LGBT staff.

Working with a partner Trust, we will conduct a review of all existing Trust practices in relation to Equality and Diversity requirements and complete the EDS2. We will develop links with local support groups and communities to engage them in the improvement plan for the Trust with assistance from Healthwatch and build a BME forum.

A new translation service for both language and British Sign Language has been agreed with a new provider and will go live on 1 June 2016. This new service will be more allow more ready access to staff and patients as it has a wider choice of forms of communication including telephone based interpreting, video-link and face to face interpreting.

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 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 99 serious incidents in 2015/2016 compared to 118 the previous year.

Actions and learning from serious incidents are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2015/2016 learning and actions included:

- All patients should have their follow up appointments booked directly following their Outpatient consultation unless discharged
- A Standard Operating Procedure has been written for Cancer and Haematology to ensure there is a robust appointment system in place to provide continuity of services after 17.00 hours
- All spinal surgery stopped for patients with a Body Mass Index greater than 35
- A review of the pre-assessment process relating to anaesthetic reviews ensuring this is completed prior to the surgery date
- A post take ward round checklist has been developed to ensure all essential actions have been completed including thrombosis risk assessments and prophylactic treatment prescribed
- Undertaking of lying and standing blood pressure on patients at high risk of falls to identify any postural instability
- Further training on moving and handling for patients post fall
- Post fall checklist for completion by medical and nursing staff
- Paediatric Early Warning System (PEWS) charts implemented that alert staff to a child with deteriorating observations and symptoms.
- Revised checklist implemented for inpatients attending radiotherapy to ensure all patient risks are identified to the department to allow plan of care to be implemented whilst in the department
- An awareness to staff that mortuary viewing should only occur out of hour if it is an emergency

Never Events

There were 2 Never Events during 2015/2016, a full root cause analysis was undertaken and presented to the Executive led panel and findings shared with the Trust Development Authority to ensure wider learning.

The first Never Event was a retained specimen bag during a laparoscopic procedure. This piece of equipment had been adapted by the surgeon to meet the needs of the patient and was not part of the theatre count. Actions included all equipment that enter the sterile field must be included in the theatre count. It is recognised that at times equipment may need to be adapted to meet individual patient's needs this must be risk assessed, discussed with the whole theatre team prior to surgery and the rationale clearly documented within the patients' healthcare records.

The second Never Event related group O Fresh Frozen Plasma being issued in error of the universal group of AB Fresh Frozen Plasma which should have been issued. The main action was that only the universal group fresh Frozen Plasma is now held within the organisation for emergency use until type specific is available.

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.

In 2015 the Trust ran a number of training events for staff outlining the duty of candour requirements. This was supplemented by articles in staff newsletters and postcard prompts. The trust has subsequently undertaken an audit to review compliance. This audit reviewed the 3 elements required to meeting in the regulations and showed good compliance with offering the first apology but identified that improvement is still required in communicating the outcome of the investigation to the relevant person. An action plan to address issues had been developed and there is on-going scrutiny of this statutory requirement at a senior level in the organisation. Duty of Candour guidance is included in the 'Being Open' policy.

'Sign up to Safety' Safety Improvement Plan

MTW developed and agreed safety pledges in 2015 and have since developed a Safety Improvement plan that will be rolled out over the next 1-3 years.

The following safety improvement domains have been identified are needed focused improvement as a result of a review of the data from legal services over claims against MTW through the NHS Litigation Authority data in the last 5 years, a review of the tends 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)

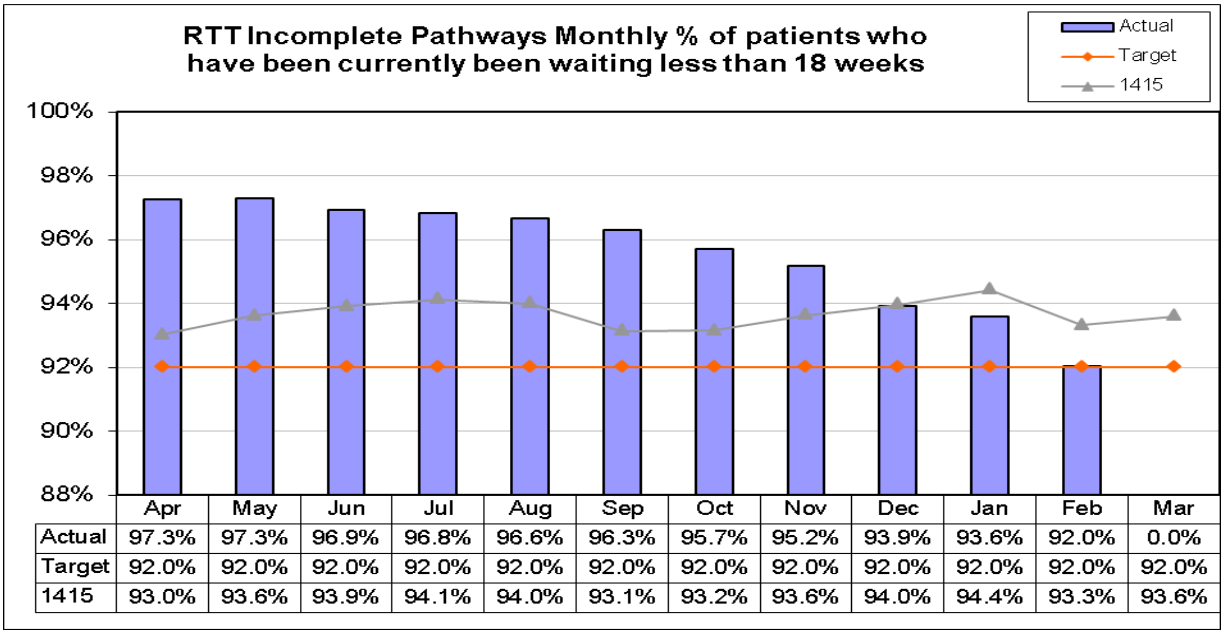
These safety improvement domains will form the heart of the Safety Improvement Plan:

- 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 will follow the Plan, Do, Study, Act (PDSA) 90 day cycle supported by the NHS England Sign up to Safety Campaign.

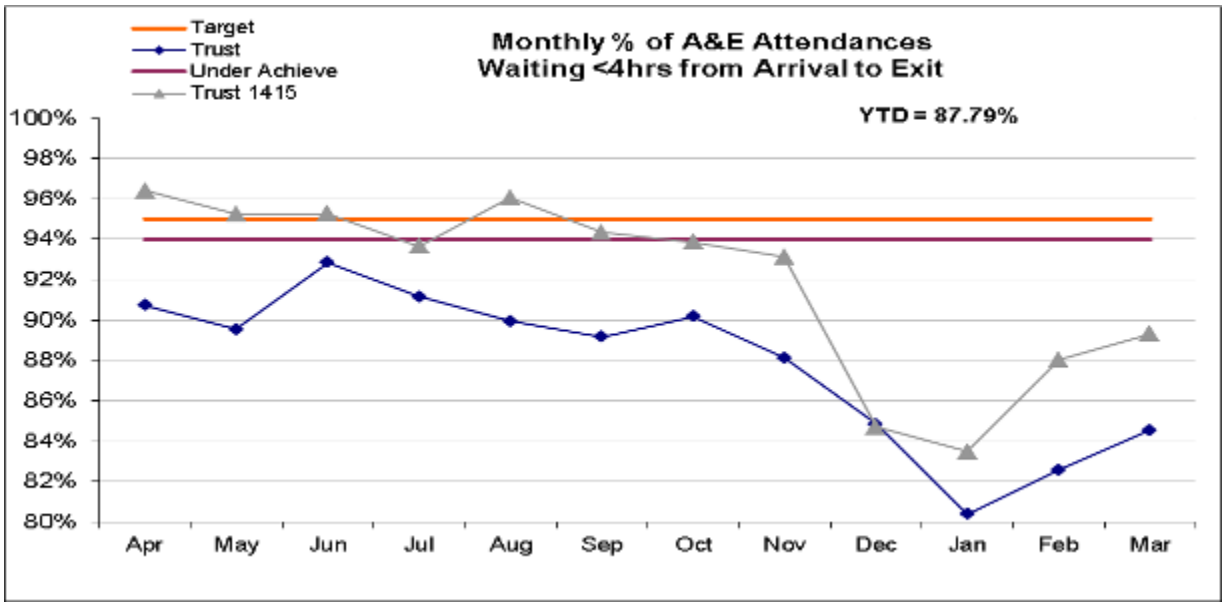
Other Quality Monitoring and Improvement Measures

18 weeks standard – The Trust achieved this standard at an aggregate Trust level, ensuring at least 92% of patients on an Incomplete Pathway had been waiting less than 18 weeks from April 2015 to February 2016, however under-achieved the target in March 2016 due to high levels of emergency activity. The Trust also ensured that at least 90% of admitted patients were treated in hospital following GP referral in 18 weeks and 95% of non-admitted patients were seen within the same period.

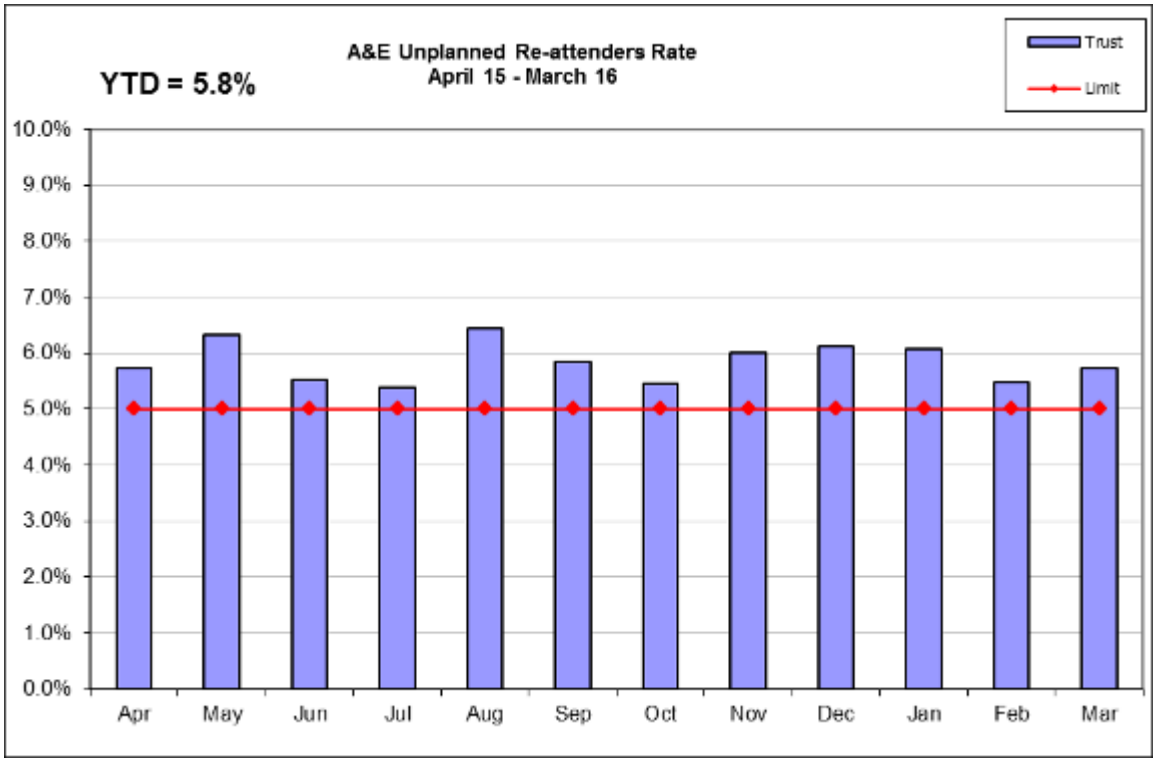


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.3%	97.3%	96.9%	96.8%	96.6%	96.3%	95.7%	95.2%	93.9%	93.6%	92.0%	0.0%
Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
1415	93.0%	93.6%	93.9%	94.1%	94.0%	93.1%	93.2%	93.6%	94.0%	94.4%	93.3%	93.6%

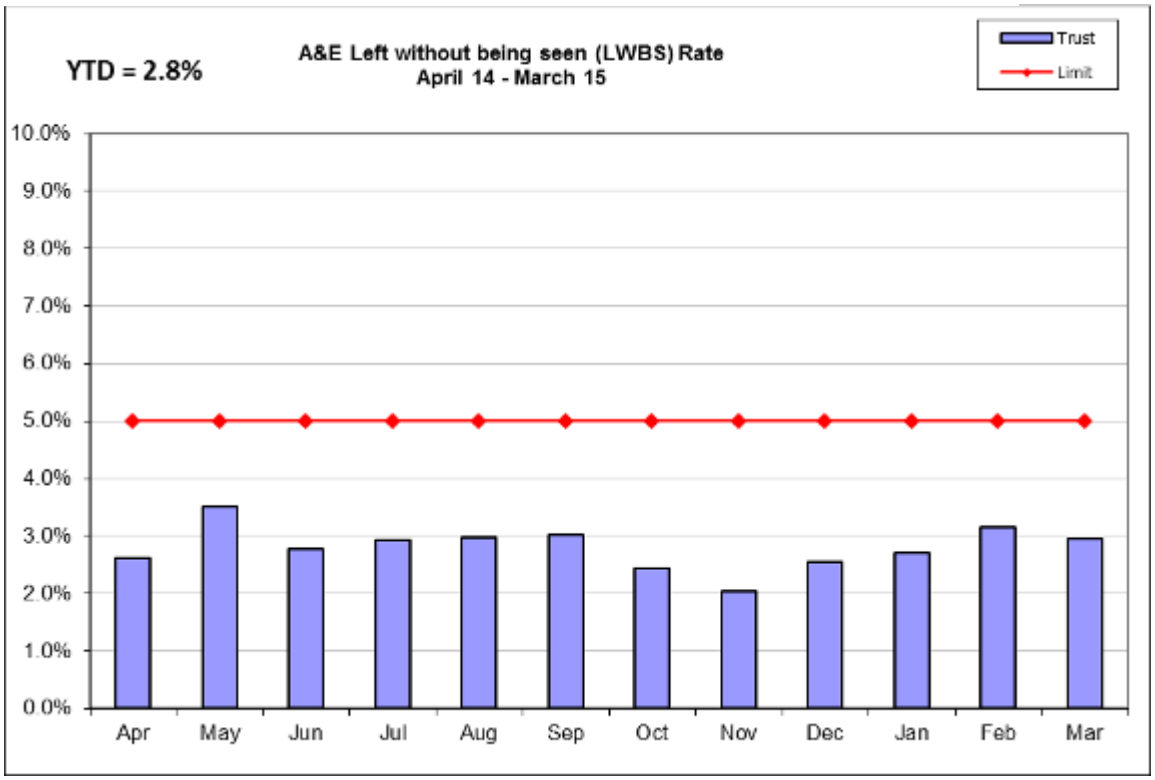
Emergency 4 hour access – Due to the extremely high level of demand the Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2015-16 at 87.8%.



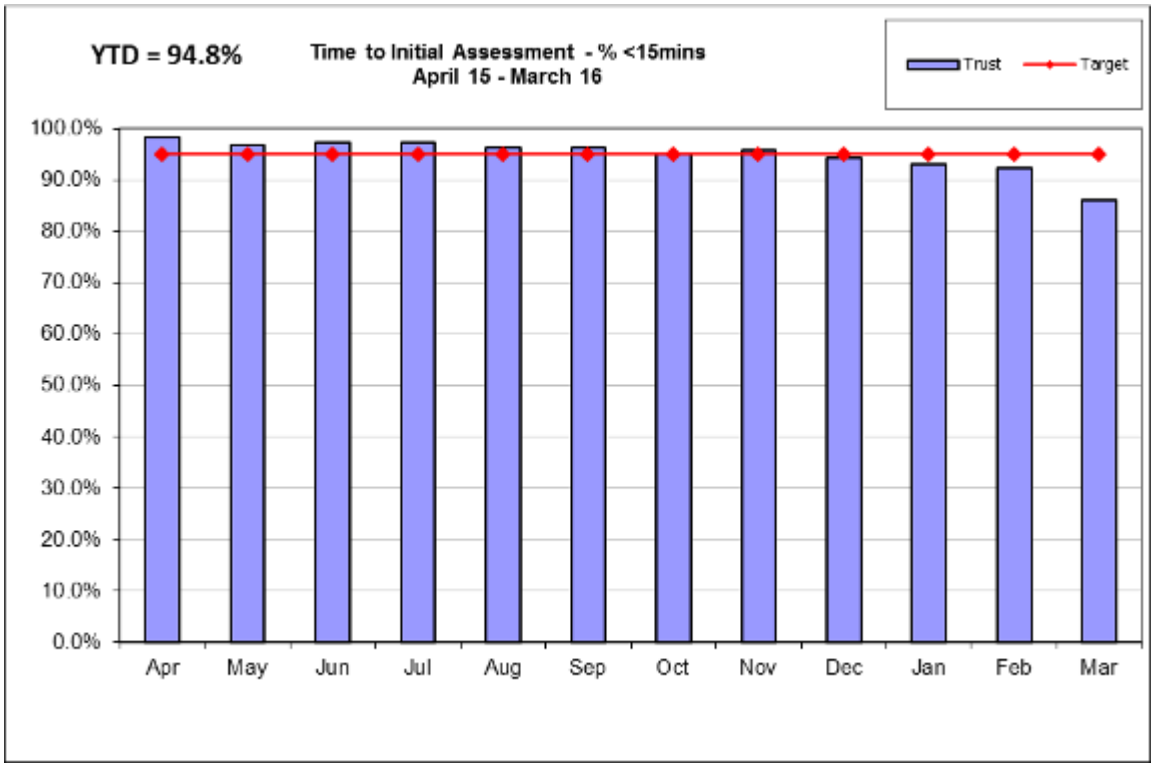
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 5.8%.



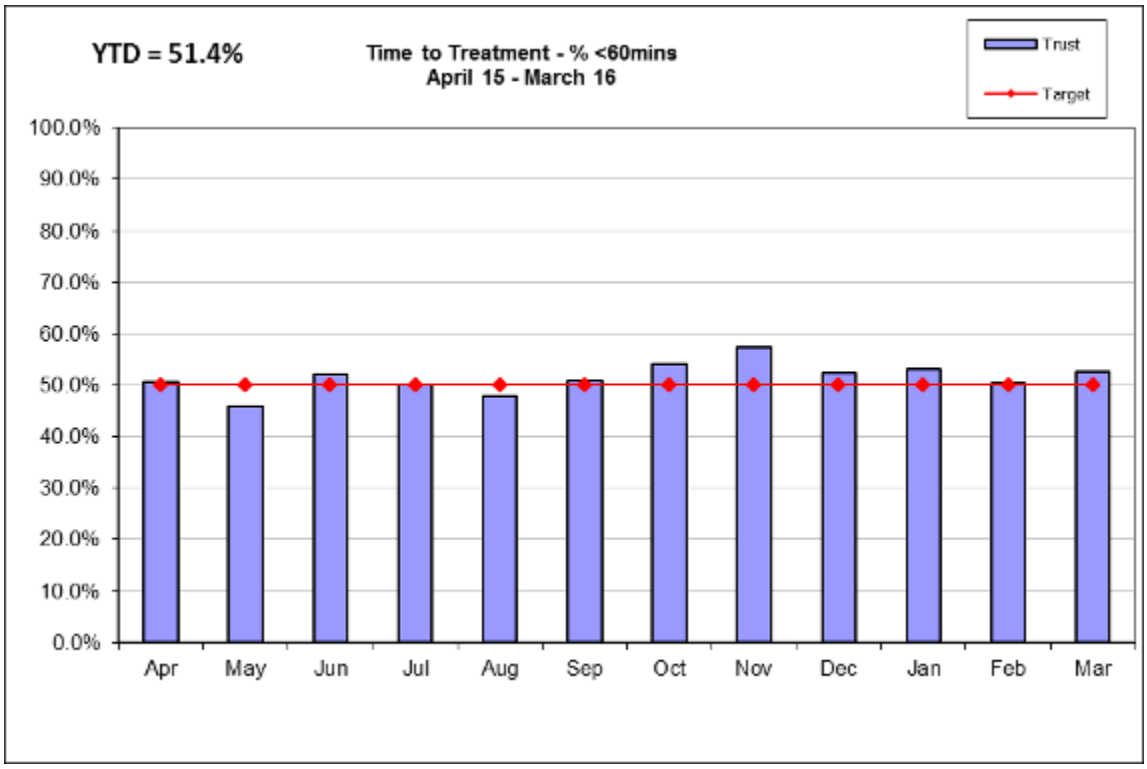
A&E Left without being Seen Rate – The Trust achieved this standard, of less than 5% of patients leaving its A&E Departments without being seen at 2.8%.



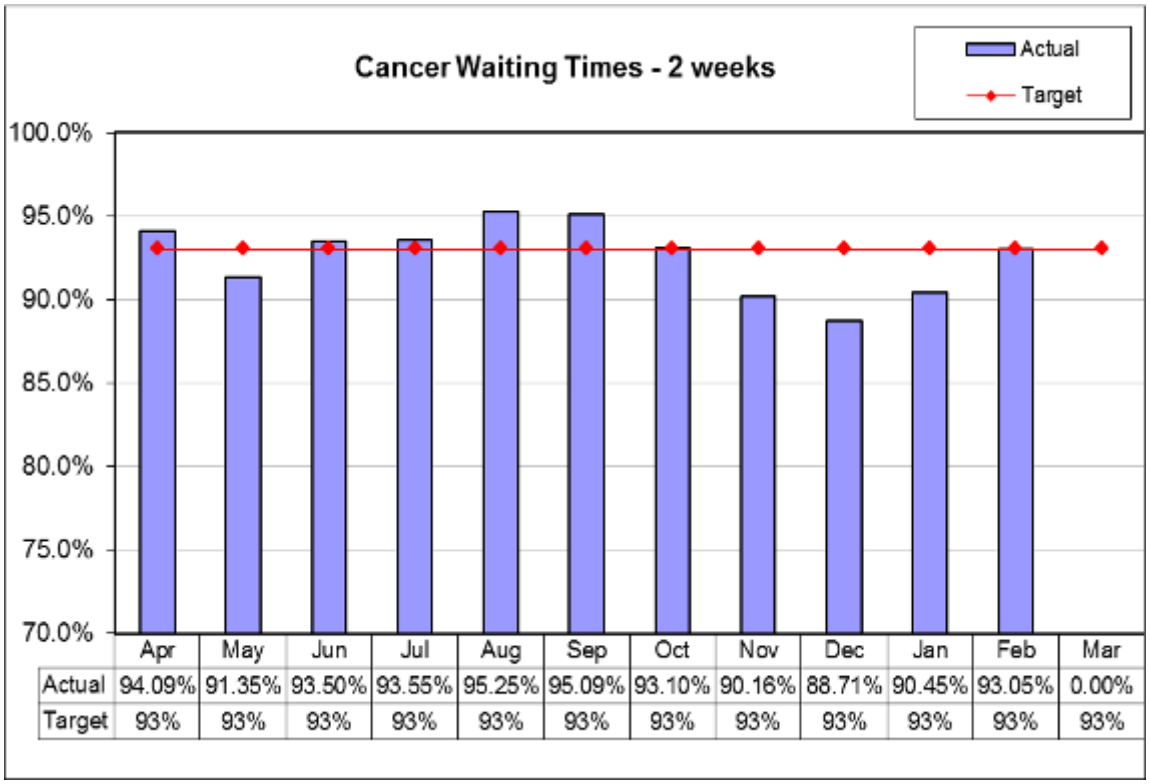
A&E Time to Initial Assessment <15 minutes – The Trust did not achieve this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival at 94.8%.



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 51.4%.

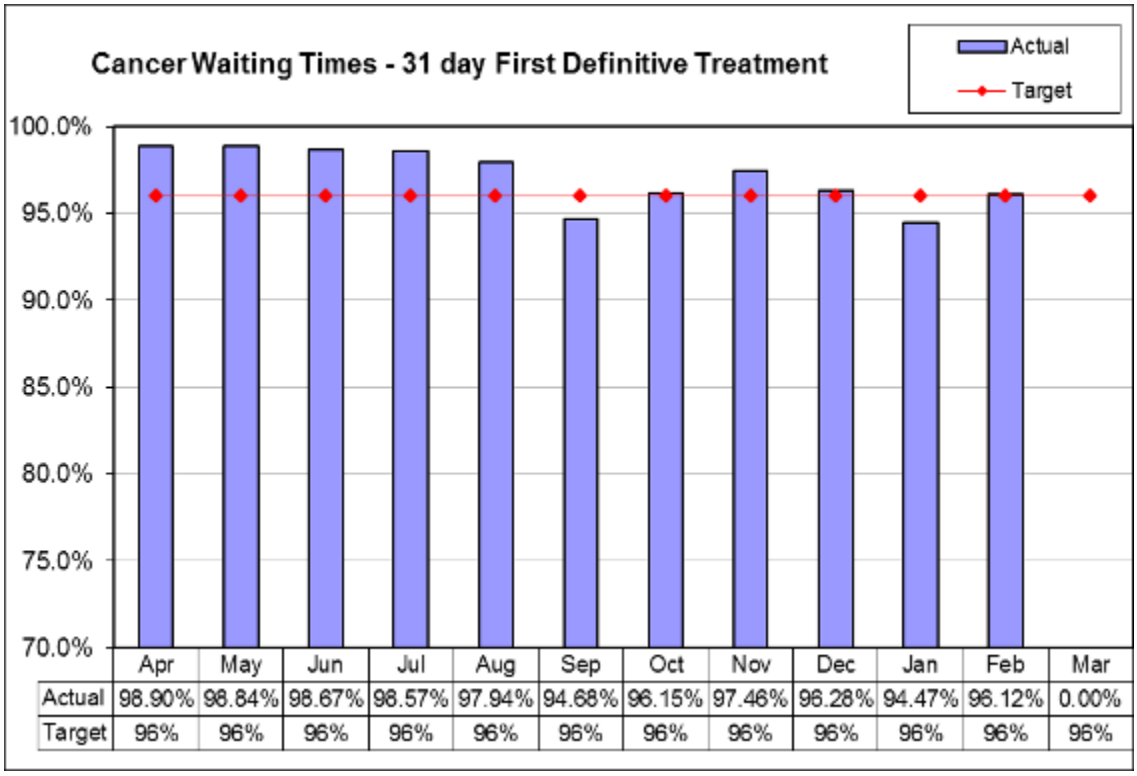


Cancer Waiting Time Targets - 2 weeks from referral – The Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



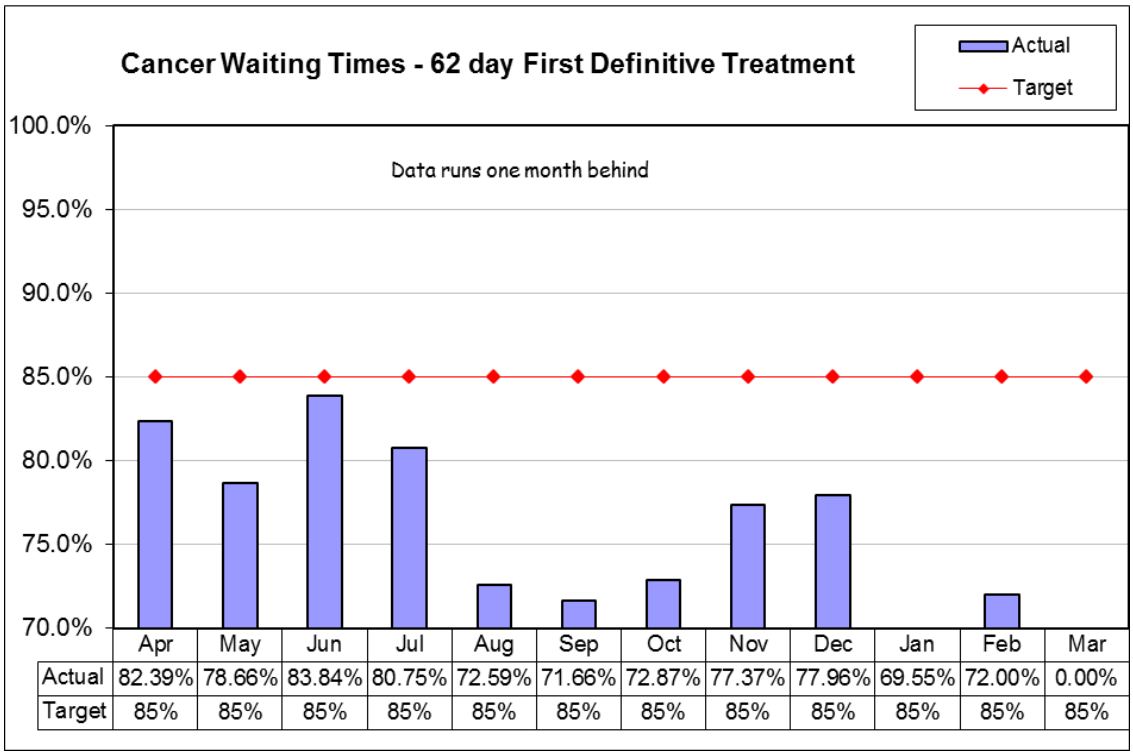
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	94.09%	91.35%	93.50%	93.55%	95.25%	95.09%	93.10%	90.16%	88.71%	90.45%	93.05%	0.00%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%

Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust did not achieve this standard of ensuring that 96% of patients who needed to start their treatment within 31 days did so.



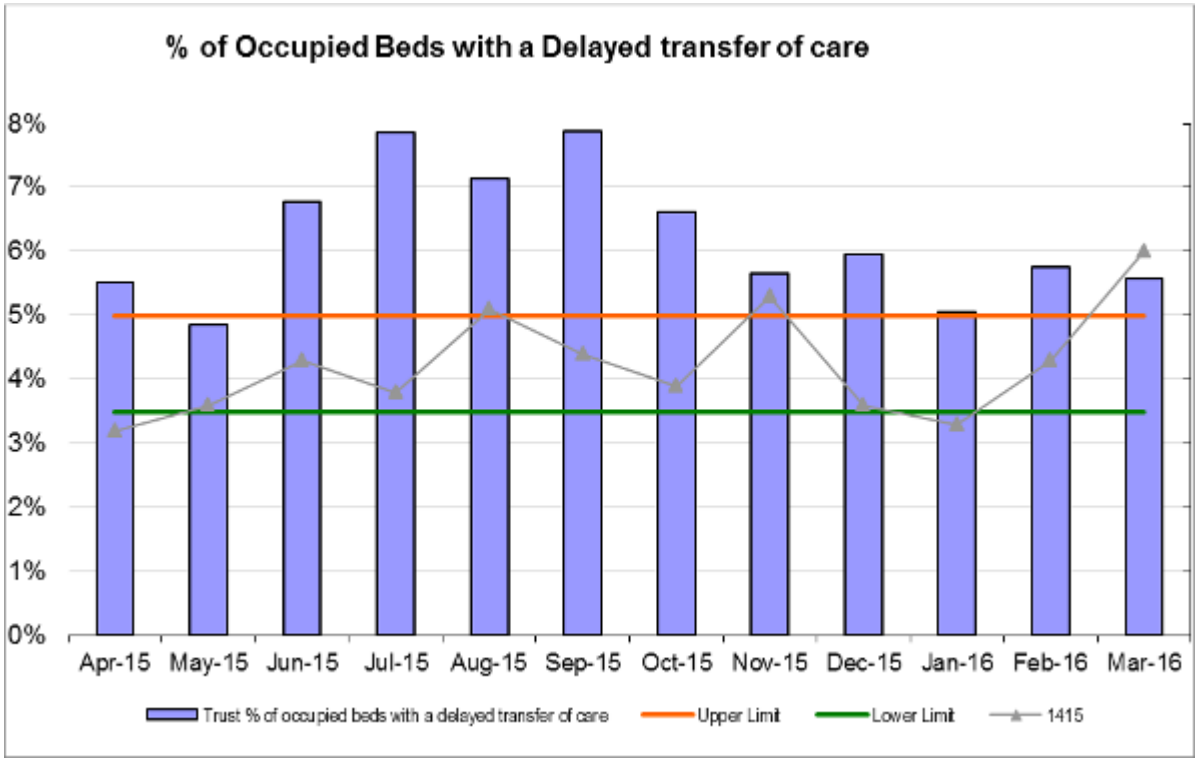
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	98.90%	98.84%	98.67%	98.57%	97.94%	94.68%	96.15%	97.46%	96.28%	94.47%	96.12%	0.00%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%

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

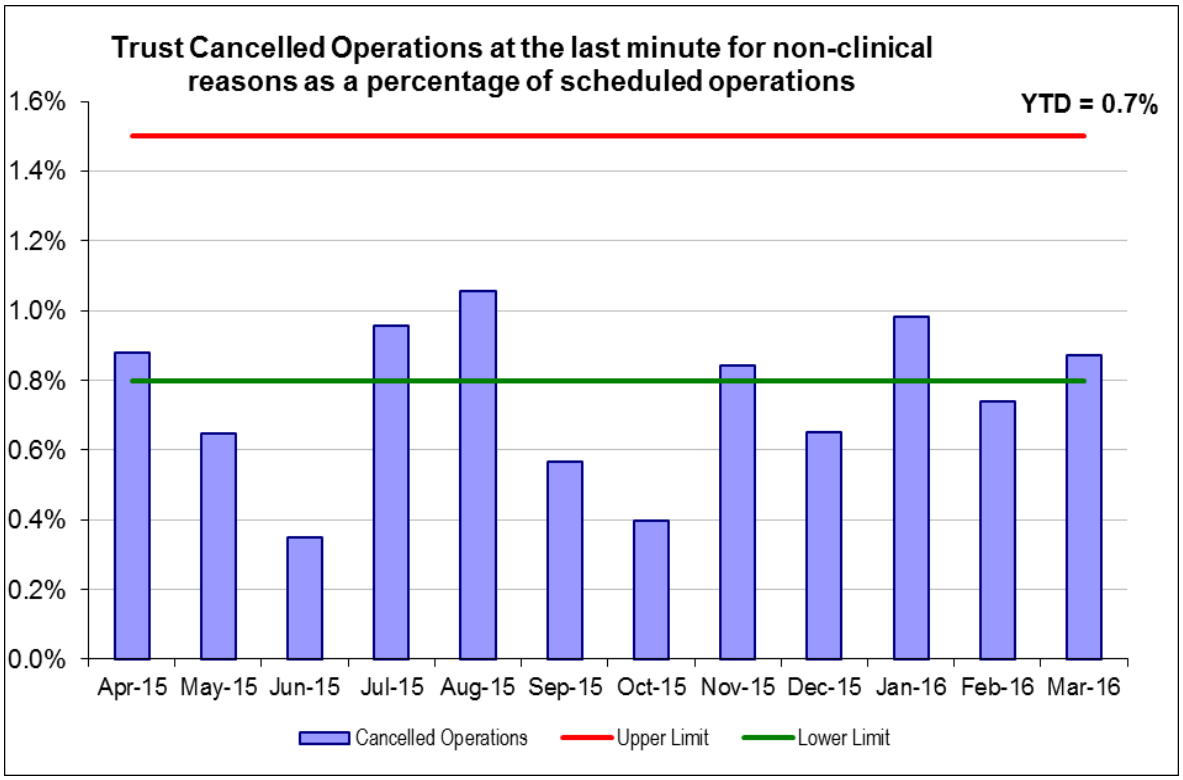


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	82.39%	78.66%	83.84%	80.75%	72.59%	71.66%	72.87%	77.37%	77.96%	69.55%	72.00%	0.00%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year at 6.2%.



Cancelled operations – The Trust achieved the cancelled operations national standard of 0.7% for the seventh year running.



National Indicators

There are a variety of national indicators highlighted within the Outcomes Framework that each Trust is required to report on.
Maidstone and Tunbridge Wells NHS Trust considers that this data is as described for the following reasons:-

The Trust has achieved level 2 for the Information Governance Toolkit. As part of this process audits of clinical coding 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 —**	**2015/16 local and national data**	**2014/15 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.	100.30 Jul 14 – Jun 15 *(Better)*	101.50 Jul 13 – Jun 14 (Worse)	100
3	PROMS			
	i) groin hernia surgery	No data available	0.084	0.084
	ii) varicose vein surgery		N/A	N/A
	iii) hip replacement surgery		0.464	0.437
	iv) knee replacement surgery		0.320	0.315
	during the reporting period *(See below for explanation of reporting data)*		(Apr 14 to Mar 15)	(Apr 14 to Mar 15)
3	the percentage of patients aged— i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.***1**	**Trust** 10.4% **Elective** 5.3% **Non-Elective** 11.2%	**Trust** 10.9% **Elective** 5.5% **Non-Elective** 11.6%	(Q1 13/14 position) **Elective:** 6.81% **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.	82.9	77	79 (2015/16)

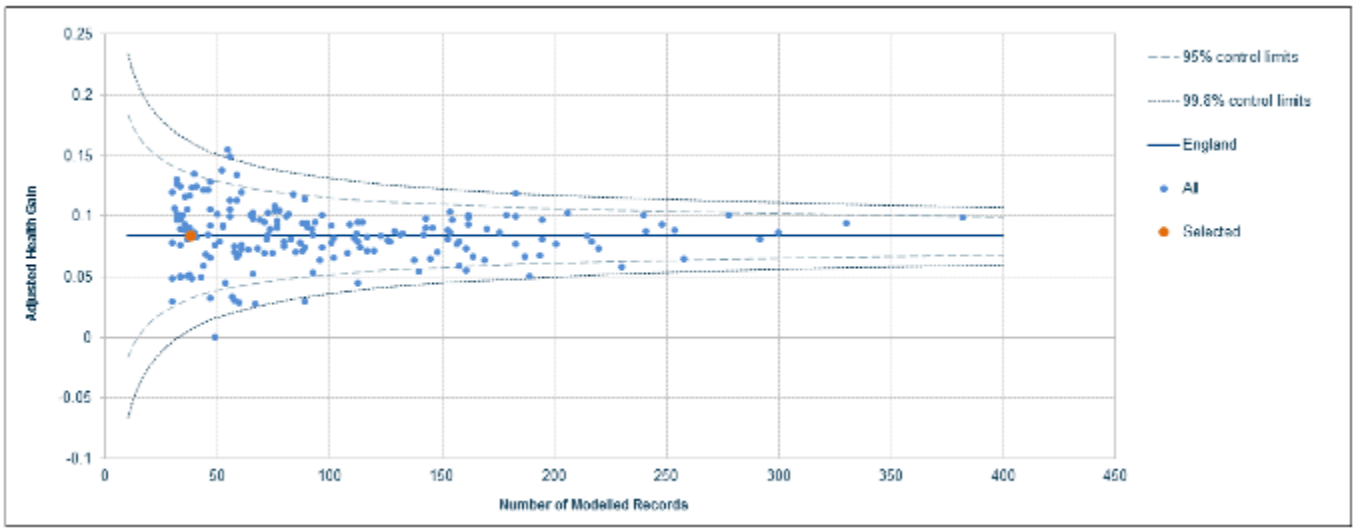
Domain	Prescribed data requirements **The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —**	2015/16 local and national data	2014/15 local and national data	National average
5	the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.3%***2**	95.5%	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.	7.4 ***3**	12.0	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)*	6911 1.2%	6173 1.6%	

*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.

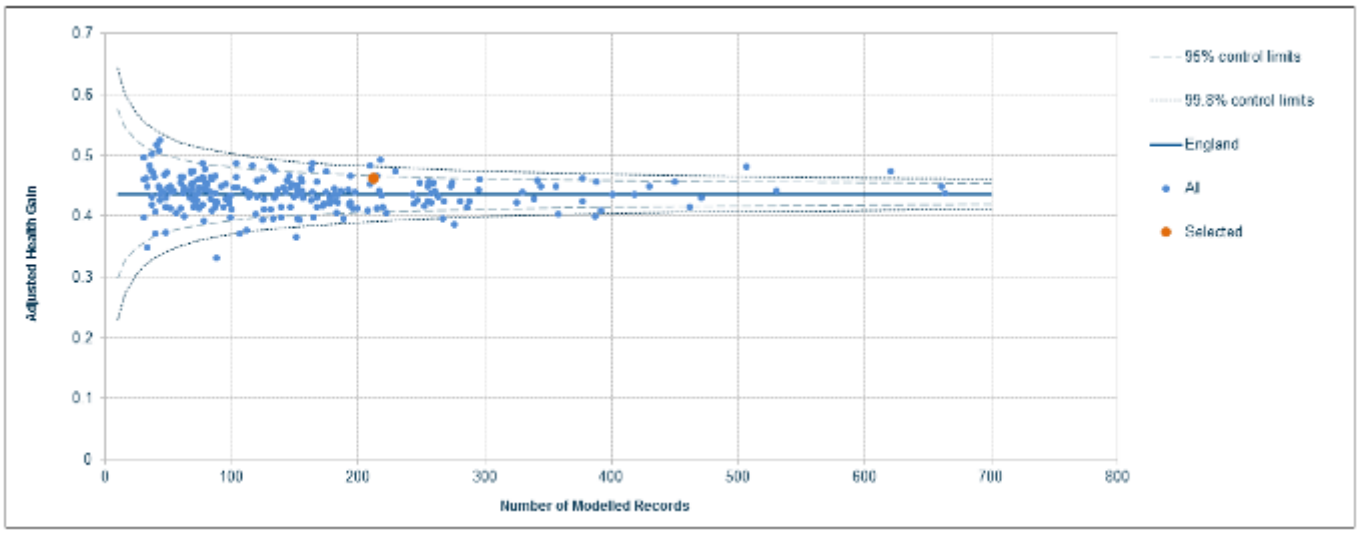
Patient Reported Outcome Measures (PROMs)
The NHS asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. Data is collected in the form of a patient questionnaire. This helps to measure and improves 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 2016 (based on April 2014 to March 2015) shows all 3 surgical procedures showing an improvement in health gain following an operation (note that there was insufficient data for varicose veins surgery)

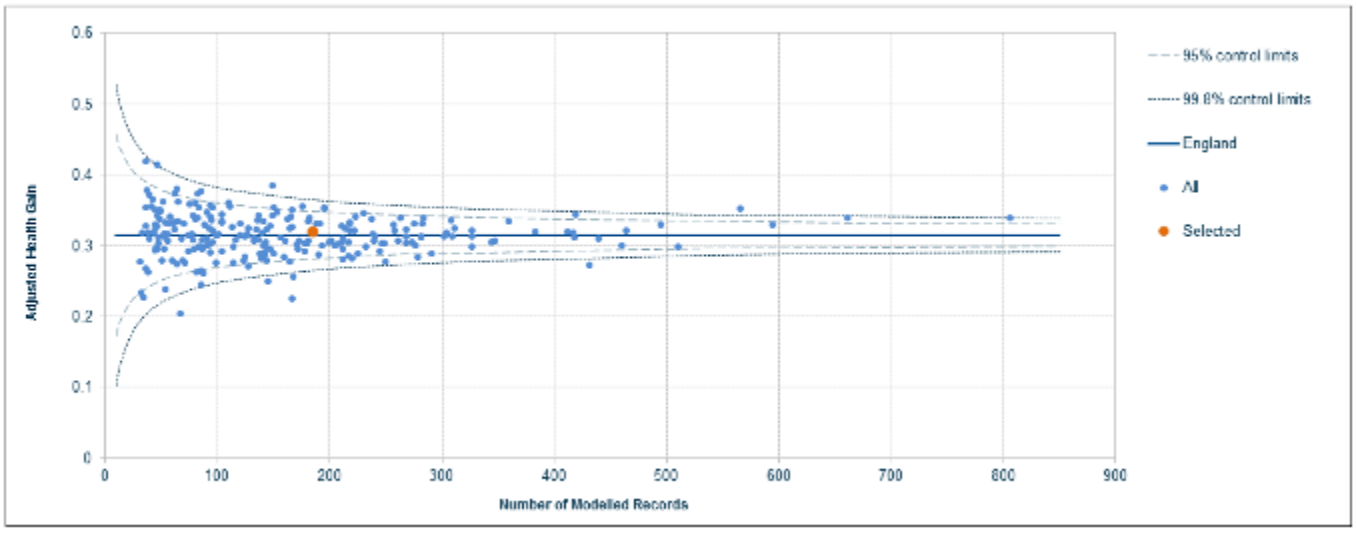
Groin Hernia – 38 returns of which 25 reported an improvement in health following the procedure.



Hip Replacement – 211 returns of which 194 reported an improvement in health following the procedure.



Knee Replacement – 185 returns of which 155 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 2015/16 was 1.2% (1.6% 2014/15). 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 6911 (6173 for 2014/15)

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 01/04/15 to 30/09/15, provided a reporting rate of 26.02 compared to 22.9 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

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

Mortality data
A Trust Mortality Surveillance Group, established in its current form in January 2016, meets monthly to review mortality data, identify trends and share learning. New process of triangulating data, an improved mortality review form and processes for patient notes access have been implemented. The group reports bi-monthly into Trust's Clinical Governance Committee and is chaired by the Medical Director.

Cdifficile
We have a rolling programme of audits to ensure three key indicators are reviewed every year in relation to Cdifficile, 18 week referral to treatment and A&E four-hour waits.

Serious Incidents
Serious incidents involving severe harm and death are investigated using Root Cause Analysis methodology and 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 Directorate and Trust clinical governance committees.

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 2015/16

This section will provide a summary update on the initiatives we prioritised last year:

Infection control

The Trust has seen a further significant improvement in C. difficile rates during the last year. Building on the improvements made in previous years a reduction of 34% overall in hospital attributable cases with a rate of infection of 7.4 cases per 100 000 bed days was achieved. Antimicrobial stewardship has been a key focus with compliance audit data fed back through clinical governance meetings and ongoing review of antimicrobial guidance to ensure that antimicrobial prescribing is optimal and appropriate in all cases.

Complaints management

In 2015 the clinical governance team undertook a review of how to better support the Directorate staff and improve the management of the complaints process. In response to this review and its recommendations we rolled out a pilot programme which was evaluated very positively by staff and showed improvements in the timeliness of complaint responses (74% of all complaints are responded to within 25 working days). The new process includes early contact with complainants to discuss concerns and agree the outcomes they are seeking, central co-ordination of requests for information and compiling a response in conjunction with the department involved. This new system means clinical staff are able to spend more time providing direct care and implementing any changes that arise from complaints.

Following the success of the pilot, this programme has now been extended across the Trust to incorporate all Directorates.

New ward (Acute Medical Unit) and integrated stroke unit at Tunbridge Wells Hospital

The opening a new ward on the Tunbridge Wells Hospital site is a key milestone in work to improve patient flow and ultimately the patient experience.
This project was completed in a comparatively short period of time and demonstrated excellent team work across the whole health economy.
This has enabled us to bring stroke rehabilitation on the main hospital site, so improving the overall experience for patients suffering stroke, the opportunity to develop our frail elderly service and enhance our acute ambulatory care service.

Part 4
Appendices A, B and C

Appendix A

37 National reports were published where the topic under review was relevant to the trust in 2015/16 with action to be taken in 2015/16

National Report Published April 2015 to March 2016	*Report received*	
Acute Care		
National Cardiac Arrest Audit (NCAA)	Yes	Report received June 2015. Cumulative data quality reports published each quarter. Results reviewed awaiting action plan.
Adult Critical Care Case Mix Programme (ICNARC) (Round 2) (CMP)	Yes	Report April 2015. Requested national assessment to be completed.
Emergency Laparotomy Audit (NELA)	Yes	Clinical report received. October 2015. With specialty for assessment and action plan. Results show improvement on all fronts. Surgeons are completing the pre-POSSUM booking passes and consultant surgeon attendances in line with national average. Consultant Anaesthetist attendance is below national average. Mortality below national average.
Severe Trauma (Trauma Audit & Research Network) TARN	Yes	Themed reports published 3 times per year. Latest report received December 2015. Rehab prescription developed in conjunction with TARN database.
National Joint Registry (NJR)	Yes	Report received September 2015. With specialty for assessment.
Adult Community Acquired Pneumonia	Yes	Report received December 2015. Continued education for frontline staff in the need for prompt chest x-ray request. Ensure PGD for antibiotic prescribing 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 and with specialty for review and action plan development.
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.
Use of Emergency Oxygen (BTS)	Yes	Report received January 2016 and with specialty for review and action plan development.
Blood transfusion		
(National Comparative Audit of Blood Transfusion Programme) National comparative audit of blood transfusion of patient information and consent 2014	Yes	Report received October 2015 and with specialty for review and action plan development
Audit of patient blood management in	Yes	Published October 2015 and with specialty for

National Report Published April 2015 to March 2016	*Report received*	
scheduled surgery		review and action plan development.
National Comparative Audit of blood transfusions: use of Anti-D 2012	Yes	Report received October 2015 and with specialty for review and action plan development
Cancer		
Lung Cancer (NLCA)	Yes	Report received December 2015 and with specialty for review and action plan development
Bowel Cancer (NBOCAP)	Yes	Report received December 2015 and with specialty for review and action plan development
Head & Neck Cancer (DAHNO)	Yes	Report received December 2015 and with specialty for review and action plan development
National Prostate Cancer Audit	Yes	Report received November 2015 and with specialty for review and action plan development
Oesophago-gastric cancer (NAOCG)	Yes	Report received December 2015 and with specialty for review and action plan development
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15	N/A	Report publication date delayed until July 2016
Heart failure 2013-14	Yes	Report received November 2015 and with specialty for review and action plan development
Cardiac Rhythm Management (CRM) 2014-15	N/A	Report publication date delayed until May 2016
Coronary angioplasty/ National audit of PCI 2014	N/A	Report publication date delayed until April 2016
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 and with specialty for review and action plan development.
Inflammatory Bowel Disease (IBD) Programme - Biologic Therapy only	Yes	242-15/16 Report received September 2015. IBD specialist nurse to be 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	Report received October 2015. Discussion to take place with the CCG to obtain funding / staffing to extend the rehabilitation programme to include MRC2 patients.
HQIP National Diabetes Footcare audit	Yes	Report published March 2016. With specialty for review and action plan development,
Rheumatoid and early inflammatory arthritis	Yes	Report received January 2016 and with specialty for review and action plan development.
National Audit of Intermediate Care	NA	Audit 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	1. Falls	1. Report received November 2015 and with specialty for review and action plan development.
	2. Falls Liaison Service	2. N/A
	3. National Hip Fracture Database	3. Report received October 2015 and with specialty for review and action plan development
Older people (care in emergency departments)	Yes	Report received June 2015 and with specialty for review and action plan development.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received January 2016 and with specialty for review and action plan development.

National Report Published April 2015 to March 2016	*Report received*	
UK Parkinson's	N/A	Report publication date delayed until end May 2016.
Other		
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Yes	Report with specialties for review.
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.
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
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	Yes	Report received September 2015. The report has been discussed at MDT meetings and clinical governance. Education programme has been developed on the use of the Infliximab pro-forma that is filled out when patients come to the ward.
National Paediatric Diabetes Audit (NPDA) 2014	Yes	Report received January 2015. With specialty for action plan development
National Pregnancy in Diabetes Audit (NPID) 2014	Yes	Report received November 2015. With specialty for action plan development
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. Report discussed and assessed at the Trust Sepsis Group Meeting: January 2016 The trust has a protocol that has been ratified and is available on Q-Pulse.

National Report Published April 2015 to March 2016	*Report received*	
		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 to aid the identification, coding and treatment of sepsis are in use and available across the trust. A trial of the use of stickers is being implemented to improve the coding and documentation of patients diagnosed with sepsis. 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. Interventional radiology service is not available on a 24/7 basis. Consultant cover is available for Medical and Surgical services during the week. Registrar cover at weekends. Consultants are on call at home and have always been contactable when required. ITU opinions are sought and available when required. Urology – No Consultant cover currently provided for hospital at night. A training package is being developed to be included on the trust mandatory training programme on antimicrobial policies and prescribing. There is not currently 24/7 senior microbiology services, plans for implementing this are being reviewed. 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 B

Updated actions on reports received during March 2014 to April 2015. 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 Annual reports published March 2014 - April 2015	Report Received	Improvements
Peri and Neonatal		
Neonatal Intensive and Special Care (NNAP) 2013	Yes	Report received October 2014. Doctors to document in medical notes; date & time conversation with parents, so the data can be entered easily on Badger. Badger training now included o new Drs induction programme for NNU staff.
Children		
National Paediatric Asthma Audit 2013	Yes	Report received April 2014. Asthma awareness training sessions have been implemented; these are attended by all clinical staff working within paediatrics. Patient information leaflets and written asthma plans have been developed and are now in use.
National Childhood Epilepsy 12	Yes	Report received December 2014. Business case for Paediatric Epilepsy Specialist Nurse awaiting finance and trust approval. This should enable children and young people to be seen within 2 weeks of presentation at hospital and reviewed at least annually as necessary.
MBRRACE-UK Saving Lives, Improving Mother's Care. Part of the Maternal infant and prenatal programme.	Yes	Report received December 2014. All the audit reports for this programme have been reviewed and assessed. Triage and Epilepsy Guidelines currently being developed.
National Pregnancy in Diabetes Audit 2013	Yes	Report received August 2014. Patient education sessions on the management of pregnancy with type 2 diabetes to be provided fortnightly by the Diabetes Specialist Nurse and Diabetes Midwife.
UK IBD Paediatric Audit	Yes	Report received August 2014. Guidelines for the management of acute ulcerative colitis are being used and teaching is taking place for nursing staff on the paediatric ward. All patients are now provided with at least annual reviews, but mostly every 3-6 months.
Acute Medicine		
CEM Severe Sepsis and Septic Shock in A&E	Yes	Report received August 2014. A staff training programme has been included on the new intake induction and forms part of the training that the trust Sepsis team delivers on recognition and recording of vital signs, the need to give and document oxygen administration, prompt IV fluid administration, taking and recording of vital signs, the need to take blood cultures before the patient leaves A&E, monitoring of urine output and prompt administration of antibiotics.
CEM Asthma in children in A&E	Yes	Report received January 2015 Staff training to include the need for nurses to monitor and record peak flow and GCS score. Additional triage training to include the need to give salbutamol promptly and prescribe appropriate steroids on discharge.
CEM Paracetamol overdose in adults in A&E	Yes	Report received January 2015 Induction and teaching programme on Toxicology and Poisoning to include information on the timing of measuring of plasma levels, the need for staggered overdose to be treated within one hour of arrival and

National Annual reports published March 2014 - April 2015	Report Received	Improvements
		patients arriving >8 hours after ingestion to be treated as per 2012 MHRA guidelines.
BTS Pleural Procedures 2014	Yes	Report received October 2014 Standardised proforma to be included in chest drain pack to be completed for each insertion and kept in patient notes. Regular teaching programme to be developed for chest drain insertions. Patients with chest drains to be cared for on appropriate specialty respiratory wards.
Acute Care		
National Cardiac Arrest Audit	Yes	Mandatory training sessions continue to be held and competency records maintained.
National Breast Screening Pathology	Yes	Report received October 2014. Standards met so no actions were required. Trust results were in line or above national results.
Long Term Conditions		
National Adult Diabetes Audit 2013	Yes	Report received January 2015 and with specialty for action plan development.
National Review of Asthma Deaths	Yes	Report received April 2014. All people with asthma are now provided with a personal asthma action plan that details their own triggers and current treatment.
National UK IBD Biologics 2013	Yes	Report received August 2014. The trust now participates in the biologics audit or the PANTS research project. Patients are entered on either of these projects depending on whether they fit the PANTS research criteria. New IBD database being set up to allow for monitoring of follow-up and disease activity.
National UK IBD 2012/13 Round 4	Yes	Report received June 2014 and with specialty for action plan development. Registered to us the new IBD national Biologics Therapy Registry. New Gastroenterologist employed from 2014 to increase capacity. This topic is now covered by the National UK IBD Biologics audit.
National Chronic Obstructive Pulmonary Disease (COPD)	Yes	Report received February 2015. Development of the Early Supported Discharge Service as per CCG commissioning is progressing. Business case to improve spirometry services has been drafted and is waiting trust approval.
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Report received December 2014 Fast track bed policy in place to ensure access to stroke unit within 4 hours of admission. Discharge delays discussed at SITREPS meeting. Speech and Language Therapy team carrying out annual dysphagia refresher training. Nursing competencies now include dysphagia awareness.
National Adult Diabetes Inpatient Audit (NaDIA)	Yes	Report received June 2014. Diabetes foot assessment form has been implemented and in use for any patients attending with diabetes. Clinical education sessions now include other clinical areas that do not specialise in diabetic care so that everyone has a general understanding of the management of the adult diabetic patient.
Elective Procedures		
Adult Critical Care Case Mix Programme (ICNARC)		Reports received June 2014. With specialty for action plan development.
National Emergency Laparotomy Audit (NELA) Organisational Report	Yes	The on-call teams now use predictor of mortality and morbidity both pre and post operatively for all emergency patients.
Cardiovascular Disease		

National Annual reports published March 2014 - April 2015	Report Received	Improvements
National Coronary Angioplasty 2012	Yes	Report received July 2014. Operators are regularly reminded to complete data fields for 'risk factors', creatinine levels and 'discharge date/status' on the cardiology IT system 'TOMCAT'.
MINAP 2013/14	Yes	Report received January 2014 Education of junior staff in the prompt prescription of appropriate secondary prevention medication and clear documentation of treatment decisions regarding medication. Ensure transfer of patients to specialist cardiology ward where possible.
Cardiac Arrhythmia 2013 (CRM)	Yes	Report received January 2015 Following implementation of new NICE guidelines, identification of patients suitable for ICD and CRT will be streamlined which will increase our submission numbers.
Heart Failure Audit 2013-14	Yes	Report publication was delayed and only received January 2016 currently with specialty for review and action plan development.
Cancer		
National Bowel Cancer (NBOCAP) 2014	Yes	Report Received March 2015. With specialty for review
National Lung (NLCA) 2014	Yes	Report Received March 2015. With specialty for review.
National Oesopho-Gastric (NAOGC) 2014	Yes	Received December 2014. With specialty for review.
Trauma		
Elective Surgery (PROMS)	Yes	Quarterly Reports received. With specialty for assessment.
National Joint Registry: Hip and knee replacements 2014	Yes	Report received September 2014. With specialty for action plan development.
Hip Fracture (National Hip Fracture Database) (NHFD) 2014	Yes	Report received September 2014. Trust-wide action plan produced from the Hip Fracture Working Group. Fast track bloods and diagnostics to enable fast track through Emergency Department to Ward. New patient information leaflets produced. Pressure damage and mortality reviews undertaken to ensure they remain within or below the NHFD national %.
Heavy Menstrual Bleeding Audit	Yes	National report received August 2014. Business case to extend the existing services to include a dedicated Menstrual Bleeding Clinic.
Sexual Health		
National audit of management of anogenital herpes	Yes	Report received December 2014. Patients are offered treatment at presentation of clinical symptoms began within the last five days. Counselling and support to be offered to patients with suspected clinical herpes. Delivery plan in place.

Appendix C

Summary of local audits undertaken during 2015/16 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 = Clinical Guidelines TA = Technology appraisal IPG = Interventional Procedures Guidance

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
NICE TA269; BRAF testing and the use of BRAF inhibitors in unresectable or metastatic melanoma	Partially compliant	Local guidelines to be developed for the management of vemurafenib associated rash. Patients who are BRAF positive should continue to be offered BRAF inhibitors unless they fit the exclusion criteria.
NICE TA145 Re-Audit: The use of cetuximab in the treatment of locally advanced squamous cell cancer of the head and neck	Fully compliant	No actions required as standards met.
NICE CG164 Audit: Identifications of Breast Cancer patients for genetic testing	Partially compliant	The referral pathway for genetic testing needs to be optimised to take into account the family history as well as phenotypical characteristics. To involve representatives from Guy's Genetic Unit when developing pathway.
NICE CG139; Central Venous Access Devices.	Partially compliant	To increase education concerning cannula insertion record documentation by bespoke ward based training to reinforce awareness of documentation requirements. Standard CVAD dressings are not efficacious. Obtain approval from IPCC to move to Tegaderm IV advanced CVC and PICC dressings as standard ward based stock. Visit wards at 3 monthly intervals for spot-checks and mini audits to provide feedback on improvements and provide local targeted education
NICE CG32 Re-audit: Use of Naso Gastric Tubes for Enteral Feeding	Partially compliant	We have increased our compliance from the last audit but we are still not reaching the required standards. NGT Competency framework to be updated to include NGT sticker completion
NICE CG094 - Early Management of Unstable Angina & NSTEMI in patients admitted to TWH only	Partially compliant	Educate colleagues in the need to calculate and record GRACE score and risk stratification of UA/NASTEMI patients to be reinforced. GRACE template to be added to the cardiology referral forms completed by the medical teams. Discuss the feasibility of having an ambulatory pathway for low risk UA/NSTEMI patients to be allowed home and recalled with 7-14 days for angiography
NICE TA120 - Heart Failure - cardiac resynchronisation - Do patients receiving CRTP/CRTD devices meet the criteria	Not compliant	Design a CRTP/CRTD insertion check list to be filed in the patients' notes to ensure all criteria are met prior to insertion. Where criteria are not met record should be made MDM discussion.
NICE TA94 Appropriate use of	Fully	All patients with a confirmed coronary artery disease

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
statins in patients with ischaemic heart disease	compliant	met the standards of having a statin prescribed with a low acquisition cost. However, this audit highlights the need to improve documentation of medication decisions and discussion with patients.
(NICE CG146 Osteoporosis - fragility fracture) Osteoporosis prevention in older patients with fragility fractures	Not compliant	The main recommendation is that these results should be given to the CCG, who should consider commissioning a Fracture Liaison Service to proactively identify, investigate and treat the patients presenting to the hospital with a non-hip fracture, as, with the current system, less than half of patients discharged from A & E have an osteoporosis assessment following a low impact fracture.
NICE TA187 - Crohn's Disease and infliximab at Maidstone Hospital	Not compliant	All Biologic therapy cases to be discussed at IBD MDM before starting therapy and again at 12 months, add this criterion on the Pharmacy request form for Biologic therapy. Appoint an IBD nurse specialist to allow 3 month and 12 month reviews.
NICE CG141 Management of Upper GI Haemorrhage incorporating	Not compliant	Olympus to add drop-down box to report template that endoscopists can enter the Rockall score predicting mortality post-endoscopy. Ensure the FFP is given during resuscitation if INR >1.5 unless there is a documented clinical decision. Admitting clinicians to specify patient to be kept 'nil by mouth' if endoscopy requested. Add 'NBM' to proforma so patients aren't fed before OGD. Publicise the iSoft request forms can be used for expediency.
NICE CG165 Hepatitis B (chronic) (adults only)	Fully compliant	We are fully compliant with all the standards that we were able to measure against.
NICE CG92; VTE trustwide re-audit	Partially compliant	It will be the responsibility of the ward, unit and department to notify Doctors if the 24 hour risk assessment has not been done. Continue to monitor for any missed doses of chemical thromboprophylaxis. At every Mandatory Training and RN Induction programmes reinforce the importance of documentation and the need to prescribe AES.
NICE IPG254; Assessing the efficacy (sensitivity and specificity) and safety of Endobronchial Ultrasound (EBUS) guided transbronchial aspiration (TBNA) mediastinal lymphnode biopsies at Maidstone Hospital	Partially compliant	To procure the navigational EBUS system that would facilitate the accurate biopsy of lesions located in difficult to reach areas. Consultant to discuss with managers about the augmentation of our EBUS system with the navigational system. Preparation of cell blocks from needle-wash and preserving needle wash samples for further testing will facilitate the concentration of cells using ficol-hypaque or cytospin media, thus facilitating further phenotypic characterisation of abnormal cells for the diagnosis of lung cancers. .
NICE TA143 & 233 Ankylosing Spondylitis - Biologics	Partially compliant	Lack of documentation, diagnosis at another centre and delayed response were the main reasons for certain criteria not being fulfilled. These can be rectified and partially historic. We have recruited one more nurse specialist and this may allow more regular monitoring to meet the criteria for 3 monthly monitoring.
NICE CG15 - Management of Type 1 Diabetes in children and	Partially compliant	Contact diabetic team on every admission of children or young people with diabetes as soon as possible

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
young people		Document all discussions with the child and carer, regarding the decision making process and the regimes offered Coeliac and Thyroid functions tests to be carried out on the ward, education to ward staff and Medical staff at their Induction
NICE NG1; Re-audit of the management of children with Gastro-Oseophageal reflux / disease in MTW	Not compliant	Clinicians should ensure that diagnosis is made as per the NICE guidelines and clearly classify the symptoms into Gastro-oesophageal Reflux or Gastro-oesophageal Reflux disease. Clinicians should consider not using Metaclopromide, Erythromycin or Domperidone in management of GORD Clinicians should recommend use of thickened formula as one of the steps in management of simple GOR. Clinicians should discuss cases with severe reflux or children with unusual presentations of reflux with the paediatric gastroenterology team before referring for pH study or Endoscopy
NICE CG99; Re-audit of Diagnosis & Management of Idiopathic Constipation in Secondary Care setting for children and young people	Not compliant	Constipation and management, included in teaching sessions to Paediatric Junior Doctors as part of their regular teaching programme Use the Information produced by the previous audit team and distribute them to Riverbank & Woodland Units
NICE CG112; Retrospective audit of quality of Neonatal "Feed and Wrap" MRI Scans	Not compliant	It is apparent that our current technique of 'feed and wrap' MRI scanning is not giving us good quality scans. Develop a new guideline to reflect the use of chloral hydrate sedation for routine neonatal MRI scans, to be available on Q-pulse. All babies requiring MRI scan should be sedated with chloral hydrate according to the dosing above. All babies must have oxygen available and saturation monitoring performed during and after the scan.
NICE CG55; Audit of Polycythaemia in the New born	Not compliant	Training of midwives and obstetric doctors of the need to not clamp and cut the baby's cord until 60 seconds following birth, or that cord milking is performed instead, if immediate resuscitation is required. Paediatricians to be proactive in encouraging appropriate delayed cord clamping
NICE CG176; Re-audit of Paediatric Neurological Documentation	Not compliant	All staff looking after children and young people to be trained in neurological assessment and the need for observations to be recorded competently and accurately. Band 6 Nurse to be identified to assist with supporting staff nursing patients with neurological conditions. Assess the current neurological observation chart to ensure it is fit for purpose.
NICE CG151; Re-audit of the Management of Febrile Neutropenia Patients (Paediatric Oncology Service)	Partially compliant	A clear referral pathway for the management of the unwell child undergoing chemotherapy needs to be developed. Consolidate febrile neutropenia guidance into a flow chart for the Unwell Oncology Child Increased ward based education for the immediate care of an unwell child who is receiving chemotherapy
NICE CG16; Re-audit of Management of paediatric Deliberate self-harm (DSH) (2/1415)	Not compliant	Education package for all ED medical staff, including psychiatric assessment (MSE) and risk assessment (statement of risk, use of Smart tool) and of the importance of notifying the Child Protection Nurse.

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
NICE CG111 - An audit of MTW's management of Nocturnal Enuresis	Partially compliant	Detailed history should be taken as per the NICE guidelines and documented in the medical notes and clinic letters Alarms should be offered as a first line in all children above 5 years with bedwetting and parents should be counselled about the use of alarms and motivated to continue them if there is a response. Parents should be given information about the ERIC website. Leaflets could be designed for this purpose. Business case to be made for a specialist nurse led enuresis clinic, where these children could be assessed at 4 weeks following start of treatment. They could also act as a first port of contact for the management of these children including offering support to the families and children
NICE CG54; Re-audit of Urinary Tract Infection in children: diagnosis, treatment & long term management	Partially compliant	History taking and documentation of UTIs needs to be improved. Staff to be reminded of the flow chart which is readily available for use. Consultants to ensure that UTIs are treated with a 10 day course of antibiotics at the time of discharge.
NICE CG92: Extended VTE prophylaxis in oncology patients undergoing major abdominal surgery	Fully compliant	All patients evaluated undergoing major elective abdominal surgery for cancer are appropriately prescribed extended VTE prophylaxis on discharge
NICE IPG113; Audit: Surgical and patient reported outcomes following Dacryocystorhinostomy (DCR)	Fully compliant	General standards have been met therefore no clinical concerns or risks to patients To improve medical recording of pre-operative and post-operative assessment of patients with epiphora needing DCR, design a proforma which will be used in all theatres for pre-operative and postoperative assessment for patients.
NICE CG145; Management of spasticity in children and young people with non-progressive brain disorders: Paediatric Orthopaedic Patients	Not compliant	Whilst standards are not fully met the reaudit has shown there have been significant improvements managing spasticity as a result of the introduction of the proforma from the previous round. A new patient leaflet on botox treatment has been introduced to inform patients about the treatment process. Paediatricians will be copied into all clinic letters with the aim to improve communication between orthopaedic doctors and paediatricians. All new patients will be referred to physiotherapists to make sure that they receive a review by this team.
NICE CG3; Audit of Pre-Assessment Blood Tests and Investigations for Gynae Surgery	Partially compliant	To liaise with the anaesthetic department lead for pre-assessment, to review the current practice and consider changes to the pre-operative investigations protocols for gynaecology day case surgery
NICE IPG's 267, 280, 282, 283 & 284 - An audit of Prolapse Surgery Management (	Partially compliant	Laparoscopic apical prolapse surgery should be preferred method of surgical repair in younger, sexually active patients
NICE CG44; Audit of Intra-operative Novasure Failure Rate	Not compliant	All patients to have USS organised prior to “Novasure” procedure. Risk of failure of procedure to be documented on consent form as currently 10% risk of failing. Training session given by “Novasure” rep on troubleshooting if cavity assessment fails.
NICE CG129; Re-audit of Antenatal Care in Twin	Partially compliant	Guidelines to be available in the Multiple Pregnancy clinical room to ensure all staff are aware of the

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
Pregnancies		guidelines for the management of multiple pregnancies. Relevant fetal cardiac referrals to be made by the Specialist midwife at the first twin antenatal clinic appointment. Assessment regarding the need for aspirin to be made by the Specialist midwife at the first twin antenatal clinic appointment. Specialist midwife to ensure a full blood count is taken between 20-24 weeks, this has been added to the proforma.
NICE CG110 - Audit of the management of pregnancy and complex social factors	Fully compliant	No actions required as all notes audited were fully compliant with the standards.
NICE CG70; Audit of the management of Induction of Labour	Partially compliant	The IOL guideline is currently being revised to clarify rational for induction at maternal request. Risks versus benefit of IOL particularly for primiparous women should receive greater consideration by consultants. A patient leaflet is being produced to inform women of the risks associated with IOL so that they are able to make a more informed decision.
NICE CG190; Re-audit of the management of retained placenta - Cycle 3	Not compliant	Produce Laminated pathway to be visible on delivery suite. Develop MROP checklist and operation notes to be used with every MROP to assist with meeting standards
NICE CG132; Post-operative Pain Management following Elective Caesarean Section	Partially compliant	Appropriate development of safe regime with input from pharmacy, obstetrics and anaesthetics and nurse specialists for patients self-medicate following C-section. Guideline to be written for safe self-administration of medications by obstetric patients on post-natal ward. Patient information leaflet to supplement patient medication self-administration framework
NICE CG154; Re-audit of Diagnosis & Management of Pregnancy of Unknown Location, Ectopic & Miscarriage within our trust	Partially compliant	Thorough documentation of standardised parameters in viewpoint to allow audit/investigation. A flowchart to be generated for the EPAC scanning room, stating the use of Viewpoint to inform those working out of hours. Registrars informed of the need to be available for review of initial bHCGs to ensure serial ones are carried out. Process to be established for EPAC histology reports to be reviewed by the Gynaecology Clinical Manager. Add EPAC to monthly teaching sessions, to include repetition of progesterone levels (Monday lunchtimes). Information regarding booking at EPAC for scans to be disseminated within other specialities and gynaecology.
NICE CG107; Re-audit of Hypertension in Pregnancy	Partially compliant	Develop a flow chart for postnatal management of Gestational Hypertension, PET and Chronic Hypertension to be displayed in postnatal wards.
NICE CG83 Rehabilitation After Critical Illness. Re-audit	Not compliant	ITU daily sheet to be adapted to include space to record NHS number, altering the order of two of the biochemistry sections, and increasing the size of the CXR analysis box. Re-design comprehensive clinical assessment forms and sheets for the problem lists and goals at the following intervals. Develop a patient/family/carer information leaflet to include: Patient diaries, Information on rehab pathway, Information about the differences between critical care

NICE Guidance	Compliance	Actions taken as a result of the audit/Evidence of compliance
		and ward based care, Named healthcare professional to co-ordinate rehab pathway, Critical care discharge summary. Physiotherapist contact card to be produced for patient/family/carer
NICE TA204:Denosumab for the prevention of Osteoporosis fractures in post-menopausal women – Criteria 2 only (Rheumatology)	Fully compliant in Rheumatology patients audited	Rheumatology fully compliant as standards are met but to share results with Medicine and Orthopaedics teams to ensure patients are appropriately treated in other specialties.

Part 5
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 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

We welcome the Quality Account 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 well with the staff at MTW with the aim of improving the quality and safety of the health care that we commission.

Patient Safety

Learning from incidents is essential and we look at how MTW intends to learn and share from serious incidents as part of our incident closure procedures. The incidents of falls are still of concern and the additional practices of having a thematic database and the use of a newsletter are welcome initiatives. Moreover, we are pleased to see that there will be more 'hands-on 'engagement from the leadership team. The CCG sits on the recently established Mortality Working Group and the focus is the interrogation of the causes of death that occur at MTW and the learning that can be taken from these.

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 acknowledges the requirement to ensure that that the patient is in the appropriate area for their care. The Trust's commitment to improving ambulatory care is welcome.

Dr Steven Beaumont
Chief Nurse
NHS West Kent Clinical Commissioning Group
23 May 2016

Health Overview and Scrutiny Committee – Kent County Council comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Draft Quality Accounts were submitted to the Kent Overview and Scrutiny Committee, Kent County Council. The Chairman, Robert Brookbank, was unable to provide comment but requested that the committee receives a final version.

Healthwatch Kent comments on the 2015/16 Quality Account for Maidstone and Tunbridge Wells NHS Trust

Healthwatch Kent response to the Quality Account for Maidstone and Tunbridge Wells NHS Trust

As the independent champion for the views of patients and social care users in Kent we have read your Quality Accounts with great interest.

Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account report is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch Kent staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.

On reading the Account, it is pleasing to see that the length of the document has been reduced significantly from previous years allowing it to be more accessible to readers. We would still like to see a summary document be produced to let the public get a feel for the Trust's activities this past year without the need to digest the whole account which can be daunting to some. Overall the account was easy to follow and understand with minimal jargon which again was an improvement from previous years.

There seems to be a good awareness of issues facing the Trust, particularly with patient flow and discharge from hospital. We know that the Trust is actively trying to address these challenges. Healthwatch would be happy to get involved and help gather feedback from patients about their experiences of these areas.

It is positive to see Translation Services are being improved to help patients, who don't speak English as their first language and also those who might need to use a British Sign Language Interpreter, access services. We would like to hear more about how hard to reach groups have been listened to and how actions have been taking forward to improve their experience of using services provided by the Trust.

Healthwatch Kent would like to be kept informed about the new complaints process which will be implemented. We support the trust's desire to deal with more complaints within the specified 25 days and improve early communication with complainants.

Healthwatch Kent would like to take this opportunity to say that Maidstone & Tunbridge Wells NHS Trust have been very open with Healthwatch Kent and we have worked together on a number of projects this year including the opening of a new ward at Tunbridge Wells Hospital and talking to

patients about the A&E service. We would like to see the Trust do more engagement with the public and listen to their views of how services could be improved.

In summary, we would like to see more detail about how you involve patients and the public from all seldom heard communities in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with the Trust to ensure we can support you with this.

Healthwatch Kent June 2016

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

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 2016 ("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 2016 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 guidance.

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH 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 2015 to June 2016;
- papers relating to quality reported to the Board over the period April 2015 to June 2016;
- feedback from the Commissioners dated May 2016;
- feedback from Local Healthwatch dated June 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2015;
- the latest patient survey dated June 2016;
- the latest national staff survey dated June 2015;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016;
- the annual governance statement dated May 2016;
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015; and
- the results of the Payment by Results coding review dated December 2015.

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 indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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
Fleming Way
Manor Royal
Crawley RH10 9GT

30th June 2016

Statement of Directors' responsibilities in respect of the Quality Account

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

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

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

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

By order of the Board

Date: 29/6/16