Maidstone and Tunbridge Wells NHS Trust

Quality Accounts
2017/18

Quality Accounts

It is the aim of Maidstone & Tunbridge Wells NHS Trust (MTW) to provide safe, sustainable high quality care to our patients. In doing so we endeavour to be improvement driven and responsive to the needs of our patients and staff making MTW a great place to work and visit.

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 2017/18 highlight the progress we have made against key priorities for the year to improve services for our patients. We also present those areas that we will be focusing on as priorities for 2018/19.

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 continue 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

Miles Scott

Welcome to our Quality Accounts for 2017/18 which explains some of the many actions we have taken and continue to build upon to improve our patient experience.

Maidstone and Tunbridge Wells NHS Trust (MTW) is committed to becoming even more of a quality-driven organisation in 2018/19 and beyond.

At the start of this year, the Care Quality Commission stated that our Trust has made "significant and sustained improvements" in the quality and safety of our services and that we are a caring organisation.

While we recognise that we have further to go to be outstanding in everything we do for our patients, the CQC's assessment reaffirms that our quality improvements are making a real difference for our patients at a time of unparalleled demand for NHS care.

This year, we are bringing all of our quality plans together as part of a cohesive approach to improving our patient experience that we are calling Best Care. This will continue our ongoing efforts to become a more caring, sustainable, and improvement driven organisation.

Best Care recognises that to continue our journey of improvement, we need to involve our staff, patients, public and healthcare partners in everything we do. With your help, we can continue to shape our quality improvements to be even more of a patient-centred provider of personalised-care. Patient and public engagement forms an important part of this year's Quality Accounts.

Our hardworking and hugely dedicated teams of healthcare professionals have continued to respond to unprecedented demand for NHS care year on year. As our healthcare needs continue to change, it is important that we have the ability to change too.

MTW continues to be ever-more responsive to our patients and innovative in meeting their needs. This is reflected in our Quality Accounts both in the way that we want to see our patients, and then in the quality of care that we want them to receive.

The information contained within this report represents an accurate reflection of our organisation's performance in 2017/18 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

Miles Scott
Chief Executive

Part Two
Quality improvement initiatives

The intention of this section of the report is to provide you with information about the areas that we have highlighted for improvement in the coming year, particularly in relation to the quality of our services and how we 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 focusing improvements in our governance structures.

The quality improvement priorities are only 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 according to need. By selecting new initiatives each year it ensures that a wide breadth of areas are covered and prioritised each year.

We have chosen three quality improvement priorities in 2018/19 which represent the views of our stakeholders, but are also in line with the Trust's overarching strategy for quality improvement. The quality priorities have been reviewed and agreed by the members of the Patient Experience committee, which include patient representatives and representatives from Healthwatch Kent.

Quality Improvement Priorities 2018/19

NHS Improving Quality

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

- Embedding an open and transparent culture that embraces 'lessons learned'
- We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.

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:-

- The development of a patient engagement strategy to ensure views are gained and triangulated with themes and trends from patient survey's, complaints etc to inform strategic direction.
- Continued work with external partners such as Healthwatch, NHSI, CQC and CCG to help inform the board of areas for concern and to address any key issues arising from our Internal Assurance Inspection programme.
- To recognise and respond to the specific needs of our patients with complex needs.

Clinical Effectiveness

To improve the management of patient flow.

Key Objectives will include:-

- Sustaining our previous work to avoid unnecessary admissions to hospital through the development of alternative care models/pathways.
- Working with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
- Working in collaboration with our community and local authority colleagues to further develop pathways that will support the timely discharge of patients.

We will monitor our progress against these objectives 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.

The opening of the Acute Frailty Unit at Maidstone Hospital June 2017

Patient Safety

Maidstone and Tunbridge Wells NHS Trust is committed to the creation of an open and honest approach to patient safety. This relies on our staff feeling empowered to raise concerns and report incidents and also for our patients to feel at ease by letting us know when the care they receive falls short of expectations.

During the course of 2017/18 we have been working to further enhance our incident recording database so that meaningful data can be extracted to identify themes and trends for learning and development. Although this work is still in progress we remain committed to providing our staff with timely information that will help to direct and improve the care and safety of our patients and staff.

Aim/goal

To create reliable processes that will build and sustain a supportive environment to reduce avoidable harm.

Description of Issue and rationale for prioritising

Building a positive and strong patient safety culture takes sustained time and effort to ensure that both our patients and staff feel supported to raise their concerns. Our aspiration is the transition to an organisation that can demonstrate a 'Just Culture', where blame is eliminated and replaced instead with recognition that saying sorry is the right thing to do when we get it wrong. In addition we want to ensure that our investigations are robust and transparent in the identification of why things went wrong and to then take the most appropriate corrective action to eliminate or minimise any remaining risk to our patients or staff. This should be evidenced in the way our staff and patients are treated when mistakes are made and also by ensuring that the correct support is provided through these challenging times.

Over the course of the year we have already seen progress in the increase of the number of serious incidents and complaints reported. Although this statement may seem counter-intuitive our complaints still remain below the expected parameters for an organisation of our size and in addition we have seen over 10% of our Serious Incidents downgraded. It is however important to recognise the knowledge that is gained during this process, and to not underestimate the value in terms of learning and the improvements that we can then make to benefit patient care.

Identified areas for improvement and progress during 2017/18

The following actions were taken in 2017/18

- The WHO safety checklist has been further revised for use in Theatres to include anaesthetic nerve blocks and to refine the process for the identification and management of specimens.
- An assurance auditing process has been introduced to monitor the standard of WHO checklists.
- A review of the National and Local Standards for invasive procedures (NatSSIPs and LocSSIPs) continues, working with all Directorates and Specialities to ensure these standards are met.
- Human Factors training was delivered in March 2018 and we now have 10 staff from varying specialities and professions trained as 'Trainers'.
- It was our intention to increase the number of reported medication safety incidents, unfortunately we have been unable to achieve this with medication errors reported at similar levels as 2016/17. In addition we aimed to reduce the number of inappropriate omissions of doses of medication, again this has remained static.

- The Medicines Safety News has been regularly published on the Trust Intranet with updates on the latest guidance and learning from recent incidents and medication related issues.
- The observed mortality rates have been reduced in keeping with expected rates and MTW are no longer an outlier amongst our peers.
- Introduction of a revised mortality review process took place in October 2017 as per National Quality Board Guidance (2017) and our mortality review compliance is now demonstrating an improvement.
- We have sustained our trajectory of improvement in the consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments. These achievements have also been formally recognised and commended by the Secretary for State, for Health and Social care.
- Improving the outcomes for our expectant mothers and their babies has become part of a system wide approach through the work of the Local Maternity system. The benefits include shared learning and a joint approach for strategic improvement. Locally we have introduced a Maternity dashboard which has allowed us to establish a benchmark. Overall these outcomes have remained variable with one notable improvement evidenced in the reduction in still births (refer to pg 42 for more detailed information).

Areas for focus and improvement during 2018/19

Key objectives will include:-

- Embedding an open and transparent culture that embraces 'lessons learned'-
    - This will include increasing the number of incidents that our staff report to support the identification of key themes and trends that require action.
    - Improved monitoring and compliance with Duty of Candour.
    - Sustained effort to reduce our Trust-level mortality figures in line with the national average (HSMR/SHMI) through the improvement in compliance with mortality reviews and the identification of key issues and trends.
    - Development of the learning and training agenda to meet the needs identified.
- The aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
    - Investigation of deaths that we believe are as a result of delayed diagnosis of sepsis.
    - Auditing of both emergency and inpatients to ensure achievement of 90% compliance for screening and treatment of sepsis within 1 hour.
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work by-
    - Reducing the number of unanticipated admissions to the neo-natal unit.
    - Reducing the number of still births.
    - Reducing the number of 3rd and 4th degree tears.
    - Reducing the number of unexpected readmissions to the post-natal unit.

Executive lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation lead: Wendy Glazier, Associate Director of Quality Governance
Monitoring: Patient Experience Committee.

Patient Experience

"How important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services." (Professor Sir Bruce Keogh).

At MTW we know that good care is linked to positive outcomes for our patients but we also recognise that a continuous cycle of improvement exists between better patient outcomes and improved levels of staff satisfaction, one impacting on the other. During the recent development of our Trust's Quality Strategy one of the most important aspects discussed was the need to improve engagement with our patients and the need to improve the care for our patients with complex needs. We are aware and acknowledge that those least likely to complain or speak out will experience the poorest care and we aim to ensure that we live by 'Our Values':-

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

Aim/goal

To 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

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

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

Identified areas for improvement and progress during 2017/18

The following actions were taken in 2017/18

- The questions previously set have now been extended based on the CQC domains, these are now fully embedded.
- The contract with 'Iwantgreatcare' has been renewed. We are actively engaging with the company to ensure that the information requested and produced is meaningful and can provide direction for the service improvements required.
- The MTW Friends & Family representative group is established and are actively working to ensure consistent response rates are maintained across the specialities.
- Regular contact meetings with Healthwatch, the CQC, NHSI and West Kent CCG are in place to seek and provide assurance in regard to standards of care provided to our patients.
- The Internal Assurance Inspection programme and PLACE inspections are established with regular support from our Patient Representatives and West Kent CCG. These provide assurance in regard to the care that our patients experience and this insight helps to provide strategic direction for improvements that are required.

- Achievements of the Friends & Family test for 2017/18 are:- (Further details can be found in Part 3, p42)

Response Rate:

	Achieved	Plan	Benchmark
Maternity Services	29.55%	25.0%	24.0%
In-Patient Services	23.85%	25.0%	25.7%
Accident & Emergency	15.35%	15.0%	12.7%

Positive score – would recommend the service:

	Achieved	Plan	Benchmark
Maternity Services	93.93%	95.0%	95.6%
In-Patient Services	95.28%	95.0%	95.8%
Accident & Emergency	91.19%	87.0%	85.5%

- Each Directorate reports monthly to the Trust Clinical Governance Committee their plaudits and positive feedback. These are then shared with our Communications team to ensure that good practice and initiatives are publicised to promote learning throughout the organisation.
- As part of our new contract with 'Iwantgreatcare' there is functionality that enables idenfication of personal feedback which staff can utilise during their appraisals and practice development plans.
- In addition 'Iwantgreatcare' can provide Word Clouds outlining the words used most often by our patients, for example:-

- Healthwatch Kent has supported us with a review of the patients' experience of hospital discharge arrangements and have remained instrumental in gaining external feedback. Formal reports are now being received on a quarterly basis.

Areas for focus and improvement during 2018/19

Key objectives will include:-

- The development of a patient engagement strategy to ensure views are gained and triangulated with themes and trends from patient survey's, complaints etc. to inform strategic direction.
- Continued work with external partners such as Healthwatch, NHSI, CQC and West Kent CCG to help inform the board of areas for concern including the Internal Assurance inspection programme.
- To recognise and respond to the specific needs of our patients with complex needs including-
    - Continue with existing dementia strategy action plan; with a particular focus on engagement with and support for carers (formal and informal).
    - Developing strategies to improve engagement with people with Learning disability.

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

Clinical Effectiveness

MTW remains committed to the optimisation of patient care through the improvement of patient flow. We actively monitor and benchmark our performance to improve clinical quality and efficiency to reduce unwarranted variation with the benefit of the Getting it Right First Time (GIRFT) programme and the Model Hospital (NHSI). In addition we support 'Best Flow' as part of our Best Care Programme. This embraces both latest technology and research thereby improving efficiencies in patient care and ensuring that our patients receive the right care the first time in the most appropriate environment to meet their clinical needs.

Aim/goal

To improve patient flow through the delivery of safe and effective care for patients by whichever pathway of care best meets those needs.

These options should include a variety of options including; support for the self-management of patients with long-term conditions; speciality-led assessment units; ambulatory care pathways; onward referral to other provider organisations who are better able to meet the patients' care needs and for those who are admitted in ensuring the minimum length of stay possible. In addition this will include the ongoing work to support the reduction in bed occupancy rates, achieving the A&E 4 hour access standard, 18 week referral to treatment and cancer access standards.

New A&E Reception TWH 9th February 2018

Description of Issue and rationale for prioritising

Safe and effective care for our patients remains at the heart of this organisation's objectives. For us to be able to deliver this there is a requirement to improve the management of patient flow.

Identified areas of improvement and progress during 2017/18

The following actions were taken in 2017/18

- Ambulatory care pathway models developed within specialities to include respiratory, gynaecology, orthopaedics, general medical and surgical conditions.
- The Acute Frailty Unit opened at Maidstone in June 2017 and at the Tunbridge Wells hospital in March 2018.
- A multi-agency working group to support patients with mental health conditions who frequently attend A&E in crisis has been established and this collaboration has seen the development of recognised plans of care for the highest attending patients. This approach has helped all agencies to be consistent and has ultimately ensured that each patient is redirected to the agreed plan of care at each point of access.
- Although we have not been able to meet the benchmark for the timely access to a ward for stroke patients we have ensured that this has not impacted upon the delivery of care and treatment expected.
- Although we have failed to meet the 4 hour standard from time of arrival for patients with a fractured neck of femur to admission to an orthopaedic ward, our overall performance has remained above that of the national average and that of our peers.

- In collaboration with our community colleagues at Kent Community Health Foundation Trust we have developed the 'Home First model' which supports three discharge pathways; home with support, transfer to a community hospital for further rehabilitation and an interim placement in a nursing home.
- Reduction in delayed transfers of care from 6.72% in 2016/17 to 4.95% 2017/2018 year end.
- Improvement in the percentage of non-elective patients over 65 returned to their original place of residence; during 2016/17 we achieved 70% and for 2017/18 we've increased this to 77.3%.

7 August 2017, via Twitter: @MTWnhs just back from A&E. Very professional, reception, triage, radiology, physio – all done in 2 hours! I didn't feel a nuisance. Thanks!!

8 November 2017, via Twitter: Having spent the last 6 months in and out of hospitals, culminating in major op last month, I've experienced many aspects of the NHS. And what a fantastic service I've had. EVERYBODY has been kind, caring and very skilled. Very impressed and grateful @MTWnhs

8 January 2018, via Twitter: @MTWnhs fantastic, kind, swift treatment for my daughter in paeds A&E at Pembury. Grateful for the #NHS

24 January 2018, via Google+: I went to A&E with my son who had a head injury. Had to wait a while but the nurse and drs were great. They kept checking on him every 20 minutes and dr we saw, Iggy, was just great. He rang me at home three times just to check he was ok. That's what I call 110%, just fantastic.

Excerpts from patient feedback in relation to pathways of care.

Areas for focus and improvement during 2018/19

Key Objectives will include:

- Sustaining our previous work to avoid unnecessary admissions to hospital through the development of alternative care models/pathways.
- Working with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.
- Working in collaboration with our community and local authority colleagues to further develop pathways that will support the timely discharge of patients.

Executive lead: Angela Gallagher, Chief Operating Officer
Board Sponsor: Angela Gallagher, Chief Operating Officer
Implementation lead: Lynn Gray, Director of Operations for Urgent Care
Monitoring: Patient Experience Committee

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

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

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

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

- Assessment or medical treatment for persons detained under the Mental Health Act 1983 (at both hospital sites).
- Diagnostic and screening procedures (at both hospital sites).
- Family planning services (at both hospital sites).
- Maternity and midwifery services (at both hospital sites plus the Crowborough Birth Centre).
- 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 or enforcement actions were applied to the registration during 2017/18.

The Nominated Individual for the Trust's Registration is Claire O'Brien, Chief Nurse.

During 2017/18 the Trust provided and/or subcontracted acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, Kent County Council and NHS England. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed in 2017/18 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 2017/18, undertaken by external organisations such as:

- HEKSS Pharmacy Programme Review – 11th April, 2017
- South East London, Kent & Medway- Centre for Trauma Sciences (SELKaM) Peer Review – 5th May, 2017
- Quality Surveillance Assessment –Cancer Acute Oncology Service – June 2017
- Quality Surveillance Assessment –Cancer Brain and Central Nervous System (Adult)– June 2017
- Quality Surveillance Assessment –Chemotherapy (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Head and Neck (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Malignant Mesothelioma (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Oesophageal and Gastric (Adult) – June 2017
- Quality Surveillance Assessment –Cancer Unknown Primary – June 2017
- Quality Surveillance Assessment –Acute Oncology Service – June 2017
- Quality Surveillance Assessment –Complex Gynaecology – Specialist Gynaecological Cancers – June 2017
- Quality Surveillance Assessment - Haemato-oncology – June 2017
- Quality Surveillance Assessment - Local Breast Cancer Team – June 2017
- Quality Surveillance Assessment - Local Colorectal Services – June 2017
- Quality Surveillance Assessment - Local Lung Cancer Team – June 2017

- Quality Surveillance Assessment - Local Urology – June 2017
- Quality Surveillance Assessment – Paediatric Oncology – June 2017
- Haemato-oncologyHEKSS O&G Programme Risk-based Review – 6th June, 2017
- HEKSS Medicine Programme Risk-based Review – 6th June, 2017
- HEKSS Surgery Programme Risk-based Review – 6th June, 2017
- Pharmacy; Aseptic Units, Regional Quality Assurance – 5th July & revisit 18th October 2017
- Pearson (Edexcel) – Diploma in Healthcare Support – 18th July, 2017
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – August 2017
- West Kent & Medway Bowel Cancer Screening Assurance Visit to Endoscopy- 19th August 2017
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – September 2017
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – 27th September, 2017
- Neonatal Peer Review Visit (NHSE) – 3rd October 2017
- Care Quality Commission (CQC) – Unannounced inspection (all services)– 18th -19th October, 2017
- Care Quality Commission (CQC) – Unannounced inspection (Paediatrics)– 7th -10th November, 2017
- Care Quality Commission (CQC) – Unannounced inspection (Acute & Emergency Medicine)– 16th -23rd November, 2017
- Care Quality Commission (CQC) – Full announced Well-Led inspection – 12th – 13th December 2017
- HSE inspection of CL3 laboratories (microbiology) – 6th December, 2017
- Kent police – Counter Terrorism Crime and Security Act Annual Inspection – 6th December, 2017
- Pearson (Edexcel) - Diploma in Healthcare Support – 18th December, 2017
- Emergency Care Improvement Programme (ECIP) – January & February, 2018
- Care Quality Commission (CQC) – Announced Inspection (Paediatrics) 1st February, 2018
- NHSI Intensive Support Team – review of Cancer Governance Processes- 9th February, 2018
- Kent Fire & Rescue Service – February 2018
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) - Blood Sciences – February 2018
- Emergency Care Improvement Programme (ECIP) – March, 2018
- General Medical Council; Trainee & Trainer Survey – opened March 2018
- Environment Agency (Radioactive substances regulation) – Maidstone Hospital – 19th March 2018
- Counter Terrorism Security Adviser (Oncology) – Maidstone Hospital – 19th March 2018

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

- Internal assurance inspections (CQC style) with participation from our patient representatives and Quality Leads from West Kent CCG.
- Internal PLACE reviews.
- Infection Control including hand hygiene audits.
- Corporate Quality Rounds.
- Trust Board member “walkabouts”.

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

25 July 2017, via Twitter: @MTWnhs Just wanted to say thanks and well done to the Eye Clinic team today after my first ever visit. Calm and welcoming and spotless.

Hygiene audits to check service quality

Clinical Audit

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

During 2017/18, MTW participated in 100% of relevant confidential enquiries and 98% of all relevant national clinical audits (2 were not submitted due to problems with software compatibility – this is currently being resolved to enable data submission to be completed in the next audit year). During the same period, MTW staff successfully completed **180** clinical audits (local and national) to action plan stage of the **371** audits on the programme to be undertaken during the year. The remaining audits are at various stages of completeness and will be monitored through to completion.

The national clinical audits and national confidential enquiries that Maidstone and Tunbridge Wells NHS Trust participated in during 2017/18 are presented as follows-

National Clinical Audits for inclusion in Quality Accounts 2017/18	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2017/18 (Any period during 01/04/2017 to 31/03/2018)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	TWH- 495 MGH – 418	100%	Continuous data collection.
Emergency Laparotomy Audit (NELA)	Y	TWH – 164 MGH - 11	100%	Continuous data collection.
Neurosurgical National Audit Programme	N/A			MTW does not provide this service
National Vascular Registry	N/A			MTW does not provide this service
Severe Trauma (Trauma Audit & Research Network) TARN	Y	MTW Trust - 436	91%	80% target is set for this project. Continuous data collection.
National Joint Registry (NJR)	Y	TWH – 556 MGH - 10	96%	
Procedural Sedation (care in the Emergency Department)	Y	TWH – 50 MGH – 9	100%	Numbers lower for MGH as sedation mainly used at TWH
Pain in Children (Care in the Emergency Department)	Y	TWH – 50 MGH – 50	100%	
Fracture Neck of Femur (Care in the Emergency Department)	Y	TWH – 50 MGH – 18	100%	Numbers lower for MGH as fractured neck of femur patients mainly present to TWH
BAUs Urology Audits: Radical prostatectomy audit	Y	MTW Trust - 68	93.4%	
BAUs Urology Audits: Female Stress urinary incontinence audit	N/A			MTW does not provide this service
BAUs Urology Audits: Cystectomy	N/A			MTW does not provide this service

National Clinical Audits for inclusion in Quality Accounts 2017/18	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
BAUs Urology Audits: Nephrectomy Audit	Y	MGH – 52	100%	
BAUs Urology Audits: Percutaneous Nephrolithotomy (PCNI)	Y	MGH – 38	100%	
Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	N/A			MTW does not provide this service
BAUs Urology Audits: Urethroplasty Audit	N/A			MTW does not provide this service
Blood transfusion				
(National Comparative Audit of Blood Transfusion Programme) – Audit of red cell and platelet transfusion in adult haematology patients	Y	MTW Trust - 39	97.5%	
2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Y	MTW Trust - 19	n/a	
Audit of Patient Blood Management in Scheduled Surgery – Re-audit September 2016	Y	MTW Trust - 22	n/a	
Serious Hazards of Transfusion (SHOT) UK. National haem vigilance scheme	Y	MTW Trust – 25	100%	Continual data collection
Cancer				
Lung Cancer (NLCA)	Y	MTW Trust - 307	100%	
Bowel Cancer (NBOCAP)	Y	MTW Trust Patient-383 Tumour-383 Surgery-217 Pathology – 152 Chemo - 129	100%	
National Prostate Cancer Audit (NPCA)	Y	MTW Trust Diagnosis- 354 Symptom-183 Treatment-120	100%	
Oesophago-gastric cancer (NAOCG)	Y	MTW Trust Tumour – 203 CT Scan - 199	100%	
National audit of Breast Cancer in Older people (NABCOP)	Y	MTW Trust - 600	100%	
Head and Neck Cancer (DAHNO)	N	MTW Trust - 0	0%	Data is still being collected but we are still unaware of the parameters in order to quality check and submit data via infoflex-. The DAHNO project coordinator has said that there is no deadline for submitting this data.
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	TWH – 180 MGH – 160		Data collection still open and data being submitted
National Heart Failure Audit	Y	TWH – 204 MGH - 191		Data collection still open and data being submitted
Coronary angioplasty/ National audit of Percutaneous Coronary Interventions (PCI)	Y	MTW Trust - 272		Data collection still open and data being submitted

National Clinical Audits for inclusion in Quality Accounts 2017/18	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Cardiac Rhythm Management (CRM)	Y	MTW Trust- 351		Data collection still open and data being submitted.
National Cardiac Arrest Audit (NCAA)	Y	MTW Trust - 175	100%	Continuous data collection.
Adult Cardiac surgery	N/A			MTW does not provide this service
National Congenital heart disease (CHD)	N/A			MTW does not provide this service
National Audit of Pulmonary Hypertension	N/A			MTW does not provide this service.
Long Term Conditions				
National Adult Diabetes Inpatient Audit (NaDIA)	Y	TWH – 54 MGH – 45	100%	
National Diabetes Foot Care Audit	Y	MTW Trust – 47	100%	This only includes inpatients. Outpatients are submitted by the community teams.
National Chronic Obstructive Pulmonary Disease (COPD) Audit Pulmonary Rehabilitation	N/A			No data collection in 2017-18
National Chronic Obstructive Pulmonary Disease (COPD) Audit - Secondary Care	Y	MGH = 230 TW = 161		Data collection still open and data being submitted
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MTW Trust – 141		Continual data submission
Endocrine and Thyroid National Audit	Y	MTW Trust - 80	100%	
National audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	N/A			No data collection in 2017-18
National Core Diabetes Audit (NDA)	Y	TWH – 2200 MGH – 1450	100%	
National Audit of Anxiety and Depression	N/A			MTW does not provide this service
UK Parkinson's audit	Y	TWH – 40 MGH – 40	100%	
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP)	Y N/A Y	1.Inpatient Fall (NAIF) TWH – 30 MGH – 30 2.Fracture Liaison Service Database organisational data 3. National Hip Fracture Database MTW Trust - 503	1. 100% 2. N/A 3. 91.2%	1. All data submitted 2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted
National Audit of Dementia (in General Hospitals) (Spotlight audit)	Y	Clinical data TWH – 20 MGH – 30	100%	
Sentinel Stroke National Audit Programme (SSNAP)	Y	1.Organisational 2. Clinical Data MGH: - 368 TWH: - 444	1. N/A 2. 100%	1. No Organisational collection in 2017-18 2. Data collection still open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement,	Y	MTW trust: Hip: 103 Knee: 135	100%	Report received. Partial assurance.

National Clinical Audits for inclusion in Quality Accounts 2017/18	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Groin Hernia, Varicose Vein		Groin: 32 Varicose: N/A		
National Ophthalmology Adult Cataract Surgery Audit	N	0	0%	Registered to participate. Software link received but trust not able to establish workable connection. Still in process of establishing link to enable data collection.
National Audit of Care at the End of Life (NACEL)	N/A			On quality accounts list but no data collection during this period.
National Bariatric Surgery Registry	N/A			MTW does not provide this service
Learning Disability Mortality Review Programme (LeDeR)	N/A			Staged introduction across England
National audit of Intermediate Care (NAIC)	N/A			MTW does not provide this service
NHS England 7 Day Hospital Study - March 2017	Y	MTW Trust -110	49%	Difficulty in obtaining sufficient numbers of case notes within the timeframe set.
NHS England 7 Day Hospital Study - September 2017	Y	MTW Trust - 103	57%	Difficulty in obtaining sufficient numbers of case notes within the timeframe set.
Mental Health				
Prescribing Observatory for Mental Health (POMH – UK) Prescribing antipsychotics for people with dementia	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – Assessment of side effects of depot and LA antipsychotic medication	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Monitoring of patients prescribed lithium	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Prescribing for bipolar disorder (use of sodium valproate)	N/A			MTW does not provide this service
Prescribing Observatory for Mental Health (POMH – UK) Rapid tranquilisation	N/A			MTW does not provide this service
Suicide and homicide and sudden unexplained death	N/A			MTW does not provide this service
Women's and Children's Health				
Neonatal Intensive and Special Care (NNAP)	Y	MTW: 492	100%	
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	Y	MTW: 0	100%	No patients fitted the criteria for selection for this study.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	MTW Trust Stillbirth: 19 Neonatal:5 Extended Perinatal:24	100%	

National Clinical Audits for inclusion in Quality Accounts 2017/18	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Y	MTW: 0	100%	No patients fitted the criteria for this study.
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	MTW Trust Stillbirth: 19 Neonatal: 5 Extended Perinatal: 24	100%	
Paediatric Inflammatory Bowel Disease	Y	MTW Trust - 53	100%	Continual data submission.
National Maternity and Perinatal Audit (NMPA)	Y	MTW Trust 6070 births	100%	
National Pregnancy in Diabetes Audit	Y	MTW Trust - 27	84%	Some cases not submitted as consent not obtained
Paediatric Intensive Care Audit Network (PICANet)	N/A			MTW does not provide this service
Paediatric Pneumonia	N/A			On quality accounts list but no data collection during this period
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 107 MGH: 118	100%	Ongoing data submission, final date for 2017/18 data is 31st May 2018.
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	N/A			On quality accounts list but no data collection during this period
National Confidential Enquiries				
NCEPOD: Peri-operative Diabetes	Y	MTW Trust 11	82%	Data collection still ongoing. Data collected from Surgeons and Anaesthetists.
NCEPOD: Acute Heart Failure	Y	MTW Trust 12	50%	
NCEPOD: Cancer in Children, Teens and Young Adults	Y	No patients met the inclusion criteria.	NA	Organisational data submitted. No patients met the inclusion criteria for the study.
Child Health Clinical Outcome Review Programme: Young Peoples Mental Health	Y	MTW Trust 7	43%	
NCEPOD: Pulmonary Embolism	N/A			On quality accounts list but no data collection during this period
NCEPOD: Acute Bowel Obstruction	N/A			On quality accounts list but no data collection during this period
Child Health Clinical Outcome Review Programme: Long term ventilation in children, young people and young adults.	N/A			On quality accounts list but no data collection during this period

59 national audits were published in 2017/2018 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including:-

National Emergency Laparotomy Audit (NELA) 2017 - We have continued to utilise an evidence based bundle of interventions forming our Emergency Laparotomy pathway. Additionally this year we have introduced a process of multi-disciplinary review of patients with a predicted mortality rate greater than 20%. This ensures that there is Consultant Surgeon, Anaesthetist and Intensivist involvement in the decision making process for the most high risk patients where surgery is being considered.

Trauma & Audit Research Network (TARN) - Highlighting the process in getting patients to CT scan has led to a substantial improvement in getting patients with head injuries to CT scan within the 60 minutes recommended in the NICE guidelines. This enables a quicker diagnosis and where applicable, quicker transfers to King's College Hospital for specialist treatment.

National Bowel Cancer Audit (NBOCA) 2017 - Following on from the 2016 national report actions were taken to ensure completeness of data reporting to improve NBOCA submission by entering all data following Multi-Disciplinary Team (MDT) discussions directly onto the trusts data recording system. Continual dialogue between surgeons takes place to ensure patients are fully informed of all surgical options available to them. Where cases are likely to need more community input, the individual surgeon will liaise with the GP to identify potential problems and make plans for discharge.

The Trust's mortality rates are lower than the national and regional average and we have good 90 day mortality rates compared with the regional and national figures. Our 18 month stoma rates are also better than the national average (48% v 52%) and stomas are closed at the earliest opportunity following completion of cancer treatment.

National Maternity and Perinatal Audit (NMPA) 2015-16 - From August 2016, a multidisciplinary team at MTW introduced a number of low-cost initiatives to help reduce rates of 3rd and 4th degree tears. These initiatives included slow birth techniques and warm perineal compresses. Each of these interventions were introduced as the result of research evidence and after appropriate staff training, new guidelines and information being made available to women. Rates have reduced over the last twelve months.

MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme; National Perinatal Mortality Surveillance (reports annually) 2015 - The Trust is fully committed to addressing inequalities in neonatal mortality and is one of sixteen organisations leading the development of the Kent and Medway Local Maternity System 5 Year Plan. From May 2016 the Gap and Grow programme was introduced which ensures women at high risk of Intrauterine Growth Restriction receive serial growth scans and customised growth charts are used for all pregnancies.

Hip Fracture Database - A business case has been developed to open an additional theatre in an effort to ensure that our patients get to theatre for their procedures within the optimum 36 hour time frame. Work is currently being undertaken to identify sufficient staffing levels to enable this additional theatre to open.

National audit of Breast Cancer in Older people - MTW will be carrying out formal patient survey's to establish whether the patient felt adequately informed about their planned treatment. We will be auditing our Breast Care guidelines to establish how we fair compared to the regional results from this national audit.

HQIP National Paediatric Diabetes Audit (NPDA) 2016 - Plans are already being made to improve education with regard to transition from the paediatric team to the young adult team. A new pro forma has been developed for use at point of diagnosis to assist staff in carrying out all the required health checks including blood taking. The diabetes clinical support worker will contact those who are having annual reviews to see if they can come earlier than the appointment time in order to have their bloods taken and urine tests completed prior to the appointment.

Royal College of Emergency Medicine National Consultant Sign-Off 2016 - Patients who present at Emergency Departments (ED) with either atraumatic chest pain (30 years and over), fever (children under 1 year), or abdominal pain (70 years and over), or patients making an unscheduled return to the ED with the same condition within 72 hours of discharge should have a review by a consultant or senior level staff prior to their discharge.

Additional consultants and senior staff have been appointed to ensure that patients receive a consultant or senior review prior to discharge from the emergency department for patients with these high risk conditions. This helps to improve clinical outcomes by reducing clinical risk and ensures that patients are only admitted to hospital if there is no reasonable alternative.

There is also now a dedicated Paediatric Unit within the Emergency Department where paediatric patients under one year presenting with fever are seen by staff specifically trained in the care of children.

National audit of Dementia in General Hospitals - Additional training has been developed for the role of our ward Dementia Champions, these are members of staff who are to provide support and advice to staff 24 hours per day, 7 days a week where staff members seek this support role when they are nursing patients with dementia. The Comprehensive Geriatric assessment (CGA) is to be utilised alongside other care pathways to ensure a robust mechanism is in place for assessing delirium in people with dementia.

Please see Appendix A for full details of progress against each of the reported national audit results 2017/18

Improvements to clinical practice from local audits

A number of improvements have been made as a result of the **134** completed local clinical audits, across all Directorates, in 2017/18, **43** of these were local re-audits. Trust staff identified local areas of concern/interest, reviewed their practice and made recommendations for change. Staff actively use clinical audit as a quality improvement process to improve patient care and outcomes through a systematic review against explicit criteria. Improvements include:

Actions taken following local audits 2017/2018	Trust Actions
Radiology	An audit carried out by the radiology team to assess an efficient method of faecal tagging without the use of a full laxative regime. It was found that patients who had taken 100mls of Gastrograffin instead and followed a specific diet plan prior to their CT Colonography (CTC) had adequate tagged residual faecal matter. This confirms that Gastrograffin is extremely effective for its cathartic effect and ability to uniformly opacify faecal residue, thus maintaining the sensitivity and specificity of CTC examinations without the need for a full laxative regime thus reducing the associated side-effects and interruptions to daily routines for patients who would normally have a full laxative regime.
Radiotherapy	The Radiotherapy Team at Maidstone and Tunbridge Wells Hospital re-audited the avoidance of gaps in the radiotherapy treatment schedule for all category 1 patients. Changes implemented from the previous audit included that all staff revise the treatment prescription for patients that have missed several treatments due to being too ill to attend, and to hyperfractionate for the days rested due to a treatment re-plan. This re-audit demonstrated that full assurance was achieved.
Paediatrics	Surfactant is a proven and effective treatment for lung disease of preterm babies with surfactant deficiency lung disease and is a mainstay of neonatal intensive care management. Following the first round of this audit, a departmental guideline was introduced to ensure that preterm babies receive their doses of surfactant at the optimum times. The re-audit shows that our results have improved for babies over 28 weeks. Effective recommended doses reduce the number of doses required for our neonatal patients, reduces the duration of ventilation and the risk of ventilation induced lung injury and chronic lung disease.
Obstetrics	Caesarean section rates are increasing nationally and it is a common, but high risk procedure. We need to ensure that we are meeting nationally agreed standards in our management of these cases. Following a previous round of this audit the team implemented an E3 electronic maternity information system to improve recording of all aspects of care provided to patients. The re-audit has shown a significant improvement in the recording of information and provides a more complete picture of our management of this service.
Gynaecology	Most patients that present with post-coital bleeding have a benign diagnosis, however serious pathologies can be missed by clinicians without adequate experience. After the last audit, a Postcoital Bleeding referral pathway was developed for use by GPs and junior doctors. Significant improvements have been noted in this re-audit, with 100% of patients with abnormal bleeding now being referred to the Trust Colposcopy Clinic.
Sexual Health	Patients diagnosed with a CD4 HIV count of greater than 500 can expect to live as near-normal life expectancy compared to those without HIV. A delay in diagnosis of HIV can affect morbidity as well as mortality causing a significant reduction in life expectancy. In order to ensure that all at risk patients are identified, the Respiratory Team are now offering screening to all patients attending their clinics that are categorised as being at risk. Gastroenterology and ENT are also working with Sexual Health to develop their service to assist in diagnosing HIV at the earliest point of contact with the Trust.
Ophthalmology	Diabetic retinopathy is the leading cause of blindness in people of working age in the United Kingdom. It may affect patients with both type 1 and type 2 diabetes but prevalence is higher in type 1 diabetics. Actions from a previous

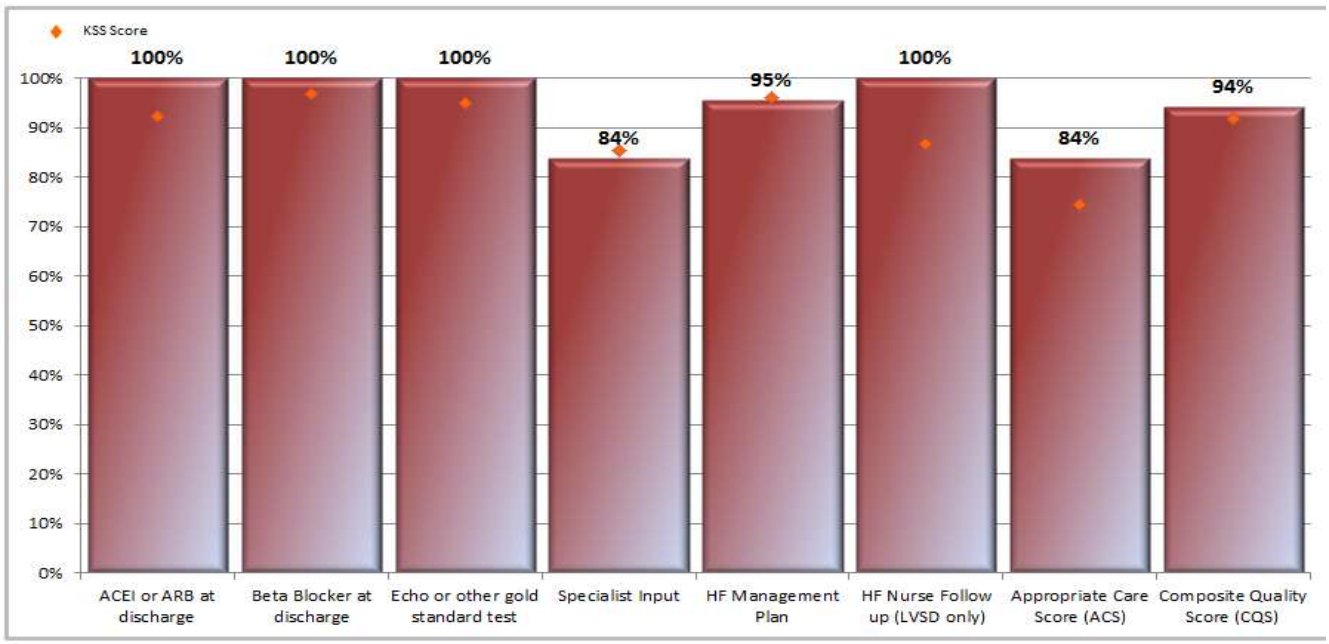
Actions taken following local audits 2017/2018	Trust Actions
	round of this audit include: increased staff awareness and familiarity with the care pathway; use of a listing form for laser treatment; better communication through documentation; a dedicated team co-ordinating the treatment timeline; patients being contacted prior to their appointments as a reminder and an increase in the number of laser lists have all contributed to improvement in patient care and better utilisation of clinic slots. A business case was also put forward for equipment to deliver Pattern Scanning Laser Treatment (PASCAL) which is in the process of review.
General Medicine	The British National Formulary (BNF) advises that patients weighing between 10 and 50 kg should not receive more than 15mg/kg IV paracetamol every 4 to 6 hours. An audit was carried out which showed that not all appropriate patients were having the dose adjusted. Following the audit, education sessions were held for junior doctors and nursing staff highlighting the need to weigh patients and to ensure this weight is documented in the patient health record. It has also highlighted the importance of reviewing the drug chart and adjusting the dose of paracetamol according to weight. A re-audit was performed which showed that 84% of patients now had their dose adjusted, an improvement of 32%. In order to continue to improve a paracetamol prescribing flowchart is to be made available in all clinical areas and a further audit will be carried out.
Respiratory	The National Patient Safety Agency (NPSA) report from January 2005 to March 2008 reported a national figure of 12 deaths and 15 episodes of serious harm from chest drain insertion (NPSA, 2008). As a result of a local audit the following actions were implemented: development and use of a chest drain insertion pathway, a pre-procedure check-list for nurses and quick reference guide for doctors for wards that regularly use chest drains. Real-time imaging for the placement of chest drain for pleural effusions and teaching sessions for clinicians on the insertion and management of chest drains. This re-audit showed an improvement in the use of Ultrasound guidance, analgesia and the level of written consent gained prior to the procedure being carried out.
Acute Medicine	In recent years our trust has witnessed a significant rise in emergency medical admissions along with reduction in the number of hospital beds. Acute Medical Units (AMUs) provide a timely service which is supported by a multidisciplinary team. The Society of Acute Medicine has recommended that patients admitted to AMU should have an initial review by a junior doctor within 4 hours and a consultant review for patients arriving between 08:00 and 18:00 within 8 hours. An initial audit showing that 88% of patients were reviewed by a junior doctor within 4 hours and 99% of patients had a consultant review within 8 hours. Teaching sessions were held for clinicians to reiterate the importance of documenting time of patient review and updating the 'pink' handover list to ensure patients were seen appropriately. A re-audit was carried out which showed an improvement in the time of junior doctor review (now 91%) but a small dip in the time of consultant review (now 90%), it was felt this was down to documentation issues rather than lack of patient review.Timely review and good management planning by a competent decision making doctor and post-take ward round (PTWR) by consultant is vital for early identification of potentially sick/deteriorating patients or well patients for potential early discharge, thus relieving bed pressures.
Tissue Viability	Pressure ulcers are a complex health problem arising from many interrelated factors. Prevention and treatment are paramount to ensure patient comfort and care. Actions from the previous round of auditing include: A trust wide education campaign to reduce the overall numbers of moisture associated skin lesions; working with individual wards to raise knowledge of pressure damage prevention and treatment; a rapid review process of all category 2 ulcers by the Tissue Viability Service. These actions have led to a sustained and continued improving picture in the reduction of pressure damage and an improvement in the assessment of patients when they are admitted to hospital. This will ensure those at risk of developing pressure damage are identified and appropriate equipment and nursing support provided.

Enhancing Quality

Clinical teams across Kent, Surrey & Sussex (KSS) agreed a number of key clinical interventions that should occur when a patient has been admitted across a number of clinical pathways as part of the Enhancing Quality (EQ) Programme.

Enhancing Quality (EQ)
The Enhancing Quality pathways include Heart failure (Acute), Chronic Obstructive Pulmonary Disorder (COPD) and Emergency Laparotomy. For each of these pathways there are a number of performance measures to attain that demonstrate compliance of the key quality indicators. These quality measures pulled together are regarded collectively as a 'care bundle'. It has been clinically proven that delivery of the full 'care bundle' improves the patients' outcomes. The Composite Quality Score (CQS) is the proportion of all clinical measures which were successfully delivered.

Heart failure (Acute)
Maidstone and Tunbridge Wells trust is one of the highest performers for this national audit and is performing in line or better than the regional score. The CQS is 94%. MTW performed slightly above the regional average.

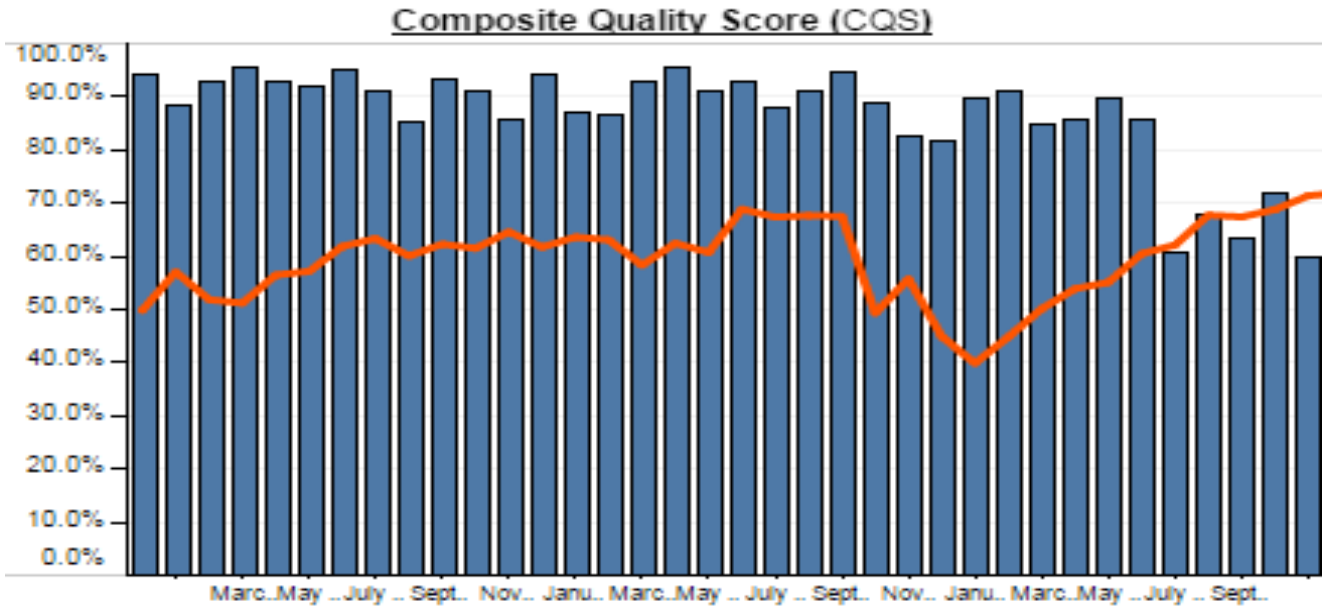


Chronic Obstructive Pulmonary Disorder (COPD).
MTW performance since implementation of the programme has been significantly above the regional average in this pathway.

- Length of stay has continued to reduce but remains above the regional average: 5.63 –v- 5.28 days.
- 30 day re-admission rate was better than the regional average: 26.3% -v- 28.4%.
- In hospital mortality has continued to reduce and is now in line with the regional average: 4.1% -v- 4.1%.

COPD - Discharge Bundle Measure Trends

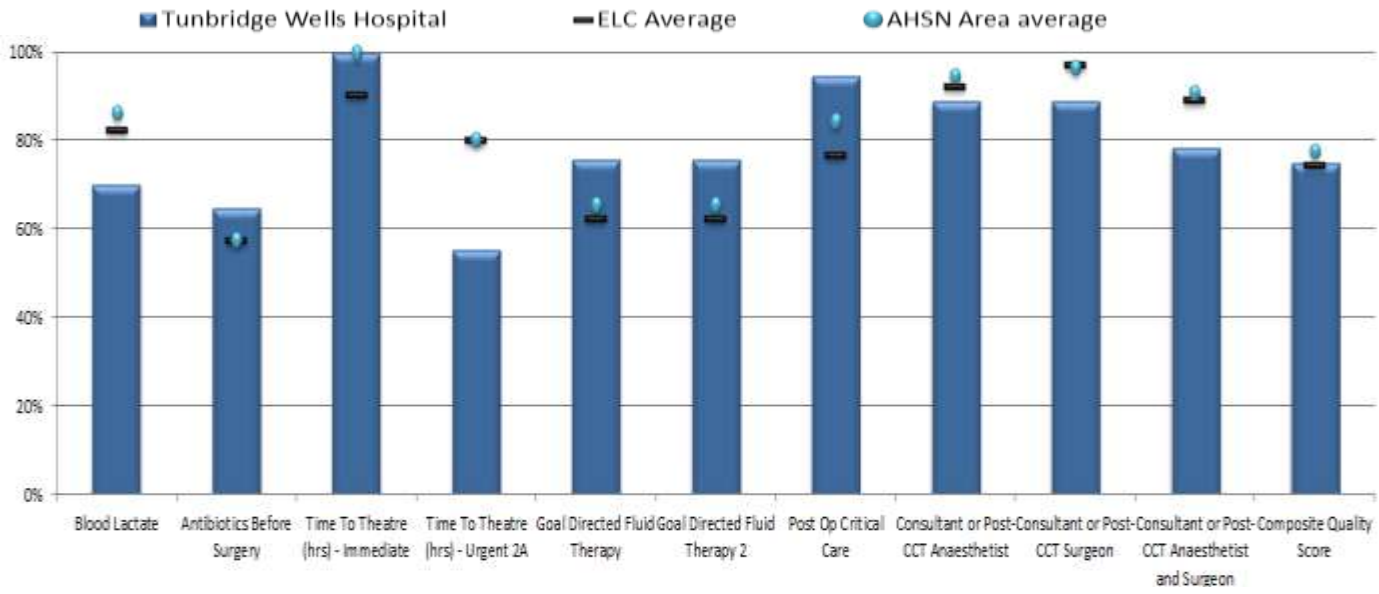
Key: KSS Average Trust Average



March 2015-Sept 2017

Emergency Laparotomy

The Emergency Laparotomy Collaborative (ELC) is led by the Kent, Surrey & Sussex Academic Health Science Network (KSS AHSN) with an aim to provide support in improving emergency laparotomy care and also to deliver quality improvement training. The following table shows results up to Q3 2017/18.



MTW CQS performance was above average for the ELC region (75.1% -v- 74%)
MTW average length of stay is of 17.7 days which is slightly above the national average of 16.2 days.
Crude Mortality for MTW was 2.7%. The KSS average is 8.5%

NICE Guidelines

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

MTW review all published guidelines produced by NICE to identify those which are relevant to the care we provide to our patients. Clinical audits are then undertaken on those guidelines identified as being relevant to assess the Trust's compliance. These clinical audits focus on a number of key quality standards; that are designed to drive measurable service improvement to enhance practice and the care of patients.

By the end of 2017/18 there have been a total of **1324** NICE guidance documents disseminated to the specialty leads throughout the Trust since guidance began to be published in 2005. Of those, **1202** (**90.8%**) have been evaluated. **370** (**30.8%**) of these evaluated guidance are considered to be relevant to the Trusts activities. Each Directorate is regularly updated of the actions required to meet compliance and monitoring of their progress is overseen by the Trust Clinical Governance Committee.

The breakdown is shown in the table below.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (NICE CGs/NGs)	**276**	**246**	**116**
Interventional Procedures (NICE IPGs)	**544**	**523**	**70**
Technology Appraisals (NICE TAs)	**504**	**433**	**184**
Totals	**1324**	**1202**	**370**

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

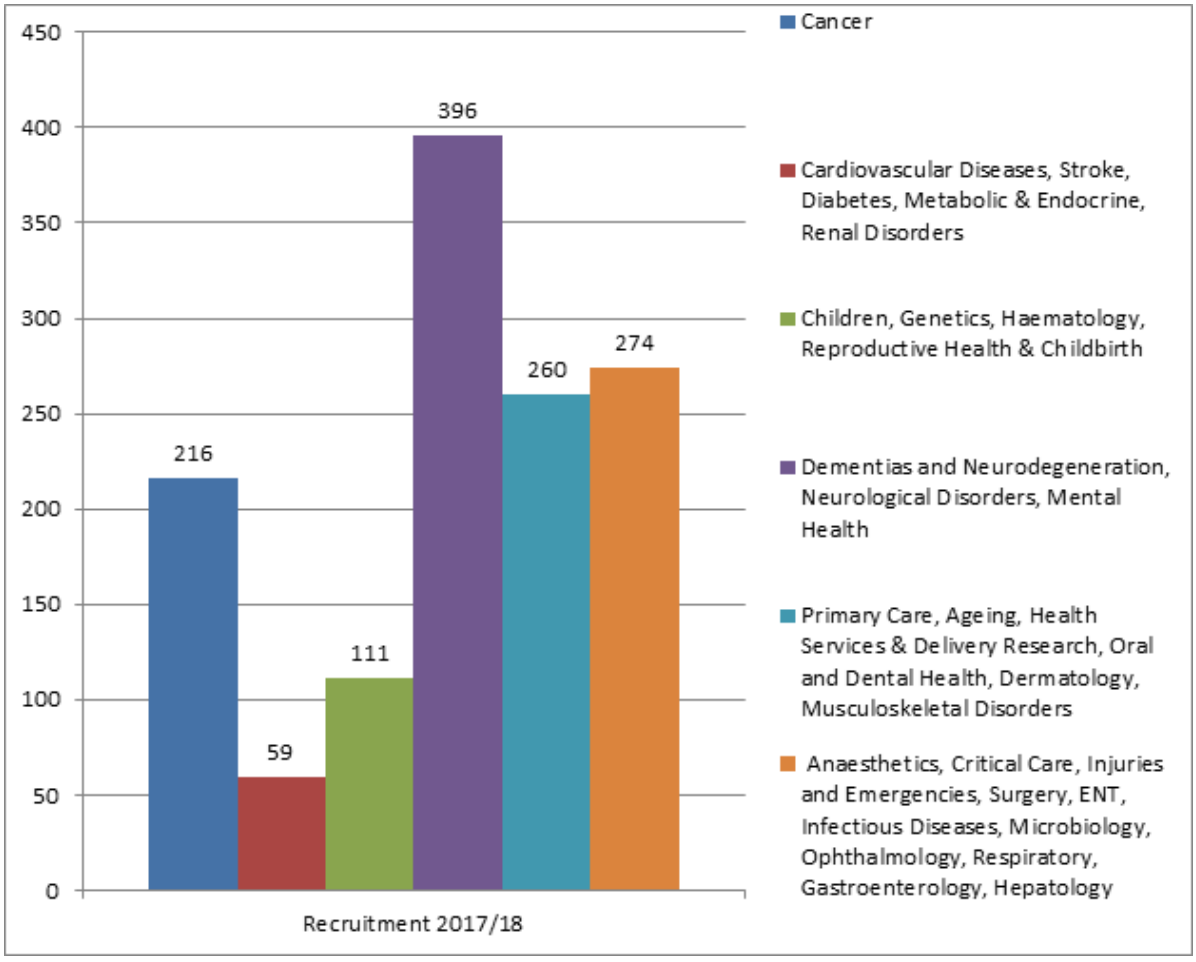
Research

Increasing opportunities for patients participating in clinical research

Maidstone and Tunbridge Wells NHS Trust aims to provide the highest, consistent quality care to our patients and recognises that participation in national and local clinical research is an important contributor to improving patient care and services. Research is central to the development of specialist services and treatments, and our aim is to increase the opportunities for participants to access our research in all specialities.

Participation in clinical research at Maidstone and Tunbridge Wells NHS Trust has increased. We exceeded our set target of 1276 and recruited 1316 participants in 2017/18 compared to the recruitment of 1250 participants (against a plan of 1174) in 2016/17. The Trust played a key part in delivering the national research agenda and met its recruitment target for this year, as set by the Kent Surrey and Sussex Clinical Research Network (KSSCRN). In addition all research participants were recruited to studies that have been approved or reviewed by the National Research Ethics Service. This means that our patients had access to ethically approved new treatments, interventions and medicines.

Recruitment by National Institute for Health Research specialty grouping 2017/18



The successful recruitment during the year has been as a result of a dedicated delivery team supported by motivated clinical trial administrators and governance staff. Improvements were demonstrated in speedier expression of interest and streamlining study set-up and the commitment of our service support departments, general managers and clinical directors in supporting research activity.

Maidstone and Tunbridge Wells NHS Trust is recognised across Kent, Surrey and Sussex for the quality and the delivery of the national clinical research that we host. The University of Oxford invited the Trust, for the second time, to collaborate in the 'Teenagers Against Meningitis' research study, which involves local secondary schools both in Maidstone and Tunbridge Wells and the wider catchment area of Ashford and Folkestone. The Research and Development team recruited 215 teenagers in the first recruitment wave with positive feedback and support from the Heads' of the Schools.

Maidstone and Tunbridge Wells NHS Trust recruited 1316 participants in 2017/18. The highest recruiting research studies were the (i) Enhancing Mental Health Awareness in Emergency Services (The Enhance Study), (ii) Investigation of wellbeing interventions of NHS staff and (iii) Developing and validating a new self-report measure of compassion.

Trust Lead Research Nurse for Research and Development

Maidstone and Tunbridge Wells NHS Trust successfully appointed a new Trust Lead Research Nurse for Research and Development. Claire Pegg, joined the team in January 2018 with 10 years ITU and critical care experience and more recently setting up research in the community. Claire is a Good Clinical Practice (GCP) facilitator and works closely with the NIHR workforce development team looking at new courses and further training for research. Claire is looking forward to working with the different teams in developing the research portfolio across the Trust.

Claire Pegg – Lead Research Nurse

Patient and Public Involvement at Maidstone and Tunbridge Wells NHS Trust

Frances Mossie has been working within the Trust for four years now as the Volunteer Patient Research Ambassador. Frances provides an active role in raising awareness of research taking place within the Trust and talking to patients, carers' and relatives.

During 2017/18 Frances has been engaged in a number of activities, including supporting the International Clinical Trials Day in May 2017 and playing an active role in promoting and disseminating research across the Trust through foyer presentations and publications across the Trust.

Also during 2017 Frances presented at a number of national and local meetings with the Kent, Surrey and Sussex Comprehensive Research Network (KSSCRN) and National Institute for Health Research (NIHR) Clinical Research Network (CRN) in London and Sussex. Frances is abreast of new developments in Patient and Public Involvement within the NIHR and helps to implement innovative ideas to further enhance patient and public involvement in research at MTW.

In November 2017 the Research and Development Department worked together with Frances to further expand the Volunteer Service of the Trust. Representatives from patients and the community were recruited as Volunteer Patient Research Ambassadors to "spread the word" about research within the Trust and to provide support to the Research Nurses. This support has been in various forms such as meeting and greeting participants, 'hand holding' and providing study information sheets to patients, carers' and relatives to support the principal investigators' and research nurses.

The Research and Development Department believe that patients, carers' and their relatives should be partners in research activity and play a central role in protocol development, study set-up and delivery of research. During December 2017 various own account projects were developed by staff from the Research and Development team. These all involved patients at the earliest stage to ensure patients were at the heart of what we do. Some of the projects developed by MTW include shoulder pain in Trauma and Orthopaedics, head injury management in Accident and Emergency and acupuncture for treatment of delay in labour.

The EPOP 2 surgical project continues to be supported by patients and clinicians working together. Regular communication and input from patients ensure the project's aims are fulfilled. This project uses the expertise of one of our consultant surgeons, alongside a university professor and our Research and Development team. The project is as a result of collaborative working and strategic planning.

A strong research delivery team.

The research and delivery team continues to grow in strength with the recruitment of 3 oncology nurses during 2017 and early 2018 and a newly advertised vacancy for an additional haematology nurse to further expand research at Tunbridge Wells Hospital to be filled during 2018/19. The growth of the team will support the increasing recruitment to a diversity of studies.

The delivery team now comprises experienced research nurses in new areas such as Intensive Care, Accident and Emergency and Midwifery. A research practitioner was appointed to the team in February 2018 as the lead for the Genomes 100,000 project. This project was endorsed by the Government back in 2012, looking into genomic medicine and patient specific treatment.

Research governance is supported by an experienced team of two governance officers and one governance coordinator. With the support of the central clinical trial administrators they focus on ensuring compliance with legislation and GCP and manage the resources to deliver the studies, safely, timely and effectively. Proposals are being considered to further strengthen the central team.

Within oncology and haematology research, two new nurses have been appointed to the oncology unit in February/March 2018. This ensures each tumour group now has a dedicated team of research nurses and a dedicated Clinical Trial Administrator to facilitate the speedy opening and effective delivery of trials.

Introduction of New Research Nurse Uniform

In October 2017, the Trust introduced a new research uniform for research nurses. The uniform promotes the professional identity of the research nurse and raises the profile of research and development. It is important that research nurses are recognized for the work they do and feel part of the wider trust clinical team delivering services to patients.

Tracey Nolan, Sue Lord, Stephanie McKinley

Awarding excellence in research

Maidstone and Tunbridge Wells NHS Trust was recognised for providing high quality quarterly research financial returns to the Kent, Surrey and Sussex Clinical Research Network in March 2018 and was awarded £500.00 from the KSSCRN. Dave Shelton, Research and Development Finance Manager, was acknowledged for the exceptional financial management in research.

Julie Knowles, Denise Day, Dave Shelton, Hazel Everest, Clare Calvert, Kevin Bishop

New Research Café

The Research Café was launched in January 2018 as a new initiative in partnership with the Academic Library and Maidstone Hospital and was opened by Miles Scott, Chief Executive.

Working collaboratively with the library, staff are encouraged to develop innovative, trust grown research and to promote the areas where research is already active. The drop in sessions have proved successful with the addition of seminars on research topics such as how to get started in research, how to write your research question and where to apply for funding.

Goals agreed with commissioners

CQUINS

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

In 2017/18 2.5% of the contract value was dependent on achieving the CQUIN targets for CCGs and 2.0% was for NHS England in line with the CQUIN payment framework. However Maidstone & Tunbridge Wells NHS Trust operate through an aligned incentive contract with our main provider (West Kent CCG) therefore no financial penalties ultimately apply. All other contracts however are subject to the standard penalties. This does not detract from the main intention of the purpose of CQUIN's however which are to improve the quality of care provided to our patients, as such delivery of these remains a high priority.

Within the commissioning payment framework for 2017/18 quality improvement and innovation goals were set as indicated in the table below.

CQUINs	Target	*Achieved (local data)	RAG Rating
National CQUINs (CCGs)			
Improvement of health and wellbeing of NHS staff- achieving a 5% point improvement in two of three staff survey questions on health & wellbeing, musculoskeletal injury and stress.	5% Improvement in 2 / 3 staff survey Questions	25%	Amber
Healthy Food for NHS Staff, visitors and patients; reduction in % of sugar/salt products displayed; increase in healthier alternatives; avoidance of overt promotion.	Delivery of three outcomes agreed with WKCCG	100%	Green
Improving the uptake of flu vaccinations for frontline clinical staff.	70% Uptake by 28th February	71.1%	Green
Timely identification of sepsis in emergency departments; percentage of eligible patients screened for sepsis.	90% for each Quarter	Q1=94% Q2=95% Q3=96.9% Q4=98.3%	Green
Timely treatment for sepsis in emergency departments.	Q1&Q2 = 85% Q3&Q4 = 90%	Q1=88% Q2=91% Q3=90.1% Q4=91.3%	Green
Timely identification of sepsis in acute inpatient settings; percentage of eligible patients screened for sepsis.	Q1=75% Q2=80% Q3=85% Q4=90%	Q1=78% Q2=81% Q3=88.3% Q4=85.1%	Amber
Timely treatment for sepsis in acute inpatient settings.	Q1=70% Q2=75% Q3=80% Q4=90%	Q1=78% Q2=75% Q3=90% Q4=90.9%	Green
Assessment of clinical antibiotic review between 24-72hrs of patient with sepsis who are still inpatients at 72hrs. Empiric reviews to be performed; % of cases in the sample	Q1=25% Q2=50% Q3=75% Q4=90%	Q1=67% Q2=83% Q3=80% Q4=90%	Green

CQUINs	Target	*Achieved (local data)	RAG Rating
Reduction in antibiotic consumption per 1000 admissions 1) total antibiotic usage 2) Total usage of carbapenem 3) total usage of piperacillin-tazobactam.	Reduction of 1% against baseline	33.3%	Amber
Improving services for people with mental health needs who present to A&E in selected cohort group.	20% reduction in A&E attendances for those in cohort	43%	Green
Offering Advice and Guidance (A&G)- to set up and operate A&G services for non-urgent GP referrals, allowing GP's to access consultant advice prior to referring patients into secondary care	75% of GP referrals are made to elective outpatient specialities which provide access to A&G services	100%	Green
NHS e-Referrals; GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments in the NHS e-Referral service	100% of Referrals to 1st O/P Services able to be received through e-RS	100%	Green
Supporting proactive and safe discharge; increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place or residence within 7 days of admission by 2.5% points from baseline whilst monitoring readmission rates.	Baseline (Q3&4 2016/17)=70% Target=72.5%	77.3%	Green
NHS England Specialist CQUINs	**Target**		
Optimising Palliative Chemotherapy Decision Making-To ensure optimal care is appropriate that, in specific groups of patients, decisions to start and continue further treatment should be made in direct consultation with peers and then as a shared decision with the patient.	Review of practice, improvement plan developed, review of audit against plan.	100%	Green
Clinical Utilisation Review (CUR) –optimising patient flows and move out of acute settings	Data submission, daily use of CUR, reduction in % of NQ patients	100%*	Green
Activation System for Patients with Long Term Conditions (LTC's)- Chronic Obstructive Pulmonary Disease (COPD) and Irritable Bowel Syndrome (IBD) ; Year 2 re-testing of patients in cohort, improvement in PAM scores, improvement in adherence and reduction in non-elective attendances/admissions, aggregate improvement in patient reported health outcomes.	Review of patients surveyed in 2016/17 re disease progression- delays in patient response to be evidenced	100%*	Green
Hospital Medicines Optimisation – adoption of best value generic/biologic products in 90% of new patients within one quarter of guidance being made available; adoption of biologics in 80% of applicable existing patients within one year of being made available; submission of HCD data; increase use of cost-effective dispensing routes for outpatient medicines; improve data quality associated with outcome databases (SACT and IVIg).	Trigger 1 Trigger 2 Trigger 3 Trigger 4	Achieved Partial Achieved Achieved 91.5%	Amber

*Revised Milestone part of CQUIN to be delivered in Q1 2017/18 due to database interface challenges

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2017/18, including what we have achieved and what has challenged us.

National CQUINs:

Achieving the Sepsis CQUIN has once again been challenging, missing the final milestone for the screening of inpatients in quarter 4 (85.1% against the target of 90%). Despite this disappointment we were commended by the Secretary of State for Health and Social Care, the Right Honourable Jeremy Hunt earlier this year for the delivery of the previous milestones. This life threatening condition which affects 260,000 people in the UK every year causes 44,000 deaths but is relatively easy to treat if diagnosed and promptly treated. The Sepsis Committee and the Sepsis leads have continued to drive this hugely important agenda throughout the year and have introduced the latest guidance and revised the Sepsis flow charts for use on the wards. We have also recruited Sepsis Champions to our wards and departments to help in the education and development of our staff which will ultimately improve patient care and experience.

The main challenge was the reduction of antibiotic use, of which three milestones were set. The reduction of carbapenem; Tazocin and the overall use of antibiotics. Unfortunately we missed this on two elements, the reduction of the use of carbapenem and the overall use of antibiotics. This was particularly noticeable in the overall usage in Quarters 2 and 3, mainly as a result of an increase in the presentation of patients with respiratory conditions.

Our Finance Director leading by example

During 2016/17 we were pleased to have achieved 66.6% of our frontline staff immunised for flu due to the competitive spirit raised between professions, this year we saw the opportunity to push this further. The Occupational Health department ensured that we had local immunisers trained in each speciality/department and liaised with our Communications team to ensure that our staff were regularly reminded of the benefits of having their vaccinations for both their own protection and that of our patients. This strategy helped us to successfully vaccinate 71.1% of our frontline clinical staff.

Collaborative working

An additional benefit of this year's CQUINs has been the opportunity to work in collaboration with our colleagues in Kent and Medway NHS and Social Care Partnership (KMPT), South East Coast Ambulance Service (SECAmb) and Kent Community Health Foundation Trust (KCHFT).

For the CQUIN 'Improving services for people with mental health needs who present to A&E' we worked with both KMPT and SECAmb to select 25 patients who most attended A&E that the team felt would most benefit from a coordinated approach. Together with the patient a plan of care was developed with all parties signing up to the delivery of this plan. The intention was to ensure that the patient received a consistent approach to their care needs and thereby reduced the number of times that they presented to A&E. The patients selected ultimately reduced their attendances by

43% during the course of the year but more importantly they are receiving the right support to self-manage their symptoms.

In addition we have worked with KCHFT to support proactive and safe discharge of patients over the age of 65 to their usual place of residence within 7 days of admission. The ethos of this CQUIN was to ensure that we optimise our patient's independence and also to reduce the risk of further harm from hospital acquired infections etc. Working collaboratively we ensured that those patients who needed additional support at home were supported by KCHFT community teams and optimised towards full independence. During this time we also closely monitored the risk for readmission for this cohort of patients and are pleased to report that these levels also reduced during this timeframe, therefore successfully delivering on all aspects of this CQUIN and supporting more of our patients to remain independent for longer.

NHS England CQUINs

This year's specialist CQUIN's have been of particular challenge, mainly due to our ability to supply the required evidence as a result of both IT interface and database issues, which have since been resolved.

Optimising Palliative Chemotherapy decision making has necessitated the need to create an additional field in our Kent Oncology Management system (KOMS). This new field encourages our nursing staff to record that a peer review of decision making has taken place ie that the patient, consultant and wider team are in agreement and support a palliative chemotherapy treatment regime. This process previously took place in paper format making auditing of the process difficult, our new challenge is to now ensure that our nursing staff record the additional field to provide the required evidence.

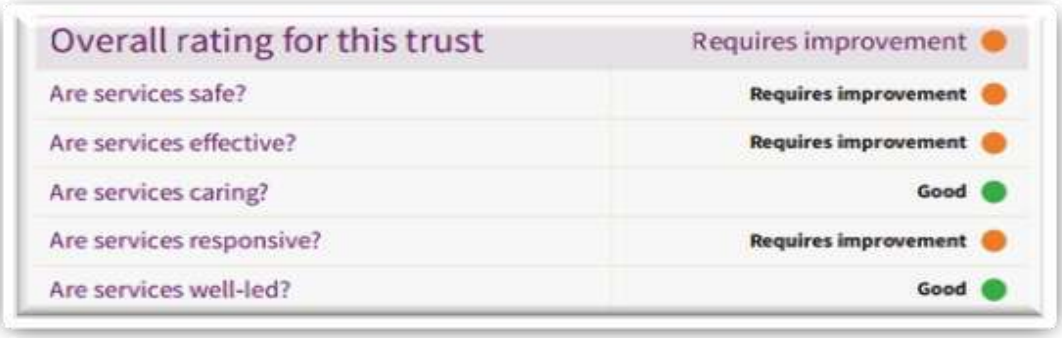
During 2017/18 MTW has been committed to the full rollout of Clinical Utilisation Review (CUR) and has succeeded in implementing the system in all adult inpatient wards. This took place by September 2017. We have a CUR Operational Group in place which meets monthly and a Senior Site Practitioner was released from 50% of her duties in order to ensure that this implementation took place. All ward managers and Junior Sisters/Charge Nurses have been trained and it is now mandatory for CUR to be completed on all wards by lunchtime every day. The Trust also implemented a new Patient Centre database (Allscripts) during 2017; CUR was switched off during this time as there were technical issues which needed to be resolved. Our overall compliance with CUR has therefore not reached the proposed 85%. NHSE have agreed that our year-end target can be moved to the end of June 2018 in recognition of the challenges we have faced. On a positive note we have been able to demonstrate a reduction in the number of unqualified patients (those whose care needs can be met outside of an acute hospital setting).

For the management of Long-term conditions, this year's objectives were to re-survey the patient's surveyed last year to review the progression of their illness and see how they have been self-managing their illness. These included patients with Chronic Obstructive Pulmonary disease (COPD) and Irritable Bowel Disease (IBD). The response rate from this group of patients has been particularly low with many declining to participate. We have also continued to experience challenges with the data requested and entering it into the database, we continue to meet with NHSE to discuss and attempt to resolve. Due to the challenges faced this CQUIN is also being extended into 2018/19.

Statements from the CQC

The Trust underwent an inspection during the period 18th October, 2017 to the 1st February, 2018 with the report published in March 2018.

The overall rating for the Trust was 'Requires Improvement'



Overall rating for this trust	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

The CQC reported that they had seen significant improvements since our previous inspection three years ago and while the CQC has rated us as 'Requires Improvement' for now, they acknowledged that significant and sustained improvements had been made and we were moving towards a 'Good' rating. In fact, the Trust has been rated 'good' in over two thirds of the CQC standards across the five core services that were inspected – a significant increase from less than a third in 2015. In addition the report saw no individual standards rated Inadequate, compared to six in 2015.

Each one of our inspected services was rated 'Good' in the caring domain. We are hugely encouraged that the inspectors recognised that we put quality at the heart of everything we do, and that we have improved numerous areas of patient care at a time of unprecedented operational and financial pressure across the NHS as a whole.

The report also highlights that Maidstone and Tunbridge Wells NHS Trust (MTW) has made improvements in several service areas since the last inspection, in particular in the areas of critical care, medical care and services for children and young people.

We have received 17 specific recommendations from the CQC and work is already underway to ensure we complete these actions as soon as possible. Our Quality Improvement Plan has been updated to reflect the key actions that are now required which include:-

- Ensuring that our staff keep up to date with their mandatory training.
- Ensuring that we respond promptly to patient complaints.
- Minimising the amount of time our patients are kept nil by mouth for surgery.
- A proactive recruitment process to ensure staff vacancies are filled.
- Proactive assessment and response to patient's pain.
- Sharing the learning from complaints and incidents.

This action plan will be overseen by the Quality Improvement committee that has superseded the CQC Project team meetings. This will be chaired by the Chief Nurse and will report into the Best Quality Workstream which is part of the Best Care Programme

The full report can be accessed via the CQC website - http://www.cqc.org.uk/provider/RWF

In addition Maidstone & Tunbridge Wells NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Improving data quality at MTW

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

Specifically, MTW needs to ensure its information is:

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

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

The Trust has developed a new Data Quality Strategy during the year, which has subsequently been launched, creating a renewed focus on data quality across the organisation. A number of governance groups have also been established to ensure the vision set out within the strategy is delivered. The vision is 'to ensure that we adhere to all relevant local and national data standards and applicable best practice guidance to support the delivery, commissioning and regulation of high quality and safe healthcare service at MTW'.

These groups will focus on the following areas:

- Governance and leadership
- Policy
- Systems and processes
- People and skills
- Data use and reporting

Progress on the work plan linked to the new strategy will be reported quarterly to Trust Management Executive and onward to the Board as appropriate.

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

which included the patient's valid NHS number was (as at Month 11):

- 99.0% (99.1% 16/17) for Admitted Patient Care;
- 99.4% (99.3% 16/17) for Outpatient Care; and
- 96.0% (97.1% 16/17) for Accident and Emergency Care.

Which included the patients valid General Medical Practice code was:-

- 100% (99.9% 16/17) for Admitted Patient Care;
- 99.7% (99.8% 16/17) for Outpatient Care; and
- 100% (99.8% 16/17) for Accident and Emergency Care.

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

Information Governance Toolkit

The Information Governance Toolkit is a performance tool produced by the NHS Digital (formerly the Health and Social Care Information Centre). It draws together the legal rules and central

guidance related to Information Governance. The Trust achieved a score of 74% (74% in 2016/17) satisfactory (Green in the toolkit grading scheme) against the Information Governance Toolkit Version 14.1, and achieved 10 (10 in 2016/17) of the 45 requirements at level 3. The remaining requirements were achieved at level 2 as required by the NHS Standard Contract (2017-19).

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 is independently audited to ensure that the coding reflects the patient's diagnosis and treatment.

In 2017/18 a Clinical Coding audit and process review was undertaken by Maxwell Stanley Ltd on behalf of MTW which was released in February 2018. The audit scored the Trust at Level 3 using the IG Toolkit's scoring mechanism. The recommendations within the audit report have been fed into an action plan to address the issues identified.

Area	Level 2	Level 3	Trust % Correct
Primary Diagnosis	>=90%	>=95%	**98.98% Level 3**
Secondary Diagnosis	>=80%	>=90%	**97.38% Level 3**
Primary Procedures	>=90%	>=95%	**96.40% Level 3**
Secondary Procedures	>=80%	>=90%	**97.27% Level 3**

The report made three recommendations for further improvements and these will be actioned during 2018/19.

Part Three

Results and Achievements for the 2017/18 improvement initiatives

Patient Safety

Aim/Goal

To create reliable processes that will build a supportive environment to reduce avoidable harm.

<table>
<tr><th>Action</th><th>Update</th></tr>
<tr><td>We will demonstrate that we have embedded a safety culture within all departments undertaking invasive procedures which comply with the World Health Organisation (WHO) surgical safety methodology.
○ Agree a programme of audits on WHO compliance to all areas undertaking invasive procedures and monitoring of compliance.
○ Promotion of ‘Human Factors’ training and methodology.</td><td>• Establishment of a WHO compliance working group which is led by the Associate Director of Nursing for Planned Care. The main objective of this group has been to ensure all areas comply with National Guidance and that they have a process in place for the monitoring of progress and required actions are taken.
○ Regular meetings in place.
○ Action plan has been drafted for further discussion and sign-off at the next meeting.
○ WHO checklists have been reviewed to ensure they meet national compliance.
○ Trust wide WHO audit registered and due for completion in August 2018.
○ Work with each Directorate and Speciality is in place to ensure that they have processes in place to meet full compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) and Local Safety Standards for Invasive procedures (LocSSIPs).
• Human Factors training took place in March 2018- 10 staff are now trained across directorates and across professions.</td></tr>
<tr><td>We will improve the reporting of medication errors within the Trust and reduce the number of inappropriate omissions of medication doses.
○ Monthly reporting of medication safety incidents and raised awareness through Governance meetings and Medicines Safety News.</td><td>
<table>
<tr><th>Metric</th><th>Quarter 1</th><th>Quarter 2</th><th>Quarter 3</th><th>Quarter 4</th></tr>
<tr><td>Number of incidents reported</td><td>217</td><td>199</td><td>182</td><td>170</td></tr>
<tr><td>Omitted doses</td><td>5.3%</td><td>22.2%</td><td>4.6%</td><td>12.5%</td></tr>
<tr><td>Omitted doses of time critical medicines</td><td>6.0%</td><td>17.4%</td><td>4.6%</td><td>7.5%</td></tr>
</table>
<u>Comments on Metrics</u>
• Number of medication related incidents –despite initial success in Q1 we have been unable to establish an increase in reporting.
• Omitted doses – Although the % of omitted doses and omitted doses of time critical medicines has remained variable, with some success evident, again we have not been able to</td></tr>
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<tr>
<td></td>
<td>establish the level of reduction anticipated.
We have however firmly established the Medicine Safety News which is regularly published on the Trust Intranet. This is used to disseminate learning, themes and trends from incidents. During 2017/18 we have published articles in regard to:-
○ Initiation of aminophylline infusion and the need to ensure levels are checked at 4-6hrs
○ The need to take care when prescribing Direct Oral anticoagulants for patients with liver disease following admission of patient with GI bleed
○ Sedation in older people: If sedation is absolutely necessary, start low, take it slow.
○ Prescribing, administering or supplying Lithium? Always think LEVEL!</td>
</tr>
<tr>
<td>We will reduce our observed mortality rates to be in line with expected rates according to speciality.
○ By the end of March 2018 every in hospital death will have been reviewed (in line with prevailing guidance)</td>
<td>The Mortality Surveillance Group continues to work with Dr Foster and the Communities of Practice for the Southeast to support an appropriate level of scrutiny and to share learning. Through the increased understanding of our data we have been able to make significant progress in reducing our rates in line with those of our peers.
<table>
<tr><th></th><th>Quarter 1</th><th>Quarter 2</th><th>Quarter 3</th><th>Quarter 4</th></tr>
<tr><td>Crude Mortality</td><td>1.20%</td><td>1.10%</td><td>1.20%</td><td>1.20%</td></tr>
<tr><td>SHMI</td><td>1.088</td><td>1.072</td><td>1.049</td><td>1.044</td></tr>
<tr><td>HSMR</td><td>106.8</td><td>104.6</td><td>106.4</td><td>103.1</td></tr>
</table>
In October 2017 we introduced a revised mortality review process in line with National Quality Board Guidance. The introduction of this revised process has resulted in a slowing down of reviews as the new paperwork embedded. This has negatively impacted on our intention to achieve 100% compliance of every patient death having undergone a Mortality Review of the care provided during 2017/18. However the latter months are now demonstrating improvements which are evidenced in our year-end figures in comparison to 2016/17.
<table>
<tr><th>Trust</th><th>YTD 2016/17</th><th>YTD 2017/18</th></tr>
<tr><td>No of Deaths</td><td>1877</td><td>1854</td></tr>
<tr><td>No of Completed Reviews</td><td>806</td><td>882</td></tr>
<tr><td>%age completed reviews</td><td>43%</td><td>47.6%</td></tr>
</table>
</td>
</tr>
<tr>
<td>We aim to achieve consistent recognition and rapid treatment of sepsis in both our emergency and inpatient departments and ultimately reduce the number of avoidable deaths.
○ Through the work of the Sepsis Committee we aim to achieve the National CQUIN. This will be monitored monthly through the CQUIN Board and reported to the Patient Experience Committee.</td>
<td>Timely identification of Sepsis in Emergency Department and acute inpatient settings-
○ A&E - achieved
○ Inpatients – partial achievement; failed trajectory for Q4
Timely treatment for sepsis in emergency departments and acute inpatient settings-
○ A&E - achieved
○ Inpatients – achieved
• Sepsis committee firmly established with developed action plan.
• Review of the guidance for Sepsis has been undertaken to ensure that MTW are following the National agenda. Red Flag and Amber Flag sepsis protocols are being reviewed.</td>
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- *Development of the role of Ward Sepsis Champions to support the sepsis agenda.*

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<tr><td>

We will improve the outcomes for expectant mothers and their babies in line with the Maternal and Neonatal Health Safety Collaborative.

- The work of the National Maternity Safety Improvement plans will be reported through the Maternity Board and the Key Performance Indicators (KPI's) will be monitored to inform their progress.

</td><td>

The Maternity service has been selected by NHSE to be a centre for the Choice pioneer work in regard to personalisation of patient care with many of our patients joining the pilot.
In addition work is ongoing to reduce:-

- *Perineal trauma through the introduction of slow birthing techniques; warm perineal compresses and good birth positioning.*
- *Unanticipated admission to NNU- introduction of the Bobble hat is currently being trialled following positive results in another organisation (see pg 74 for further detail).*
- *Stillbirths- review of gap and grow training; move to face to face training from online.*

KPI's-

Metric	Q1	Q2	Q3	Q4
No of deliveries	*1476*	*1552*	*1486*	*1469*
Post-Partum Haemorrhage >2000mls	*17*	*13*	*15*	*15*
3rd/4th degree tears	*25*	*28*	*35*	*27*
Postnatal Readmissions	*12*	*21*	*16*	*24*
Total Stillbirths	*5*	*9*	*4*	*4*
Unanticipated admission to NNU	*33*	*39*	*39*	*34*

</td></tr>
</table>

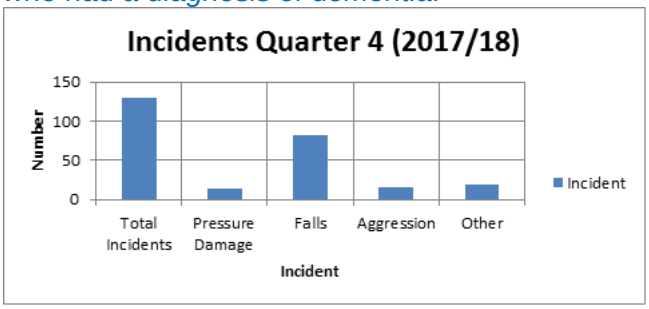
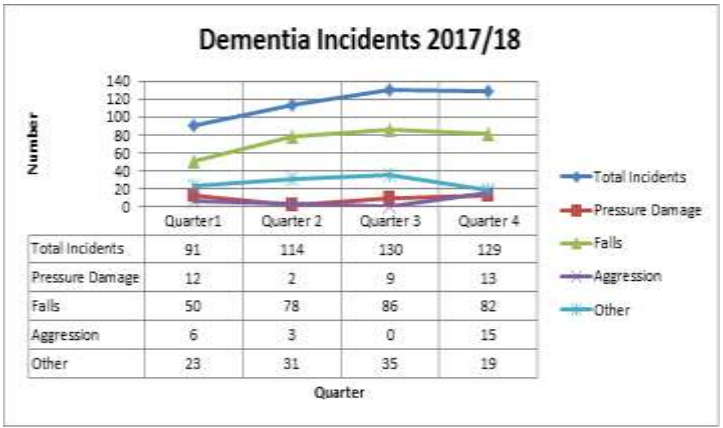
Patient Experience

Aim/goal

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

Action	Update
• Implementation of the revised Friends and Family Test methodology to provide a more targeted focus on 5 questions relating to the patient's overall experience.	• *The extended question set based on the CQC domains is now fully embedded and seeks to provide richer data and deeper insight on the quality of care and safety in the trust.* • *The 'iWantGreatCare' (IWGC) contract has now been extended following a review of the functionality provided. The additional benefits are a new dashboard 'Iris' which is an early warning system for monitoring* • *MTW's representative group are looking to work collaboratively with IWGC to further develop the monitoring system for quality and safety issues and to align the new design of the dashboard to the CQC's key lines of enquiry (KLOE).*
• To achieve consistent monthly response rates to the Friends and Family Test.	• *The MTW Representative group continues to meet regularly to review the project pathways, data analysis and to maintain a raised awareness of the Friends and Family question. Following the Winter period and escalation, work is now progressing to re-engage with the speciality nominated leads to have representation at these meetings.* • *The meetings continue to focus and review how to*

	embed the process of collecting feedback into daily routines and sharing good practice. • *Standing agenda item for the meetings include an opportunity to review areas, a review of 'red' word clouds and to promote innovations and their progress.* • *'Word Clouds' are now being produced monthly and can be accessed via the N-Drive.* • *The group continue to explore the feasibility of establishing e-mail alerts to enable earlier response to feedback. The collection dates have now increased to weekly to facilitate this change.* • *There was a drop in inpatient response rate during February (now including day case and children) however, the response rate increased from 17.4% in February to 32.7% in March with over double the number of respondents from the previous month. For A&E (now including children) it increased from 9.07% in February to 18.82% in March, again more than doubling the previous month's respondents. For Maternity Q2 (as nationally they will not publish response rates for Q1,Q3 and Q4 anymore) it increased from 15.2% in February to 39.42% in March. All supporting a refocus on patient feedback.* • *For the % Positive for March, the Inpatient data demonstrates a minimal statistical change from 94.9% last month down to 94.4%, A&E from 90.3% last month to 93.6% and Maternity (all 4 combined) from 92.7% last month to 90.9%.* • *Work is progressing between IT and the Paediatric lead for IWGC to review the IWGC app within Children's services which will seek to promote an increase in feedback.*
• To work with external partners such as Healthwatch, NHSI, CQC and CCG to identify key themes of good practice and emerging issues that may give cause for concern. Activities may include engagement with compliance Assurance, formal and informal PLACE assessments, engagement with service improvement initiatives and patient experience improvement groups.	• *Review of Patient Discharge processes undertaken by Healthwatch.* • *Bimonthly Quality Review Group meetings with WKCCG.* • *PLACE assessments undertaken in March and April 2018. Dates are shared with health care professionals and our Patient representatives.* • *The Trusts Internal Assurance programme has been updated reflecting a new reporting format. A schedule of assurance visits is mapped throughout 2018/19.* • *The Quality Governance Associate for NHSI has supported the Trust with a review of Governance processes.* • *A series of unplanned and planned CQC inspections were undertaken between October 2017 and February 2018 and consisted of 12 separate visits. This included a Well Led Inspection on 12-13th Dec 2017. Five core services at our hospitals were inspected in total.* • *The final report was published on 9th March 2018.* • *The Trust's overall position remained as 'Requires Improvement' however, the report identifies 'significant and sustained improvement throughout*

	the Trust' since the last inspection report in 2015. *Key highlights:* • *Rated 'Good' in over two thirds of the CQC standards across the five core services that were inspected – a significant increase from less than a third in 2015.* • *All inspected services rated 'Good' in the caring domain.* • *No individual standards rated 'Inadequate', compared to six in 2015.* • *Examples of outstanding practice noted in urgent and emergency care, surgery, critical care services and services for children and young people.* • *The Trust's Well Led rating significantly improved from `inadequate' to `good'* • *17 recommendations were made by the CQC compared with 52 'should do's' and 18 'must do's' in 2015 – a substantial difference* • *No 'must do's' identified.*
• Develop a framework to report and monitor the incidence of harm affecting those with cognitive impairment (dementia).	• *Framework for reporting devised via the Dementia Strategy Group.* • *Incidents are identified via Datix and are made up of four categories; pressure damage, falls, aggression and other. Of the overall Trust reported incidents the table below represents those patients who had a diagnosis of dementia.*  • *A total of 129 incidents were reported for dementia patients, of these 13 were due to pressure damage; 82 due to falls; 15 due to aggression and 19 due to other.*  • *Of note is that falls continue to be the main cause of incidents for patients with dementia. There was a rise in aggressive incidents in Quarter 4 due to 2 particularly challenging patients.*

Clinical Effectiveness

Aim/Goal

To improve the management of patient flow

Action	Update
• Avoiding unnecessary admissions to hospital through the increased use of ambulatory pathways of care for patients who attend our emergency departments. ○ Increase of specialities available on the ambulatory pathway model. • Development of frailty units on both the Tunbridge Wells and Maidstone hospital sites.	• *Ambulatory pathways in place.* • *Following a 4 week intensive project at TWH, the Ambulatory Emergency Care (AEC) bay opened on the Acute Medical Unit (AMU) on Thursday 14th December, accepting all non-elective ambulatory patients. This has provided 4 spaces which have been configured as 3 trolleys and 3 chairs. In addition the Ambulatory (Amb) score (identifying suitable ambulatory patients) has been embedded into ED at TWH and is recorded on Symphony. This allows visibility of suitable patients in ED and in AMU. AMU nurses and doctors have been very proactive in improving patient flow to the AEC bay on AMU. This was supported by the introduction of the nurse led service answering GP phone calls with GP referrals from 20th December. Despite considerable pressures over the Christmas bank holidays, the AEC bay has remained de-escalated and continues to improve the patient flow from ED.* • *Acute Frailty Unit for Maidstone site opened June, 2017. Working with clinicians to develop Frailty pathways on W2 at TW with the lead clinician. Capacity and staffing challenges have prevented the opening of a full Frailty Unit at this stage (see pg 75 for further details).* • *Acute Frailty Unit for Tunbridge Wells opened March 2018.*
• Work with our mental health partners to reduce the frequency of patients in crisis attending our emergency departments. ○ As part of the national CQUIN we aim to improve the pathways of care for patients with mental health needs by reducing the frequency of these attendances by 20%.	• *Multi-Agency Project Group has been established with attendance from KMPT, SECAmb, Mental health Liaison (CCG funded) and MTW.* • *Individualised care plans developed with those identified in selected cohort.* • *Regular review of patient list to ensure that those who are no longer attending are investigated and for those attending more frequently that their plan of care is reviewed.* • *For year end 17/18 a 43% reduction in attendances was reported for the 25 patients, who had been identified, who would most benefit from a targeted multi-professional approach of their health needs.*
• Improved access to ring-fenced beds for Stroke and fractured neck of femur patients. ○ We will work with the speciality leads	*The indicators shown below are based on real-time data entry. Please note that these are not official results and may be different from official calculations in RCP SSNAP reporting.*

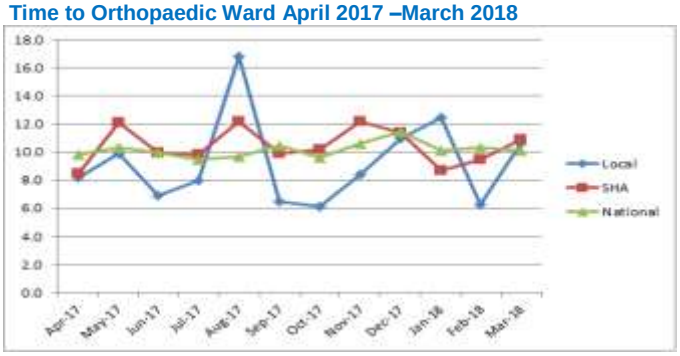
for both Stroke and Hip Fracture pathways of care to make sustained improvements in the national key performance indicators for each speciality and improve the standards of care.

Time to Stroke Unit- April to March 2018 (Target within 4 hrs)

	Time (hours)			
	Site		Average	
Month	MGH	TWH	Trust	National
Apr-17	3hrs 26mins	3hrs 52mins	3hrs 39mins	3hrs 47mins
May-17	3hrs 6mins	4hrs 1min	3hrs 34mins	3hrs 47mins
Jun-17	2hrs 50mins	3hrs 51mins	3hrs 21mins	3hrs 47mins
July-17	4hrs 54mins	13hrs 30mins	9hrs 13mins	3hrs 31mins
Aug-17	3hrs 50mins	7hrs 28mins	5hrs 39mins	3hrs 31mins
Sept-17	6hrs 14mins	16hrs 39mins	11hrs 27mins	3hrs 31mins
Oct-17	6hrs 8mins	8hrs 15mins	7hrs 12mins	3hrs 31mins
Nov-17	10hrs 11mins	15hrs 39mins	12hrs 75mins	3hrs 31 mins
Dec-17	8hrs 21mins	12hrs 30mins	10hrs 25mins	3hrs 31mins
Jan-18	4hrs 26mins	4hrs 58mins	4hrs 42mins	Not available
Feb-18	4hrs 4mins	4hrs 23mins	4hrs 43mins	Not available
Mar-18	4hrs 32mins	4hrs 54mins	4hrs 43mins	Not available

Although we have failed to meet the 4hr target consistently since July, this is not dissimilar to the National picture re increase in attendances to A&E. Since January, 2018 a culmination of other admission advoidance and discharge pathways are beginning to take affect to improve this picture. Despite this delay the plan of care is continued as per protocol.

Time to Orthopaedic Ward April 2017 –March 2018



Admission to the Orthopaedic unit at TWH has also been challenged during the course of the year and follows a similar pattern to Stroke (TWH site only) with 6hrs being the earliest timeframe for admission. As with Stroke patients every effort is made to deliver the standard pathway of care during this time.

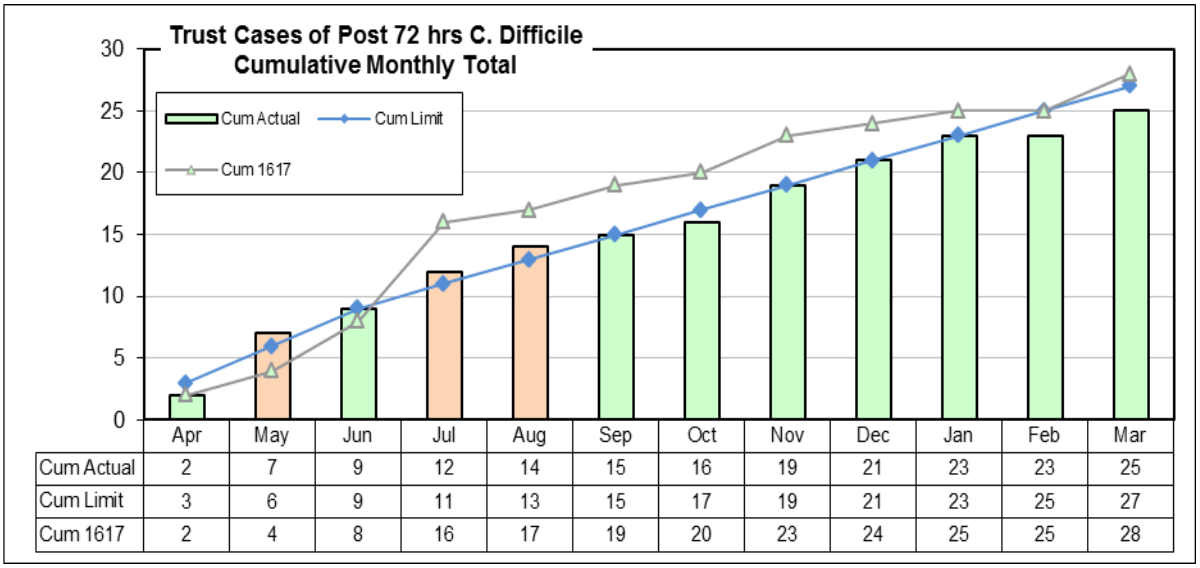
- Development of pathways that will support the timely discharge of patients.
  - To work in partnership with our Community Trust and Social care partners to develop alternative models of care for our patients.
  - To improve the percentage of non-elective patients over 65 who return to

- *Collaboration with KCHFT to support the timely discharge of patients back into primary care.*
- *Delayed Transfers of Care – Q1 5.9%; Q2 5.1%; Q3 5.2%; Q4 4.95% (national average is 3.5%).*
- *Establishment of 'Home First' Model which consists of 3 pathways:-*
  - *Pathway 1 – focuses on discharging the patient home with an emphasis on enablement and*

their original place of residence by 2.5%.	*independence now fully operational on both sites, capacity to take 47 patients per week who need care at home.* ○ *Pathway 2 – aimed at those needing ongoing rehabilitation in an inpatient setting before going home- using 12 beds at Tonbridge Cottage hospital to focus on patients who need therapy but no nursing care.* ○ *Pathway 3- for individuals who are likely to require ongoing long-term care, probably in a care home. Proof of concept completed and now agreed to full scale trial.* • *Work with local borough councils to establish a housing and health role to assist patients with housing needs, tenure neutral. This includes those who are homeless.* • *Baseline for 17/18 was 70% therefore the target was set at 72.5%; Year-End achieved at 77.3%.* • *Readmission rate for patients discharged home is also reducing – from 25.23% baseline period 2016/17 to 23.33% 2017/18.*

Review of Quality Performance

Infection Control – Clostridium Difficile cases – The Trust achieved this standard with 25 cases against a maximum of 27 cases for the year equating to a rate of 9.5 CDifficile Case per 100,000 occupied bed days.

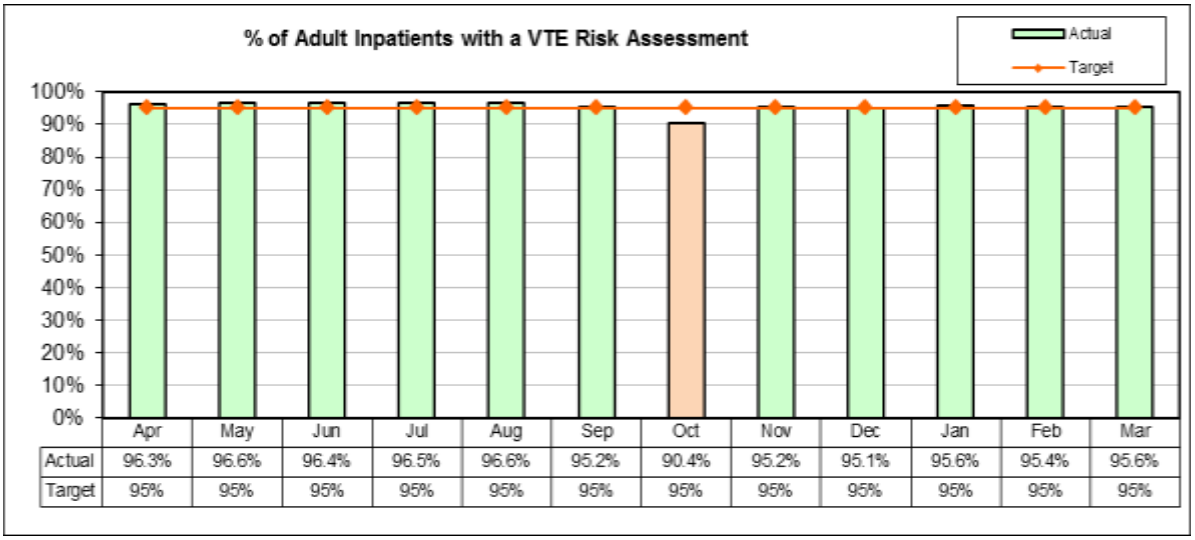


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	2	7	9	12	14	15	16	19	21	23	23	25
Cum Limit	3	6	9	11	13	15	17	19	21	23	25	27
Cum 1617	2	4	8	16	17	19	20	23	24	25	25	28

Infection Control – MRSA Bacteraemia cases – The Trust achieved the standard with zero cases of post 48 hr MRSA bacteraemia through the year.

Prevention of blood clots or venous thromboembolism (VTE)

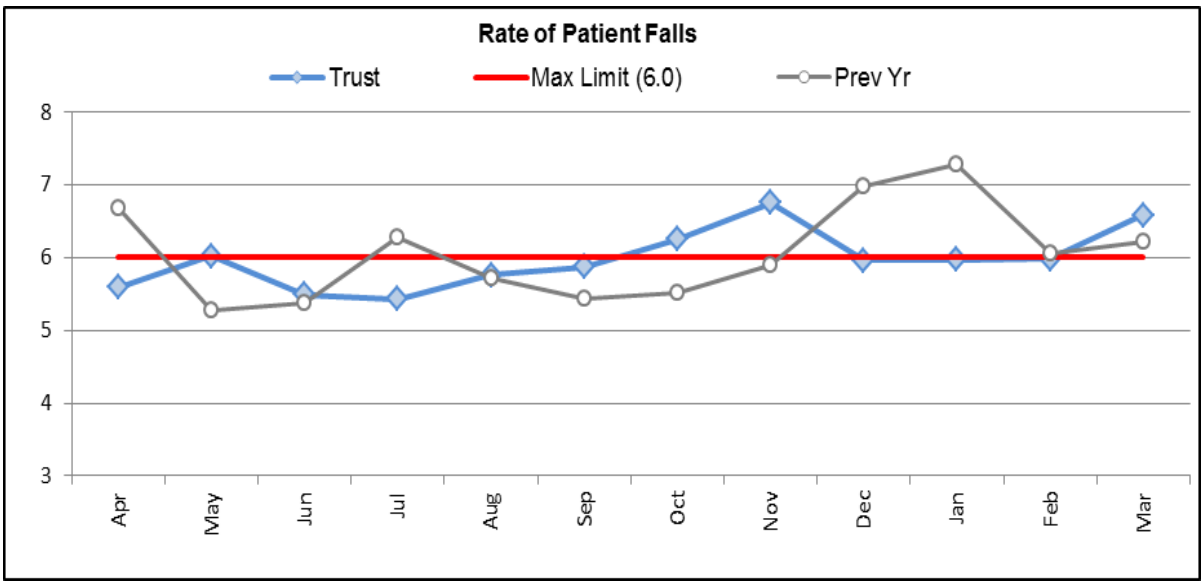
% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2017-18 at 95.4%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	96.3%	96.6%	96.4%	96.5%	96.6%	95.2%	90.4%	95.2%	95.1%	95.6%	95.4%	95.6%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

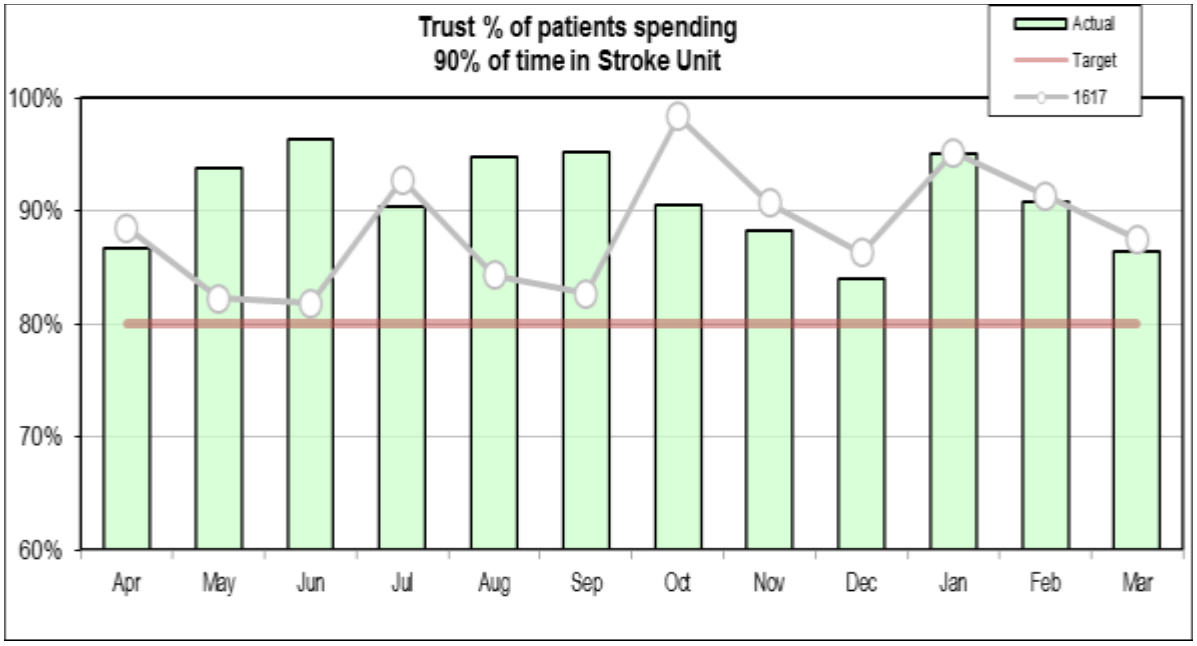
Reducing the number of patient falls

Rate of Falls – The Trusts' rate of Falls per 1,000 Occupied Bed days is below the Trust maximum limit of 6.0 at 5.98 at year end (6.07 for the previous year).



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

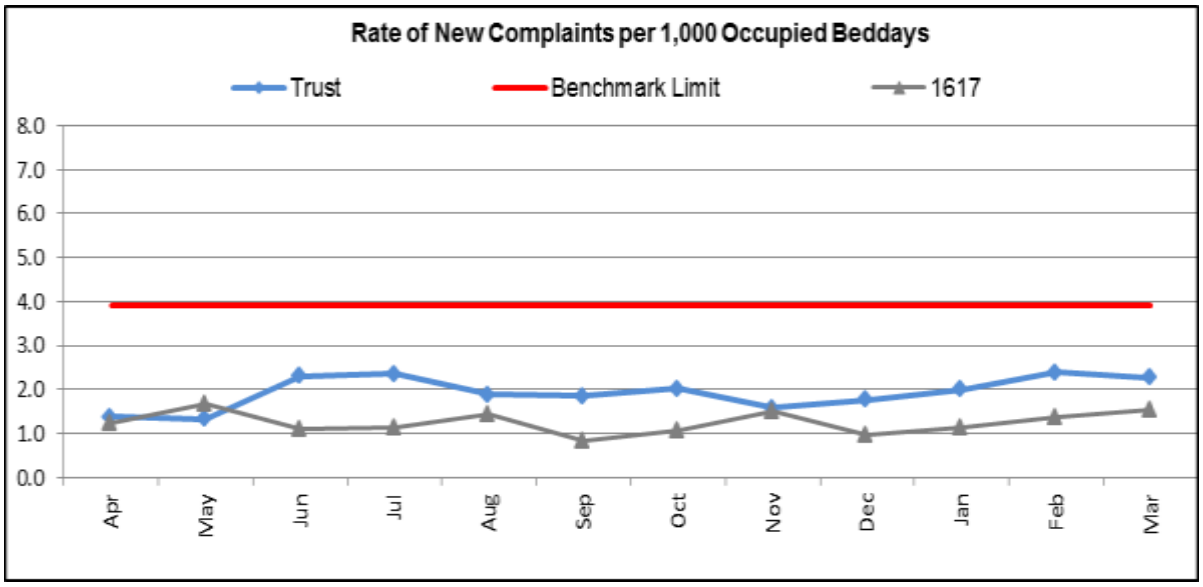
80% of patients spending 90% of time on the Stroke Unit - The Trust achieved this standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2017-18 at 91.08% compared to 88.5% in 2016-17.



PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 episodes is within the expected range of between 1.318 and 3.92 at 1.93 for the year (2.47 for the previous year).



Complaints report summary

(Regulation 18 of the Local Authority, Social Services and NHS Complaints (England Regulations 2009).

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

QUOTE: *Following our meeting on Wednesday, 11th October, 2017, I will begin by expressing that I felt our concerns over the nursing care of our Mother…….whilst a patient with you, were accurately listened to and we were shown sincere empathy.*

Complainant

During 2017/18 we received 503 new complaints compared to 332 during 2016/17. The rate of complaints per 1,000 occupied bed-days was 1.93 for the year (lowest/highest decile range of 1.32 to 3.92). It is our aim to investigate and provide a full response to all formal complaints within an agreed timeframe of either 25 or 60 working days of the complaint being received, depending on the severity of the complaint. We responded to 60.2% of complaints within the agreed timescale against a target of 75%. Meeting our target has been challenging this year due to a combination of recruitment challenges within the central complaints team and significant and sustained levels of operational activity, resulting in prioritisation of the delivery of clinical care over other responsibilities. We are confident in our complaints handling approach; however we recognise that complaints requires greater focus within the clinical directorate teams in order to improve our response times and meet the expected standards in 2018/19.

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

Patient Surveys

NHS Surveys
Focused on patients' experience

National Patient Surveys

During 2017 the Trust undertook three National Surveys. Although they are led by Picker Europe and the CQC we have been undertaking these in house. The surveys include the following:

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

The Maternity Department survey previously was undertaken on a bi-annual basis, the last audit performed prior to 2017 was in 2015. The 2017 results were published on the CQC website on the 30th January 2018. The Children and Young Persons Survey was a further survey added to the NHS Patient experience survey programme. The results were published on the CQC website on the 28th November 2017. The Inpatient Survey is run on an annual basis. The data was submitted to CQC/Pickers Europe in January 2018 and the results are yet to be published. Responses to these questions are also regularly collected as part of our local patient survey and the corresponding actions plans are monitored by the Patient Experience Committee.

Adult Inpatient Survey 2016

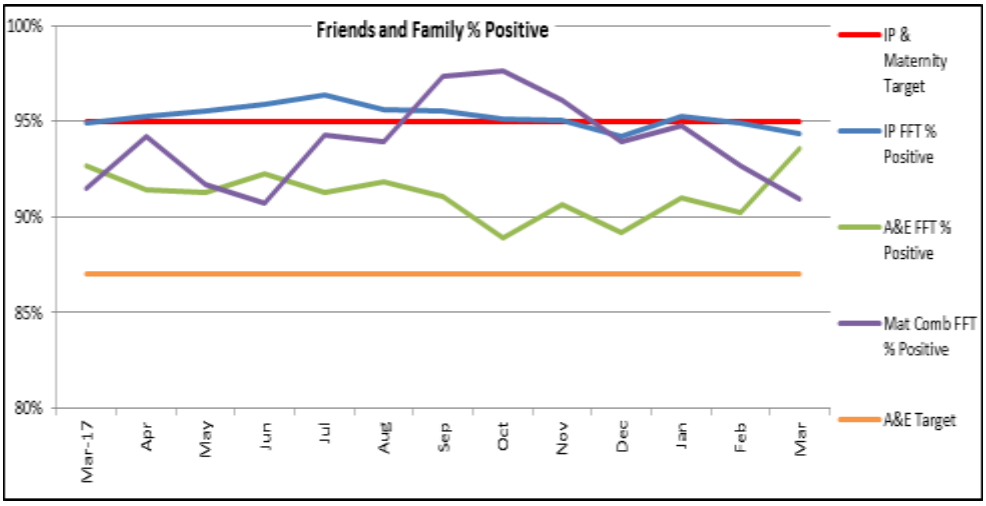
Focus questions from National Inpatient Survey		National Inpatient Survey	Local Survey	Local Survey
		2016	2016/17	2017/18
1	Were you involved as much as you wanted to be in decisions about your care and treatment?	91.0%	88.0%	89.0%
2	Did you find someone on the hospital staff to talk to about your worries and fears?	47.7%	92.0%	94.0%
3	Were you given enough privacy when discussing your condition or treatment	92.8%	96.0%	97.0%
4	Did a member of staff tell you about medication side-effects to watch for when you went home?	39.4%	80.0%	85.0%
5	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	66.3%	87.0%	87.0%

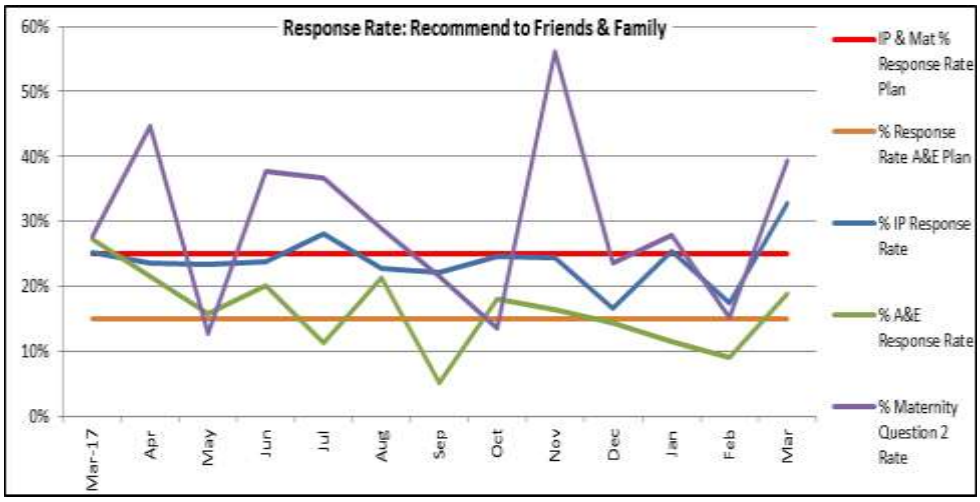
Friends and Family

The Inpatient and A&E positive response rates (95.3%, 91.2% respectively) have exceeded the Trust plan indicating that patients would recommend the Trust to their Friends and Family. However the Inpatient positive response rate narrowly missed the national benchmark of 95.8% at 95.3%. Maternity did not meet either the Trust target of 95% or the national benchmark of 95.6% at 93.9%.

Maternity and A&E response rates however both exceeded the planned Trust rate and the national benchmarks at 29.5% and 15.3% respectively, whereas the Inpatient response rate did not achieve either at 23.9%.

MTW Friends and Family scoring





Staff Survey 2017

This section outlines our most recent staff survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that the Trust provides equal opportunities for career progression 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 26% which is a 1% increase from the 2016 survey findings and is 1% higher than the National 2017 average for acute Trusts.

The unweighted scores for KF 25, 26 and 21 split between White and BME staff is as follows:
White 26% (2016 findings – 25%) (National average for acute Trusts – 25%)
BME 25% (2016 findings – 21%) (National average for acute Trusts – 27%)

KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.
This is reported at 90% which is the same as the 2016 survey findings and is 5% higher than the National 2017 average for acute Trusts.

The unweighted scores for KF21 split between White and BME staff is as follows:
White 91% (2016 findings – 89%) (National average for acute Trusts – 87%)
BME 78% (2016 findings – 91%) (National average for acute Trusts – 75%)

NHS National Staff Survey Actions
One of the key findings from the 2017 NHS National Staff Survey is an increase in the reports of staff experiencing harassment, bullying or abuse from patients and the public. This is reflected in the Trust's action plan which sets to launch a Zero Tolerance campaign with visible signage around the Trust sites, action warnings and provision of support for staff. Alongside this will be the publishing of reporting mechanisms including the use of Freedom to Speak Up Guardians, staff networks and champions.

Workforce Race Equality Standard (WRES)
The WRES for 2017 was published in July along with an action plan which is overseen by the Cultural Diversity Network and progress reported to the Workforce Committee. The action plan focuses on recruitment which includes ensuring a positive inclusion statement is seen in all MTW job advertisements, unconscious bias training is built into the recruitment training programme and a review of selected recruitment outcomes occurs annually to ensure fair process. In addition, a review of selected disciplinary cases has been undertaken which shows evidence of fair process in all decisions.

Cultural Diversity Network
A range of activities marked the launch of the Trust's Cultural Diversity Network in June 2017. The Trust hosted talks from NHS Employers, which prompted discussion about what diversity means to individuals, a powerful and poignant talk from a senior member of staff about resilience and a panel consisting of staff, the NHS Leadership Academy and NHS Digital which profiled cultural differences and inclusion within the NHS. Periodically during the year, the Network produces articles relating to belief and religious festivals including "12 days of Christmas – a look at how Christmas is celebrated by different cultures", Chinese New Year, Diwali, Easter, Ramadan and May Day.

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 (SI's) centrally to a national system and identify trends and themes to help reduce risks going forward.

All SI's are assigned a lead investigator or reviewer independent of the area where the event occurred and undergo a root cause analysis using recognised investigative tools. Action plans are developed to share learning across the organisation to prevent a similar event occurring. All SI's 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 173 SI's in 2017/2018 compared to 100 the previous year.

Although there has been an increase in the number of SI's being reported during 2017/18, we have attributed a proportion of these to changes in the National agenda ie the Early Notification Scheme for Maternity and Learning from Deaths. In addition we also believe that the SI investigatory process has matured to an extent where a fair and transparent process is evident to both our patients and staff supporting them to raise appropriate concerns that warrant further investigation.

As a result of the 173 SI's declared, 23 were subsequently downgraded following completion of the investigation. It was identified that there was no significant learning for the Trust and all appropriate actions were already in place. These cases were discussed with the West Kent Clinical Commissioning Group Quality Leads who substantiated our findings that these cases no longer met the SI criteria. This has reduced our total incidents reported down to 150 during 2017/18. This number has the potential to reduce further as we continue to investigate those that remain open.

Actions and learning from SI's are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2017/2018 learning and actions included:-

- Revision of the WHO safety checklist to include:-
    - a section for anaesthesia; 'Stop Before You Block'.
    - Central Venous Access (CVA) line insertions.
    - clarification and a change of wording to make explicit the number of specimens with suitable descriptors.
- 'Stop Before You Block' to become mandatory practice.
- Revision of specimen standard operating procedure to include verbalisation of detached specimen by surgeon and recording of said specimen on practitioners swab count board.
- Relaunch of the Swab, Sharps and Instrument policy and procedure to ensure good communication to all theatre staff.
- Relaunch of the Sepsis policy and procedure, Screening and action plan in the Emergency Department.
- Standard Operating Procedure implemented for the delivery, receipt and supply of external prescriptions (FP10s).
- Education to all staff on the importance of incident reporting on Datix.
- Creation of the perfect Accident & Emergency assessment (CAS) card to include:-
    - amendments to the prescription section and time at which medication is prescribed.
    - column to record the time of initial observations.
- Training for staff on the Gap and Grow pathway.
- Review of capacity for scanning and creation of additional scanning slots.

- Development of a clear pathway for scans required within 72 hours.
- Review of the Standard Operating Procedure for the Birth Centre to ensure allocation of substantive staff during periods of short notice vacancies.
- Training on 'informed consent'.
- Importance of quality communication between teams.
- Importance of the quality of documentation in the patients records.

the 173 SI's declared in which the investigations had completed, it was identified that there was no significant learning for the Trust and all appropriate actions were already in place for 23 of these. These cases were discussed with the West Kent Clinical Commissioning Group Quality Leads who substantiated our findings that these cases no longer met the SI criteria. These were subsequently downgraded bringing our total incidents reported down to 150 during 2017/18. This number has the potential to reduce further as we continue to investigate those that remain open.

Never Events

There were 4 Never Events during 2017/2018, a full root cause analysis was undertaken and presented to the Executive led panel and findings shared with NHS Improvement to ensure wider learning.

The first Never Event was identified in October 2017 – Wrong side shoulder nerve block
A patient was admitted for a sub-acromial decompression and arthroscopy on their ***left*** shoulder. The patient had been previously seen for pre-assessment checks and advised of the risks and benefits. The surgical site was marked appropriately as part of the pre-operative checks and the patient was subsequently induced for Anaesthesia. Following this a ***right*** sided interscalene nerve block was performed.

A number of factors contributed to this incident:-

- The anaesthetic chart was not completed at the same time as the patient was assessed prior to their surgery, this was recorded afterwards and there was a reliance on memory. Subsequently the patient's notes were marked with the incorrect side.
- The marking of the surgical site (upper forearm) was not visible at the time of the block having been covered up by the patient's gown.
- The anaesthetist performing the block was not present at the time of the WHO surgical checklist procedure and there was no formal 'Stop Before You Block' check prior to the regional block being administered.

The second Never Event was identified in November 2017 – Retained swab
The patient was admitted for an elective right hemicolectomy and defunctioning loop ileostomy for Crohn's disease at Maidstone Hospital in August 2017 under the care of the Lower Gastrointestinal team. He later attended an outpatient appointment during October 2017 to discuss a reversal of the ileostomy and underwent a CT scan which highlighted that in the right upper quadrant some dense material could be seen. This was discussed with the patient and he was booked for a closure of ileostomy and removal of foreign body in November 2017. During this procedure the dense material in the patient's abdomen was found to be a retained swab.

The contributing factors were:-

- The challenge of the initial surgery due to the longstanding history of Crohns having unsuccessfully tried various courses of medication.
- Lack of consistency in performing the swab counts with several circulating practitioners participating with the scrub practitioner. Compounded by the lack of consideration given to the fact that the second theatre practitioner was scrubbing for the next case and would

need to leave the theatre early.
- 3 x 4 swabs do not have tags sewn into them so they cannot be clipped onto the sterile field as a precautionary measure.
- A clear plastic bag was used for the countdown of the swabs leaving the sterile field, difficulty in clarifying the number of swabs in each bag, challenge of checking number once initial count performed.

The third Never Event was identified in January 2018 – Medication Incident
Currently under investigation, the details known to date include:-
- Administration of oral oxycodone via a subcutaneous syringe driver rather than injectable oxycodone.

Actions immediately taken:-
- Duty of candour - apology given to relatives.
- Staff members concerned supported via Practice Development Nurse and line manager.
- Reflective accounts undertaken.

The fourth Never Event was identified in January 2018 – Patient underwent wrong procedure
Currently under investigation, the details known to date include:-
- Patient was consented for a flexible sigmoidoscopy using consent form 4 (for adults who are unable to consent to investigation or treatment).
- Patient underwent an oesphago-gastro duodenoscopy (OGD).
- Wrong procedure was identified by the ward on handover from endoscopy staff.

Actions immediately taken:-
- Duty of candour - apology given to relatives.
- Memo sent to all endoscopy staff highlighting issue and extra vigilance with checking procedures.

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.

Serious Incidents
173 Serious Incidents were declared in 2017/18.

During this financial year, we have demonstrated a decreased compliance with the 3 elements of meeting Duty of Candour for patients involved in a Serious Incident (SI).

According to our current database 17.4% of patients involved in a SI did not receive an initial Duty of Candour letter in 2017/18 compared to 10% the previous year.

At the time of this report, 15% of the declared SI's remained open and under investigation. Of the 85% that were closed, 48.9% have been sent the final outcomes of the investigation. This is

compared to 55% compliance during 2016/17 and means that communicating the outcome of the investigation to the relevant person has also demonstrated a decrease in compliance.

Incidents
Excluding Serious Incidents, 294 incidents were reported on the incident reporting system which also met the criteria for Duty of Candour. 44% of these had evidence that an initial Duty of Candour letter was sent to the patient / relevant person. Of these 44%, 54.6% were within the 10 day standard. At present, we are not able to ascertain the number of verbal apologies or shared outcome of investigations that have occurred as there is presently no reliable way of capturing this data.

Actions for 2018/19 to achieve compliance
In addition to Root Cause Analysis training sessions arranged for 2018, we are reviewing the education required for departmental managers and will be launching a revised training agenda.

A review of all initial letters by the central team in terms of quality whilst ensuring that the standard meets the level of compliance required. The central team will also ensure that there is an identified person and relevant address to support communication of the outcome of that investigation.

Dedicated time has also been established to concentrate on these levels of incidents which meet the Duty of Candour criteria in order to improve compliance with these requirements.

Engagement is being sought with our database administrators to look at the incident reporting system as a repository for the evidence for Duty of Candour and also to look at the possibility of flagging the incidents which meet the criteria.

A quarterly report will be implemented during 2018/19 to help support improvement with monitoring and provide assurance to the Trust Clinical Governance Committee.

Duty of Candour training will also be revisited to ensure that the maximum number of staff requirements can be met through a variety of approaches, both formal and informal.

Seven Day Services- 7DS

The national Seven Day Services Programme (7DS) is designed to ensure that patients who are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh which involved a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges on consultant-delivered acute care. These standards define what seven day services should achieve, no matter when or where patients are admitted.

The aim is to deliver a faster diagnosis to patients, faster diagnostic testing and for patients to spend less time in hospital. The standards focus upon the time between the patient's admission to hospital and their first review by a Consultant, the timing of consultant-led ward rounds, the protocols and arrangements that must be in place for patients who do not require consultant-delivered care, standards regarding the timing of diagnostic tests, and other standards covering patient experience and quality, the content and timing of shift handovers, the involvement of the multidisciplinary team and some standards for primary, community and mental health provider colleagues. Four of these standards were designated as priority standards. These are the minimum set of clinical standards needed to tackle variation in mortality, patient flow and

experience and focus mainly on the consultant-delivered and diagnostic aspects of the standards outlined above.

MTW has a mature project in place to oversee the implementation of the 10 National Clinical Standards and during 2017/18 the project team have:-

- Forged formal links with the national team.
- Engaged a lead from West Kent CCG.
- Identified the CCG's monitoring requirements and submitted monthy reports.
- Created and regularly updated the MTW 7DS programme plan.
- Completed the National survey – September 2017.
- Met compliance for the 4 priority standards in both Ophthalmology and Children's services.
- Instigated an evening Ward Round in Orthopaedics.

Preparation is underway for the next round of auditing, the results of which will help inform the further development of the action plan and team objectives. Regular updates are provided to the Trust Management Executive which monitors and supports the project's schedule for delivery.

Learning from Deaths

Following guidance published by the National Quality Board (NQB) in March 2017 and the CQC (Learning, Candour and accountability Report) in December 2016, a Learning from Deaths Review Group was established. Its purpose was to oversee and support the key deliverables of the Mortality Surveillance Group, thereby ensuring that a robust process was established to review each death attributable to MTW.

The key deliverables of the Learning from Deaths Review group included:-

- Introduction of a Revised Policy & Procedure for undertaking Mortality Case record reviews.
- Revision of the mortality review documentation in line with recommendations from the Royal College of Physicians.
- Establish a reporting process and structure.
- Production of a Duty of Candour patient information leaflet.
- Review of the trust Mortality review database and potential for alternative solutions that would support the process to be timely and accessible.

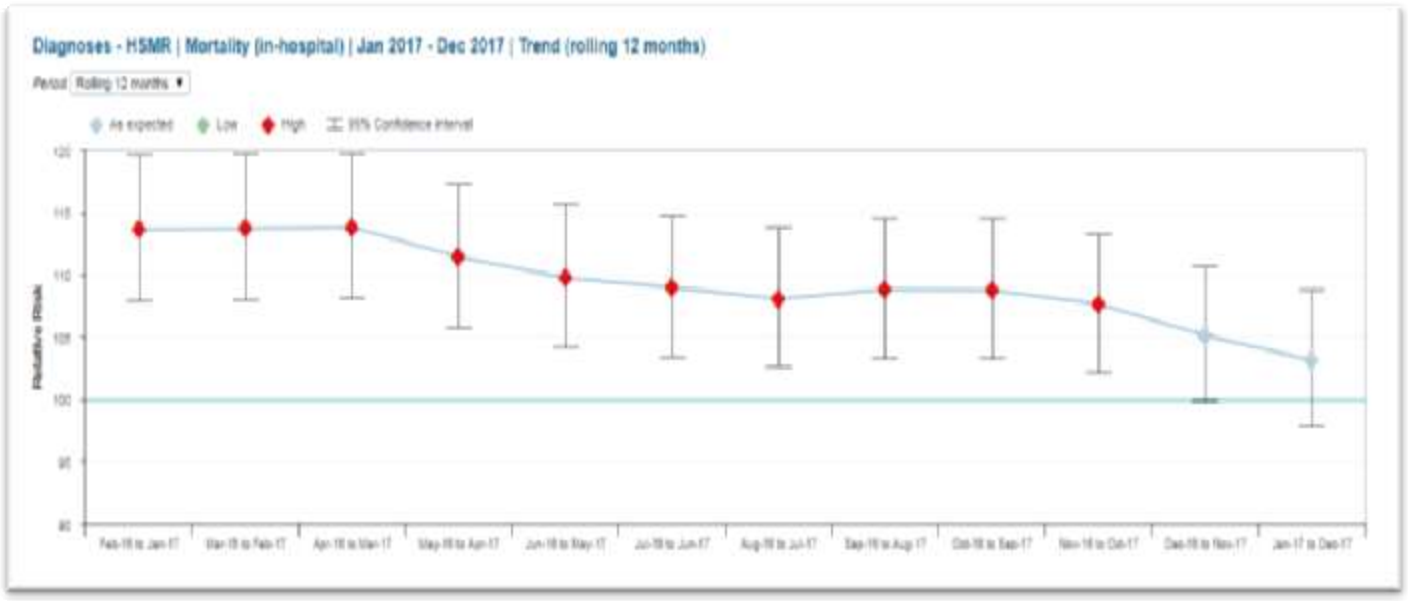
The Trust Mortality Surveillance Group (MSG) has been in place since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning.

The MSG reports bi-monthly to the Trust Clinical Governance Committee and in addition regular reports are submitted to the Quality committee and Trust Board. The chair of this Group is the Deputy Medical Director.

The MSG closely monitors both local and national data and interrogates these to identify themes and trends that may be impacting upon our patient care. In particular we use the Hospital Standardised Mortality Rate (HSMR). This is a key indicator that compares us with our peers. When tracked over time the HSMR can indicate how successful a hospital has been in reducing deaths and improving care. In April 2017 our HSMR was recorded as 110 (a ratio of the actual number of deaths to the expected number of deaths) and in March we reported 103.1, the expected rate is 100 or below.

2 May 2017, via email (excerpt): … My father sadly died today following a 4 week hospital stay at Maidstone Hospital, initially on Pye Oliver and then ICU. We are very quick to criticise but not very good at praising those professionals that go above and beyond in the most difficult of situations. I would like to thank all the staff including critical care nurse Tanya, ICU staff and consultant,the ward sister on Pye Oliver and consultant Dr Barnardo who took time throughout my father's stay to keep us informed…

Rolling 12 Month view- data from January-December 2017.



During 2017/18 the MSG has reviewed several conditions that were red flagged by Dr Foster as outliers against our peers. These included Fractured Neck of Femur; Pneumonia, Non-Hodgkins lymphoma and phlebitis. As a result of these audits actions taken include:-

- Opening of Theatre 6 at TWH. The audit revealed delays experienced by patients with hip fractures getting to surgery within 36-48hrs as per national guidance, this is known to negatively impact on mortality.
- Review of education for Junior doctors when completing death certificates. From the pneumonia audit there was recognition that in some cases this was not the most likely cause of death. As a result -
    - Training package was developed;
    - Inquest training day was arranged with support from the local Coroner;
    - Revised documentation made explicit that the Cause of Death must always be discussed with a Consultant or Registrar.
- Undertaking an audit of coded co-morbidities. As a result we have ensured that Senior coders review all deaths due to the complexities of order of codes required. This will ensure that the Charlson indicators are captured were appropriate. http://www.drfoster.com/wp-content/uploads/2014/09/HSMR_Toolkit_Version_9_July_2014.pdf pg 36.

Subsequent to these actions being taken these conditions no longer present with red flags.

In addition to monitoring national and local data the MSG also appraises the mortality reviews both in terms of compliance but also those reviews that warrant a more indepth investigation.

Each death that occurs in hospital is a sad and distressing event for the loved ones and staff involved in that person's care. For those deaths that are considered to be unexpected it is even more so. At MTW we recognise our responsibility to review the care that was provided to our patients and during September 2017 the methodology for these reviews was revised in line with national guidance (NQB) to follow a Structured Judgement Review (SJR) methodology endorsed by the Royal College of Physicians (RCP).

During 2017/18 MTW recorded 1858 patients who had died. 1732 inpatient (Inpt) deaths and 126 in Accident & Emergency (A&E). The revised process for undertaking mortality reviews was instigated in October 2017, at which point we moved from the old review system to the new. The previous process was labour intensive with a requirement for in depth reviews for all patients;

however there were low compliance rates. The findings from those reviews resulted in gradings of suboptimal or no suboptimal care (as demonstrated below). The new process involves a preliminary screen to determine those patients who require a more indepth review (SJR), the classification system previously used (Q1 & Q2) is no longer recorded, this transition is evident in the table below and reflected in Quarter 4*. The backlog in regard to reviews being undertaken is also demonstrated with new paperwork being completed for patients who had died in Quarter 2^.

Reporting Period April 2017 – March 2018

Maidstone & Tunbridge Wells NHS Trust	Q1	Q2	Q3	Q4	YTD
No of Deaths	448	396	470	544	1858
No of Completed Reviews	258	202	242	390	1092
%age completed reviews	**57.6%**	**51.0%**	**51.5%**	**71.7%**	**58.8%**
Unavoidable deaths, No Suboptimal Care	224	139	33	0*	396
Unavoidable Death, Suboptimal care	30	12	2	0*	44
Suboptimal care, possible Serious Incident	1	2	0	0*	3
Suboptimal care, a Serious Incident	1	0	0	0*	1
Unknown Classification	2	7	9	221	239
Preliminary Form Completed - SJR Not Requested	0^	23	96	61	180
Preliminary Form Completed - SJR Requested	0^	8	18	27	53
First Stage Review - SJR Not Requested	0^	9	67	66	142
First Stage Review - SJR Requested	0^	1	11	11	23
SJR Completed	0^	1	6	4	11
%age Unavoidable deaths, No Suboptimal Care	**87%**	**69%**	**14%**	**0%**	**36%**
%age Unavoidable Death, Suboptimal care	**12%**	**6%**	**1%**	**0%**	**4%**
%age Suboptimal care, possible Serious Incident	**0%**	**1%**	**0%**	**0%**	**0%**
%age Suboptimal care, a Serious Incident	**0%**	**0%**	**0%**	**0%**	**0%**
%age Preliminary Form Completed - SJR Not Requested	**0%**	**11%**	**40%**	**16%**	**16%**
%age Preliminary Form Completed - SJR Requested	**0%**	**4%**	**7%**	**7%**	**5%**
%age First Stage Review - SJR Not Requested	**0%**	**4%**	**28%**	**17%**	**13%**
%age First Stage Review - SJR Requested	**0%**	**0%**	**5%**	**3%**	**2%**
%age SJR Completed	**0%**	**0%**	**2%**	**1%**	**1%**

The purpose of the mortality review is to determine any death were it is considered that sub-optimal care has been provided, at which point the Serious Incident process is followed and Duty of Candour is instigated. This is an opportunity to then review our processes and procedures to make the necessary changes as a result of lessons learned.

During 2017/18 we identified 15 patients (0.8%) of the patient deaths who were judged to be more likely than not to have been due to problems in the care provided. In relation to each quarter this consisted of:-
2 representing 0.45% for the first quarter;
3 representing 0.76% for the second quarter;
6 representing 1.27% for the third quarter;
4 representing 0.74% for the fourth quarter.

Of the SJRs completed these deaths were considered to be:-
Probably avoidable x 1
Possibly avoidable but not very likely x 1
No evidence of avoidability x 5
Ungraded x 8
Subsequent to the release of the NQB Dashboards the RCP issued guidance that grading of deaths was not a requirement, at which point this practice ceased and is no longer collected.

In addition during 2017/18 221 reviews were undertaken between April – September 2017 which related to patients who had died in 2016/17. Of these 5 patient deaths were judged to be more likely than not to have been due to problems in the care provided to the patient

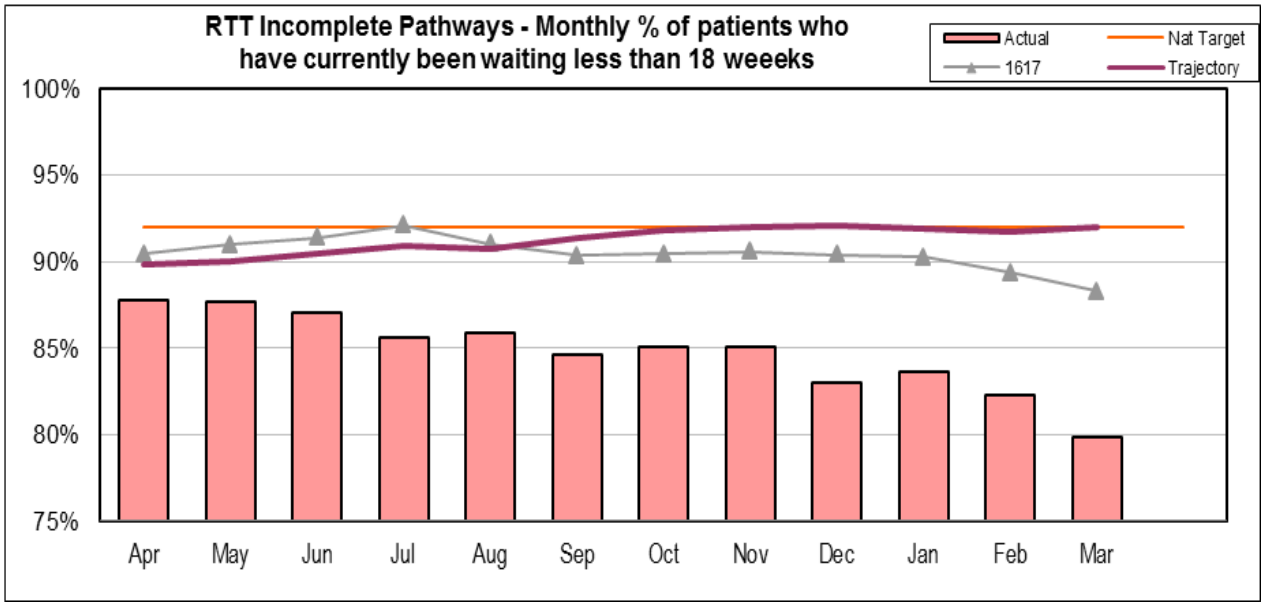
In an ongoing effort to improve the efficacy of the MSG and to learn lessons from the review process during 2017/18 we have:-

- Invited the local Dr Foster representative to attend our Mortality Surveillance Group to help us understand our data in more depth.
- Developed our own internal reporting framework for MSG to provide an integrated mortality report highlighting themes and trends for further investigation and assurances.
- Integrated Mortality Reviews with sub-optimal care with our Serious Incident process.
- Undertaken an external visit to a neighbouring acute trust to share information, processes and learning.
- Collaborated with Kings college hospital in the Amber Care Bundle research for Care of the dying patients.
- Benchmarking of our organisation with local trusts in regard to the coding list that is used to record co-morbidities to satisfy the requirements of Dr Foster.
- Local learning for Acute & Emergency medicine following declaration of SI following Mortality review:-
    - Revise the process for reviewing blood gases, local audit to be undertaken.
    - Frequency of observations, assurance required, local audit to be undertaken.
    - Adherence to VTE thromboprohylaxsis guidelines and raised awareness in regard to the need to escalate concerns and report on Datix.
- Local learning for specialist medicine following declaration of Serious Incident following mortality review:-
    - Guidance to be shared at clinical governance meeting re the potential for hiatus hernias to strangulate and rapidly deteriorate.

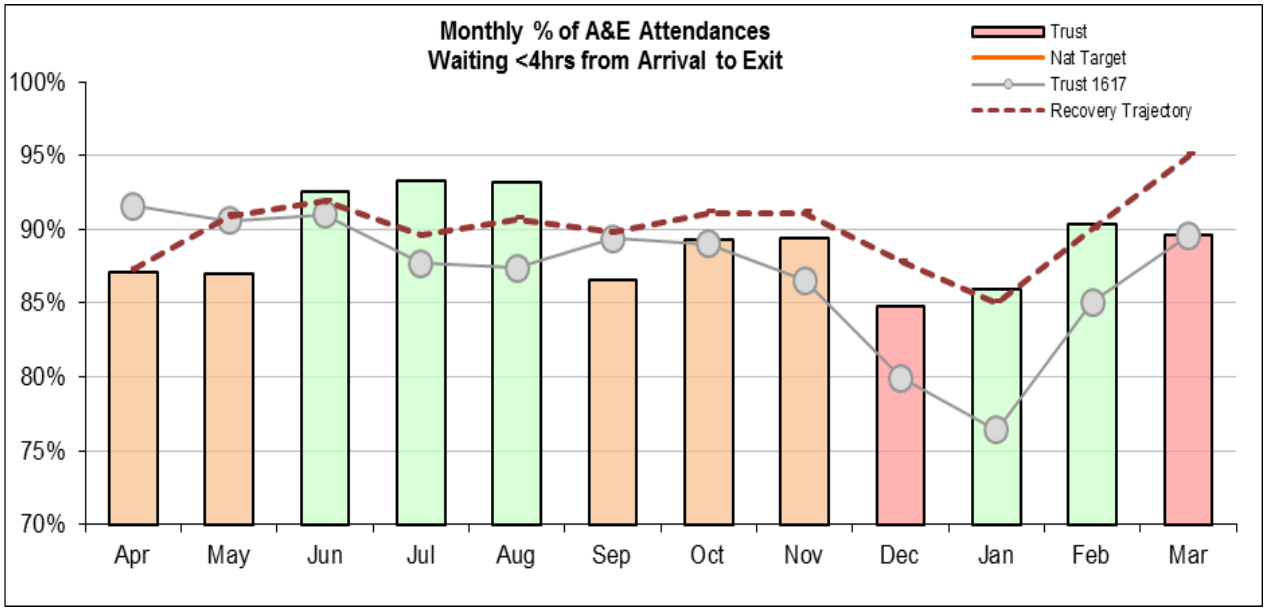
Other Quality Monitoring and Improvement Standard

The following Standards are reported to theTrust Board on a monthly basis with ongoing action approved.

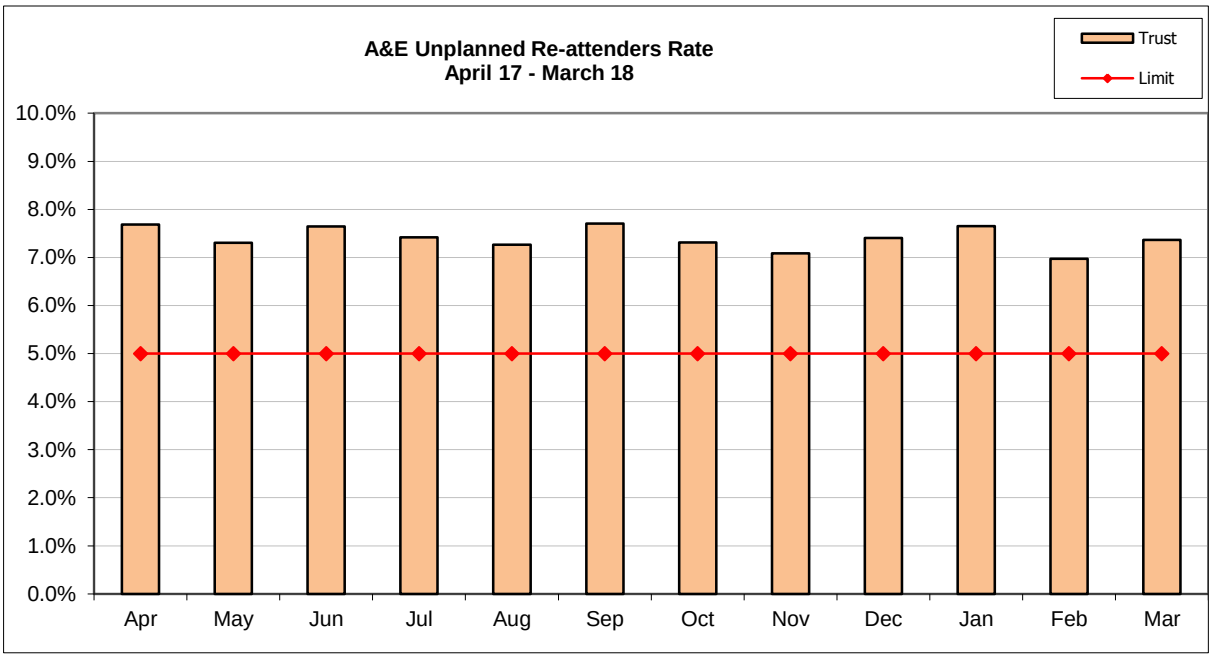
18 weeks standard – The Trust did not achieve this standard at an aggregate Trust level of at least 92% of patients on an Incomplete Pathway waiting less than 18 weeks.



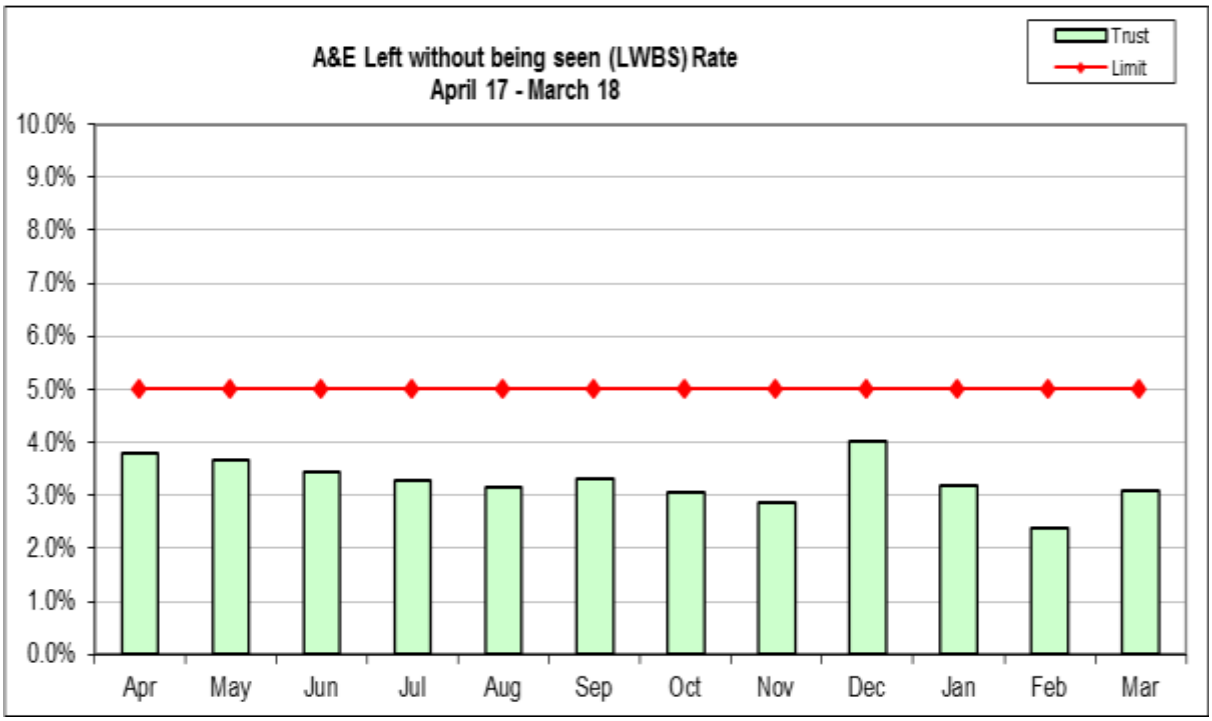
Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2017-18. However at 89.1%, this is a 2% improvement on 2016-17.



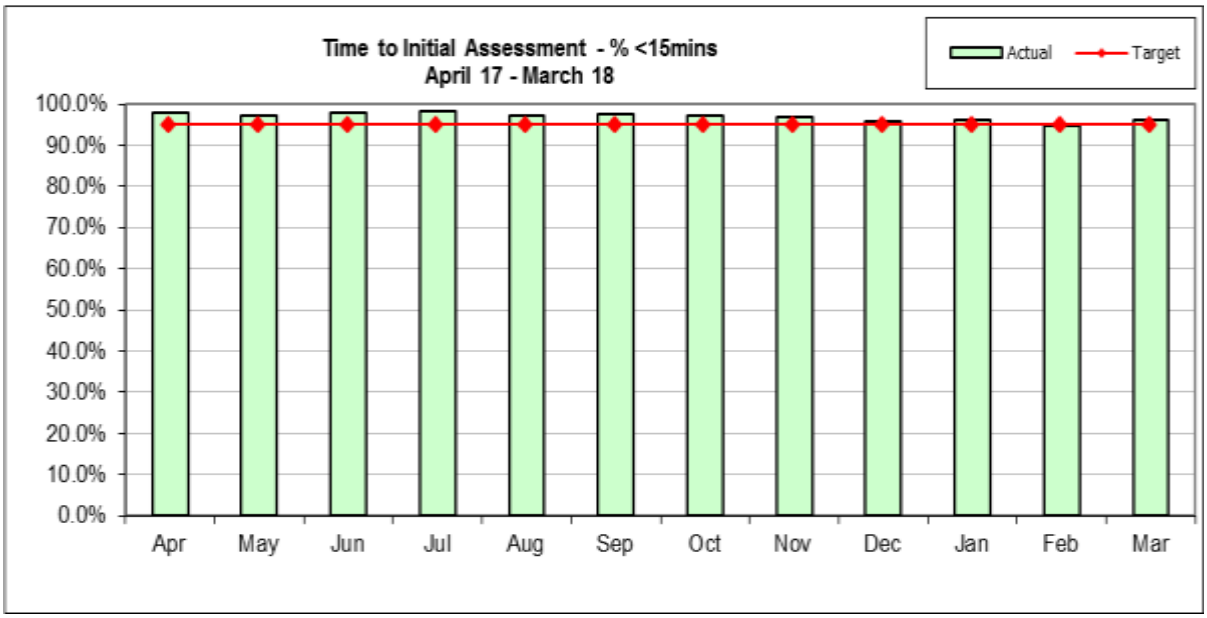
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 7.4%.



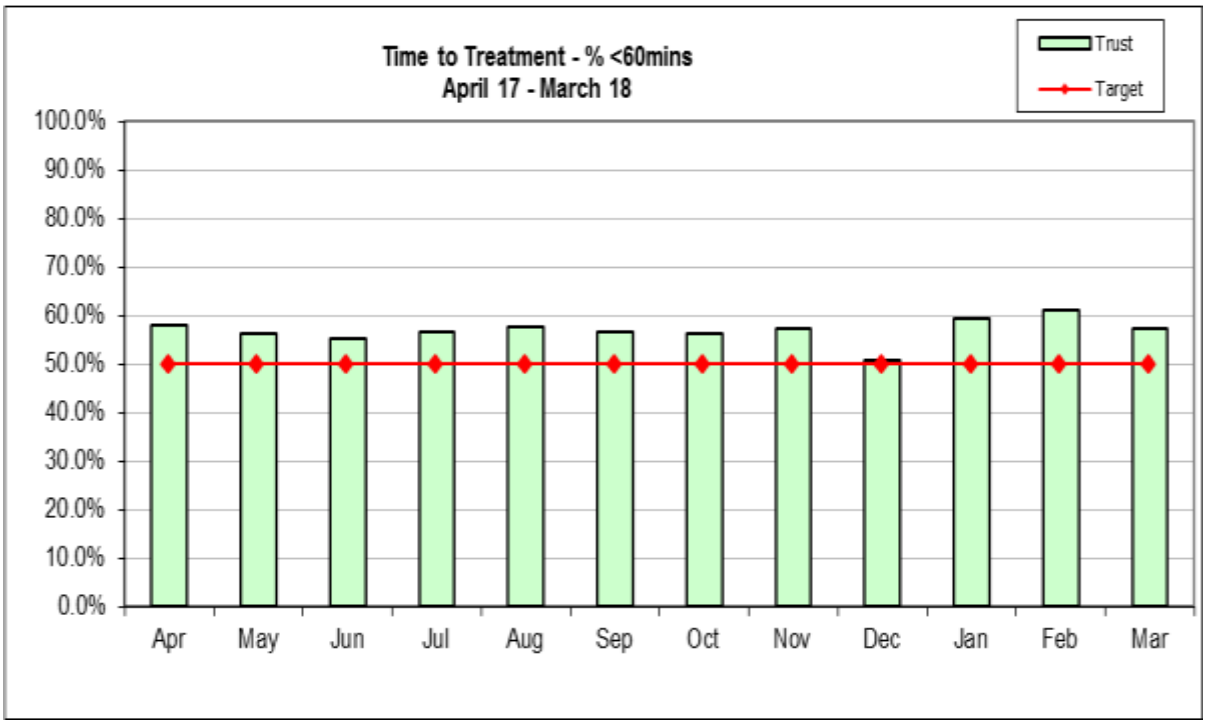
A&E Left without being Seen Rate – The Trust achieved this standard of less than 5% of patients leaving its A&E Departments without being seen.



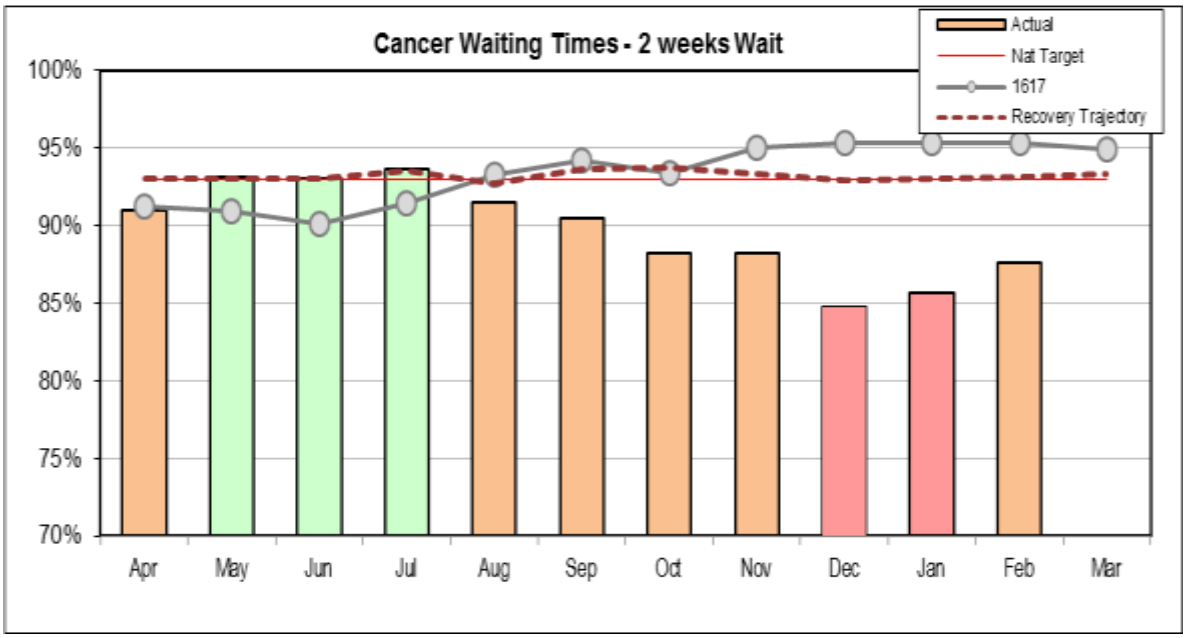
A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



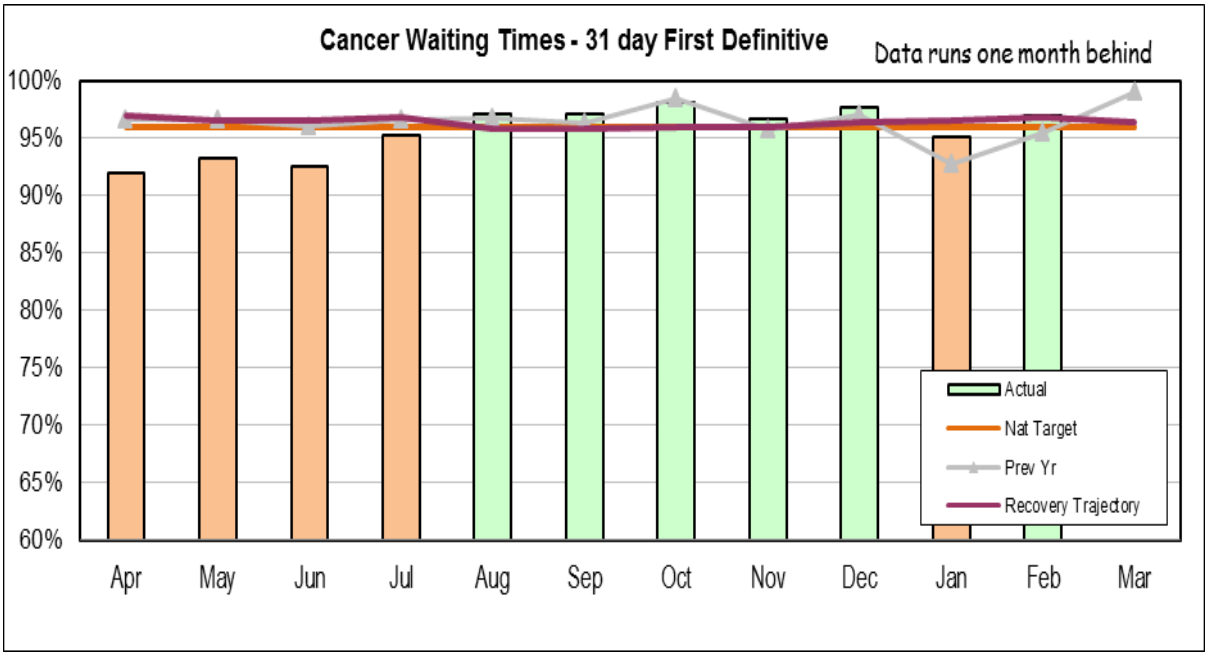
A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in it's A&E Departments being treated within 60 minutes of arrival at 56.8%. This is no improvement on last year.



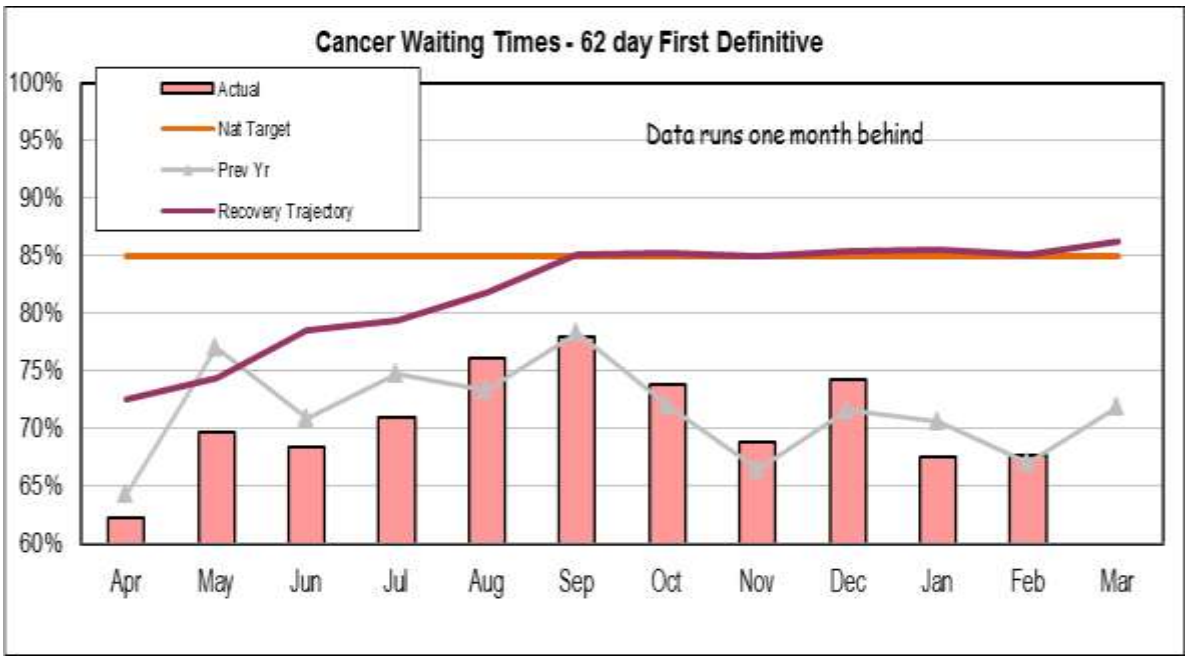
Cancer Waiting Time Targets - 2 weeks from referral – The Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



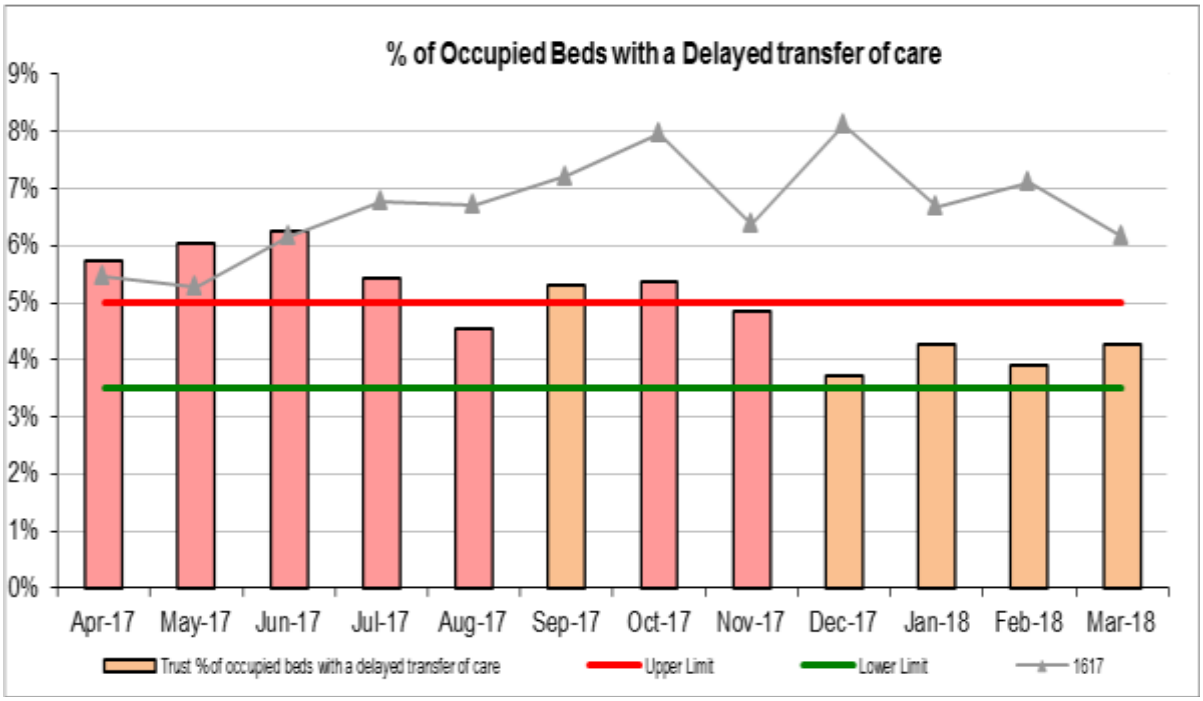
Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



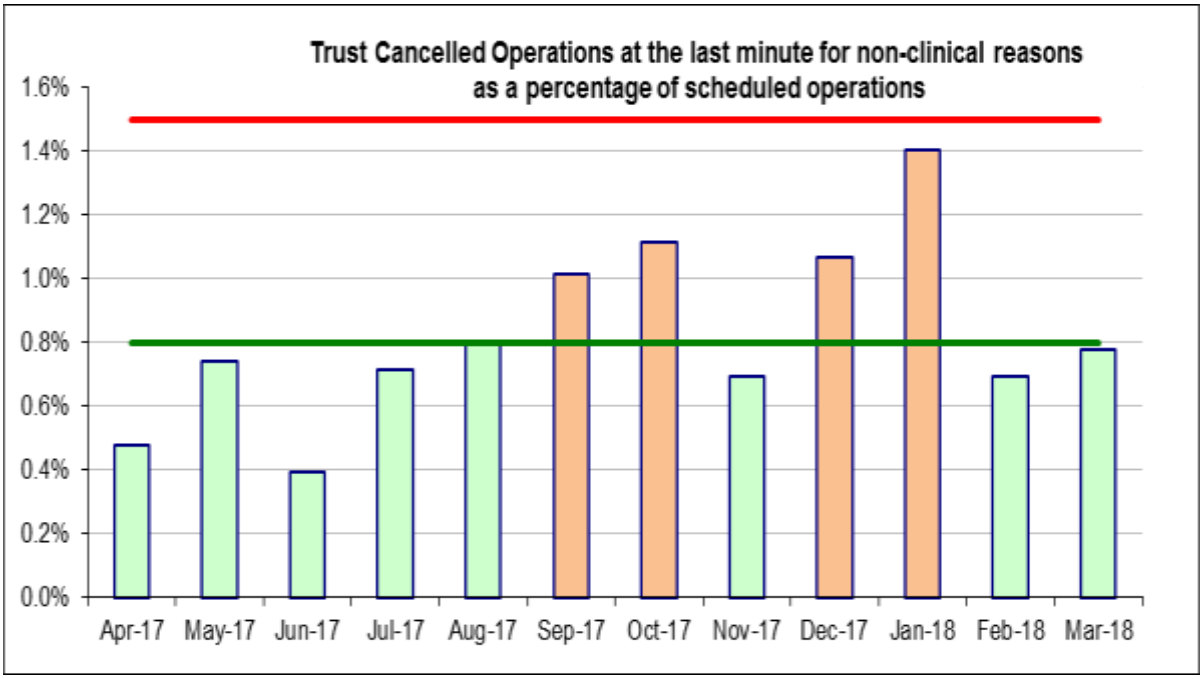
Cancer Waiting Time Targets – 62 day First Definitive Treatment – The Trust did not achieve this standard of 85% of patients who needed to start their first definitive treatment within 62 days.



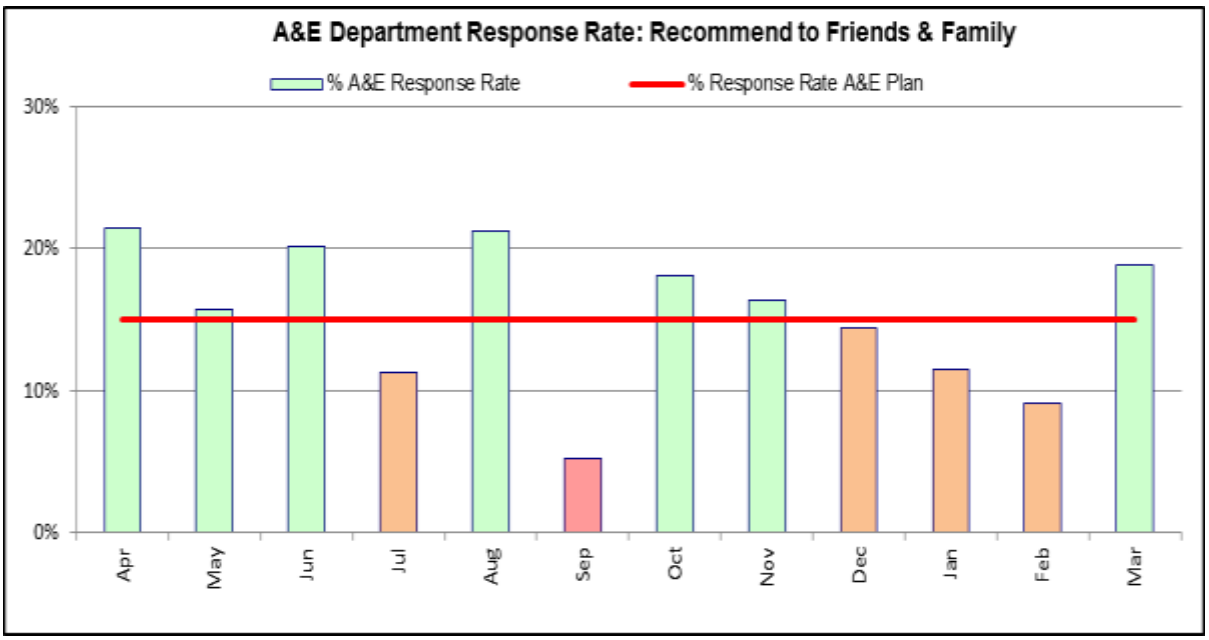
Delayed transfers of care – The Trust did not achieve this standard of Delayed transfers of care remaining below the national limit of 3.5% for the year. However, at 4.95% this is a 1.72% improvement on 2016-17.



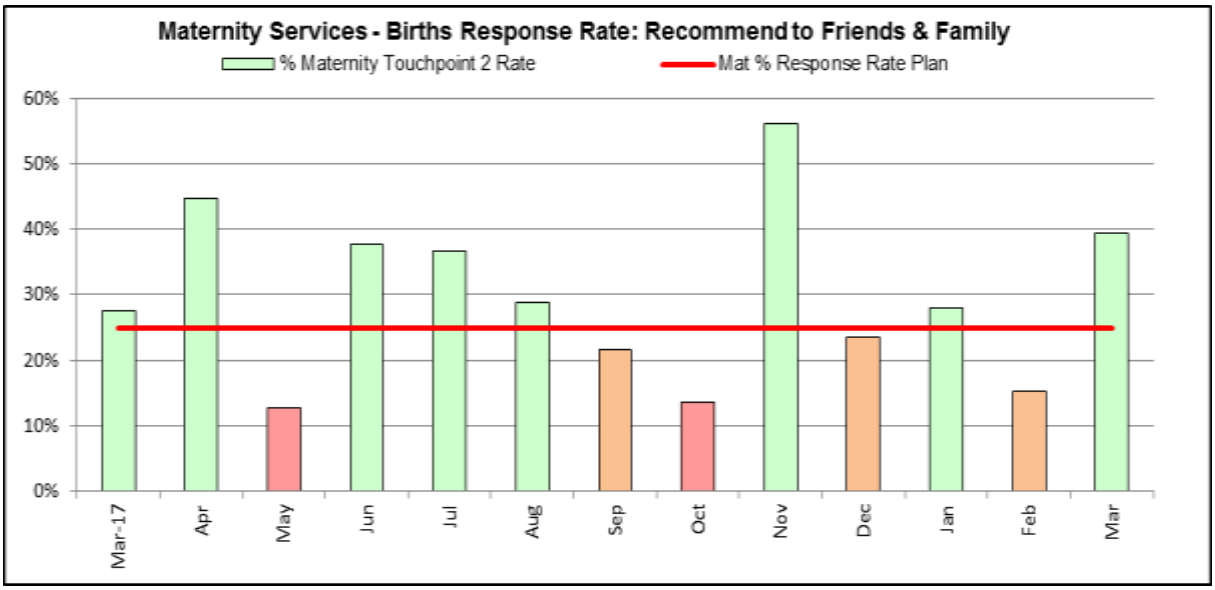
Cancelled operations – The Trust achieved this standard with 0.8% of operations cancelled at the last minute against the national maximum limit of 0.8%.



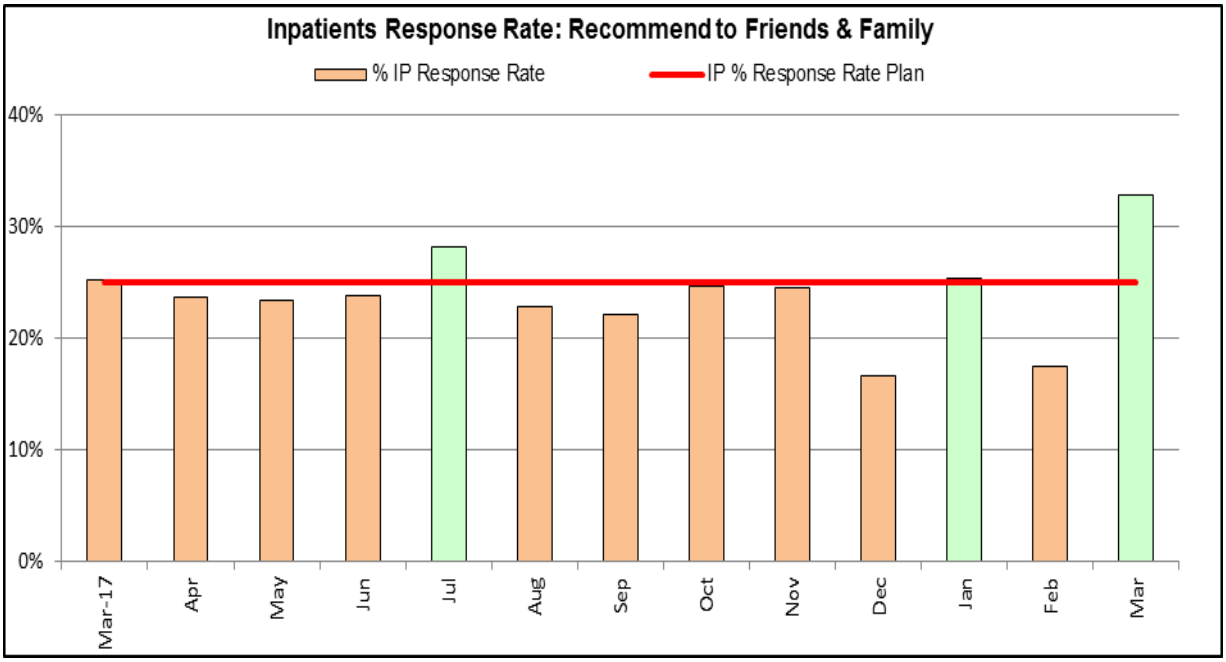
Friends and Family Test Response Rate A&E- The Trust achieved the target of 15% response rate for the Friends and Family Test given to patients in the A&E Departments at 15.3%. Of the responses received 91.2% were positive.



Friends and Family Test Response Rate Maternity- The Trust achieved the target of 25% response rate for the Friends and Family Test given to patients after giving birth at 29.5%. Of all the responses received for patients accessing Maternity Services 93.9% were positive.



Friends and Family Test Response Rate Inpatients- The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients at 23.9%. Of the responses received 95.3% were positive.



National Indicators

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

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

The Trust has achieved a satisfactory rating of 74% 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 —**	**2017/18 local and national data**	**2016/17 local and (national) data**	**National average**
1 & 2	(a) the value and banding of the Summary Hospital-level Mortality Indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	1.044 (Band 2 – "As Expected" 31.9 Oct 2016 – Sept 2017	1.0762 (Band 2 – "As Expected" 29.0 (29.7) Oct 2015 – Sept 2016	100 31.5
3	PROMS			
	i) groin hernia surgery ii) varicose vein surgery iii) hip replacement surgery iv) knee replacement surgery during the reporting period (*See below for explanation of reporting data)*	0.128 No data 0.463 0.298 (Apr 16-Mar 17)	0.074 No data 0.442 0.337 (Apr15-Mar 16)	0.086 No data 0.437 0.323
3	the percentage of patients aged— i) 0 to 15; and	**Elective** 5.1%*1 **Non-Elective** 4.7%*1	**Elective** 3.9% **Non-Elective** 5.0%	**Elective** 4.1% **Non-Elective** 9.4%

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 —	2017/18 local and national data	2016/17 local and (national) data	National average
	(ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	**Elective** 3.4%*1 **Non-Elective** 13.4%*1	**Elective** 2.9% **Non-Elective** 14.5%	**Elective** 3.8% **Non-Elective** 14.0%
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.	75.2	82.1	69.93% 2017
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	95.4%*2	95.4%	95.53% 2015/16 Q4 data
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.	9.5 *3	10.5	13.85 2017/18 tbc
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)*	7,423 128(1.72%)	7,716 78(0.99%)	Data currently unavailable

*1 2017/18 data is Apr-17 – Jan- 18 as Feb & March not currently available
*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 improve the quality of care.

There are three surgical procedures for which PROMs data is captured; Hip and Knee replacements as well as Groin Hernia and up to three measures are used to assess the outcomes of these procedures (only two are used for the Groin Hernia). Results are uploaded on the NHS Digital website from which the graphs below are provided.

The data published in February 2018 (based on April 2016 to March 2017), shows all three surgical procedures showing an improvement in health gain following an operation.

Adjusted average health gain

Figure 1: Adjusted average health gain on the EQ-5D™ Index by procedure

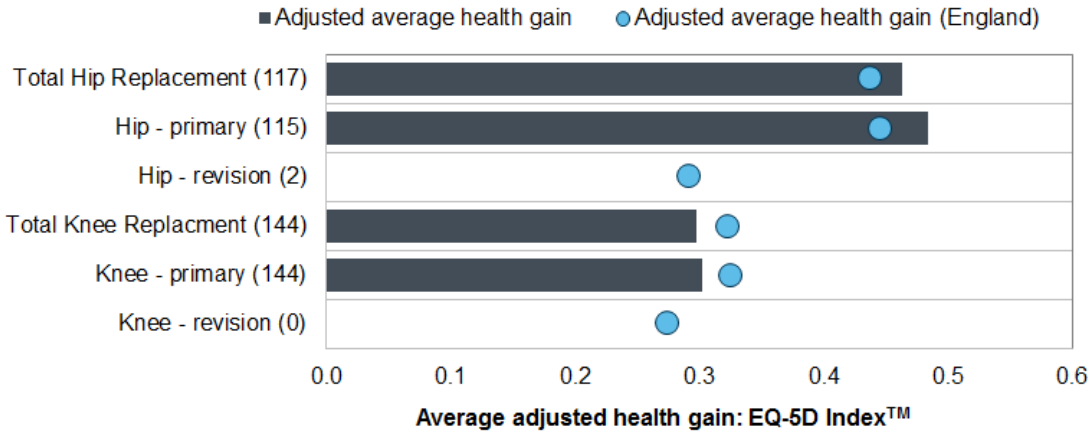


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

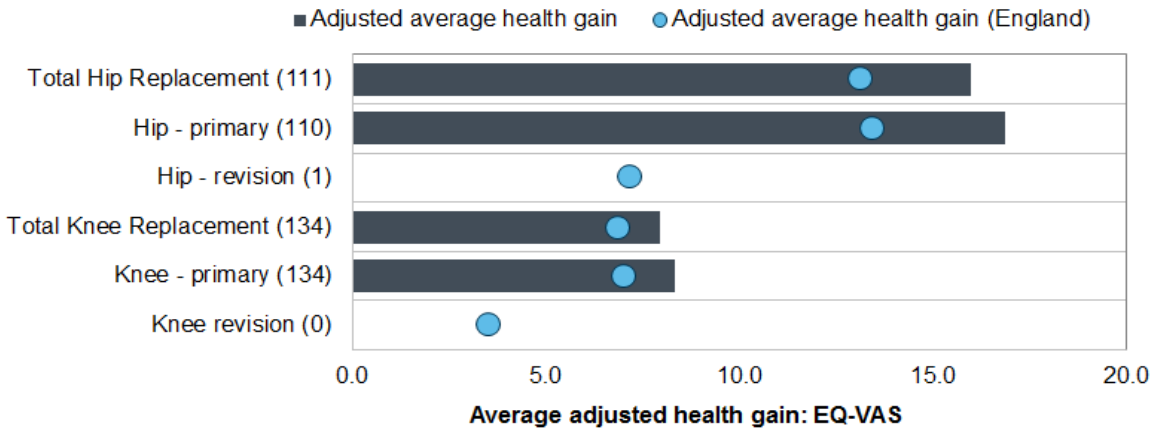


Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

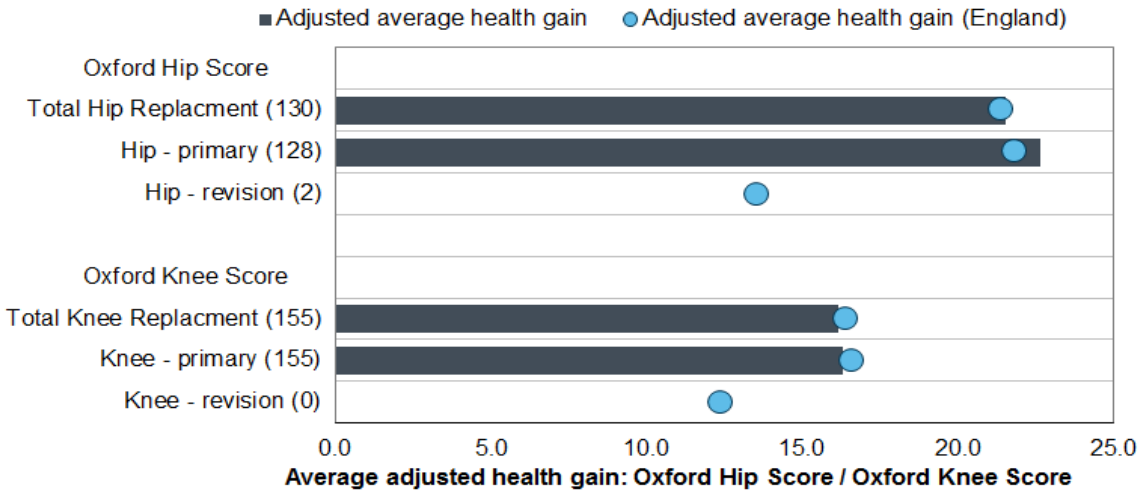


Figure 4: Adjusted average health gain on the EQ-5D Index procedure

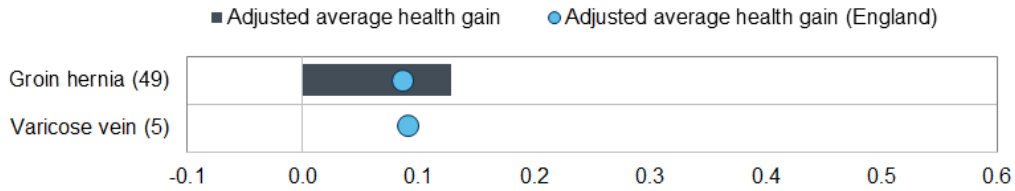
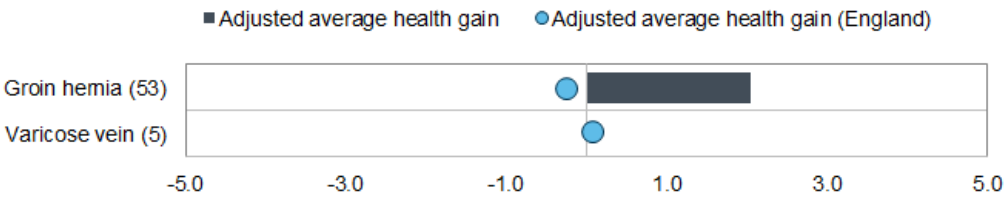
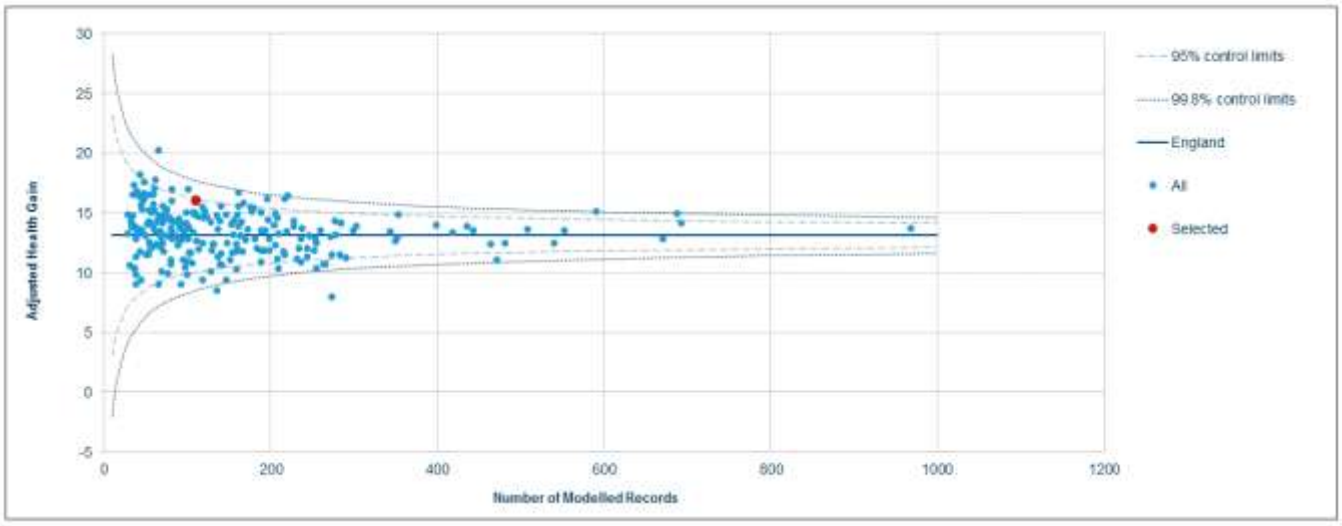


Figure 5: Adjusted average health gain on EQ-VAS by procedure

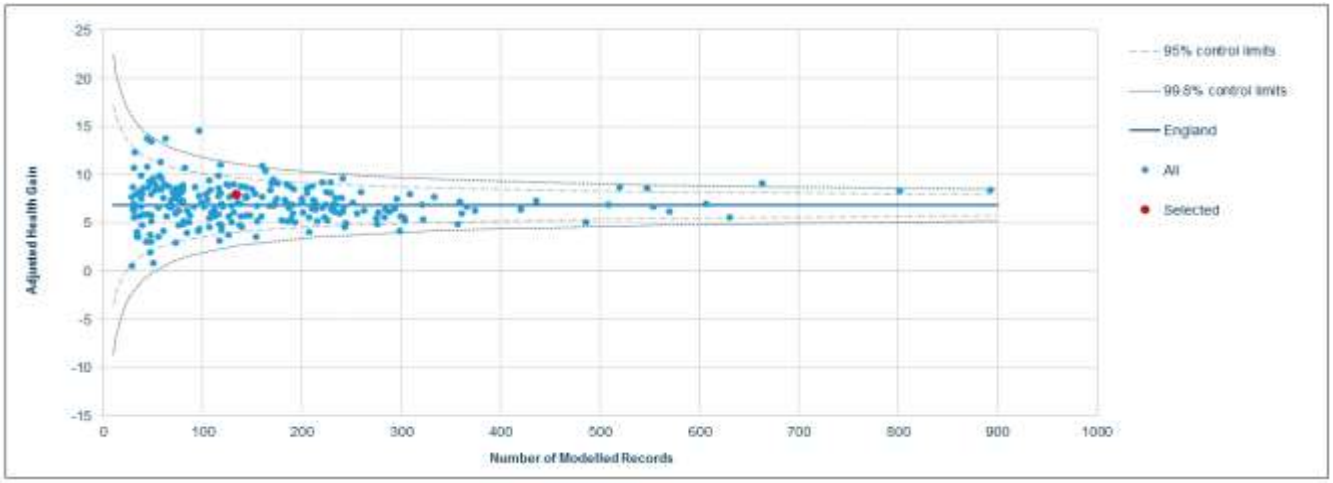


As can be seen, the Trust scored favourably when compared to the national average for all three measures for Hip replacements and also for the EQ-VAS measure for Knee Replacements but fell below the national average for the other outcome measures. In addition, for Groin Hernia, the Trust scored favourably for both measures against the adjusted average health gain.

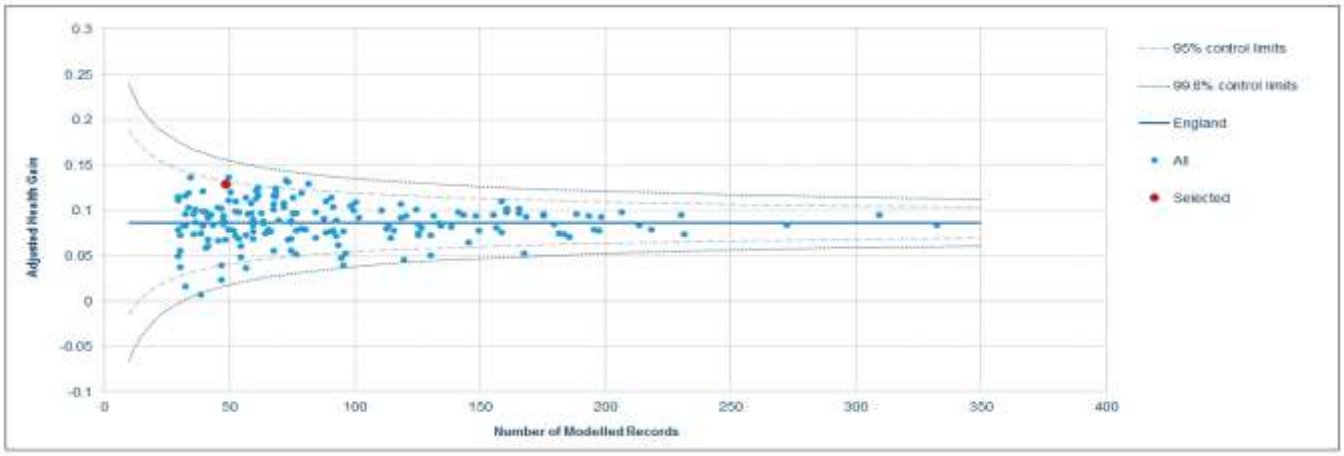
Hip Replacement – 111 patient questionaires were returned. 84 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Knee Replacement – 134 patient questionaires were returned. 80 reported an improvement in health following the procedure (using the EQ VAS PROMS measure).



Groin Hernia – 49 patient questionaires were returned. 31 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Patient Safety Incidents

The proportion of Patient Safety Incidents which resulted in severe harm or death for 2017/18 was 1.72% (0.99% 2016/17). This is calculated by dividing the number of serious and catastrophic incidents (128) reported by MTW by the total number of patient safety incidents 7,423 (7,716 for 2016/17).

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 2017 and covers the period of 01/04/17 to 30/09/17, provided a reporting rate of 23.70 compared to 26.32 for the same period last year. The rate of incidents reported is per 1,000 bed days. This places the Trust within the lowest 25% of reporters and a position we continue to improve upon.

Improving performance

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

These meetings include:-

Serious incidents pertaining to severe harm and death are investigated using Root Cause Analysis methodology and are monitored via an executive-led panel which meets monthly. This group reviews all serious incident investigations and considers the root causes of incidents to identify learning and ensures that actions can be put in place to mitigate the risk of recurrence of similar events. The learning is disseminated across the Trust through the Directorate and Trust clinical governance committees. In addition a 'Learning Lessons' workstream has been initiated during 2017/18 with the intention of strengthening and formalising this approach across MTW. The objectives include a review of- the incident reporting database; the role and format of the clinical governance meetings and further roll-out of human factors training to our staff.

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

Each Division is required to undertake a regular Executive Performance review. These meetings monitor compliance through the Divisional dashboards. In particular Urgent Care have responsibility for the Accident & Emergency four-hour access standard and Planned Care responsibility for the 18 week referral to treatment access standard. The Director of Operations and the Clinical Directors of these Divisions also work in collaboration with our commissioning teams to address non-compliance and to look at the implications of the wider health economy to ensure that our patient's needs are met.

<u>Scrutiny</u>

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 2017/18

This section will provide a summary update on further initiatives that have been undertaken during the last year:-

Women's, Children's and Sexual Health

Bobble Hat Campaign

Bobble Hat care is an initiative which has been created and piloted at the Royal Surrey County Hospital and has shown to prevent unnecessary admissions to the Neonatal unit. Babies can get cold rapidly and have a large surface area on their heads. Putting a hat on a baby as soon as possible following birth will aid in preventing them getting cold and requiring medical intervention.

Following birth all babies are provided with a bobble hat which will be red, yellow or green. The colour represents how much care that the baby requires following delivery. This is based on several different factors such as: whether the baby was full term or premature, type of birth and any additional observations that a baby may require.

It can take up to 24 hours for babies to stabilise their temperatures following birth, so our babies keep their bobble hats on for either 24 hours or until they go home, whichever happens first.

Breaking Bad News

A quiet room for parents-to-be who need privacy has been refurbished thanks to a generous donation from the Sands Group in Tunbridge Wells and the hard work of our staff. The room, which is located in the Women's and Children's Outpatients' area at Tunbridge Wells Hospital, was officially opened in January 2018.

"When a fetal abnormality is detected by an ultrasound scan, the screening tests reveal a high risk result or ultrasound confirms the death of a baby at any gestation in pregnancy, a quiet area provides privacy and space for parents who are shocked, distressed and need time to take in information," said bereavement midwife Ruth Paul.

Feedback from our parents suggested that the décor was previously tired and unwelcoming so with generous support from the local Sands group in Tunbridge Wells this room has undergone a much needed makeover. We are now looking to do something similar on the Maidstone site.

Jan Pullinger, Antenatal & Newborn Screening & Ruth Paul, Bereavement Support Midwives

Urgent Care

Acute Frailty Unit

The development of two Acute Frailty units at MTW in the last 6 months have been instrumental in providing the best quality of care for a group of acutely frail patients. Clinicians, nurses, Allied Health Professionals and managers have joined forces to create Acute Frailty Units on both sites with excellent results, providing improved quality of care for patients, co working with patients' families, improving staff experience and supporting these patients to go home.

What do we mean by an 'acute frailty unit'? An Acute Frailty Unit offers a multidisciplinary approach to care for older hospitalised patients with four key elements:

- specially designed environment
- patient-centred care
- focus on planning for discharge
- review of medical care by a multidisciplinary team.

Maidstone Hospital

The Frailty Unit opened in June 2017 on Chaucer Ward and is known as CAFU (Chaucer Acute Frailty Unit). Many of the team who are part of the unit's every-day running were instrumental in its development and implementation and all are absolutely committed to providing the best service, care and environment possible to elderly patients. The staff are determined to ensure that older patients are always given the most appropriate care and treatment, that they are respected, listened to and supported at all times. This has been evidenced through our Friends and Family survey responses where our patients rate the staff, the care and the service highly.

18 September 2017, via Twitter: Big thanks to all the staff in Chaucer Ward and A&E. First time in a hospital dad's dementia and elderly age has been understood and respected.

The unit offers 11 assessment spaces and is open from 9am to 8pm Monday to Friday. The ward also offers 14 short-stay inpatient beds should our patients need to stay for up to 48 hours. The pathway promotes national best practice, and supports rapid turnover and admission avoidance where it is safe and appropriate to do so. The unit sees up to 12 patients a day with 35% of these discharged home with personalised support to prevent further hospital admissions.

Because the unit has its own speciality we have been able to recruit staff with specialist skills and promote a positive working environment for staff which has had a positive effect on retaining staff within the organisation. Visiting times are largely unrestricted so family members can come in at a convenient time to them which supports their involvement in decision making with that patient and gives them confidence that the patient has the correct support services to remain independant at home.

Tunbridge Wells Hospital

Following the successful implementation of the unit at Maidstone, development of a further frailty unit commenced in March 2018. Building works have been necessary with completion expected in June 2018. In the interim a temporary "pop up" Acute Frailty Unit has been set up to provide improved quality of care for this group of patients. The unit is currently based in Ward 2 at TWH providing care to emergency patients who fit the criteria for acute frailty on a small scale, this will increase to 10 patients once building works have been completed.

These patients are reviewed by a multi-disciplinary team including the support of a senior geriatrician, nursing, therapy, pharmacy and the Integrated Discharge Team (IDT), to offer rapid intervention and safe and timely discharge. Patients who are not discharged are subsequently transferred to short stay beds on another ward and then discharged accordingly.

The feedback for the Chaucer Acute Frailty Unit (CAFU) has been extremely positive and comments include:

- "All the staff were professional, caring and compassionate. Nothing was too much trouble and they made every effort to ensure that that my stay was a good experience".
- "The attention was good that the staff gave when asked any questions about my illness".
- "Most genuine people I have ever met. Treated really well as part of the family".
- "Nurses very kind. Doctor very patient and took time to explain everything".

This service improvement is only the beginning of an important change in the way acute hospital care is wrapped around our frail and elderly patients. The acute frailty unit will continue to develop its links with community service providers to ensure that our patients can benefit from services traditionally delivered in a hospital environment whilst remaining in their own home. In contrast those community services will work in partnership with the hospital to ensure that frail patients only remain in hospital where absolutely necessary and when fit to do so return to their home seamlessly and without delay. Going forward a 7 day service remains the focus of continuing the service development.

Planned Care

Innovations- the Air Glove

The Kent Oncology Centre continues to be actively involved with the Innovations committee and the development and design of the Air Glove. This is a unique warming system used to heat arms which promotes easier access to our patient's veins to be able to deliver intravenous drugs including chemotherapy. Patients undergoing cancer treatment with cytotoxic drugs are known to have difficulty with venous access. The Air Glove is a unique air warming sytem which ensures the arm is heated safely allowing vasodilation and therefore more successful cannulation.

Previously patients with difficult venous access had to have their arms heated with hot water or heat packs. This in itself was difficult to maintain. The original idea for the heated Air Glove came from the chemotherapy staff and management teams working within the Oncology Centre. Together with Green Cross Medico and NHS Innovations we were able to put our ideas into the final product Air Glove.

Over the past year we have taken part in a successful service evaluation which has

supported us to use the air glove with patients and to obtain their feedback. The feedback was mainly positive and it has changed the practice within the chemotherapy unit. It demonstrated an 87.7% successful cannulation rate following 'warming' with the Air Glove.

Pactosafe

Early research has highlighted the risk to oncology health care workers who are handling cytotoxic drugs. A three month trial evaluation was undertaken at the Kent Oncology Centre to implement an innovative air tight waste disposal system within the chemotherapy day unit to reduce the risk of vapour, environmental and surface exposure.

Through implementation of the innovative Pactosafe system, key benefits were highlighted to include improved patient and staff safety, cost efficiencies and ultimately a greener environment. In addition to staff and patient health benefits and improving the environmental footprint, an estimated 50% cost efficiency saving is forecast with the plan to further roll this initiative out across the cancer directorate.

In the absence of further research to substantiate the early evidence of exposure risks in the handling of cytotoxic drugs, all organisations and oncology healthcare workers have a duty of care to ensure accidental exposure is minimised.

The new PET-CT Centre

The new PET-CT scanner was opened in February 2018 at Maidstone Hospital. Alliance Medical, in partnership with MTW and the Kent Oncology Centre, have invested in the provision of the first purpose-built static PET-CT centre in Kent, which adjoins the Nuclear Medicine Department. The service was previously provided using mobile scanners.

This form of scanning provides a combination of Positron Emission Tomography (PET) and CT information to show the physiological aspects of cancer tumours, infection and other conditions in addition to the response to treatment and simultaneous anatomical information.

Having a static scanner in Maidstone will improve both the quality and the availability of PET-CT. The newly built centre is more spacious and comfortable for patients and has increased capacity. In addition the facility will facilitate future national research.

Part Four
Appendices A, B and C

Appendix A

59 National reports were published where the topic under review was relevant to the Trust in 2017/18 with action to be taken in 2017/18

National Report Published April 2017 to March 2018	*Report received*	Date report due
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**Full Report received July 2017.** Quarterly reports generated and reviewed by the resuscitation team to review performance. The trust figures compare well in national comparisons and shows higher than national survival rates.
Adult Critical Care Case Mix Programme 2016 (ICNARC) (CMP)	**Y**	**Full report received June 2018** Quarterly reports generated and regularly reviewed by team. Re-admission rates are very low across the trust, some delay in discharging the patient from the unit to a general ward due to operational pressures. No areas of concern were identified.
Emergency Laparotomy Audit (NELA)	**Y**	**Report received - 13 October 2017** Continued to perform well against the majority of national recommendations. There is a clear pathway of evidence based interventions in place for the management of all patients undergoing an emergency laparotomy. Trust level change to ensure adequate Consultant Geriatricians in place with dedicated time in job plan to support decision making.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	Quarterly dashboards are received and reviewed by the T&O team. 3 injury specific reports are published March, July and November reviewed by team. Data submission for the trust is very good and is well above the regional numbers. Patients are reviewed and discussed at Trauma Board meetings to ensure best quality of care was met. Any patients with a high injury severity score all have their cases reviewed on an individual basis.
National Joint Registry (NJR)	**Y**	**Report received September 2017** The NJR is a standing item at the Orthopaedic department Clinical Governance and directorate meetings. Our trust is not an outlier during this audit year. Our audit of NJR completeness against Hospital Episode Statistics data scored very well. 904 procedures were submitted to the NJR with a consent rate of 98%. This is an ongoing National audit which our trusts continually participates in year after year.
Royal College of Emergency Medicine (RCEM) Consultant Sign Off 2016	**Y**	**Report received May 2017.** Significantly better than national results across both sites in all four standards. This continues the trend of increased consultant sign off at Maidstone Hospital and Tunbridge Wells Hospital that has occurred over the last five years. Tunbridge Wells continue to have slightly better results as they often have more senior staff within the hospital site. This reflects the patient cohort (higher volume and sicker patients at Tunbridge Wells). Review of children under one year of age presenting with fever is significantly better than national averages due to the dedicated Paediatric Unit in the Emergency Department.

National Report Published April 2017 to March 2018	*Report received*	Date report due
		Maidstone 90%, Tunbridge Wells 100%, national average 48%.
RCEM Severe Sepsis and Septic Shock 2016	**Y**	**Report published May 2017.** There were three fundamental standards which all had excellent results compared to both the national medians and the expected standards of 100%. These were for a complete set of observations on arrival, obtaining intravenous crystalloid fluid with 4 hours and obtaining intravenous antibiotics with 4 hours. A sepsis proforma to be made available along with regular teaching sessions for clinicians to remind them of the importance of treating patients in a timely manner.
National Audit of Small Bowel Obstruction (NASBO)	**Y**	**Report published December 2017** Report is with the specialty for review and action plan development.
RCEM Adult Asthma 2016	**Y**	**Report published May 2017.** This was a complex audit, involving 15 separate standards. The Trust was partially compliant against these standards. Whilst we fared well in giving patients oxygen and ensuring vital signs were measured on arrival, it was felt that the timings for these was not always documented appropriately. A standardised Asthma proforma is to be introduced to ensure all asthma patients are treated appropriately and in a timely manner.
National SAMBA 17 (Society for Acute Medicine Benchmarking Audit)	**Y**	**Report received September 2017.** The Trust is partially compliant. Trust-wide education to take place to ensure all patients admitted to AMU have an Early Warning Score (EWS) measured upon arrival at AMU and reviewed by a competent decision maker within 4 hours of admission.
National Potential Donor Audit- NHS Blood and Transplant	**Y**	**Report published in November 2017.** In the first six months of the year, from 6 consented donors, the Trust facilitated 4 actual organ donations resulting in 9 patients receiving a life-saving or life-changing transplant. There were no occasions where a Specialist Nurse for Organ Donation was not present.
UK Cystic Fibrosis Registry (Paediatric and Adult)	**N/A**	The Trust does not provide this service.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	**N/A**	The Trust does not provide this service.
Use of Emergency Oxygen (BTS)	**Y**	**Report received May 2016.** Trust is partially compliant. Respiratory Clinical Nurse Specialists to continue drug prescription chart for all patients requiring emergency oxygen. Implementation of Nerve Centre database to allow for target parameters to be entered for each patient. Explore purchasing of ear SpO2 probes to ensure appropriate monitoring equipment is available in all clinical areas.
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**N/A**	Report publication delayed to April 2018.

National Report Published April 2017 to March 2018	*Report received*	Date report due
(National Comparative Audit of Blood Transfusion Programme) Comparative audit of transfusion associated circulatory overload 2017	**N/A**	Report publication delayed to April 2018.
(National Comparative Audit of Blood Transfusion Programme) Audit of the patient blood management in scheduled surgery re-audit	**Y**	**Report received 23 October 2017.** Report currently with blood transfusion team for assessment of compliance and action planning.
(National Comparative Audit of Blood Transfusion Programme) Use of blood in lower GI bleeding	**Y**	**Report received May 2017.** Both hospitals are linked with St Thomas' Hospital who provide an acute 24/7 hotline covered by a consultant level doctor. Improvements have been made to facilitate the care of elderly patients admitted under the surgical teams, and there is now a referral system with time built into job plan.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**Y**	**Report received September 2017** We have the lowest rate for serious adverse reactions compared to the other 13 regions, but have a higher than anticipated rate of near misses. Following SHOT's focus on human factors, a number of questions were added to the questionnaires to learn more about staffing levels and training. Overall, transfusion components themselves are very safe. The regular use of a bedside checklist is planned for implementation.
Cancers		
National audit of Breast Cancer in Older People (NABCOP)	**Y**	**Report published September 2017** We have 8 dedicated Breast Cancer operating lists per week. The following patients are always discussed at Breast Cancer MDT meetings; new patients with biopsy confirmed Breast Cancer, new patients with metastatic disease and previous Breast Cancer patients with metastatic disease and patients requiring palliative care input . The Care of the Elderly team is involved with Breast Cancer patients on a Case by Case basis. A patient survey is needed to establish if patients feel they have been adequately involved. A further local project is planned to establish length of stay and a policy regarding Mental Capacity and WHO scoring is to be written.
National Audit of Lung Cancer (NLCA)	**Y**	**Report received 24 January 2018** This report is currently with clinical team for assessment of compliance and action planning.
National Audit of Bowel Cancer (NBOCAP)	**Y**	**Report received 14 December 2017** This year MTW is fully compliant in all of the recommendations made, our mortality rates are lower than the national and regional average which demonstrates the high quality provided by this service.
Head & Neck Cancer (DAHNO)	**N/A**	National Report due later in year 2018.
National Prostate Cancer Audit 2017	**Y**	**Report received 22 November 2017** Overall this audit demonstrates a very good level of care and treatment for our patients. There are no outlying results when benchmarked across the country. The patient reported outcomes show that patients are generally very pleased with the overall quality of care.
Oesophago-gastric cancer (NAOCG)	**Y**	**Report received on 14 December 2017.** Overall the results are positive and demonstrate

National Report Published April 2017 to March 2018	*Report received*	Date report due
		that MTW performed better than the national average with patients being discussed at MDT meetings and MTW patients reported to have a CT scan. All NHS trusts / local health boards in England and Wales achieved similar outcomes after curative surgery, and the overall rates of mortality continue to improve.
Endocrine and Thyroid National Audit	**N/A**	**Report due January 2018** Delay in publishing this national report.
National Ophthalmology Database Audit Project	**N/A**	The Trust was unable to submit data to this national audit due to software issues. It is anticipated that this IT issue will be resolved so that trust data can be submitted for the next round of this audit.
Urology		
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	**N/A**	The Trust does not provide this service.
BAUS Urology Audits: Radical Prostatectomy Audit	**Y**	**Report published September 2017** Results are very good compared with the National averages. Low number of low grade cancer reflects, use of brachytherapy and active surveillance and is a positive factor.
BAUS Urology Audits: Cystectomy	**N/A**	The Trust does not provide this service.
BAUS Urology Audits: Nephrectomy Audit	**Y**	**Report received 14 December 2017** MTW is better than the National average in all domains and full assurance was achieved.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**Y**	**Report received 14 December 2017** Report with the urology team to assess trusts compliance and develop an action plan if needed.
BAUS Urology Audits: Urethrolasty audit	**N/A**	The Trust does not provide this service.
Chronic Kidney Disease in Primary Care	**N/A**	Primary Care Only.
Renal Replacement Therapy (Renal Registry)	**N/A**	The Trust does not provide this service.
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2015-16	**Y**	**Report published June 2017.** Trust is partially compliant with national recommendations. The majority of patients are seen by a member of the cardiology team during their hospital stay, matching national averages. Slight dip in figures for patients receiving secondary prevention medication for this year. This has been identified as a data collection issue and should show as an increased number in 2016-17 results. The average length of stay at Maidstone Hospital is slightly higher than at Tunbridge Wells (Maidstone 7 days, Tunbridge Wells 4 days). This is thought to be due to the need to transfer patients to Tunbridge Wells due to bed shortages.
Heart failure Audit 2015-16	**Y**	**Report published August 2017.** This report is with the cardiology team for review and action plan development.
Cardiac Rhythm Management (CRM) 2015-16	**Y**	**Report published April 2017.** Trust is fully compliant with national recommendations. Overall performance on both sites was good with particularly good data on physiological (dual chamber) pacing for SSS. CRT and ICD implant rates are in line with national performance.
Coronary angioplasty/ National audit of PCI 2015	**Y**	**Report published September 2017.** The Trust is largely compliant with the national recommendations. The specialty continues to develop radial access experience amongst local

National Report Published April 2017 to March 2018	*Report received*	Date report due
		PCI operators and plans to open a recovery area for TWH catheter lab.
Adult Cardiac surgery	**N/A**	The Trust does not provide this service.
Congenital heart disease (Adult cardiac surgery)	**N/A**	The Trust does not provide this service.
Congenital heart disease (Paediatric cardiac surgery)	**N/A**	The Trust does not provide this service.
Pulmonary Hypertension	**N/A**	The Trust does not provide this service.
National Vascular Registry	**N/A**	The Trust does not provide this service.
COPD Audit – Pulmonary Rehabilitation	**N/A**	Date of publication of national report still to be confirmed by national body.
National diabetes inpatient audit (NaDIA) 2017	**Y**	**Report published 14 March 2018** This report is with the Specialty for review and action plan development.
National Diabetes Audit – Adults Foot Care Audit (NDFA) 2016-17	**Y**	**Report published 14 March 2018** This report is with the Specialty for review and action plan development.
National Core Diabetes Audit (NDA) 2015-16	**Y**	**Report published July 2017.** This report is with the specialty for review and action plan development.
National Core Diabetes Audit (NDA) 2016-17	**Y**	**Report published 14 March 2018** This report is with the Specialty for review and action plan development.
National Diabetes Transition audit (NDTA) 2003-14	**Y**	**Report published July 2017** This is the first published report for the NDTA and has linked data from the National Paediatric Diabetes Audit (NPDA) and National Diabetes Audit (NDA) for the audit period 2003-04 to 2013-14 which focusses on young people with type 1 diabetes. This report reflects national findings only. Clear transition pathways already exist at MTW and we continue to review these, with a view to improving the process to ensure it is user-friendly and flexible according to the needs of the patient.
Inflammatory Bowel Disease (IBD) Programme – IBD registry, Biological Therapies Audit 2016-17	**N/A**	IBD Registry confirmed that no national report will be published for the 2016-17 data for MTW as the Trust has not subscribed to the additional funding for this element of the service. Charts for local trust data are available from their website (currently not working) to download but no national comparative data is available.
Neurosurgical National Audit Programme	**N/A**	Trust does not provide this service.
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	**Y**	**1. Inpatient Falls (NAIF).** **Report published November 2017.** This report is with the Specialty for review and action plan development.
	N/A	**2. Fracture Liaison Service** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture database** **Report received 3 October 2017** MTW were compliant with all recommendations, apart from participating in the Physiotherapy Hip Fracture Sprint Audit in the previous year, this is now being undertaken for the 2018/19 programme year.
Sentinel Stroke National Audit Programme (SSNAP)	**Y**	**Report published November 2017.** This report is with the specialty for review and action plan development.
National UK Parkinson's 2017	**Y**	**Site specific reports published 27 March 2018.** This report is with the specialty for review and action plan development.

National Report Published April 2017 to March 2018	*Report received*	Date report due
National Audit of Dementia in General Hospitals	**Y**	**National Report published July 2017** Carers rated information, communications and patient care as above the national average. Action is planned to integrate the Dementia Care pathway with the Stroke Pathway and the Fractured Neck of Femur pathway. Dementia champions are to be identified within the trust so that there is support available to staff 24 hours per day, 7 days a week. Comprehensive Geriatric assessment (CGA) is to be utilised alongside pathways to ensure robust mechanisms are in place for assessing delirium in people with dementia.
National audit of Dementia Spotlight audit 2017 (Delirium screen and assessment)	**N/A**	Report Due March 2018 National report publication delayed.
National Patient Reported Outcome Measures (PROMs) Programme Elective surgery Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein*	**Y**	**Report published January 2018** Before a patient undergoes one of the three PROMs procedures, for Maidstone & Tunbridge Wells NHS Trust - groin hernia, primary hip replacement or a primary knee replacement – they are offered a questionnaire for completion at pre-operative assessment. After three or six months, depending on procedure, the contractor posts out the follow-up post-operative questionnaire to the patient's home**.** The questionnaires are used to assess improvement in health as perceived by the patients themselves. Hip – MTW are slightly above the England average for the adjusted average health gain. Knee – Slightly below England average for the adjusted average health gain. Groin - Slightly below England average for the adjusted average health gain. The Trust will continue with promotion of PROMS questionnaires to patients in pre-op setting to increase the number of questionnaires returned. (* not performed at MTW).
Mental Health		
Prescribing Observatory for Mental Health (POMH)	**N/A**	The Trust does not provide this service.
Suicide and homicide in mental health (NCISH)	**N/A**	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Prescribing anti psychotics for people with dementia	**N/A**	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Monitoring of patients prescribed lithium	**N/A**	The Trust does not provide this service.
Women & Children		
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance 2015 (reports annually)	**Y**	**Report received 22 June 2017** There were 5,700 births in 2015 within our Trust. Stillbirths = 22, 3.86 per 1000 births (MTW up to 10% higher than average for group) Neonatal Death = 2, 0.35 per 1000 births (MTW are more than 10% lower than average for group) Extended Perinatal death = 24, 4.21 per 1000 births (MTW are up to 10% lower than average for group).
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality Surveillance of Deaths in the UK 2013-15 (reports annually)	**Y**	**Report received 7 December 2017** This report has been reviewed by the Maternity Team, the action plan is being completed.
MBRRACE-UK Maternal, Newborn and Infant	**Y**	**Report received 28 November 2017**

National Report Published April 2017 to March 2018	*Report received*	Date report due
Clinical Outcome Review Programme Perinatal Mortality and morbidity confidential enquiry (reports every second year)		The Trust is partially compliant; the Trust is working hard to reduce the incidence of perinatal mortality and has just finalised its action plan to improve its service further. A Consultant from Kings recently visited the Trust to pass on advice on helping bereaved families to understand their loss and on obtaining consent for post-mortems. Meetings are set up to review all cases on a six monthly basis.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives; Women with severe epilepsy (October 2015 to March 2017)	**Y**	**Report received 7 December 2017** This report has been reviewed by the Maternity Team, the action plan has been prepared and is being finalised.
National Diabetes Audit – Adults Pregnancy in Diabetes	**Y**	**Report received 12 October 2017** This report has been reviewed by the Maternity Team, the action plan has been prepared and is being finalised.
National Maternity and Perinatal Audit (NMPA)	**Y**	**Report received and distributed 10 November 2017.** The trust is Partially compliant, with higher than expected numbers for a site of this size for instrumental births, 3rd/4th degree tears and small for gestational age (SGA) at 40 weeks. We were lower than expected for inductions. Actions have already been taken to address 3rd/4th degree tears, improvement seen already. SGA being further addressed by ongoing Growth Assessment Protocol (GAP) implementation, induction rates also improving with GAP. MDT review of instrumental deliveries in progress.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	**N/A**	IBD Registry confirmed that no national report will be published for the 2016-17 data for MTW as the Trust has not subscribed to the additional funding for this element of the service. Charts for local trust data are available from their website (currently not working) to download but no national comparative data is available.
National Paediatric Diabetes Audit (NPDA**)**	**Y**	**Report received and distributed 10 October 2017.** The trust results were hampered by issues with data submission software. Meetings with the software provider have taken place to resolve these issues. Action has been taken to improve the transition between children and adult diabetic services.
Neonatal Intensive and Special Care (NNAP)	**Y**	**Report received 31 October 2017** This report is with the paediatric Team for review and action planning.
Paediatric Intensive Care (PICANet)	**N/A**	The Trust does not provide this service.
National BTS Paediatric Pneumonia Audit 2016	**Y**	**Reports received in July 2017 and January 2018**. Results show that there has been an improvement in planning follow-ups for this group of patients. The team is continuing to work on decreasing the use of chest x-rays and blood cultures for the diagnosis of paediatric pneumonia. A Poster for paediatric pneumonia management has been designed and distributed in acute and ward settings.
Confidential Enquiries		
NCEPOD: Treat as One (Adult Mental health in Acute hospitals)	**Y**	**Report received 26 January 2017.** The Trust and the Psychiatric Liaison Services are largely compliant with the recommendations. The Psych Liaison team is fully integrated into the hospital but the out of hours teams are not. To

National Report Published April 2017 to March 2018	*Report received*	Date report due
		achieve compliance would require both national and local money to be in place and then to find staff to provide the service. Liaison Managers are in discussion with the trust and the CCG on how to best use the resources currently available. Liaison Services are not Psychiatric Accreditation Liaison Network (PALN) Accredited. Essentially due to the cost implications of registering with the network. However the PALN guidance is used when developing services. A new admission and discharge documentation has been developed within ITU to ensure that mental health is included and documented when patients are admitted to critical care. There is no centralised system in use for patients detained under the Mental Health Act within the Acute Trust. There may be one for DOLS within the Mental Health Capacity Act. Clinical lead (County Liaison Services) is currently drawing up processes across Kent to implement this. An SLA will need to be developed once agreed.
NCEPOD: Inspiring Change (Non-Invasive Ventilation)	**Y**	**Report received 13 July 2017.** Report disseminated and with specialties for assessment.
NCEPOD: Each and Every Need (Chronic Neurodisability)	**Y**	**Report received 8th March 2018.** Report disseminated and with specialties for assessment.
Others		
NHS England 7 Day Hospital Study – March 2017	**Y**	**Report received May 2017.** 76% of patients were seen and assessed by a consultant within 14 hours of admission. 100% compliant when acutely ill patients require a twice daily consultant reviews. 75% compliant documented where patients require a once daily consultant review. 100% compliant with patients having 7 day access to diagnostic services and also to Consultant directed interventions. The trusts performance was in line with or above the national and SE regional mean. The trust is continuing to work towards the NHS England 7 Day hospital working agenda.
NHS England 7 Day Hospital Study – September 2017	**Y**	**Report received December 2017.** Only one Standard was audited for this round of the study: the proportion of MTW patients seen and assessed by a consultant within 14 hours of admission is 74%. No national comparative data was provided this round by NHS England. The trust is continuing to work towards the NHS England 7 Day hospital working agenda.

Appendix B

Updated actions on reports received during March 2016 to April 2017. These were awaiting review or had previously been reviewed and action plans developed. These reports have been reviewed and the table below shows which actions have been completed and implemented or where reviews are still outstanding.

National Report Published April 2015 to March 2016	***Report received***	
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**National report received June 2016** Local reports with national comparative data. Reviewed and reported to the Trusts Resuscitation Committee. There were no abnormal variants regarding age, sex or location. The Trusts survival to discharge rate is better than the predicted figures for similar hospitals. To continue to submit data to this national audit.
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	**Y**	**Report received July 2017.** Annual ICNARC Report for 1 April 2016 to 31 March 2017 was presented and discussed. Generally results were very encouraging for both Units when benchmarked against similar Units. Excellent SMR for both Units. Areas of concern were delayed admissions at TWH, delayed discharges on both sites. A business case to increase the dependency at TWH to 8 which should improve delayed admissions considerably. High levels of high risk sepsis admissions on both sites were thought to be due to the case mix the Units see i.e. Emergency abdominal surgery at TWH and Haem/Oncology at Maidstone.
National Ophthalmology Audit	**Y**	**National report received May 2016** and reviewed by specialty**.** Plan to enter data for next round of the audit if the problem with the Electronic Medical Records system has been resolved – still have a software problem but we're getting close to it working and being able to participate.
Emergency Laparotomy Audit (NELA)	**Y**	**5 July 2016** Report received and disseminated to team for review and assessment. Audit results regularly reviewed and assessed at clinical sessions.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	**July 2017 (Orthopaedic Injuries) / November 2017 (Head & Spinal Injuries) March 2017 (Thoracic and Abdominal Injuries)** These are reviewed by the Clinical Lead for Trauma and discussed at Trauma Board. Any areas of underperformance are highlighted and actions for improvement identified. A report highlighted a lower than average percentage of patients with head injuries getting to CT scanning within 60 minutes of admission. Prioritising these patients for CT has led to improved results.
National Joint Registry (NJR)	**Y**	**Report received November 2016.** Annual NJR Report for 1 January to 31 December 2015. The report shows overall great compliance of 99% for the Trust. Our Trust is not an outlier.
Smoking Cessation	**Y**	**Comparative data received 7 December 2016.** The Trust is partially compliant. Patients are appropriately referred to Smoking Cessation Services. Doctors are aware of the availability of

National Report Published April 2015 to March 2016	*Report received*	
		Nicotine replacement Therapy and prescribe as necessary.
Vital Signs in children (care in the emergency department)	**Y**	**National report received 31 May 2016.** Site specific reports received June 2016. Both sites performed well in the taking and recording of vital signs with 97% compliance. Results for Maidstone were slightly better than TWH but this should show an improvement with the opening of a specific Paediatric Emergency Department.
VTE Risk in lower limb immobilisation (care in emergency department)	**Y**	**National report received 31 May 2016;** site specific reports received June 2016. Both sites performed well: Maidstone 97% and TWH 100%. Need to ensure there is evidence that patient information leaflets are being given to all patients.
HQIP National SAMBA 16 (Society for Acute Medicine Benchmarking Audit)	**Y**	**Report received January 2017 with specialty for assessment.** The Trust is partially compliant. Trust-wide education to take place to ensure all patients admitted to AMU have an Early Warning Score (EWS) measured upon arrival at AMU and reviewed by a competent decision make within 4 hours.
Procedural sedation in Adults (Care in emergency department)	**Y**	**National report received 31 May 2016**. Site specific reports received June 2016. The Trust is partially compliant. Implementation of new sedation proforma to ensure all relevant observations are taken and recorded.
UK Cystic Fibrosis Registry (Paediatric and Adult)	**N/A**	The Trust does not provide this service.
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	**N/A**	The Trust does not provide this service.
Use of Emergency Oxygen (BTS)	**Y**	**Report received May 2016.** Trust is partially compliant. Respiratory Clinical Nurse Specialists to continue drug prescription chart for all patients requiring emergency oxygen. Implementation of Nerve Centre database to allow for target parameters to be entered for each patient. Explore purchasing of ear SpO2 probes to ensure appropriate monitoring equipment is available in all clinical areas.
National Comparative Audit of Blood transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology 2017	**Y**	**Report received August 2016.** Haematological patients are high blood users and those with chronic Bone Marrow Failure (BMF) receive more blood than those with reversible BMF. Single unit red cell transfusions are uncommon and prophylactic single unit platelet transfusions would almost certainly be increased if counts were performed prior to transfusions of further units. Local hospital guidelines are frequently discrepant with national guidelines and contribute to inappropriate transfusion practice. Compliance is similar across all levels of care.
Use of blood in lower GI bleeding	**Y**	**Report received May 2016** with the speciality awaiting assessment completion. Update – The results show that more work is needed in areas such as improving out of hours cover and exploring the recruitment of more interventional radiologists. We like other Trusts struggle with the lack of elderly care physicians with time built into their job plans to deliver this service, but improvements have been made to facilitate

National Report Published April 2015 to March 2016	*Report received*	
		appropriate care of elderly patients admitted under the surgical teams and there is now a referral system in place with time built into job plan.
Audit of patient blood management in scheduled surgery	**Y**	**Report received January 2017.** The Trust performance was below national average on delivering the recommendations within Patient Blood Management (PBM) in surgical patients. The results are being discussed and managed at a Trust-wide level.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**N/A**	No report available this year.
Cancers		
National Cancer Diagnosis Audit	**N/A**	Primary Care Audit only.
Lung Cancer (NLCA)	**Y**	**National Report received 25 January 2017.** With speciality for assessment, assessment should be completed by end April 2017. Update - Out of the 15 recommendations MTW was fully compliant in 9 domains and partially compliant in 1. 4 of the recommendations are not currently applicable to the published report as they are new for the 2017 NLCA audit. Therefore there are no current results to be analysed. MTW was not compliant in 1 domain. This was due to an extended period where there was no lung pathway co-ordinator in post and as a result some data was missed and not entered.
Bowel Cancer (NBOCAP)	**Y**	**National Report received January 2017.** With speciality for assessment. Assessment due for completion end April 2017 Update - The audit confirms that, although we are one of the busiest colorectal units in the country, our outcomes are good. There are no circumstances highlighted where we are a negative outlier and in fact this year's data has seen a significant improvement in some regards (such as data capture).
Head & Neck Cancer (DAHNO)	**N/A**	**February 2017 –** No report from DAHNO yet. Update -delayed report due March/ April 2018 – date TBC.
National Prostate Cancer Audit	**Y**	**National Report received January 2017.** Update - audit demonstrates a very good level of care and treatment for our patients. There are no outlying results when benchmarked across the country. There is some room for improvement in communicating choice and decision making for patients.
Oesophago-gastric cancer (NAOCG)	**Y**	**National Report received January 2017.** Maidstone & Tunbridge Wells NHS Trust has not performed major upper gastrointestinal cancer surgery since 2013. However the Trust participates in the diagnostic pathway for this group of patients. Update - The audit highlighted that we are not compliant regarding the number of new diagnoses of OG cancer that have a staging CT scan – at the moment this is only 52%. This could be due to poor reporting – mechanisms have been put in place to ensure this information is captured in the future e.g. at time of MDT meetings.
Urology		
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	**N/A**	The Trust does not provide this service.
BAUS Urology Audits: Radical Prostatectomy	**N/A**	No report available.

National Report Published April 2015 to March 2016	*Report received*	
Audit		
BAUS Urology Audits: Cystectomy	**N/A**	The Trust does not provide this service.
BAUS Urology Audits: Nephrectomy Audit	**N/A**	No report available.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**N/A**	No report available.
BAUS Urology Audits: Urethrolasty audit	**N/A**	The Trust does not provide this service.
Chronic Kidney Disease in Primary Care	**N/A**	Primary Care Only.
Renal Replacement Therapy (Renal Registry)	**N/A**	The Trust does not provide this service.
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP) 2014-15 data (202)	**Y**	**National report received 30 January 2017.** With Specialty for assessment. The Trust is fully compliant and better than national average with heart attack patients being seen by a cardiologist. However there are issues with patients not being admitted to cardiology wards and length of stay. Further work is being carried out to investigate reasons for this.
Heart failure Audit 2014-15	**Y**	**National report received August 2016.** Performance at both sites is above national average. Both hospitals have a designated Heart Failure Nurse Service for inpatients, excellent echocardiogram services, cardiologist support for inpatient referrals and regular multi-disciplinary heart failure meetings.
Cardiac Rhythm Management (CRM) 2014-15	**Y**	**National report received 3 August 2016.** Overall performance on both sites was good with particularly good data on physiological (dual chamber) pacing for SSS. CRT and ICD implant rates are in line with national performance.
Coronary angioplasty/ National audit of PCI 2014	**Y**	**National report received 1 April 2016.** Radial access to be established as default access route for PCI, compliance increases year on year. Data completeness to be improved for patient diabetic status and renal function.
Adult Cardiac surgery	**N/A**	The Trust does not provide this service.
Congenital heart disease (Adult cardiac surgery)	**N/A**	The Trust does not provide this service.
Congenital heart disease (Paediatric cardiac surgery)	**N/A**	The Trust does not provide this service.
Pulmonary Hypertension	**N/A**	The Trust does not provide this service.
National Vascular Registry	**N/A**	The Trust does not provide this service.
National Pregnancy in Diabetes Audit 171	**Y**	**National report received 1 November 2016.** Our numbers were too small to be included in some of the analysis of this report. MTW were better than National and Regional results for Glucose Control, along with Folic acid supplement prior to pregnancy. However, we were lower with our Antenatal Care. MTW are to continue regular contact with local GP's and maintain the leaflets in the surgeries. Consider development of a preconception clinic. **28th March 2018, actions still outstanding.**
National diabetes inpatient audit (NaDIA) 2016	**Y**	**National report received 8 March 2017.** With specialty for assessment.
National Core Diabetes Audit (NDA) 2015-16	**Y**	**Report published 31 January 2017**. Downloaded April 2017, report missed due to double reporting by NDA. Currently with specialty for assessment.
Inflammatory Bowel Disease (IBD) Programme – IBD registry 2015-16	**Y**	**National report received 23 September 2016**, The Trust partially compliant. IBD specialist nurses

National Report Published April 2015 to March 2016	*Report received*	
		now in place to assist with ensuring patients are followed up within appropriate timescale.
Rheumatoid and early inflammatory arthritis (NCAREIA) 2015-16	**Y**	**National report received 24 July 2016.** Overall the Trust is partially compliant. Poor GP referrals make it difficult to triage patients into appropriate ESYN (early synovitis) clinics. GP referral database (DORIS) is available but not always used. Additional clinic capacity required to ensure patients are seen within 3 weeks of referral. Advice line available for direct access to department. 24 hour answer phone service with calls returned within 48 hours.
Neurosurgical National Audit Programme	**N/A**	Trust does not provide this service.
Falls and Fragility Fractures Audit Programme (FFFAP) pilot	**N/A**	**1. Inpatient Falls (NAIF) No report this year.**
	N/A	**2. Fracture Liaison Service** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture Database Report Received October 2017.** Received and discussed within the team. Designated #NOF nurse is now in post to identify areas where the patient journey can be shortened. Hip fracture lists are now performed every weekday morning to allow timely orthogeriatric review and physiotherapy post-op. The Fracture Liaison Service is still in development within the Trust and not able to accept patients as yet.
Sentinel Stroke National Audit Programme (SSNAP)	**Y**	**National report received October 2016** With specialty for assessment.
UK Parkinson's	**Y**	**National report received August 2016.** The Trust is partially compliant with the recommendations made. More clinic time is to be allocated to allow sufficient time for for discussions and anticipatory care planning. Need to be more aware of the management of bone health particularly in patients that have had a fall.
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	**Y**	**National Report received August 2016** MTW are to review the promotion of the PROMS questionnaires to patients in the pre-operative setting and reviewing the data that is being collected internally.
Mental Health		
Prescribing Observatory for Mental Health (POMH)	**N/A**	The Trust does not provide this service.
Suicide and homicide in mental health (NCISH)	**N/A**	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Prescribing anti psychotics for people with dementia	**N/A**	The Trust does not provide this service.
Prescribing Observatory for Mental Health (POMH-UK): Monitoring of patients prescribed lithium	**N/A**	The Trust does not provide this service.
Women and Children		
MBRRACE-UK; National Surveillance of perinatal deaths (Late foetal losses)	**Y**	**Report received May 2016** Each Cause of Death is checked by the Bereavement Midwives or Maternity Clinical Risk Manager before signing off. It's also discussed at Risk meeting if no post mortem was performed.
MBRRACE-UK; National Surveillance and confidential enquiries into maternal deaths	**Y**	**Report received 7 December 2016** Plan to extend the Emergency Gynaecology

National Report Published April 2015 to March 2016	*Report received*	
		Assessment Unit to 12 hours a day. A business case is in place for scanning at the weekend. **Update 6th April 2018,** scanning now available for longer hours on weekdays, but business case for weekend scanning has not been approved. Currently working on providing clinicians to perform emergency scans where clinically indicated, Trust still has work to do on this including ensuring availability of chaperones for the patient/doctor.
MBRRACE-UK; Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)	**N/A**	The Trust does not provide this service.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	**Y**	**Report received September 2016.** Biological therapies are safe. Treatment rates for Ulcerative Colitis have increased substantially in the past year. Plan to switch patients already on Remicade to Biosimilars. New starters to only be prescribed Biosimilars.
National Paediatric Diabetes Audit (NPDA) 2015	**Y**	**Report received June 2016** Overall the Trust was higher on a number of treatment regimens and met the criteria best practice for children with adjusted percentage HbA1c. The remaining criteria indicate the Trust outcomes were slightly lower than the National average and this is due in part to a problem with the data quality. Remedial actions have been put in place to improve data quality. **Update 29/03/18** meetings with HiCom the data software provider have taken place and the quality of the data we submit has since improved.
Neonatal Intensive and Special Care (NNAP) 2015	**Y**	**Report received September 2016** Trust performance is in line with national figures. Baby Friendly training starts April 2017 to be Baby Friendly Initiative compliant at Level 2 for all Neonatal Unit staff. All Dr's, NNU nursing staff and night staff to complete information on Badger information system to improve the quality of data entry.
Paediatric Asthma	**Y**	**Report received March 2016** The Trust is largely compliant with the national standards. More of our patients are given steroids and antibiotics than the national average. Asthma awareness training sessions are to be set up and new guidelines and information to be uploaded to intranet.
Paediatric Intensive Care (PICANet)	**N/A**	MTW does not provide this service.
Confidential Enquiries		
NCEPOD: Acute Pancreatitis (Treat the Cause)	**Y**	**Report received 7 July 2016.** Trust mainly compliant with recommendations. A Business Case for more dedicated theatre lists (hot lists) is being discussed to enable more timely access to theatres. Planning to reinstate the system of GP referral letter post-discharge advising of the need to refer patient to support services (Alcohol Support Services) as this service is provided by another Trust and will require referral by the patients GP.

Appendix C

Summary of local audits undertaken during 2017/18 against NICE Guidelines

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

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

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

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG86 Early recognition and diagnosis of coeliac disease in adults re-audit	Fully compliant	No clinical concerns identified. Standards have been met Re-audit to cover a wider spectrum of patients for example GP referrals and those with negative serology.
NICE CG137 - Epilepsy- adult criteria only	Fully compliant	No clinical concerns as standards met.
NICE QS20; Colorectal Cancer Follow-up (Kent & Medway Cancer Collaborative network audit)	Fully compliant	No clinical concerns identified. Standards have been met. Continue to monitor the follow up compliance through the peer review process to ensure adherence.
NICECG 171; Audit of intravescal Botox outcomes	Fully compliant	No risks identified as improvements noted and standards met. **Actions** developed for next round of the audit: All patients to have antibiotic prophylaxis stat dose (Gentamycin, or per C&S of prior UTI, or empirically Nitrofurantoin / Trimethoprim 3-5/days). New patients with Botox to have 100U if Idiopathic overactive bladder (IDO) and 200U if NDO
NICE CG175; How accurate is MRI in picking up clinically significant prostate cancer?	Fully compliant	Audit shows good current level of Multi-Disciplinary Team practice with expected portfolio of treatment options. Standards have been achieved.
NICE CG144 & TA287; Diagnosis, management and follow-up of patients with PE (pulmonary emboli) at TWH re-audit	Partially compliant	Wells scores are inadequately utilised and documented in notes. **Action:** e-learning teaching to assist junior doctors when they are discussing thrombolysis with patients. Readily accessible guideline on a system doctors like to use (Focus group to identify this). Change D-Dimer request system when the replacement for iSoft goes online (Already discussed and prototyped with IT but changeover delayed)
NICE CG 92. Thromboprophylaxis re-audit	Partially compliant	Despite the slight drop in performance since the last audit in general these results are encouraging. **Action**: Consultants and registrars to re-inforce trust policy within their teams. Re-visit implementation of a Post-Take Ward Round checklist within medicine and emergency surgery. To be piloted and then included in the speciality proforma. Raise further awareness of missed anticoagulation doses during mandatory training sessions on VTE prevention. All ward managers to ensure staff are aware of their responsibilities in relation to mechanical thromboprophylaxis (compression).

CG144. QS 29: Suspected DVT and administration of interim therapeutic anticoagulation if investigation will take over 4 hours to occur	Partially compliant	90% patients are either having their scan or receiving treatment anticoagulation within 4 hours of the scan being requested. **Action:** Raise awareness of the importance of commencing treatment anticoagulation for suspected VTE as part of the re-launch of the trust policy. The importance of commencing treatment anticoagulation for suspected VTE to be included in induction / training programmes for the new junior doctors commencing at MTW this summer.
CG 179: Prevalence Audit - April 2017	Partially compliant	Hospital acquired damage (HAD) has increased slightly to 3.2% which is over the trust target of 3%. Damage to the sacrum and heel areas has increased from the last round of the audit. **Action:** Continued formal and informal training ward based training by the Tissue Viability Team. Training on recognising and preventing moisture associated skin lesions. Root cause analysis on all category 2+ ulcers.
CG 32: Insertion and ongoing care of naso gastric tubes	Partially compliant	The majority of audited care scenarios met 70-80% of the expected standards, with 30% of the cohort demonstrating 100% compliance **Action:** NG tube in house learning delivery, to highlight best practice and adherence to Trust NG practice. Review unit access to current guidelines on placement and ongoing care (including flow charts). Presentation on ITU chart and/or Saving Lives form to show failed aspiration, nostril side, PH/length and need for repeat CXR.
NICE CG130: Delirium screen and prevention: A reflective practice.	Partially compliant	Pain was higher than 3 (0-10 scale) in half of the patients' population. Early rehabilitation and mobilisation, reorientation strategies recommended are being achieved **Action:** CPOT scoring to be implemented for non-verbal patients e.g. ventilated patients. Bowel Guideline to be updated and disseminated across staff.
NICE QS63 Delirium Round 3 re-audit	Partially compliant	We found no evidence that de-escalation techniques had been used. 48% of patients who were diagnosed with delirium didn't have their diagnosis communicated to GP on their electronic discharge summary. **Action:** Mandatory teaching to junior doctors about delirium. Visit wards to make sure ward managers know about the delirium leaflet. Education of new junior doctor intake about the need to communicate results to GP regarding diagnosis of delirium.
NICE TA188; Re-audit of the Human Growth Hormone (somatropin) Treatment of Growth Failure in Children	Partially compliant	A sticker was produced to be added to the patient's notes to prompt staff regarding giving information to patients and parents/carers. Full compliance in care standards but failing in audit standards with regards giving awareness on the "understanding of NICE guidance booklet". **Action:** To include the link to "understanding of NICE guidance booklet" on the leaflet that patients/parents are given at discussion of growth hormone commencement.
NICE CG151; Re-audit of Febrile Neutropenia Patients (Round 3)	Partially compliant	85% of children seen received antibiotics within 1 hour however all children did receive antibiotics by 75 minutes. **Action:** Continue use of Oncology Admission pro-forma and continue staff support/education Continue ward based education for the immediate care of an unwell child who is receiving chemotherapy.
NICE CG 162 Are realistic goals being identified for stroke patients on the acute stroke units at MTW?	Partially compliant	The main clinical concerns are the inconsistent recording and the inconsistent use of the correct goal setting paperwork. **Action:** Put goal setting advice sheet including information on prognostic indicators on the current goal paperwork. Key worker to ensure correct paperwork is used. Fortnightly goal setting meetings with patients included on stroke unit timetables.MDT teaching on the use of the prognostic indicator tool.
NICE CG92; Audit of post-operative extended thromboprophylaxis for patients undergoing major abdominal surgery for Cancer	Partially compliant	Compliance rates of 85.5 % for elective and 45.5 % for emergency patients. **Action:** Place posters in strategic areas of the wards and doctor's offices, along with banners above every computer in the department. The Thrombosis Committee who are currently in the process of debating a newly proposed algorithm to be included in the electronic discharge summary software. The purpose of the algorithm is to give a decision tree to aid the doctor completing it to arrive at the appropriate extended thromboprophylactic treatment on discharge.
NICE NG:24 Audit of Tranexamic acid use in developmental Dysplasia of the hip surgery to reduce blood loss	Partially compliant	**Action:** We would advise Tranexamic acid's continued use in cases where there is higher risk of bleeding until further high powered evidence is available and anaesthetists and surgeons sought to decide on a case based basis. Tranexamic Acid to be administered for all open DDH surgeries where blood loss >10% is anticipated. Re-audit not required as now standard practice in this type of surgery.

NICE CG124 & 161; Are we providing written information to our Hip Fracture patients?	Partially compliant	Standard has improved to 68% since the last round of this audit. Having a new NOF nurse has been key factor for improvement, as this role that will provide continuity of practice throughout the year **Action:** Neck of femur nurse should provide information booklets to newly diagnosed #NOF patients on the daily ward round. A Tick box has been added to the SHO printable on call template as a prompt to give information leaflets to patients. NOF booklets to be kept in the trauma room and no Ward 31.
NICE CG124 & QS49; Reducing Surgical Site Infections (SSI) rates in Neck of Femur (#NOF) Fractures - Sutures or Staples?	Partially compliant	These results (although only small numbers) indicate a greater risk of complications associated with clips for skin closure in hip fractures (0% - Sutures. 10.4% Clips). **Action:** A prospective trial will be commenced to further evaluate the perceived benefit of suture closure vs clips. Routine Daily Wound Reviews and senior review prior to discharge.
NICE CG132 - Re-audit of indications, categories and surgeons for Caesarean Section in Maidstone & Tunbridge Wells NHS Trust	Partially compliant	Completion of operation notes has improved with the introduction of the E3 operating system, but remains suboptimal. **Action:** E3 training at induction for all new doctors (at every level).Ensure Obstetric team aware of indications for and mode of referral to Birth Choices clinic. Ensure Obstetric team aware of indications for and mode of referral to Birth Choices clinic.
NICE TA377 Improving the monitoring of toxicities associated with the use of Abiraterone and Enzalutimide	Partially compliant	This project identified the shortcomings of toxicity monitoring of both these agents. **Actions:** We have developed a simple nurse led checklist with each of the monitoring parameters identified. This checklist can also be used by physicians and supporting medical professionals who see patients in clinics. The primary benefit will be to serve as not only a memory aid of the monitoring requirements required at the relevant timelines but will also serve as a place to document this information in one place. The ultimate aim will be to have the checklist available on the online KOMS database.
NICE CG16; Re-audit of the management of Deliberate self-harm in children who present to the Emergency Department	Not compliant	Lack of documentation regards needs assessment. Improved documentation of referral to CAMHS. **Action:** Education of all ED staff regarding paediatric self-harm and taking an effective psychiatric history. Training to be delivered by CAMHS as part of clinical governance. Targeted staff training (Paediatric ED staff (Medical and Nursing) followed by staff in adult areas. DSH Checklist to be circulated, available and included in the ED handbook. Checklist and Safeguarding checklist to be completed for all patients presenting with DSH.
NICE CG75; Metastatic spinal cord compression in adults: risk assessment, diagnosis and management	Not compliant	This audit demonstrated that many patients fall outside of the treatment window from diagnosis to treatment. **Action:** Update and/or change local guidelines at Maidstone hospital to allow for quicker response for patients.
NICE CG68; Carotid Doppler Ultrasound audit	Not compliant	Only half of the patients audited had an early Carotid US imaging within the recommended timeframe. Only a third of the patients audited had a CEA within the recommended time frame. **Action**: Improving the knowledge of junior doctors about the importance of the carotid imaging for the prognosis and further management of patients with non-disabling stroke/TIA. Improving availability of carotid Doppler to ensure that patients can be scanned within 48hours. Lack of US availability is due to insufficient staffing. More staff currently being trained. Clear, simple but robust and straightforward referral pathway to Vascular team, Online referral form to be developed.
NICE CG152 Crohn's Disease	Not compliant	37% of cases were patients with a first presentation or a single inflammatory exacerbation of Crohn's disease in a 12 month period are offered monotherapy with a conventional glucocorticosteroid **Action:** Patients starting steroids for Crohn's disease should be discussed in the virtual biologics and immunosuppression clinic and reviewed in the nurse-led clinic at the end of the course of treatment.
NICE CG141; Management of Upper Gastrointestinal Bleeds re-audit	Not compliant	49% underwent Blatchford score at initial assessment. 0% of patients received a Rockall assessment score post endoscopy. 50% of stable patients had an endoscopy within 24 hours **Audit:** Mandatory use of electronic endoscopy requests to ensure uniformity in the clinical information provided by the requesting doctor, and especially to encourage the use of the Blatchford score. iSOFT request will be required for all endoscopies to proceed. Completion of a post-endoscopy Rockall score to be a mandatory field.

NICE CG186 - Multiple sclerosis - management of multiple sclerosis in primary and secondary care	Not compliant	We are not identifying patients with a potential diagnosis of MS reliably from referral letters (GPs, A&E and other specialities) so they cannot be fast-tracked into Urgent slots. **Action:** All neurology consultants to read the referral letters and mark as URGENT so appropriate clinic slots can be arranged. Consultant to mark test as URGENT either on paper form or by phone call with MRI. Beds to be made available on AMU at Tunbridge Wells to enable LPs to be performed. Proforma to be developed for completion at follow-up appointments to act as an aide to ensure all potential symptoms are reviewed.
NICE CG124; Insufficient Orthopaedic Theatre Time Audit	Not compliant	73% of patients receive their operation within 36 hours of diagnosis. Not meeting best practice targets for NOF's. Large number of bed days used as a result of cancellations & prolonged inpatient waiting. **Action:** Business case to support Orthopaedics using theatre 6 when it re-opens in June along with opening at weekends.
NICE CG132 & NG15; Re-audit of anti-microbial prescribing in the Obstetric & Gynaecology departments within MTW (Round 2)	Not compliant	The lack of documentation of duration of antibiotic courses leaves patients at greater risk of receiving unnecessary doses of antibiotics. There was a general problem with unclear documentation of the indication for antibiotics in the medical notes **Action:** Teaching on antimicrobial prescribing during local departmental induction at the beginning of each block. A single document on the intranet (Q pulse) with antibiotic guidelines listed, compared to currently having to search pages of separate documents. Produce a sheet on the guidelines and documentation needed on a drug chart concerning antimicrobial prescribing. Laminate the sheet and put up around Delivery Suite, Postnatal Unit & Gynaecology wards across the trust.
NICE CG 171 Re-audit for the outcomes and procedures of TVT/TVT-O 592	Not compliant	Consenting standards have improved since the last round of this audit however there still remains an issue with failing to document all risks. Only 53% of patients are having the recommended 3 months supervised physiotherapy before being recommended the procedure. **Action:** Staff were reminded to document if physiotherapy has been recommended and taken up. If not taken up then staff to document the reason why the patient declined. All clinics to have the appropriate leaflets available and clinicians to document when the leaflet has been given to patients. A standard consent sticker and leaflet reminder has been produced and distributed for use in clinics to improve the level of documentation. A Urogynaecology MDT is to be set up to review and document all cases.

Part Five

Stakeholder feedback

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

West Kent Clinical Commissioning Group comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

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

Patient Safety
Learning from incidents and embedding change is an essential part of a safety culture. We look at how MTW learns and shares from serious incidents as part of our incident closure process, identifying themes and trends to help provide greater scrutiny in some areas. It is pleasing to note that several changes have been implemented this year including the further development of the WHO checklist and the delivery of human factors training. Observed mortality rates have continued to decline throughout the year.

Patient Experience
Listening to feedback from patients and their relatives is essential to enable improvements in care. The CCG is pleased to see that the Trust is committed to improving the response rates from the Friends and Family Test to influence their changes and welcome their continued commitment to include service user engagement.

Clinical Effectiveness
Effective patient flow is conducive to improved patient care and outcomes and remains a large focus of the work within MTW. We are working with all stakeholders to support MTW in reducing the length of stay and facilitating effective discharge, the opening of the acute frailty unit has ensured some of the most vulnerable patients attending the ED receive the most appropriate care to allow them to return home.

The recent CQC inspection noted the Trusts significant and sustained improvement which the CCG has also recognised and fully support them in aiming for good or outstanding in their next inspection.

Paula Wilkins

Chief Nurse
West Kent CCG

May, 2018

Health Overview and Scrutiny Committee – Kent County Council comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

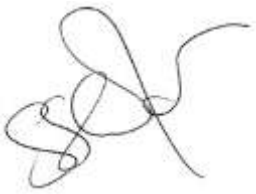
Maidstone & Tunbridge Wells NHS Trust Quality Account 2017/18

Thank you for offering Kent County Council's Health Overview & Scrutiny Committee (HOSC) the opportunity to comment on the Maidstone & Tunbridge Wells NHS Trust's Quality Account for 2017/18.

As the Committee did not formally scrutinise any services directly provided by the Trust in 2017/18, the Committee will not be making any comments on the Trust's Quality Account this year.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of the finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Kind regards



Sue Chandler

Chair, Health Overview and Scrutiny Committee Kent County Council

9th May, 2018

Healthwatch Kent comments on the 2017/18 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

This takes up a large amount of time, so we have taken the decision to prioritise our resource on making a difference to services rather than reading Quality Accounts.

However, we would like to support the Trust with a comment which reflects some of the work we have undertaken together in the past year.

We have seen that Maidstone and Tunbridge Wells value and understand our role as a "critical friend" which has translated into a good working relationship. Some of our involvement with the Trust this year has included:-

- Being a proactive member of the Patient Experience Committee and supporting the group's development
- Meeting regularly with the Director and Deputy Director of Nursing to discuss involving and listening to patients and families
- Gathering feedback from over 100 patients about their experience of being discharged from hospital in West Kent.
- Working with the Trust to amplify the experience of a Parkinson's patient. This patient has shared her story directly with the Board and is now working with us and the Trust on some of the issues she raised.
- The Trust regularly invites us into the hospitals to listen to patients about their experience and acts upon our findings.
- This year we will be visiting the Trust to test out how they are implementing the Accessible Information Standard.

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

Healthwatch Kent

May 2018

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

We have been engaged by the Board of Directors of Maidstone and Tunbridge Wells NHS Trust to perform an independent assurance engagement in respect of Maidstone and Tunbridge Wells NHS Trust's Quality Account for the year ended 31 March 2018 ("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, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to the limited assurance engagement 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 the directors and Practitioner
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement 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 and NHS Improvement 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 the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and 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 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from commissioners dated May 2018;
- feedback from local Healthwatch organisations dated May 2018;
- feedback from the Overview and Scrutiny Committee dated 9 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2018;
- the national patient survey dated 13 June 2018;
- the local patient survey dated September 2017;
- the national staff survey dated 6/3/2018;
- the local staff survey dated July 2017;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2018;
- the Annual Governance Statement dated 24 May 2018;
- the Care Quality Commission's inspection report dated 9 March 2018;
- the results of the Payment by Results coding review dated February 2018; and

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for 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, except 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;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against 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 that can result in materially different measurements and can affect 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 of these criteria, 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 and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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

Our audit work on the financial statements of Maidstone and Tunbridge Wells NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Maidstone and Tunbridge Wells NHS Trust's external auditors. Our audit reports on the financial statements are made solely to Maidstone and Tunbridge Wells NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Maidstone and Tunbridge Wells NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Maidstone and Tunbridge Wells NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Maidstone and Tunbridge Wells NHS Trust and Maidstone and Tunbridge Wells NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion
Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018

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

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Gatwick

29 June 2018

Statement of Directors' responsibilities in respect of the Quality Accounts

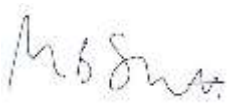
The directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality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

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

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

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

By order of the Board



Miles Scott
Chief Executive

29th June, 2018