NHS
Maidstone and Tunbridge Wells
NHS Trust

Quality Accounts
2018/19

MTW
exceptional people, outstanding care

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 2018/19 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 2019/20.

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.

About Us

Maidstone & Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. It provides a full range of general hospital services to around 590,000 people living in West Kent and East Sussex. The Trust also provides some aspects of specialist care to a wider population.

The Trust employs a team of over 5000 staff. It operates from two main sites but also has services at Canterbury and Crowborough hospitals and outpatient provision at several community locations. It has over 800,000 patient visits a year, 150,000 of these coming through our Emergency Departments which are accessible on the main sites. Maidstone Hospital has 325 overnight beds and Tunbridge Wells Hospital has 475 overnight beds.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital, providing mainly single bedded en-suite accommodation for inpatients in a modern, state of the art environment. It is a designated Trauma Unit, undertakes the Trust's emergency surgery and is the main site for Women and Children and Orthopaedic services.

Maidstone Hospital benefits from its central county location. It hosts the Kent Oncology Centre providing specialist cancer services to around 2 million people across Kent and East Sussex, the fourth largest oncology service in the country. The Trust offers PET CT services in a new, dedicated building and has a rolling programme to upgrade its Linear Accelerator radiotherapy machines.

The Maidstone site also has a state of the art birth centre, a new £3 million dedicated ward for respiratory services and an impressive academic centre with a 200 seat auditorium. With the academic centre at Tunbridge Wells, and its full resuscitation simulation suite, the Trust is able to offer excellent clinical training. The Trust has strong clinical, academic and research links with London hospitals, including joint appointments and a growing research capability. Many staff are also nationally recognised for excellence in their fields.

MTW exceptional people, outstanding care

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Part One
Chief Executive's Statement

Miles Scott Chief Executive

Welcome to our Quality Accounts for 2018/19 which outlines the many actions we have taken and continue to build upon to improve the patient experience at Maidstone & Tunbridge Wells NHS Trust.

We have made significant progress in the quality and safety of our services over the past year. We have changed our organisational structure to put more frontline and clinical staff at the heart of running our services, worked better and smarter with other local healthcare partners to deliver innovation in clinical care, delivered our winter plan at a time of unprecedented demand for our services and been removed from Financial Special Measures, hitting our financial plan and delivering our first surplus in five years, meaning we can invest this back into patient care.

We are committed to building on these successes to further enhance the care we provide to our patients.

Our ambition is to become an Outstanding provider of NHS care with hospitals that we can all feel rightly proud of because they are patient-focused and clinically-led. While we recognise that we have further to go to be outstanding in everything we do for our patients, putting quality improvement at the core of our organisation is making a real difference for our patients at a time of unparalleled demand for NHS care.

Our Best Care programme brings together all our quality plans in a focused and cohesive approach that allows us to continue to improve patient care and move forward with our ongoing efforts to become a more caring, sustainable, and improvement driven organisation.

Best Care recognises that our journey of improvement needs to involve our staff, patients, public and healthcare partners in everything we do. With your help, we can shape our quality improvements to be even more of a patient-centred provider of personalised-care.

Our hardworking and hugely dedicated teams of healthcare professionals have continued to respond to this unprecedented demand year on year. As our healthcare needs evolve and change, it is important that we have the ability to quickly adapt to these changes 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 2018/19 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 for 2019/20 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 2019/20

Patient Safety

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

Key objectives will include:

- Creating a safety culture that embraces 'lessons learned'
- Reducing healthcare associated infections
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.
- Improve the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation.

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:-

- Launch and delivery of the new Patient Engagement and Experience strategy 'Making it happen'.

- Improving End of Life Care in the acute trust.
- To recognise and respond to the specific needs of our patients with complex needs

Clinical Effectiveness

To improve patient flow through the delivery of safe and effective care for patients by whichever pathway of care best meets those needs.
Key Objectives will include:-

- Improving the delivery of clinical quality standards and therefore timely treatment for our patients accessing care through both our emergency and planned pathways of care.
- Improving patient flow through the development of alternative care models/pathways.
- Reduction in cancelled operations.
- Development of new and advanced roles to improve pathways of care and raise staff morale.

We will monitor our progress against these objectives through our Divisional 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.

Maidstone Birth Centre welcomed its 3000th Baby on 4th October, 2018. The new born is pictured with her parents Abbie and Elliot Mason.

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 2018/19 the Best Safety work stream has overseen the delivery of 'Lessons Learned'. This has been instrumental in ensuring that our governance processes and procedures are redesigned in a manner that will support the meaningful flow of information. This has included the procurement of an enhanced incident reporting database and a review of the agenda for each Directorates Clinical Governance sessions. The intention is to ensure that our staff will have the ability to gain insight into the services they provide by having access to meaningful data that 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 through the process of learning.

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 and know we will act appropriately to improve patient safety as a whole organisation. Our aspiration is the transition to an organisation that demonstrates 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 and 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 continued to work with our commissioners in regard to the declaration of serious incidents (SI's). During 2017/18 we had seen an increase in the number of SI's being declared, of note SI's are being reported which following investigation is then evident that the severity of the incident wasn't as high as initially thought so they were downgraded. During 2018/19 we have seen these numbers plateau as commissioner confidence and transparency of our processes has grown. Both NHS Improvement and our CCG quality leads have attended SI Panels and contributed to this process.

We have seen the number of complaints increase; while this may seem counter-intuitive, our complaints still remain below the expected parameters for an organisation of our size. Supporting our patients to raise their concerns is important to us. This feedback helps to inform improvements to pathways of patient care for the organisation and helps inform education for our staff to support change and constant improvement.

Identified areas for improvement and progress during 2018/19

The following actions were taken in 2018/19

- During the year we have seen a degree of success with improving our incident reporting, the numbers initially did rise and have continued to remain static. However, this has not been sufficient to improve our profile nationally.
- Positively we have seen greater improvement in the investigation and closure of incidents. This has helped to ensure that staff receive timely feedback when they've made the effort to report an incident and supports organisational learning.
- Investment in our Incident reporting system has been approved with the rollout of an enhanced system due in 2019/20.
- During the course of the year we've been raising awareness of Duty of Candour and have assurance that the standard is complied with for Serious Incidents. Data capture for moderate incidents has proved more challenging and will be addressed during the upgrade of our incident reporting system.
- The Trust's Mortality Steering Group has continued to review themes and trends from both our Mortality Reviews and the data supplied by Dr Foster. Investment and improvement in our coding and requirements for seven day services (7DS) has seen a sustained improvement in both SHMI and HSMR resulting in a sustained improvement comparable to our peers.
- Human Factors training received further investment this year with 24 courses made available to all grades of staff from June 2018 – March 2019.
- Review of the Schwarz Round process resulted in a task and finish group with three clinical leads now trained in the methodology. This process is launching in April 2019 with the aim and intention of supporting our staff with the emotional and social aspects of working in healthcare.
- Investment was made in providing Root Cause Analysis workshops to support our staff to become more involved in the incident reporting and investigation process, with the benefit of learning about pathways of care external to their own Directorates.
- We have sustained our trajectory of improvement in the consistent recognition and rapid treatment of sepsis in our emergency and inpatient departments achieving all quarters with the exception of Quarter 1 which we narrowly missed for inpatients.
- Sepsis Study Day – 'Let's all talk sepsis' 11th September, 2018 which included a patient who had survived sepsis as the keynote speaker.
- Introduction and rollout of NEWS2 - the new patient at risk score to support early identification of the key triggers for sepsis, comprising of bespoke training sessions for our clinical staff.
- Introduction of a new Emergency Department sepsis screening tool for completion during triage.
- Sepsis scenario incorporated into our portfolio of Simulation training.
- 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.
- MTW are working with NHS Improvement; Maternal & Neonatal Safety Collaborative (MatNeo) and have introduced a lead matron for smoking cessation.

- MTW are part of the safety collaborative PreCePT imitative to identify Mothers who may be at risk of an imminent premature birth. This is to ensure they are given Magnesium Sulphate which is shown to improve neurological outcomes for premature babies.
- Investment and upgrade of the services at Crowborough Birth Centre to improve the choice agenda for our expectant parents.

Areas for focus and improvement during 2019/20

Key objectives will include:-

- Creating a safety culture that embraces 'lessons learned'-
    - Increasing the number of incidents that are reported to identify themes to support positive change and improvement
    - Continued focus on reducing our Trust-level mortality figures in line with the national average (HSMR/SHMI) through learning from mortality reviews
    - Supporting staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety.
    - Embed a safety culture within all departments undertaking invasive procedures which complies with the WHO surgical safety methodology.
- Reducing healthcare associated infections, in particular:-
    - Clostridium Difficile
    - Gram negative bloodstream infections
    - MRSA/MSSA bloodstream infections
- Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.
- Improve the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation.

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 improving quality and experience is fundamental in our transformation and improvement journey to become an Outstanding provider of NHS care. We also know that a key enabler of that cultural shift is in demonstrating that we put patients and staff at the heart of planning and decision making as outlined in our Trust's Quality Strategy.

We also recognise that positive outcomes for our patients are synonymous with improved levels of staff satisfaction, each impacting on the other. In September 2018, the Trust Board approved the development of a more Clinically Led Organisation with a revised reporting structure to promote greater engagement and responsibility within our clinical departments. One of the key characteristics of promoting this level of autonomy is to ensure that our services are clinically-led, patient centred and committed to excellence.

In addition, we committed to improve engagement with our patients and improve the care for our patients with complex needs which is overseen by the Best Quality workstream. This has resulted in the development of the Patient and Carer Experience Strategy, 'Making it Personal'. The strategy has been co-designed and co-produced with our patients, carers and partners identifying 10 key 'Always Do's' that would help to improve their experience whilst in our care. These include:-

- **Be kind to me, respect me and relate to me as an individual**
- **Ask me how I want to be addressed**
- **Let me know who is caring for me**
- **Support me to be part of the discussion about my care planning and decision making**
- **Make good use of my time and that of my loved ones**
- **Support me in retaining my independence and respecting my preferences and daily routines**
- **Give me accurate, tailored information about my care that helps me stay in control**
- **Seek out and respond to the issues and questions about my care that matter to me**
- **Help me navigate and move between different services and providers**
- **Help me stay well and out of hospital for as long as possible**

Aim/goal

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 2018/19

The following actions were taken in 2018/19

- Engagement events were undertaken in Ditton and Tunbridge Wells in October to understand what really matters to patients and carers. This was then followed-up in November to co-design the improvements identified.
- In December and January outreach engagement was undertaken with harder to reach groups to ensure their views were gained and incorporated.
- In February and March, engagement and invitation to comment on the draft strategy; 'Making it Personal' which also used information gained from complaints, surveys and Healthwatch insight reports.
- Healthwatch have been actively engaged with A&E site visits, attendance at the Patient Public and Engagement events and also regularly supported us with our internal assurance inspections of wards and departments. They also attended the Trust Board in December, 2018.
- The CQC have undertaken four separate engagement events over the course of the year. During these visits our staff are supported to present their services and discuss any issues that they face alongside the actions that are being taken to address these. All visits were very positively received and were an opportunity for direct questioning and feedback to be given to the staff that they met.
- Regular meetings also take place between the Executive leads and the leads from NHS Improvement; their quality lead has also attended an internal Never Events action group and a Serious Incident learning & improvement panel.
- The Quality leads for MTW, West Kent CCG and the Sussex Alliance regularly meet to discuss quality aspects of care and also are integral to the internal assurance inspection process in regard to the 'fresh eyes' approach.
- The Lead Nurse for Dementia care has been working collaboratively with the West Kent Alliance to ensure that the dementia strategy is progressed. In addition she has been attending the community dementia hubs to gain valuable feedback in regard to our patients' experiences at MTW.
- The Learning Disability Liaison Nurse has provided updates and training for a wide range of staff from A&E to Maternity to continue to raise awareness and support for patients with a learning disability (PWLD) who use our service. She has also actively supported PWLD's to attend their appointments and undergo pathways of care.

- In addition our Learning Disability Liaison Nurse has developed a sub-group of the Accessible Information Committee to review patient information for PWLD.

Areas for focus and improvement during 2019/20

Key objectives will include:-

- Embed and delivery of the Quality Improvement plan.
- Improving End of Life Care in the acute trust.
- To recognise and respond to the specific needs of our patients with complex needs including:-
    - Working with our partner organisations to deliver all aspects of the accessible information standard
    - Development of training strategies to support our staff in delivering care appropriate to their patients' needs

Executive lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation lead: Judy Durrant & Gemma Craig, Deputy Chief Nurses
Monitoring: Patient Experience Committee.

As the Trust takes huge strides to become even more Dementia-friendly, our colleagues on Mercer Ward have been rolling out special coloured Zimmer frames courtesy of the Maidstone Hospital League of Friends, to help our patients get up and around. It has been recognised through our Allied Health Professionals project that dementia patients find it difficult to identify objects that are all of a similar colour, such as the standard grey frames. These frames will also be beneficial for those with sight impairments helping to reduce the risk of patient falls.

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 routes 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 to our inpatient areas, ensuring the minimum length of stay possible. Additionally this will include the ongoing work to support the reduction in bed occupancy rates, achieving the A&E 4 hour quality standard, 18 week referral to treatment and the cancer quality standards.

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 for improvement and progress during 2018/19

The following actions were taken in 2018/19

- Development of streaming criteria directly to Ambulatory Emergency Care (AEC) to facilitate a timely clinical review.
- Development of direct GP and Southeast Coast Ambulance (SECAmb) conveyance to the appropriate unit i.e. AEC or Frailty units.
- Collaborative working with SECAmb and Kent Community Health Foundation Trust (KCHFT) in the development of alternative pathways of care to support patients in their own home.
- Increase of GP hours within the Emergency Department (ED).
- Continued collaboration with Kent and Medway NHS and Social Care Partnership Trust (KMPT) and SECAmb to develop plans of care which will support patients with mental health needs who frequently attend ED to seek help in the most appropriate place.
- Launch of Hospital@Home service to support patients with their care needs in their own homes. These patients are overseen by a Consultant at MTW with their care being provided by KCHFT.
- New pathway of care provided for patients recovering from a fractured hip to rehabilitate at Tonbridge Cottage hospital.

The pharmacy team has launched ward based dispensing on Ward 2 and the Acute Frailty Unit at Tunbridge Wells Hospital. This allows the pharmacy team to facilitate prompt patient discharge through dispensing some discharge medication using ward pharmacy stocks. This has proved particularly beneficial to those patients who may only require a small number of items dispensed. This dispensing would normally join the large volume of work undertaken in the hospital pharmacy and can necessitate a wait for these items before discharge is possible.

Areas for focus and improvement during 2018/19

Key objectives will include:-

- Improving the delivery of clinical quality standards and therefore timely treatment for our patients accessing care through both our emergency and planned pathways of care.
    - To ensure that an increasing number of patients are promptly seen and treated through our emergency departments
    - To reduce the number of patients waiting for their procedures on our elective waiting list whilst ensuring that they do not come to harm
    - Improvements in timeliness of diagnosis, decision making and treatment for our cancer patients
- Improving patient flow through the development of alternative care models/pathways.
- Reduction in cancelled operations.
- Development of new and enhanced roles to improve pathways of care and raise staff morale.

Executive lead: Sean Briggs, Chief Operating Officer
Board Sponsor: Sean Briggs, Chief Operating Officer
Implementation lead: Lynn Gray, Divisional Director of Operations Medicine & Emergency Care/Deputy Chief Operating Officer
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 required to register with the Care Quality Commission and its current registration status is 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 2018/19.

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

During 2018/19 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 (3). The Trust has reviewed all the data available to them on the quality of care for these three NHS services.

The income generated by the NHS services reviewed in 2018/19 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 2018/19, undertaken by external organisations such as:

- 2017/18 Annual Accounts External Audit; Grant Thornton – concluded May 2018
- General Medical Council; Trainee and Trainer Survey – May 2018
- CQC Engagement Event – 6th June 2018
- HM Revenue and Customs (Tax and NI compliance inspection) – June 2018
- Environmental Health visit to catering facilities (Full 5 star hygiene rating awarded) – June 2018
- HEKSS Surgery Programme Risk-based Review – 10th July, 2018
- Pharmacy; Aseptic Units, Regional Quality Assurance – 4th September, 2018
- CQC Engagement Event – 5th September 2018

- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – September, 2018
- 2017/18 Charitable Funds independent examination by external auditors, Grant Thornton – concluded October 2018
- HEKSS Paediatrics Programme Risk-based Review – 20th November, 2018
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – November 2018
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – November 2018
- Medicines and Healthcare Products Regulatory Agency (MHRA) – Transfusion – November 2018
- CQC Engagement Event – 6th December 2018
- Human Tissue Authority – Tunbridge Wells Hospital mortuary – December 2018
- CHKS Accreditation ISO9001 –February 2019
- NHS Improvement, Kathy McClean, Medical Director – Cancer review 20th February 2019
- HEKSS Surgery Visit – Risk based review (Senior Led Conversation) – 4th March 2019
- CQC Engagement Event – 21st March 2019

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 and Sussex Alliance CCG's.
- 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.

26 November 2018, via Facebook: Thank you to the NHS staff at Pembury Hospital who treated me! Pembury hospital is clean and full of wonderful staff!

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 2018/19, MTW participated in 4 (100%) relevant confidential enquiries and 55 (98%) relevant national clinical audits (1 was not submitted due to problems with software compatibility – this is currently being resolved). During the same period, MTW staff successfully completed **192** clinical audits of the **219** due to be completed (local and national) to action plan stage of the **391** 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 2018/19 are presented as follows-

National Clinical Audits for inclusion in Quality Accounts 2018/19	***Participation*** Y, N or NA	***No of cases submitted***	***% cases submitted***	***Comments***
Recruited patients during 2018/19 (Any period during 01/04/2018 to 31/03/2019)				
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	MGH – 405 TWH- 573	100%	Continuous data collection.
Emergency Laparotomy Audit (NELA)	Y	MGH – 18 TWH – 196	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 - 330	66 - 84%	For some months there has not been dedicated input for TARN which has caused a fall in submission numbers. Data collection still open and data being submitted
National Joint Registry (NJR)	Y	MTW Trust - 715	100%	Data collection still open and data being submitted

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
RCEM VTE risk in lower limb immobilisation (care in the ED) 2018	Y	MGH – 50 TWH – 50	100%	
RCEM Vital Signs in Adults (care in the ED) 2018	Y	MGH – 50 TWH – 50	100%	
RCEM Feverish Children (care in the ED) 2018	Y	MGH – 33 TWH – 50	100%	Majority of children taken directly to TWH Emergency Department
BAUs Urology Audits: Radical prostatectomy audit	Y	MTW Trust - 59	100%	
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
BAUs Urology Audits: Nephrectomy Audit	Y	MTW Trust - 26	100%	This is the number of cases for the Urology Consultant and includes his activity at Medway Hospital. Activity is reported by surgeon rather than site.
BAUs Urology Audits: Percutaneous Nephrolithotomy (PCNI)	Y	22	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				
Serious Hazards of Transfusion 2018 (SHOT) UK. National haemovigilance scheme	Y	MTW Trust - 20	100%	Continuous data collection.
(National Comparative Audit of Blood Transfusion Programme) Audit of massive haemorrhage	Y	MTW Trust - 2	100%	All cases submitted, major haemorrhage is rare.
(National Comparative Audit of Blood Transfusion Programme) Audit of FFP and cryoprecipitate in children and neonates.	N/A	N/A	N/A	Trust did not register to take part. Too few cases to warrant inclusion in this audit.
Cancer				
Lung Cancer (NLCA)	Y	MTW - 226	100%	Yearly rolling audit with continuous data collection. Figures up to February 2019.
Bowel Cancer (NBOCAP)	Y	MTW – data not available yet	100%	Continuous data collection. Yearly upload to website due in June 2019 -

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
				final data submission has not yet taken place.
National Prostate Cancer Audit (NPCA)	Y	MTW - 400	100%	Yearly rolling audit with continuous data collection. Figures up to February 2019.
Oesophago-gastric cancer (NAOCG)	Y	MTW - 71	100%	Participation in diagnostic pathway element only – MTW does not perform major Upper GI surgery.
National audit of Breast Cancer in Older people (NABCOP)	Y	Exact numbers not available from national organisation	100%	NABCOP uses existing sources of patient data collected by national organisations including the National Cancer Registration and Analysis Service (NCRAS) in England and cannot provide data on exact numbers submitted by the trust. Trust numbers will be published in the next national report (most recent national report published in June 2018 with 2014-16 data showed 1,919 patients diagnosed from MTW during that timeframe.
Heart				
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Y	MGH – 148 TWH – 168	100%	Data collection still open and data being submitted
National Heart Failure Audit	Y	MGH – 184 TWH – 271	100%	Data collection still open and data being submitted
Coronary angioplasty/ National audit of Percutaneous Coronary Interventions (PCI)	Y	MTW - 265	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	MTW: 319 - Pacemaker 46 – electrophysiology procedures	100%	Data collection still open and data being submitted
National audit of Cardiac Rehabilitation (NACR)	Y	MGH – 392 TWH – 459	100%	Data collection still open and data being submitted
National Cardiac Arrest Audit (NCAA)	Y	MTW - 137	100%	Continuous data collection.

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
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) 2018	Y	N/A	N/A	Only hospital organisational data was required for 2018. These have been submitted.
National Diabetes Inpatient Audit – Harms	Y	MGH – 16 TWH – 11	100%	Data collection still open and data being submitted
National Diabetes Foot Care Audit	Y	MTW – 99	100%	Data collection still open and data being submitted
National Core Diabetes Audit (NDA) 2017-18	Y	MGH – 1693 TWH – 2243	100%	
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Pulmonary Rehabilitation	Y Trust registered as West Kent Community Pulmonary Rehabilitation Service.	MTW - 2	100%	Data collection started 1 March 2019. Data collection ongoing
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Secondary Care	Y	MGH – 301 TWH – 302	100%	Data collection still open and data being submitted
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – Adult Asthma Secondary Care	Y	MGH – 53 TWH – 46	100%	Data collection started in Feb 2019. Data collection open and data being submitted
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MTW – 217	100%	
National Early Inflammatory Arthritis Audit (NEIAA)	Y	MGH – 24 TWH – 22	100%	Data collection open and data being submitted
National Audit of Anxiety and Depression	N/A			MTW does not provide this service
Older People				

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	1.Inpatient Fall National Audit of Inpatient Falls (NAIF) MTW – 1 2.Fracture Liaison Service Database organisational data 3. National Hip Fracture Database MTW Trust - 512	1. 100% 2. N/A 3. 88.4%	1. Data collection started in February 2019. Only notified about 1 patient from NAIF 2. MTW does not provide this service. This is a community service. 3. Data collection still open and data being submitted
Sentinel Stroke National Audit Programme (SSNAP)	Y	1.Organisational 2. Clinical Data MGH: - 354 TWH: - 433	1. N/A 2. 100%	1. This element not required for 2018-19 2. Data collection open and data being submitted
Other				
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein	Y	MTW: Hip: 248 Knee: 190 Groin: N/A Varicose: N/A	100%	The Trust only collects data for Hip and Knee procedures
National Ophthalmology Adult Cataract Surgery Audit	N	MTW - 0	0%	Registered to participate but waiting for OpenEyes cataract module to be purchased to enable us to upload data.
National Audit of Care at the End of Life 2018 (NACEL)	Y	MTW - 60	75%	Submitted data for all available notes. Organisational data also submitted.
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 2018	Y	MTW - 69	50%	Difficulty in obtaining sufficient numbers of case notes within the timeframe set by NHS England. This issue has now been resolved at a national level for future audits.
Mandatory Surveillance of bloodstream infections and Clostridium Difficile infection.	Y	MRSA – 3 C.diff – 39 MSSA – 17 E.coli – 62 Pseudomonas-13	100%	Data from April 2018 to February 2019. Continuous data collection.

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
		Klebsiella - 27		
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antibiotic Consumption.	Y	MTW - 5,955 (total antibiotic prescribing per 1000 admissions)	On track to achieve 100%	Continuous data collection.
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) Antimicrobial Stewardship.	Y	MTW- 149	On track to achieve 100%	Continuous data collection. Achieved Q1 (46%, target of 25%) Achieved Q2 (53%, target of 50%) Achieved Q3 (80%, target of 75%)
BTS National Adult Community Acquired Pneumonia (CAP) 2018-19	Y	Data still being collected		Data collection still open and data being submitted
BTS National Adult Non-Invasive Ventilation (NIV) 2019	Y	Data still being collected		Data collection still open and data being submitted
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 - 496	100%	
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	Y	MTW - 0	100%	The trust had no cases that met the criteria for this audit.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	MTW Stillbirth: 10 Neonatal: 1 Extended	100%	

National Clinical Audits for inclusion in Quality Accounts 2018/19	*Participation* Y, N or NA	*No of cases submitted*	*% cases submitted*	*Comments*
		Perinatal: 11		
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Y	MTW - 0	100%	The trust had no cases that met the criteria for this audit.
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	MTW Stillbirth: 10 Neonatal: 1 Extended Perinatal: 11	100%	
Paediatric Inflammatory Bowel Disease	Y	MTW - 33	100%	Data submitted quarterly
National Maternity and Perinatal Audit (NMPA)	Y	MTW - 6066 births	100%	Submitted automatically via NHS Digital.
National Pregnancy in Diabetes Audit	Y	MTW - 42	100%	
National Comparative Audit of Blood Transfusion Programme - Audit of the Management of Maternal Anaemia	Y	MTW - 10	100%	
Paediatric Intensive Care Audit Network (PICANet)	N/A			MTW does not provide this service
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 95 MGH: 131	100%	Ongoing data submission, final date for 2018/19 data is 31/05/2019
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	Y	MTW - 28	100%	Continuous data submission when cases are identified.
National Confidential Enquiries				
NCEPOD: Cancer in Children, Teens and Young Adults	Y	MTW - 0	100%	The trust submitted organisational data but had no patients that fitted the inclusion criteria for this study.
NCEPOD: Perioperative Diabetes	Y	MTW 6 Surgical 5 Anaesthetic	50%	
NCEPOD: Pulmonary Embolism	Y	MTW - 4	40%	Data collection still open for Clinical Questionnaires
NCEPOD: Acute Bowel Obstruction	Y	MTW - 1	10%	Data collection still open for Clinical and Organisational Questionnaires
Child Health Clinical Outcome Review Programme: Long term ventilation in children, young people and young adults.	N/A			Not applicable as this service is not provided by the trust.

38 national audits were published in 2018/2019 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 Pregnancy in Diabetes (NPID) - our Diabetic Link Midwives have been working hard to increase access for women with type 2 diabetes to specialist support in early pregnancy. On average, 25 women had data submitted to the NPID each year from 2014 to 2017, with approximately 20% of those patients having type 2 diabetes. In 2018, we submitted data for a total of 42 patients and just over 40% of them had type 2 diabetes which shows a very encouraging improvement in type 2 diabetic women having early access to specialist support. The team is continuing to work on information for the Trust website so that more women are aware of the services we provide and also improving communication between the Trust and GPs.

National Neonatal Audit Programme (NNAP) – our Neonatal Team have managed to improve our results almost across the board. There has been a notable improvement for mothers at risk of delivering a preterm baby being given magnesium sulphate to reduce the chance that their baby will develop cerebral palsy (from 38% in the 2017 report to 70% in the 2018 report and presently we are almost fully compliant). Additionally the Trust is now fully compliant with ensuring parental consultations occur on a daily basis so that new parents are kept informed and feel supported.

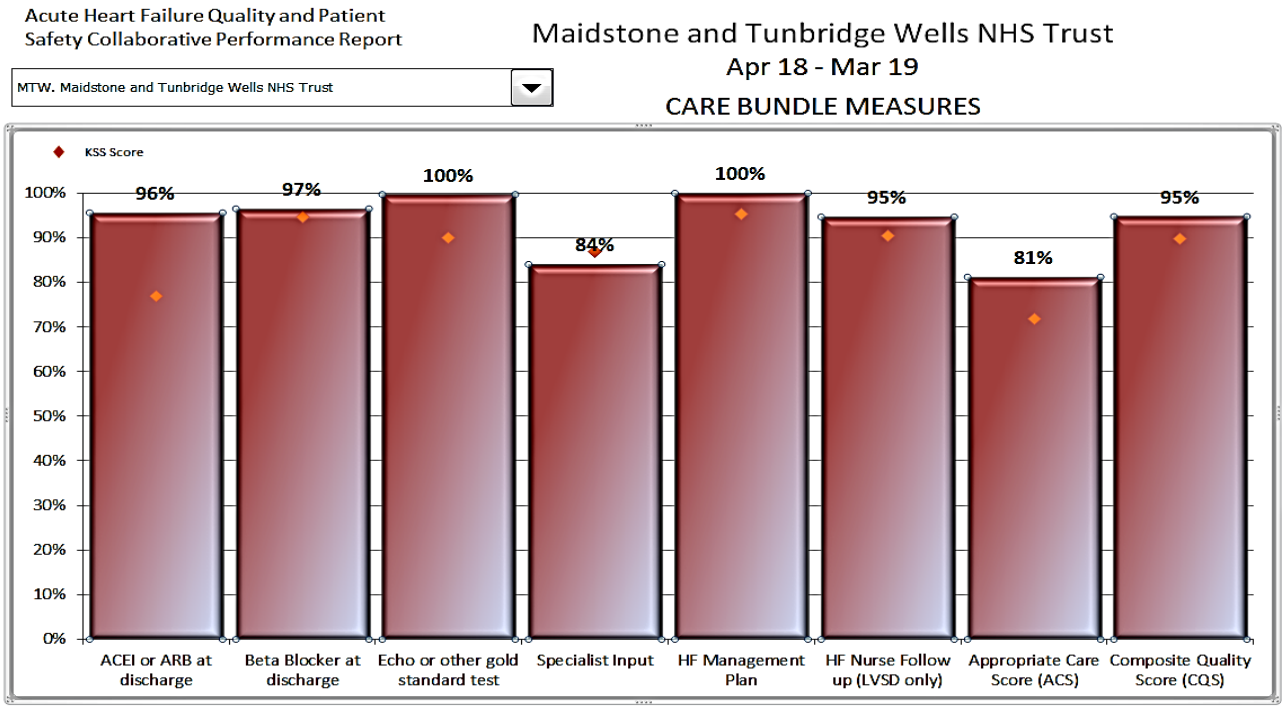
MBRRACE-UK; Perinatal Mortality Surveillance Report; UK Perinatal Death for births in 2016 – we were fully compliant with the MBRRACE recommendations from this report having previously implemented half yearly reviews of all neonatal deaths and put in place plans to undertake placental histology for all stillbirths (where parents have consented). Our results indicate that we are up to 10% lower than average for the group for stillbirths, where in the previous set of results we were up to 10% higher for the group.

National Emergency Laparotomy Audit (NELA)

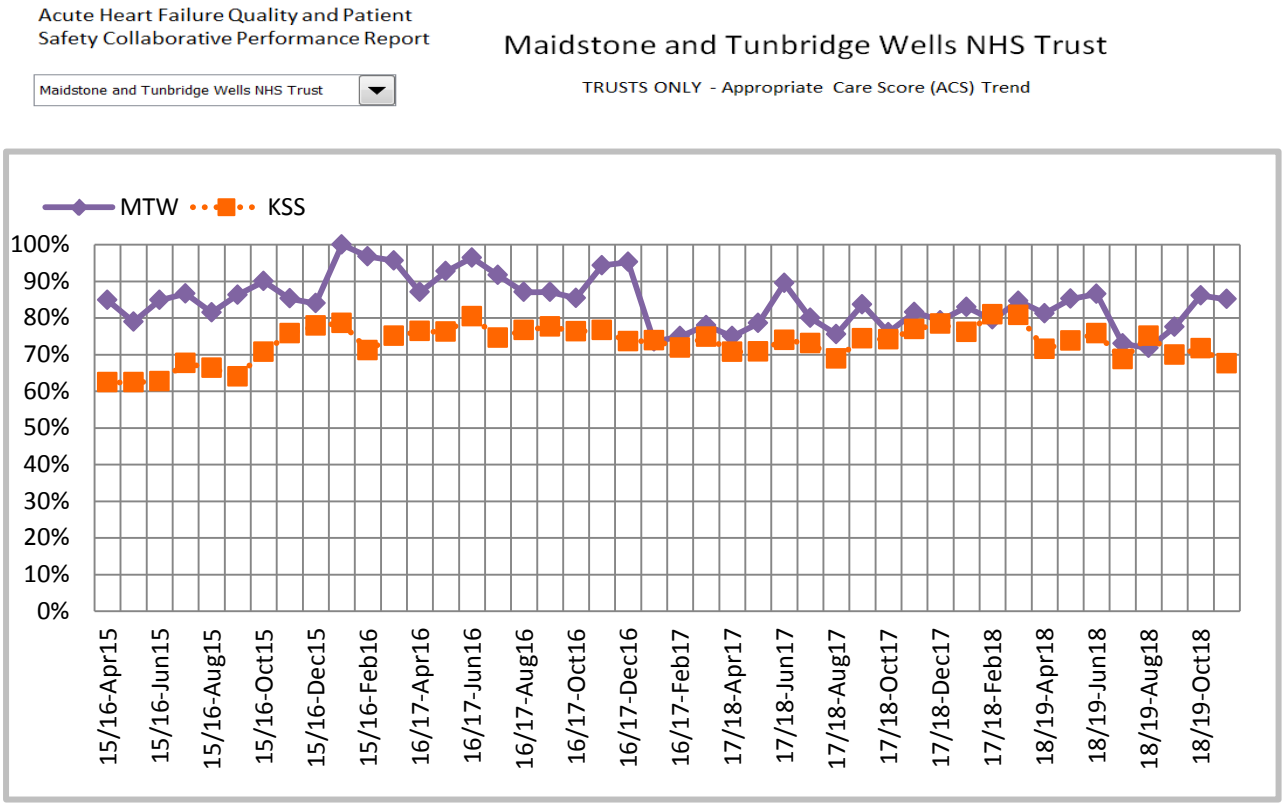
Surgical, Anaesthetics & Theatres NELA Team

We are currently within Year 6 of data collection for NELA and were proud to have the Trust surgical / theatre team appear on the cover of the Fourth Patient Report of the National Emergency Laparotomy Audit (Dec 2016 – Nov 2017) that was published in 2018. We have made great progress over the years and are one of the top performing trusts in England. We have a low mortality rate (5.6%) compared to the national average (9.5%) based on the most recent published results (2016/17). However further improvements in our performance against national standards can be made and a robust action plan to achieve this is in place.

Heart Failure – The Trust continues to participate in the Acute Heart Failure Quality and Patient Safety Collaborative with the Kent Surrey Sussex Academic Health Science Network (KSSAHSN).The chart below provides the Trust performance report for the care bundle measures for the period April 2018 – March 2019.



The Trust has continued to perform above KSS for the Acute Heart Failure Appropriate Care Score over the last 4 years.



Appropriate Care Score (ACS) - “Patient Level” The Appropriate Care Score (ACS) is a measure of the number of times patients received all the care they were eligible for. The ACS is the total number of patients that received all the care they were eligible for divided by the total number of patients eligible for the focus area. Numerator is the total number of

patients that received all the care they were eligible for. Denominator is the total number of patients that were eligible for at least one measure.

Stroke Audits - Overall compliance for data submission to the national audit has risen at both sites from Band D in 2013-14 to Band A in 2016-17 at Maidstone and from Band C in 2013-14 to Band A in 2017-18 at Tunbridge Wells following the employment of a stroke specific data entry administrator.

Nationally and Trust wide there is now a greater awareness of stroke in general and the need for prompt action in identifying patients with a suspected stroke. All nurses working on the stroke wards now have to undertake stroke specific competencies which have helped improve care of patients following a stroke. Also nurses who have been identified in the role of stroke assessors have additional training which includes being able to request a plain CT of the head for patients with suspected strokes within 1 hours of arrival. This will improve the time for scans to be carried out and reported and allow the decision to thrombolyse to be made quicker and benefit patients' treatment.

Please see Appendix A for full details of progress against each of the reported national audit results 2018/19.

Improvements to clinical practice from local audits

A number of improvements have been made as a result of the **145** completed local clinical audits, across all Directorates, in 2018/19, **65** 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 2018/2019	Trust Actions
NICE CG190 Re-audit of massive obstetric haemorrhage (PPH) Obstetrics	Haemorrhage (predominantly postpartum haemorrhage) is a leading cause for maternal mortality. The introduction of a simplified escalation policy following the last round of this audit appears to have had a significant effect on senior staff involvement, with the Obstetric Consultant and Anaesthetic Consultant documented as being present, attending, or informed about 100% of cases in the second cycle (previously 48%). Since the original audit took place, much of the data is now collected on E3 (Electronic maternity database). The team also now continuously monitor the monthly severe PPH rate (>1500 ml) via the Maternity dashboard. Their clinical team frequently run reports on E3 looking at risk factors, etc. All of the information that cannot easily be obtained from E3 is regularly reviewed at the weekly Maternity Risk meetings, where the team review the notes for all major PPHs (>1000 ml).
ECG labelling practice Cardiology	ECGs are a vital investigation that forms part of clinical diagnosis in cardiac emergencies and in decision making for life saving interventions. Unlabelled ECGs pose a risk that incorrect clinical decisions may be made based on findings on ECGs which do not belong to the relevant patient, leading to possible missed diagnosis or inappropriate treatment. Following the first round of this audit an education programme and ward posters were put in place to remind staff of the need to record patient identifiers when undertaking ECGs. The re-audit has shown significant improvements in documentation thereby reducing risks of incorrect decision making based on ECG results that do not relate to the patient.
Large volume paracentesis Acute Medicine	Large-volume paracentesis (LVP) is a safe and effective clinical treatment used for removal of 4 - 6 litres or more ascetic fluid (build-up of fluid between two layers of the peritoneum) in a single session. This procedure reduces intra-abdominal pressure and relieves the associated breathing difficulties, abdominal pain, and early satiety resulting from ascites of different conditions such as cirrhosis of the liver, cardiac failure or malignancy. Following the first round of this audit a LVP proforma was introduced with prompts to review diuretics and advise on dietary salt restriction. They also found maintenance of the standard in regards to sectors such as consent taking, using aseptic technique, platelet transfusion in appropriate patient, use of albumin for volume expansion leading to improved patient care / outcome.
Extended VTE prophylaxis General Surgery	The General Surgical Team carried out a re-audit of patients who undergo major abdominal surgery due to malignant disease who should be prescribed extended VTE prophylaxis postoperatively for 28 days to reduce the risk of DVT, PE and re-admission. Changes implemented include the specification of extended VTE on the patients' postoperative plan. The patient list also now includes a reminder to check histopathology from perioperative sampling. The re-audit found that VTE compliance has improved dramatically with all patients with confirmed malignancy on histopathology now receiving

Actions taken following local audits 2018/2019	Trust Actions
	extended pharmacological VTE thus reducing the risk of patients developing DVT, PE and re-admission.
Audit of Annual Cervical Cytology Uptake by HIV Positive Women Who Attend MTW HIV Clinics Sexual Health	The last audit carried out by the Sexual Health team showed that 53% of the HIV +ve women attending their clinics have a history of having an abnormal smear test. All HIV +ve women are therefore encouraged to have had a smear test in the preceding 12 months prior to their appointment. Following the first round of the audit an “Action List” was added to the GP’s letters to highlight those patients who had declined to have the test at the GUM Clinic and would require a smear test in the primary care setting. At every follow-up appointment, cervical smears are now discussed and the dates of the last tests are documented in the dedicated screening table, if a patient is offered a smear and declines it, it is documented in their notes. 98% of patients have now had a smear test in the preceding 12 months or have it documented that the test was offered and they chose to decline.
Insertion of and ongoing care of nasogastric tubes ITU/HDU	Incorrect placement of nasogastric feeding tubes can result in serious complications including death and is consider a 'never event' in the NHS. Complications are largely due to either misplaced tubes entering the lungs or a failure to carry out standard levels of ongoing care. Changes actioned include an NG tube placement e-Learning course undertaken by staff to highlight best practice. Documentation on the ITU chart and the Nursing Care Plan continues to be used, as does changing the NG tube dressing and securing it every 24 hours and dating it daily. This re-audit has shown improvements in documenting care given to patients in the medical notes and recording the management of the NG tube when in situ in the bedside folders.
Pain assessment with diagnosis of dementia Chronic Pain	Dementia patients are at risk of misdiagnosis of medical conditions and the under treatment of pain leading to suffering if not appropriately assessed. The Pain Management Team introduced a standardised validated pain assessment tool for patients with dementia (Abbey Pain Scale) into the Maidstone and Tunbridge Wells NHS Trust and training for clinical support workers in assessment of pain. The re-audit has shown an improvement in the number of patients who now have their pain assessed with an appropriate pain assessment tool and who have a care plan for cognitive impairment in place. Following this audit the team will be introducing additional training sessions for clinical support workers which they feel will benefit patient care as staff will be more informed and hopefully feel more confident in assessing a patient’s pain.
Documentation of obstetric anaesthetic chart Anaesthetics	Following a litigation case which found poor documentation, a specific obstetric anaesthetic chart was developed and put into use on the labour ward at Tunbridge Wells Hospital. Since the introduction of the new chart, documentation has shown significant improvement and quality of information recorded is now better across all criteria measured. The chart has been designed to ask specifically whether the patient was comfortable throughout, and if not, whether additional analgesia or GA was offered.
Glaucoma Audit Ophthalmology	Chronic open angle glaucoma (COAG) is a common and potentially blinding condition. Once diagnosed people with COAG need lifelong monitoring so that any progression of visual damage can be detected. Controlling the condition to prevent or minimise further damage is crucial to maintaining a sighted lifetime. It is essential that patients are fully informed at all stages of their consultation (written or verbally) in order to keep them informed of their condition and the treatment required. Patients now receive an information leaflet at their first visit to

Actions taken following local audits 2018/2019	Trust Actions
	supplement verbal explanations about their condition and treatment therefore ensuring patients are better informed at all stages of their care.
Ward Round documentation audit - Urology	Good documentation is important for safe and effective patient care and is also a medical-legal requirement. Ward round documentation forms an essential part of the continuity of patient care and in the communication between colleagues. A specialty specific proforma has been developed for the use on urology wards to act as a prompt and incorporate all the required elements of ward rounds and handover. Results showed an overall improvement with the documentation particularly with the recording of clinical data which will improve communication between colleagues about the care provided and the decision making process. Accurate and full documentation of clinical care and results of investigations will improve the safe and effective delivery of patient care.
An Observational Re-Audit; Skin Preparation for Trauma Cases Orthopaedics	Preparation of skin intra-operatively is a key measure to reducing incidence of surgical site infection (SSI), removing debris and minimising microorganism translocation into the wound. This re-audit highlights the improvements made in skin preparation with regards to pre-cleaning of skin reducing the risk of SSI. This was due to extra swabs being available on the prepared scrub trays and a copy of the guidelines being placed on the wall in the trauma theatre.
Re-audit of Are we following the Emergency Care Pathway for Urology patients? Urology	Following the original audit it was recommended to have a Consultant of the Week system and emergency urology pathway to ensure the decision making process and timings of decisions are accurately recorded and that patients receive a consultant review within 24 hours of admission. As a result of the new consultant of the week system there has been a significant improvement in the proportion of patients receiving a consultant review within the recommended 24 hours of admission. Delay in receiving a consultant review has the potential to affect patient care and delay discharges. Further actions planned include the introduction of an afternoon ward round to capture the day's admission and the cancellation of other commitments for the Consultant of the Week to further increase the number of patients that receive a consultant review.
Re-Audit : Elective inpatient treatment on Lord North Ward Haematology	During the initial round of the audit, the Service Improvement Team identified increasing length of stays for haematology patients. An audit of the inpatient treatment regimens was undertaken. Actions were implemented to ensure ward clerks retrieve notes and the last two clinic letters prior to admission and to move regimens of five days or less outside Lord North Ward to outpatient settings. Where practical, all patients are now being discharged home between treatments. All patients now have a recorded reason for admission to hospital due to clinical need, or for a regime that has not been determined to be safe for the day case setting. Ensuring an appropriate patient pathway is in place reduces length of stay for patients.

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 2018/19 there have been a total of **1581** NICE guidance documents disseminated to the specialty leads throughout the Trust since guidance began to be published in 2005. Of those, **1462 (93%)** have been evaluated. **479 (33%)** 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.

Guidance published from 1 April 2018 to 31 March 2019.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (CG/NG)	**29**	**20**	**13**
Interventional Procedures (IPG)	**33**	**26**	**2**
Technology Appraisals (TA)	**50**	**28**	**17**
Others (DG, HST, MIB, MTG)	**16**	**9**	**4**
Totals	**128**	**83**	**36**

Please see Appendix C for full details of Trust compliance with guidance that has been audited and completed during 2017/18.

RESEARCH

Research Performance

Maidstone and Tunbridge Wells NHS Trust (MTW) have recruited 3,023 people to research projects during 2018/19 that were approved by the research ethics committee, against an annual plan of 1372. This achievement meant more local people than ever before chose to participate in a trial either for their own or the greater benefit. Thanks to the Trusts participation in the national 'Meningitis Be on the Team – Teenagers Against Meningitis' study, over 1,000 young people between the ages of 16 and 19 directly benefitted from research last year.

Research Staff at Invicta Grammar School, Maidstone for the Meningitis- Be on the Team Study

The number of studies opened at MTW continued to rise during the period with the trust being in the top three trusts in the Kent, Surrey and Sussex region for number of studies open. At the end of the financial year the trust had 93 active studies and still maintains a balanced portfolio of studies on offer to patients including interventional, commercial, large scale and observational. Notable studies delivered and completed in 2018/19 include the National 100,000 Genomes Study which is run in collaboration with Guys and St Thomas Hospital, the Trust's first skin cancer study looking at treatments for stage 3 unresectable and metastatic melanoma, opened by Dr O'Hanlon-Brown, and the world's first study into Meningitis B in teenagers, in collaboration with the University of Oxford.

2018/19 also saw the expansion of studies into new treatment areas, most notably in intensive care and anaesthetic services across both hospital sites, an increase in neurological studies including studies into Parkinson's disease and Multiple Sclerosis and within sexual health services, in particular studies of HIV.

How quickly can we open studies to offer to patients?

All NHS trusts are monitored on the time it takes to set up and deliver commercial and non-commercial trials to ensure that we remain attractive to industry as a place to conduct research. The National Institute for Health Research (NIHR) national target is 80% of all studies to be delivered within the agreed recruitment time frame (agreed with the sponsor and usually 40 days) and to recruit the agreed number of participants. At the beginning of the year MTW's year-end predicted compliance was 36% of studies meeting the time to

target metric, falling far short of the national target. However, through work led by the Trust Lead Research Nurse in collaboration with the local research network, the end of year compliance was nearer 50%. The Trust continues to work hard to address the barriers to get study opportunities to patients as quickly as possible.

Developing our own research studies at MTW

A number of Trust staff have successfully developed their own research projects throughout the year and these are in various stages of delivery. Most notable are studies into how acupuncture could shorten labour and increasing the involvement of radiology staff in detecting cancer in the lymph nodes of women with breast cancer. Both studies, led by clinical research leads at the Trust, plan to be delivered in 2019/20 with the aspiration of bringing direct improvements to the delivery of care to patients.

Research Staffing

The research department has recruited a number of new staff this year including a Research Costing and Contracts Officer. The post holder provides oversight of all research invoicing, contracting and costing processes and is already having an impact on securing income and receiving research income in a timely manner into the department which enables the Trust to deliver more research for patients.

Research Practitioners- Banher Sandhu, Rutendo Nyagumbo, Maureen Williams, Bethany Jones.

The delivery section of the Research and Development Department has also welcomed a number of Research Practitioners to their team. This role reflects the changing and diverse studies adopted by the Trust which requires a flexible workforce. Many trials that do not involve a medicinal product do not require a qualified research nurse to lead the trial. This change has allowed staff to work more flexibly across specialties on a wide range of studies.

A growing number of Trust clinical staff have joined the Research and Development team in a job share and/or part-time capacity to increase delivery capability and to give staff experience of being research active whilst maintaining their substantive role. The initiative which has been running since April 2018 is now gaining in popularity. The Research and Development Department now employ staff from critical care, midwifery, physiotherapy and ophthalmology nursing staff who work alongside the substantive research team.

All research staff are now in research uniform including the oncology research nurses, physiotherapists, radiologists and practitioners. The uniform allows both staff and patients/visitors to recognise research staff and strengthens the professional identity of

research staff. This is of particular importance when delivering research studies in the local community.

Delivery of the Research and Development Strategy 2018-2021

During the past 12 months delivery of the MTW Trust Research and Development five year strategy has been fast-paced with a number of key objectives developed and delivered in-year.

Key areas of improvement have included:-

- Opening more trials that widen recruitment potential to include the local community
- Functioning as a single research team across the organisation, promoting research as a strong, dynamic, efficient professional team
- Encouraging open dialogue within and across research teams to share knowledge and expertise and create a research communication culture
- Ensuring trust staff and the public have access to performance data on the Trust website and increasing staff access to research information
- Use of a Research Patient Questionnaire which is used to report patient feedback to our research teams on a quarterly basis.

The focus for 2019/20 will be:-

- To maintain areas of improvement and to build on the work already undertaken to include research as a core business in job planning and developing collaborative posts with the new Kent and Medway Medical School
- Improve income potential
- Continue engagement with academic institutions to encourage students to gain experience of working in research

Other Research Achievements 2018-2019

Maidstone and Tunbridge Wells NHS Trust hosted a Shoulder and Elbow symposium on Friday 22nd March at the Academic Centre Maidstone, organised by the Research Extended Scope Practitioner, Jayanti Rai. This event was an opportunity for orthopaedic staff to network and share research ideas and was well attended. As a result of the symposium, a number of collaborations are in place to increase research in trauma and orthopaedics in the coming year.

Speakers at the Shoulder and Elbow symposium, organised by Research and Development

We are also extremely fortunate at MTW to have a very active Research Volunteers Group made up of Research Ambassadors.

This year they hosted a research event at the Academic Centre on the Maidstone hospital site in January 2019 to promote research to members of the public. Research patients spoke about their experiences of being on a trial and what it meant to them. Many members of the audience were researchers who found the patient stories very moving.

The Research and Development team attended the Trust Careers Fair in March 2019 to raise the profile of a career in research to secondary school students. Research staff have also visited local schools to talk about a career in the NHS and research.

MTW have also hosted the Renal, Benign Urological and Uro-gynaecological Disease Research meeting in early March 2019. The event allowed key research-active clinicians to share their work and network and develop ways in which to increase research activity across the region.

The Trust Lead Research Nurse was asked to talk at the Medway Community Healthcare Research Day in March 2019 to share her experiences of setting up a commercial research study in a primary care setting. She has also been asked to join the panel of judges at the 2018/19 Nursing Times Awards.

National recognition of Maidstone and Tunbridge Wells NHS Trust Research.

The ophthalmology study 'Star' was featured in the local press during March 2019 with one of their patients giving her personal account of how the study had helped her to keep her sight by receiving radiotherapy treatment. She also explained that the treatment was more beneficial as the conventional treatment regime included eye injections which she had found to be very uncomfortable.

The critical care research team at Tunbridge Wells Hospital at Pembury were recently congratulated on being the second highest recruiter in the country for the Poetics 2 study. This study seeks to develop a prognostic score for specifically very elderly, critically ill patients (defined as patients over 80 years). Age-specific information about the elderly patient such as frailty, cognitive function, activity of daily life and co-morbidity, in addition to organ failure score is gathered.

The trauma and orthopaedic research team at Tunbridge Wells hospital were commended for being the highest recruiting site to the Proximal Fracture of the Humerus study out of 22 sites taking part across the country.

The Research and Development Department were congratulated by the University of Oxford for successfully recruiting over 1000 local students to the MenB meningitis study during 2018/19 and have successfully vaccinated over 250 students against Meningitis B so far.

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 2018/19 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 providers (West Kent CCG and CCGs in Sussex and East Surrey) therefore no financial penalties ultimately apply. All other commissioning contracts are subject to the standard CQUIN process and payment is based on % achievement. This does not detract from the main intention or purpose of CQUIN's which are to improve the quality of care provided to our patients, as such delivery of these remains a high priority for the Trust.

Within the commissioning payment framework for 2018/19 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	0%	Red
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	78.1%	Green
Timely identification of sepsis in emergency departments; percentage of eligible patients screened for sepsis.	90% for each Quarter	Q1=100% Q2=97% Q3=95.5% Q4=93.8%	Green
Timely treatment for sepsis in emergency departments.	90% for each Quarter	Q1=90% Q2=90% Q3=91.3% Q4=92.3%	Green
Timely identification of sepsis in acute inpatient	90% for each Quarter	Q1=89% *	Green*

CQUINs	Target	Achieved (local data)	RAG Rating
settings; percentage of eligible patients screened for sepsis.		Q2=90.6% Q3=90.1% Q4=91.4%	
Timely treatment for sepsis in acute inpatient settings.	90% for each Quarter	Q1=85% Q2=100% Q3=92.3% Q4=100%	Green*
Assessment of clinical antibiotic review between 24-72hrs of patient with sepsis who are still inpatients at 72hrs.	Q1=25% Q2=50% Q3=75% Q4=90%	Q1=46% Q2=53.3% Q3=80% Q4=90%	Green
Reduction in antibiotic consumption per 1000 admissions 1) Total antibiotic usage 2) Total usage of carbapenem 3) Total usage of piperacillin-tazobactam.	Reduction of 2% against baseline 1. Failed 2. Achieved 3. Achieved	66.6%	Amber
Improving services for people with mental health needs who present to A&E in selected cohort group. The number of attendances for 17/18 cohort remains at 20% or less than the baseline level in 2016/17 20% reduction in the 2018/19 among the new cohort of frequent attenders from the baseline level in 2017/18	20% reduction in A&E attendances for those in cohorts 1 & 2	Cohort 1= 46% 2017/18 45% 2018/19 Cohort 2= 51% 2018/19	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 Advice & Guidance achieves a turnaround time of two working days against a target of 80%	84% 85.7%	Green
Risky Behaviours focuses on identifying and, where required, providing advice and offering referral to specialist services for inpatients who require support with reducing or cessation of smoking and alcohol consumption.	Collaborative working with KCHFT ('OneYou'- smoking cessation services) and CGL (Care Grow Live- alcohol cessation services), trajectory of improvement in regard to numbers of referrals made by MTW during 2018/19.	Achieved	Green
NHS England Specialist CQUINs			
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	Review of practice, improvement plan developed and review of audit against plan.	92.3%	Green

CQUINs	Target	Achieved (local data)	RAG Rating
made in direct consultation with peers and then as a shared decision with the patient.			
Clinical Utilisation Review (CUR) –optimising patient flows and move out of acute settings	Data submission, daily use of CUR, reduction in % of NQ patients	83%	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). Reviewing and switching of applicable existing patients to appropriate regimen treatments in line with NHS England agreed policy/ consensus guidelines, e.g. HIV, MS, (except if standard treatment course is < 6 months).	Trigger 1 Trigger 2 Trigger 3 Trigger 4 Trigger 5	Achieved Achieved Partial Achieved Achieved 91.5%	Amber
Two year Outcomes for very preterm infants	Q2 Trigger: 60% Q4 Trigger: 75%	Q2 69% Q4 76%	Green

*Sepsis screen achieved for inpatients as CQUIN reliant on combined figures with ED, combined figures >90%

Commentary

In this section we highlight some of the CQUIN improvements and developments in 2018/19, including what we have achieved and what has challenged us.

National CQUINs:

Achieving the Sepsis CQUIN has once again been challenging, at the end of 2017/18 we declared a serious incident following the death of a young man who we failed to screen for sepsis and to therefore appropriately treat. Following this we then failed to achieve the first quarter for the screening and treatment within one hour for inpatients (89% and 85% respectively against the target of 90%).

Key messages were shared across MTW by our clinical leads who have remained committed to raising awareness and improving the standard of care for our patients. The Sepsis Committee and the Sepsis leads and champions have continued to drive this hugely important agenda throughout the year. Some of this year's initiatives include:-

- The lessons learned from the serious incident used to create simulation training scenario

- Revision of the A&E sepsis screening tool and its incorporation into the casualty assessment card for use during triage
- Following a safety alert the trust changed its track and trigger system from PAR (Patient at Risk) to NEWS2 (National Early Warning score) in December 2018
- The Observation chart & Nervecentre (IT system for recording observations) have been updated and are now aligned to the Resuscitation council (UK) ABCDE.

A further element of this CQUIN was a 2% reduction in antibiotic usage, of which three milestones were set. The reduction of Carbapenem, Tazocin and the overall use of antibiotics. We achieved the reduction in both Carbapenem and Tazocin but unfortunately in reducing these we conversely increased our overall use of antibiotics to provide a broader spectrum cover. This was particularly noticeable in the overall usage in Quarters 3 and 4, mainly as a result of an increase in the presentation of patients with respiratory conditions.

Our Chief Executive leading by example

During 2018/19 we were delighted to have achieved 78.1% of our frontline staff immunised for flu, and to be recognised by NHS England as the fifth best acute trust in the South (Kent, Surrey & Sussex). Our Occupational Health team were proactive in the recruitment of a number of immunisers who worked across the organisation and competitively worked to be the immuniser who administered the greatest number of flu jabs. In addition, they worked collaboratively 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.

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), Kent Community Health Foundation Trust (KCHFT) and Care Grow Live (CGL).

For the CQUIN 'Improving services for people with mental health needs who present to A&E' we have been able to build on last year's experiences and together with KMPT and SECAmb a further cohort of patients were selected who would benefit from the joined up approach to their care needs in working with both KMPT and SECAmb. 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 45% for cohort 1 and 51% for cohort 2 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 collaboratively with KCHFT and CGL in regard to the delivery of the Risky Behaviours CQUIN. The delivery of this CQUIN has been disadvantaged by the introduction of our new Patient Administration system and as such was delayed; despite the increase in referrals achieved we unfortunately have not realised the numbers initially anticipated. During the course of the year we have been working with our IT Sunrise leads in the development of assessment pathways for smoking and alcohol. It is our intention to introduce this at the point of admission for all patients during 2019/20 instead of reliance on referral for those who overtly require these services.

NHS England CQUINs

Optimising Palliative Chemotherapy decision making has necessitated the need to create an additional field in our Kent Oncology Management system (KOMS). This new field has encouraged 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; however, during the course of 2018/19 we have ensured that our nursing staff record the additional field which has supported our ability to provide the required evidence.

During 2018/19 MTW has been committed to the application of the Clinical Utilisation Review (CUR) and has succeeded in using the information that it produces to support the Best Flow workstream. MTW have developed their own interactive CUR reporting tool which updates hourly, as reviews are completed. The tool has a number of filter options and is accessible to matrons, GM's, service leads and operational staff. The tool can highlight delays including '**Red Days'** by speciality, ward and/or by estimated day of discharge (EDD).

Red to **Green** is a simple initiative that helps turn patients' '**red days**' into value-adding '**green days**' which help to facilitate a safe discharge from hospital. A **red day** is when a patient does not receive an intervention to support their pathway of care. For example, a planned diagnostic is not undertaken.

		Red or green day		
		Green	Red	Total
Specialty	Haemotology	12	1	13
	Medicine	206	114	320
	Surgery	54	0	54
	T&O	25	31	56
	Total	297	146	443

The ‘non-qualified’ rate has reduced 22% over the financial year and was reported as 24.6% in Quarter 4, coinciding with the success of our new Hospital @ Home service, Acute Frailty Unit, expanding Ambulatory Emergency Care pathways and introduction of ward flow coordinators.

In addition a repeat audit of our diagnostics project, as published in the CUR Transformation directory has shown the average inpatient wait for an echocardiogram has now reduced by one working day all of which help to ensure that patients receive timely treatment with limited delays.

The Medicines Optimisation CQUIN was split into three triggers, moving appropriate patients onto Biologics, recording data on Pharmex and moving appropriate patients onto the homecare method of dispensing. The benefit of the latter objective is realised through the vat savings that are derived from this method of delivery. The Trust is actively planning to develop an outsourced pharmacy model, which would derive the same savings as the homecare model, but has the added benefit of a much wider application. To maximise the benefit of this the pharmacy department decided not to move our patients to the homecare model in favour of including them in the outsource model, when its implemented. We therefore did not meet the required milestone within the CQUIN which we reasoned was the right thing to do for our patients.

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 although we have been rated as 'Requires Improvement', 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 received 17 specific recommendations from the CQC and work has been underway to ensure these actions are completed. Our Quality Improvement Committee, which is chaired by the Chief Nurse and reports to the Best Quality workstream, has been pivotal in overseeing timely delivery. These have included:-

- Ensuring that our staff keep up to date with their mandatory training – a new IT learning database has subsequently been introduced.
- Ensuring that we respond promptly to patient complaints, compliance has now been reached in Quarter 4.
- Minimising the amount of time our patients are kept nil by mouth for surgery – new policy and process have been approved.
- A proactive recruitment process to ensure staff vacancies are filled – Recruitment and retention strategy group is operational.

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 progressed with implementation of the Data Quality Strategy during the year, continuing to focus on data quality as a priority across the organisation. A number of governance groups are now in place to ensure our vision set out within the strategy is delivered. Our 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 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):

- 99.60% (99.0% 17/18) for Admitted Patient Care;
- 99.8% (99.4% 17/18) for Outpatient Care; and
- 98.1% (96.0% 17/18) for Accident and Emergency Care.

Which included the patient's valid General Medical Practice code was:-

- 100% (100% 17/18) for Admitted Patient Care;
- 99.9% (99.7% 17/18) for Outpatient Care; and
- 100% (100% 17/18) for Accident and Emergency Care.

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

Data Security and Protection Toolkit

The Data Security and Protection Toolkit is a performance tool produced by the NHS Digital (formerly the Health and Social Care Information Centre) which sets out the National Data Guardian's (NDG) data security standards. The Toolkit is a self-assessment and is completed by providing evidence and judging whether the assertions are met and demonstrates that the Trust is working towards or meeting the NDG standards. The Trust submitted a Standards Met Toolkit providing evidence against 100 mandatory evidence items and confirming 40 out of 40 assertions.

In addition to completing the Toolkit 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 Senior Information Risk 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 2018/19 a Clinical Coding audit and process review was undertaken by Maxwell Stanley Ltd on behalf of MTW which was released in January 2019. 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%	**98.00% Level 3**
Secondary Diagnosis	>=80%	>=90%	**96.28% Level 3**
Primary Procedures	>=90%	>=95%	**100.0% Level 3**
Secondary Procedures	>=80%	>=90%	**99.57% Level 3**

The report made three recommendations for further improvements and these will be actioned during 2019/20. These include:-

- Liaison with the Endoscopy departments to raise awareness of the need to use the drop down co-morbidities function on their report
- Additional training provided to coders to further appreciate and understand endoscopy procedures
- Additional training provided to coders in regard to national standards relating to ultrasound gynaecological procedures and workshops procured for oncology, T&O, ENT and respiratory
- Standard of data entry regularly reviewed with corrective action taken and feedback relayed to the relevant department as required. Quick reference guides and training provided to raise standards

Part Three

Results and Achievements for the 2018/19 improvement initiatives

Patient Safety

Aim/Goal

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

Action	Update
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.	

	Q1	Q2	Q3	Q4
Number of Incidents Reported	*646*	*↑709*	*↓668*	*↑684*
Number of Incident investigations completed	*687*	*↑700*	*↑769*	*↓595*
Number of Incidents closed	*502*	*↑616*	*↑829*	*↓582*

Duty of Candour (Incidents and Serious Incidents) Apr-Mar 2019				
Overall	**Moderate**	**Serious**	**Catastrophic**	**Total**
Acute Med and Geriatrics	*47*	*19*	*6*	*72*
Children's Services	*9*	*0*	*2*	*11*
Clinical Haematology	*0*	*0*	*0*	*0*
Corp Services	*1*	*0*	*0*	*1*
Emergency Medicine	*12*	*12*	*6*	*30*
External Agencies	*1*	*0*	*0*	*1*
Facilities	*1*	*0*	*0*	*1*
General Surgery	*17*	*5*	*3*	*25*
Head and Neck	*1*	*1*	*0*	*2*
Imaging	*5*	*1*	*0*	*6*
Medical Specialties	*40*	*9*	*6*	*55*
Oncology	*6*	*2*	*0*	*8*
Orthopaedics	*10*	*3*	*2*	*15*
Pathology	*2*	*0*	*0*	*2*
Pharmacy	*0*	*0*	*0*	*0*
Planned Care	*1*	*2*	*1*	*4*
Sexual Health	*0*	*0*	*0*	*0*
Theatres and Critical Care	*6*	*2*	*0*	*8*
Therapies	*1*	*0*	*0*	*1*
Urology, Gynae-oncology, Breast and Vascular Surgery	*1*	*2*	*0*	*3*

Women's Services	*16*	*2*	*1*	*19*
	177	*60*	*27*	*264*

	Q1	Q2	Q3	Q4
Crude Mortality	0.9%	1.0%	0.9%	1.1%
SHMI	1.044	1.022	1.028	1.039
HSMR	103.9	105.7	102.8	100.9

- *Business Case approved to employ Interim Datix administrator to upgrade and revise incident reporting system*
- *Purchase of additional mortality and performance modules and upgrade to Datix IQ approved*
- *Revision of agenda's for clinical governance meetings to promote 'lessons learned' agenda*
- *Investment in RCA training – five modules*
- *Dates for incident training and Duty of Candour training published*
- *Schwarz rounds due to commence April 2019*

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.

- *One Serious Incident declared in Quarter 4 and zero declared in Quarters 1, 2 & 3 as a result of a delayed diagnosis of Sepsis.*

Compliance of 90% Standard (Q's 1-4):-

- *Screening for Sepsis ED- 100%, 97%, 95.5% & 93.8%*
- *Screening for Sepsis Inpatients- 89%, 90.6%, 90.1% & 91.4%*
- *Treatment for Sepsis ED- 90%, 90%, 91.3% & 92.3%*
- *Treatment for Sepsis Inpatient- 85%, 100%, 92.3% & 100%*

Full compliance with the standard for screening and treatment was met during Q's 2, 3 & 4 although we narrowly missed this for inpatients during Q1.

Raising the profile of Sepsis remains high on the Trust Agenda with the :-

- *'Let's all talk sepsis' Study day 11th September, 2018*
- *Sepsis Introduction and rollout of NEWS2 - the new patient at risk score to support early identification of the key triggers for sepsis. This has included bespoke training sessions for our clinical staff.*
- *Sepsis scenario used in Simulation training.*

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

Metric	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Unanticipated admissions to NNU >37 wks	11	14	15	14
Number of Stillbirths >24wks	0.7	1	0.3	1.3
Number of 3rd/4th degree tears	7	11	12	11
Unexpected number of Postnatal Readmissions	6.7	7	10	6.7

KPI's-

MTW are also working with the NHS Improvement Maternal & Neonatal Safety Collaborative (MatNeo) whose aims are to provide "support for front line staff to create the conditions for continuous improvement, a safety culture and a national

3rd and 4th degree tears. • Reducing the number of unexpected readmissions to the post-natal unit.	*maternal and neonatal learning system".* *Through this work a project have been identified and is moving forward:-* • *Reducing smoking in pregnancy (specifically increasing the number of women who stop smoking between booking and delivery)* • *In addition to this we are increasing the administration of Magnesium Sulphate to women in whom we anticipate imminent premature birth. MgSO4 has been shown to improve neurological outcomes in premature babies and is part of the PreCePT initiative that is supported by the safety collaborative. Compliance in Q4 achieved 100%* • *We are also continuing to drive the ATAIN work forward in an attempt to reduce the amount of term admissions into the neonatal unit.*

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
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.	• *Patient engagement and experience continues as a high priority work stream monitored within the Best Quality programme board. The first draft of the engagement strategy (having been shared with the engagement network and external partners including Healthwatch Kent) has received positive feedback and comments which are being incorporated into the strategy.* • *Launch and delivery of the strategy is currently being mapped into a series of key requirements over a 3 year timeframe. Following a gap in support there is now a new Project Management lead and the business case has also been approved to recruit a new role that will lead on Patient Engagement / Experience and implement the strategy and further embed patient engagement and experience across the organisation.*
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.	• *MTW continue to engage regularly with external partners and receive feedback to help improve patient pathways. Recent work has included A+E and audiology site visits by Healthwatch, and Healthwatch representation at the Patient Public and engagement events. Healthwatch also attended the December 2018 Trust Board following the previous review against the Accessible Information Standard (AIS).* • *Four successful CQC engagement days have*

	taken place with core service presentations given by staff members in Maternity, Outpatient services, End of Life care, Complaints, Safeguarding leads, Oncology, Radiology, and Pathology services. All were well received and the days were supported by both Executive and Non-Executive Directors. • *Work with the CCG continues through the quality review group and the internal assurance programme. This has been collaboratively scheduled to agree key areas of focus with members of the CCG Quality team integral to the inspection team. The inspection schedule has been agreed for 2019 which remains on track and the updated SOP has been shared with the CCG for review.* • *NHS Improvement leads have also undertaken service reviews including Cancer services, Serious Incident Review Panel and participation in Never Events working group.*
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.	• *A new monthly Dementia Hub has been launched by the Alzheimer's Society in Sevenoaks to support people with dementia and their carers both formally and informally. The Lead Nurse for Dementia Care represents MTW at this hub, and provides advice and support as well as gaining feedback on experiences and new concepts – in Quarter 4 the medilock box was taken to gain feedback from the perspective of the patient with dementia and their carers and fed back to the Patients and their own medications work stream of Best Quality.* • *Work continues in collaboration with the Aligned Incentive Contract (West Kent Alliance) and the Best Quality Work Stream as well as Dementia Strategy Group.* *The Learning Disability Liaison Nurse (LDLN) has:-* • *Co-ordinated an event for World Down Syndrome Day in March 2019, this was celebrated across the Trust.* • *In the past year facilitated learning disability training for 353 staff including; clinical, non-clinical and volunteers, some have completed the half day course, others have completed the 15 minute "key points" training.* • *Developed a Venepuncture pathway for people with learning disabilities which has been approved by Emergency Department staff at Consultant and Matron Level. The LDLN aims to have this pathway implemented during 2019-20* • *Continued to flag patients via our Patients administrative system to ensure our clinicians are aware of their LD diagnosis, we now have 260 people on this system.* • *Supported patients with a LD to attend the trust to access their health care including supporting individualised meetings for people with learning*

	disabilities such as safeguarding panel meetings and case conferences, best interest meetings and discharge planning meetings. • *Continues to work with the Accessible Information Committee to review patient information and has developed a sub-group for service users with LD.*

Clinical Effectiveness

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.

<table>
<tr><th>Action</th><th>Update</th></tr>
<tr><td>Sustaining our previous work to avoid unnecessary admissions to hospital through the development of alternative care models/pathways.</td><td>
• Increase of 0 LOS pathways (i.e. patients do not stay overnight). While this technically creates an admission to hospital, there is no overnight stay.
• Development of streaming criteria directly to AEC to improve management of patients in a timely manner.
• Development of direct GP admissions and direct Secamb conveyance to the appropriate unit within the hospital, i.e. Ambulatory Emergency care (AEC) or Frailty Unit.
• Creation of further ambulatory pathways to further increase 0 length of stay.
• Regular links with Secamb to ensure that only appropriate patients are transferred to A&E
• Working with external partners (eg KCHFT) to support patients/ GPs to allow patients to remain in their usual place of residence
• Roll out of CPMS (Care Plan Management System) at MTW to give greater patient information on patient's care in the community.
• Development of offsite ambulatory clinics in conjunction with KCHFT.
• Approval of additional hours for GP's within ED.
</td></tr>
<tr><td>Working with our mental health partners to reduce the number of frequent attendances of patients in crisis attending our emergency departments.</td><td>
• Following last year's success in reducing the number of attendances for a cohort of 25 patients by 43%, a further 25 patients have been selected.
• The Multidisciplinary and professional team that includes Secamb and KMPT are currently reviewing the plans of care for these patients to ensure that a consistent and cohesive approach is applied by all providers to support their ongoing care needs.
• WKCCG 'Frequent Attenders' funded post has now been increased to support two members of staff due to the impact this has had on patient experience.
<table>
<tr><th>Cohort</th><th>Previous Years Total No of Attendances</th><th>Q1 No of Attend-ances</th><th>Q2 No of Attend-ances</th><th>Q3 No of Attend-ances</th><th>Q4 No of Attend-ances</th></tr>
<tr><td>2017/18</td><td>705 (Av 176 per Quarter)</td><td>↓86</td><td>↓106</td><td>↑119</td><td>↓74</td></tr>
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	<table><tr><td>2018/19</td><td>698 (Av 175 per Quarter)</td><td>↓109</td><td>↓120</td><td>↓65</td><td>↓43</td></tr></table> • *Overall achievement for Cohort 1 has been a sustained reduction from 17/18 of 43% plus an additional 2.9% during 18/19.* • *Overall achievement for Cohort 2 has been a reduction of 51%*
Working in collaboration with our community and local authority colleagues to further develop pathways that will support the timely discharge of patients.	*Continue to work with our partners in regard to the timely discharge of our patients. Including :-* **Pathways 1,2,3** • *Seasonal variation of capacity - 25% increase in capacity for pathway 1 over winter period and expected Brexit period* • *Alternative pathways into community hospitals with the possibility of specialisation* • *Increase capacity for P3 beds in nursing homes, ongoing discussions with WKCCG in regard to medical cover to maintain improved utilisation* • *Development of pathway for patients recovering from a fractured neck of femur to transfer to Tonbridge Cottage for rehabilitation* **Rapid Response, Home treatment service** *Working with external partners to amalgamate a variety of services so that referrers have a single access portal and referrals are triaged efficiently the first time. New process is currently being piloted with therapy services* **Virtual ward/ Hospital at home** *Hospital at home has been implemented, high level of Intravenous antibiotic administration pathways being facilitated. 1 year funding to be agreed to fully evaluate outcomes and level of service required.* *Ongoing conversations continue with East Sussex CCG's re parity of access for all MTW patients.*

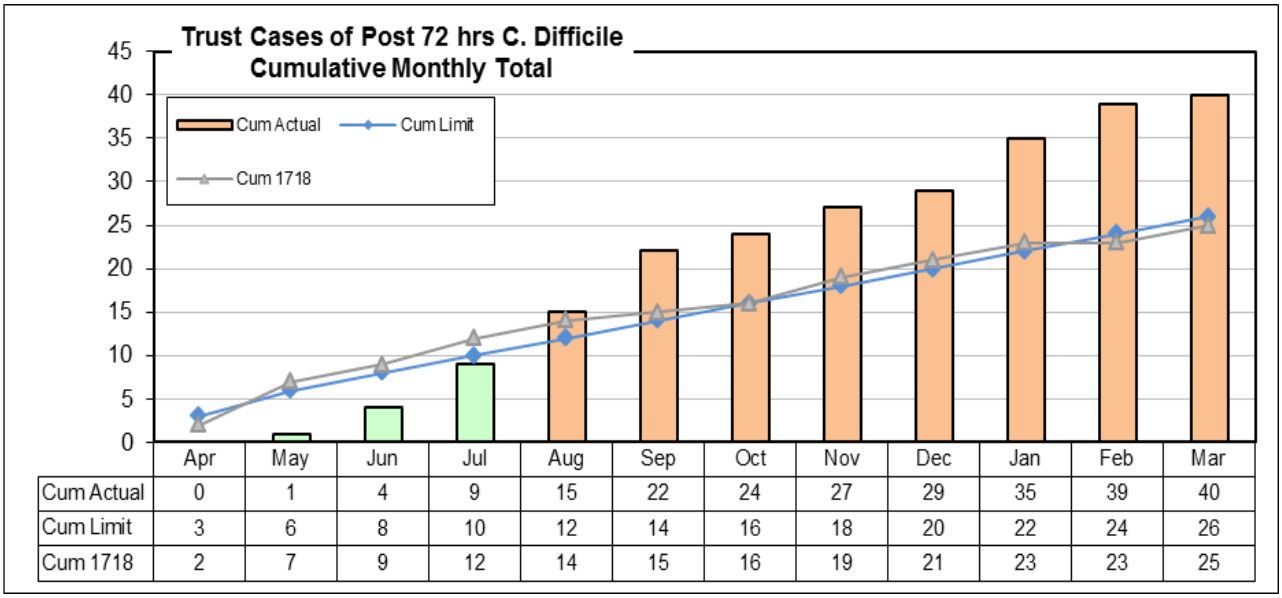
16 March 2019, via Twitter: shout out tonight for the team there for looking after T today. Kind, gentle and first rate, from the all stars in A&E to the A team in the Acute Medical Unit. And Shirley, of course.

18 February 2019, via Twitter: Very impressed by your Xray department today. Very efficient, running on time and kind to my elderly parents. Thank you.

11 March 2019, via Twitter: Just been to Maidstone Hospital, got seen, had blood test and left all before my appointment time.

Review of Quality Performance

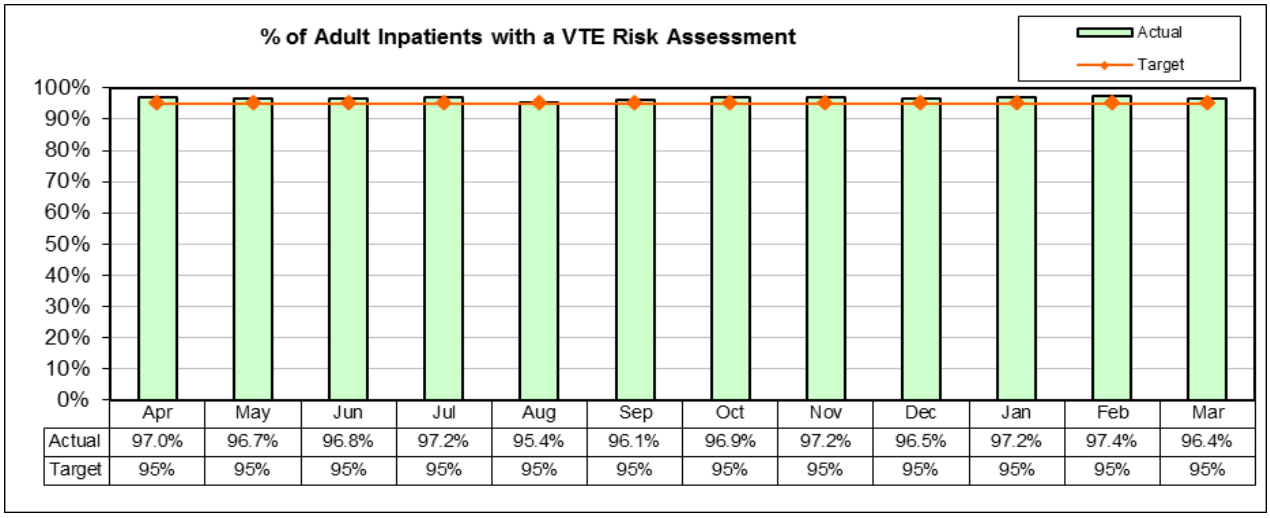
Infection Control – Clostridium Difficile cases – The Trust did not achieve this standard with 40 cases against a maximum of 26 cases for the year equating to a rate of 15.6 C-Difficile Case per 100,000 occupied bed days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cum Actual	0	1	4	9	15	22	24	27	29	35	39	40
Cum Limit	3	6	8	10	12	14	16	18	20	22	24	26
Cum 1718	2	7	9	12	14	15	16	19	21	23	23	25

Infection Control – MRSA Bacteraemia cases – The Trust did not achieve this standard with 3 cases of post 48 hr MRSA bacteraemia through the year.

% Patients VTE Risk Assessment – The Trust ensured that 95% of patients were given a VTE Risk Assessment in 2018-19 at 96.7%.

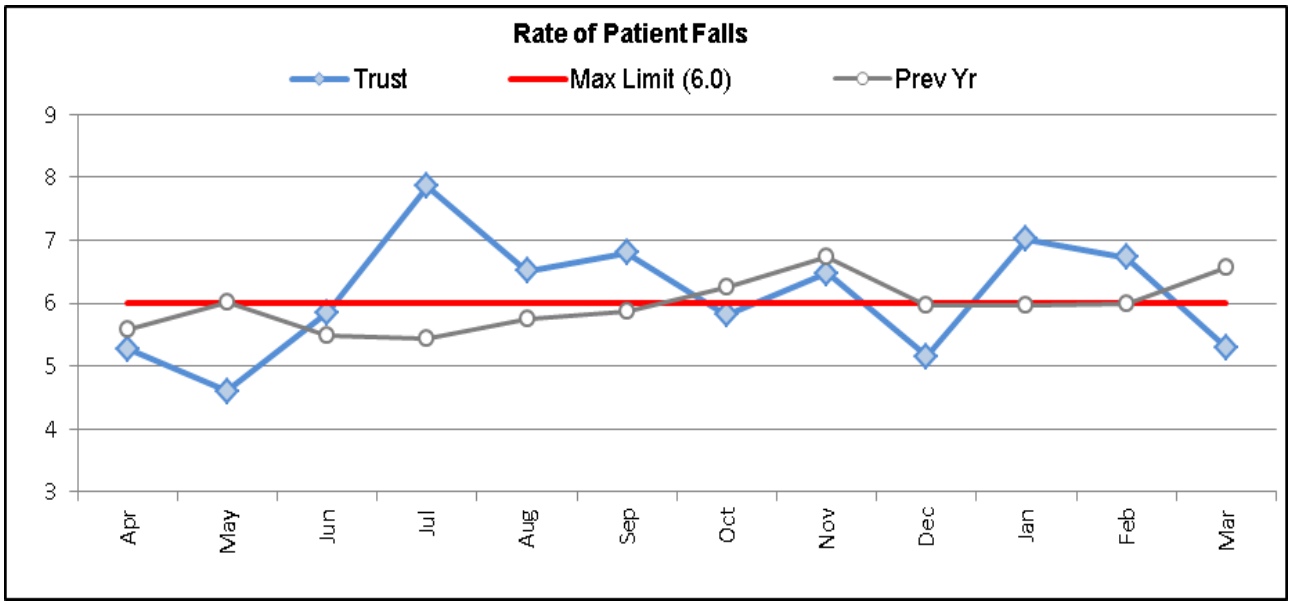


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.0%	96.7%	96.8%	97.2%	95.4%	96.1%	96.9%	97.2%	96.5%	97.2%	97.4%	96.4%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

MTW exceptional people, outstanding care

Reducing the number of patient falls

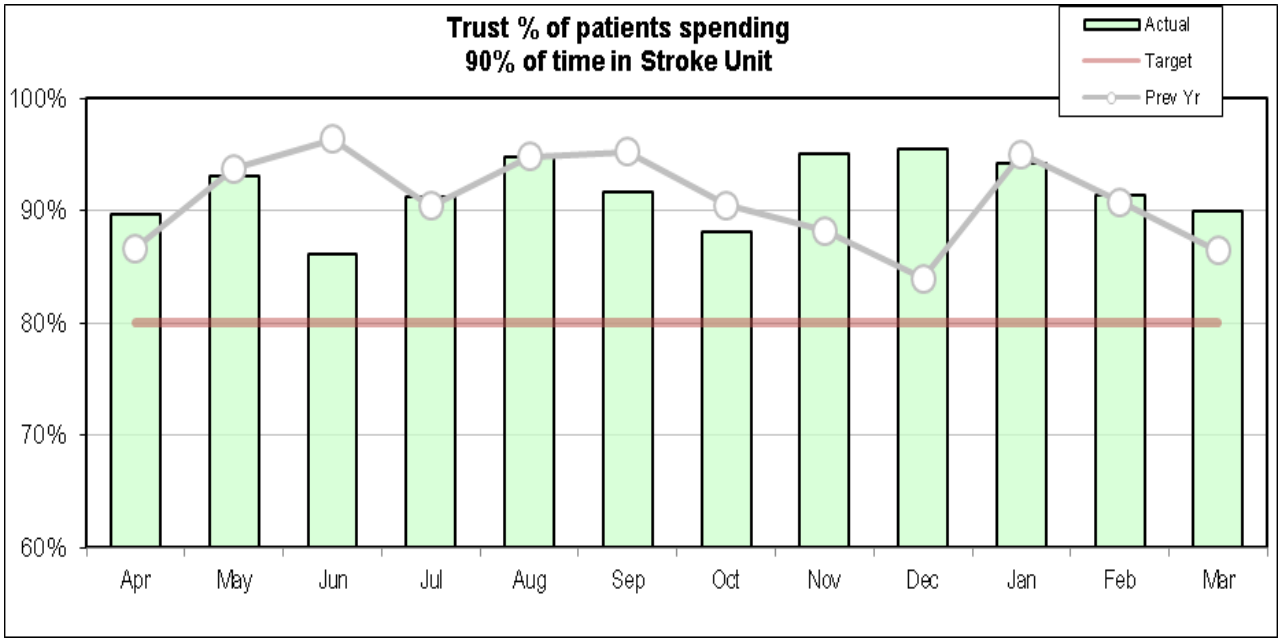
Rate of Falls – The Trusts' rate of Falls per 1,000 Occupied Bed days is slightly above the Trust maximum limit of 6.0 at 6.10 at year end (5.98 for the previous year).



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 2018-19 at 91.67% compared to 91.08% in 2017-18.

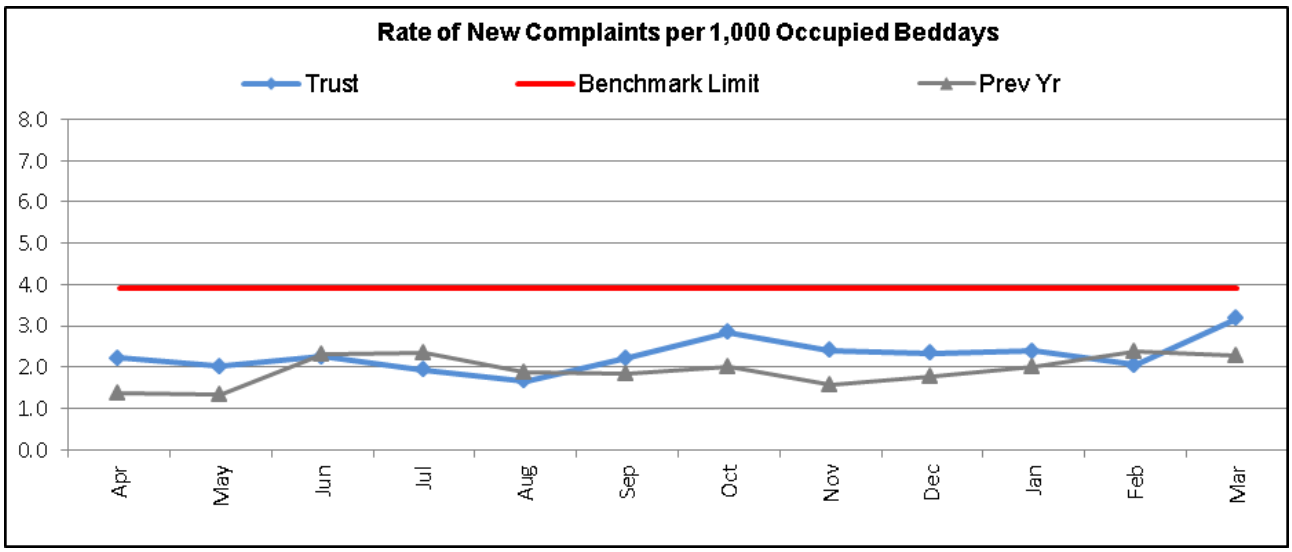


MTW exceptional people, outstanding care

PATIENT EXPERIENCE

Complaints management

Rate of New Complaints- The Trust's rate of New Complaints per 1,000 occupied bed days is within the expected range of between 1.318 and 3.92 at 2.30 for the year (1.93 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: *It is clear you have investigated thoroughly and we are satisfied that you have followed up our concerns and taken action to make sure the issues we identified will not happen to others. Thank you for confirming that our complaints were upheld and for the apologies within the response. My brother and I were gratified by the thoroughness and sincerity of the letter you sent and thank you for dealing with our concerns in such a professional and thoughtful way.*

Complainant

During 2018/19 we received 550 new complaints compared to 503 during 2017/18. The rate of complaints per 1,000 occupied bed-days was 2.30 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 60.8% of complaints within the agreed timescale against a target of 75%. Meeting our target has been challenging this year due to 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 following trials, we recognise that improvements can be made to our policy and procedure to further support the consistent achievement of our response target 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

National Patient Surveys

During 2018/19 the Trust participated in five National Patient Surveys. Picker Europe led on four of these national surveys on behalf of the CQC. We have undertaken the following surveys in house:-

- Maternity Department Survey
- Adult Inpatient Survey
- Urgent and Emergency Care Survey
- Children and Young People Survey

The Maternity Department survey had its final data submission on the 31st August 2018. The results were published on the CQC website on 29th January 2019.

2018 Maternity Survey
Respondents & Response Rate
• **230** Maidstone and Tunbridge Wells NHS Trust maternity service users responded to the survey • The response rate for Maidstone and Tunbridge Wells NHS Trust was **48.83%**
Banding
MTW's results were better than most trusts for **8** questions.

MTW's results were worse than most trusts for **1** question. 1. C12. Did the staff treating and examining you introduce themselves? MTW's results were about the same as other trusts for **42** questions.
Comparisons with last year's survey
*MTW's results were significantly higher this year for **2** questions* B4. Were you offered any of the following choices about where to have your baby? B12. During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?
*MTW's results were significantly lower this year for **5** questions* C12. Did the staff treating and examining you introduce themselves? C14. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you? C16. If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time? D5. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you within a reasonable time? D6. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?
Actions
The action plan for the Maternity survey will be overseen by the Maternity Board

The Adult Inpatient Survey data was submitted to CQC/Pickers Europe in January 2019 and the results are due to be published in May/ June 2019.
The Urgent and Emergency Care Survey data was submitted to CQC/Pickers Europe on the 26th March 2019 and the results are due to be published in August 2019.
The Children and Young Persons Survey data collection is still ongoing. The CQC/Pickers Europe co-ordination centre are yet to release the excel spreadsheet needed to enter the data.

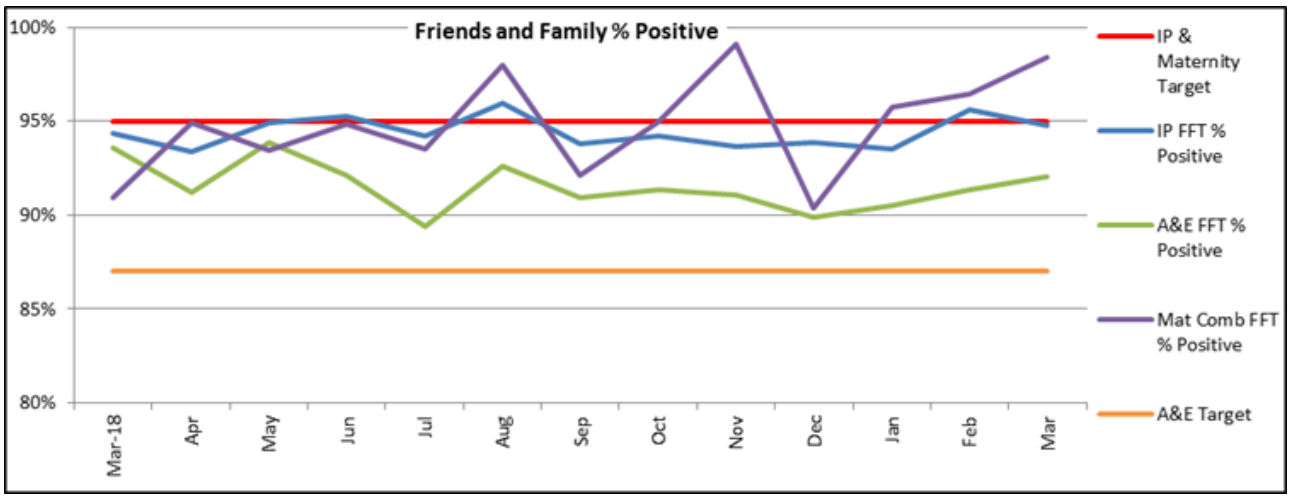
The Trust also participated in the National Cancer Patient Experience Survey and achieved a 68% response rate. This national survey is undertaken by Quality Health on behalf of NHS England. The data collection phase has recently closed and the results are yet to be published.

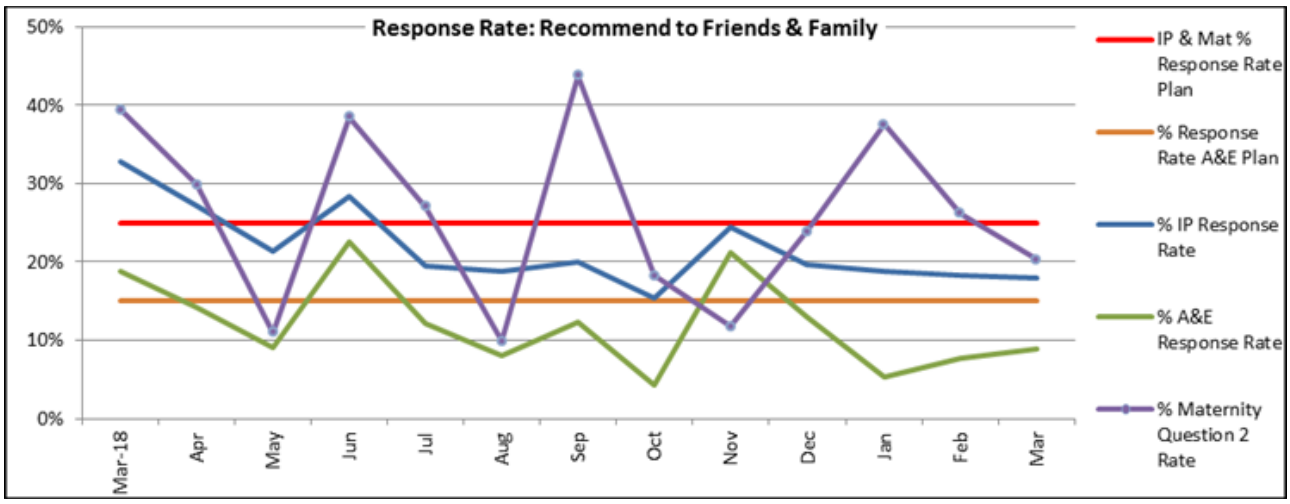
Friends and Family

The A&E positive response rate has continued to exceed the Trust plan achieving a 91.3% positive response against a plan of 87% and, exceeding the national benchmark of 85.5% indicating patients would recommend these services to their Friends and Family. Inpatient and Maternity positive responses at 94.4% and 94.9% respectively narrowly missed the Trust plan and subsequently fell short of the national benchmark of 95.8% and 95.6% correspondingly.

Response rates did not achieve the Trust Plan with Inpatients at 20.9% against a target of 25%, A&E 11.5% against a target of 15% and Maternity (Question 2) 24.5% narrowly missing the 25% target.

MTW Friends and Family scoring





Staff Survey 2018

This section outlines our most recent staff survey results for indicators Q13c (percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months), Q14 (percentage of staff believing that the Trust provides equal opportunities for career progression or promotion) and Q13b (percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months) for the Workforce Race Equality Standard.

Q13c Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

White: 26.9% (2017 findings - 25.7%) – National average for acute Trusts 26.4%
BME: 25.7% (2017 findings – 24.6%) – National average for acute Trusts 28.6%

Q14 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

White: 83.9% (2017 findings – 90.7%) – National average for acute Trusts 86.5%
BME: 67.0% (2017 findings – 77.8%) – National average for acute Trusts 72.3%

Q13bPercentage of staff experiencing discrimination at work from manager/team leader in the last 12 months

White: 6.8% (2017 findings - 8.0%) – National average for acute Trusts 6.6%
BME: 13.3% (2017 findings – 18.3%) – National average for acute Trusts 14.6%

NHS National Staff Survey Actions

The 2018 NHS National Staff Survey has seen a significant reduction in the number of BME staff experiencing harassment, bullying or abuse from managers/team leaders since 2017. However, there has been a slight increase in the percentage of BME staff experiencing this from colleagues since 2017 and a more significant increase in the number of BME staff believing that the Trust provides equal opportunities for career progression. The Corporate Action Plan from this survey will ensure that B&H training is offered to both staff and managers, that cases of B&H reported through Datix are followed up through the HR Business Partnering team and that communications demonstrating zero tolerance for B&H from staff, managers, patients and visitors will be highly visible throughout the Trust. The Trust promotes the role of the Freedom to Speak Up Guardian to all staff within the Trust.

Workforce Race Equality Standard (WRES)

The WRES data for 2018 was published in July, along with an action plan overseen by the Cultural Diversity Network. The plan focusses on validation of data around White and BME staff being shortlisted, appointed and within leaver data. B&H training is being designed and reviewed by all staff networks including Staff Side to ensure that it is fit for purpose along with supporting communications.

Cultural Diversity Network (CDN)

The Cultural Diversity Network hosted Black History Month in October 2018 – an event that heard from four inspirational black female speakers about how they have succeeded in their lives – Mrs Rantimi Ayodele, Consultant Paediatric T&O Surgeon at MTW, Mildred Johnson, Chief Pharmacist at MTW, Preeya Baillie, Chief Procurement Officer at NHSi (formerly of MTW) and Professor Jacqueline Dunkley-Bent, Head of Midwifery at NHS England.

The Cultural Diversity Network Chair was involved in a review of disciplinary cases which demonstrated that ethnic origin did not appear to be an influence in terms of the investigations and outcomes for each case. They were also involved in a joint review by staff network leads of Bullying & Harassment Cases where all investigations and

outcomes were felt to be appropriate. It was recognised that the Trust could do more in ensuring that staff know the correct channels for raising issues and concerns.

The CDN presented their annual action plan to the Trust Board for the first time and will report on progress on an annual basis.

Freedom to Speak Up (FTSU) Guardian

During 2018 MTW interviewed and appointed a new FTSU Guardian. The role is to ensure our patients are cared for in a safe way. Where staff have concerns that they feel are not being heard or feel they can't raise with management, our FTSU Guardian will listen to them in confidence, take on board their concerns and raise the issue through the appropriate channels. This might involve instructing an investigation and providing feedback to the staff member. The FTSU Guardian has the authority to escalate to the highest levels if he feels appropriate action hasn't been taken.

Contact can be made directly to the FTSU Guardian by phone or by confidential phone-line with answer machine, by email mtw-tr.freedom2speak@nhs.net; through the anonymous reporting incident reporting system, post boxes available in both staff restaurants or via a web page on the Trust intranet.

Implementing the Role - The key issues of developing robust recording keeping and a database has been addressed to ensure the valuable information provided by staff raising concerns is effectively captured for learning and improvement, as well as for governance and audit. A feedback form has been created to capture the experience of staff using the FTSU Guardian to enable continued learning, development of the role / process and support offered.
A new policy has been drafted along with FTSU Aims and Strategy. The FTSU self-review tool has been presented to the Workforce Committee and is subsequently being reviewed before submission to the Board.

Re-Writing the Policy (Freedom to speak up: raising concerns policy and procedure)
A new policy has been drafted to replace the “Speaking Out Safely (SOS) policy and procedure” which uses the National Guardian’s template as its basis to provide assurance that the Trust is following national best practice.

The new policy purposely avoids using the term “whistleblowing” as this is seen to have negative connotations and can in itself be a barrier to staff speaking up. The focus is very much on encouraging staff to talk about genuine “concerns” they have within the remit of the FTSU Guardian.

Freedom to Speak Up Ambassadors - The FTSU Guardian has also created the role of FTSU Ambassadors to support the FTSU agenda. To date we have recruited one Ambassador with more envisaged during early 2019/20 to further grow and support the service.

Rota Gaps

In August 2018 we identified six rota gaps at Foundation Year 2 level. The Medical Workforce team have adapted a pro-active approach in the early advertisement of these roles which takes place before receipt of the final confirmation from the Deanery and prior to the second round of recruitment. This is undertaken in collaboration with the Directorate leads to ensure that financial agreement has been confirmed to mitigate the risk of over-establishment, in the knowledge that this would be balanced out by the reduced use of agency doctors.

In addition we have a number of key initiatives supported by our Post-graduate Centres-

- WAST (Widening Access to Specialty Training) – national Health Education England scheme for overseas doctors to gain experience in the UK in order to better prepare them for application to their chosen specialty training programme. Whilst these doctors have limited or no understanding of the UK/NHS system, they are diligent and keen to learn, and have worked hard to fill their educational gaps. WAST doctors initially spend six months in Psychiatry before moving to the Acute Trust to work in Medicine. One WAST doctor will be joining the Trust in August and we have indicated that we can take additional doctors under this scheme.
- Fellow Posts with help undertaking Post-Graduate Certificate (PG Cert):
  Emergency Medicine have recruited Educational Fellows and are advertising for similar roles in Leadership and Management, Simulation and Trauma. Three Simulation Fellows were appointed in Anaesthetics with funding for PG Cert course fees and backfill of posts while attending University sessions at Canterbury Christ Church University. Similarly, one Education Fellow was appointed in Emergency Medicine with funding to support a PG Cert at Brighton and Sussex Medical School. These appointments have been going well. We have been informed that there will be no further funding for the Education Fellow, but it is hoped that funding from Canterbury Christ Church University will again be available.
- Chief Registrar Role in Medicine: 50% management
  Darzi Fellowship: - The Trust along with local NHS partners has been successfully shortlisted to be a Darzi Sponsor to drive forward “Interface Geriatrics” across West Kent. The Medical Director is the Clinical Sponsor. Unfortunately, on this occasion the Trust was not matched with a suitable candidate.
- Medical Training Initiative (MIT) - training Overseas Doctors in the NHS in a number of Departments including Anaesthetics, Paediatrics, O&G, Medicine etc.
- Physician Associate and Advanced Practitioner roles are also being recruited to provide multi-professional support to our services and rotas.

This approach is ongoing and will continue for the medical intake in August 2019, updates are provided on a quarterly basis to the Trust’s Workforce Committee.

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 154 SI's in 2018/2019 compared to 173 the previous year.

Of the 154 SI's, the completed investigations demonstrated 27 occasions where no significant learning for the Trust was required 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. These were subsequently downgraded bringing our total incidents reported down to 127 during 2018/19. This number has the potential to reduce further as we continue to investigate those that remain open.

Although there has been a decrease in the number of SI's being reported during 2018/19, this has been attributed to an increasing maturity and confidence in the reporting process in addition to increased clarity from the national agenda i.e. the Early Notification Scheme for Maternity and Learning from Deaths. In addition the Trust SI and incident investigatory processes have matured to an extent where both course of action equally provide a fair and transparent investigation that gives the patient and reporter the confidence that their concerns have been managed effectively. In addition the Trust has welcomed both West Kent Clinical Commissioning Group and NHS Improvement quality leads to the Trust's Learning and Improvement panels this year to gain feedback and assurance of our processes.

Actions and learning from SI's are key to improving patient care and ensuring patients are safe and provided with high quality care. In 2018/2019 learning and actions included:-

- Publication of training dates for all staff on the importance of incident reporting on our incident reporting database, Datix
- Publication of training dates for all staff on Duty of Candour (DOC) and the key requirements that must be undertaken following awareness that an incident has occurred
- Revision of the accident & emergency assessment (CAS) card to include an updated sepsis screening tool
- Reissue of the Standard Operating Procedure to all staff in contact with prescription pads, to familiarise themselves with the correct process/procedures in handling FP10's (prescriptions that can be dispensed by local pharmacists)
- Issue of new guidance for administrative staff on the process to follow for typing and sending out of clinic letters
- Update provided to ensure the process for receipt and storage of patient identifiable data is followed at all times

- Clear guidance on referral process for staff following violent and aggressive incidents to be included in the form of a flowchart to relevant policies with appropriate designation of staff duties
- Introduction of competencies that support extended roles for experienced clinical staff
- Mental capacity assessment to be undertaken before considering use of chemical restraint
- Raised awareness of the need to adhere to guidance and policy relating to blood transfusion and prohylaxsis to prevent blood clots, i.e. Haemoglobin checks
- Ensure complete and accurate documentation of risks and associated risks of the clinical procedure to ensure adequate and complete consent has been obtained
- To promote good practice to others on robust consenting and documentation
- Importance of clear and accurate record keeping regarding involvement of medical staff opinion, time, printed name, designation and signature

Never Events

There was 1 Never Event declared during 2018/2019, a full root cause analysis was undertaken and presented to the Executive Led Panel and findings shared with NHS Improvement to ensure wider learning.

This never event was identified in July 2018 – retained foreign object post procedure
Patient had undergone an instrumental delivery with suturing and subsequently developed a post-partum haemorrhage which was treated appropriately with patient being discharged home three days later.

Six weeks later the patient presented to the hospital having discovered a ‘string’ following vaginal examination. She had been feeling unwell and had received two courses of antibiotics from her General Practitioner.

Through the course of the investigation it is believed that this string was the ‘red tag’ used to bundle together 5 swabs in each theatre pack.

A number of factors contributed to this incident:-

- Failure to count the red tag as part of the swab and instrument count
- The red tag is believed to have inadvertently caught on a swab that was placed in the vagina during the management of the patient’s haemorrhage post-delivery.

Actions taken include:-

- Revision of the guidance for swab counting to include red tags in Obstetrics
- Dissemination of learning throughout Obstetrics and Theatres

Duty of Candour

Since April 1st 2015 all registered providers are required to meet Regulation 20 of the Health and Social Care Act 2008 (regulated activities): 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

154 Serious Incidents were declared in 2018/19.

During 2018/19, we have demonstrated an improvement in compliance with the 3 elements of meeting Duty of Candour for patients involved in a Serious Incident (SI).

According to our current data 5.19% of patients involved in a SI did not receive an initial Duty of Candour letter in 2018/19 in comparison to 17.4% the previous year.

At the time of this report, 23% of the declared SI's remain open and under investigation. Of the 61% that were completed, 50.5% have been sent the final outcomes of the investigation. This is compared to 48.9% compliance during 2017/18 and demonstrates that communicating the outcome of the investigation to the relevant person increases compliance.

Of note

- SIs completed and linked to a complaint = 7.37%
- SIs where patient/next of kin/carer do not wish to receive the outcome of investigation = 21%

Incidents

Excluding Serious Incidents, 207 incidents were reported on the incident reporting system which also met the criteria for Duty of Candour. 8.7% of these had evidence that an initial Duty of Candour letter was sent to the patient / relevant person. Of these 8.7%, 38.9% 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.

Of note: (compliance currently recorded on Datix)

- Was the Duty of Candour process followed for this incident? = 70.5% (146)
- Is it documented in the medical notes? = 32.4% (67)

Actions for 2019/20 to achieve compliance

In addition to Root Cause Analysis training sessions arranged for 2019, the Trust is undertaking a training needs analysis of departmental managers to ensure their training needs are revising the training agenda accordingly.

A review of all documentation is to be undertaken by the Patient Safety team in regard to the standard of information being sent to our patients and carers to ensure that the necessary compliance is met. This 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 Interim Datix Administrator to look at the newly procured upgrade to the incident reporting system to ascertain whether it is able to act as a repository for the evidence for Duty of Candour and also to look at the possibility of flagging and escalating the incidents which meet the criteria and improve compliance.

A quarterly report will continue to be provided to help support improvement with monitoring and provide assurance to the Quality Committee.

Dates for Duty of Candour training have been circulated for 2019 and will be regularly evaluated to gain feedback from our staff whilst triangulating this with alternative opportunities for training and education.

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 and are:-

- Standard 1: Patient Experience
- **Standard 2: Time to Consultant Review**
- Standard 3: Multi-Disciplinary Team Review
- Standard 4: Shift Handover
- **Standard 5: Diagnostics**
- **Standard 6: Consultant Directed Interventions**
- Standard 7: Mental Health
- **Standard 8: On-going review in high dependency areas**
- Standard 9: Transfer to primary, community and social care
- Standard 10: Quality Improvement.

**Those highlighted in bold are the priority standards.*

Request:- Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement.

Response:- Significant progress has been made within the Trust's Seven Day Services (7DS) project since its inception in January 2017. Almost full compliance is being achieved against the 4 priority standards during the weekdays and weekends across the majority of the Surgical, Critical Care and Women's and Children's Directorates. A small compliance issue remains in respect of standard 2 in some of these services (ENT, Urology, General Surgery). This occurs during part of the weekend when these consultants are not currently routinely job planned to be resident (between mid - late afternoon on a Saturday and 08.00hrs on a Sunday), for which mitigating arrangements are in place until full compliance can be achieved to comply with the March 2020 national requirement. With respect to Acute and Geriatric Care and Specialist Medicine, full compliance has been achieved with standard 2, but there is a significant consultant workforce challenge in respect of standard 8 and thus, these services will be very unlikely to be in a position to achieve full compliance by March 2020. Acute and Geriatric Care and Specialist Medicine services are also in the process of implementing a 24/7 GI Bleed rota which will ensure full compliance with this element of standards 5 and 6. The remainder of the Trust are fully compliant for standards 5 and 6. The project now reports via the Best Care Programme (Best Safety Workstream).

Compliance Status

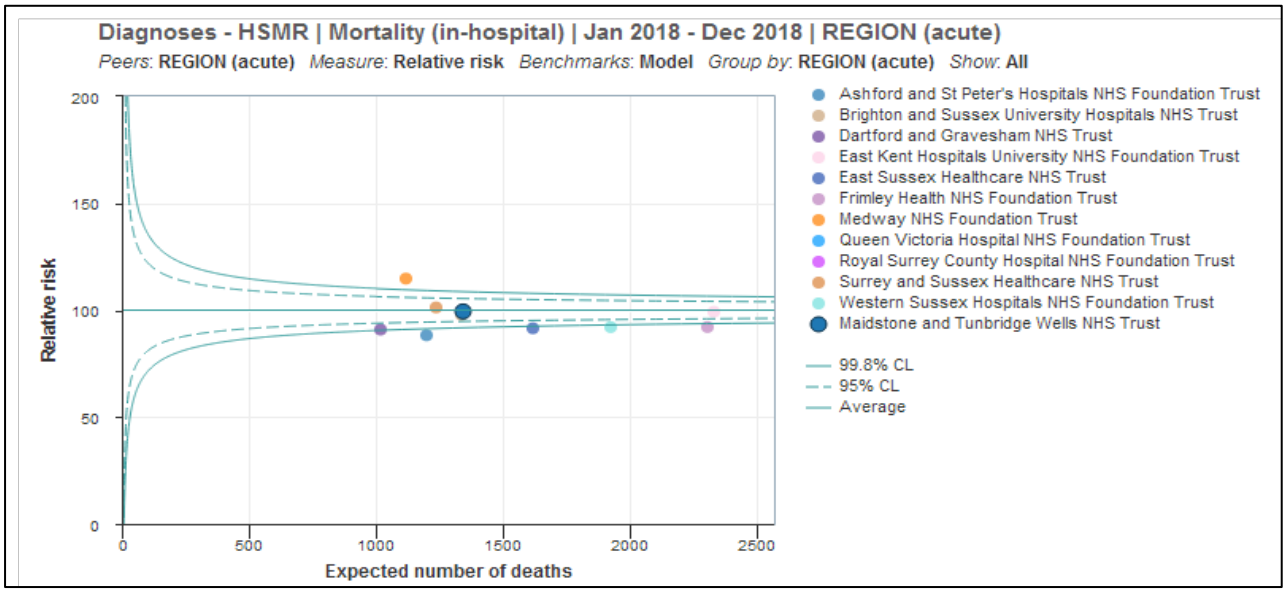
'Exempt' relates to services that do not have non-elective (NEL) patients under the direct care of the specialty consultant, but are under the primary care of another service (normally a physician due to co-morbidities).

Service	Std 2	Std 5	Std 6	Std 8	Comment/Actions in progress
Surgery	✓ (w/day) X (w/end)	✓	✓	✓	There is not a resident consultant on site on Saturdays and Sundays from 14.00hrs – 08.00hrs (consultants are on call from home). There are on average 8.5 non-elective admissions each day Saturday & Sunday which could be medically active. Service reconfiguration is the longer term solution. Mitigation in the meantime is the implementation of a virtual ward round between 18.00 and 20.00hrs on Saturday and Sunday, (went live on 21.1.19) and further exploration of potential for a face to face evening post-take ward round from existing consultant staff via changes to working patterns prior to reconfiguration.
Urology	✓ (w/day) X (w/end)	*N/A	✓	✓	The gap relates to a small number of NEL admissions (who could be potentially medically active) on Saturday and Sundays (a total of 1.2 – 1.4 patients per weekend, on average). A business case for a 6th Consultant has been submitted which will allow full implementation of the standards. Pathways are being finalised for all medically optimised patients. Mitigation for the NEL patients is the implementation of a virtual ward round during the evenings on Saturday and Sundays (requires confirmation of w/e shifts of all middle grades prior to implementation).
Women's Health	✓ (w/day) X (w/end)	✓	*N/A	✓	Principle for an exception pathway for a very small cohort of patients (<1 per weekend) has been informally agreed via the Challenge Event with NHSI/E/CCG in October 2018. – To sign off at Quarterly Review with NHSI/E/CCG on 14.3.19 – Please see appendix 3.
T&O	✓	*N/A	✓	✓/X	This service is technically compliant but the CD made decision to declare non-compliance for standard 8 until re-escalation processes have been assured for all patients who may become or revert back to a medically active status throughout their length of stay (LOS). A Standard Operating Procedure (SOP) has been drafted by the Clinical Director and this is being implemented. This includes piloting a new rota for 2 months from April which will release the Consultants time to be able to see all medically active patients as per SOP. The results of the implementation will be reviewed in May 2019.
ENT	X	*N/A	N/A	X	The NEL activity for this service has been identified and is on average 2.5 patients per day. Work is in progress with the Ear, Nose & Throat (ENT) Team to identify the medically active cohort who are under the direct care of an ENT surgeon and not under the care of a physician due to comorbidities. Once fully understood, a mixture of consultant-delivered assessment/review and pathway delivered care is required. Discussions are taking place with the ENT Team to increase the number of daily ward rounds from 3 days per week to daily and to implement a virtual ward round each evening as a mitigating measure in the interim.
Acute and Geriatric Care and Specialist Medicine	✓	X (Endos-copy)	X (Interve-ntional Endos-copy)	X	Non complaint for standards 5 & 6 until the 24/7 GI Bleed rota is implemented – plans in progress to implement this by the end of quarter 2 of 2019/20. There is a major compliance issue for standard 8 – the main contributory factor is consultant numbers. *(Please see appendix 2 for full detail).*
Paediatrics	✓	*N/A	✓	✓	Compliant
Critical Care	✓	*N/A	✓	✓	Compliant
Ophthal-mology	Exempt	*N/A	*N/A	Exempt	Exempt: All medically activity patients are under the care of a Physician.
Clinical Haemat-ology	✓	*N/A	*N/A	Exempt	Nature of casemix – patients are known to the service. Audit undertaken to demonstrate.
Emergency Medicine	Exempt	*N/A	✓	Exempt	Standards commence from point of admission

** Note: N/A means that the service is not responsible for providing that part of the standard and is thus compliant by default*

Learning from Deaths (Mortality Reviews)

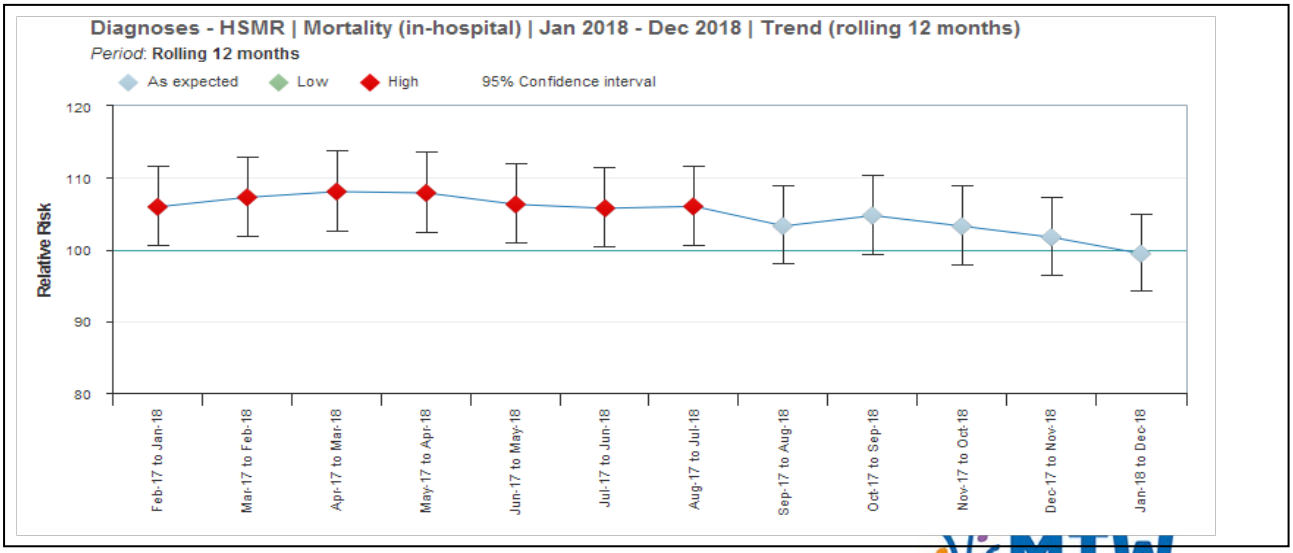
During 2018/19 MTW has progressively seen mortality rates reduce, to the extent that at year end MTW were no longer considered to be an outlier amongst their peers and compliance is at a sustained acceptable level.



The Trust Mortality Surveillance Group (MSG) has been operational since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning. This group subsequently 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 Chief of Service for the Medicine & Emergency Care Division.

The MSG closely monitors both local and national data in an effort to identify themes and trends that may impact on our patients care. In particular we use the Hospital Standardised Mortality Rate (HSMR). This is a key indicator that benchmarks 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 2018 our HSMR was recorded as 105 (a ratio of the actual number of deaths to the expected number of deaths) and in March we reported 99.4, the expected rate is 100 or below.

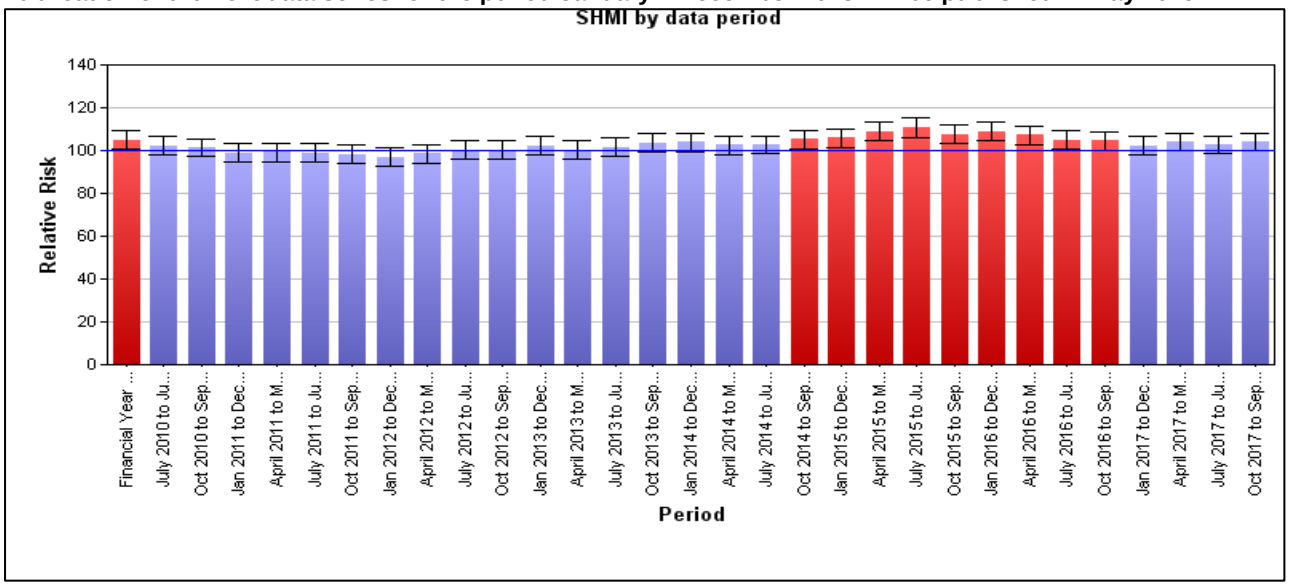
Rolling 12 Month view- data from January-December 2018.



Further evidence of improvement in Mortality at MTW is seen in the Standardised Hospital Mortality Indicator (SHMI), this is a measure of mortality and performance which includes all deaths in hospital regardless of diagnosis, in addition it includes all those individuals who die within 30 days of discharge from hospital.

SHMI published by the Health & Social Care Information Centre (HSCIC) for the period October 2017 – September 2018 shows MTW's SHMI as 1.0391 which is banded as level 2 'as expected' (1.0492 in March 2018).

Publication of the next data series for the period January – December 2018 will be published in May 2019.



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 when concerns are identified with the care provided these deaths are then allocated for a more in-depth review (structured judgement review).

During 2018/19 MTW recorded 1600 patients who had died. 1484 inpatient (Inpt) deaths and 116 in Accident & Emergency (A&E). The process for undertaking mortality reviews has been revised this year in an effort to make explicit all aspects of good practice and elements for learning. The current process has been recognised as being labour intensive with learning having to be manually extracted, however a business case had been approved to purchase the Mortality Module for Datix with the understanding that themes and trends could be automated and used to support the 'Lessons Learned' agenda.

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 Trust processes and procedures to make the necessary changes as a result of lessons learned.

Each Directorate has a nominated Mortality Lead with the key objective of ensuring that the Mortality review process is embedded locally and that deaths that have raised concern are fed-back to the MSG and vice versa that learning is shared from MSG to the Directorates.

Reporting Period April 2018 – March 2019

Trust	Q1	Q2	Q3	Q4	Total
No of Deaths	379	398	358	465	1600
No of Completed Reviews	338	340	301	375	1354
%age completed reviews	**89.2%**	**85.4%**	**84.1%**	**80.6%**	**84.6%**
SJRs Requested	30	22	15	23	90
SJRs Completed	17	11	7	6	41
%age SJRs requested of all deaths	7.9%	5.5%	4.2%	4.9%	5.6%

90 Structured Judgement Reviews representing 6% of the 1600 patient deaths that have occurred during 2018/19 where requested during this time frame. Of these 48% have been completed to date equating to 3% of all deaths having had an in-depth review undertaken of the care that they received. Reviews are undertaken for several reasons which include concerns with care provided, in addition the review process will also make this judgement. Of the 41 reviews undertaken the judgements in regard to care provided were:-

- Very poor care- 3
- Poor care- 4
- Adequate care - 11
- Good care - 20
- Excellent care - 3

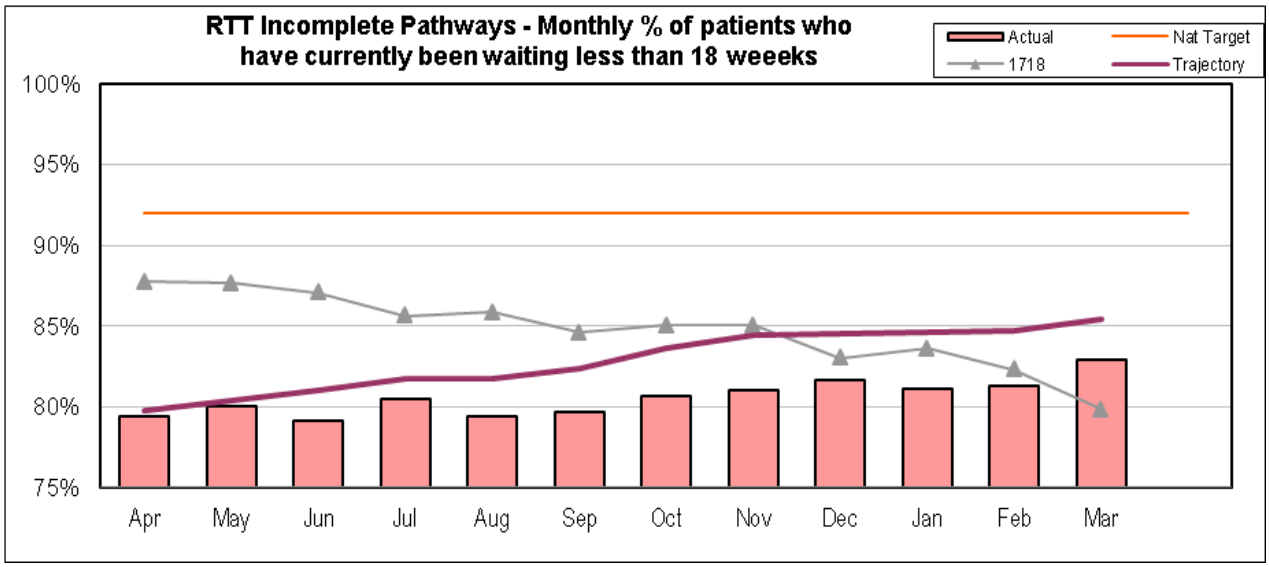
Learning identified from Mortality Reviews during 2018/19 includes the need for:-

- Improved communication with patient and/or family re decision making for Do not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Improved documentation re decision making of ceiling of care and plan for palliation
- Prompt senior oversight of decision making re End of Life Care (EOLC), to include review of DNACPR form signed by Consultant lead
- Prompt referral to palliative care team when decision made for EOLC
- When discharging patient home for EOLC ensuring that the family know what to expect i.e. what death looks like and prompt review by Hospice palliative care team
- Consideration in regard to the appropriateness of clinical treatment i.e. scans, blood test and antibiotics for a patient at the end of their life
- Consideration of fluid and nutritional replacement when patient nil by mouth due to inadequate swallow, prompt referral to Speech & Language Team and Dietetics and consideration re feeding at risk.
- Patients clearly dying should, wherever possible, be fast-tracked to a side-room with clear communication with receiving ward so staff aware of imminent death.

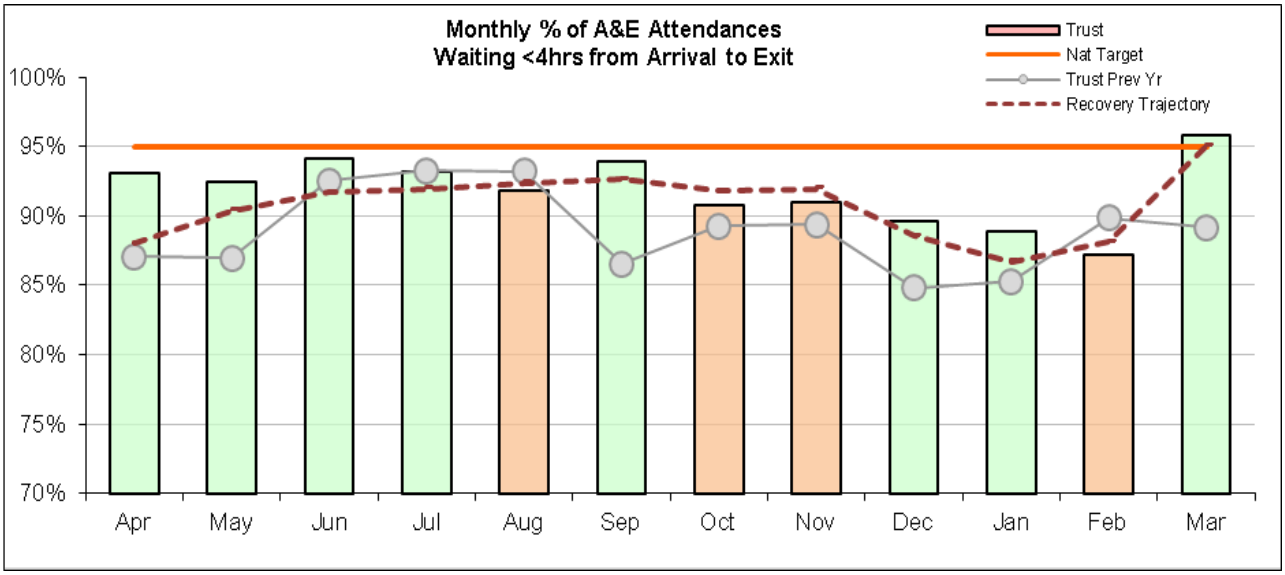
Other Quality Monitoring and Improvement Standard

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

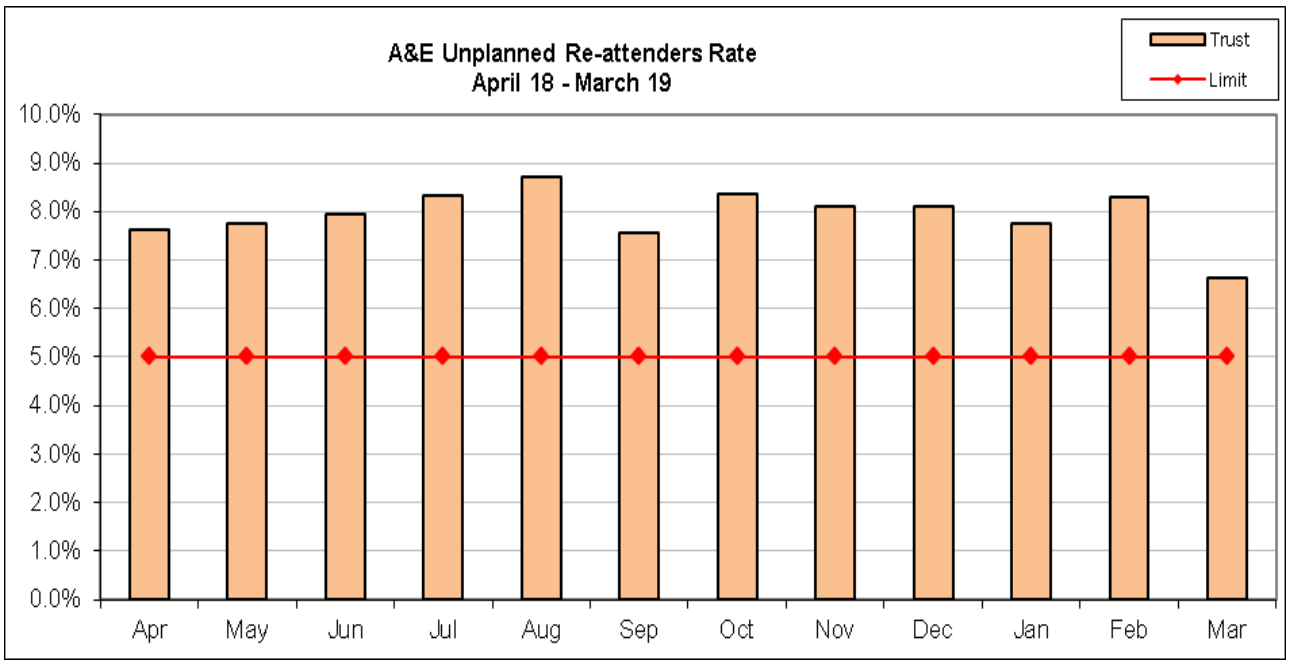
18 weeks standard – The Trust did not achieve this standard at an aggregate Trust level of at least 92% of patients on an Incomplete Pathway waiting less than 18 weeks.



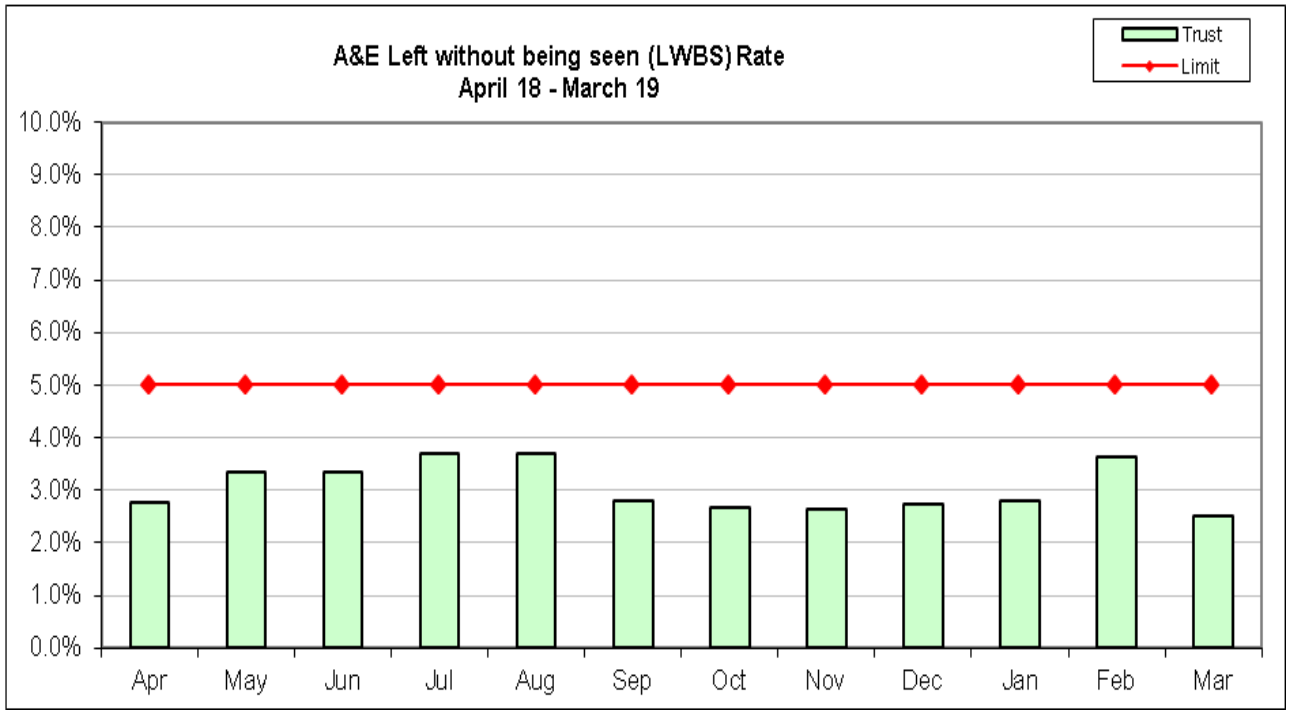
Emergency 4 hour access – The Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its A&E departments in 2018-19. However, the Trust did achieve our Trust Recovery Trajectory for each of the quarters of the year (slightly under for Quarter 3) as well as achieving 95% compliance in March 2019. The Performance for the year of 91.9% is a 2.9% improvement on 2017-18 despite a 7.1% increase in Type 1 A&E Attendances compared to 2017-18.



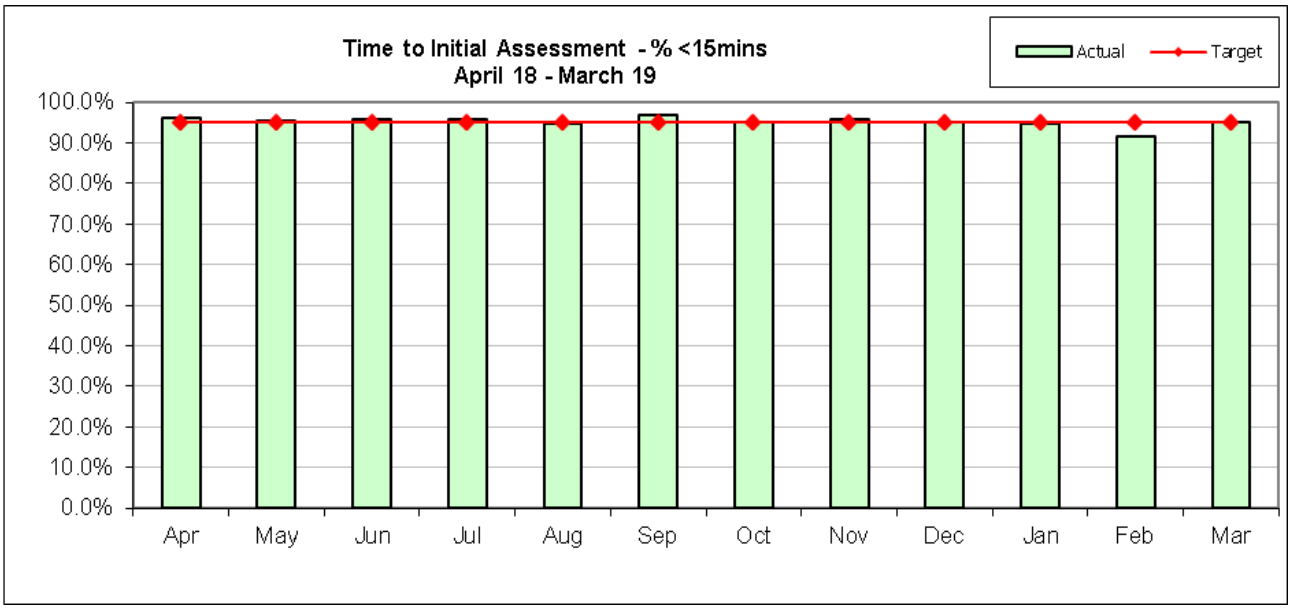
A&E Unplanned Re-attendance Rate – The Trust did not achieve this standard of less than 5% unplanned re-attendance rate at 8%.



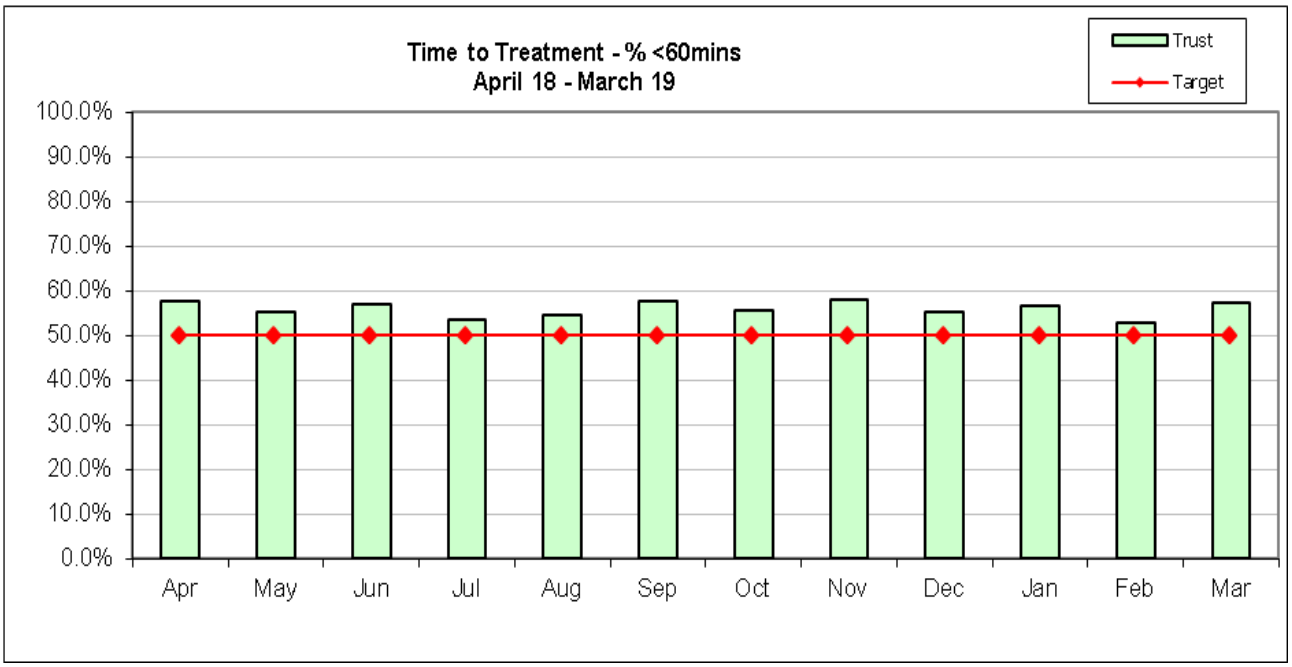
A&E Left without being Seen Rate – The Trust achieved this standard of less than 5% of patients leaving its A&E Departments without being seen.



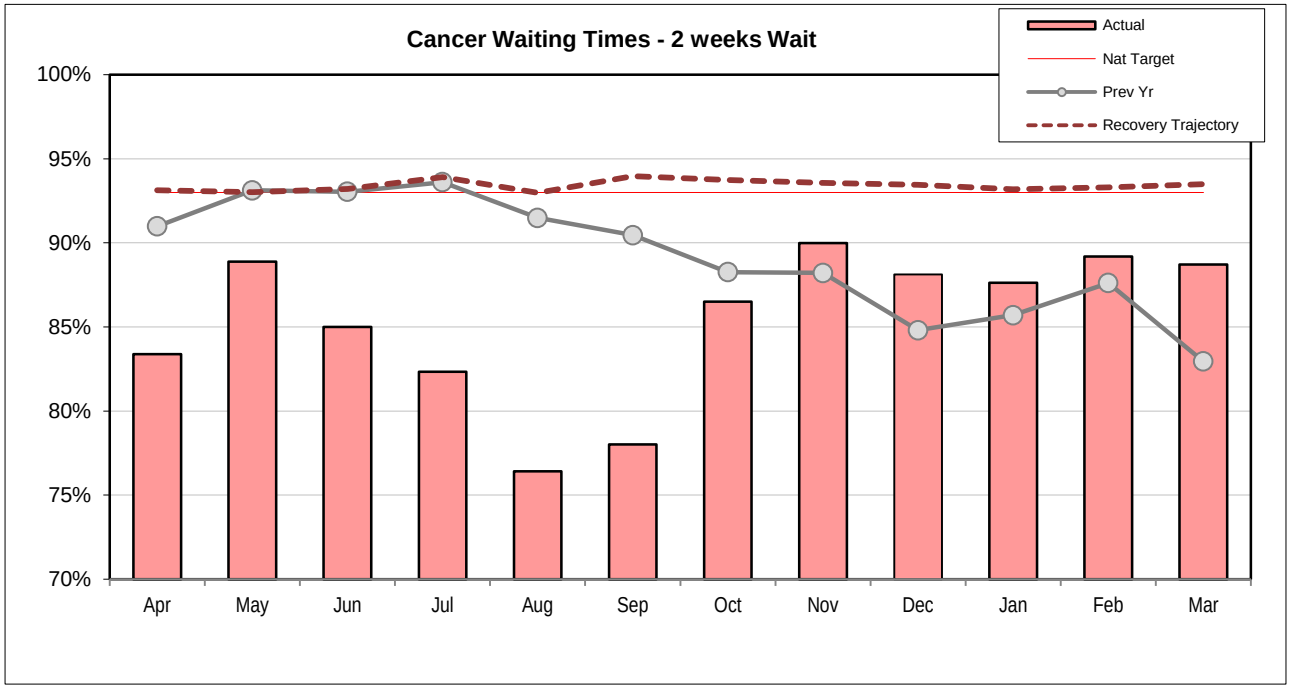
A&E Time to Initial Assessment <15 minutes – The Trust achieved this standard of 95% of patients arriving in its A&E Departments being assessed within 15 minutes of arrival.



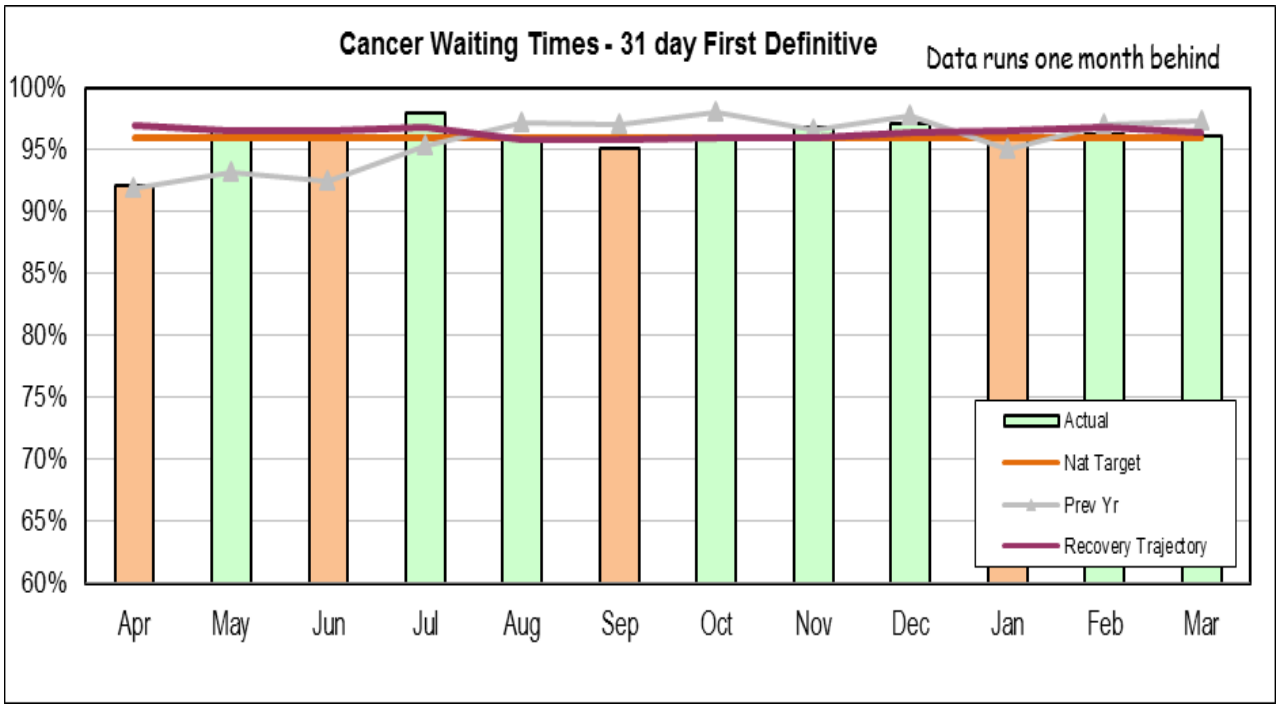
A&E Time to Treatment <60 minutes – The Trust achieved this standard of 50% of patients arriving in its A&E Departments being treated within 60 minutes of arrival at 55.9%. This is no improvement on last year.



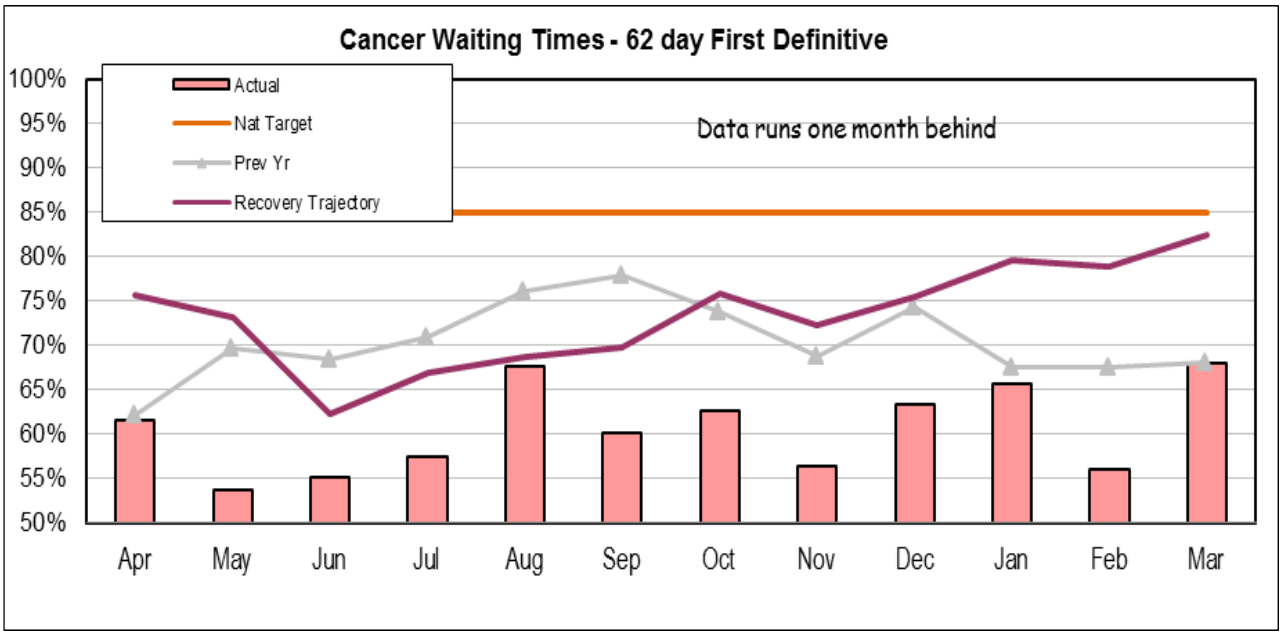
Cancer Waiting Time Targets - 2 weeks from referral – The Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks.



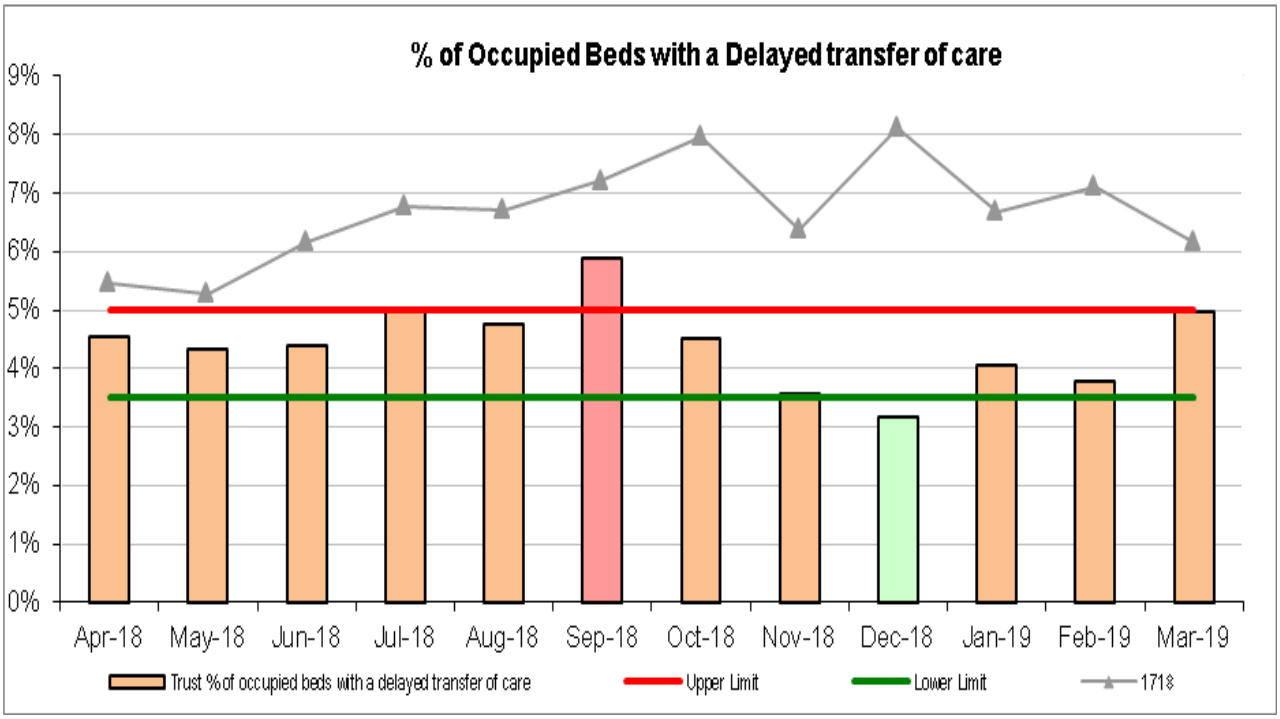
Cancer Waiting Time Targets – 31 Day First Definitive Treatment – The Trust has achieved this standard ensuring that 96% of patients who needed to start their treatment within 31 days did so.



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 4.42% this is a 0.53% improvement on 2017-18.



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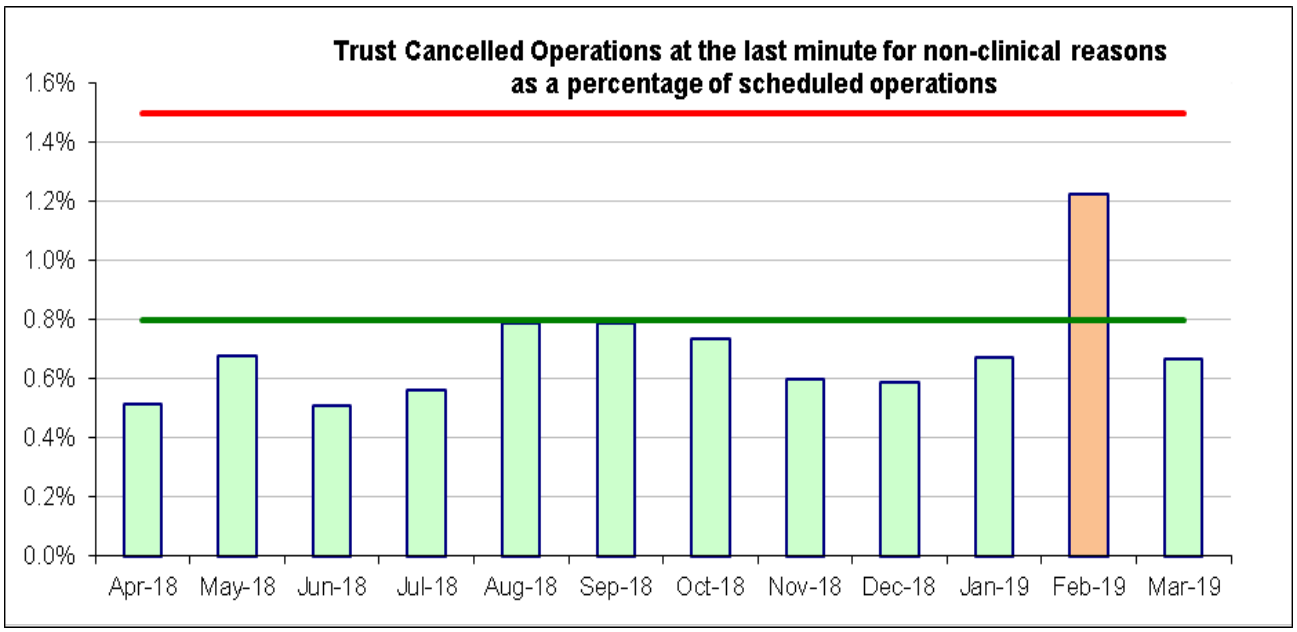
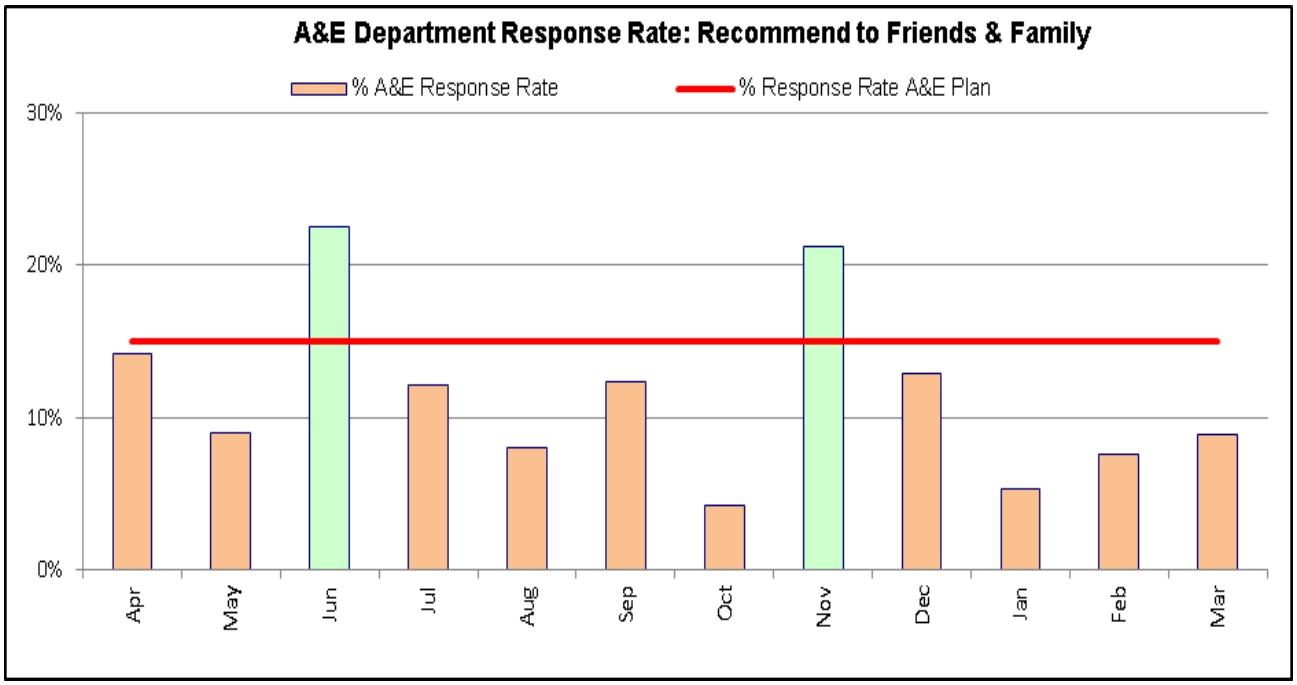
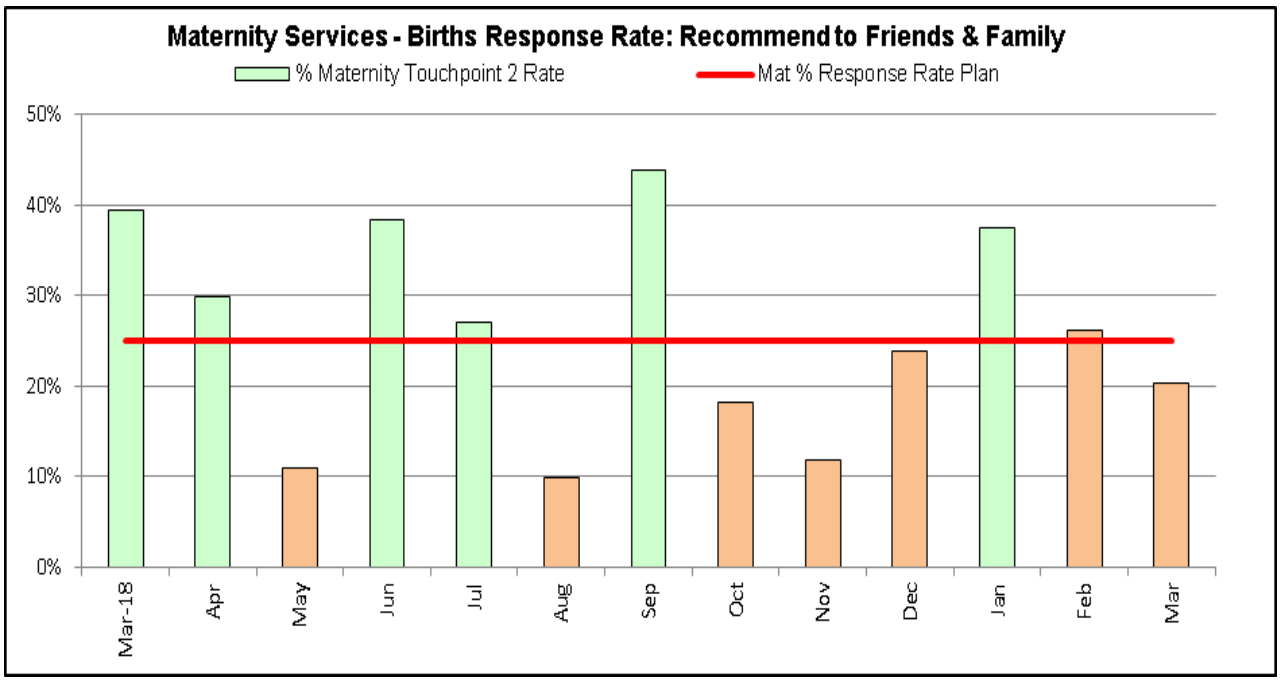
Cancelled operations – The Trust achieved this standard with 0.69% of operations cancelled at the last minute against the national maximum limit of 0.8%.



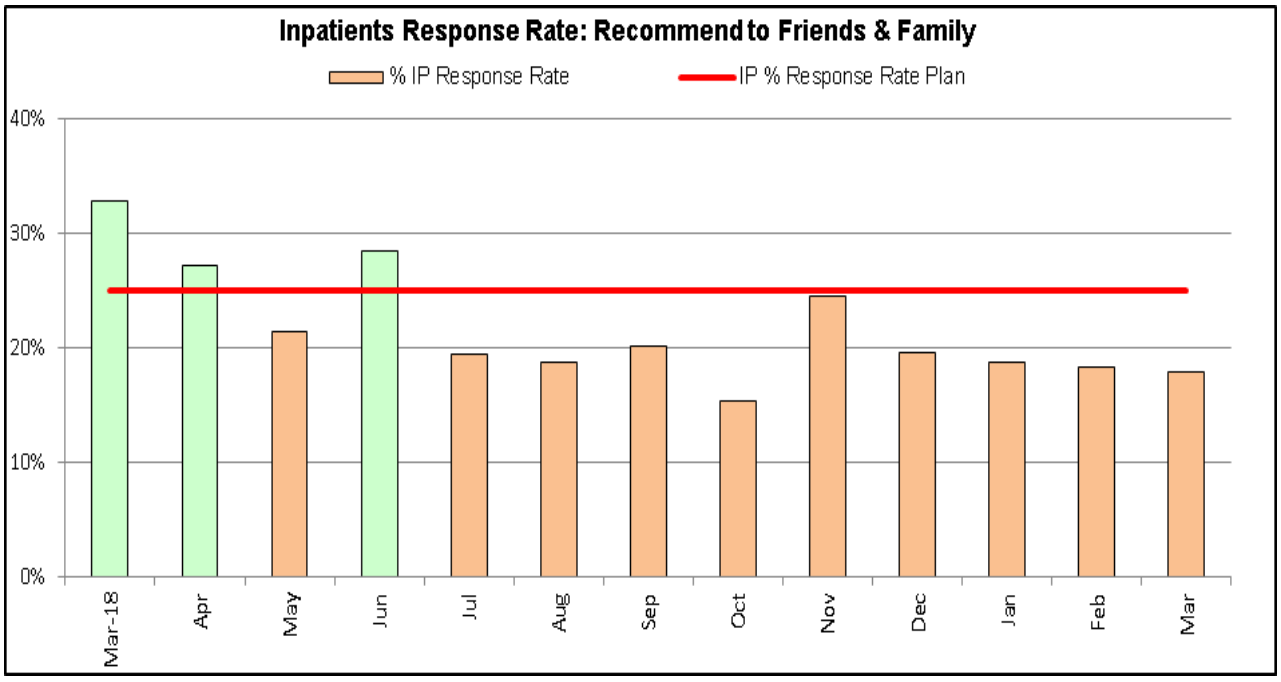
Friends and Family Test Response Rate A&E- The Trust did not achieve the target of 15% response rate for the Friends and Family Test given to patients in the A&E Departments at 11.5%. Of the responses received 91.3% were positive.



Friends and Family Test Response Rate Maternity- The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to patients after giving birth at 24.5%. Of all the responses received for patients accessing Maternity Services 94.9% 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 20.9%. Of the responses received 94.4% 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 submitted a 'standards met' Data Security and Protection 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 —**	**2018/19 local and national data**	**2017/18 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.	1.0391 (Band 2 – "As Expected" 30.7 Oct 2017 – Sept 2018	1.0371 (Band 2 – "As Expected" 28.6 April 2017 – March 2018	1.00 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)*	0.100 No data 0.466 0.329 (Apr 17-Mar 18)	0.128 No data 0.463 0.298 (Apr16-Mar 17)	0.089 No data 0.458 0.337 (Apr 17-Mar 18)

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 —	2018/19 local and national data	2017/18 local and (national) data	National average
3	the percentage of patients aged— i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	**Elective** 3.3%*1 **Non-Elective** 4.8%*1 **Elective** 7.2%*1 **Non-Elective** 16.5%*1	**Elective** 5.1%*1 **Non-Elective** 4.9%*1 **Elective** 6.0%*1 **Non-Elective** 14.8%*1	Update is expected in April/May 2019 following methodology review
4	The Trust's responsiveness to the personal needs of its patients during the reporting period	90% (Local audit)	90% (Local audit)	No national data available
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.	89.0%*2	71.4%*2	82% 2017-18
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96.7%*3	95.4%	95.6% 2018/19 Q3 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.	16.3 *4	10.6	13.7 2017/18
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	8,113 80(0.98%)	7,423 128(1.72%)	0.5% (Oct 17-Sept 18)

*1 2018/19 data is Apr-18 – Feb- 19 as March not currently available. Data taken from local tables and readmissions within 30 days (not 28 days)
*2 Based on Quarter 4
*3 Q4 not yet published so taken from local data.
*4 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.

Data published in February 2018 (based on April 2017 to March 2018) shows all 3 surgical procedures showing an improvement in health gain following an operation.

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

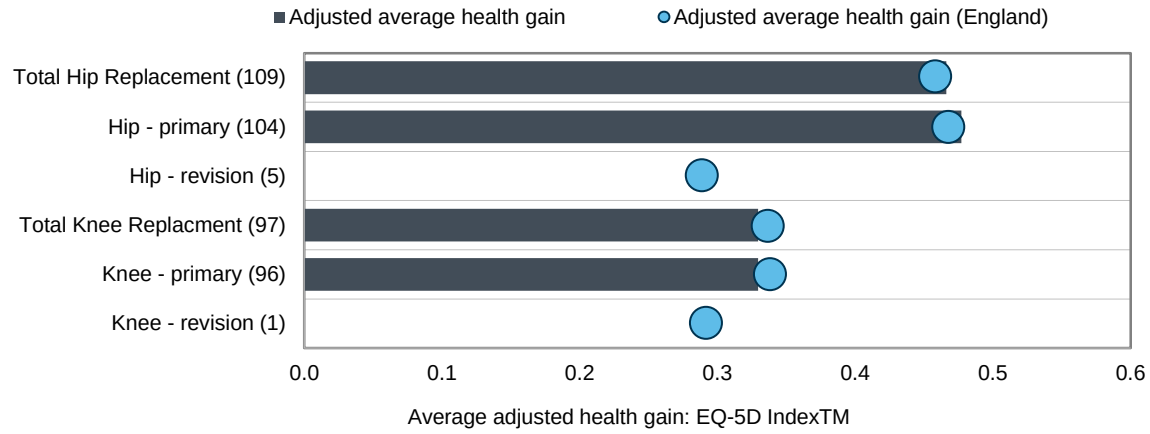


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

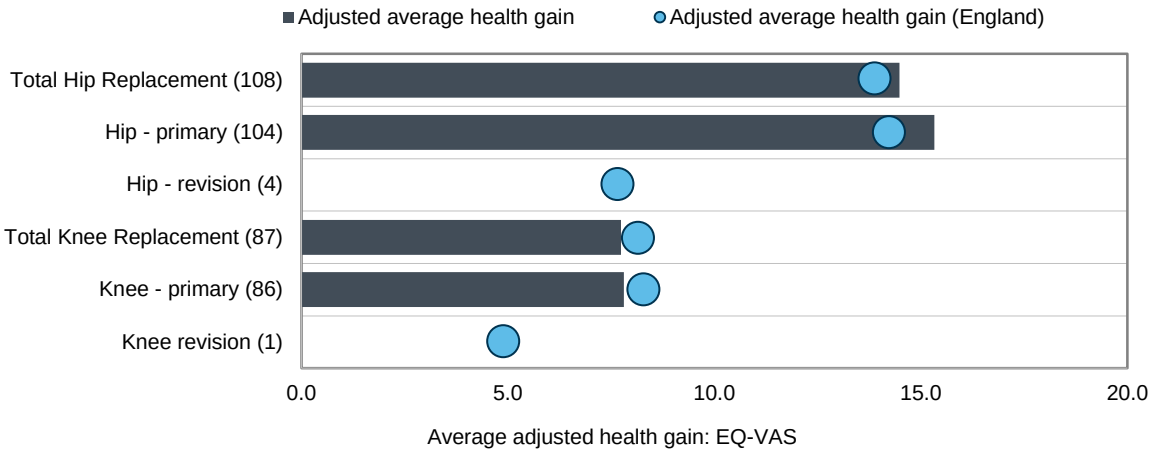
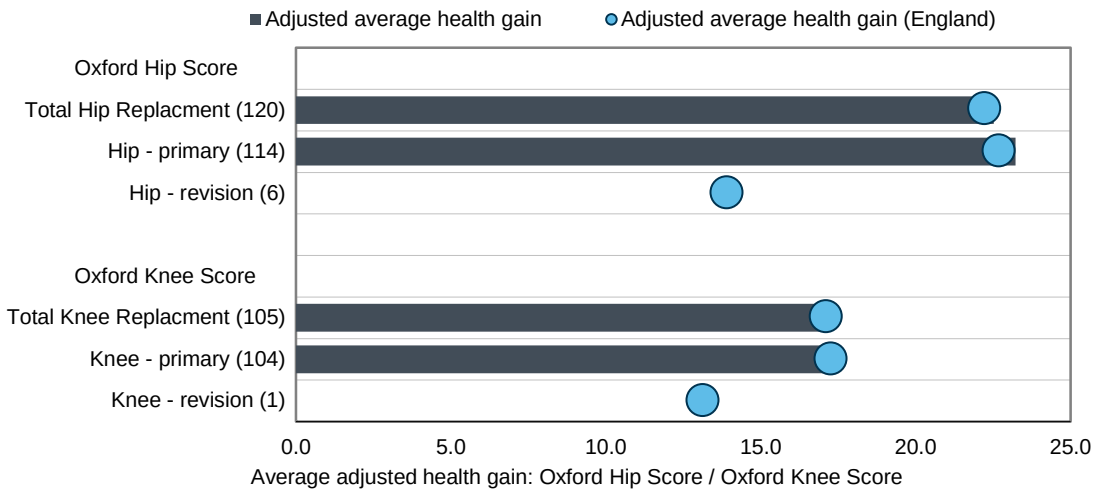
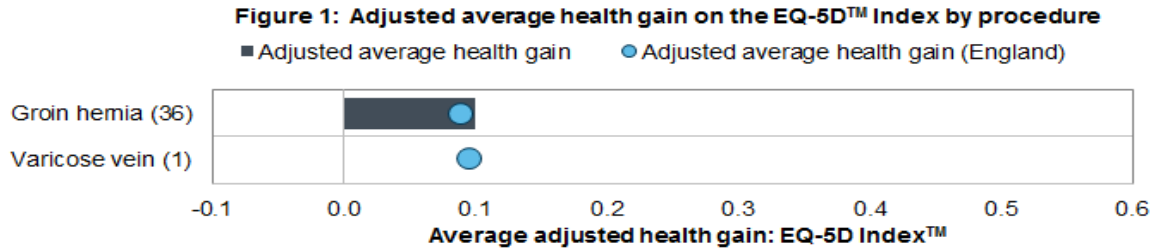


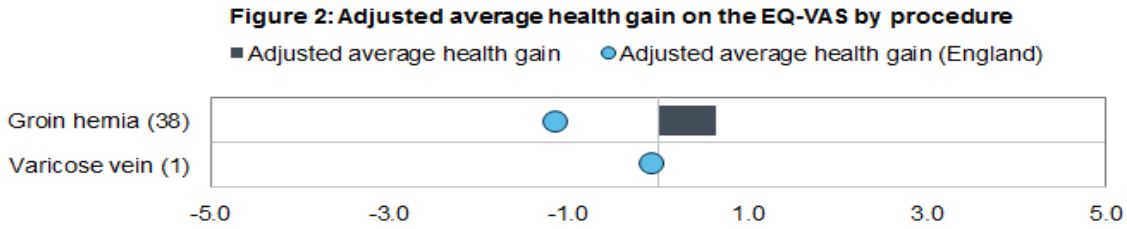
Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure



Groin Hernia

Procedures in the period April 2017 – September 2017. Data published June 2018.





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 Oxford Knee score for Knee Replacements, but fell below the national average for the other two outcome measures. As can be seen for Groin Hernia, the trust scored favourably for both measures against the adjusted average health gain.

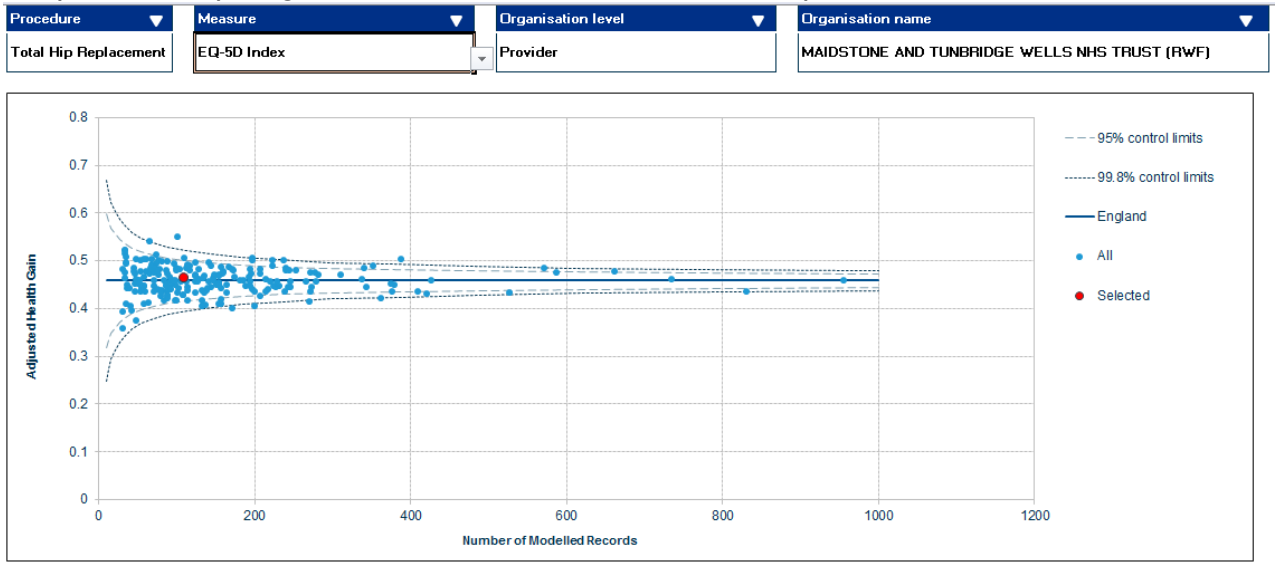
MTW considers that the outcome scores are as described for the following reasons:-

Nationally it is recognised that recovery from a total knee replacement is slower in comparison to that of a total hip replacement as a knee replacement will require the patient to undertake a strict physiotherapy regime to gain the ultimate benefits in terms of flexibility of the joint. Review of these pathways of care have highlighted that a higher percentage of patients, in comparison to the previous year, are not attending 'Hip and

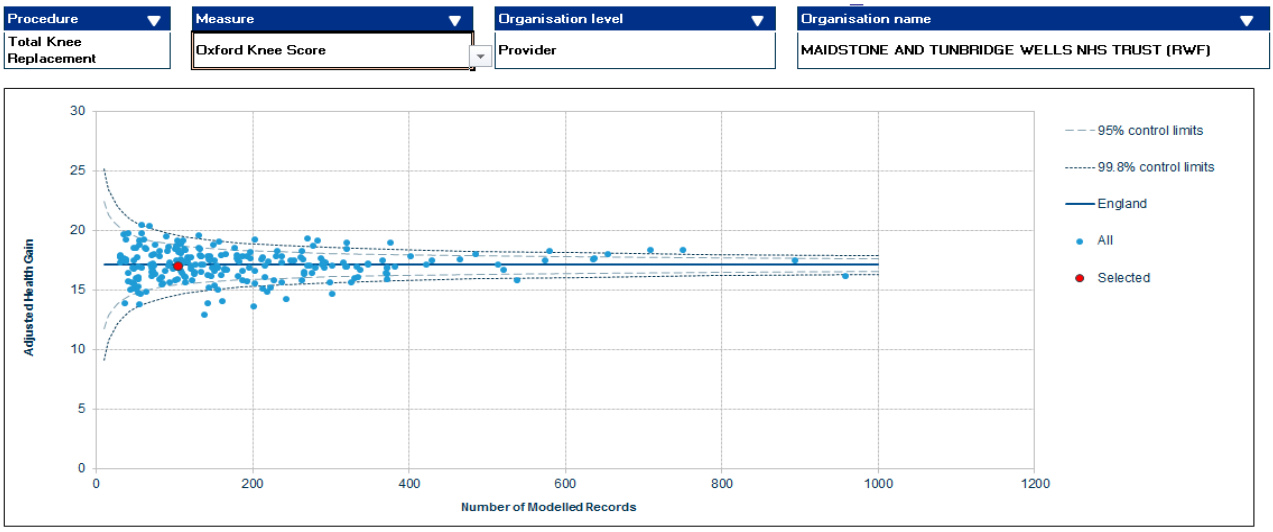
Knee' classes. These classes are invaluable in educating our patients as to what they can expect following their surgery and to explain that the benefits of a knee replacement are slower to recognise than those of a hip replacement.

MTW have recognised the increasing non-compliance with attendance to the 'Hip and Knee' classes and are now working with the administration unit to ensure that patients are given advance warning of their need to attend and to ensure that surgery is not booked until attendance has been confirmed. It is anticipated that this will help to address this year's lower scores and thereby improve the quality of its services and improve patient expectations.

Hip Replacement – 109 returns of which 102 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Knee Replacement – 105 returns of which 102 reported an improvement in health following the procedure (using the Oxford Knee Score PROMS measure).



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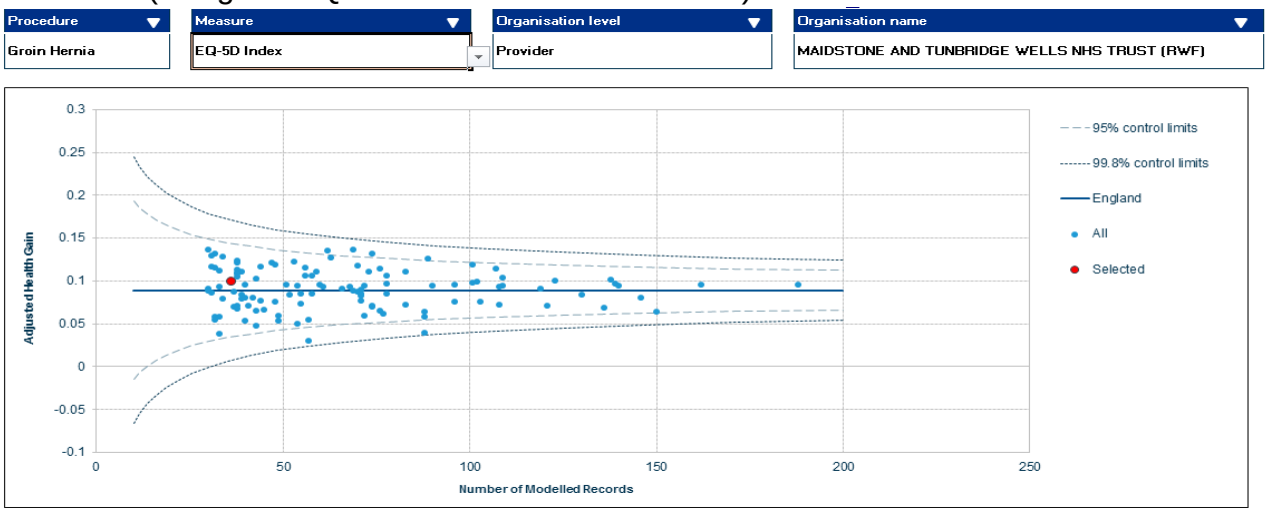
Groin Hernia – 36 returns of which 19 reported an improvement in health following the procedure (using the EQ-5D Index PROMS Measure).



Patient Safety Incidents

The proportion of Patient Safety Incidents which resulted in severe harm or death for 2018/19 was 0.98% (1.72% 2017/18). This is calculated by dividing the number of serious and catastrophic incidents (80) reported by MTW by the total number of patient safety incidents 8,113 (7,423 for 2017/18).

The latest report from the National Reporting and Learning System (NRLS), which was published in March 2019 and covers the period of 01/04/18 to 30/09/18, provided a reporting rate of 31.06 compared to 23.70 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, of note MTW continues to make improvements in their number of incidents reported and are now graded as 'no evidence for potential under-reporting'.

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 cause 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 the 'Learning Lessons' workstream remains operational and continues to strengthen and formalise this approach across MTW. Their objectives have included purchase of an upgrade of the

incident reporting database, review of the Clinical Governance agenda's and further investment in human factors training for 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 Divisional Performance review with the Executive leads. These meetings monitor compliance through the Divisional dashboards. In particular the Medicine & Emergency Care Division has responsibility for the Accident & Emergency four-hour access standard, the Surgical Division has responsibility for the 18 week referral to treatment access standard and Cancer Services has responsibility for the Cancer standards. The Chiefs of Service, Divisional Director of Operations and the Divisional Directors of Nursing & Quality also work in collaboration with our commissioning teams to address non-compliance and to look at the implications of the wider health economy to ensure that our patient's needs are met.

Scrutiny

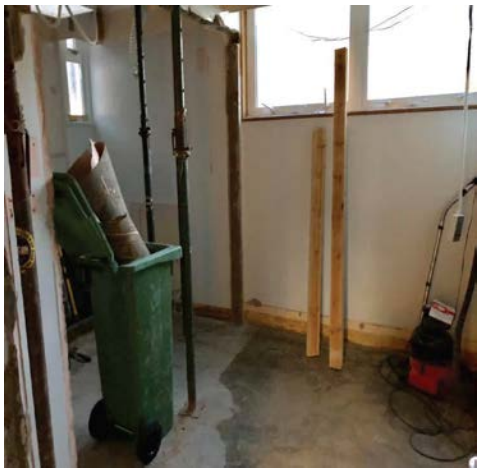
Along with the key priorities for the year these indicators are scrutinised by the relevant governance committees, Trust Management Executive and the Quality Committee.

Additional areas of significant improvement during 2018/19

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 Division

Crowborough Birth Centre Refurbishment



A major project to refurbish the birthing centre at Crowborough was undertaken during 2018/19 with the aim of improving the physical services and ensure that the service meets the needs of the community. The opportunity was also taken to ensure that safety standards were improved in line with other maternity units within the NHS.

Whilst the building works took place the centre continued to operate whilst making every effort that disruption to service was minimised. The new look centre was unveiled at the end of January and is to be used as the pilot site for Continuity of Carer teams.

Surgical Services Division

Urology Directorate

The Trust has begun using a ground-breaking procedure for patients with prostate cancer after a £355,000 donation from a local family funded innovative equipment. Our specialist Urology team treated its first patient at Maidstone Hospital earlier this year using tiny gold markers to more accurately deliver radiotherapy for prostate cancer. We are the first in the UK to routinely offer this technique.

The procedure allows surgeons to insert special gold markers known as 'Fiducial markers' inside the prostate, enabling

radiotherapy to be focussed on the area and minimising radiation to the surrounding, healthy organs. The usual method in which the Fiducial markers are placed in position can possibly lead to a risk of infection, but MTW urologists have now developed a special technique of inserting the gold markers through the skin. The technique significantly reduces the risk of infection and has been shown to be safe in other studies around the world. The equipment to carry out the procedure was funded by Roy and Margaret Sutcliffe, from Maidstone, who gifted the money to MTW's Kent Oncology Centre in August 2018, after Mr Sutcliffe was treated by the Trust for bladder cancer.

The Wells Suite– Private Patients Day Unit

Last week, our private patient service re-opened its doors, with a new clinical and administration team leading the unit. The day unit has undergone a refurbishment, with improvements made to patient accommodation and waiting areas. The day unit will offer outpatient consulting rooms including a room for ultrasound scanning, pre-operative assessments, such as blood tests and swabs, as well as providing three ensuite rooms for patients to recover following day case procedures, such as imaged-guided biopsies, cardiac catheter lab procedures and minor surgical procedures. The new day unit supports our plans to improve patient flow across our hospitals. All surpluses from private patient services are reinvested in NHS services in the Trust.

Medicine & Emergency Care Division

Edith Cavell trials Coloured Blankets

Edith Cavell at Maidstone Hospital is handing out coloured and patterned blankets to elderly patients as part of a trial to see if it helps reduce falls. The first blankets were given to two patients on the ward this week and were received very positively by them and their families.

The blankets help older patients, particularly those with dementia, find their way back to bed more easily. They also allow patients to see the edge of the bed more clearly, when getting up and down,

and provide a more homely feel to the ward.

The scheme has been successful at other NHS hospitals and was picked up by the ward team and Karen Carter, Directorate PA for Specialist Medicine, to see if it worked at MTW. So far, nine blankets have been knitted or donated. Due to infection control, blankets are single use items and are taken home with the patient, following discharge.

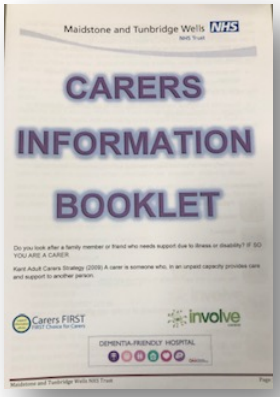
Corporate Services

Dementia-Friendly Care

As an organisation we are signed up to the Dementia Friendly Hospital Charter. www.dementiaaction.org.uk/dementiafriendlyhospitalscharter. This means we have made a commitment to people with dementia, their families and friends, in respect of what to expect during a stay at MTW.

We are progressing well with these commitments and work will continue to embed these in 2019/20, they include:-

- Ensure our staff and volunteers understand and are skilled in dementia care – this training is mandated across the organisation for all clinical staff.
- Actively involve patients, families and friends as essential partners in providing care and planning discharge – this is encouraged and we also have a Carer's information booklet as well as Carer's organisations on both sites to provide support and guidance.



- Provide family and friends with flexible visiting times, including overnight stays where possible – we are signed up to John's Campaign https://johnscampaign.org.uk/#/
- Use information that patients, families and friends have provided to us – we actively encourage the use of the 'This Is Me'.
- Provide access to dementia specialists to whom patients, families and friends can talk to and provide feedback.
- Seek to ensure that the surroundings of where patients stay are as friendly, comforting and accessible as possible; work continues to enhance our environments.

Looking ahead to 2019/20 we wish to further progress our work in relation to:-

- Respect patients' rights to make decisions themselves or decisions made on their behalf by families and friends – to place more emphasis on training and education for staff on the Mental Capacity Act and Best Interest decisions and ensuring these are clearly documented.
- Provide assistance to patients with eating and drinking – further work is being embedded by our nutritional steering group.
- Minimise the number of times patients are moved during their hospital stay.

MTW
exceptional people, outstanding care

We will also continue our work as part of the West Kent Alliance and Aligned Incentive Scheme in collaboration with our partner organisations and through our Best Quality Work Stream.

Professional Standards Team - Skills for Health Quality Mark

MTW has, once again, been awarded the Skills for Health Quality Mark. The Skills for Health Quality Mark endorsement means that MTW is meeting the nationally recognised benchmark which epitomises the health sector's ethics and values, whilst demonstrating a commitment to develop a safe and competent workforce.

The programmes assessed by Skills for Health were the Clinical Support Worker (CSW) Induction Programme and the Care Certificate which are facilitated by the Professional Standards Team.

The training delivery for these programmes has been verified as being in alignment with OFSTED requirements. Positive feedback was received from the Skills for Health Assessor, Kathryn Attwood, for the training delivery of both programmes. Feedback demonstrated that CSWs felt supported by trainers, employers and assessors on their learning journey. Feedback from the surveys sent to the CSWs and their managers, confirmed that CSWs are prepared well during the CSW induction programme, which helps confidence, self-esteem, aspirations and improved patient care. One comment was, 'outstanding support, always on hand to help and guide'.

Part Four
Appendices A, B and C

Appendix A

38 National reports were published where the topic under review was relevant to the Trust in 2018/19 with action to be taken in 2018/19

National Report Published April 2018 to March 2019	*Report received*	Date report due
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**Full report received July 2018** Quarterly reports generated and reviewed by the resuscitation team to evaluate performance. The trust figures perform well with national comparisons and show higher than national survival rates.
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	**Y**	**Full report due March/April 2019** Quarterly reports are 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 November 2018** We have continued to implement our Emergency Laparotomy Pathway to improve patient care. This consists of a bundle of evidence based interventions to improve the care and outcomes provided to these patients. Over the course of this year we have formalised our pathway and the Code Laparotomy CT request protocol. Those patients at higher levels of risk now trigger a multi-disciplinary discussion between Surgical, Anaesthetic and Intensive Care Consultants to ensure optimal levels of care. Our outcomes remain amongst the best in the country, with the most recent NELA Annual Report demonstrating a risk-adjusted mortality of 5.6% compared to a national average of 9.5%.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	Quarterly dashboards and 3 injury specific reports are published annually and reviewed by the A&E Consultant Lead. Patients are reviewed and discussed at Trauma Board meetings to ensure best quality of care. Any patients with a high injury severity score have their cases reviewed on an individual basis
National Joint Registry (NJR)	**Y**	**Report received September 2018** Review of 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. 660 procedures were recorded on the 2018 annual report (2017 data) with a consent rate of 97%, which is above the national average. This is an ongoing national audit which our trusts continually participates in year after year
RCEM Pain in Children 2017	**Y**	**Report published May 2018** There were two fundamental standards which both had excellent results for the trust. These were for the pain score to be assessed within 15 minutes of arrival and patients in severe pain (pain score 7 to 10) receiving appropriate analgesia within 60 minutes of arrival or triage. A paediatric-trained nurse is to be appointed at Maidstone Emergency Department to address the nursing skill mix between the two sites.
RCEM Procedural Sedation 2017	**Y**	**Report published May 2018** Patients undergoing procedural sedation should have documented evidence

National Report Published April 2018 to March 2019	*Report received*	Date report due
		of ASA grading, prediction of difficult airway management and pre-procedural fasting status, the low compliance is deemed to be a reflection of lack of documentation rather than poor working practices. Procedural sedation should take place in a room with resuscitation facilities was fully met. Procedural sedation requires the presence of a sedationist, second doctor, Emergency or Advanced Nurse Practitioner and a nurse. Monitoring during sedation must be documented to have included non-invasive blood pressure, pulse oximetry, capnography and ECG. Both sites fall short likely due to the lack of use of capnography. Following sedation, patients should only be discharged after formal assessment of return to baseline level of consciousness, vital signs with normal limits for patient, absence of respiratory compromise, absence of significant pain and discomfort and written advice. Results showed poor documentation with this statement. A procedural sedation proforma to be implemented on both sites to ensure documentation of all required elements for this procedure.
RCEM Fractured Neck of Femur 2017	**Y**	**Report published May 2018** There were two fundamental standards which both had excellent results. These were for the pain score to be assessed within 15 minutes of arrival and patients in severe pain (pain score 7 to 10) receiving appropriate analgesia within 60 minutes of arrival or triage. A programme initiation on practice of fascia iliaca blocks will improve early effective analgesia.
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
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**Y**	**National report published in June 2018** Local hospital guidelines continue to be discrepant and lag behind national guidelines contributing to inappropriate transfusion practice. Compliance is similar across all levels of care. Routine regular audit of use is unlikely to be achieved without an IT solution. Single unit red cell transfusions continue to be less common than 2 unit transfusions and multiple units continue to be given to low weight patients. This practice is unsafe because it puts patients at risk of Transfusion Associated Circulatory Overload (TACO).
(National Comparative Audit of Blood Transfusion Programme) Comparative audit of transfusion associated circulatory overload 2017	**Y**	**National report published in June 2018** Patients are not always weighed on admission to hospital and if they are, it is not usually done in the context of blood transfusion. Patient Blood Management (PBM) covers a multitude of recommendations across all aspects of Blood Transfusion and is gradually being introduced in the Trust. Blood Transfusion is already a part of Clinical Induction and Mandatory Training and covers some aspects of PBM. Appropriate Transfusion Project was launched in March 2017 to promote empowerment of nurses and BMS's. A review after every unit is encouraged but not enforced. Observations are performed during every transfusion and escalated to

National Report Published April 2018 to March 2019	*Report received*	Date report due
		senior staff when appropriate. Any patient who experiences worsening symptoms during a transfusion is assessed clinically. All cases reported to the Transfusion Team are reported to Serious Hazards of Transfer (SHOT)
(National Comparative Audit of Blood Transfusion Programme) Audit of the patient blood management in scheduled surgery re-audit	**Y**	**Report received 23 October 2018** The HTC (Hospital Transfusion Committee) and Pre-Assessment Teams are currently working together to establish testing and treatment pathways for patients who are found to be anaemic at the Pre-Assessment Clinics. Pre-Assessment bloods are reviewed by the Pre-Assessment Team. ICAG (Informed Consent Action Group) Consent Pad introduced in the Trust in October 2017 to help in the consent process for blood transfusion. Appropriate Transfusion Project launched in March 2017 with the aim to empower lab staff to query requests that fall outside of the NICE guidelines and to educate the clinical staff in the recommendations contained within the NICE guidelines. PBM (Patient Blood Management) workshops run for the doctors and nurses in October and November 2016 including local audit results.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**Y**	**Report received September 2018** 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. Overall, transfusion components themselves are very safe. All Blood Transfusion Lab staff follow an extensive competency assessment program. All clinical staff undergo mandatory training updates every 2 years. Electronic blood tracking system is in place for blood collection and completion of the validation process for the new Kiosks and handheld equipment from Microsoft is underway.
Cancers		
National audit of Breast Cancer in Older People (NABCOP)	**Y**	**Report published September 2018** 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. Due to lack of time and staff, results in the 2018 annual report show data is not being uploaded onto the national registration services from which the NABCOP draw their data.
National Audit of Lung Cancer (NLCA)	**Y**	**Report received June 2018** The National Lung Cancer Audit revealed the trust showed good local practice in comparison with national standards. Our surgical resection rate at 22.3% is above the national audit standard set of 17%. Since 2016 significant progress has been made to improve the lung cancer pathway. We are very keen to implement a lung nodule Multi-Disciplinary Meeting, but as yet there are no plans to separate the diagnostic part of the MDM from the confirmed cancers.
National Audit of Bowel Cancer (NBOCAP)	**Y**	**Report received 14 December 2018** The report showed that MTW is fully compliant in all of the recommendations made and our mortality rates are lower than the national and regional average.

National Report Published April 2018 to March 2019	*Report received*	Date report due
		MTW has good 90 day mortality rates compared with the regional and national figures and our two year mortality rate is consistent with the national average. All patients seen at MTW are considered for chemotherapy based on local and national guidelines irrespective of postcode. MTW's 18 month stoma rates are better than the national average (48% v 52%) and stomas are closed at the earliest opportunity following completion of cancer treatment.
Head & Neck Cancer (DAHNO)	**N/A**	The national report has been delayed while the contact is being re-negotiated.
National Prostate Cancer Audit 2017	**Y**	**Report received 14 February 2019** This is currently with the team for assessment.
Oesophago-gastric cancer (NAOCG)	**Y**	**Report received on 14 September 2018** 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. The annual report shows that the Trust submitted 175 tumours records which equates to 90% case ascertainment rate. 23 patients of the 175 were diagnosed after emergency admissions (14.6%). Patients with an unknown referral source totalled 14 (8%). CT scans were performed on 98% of patients. The number of patients receiving palliative treatment at MTW was 96 (54.86%). The number of patients receiving a CT scan was 199 giving us a case ascertainment of 98%.
BAETS - Endocrine and Thyroid National Audit	**N/A**	There are continuing delays with publishing the national reports. The sixth and seventh reports are awaited. No publication dates given by provider.
National Ophthalmology Database Audit Project	**N/A**	The Trust was unable to submit data to this national audit due to software issues. We are still waiting for the OpenEyes package to be purchased. This is underway.
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 2018** Report is with the urology team to assess the trusts compliance and develop an action plan if needed.
BAUS Urology Audits: Cystectomy	**N/A**	The Trust does not provide this service
BAUS Urology Audits: Nephrectomy Audit	**Y**	**Report received 14 December 2018** Report is with the urology team to assess the trusts compliance and develop an action plan if needed.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**Y**	**Report received 14 December 2018** Report is with the urology team to assess the 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**	The trust does not provide this service - Primary Care Only
Renal Replacement Therapy (Renal Registry)	**N/A**	The Trust does not provide this service
Heart		
Cardiac Rhythm Management (CRM) 2016-17	**N/A**	**Report publication delayed until 2019-20 by national body**
Coronary Angioplasty / PCI 2016-17	**Y**	**Report published November 2018.** This report is with the Cardiology team for review and action plan development.
MINAP 2016-17	**Y**	**Report published November 2018.** This report is with

National Report Published April 2018 to March 2019	*Report received*	Date report due
		the Cardiology team for review and action plan development.
Heart Failure 2016-17	**Y**	**Report published November 2018.** This report is with the Cardiology team for review and action plan development.
Cardiac Rehabilitation 2016-17	**Y**	**Report published November 2018.** The Trust is fully compliant with national recommendations. All applicable patients are offered cardiac rehabilitation. Nationally there is a low uptake for female patients. At MTW the majority of females are elderly with co-morbidities and therefore less likely physically able to participate. To address this, two new programmes are being promoted (home and walking). There are also ongoing discussions with the local Clinical Commissioning Group for funding to expand the service to include heart failure patients.
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
Long-term Conditions		
National Diabetes Audit (NDA) Core audit 2017-18	**N/A**	**National report publication delayed until May 2019**
National Adult Diabetes Inpatient Audit (NaDIA) 2018 (Hospital Characteristics only)	**N/A**	**National report publication delayed until May 2019**
National Adult Diabetes Inpatient Audit – Harms (NaDIA-Harms) 2018	**N/A**	**National report publication delayed until May 2019**
National Diabetes Foot Care Audit (NDFA) 2014-18	**N/A**	**National report publication delayed until July 2019**
National Diabetes Transition Audit 2011-2017	**Y**	**Report published January 2018** This report is with the Diabetes team for review and action plan development.
Inflammatory Bowel Disease (IBD) Programme – IBD registry, Biological Therapies Audit 2016-17	**Y**	A National comparative quarterly report has been received by the specialty and is being reviewed for action plan development. The Trust has not subscribed to the additional funding for the national reporting element of the service. IBD Registry confirmed that no data for MTW will be published in the national report for 2016-17.
Neurosurgical National Audit Programme	**N/A**	Trust does not provide this service
Falls and Fragility Fractures Audit Programme (FFFAP)	**N/A**	**1. Inpatient Falls (NAIF).** No national report published in 2018-19
	N/A	**2. Fracture Liaison Service** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture database (NHFD)** **Report published September 2018** The NHFD is a standing item at the Orthopaedic department Clinical Governance and directorate meetings. MTW were compliant with all recommendations, but scored below the national average for eligible patients being treated with Total Hip Replacement. MTW score of 22.8% compared to a national average of 31.4%. All patients are discussed at the daily trauma meeting and total hip replacement

National Report Published April 2018 to March 2019	*Report received*	Date report due
		considered where appropriate. Regular Neck of Femur fracture meetings are held to discuss any issues. This is an ongoing National audit which our trusts continually participates in year after year
National audit of Dementia Spotlight audit 2017 (Delirium screen and assessment**)**	**Y**	**National Report Published August 2018** This report is with the specialty for review and action plan development.
National Patient Reported Outcome Measures (PROMs) Programme Elective surgery Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein* * not performed at MTW)	**Y**	**Report published December 2018** Before a patient undergoes primary hip replacement or a primary knee replacement at Maidstone & Tunbridge Wells NHS Trust they are offered a questionnaire for completion at pre-operative assessment. (Data for groin hernia no longer collected) 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. The report is with the Divisional Director of Nursing and Quality to assess trust compliance and develop an action plan if needed. Validity and completeness is consistently above the national average for both Hip and Knee Replacement. The Trust will continue with promotion of PROMS questionnaires to patients in pre-op setting to increase the number of questionnaires returned.
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 Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance 2016 (reports annually)	**Y**	**Report received 15 June 2018** The Trust is fully compliant with MBRRACE recommendations. There were 5,890 births in 2016 within our Trust. Stillbirths = 19, 3.23 per 1000 births (MTW up to 10% lower than average for group), Neonatal Death = 5, 0.85 per 1000 births (MTW are up to 10% lower than average for group) Extended Perinatal death = 24, 4.07 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 2014-16 including Confidential Enquiries into women who died from mental health conditions, thrombosis and thromboembolism, malignancy and homicide(reports annually)	**Y**	**Report received and distributed 1 November 2018** The Trust is partially compliant. The Trust has plans to develop a standard operating procedure or guideline to address the needs of pregnant and postpartum women presenting to the emergency department. Additionally there are plans to set up a local audit to assess if thromboembolism risk assessments were performed and whether the calculated risk score was correct.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives, Improving Mother's Care ; Women with major	**Y**	**Report received and distributed 1 November 2018** The Trust is partially compliant and is working hard to improve the care it offers mothers with particular focus on

National Report Published April 2018 to March 2019	*Report received*	Date report due
obstetric haemorrhage (2014-2016)		reducing the incidence of post-partum haemorrhage (PPH). A working group has been set up to fully review the pathway and the PPH proforma. Additionally the Trust is putting in place a formal documentation process for the debriefing of severe PPH patients.
National Maternity and Perinatal Audit (NMPA)	**Y**	Sprint reports for Maternity Admissions to Intensive Care and Neonatal Research **received and distributed 11 January 2019**. Full NMPA report not published to date. The sprint reports are being reviewed by the Maternity Team.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	**N/A**	IBD Registry confirmed that no national report will be published for the 2017-18 data for MTW as the Trust has not subscribed to the additional funding for this element of the service.
National Paediatric Diabetes Audit (NPDA**)**	**Y**	**Report received and distributed 13 July 2018** The Trust is partially compliant with results for overall health checks and patients receiving all 7 health checks, this is just above the national average. Ongoing interface problems with the data submission software (Twinkle) and the Trust's electronic patient records system continue to effect data quality. Plans are in place to improve documentation and to increase screening for psychological co-morbidities include ensuring all clinic staff have access to Twinkle and booking psychologist assessments as part of the patient's annual review in MDT consultant led clinics.
Neonatal Intensive and Special Care (NNAP)	**Y**	**Report received and distributed 1 October 2018** The Trust is partially compliant. Continued issues with data entry into the data submission software (Badger). Badger Champions are now checking and validating the Neonatal Unit (NNU) data entry. Improvements to E3 (maternity electronic patient records) will allow improved interface with Badger including some new mandatory fields to ensure complete data capture. The Neonatal Unit was awarded Unicef Baby Friendly Initiative Level 1 in September 2018 and is working towards Level 2 for assessment in September 2020.
Paediatric Intensive Care (PICANet)	**N/A**	The Trust does not provide this service
Confidential Enquiries		
Failure to Function - Acute Heart Failure	**Y**	**Report received 22 November 2018** Report disseminated and with specialties for assessment
On the right course - Cancer in Children, Teens and Young Adults	**Y**	**Report received 13 December 2018** The trust is compliant with all recommendations within this national report. Protocols and Pathways are in place so that any patients requiring critical care are referred to the Royal Marsden. Any patients requiring Paediatric Intensive Care Unit (PICU) are sent to St Georges University Hospital. All patient information is fully documented in the patient's case notes and discussed with patient and/or relatives / referring clinician and admitting critical care consultant. Nursing assessments are undertaken before each cycle of chemotherapy, these are done formally by nurses and intermittently by the doctors. Patients can receive chemotherapy treatment on the Tunbridge Wells Day Care Unit staffed by a multidisciplinary team. A fully trained Paediatric Oncology Trained Nurse administers the treatment on the unit. The trust holds regular Morbidity & Mortality meetings looking at mortality relating

National Report Published April 2018 to March 2019	*Report received*	Date report due
		to systemic anti-cancer therapies (SACT). Results of these discussions are recorded and are available. The trust does not have transition from paediatric, teenage and young adult to adult teams. Paediatrics are managed by the Paediatric Services (Royal Marsden, Great Ormond Street (for <1 years of age) Teenagers and Young Adults (TYA) are managed by the TYA Centre (University College Hospital London Teenage Unit)
Highs and Lows - Perioperative Diabetes	**Y**	**Report received 13 December 2018** Report disseminated and with specialties for assessment
Others		
NHS England 7 Day Hospital Study Spring 2018	**Y**	**Report received October 2018** The trust was partially compliant with the standards audited. 67% of patients were seen and assessed by a consultant within 14 hours of admission.100% of patients who required a twice daily (High Dependency needs) consultant review received them. 91% of patients who required a once daily review received one. This was in line with SE Region and National results for weekdays and above SE region and national results for weekend reviews. The trust continues to work towards the NHS England 7 day hospital working agenda. A trust programme plan has been produced and work is on target to meet the key performance criteria.

Appendix B

Updated actions on reports received during March 2017 to April 2018. 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 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. Audit results shared at Clinical Governance sessions and in the Trust's Governance Gazette. Staff will be reminded of the need to complete the cardiac arrests forms.
Adult Critical Care Case Mix Programme 2016 (ICNARC) (CMP)	**Y**	**Full report received June 2018** Quarterly reports generated and regularly reviewed by team. No areas of concern were identified and therefore no major changes required.
Emergency Laparotomy Audit (NELA)	**Y**	**Report received - 13 October 2017** This audit has now moved to a Best Practice Tariff and we continue 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 is in place, with dedicated time in job plans to support decision making.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	Quarterly dashboards and 3 injury specific reports are published annually and reviewed by the A&E Consultant Lead. 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. Maidstone 90%, Tunbridge Wells 100%, national average 48%.
RCEM Severe Sepsis and	**Y**	**Report published May 2017**

National Report Published April 2017 to March 2018	*Report received*	Date report due
Septic Shock 2016		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 has been 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 downloaded and is with the specialty for review and action plan development. **Update:** Patients are being risk assessed prior to surgery so that those patients at high or moderate risk are proactively admitted to critical care facilities. Patients who are initially managed conservatively receive close assessment to ensure that the obstruction is resolving, if not then patients may need to proceed to surgery. A local policy is being developed to ensure that all patients have a nutritional assessment within 24 hours of admission. Discussions are also being had with the radiology team to optimize the timing of CT scans.
RCEM Adult Asthma 2016	**Y**	**Report published May 2017** 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 has been 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 has taken place to ensure all patients admitted to the Acute Medical Unit (AMU) have an Early Warning Score (EWS) measured upon arrival and reviewed by a competent decision maker within 4 hours of admission.
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 continue to complete drug prescription chart for all patients requiring emergency oxygen. The Nerve Centre database has been updated to allow oxygen saturation target parameters to be entered for each patient. Some SpO_2 ear probes were purchased for the Respiratory Wards but over time have been borrowed by other areas so they continue with the finger monitors.
National Comparative Audit of Blood Transfusion Programme		
(National Comparative Audit of Blood Transfusion Programme) Red cell and platelet transfusion in adult haematology	**Y**	**Report publication delayed and not available at time of 2017/18 report.** **Update: Report published January 2018** The team are implementing a number of actions to improve our compliance. The Clinical Guideline for the Use of Blood Components and Alternative Treatments will have a section

National Report Published April 2017 to March 2018	*Report received*	Date report due
		added on how to manage transfusions in patients at high risk of Transfusion-related circulatory overload (TACO). The team are raising awareness of the Informed Consent Action Group (ICAG) Pad and auditing its use. They are also moving to the use of electronic issue for cross-matching bloods. They are encouraging the lab staff to only issue one unit of red cells for routine top-up transfusions and to only release subsequent units on repeat Hb.
(National Comparative Audit of Blood Transfusion Programme) Comparative audit of transfusion associated circulatory overload 2017	**Y**	**Report publication delayed and not available at time of 2017/18 report.** **Update: Report published in June 2018**. The team are implementing several actions to ensure our compliance. A Transfusion-related circulatory overload (TACO) checklist will be developed and approved, implementing electronic issue and updating the Trust's Transfusion Policy.
(National Comparative Audit of Blood Transfusion Programme) Audit of the patient blood management in scheduled surgery re-audit	**Y**	**Report received 23 October 2017** The Hospital Transfusion Team and Hospital Transfusion Committee teams are implementing a number of actions to improve our compliance. To establish testing pathways for patients found to be anaemic at Pre-Assessment Clinics. The team will establish Trust Guidelines for the investigation and treatment of anaemia. They will continue to perform local audits on blood use and its appropriateness and feedback the findings through regular workshops. There is also a move towards using Electronic Issue in the Blood Bank which will facilitate issuing one unit at a time in non-bleeding patients and insisting on a repeat Hb after every unit.
(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. A new geriatrician has been appointed and it has been built into the job role that they would review elderly surgical patients on wards, via the care of the elderly referral.
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**Y**	**Report received September 2017** The team are promoting the key messages of using the handover log, communicating effectively, and raising issues promptly to reduce the risk of errors. 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	**Y**	**Report received 24 January 2018**

National Report Published April 2017 to March 2018	*Report received*	Date report due
(NLCA)		This report is currently with the clinical team for assessment of compliance and action planning. **Update:** Actions have been put in place for entries to be checked during data entry validation. Detailed case note review will be performed for patients who did not receive curative treatment. Multi-Disciplinary Meeting (MDM) leads will continue to review the weekly list of patients. The MDM aim is to adopt a national optimum lung cancer pathway and endeavour to discuss patients only once if possible. The MDM lead will discuss funding with management for a pulmonary nodule MDM.
National Audit of Bowel Cancer (NBOCAP)	**Y**	**Report received 14 December 2017** The team is regularly reviewing the morbidity and mortality cases to include emergency bowel cancer presentations. There have been improvements in liaison between the hospital and community teams regarding patients who might need additional support post operatively.
Head & Neck Cancer (DAHNO)	**N/A**	Delays with publishing national report. Put on hold while contract is renegotiated.
National Prostate Cancer Audit 2017	**Y**	**Report received 22 November 2017** The prostate cancer team continue to work with the urology team, through Multi-disciplinary Meetings, to identify those patients who will potentially benefit from treatment for locally advanced disease.
Oesophago-gastric cancer (NAOCG)	**Y**	**Report received on 14 December 2017** We remain fully compliant with most recommendations, but the team are continuing to review the protocols in place for HGD (high grade dysplasia) patients being presented at Multi-Disciplinary Teams.
Endocrine and Thyroid National Audit	**N/A**	Continuing delays with national reports being published. No proposed publication dates provided.
National Ophthalmology Database Audit Project	**N/A**	The Trust was unable to submit data to this national audit due to software issues. Awaiting purchase of the Open Eyes module.
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. **Update:** MTW performance is in line with national standards and full assurance was achieved. No actions were required and the urology team continue to submit annual returns to this national audit.
BAUS Urology Audits: Urethrolasty audit	**N/A**	The Trust does not provide this service
Chronic Kidney Disease in	**N/A**	The Trust does not provide this service - Primary Care Only

National Report Published April 2017 to March 2018	*Report received*	Date report due
Primary Care		
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** The Trust performs significantly above national average and equitably between both sites. Logistical issues still persist with outliers and lack of beds on cardiology wards. All patients received an ECHO and were discharged on the appropriate medication. Not all heart failure patients have been able to participate in cardiac rehabilitation due to lack of funding from the CCG to increase this service.
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 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
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** The Trust is largely compliant with national targets. Our results only include inpatients with more severe ulceration rather than out-patients attending clinic. Nearly 50% of patients are seen by the foot MDT team within 2 days of presentation compared to 14% nationally. 53% of patients are still having persistent ulceration at 12 weeks compared to 44% nationally and 24% at 24 weeks (equalling national results). On reviewing the results it demonstrates that our diabetic patients have more severe infection, greater depth and size.
National Core Diabetes Audit (NDA) 2015-16	**Y**	**Report published July 2017** The Trust is compliant with the national recommendations.

National Report Published April 2017 to March 2018	*Report received*	Date report due
		All Type 1 patients are offered structured education (DAFNE) and all Type 2 patients are offered community run education (DERIK). MTW is the biggest single Diabetes Pump Service in the whole of Kent. Patients with Type 1 diabetes who meet NICE criteria for insulin pump therapy are assessed using the 'pre-pump assessment pathway'.
National Core Diabetes Audit (NDA) 2016-17	**Y**	**Report published 14 March 2018** The Trust is compliant with the national recommendations. All Type 1 patients are offered structured education (DAFNE) and all Type 2 patients are offered community run education (DERIK). Young adult patient clinics are available as well as a Facebook patient page administered by MTW.
National Diabetes Transition audit (NDTA) 2003-14	**Y**	**Report published July 2017** This is the first published report for the National Diabetes Transition audit (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 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 indicates that key indicator assessment for delirium, measurement of lying and standing blood pressure and medication that increases risk of falls are areas that require work to improve. Actions include education of medical staff to ensure that they carry out delirium screening while the patient is still in the Emergency Department. To relaunch the RCP clinical practice tool which will standardise practice and prompt staff to carry out all necessary assessments and medication reviews.
	N/A	**2. Fracture Liaison Service.** MTW does not provide this service. This is a community service.
	Y	**3. National Hip Fracture Database (NHFD)** **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** **Update:** This was in essence a public report that detailed QIP projects that had been carried out by participating trusts. No results or recommendations were included.
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. **Update:** MTW were partially compliant with national

National Report Published April 2017 to March 2018	*Report received*	Date report due
		recommendations. All patients had a review at 6-12 month intervals and had communications individually tailored for their needs. For those patients that have sudden onset of sleep, it is not always documented that they have been advised not to drive and to consider occupational hazards.
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 have been 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 being 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. **Update:** Received August 2018 and reviewed in Appendix A
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 and Children		
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance	**Y**	**Report received 22 June 2017** There were 5,700 births in 2015 within our Trust. Stillbirths = 22, neonatal death = 2, extended perinatal death = 24, 4.21 per 1000 births (MTW are up to 10% lower

National Report Published April 2017 to March 2018	*Report received*	Date report due
2015 (reports annually)		than average for group). Training schedule set up to ensure staff are able to give relevant information regarding post-mortems and placental histology to bereaved parents sensitively.
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** The Trust is almost fully compliant. To improve prevention and treatment of sepsis, staff attend mandatory PrOMPT emergency training days annually and team has completed a local audit and continues to raise awareness of importance of investigation and prompt treatment of sepsis amongst team for all patients to include the critically ill pregnant women.
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality and morbidity confidential enquiry (reports every second year)	**Y**	**Report received 28 November 2017** The Trust is partially compliant; a review of midwifery staffing was completed using Birthrate Plus and multidisciplinary training in situational awareness and human factors to be undertaken by all staff who care for women in labour being implemented. Bereavement checklists are already in use and an email was sent out to all consultants and secretaries to ensure seamless care for parents following intrapartum related deaths.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives; Women with severe epilepsy (October 2015 to March 2017)	**Y**	**Report received 7 December 2017** This report was been reviewed by the Maternity Team, the Trust is partially compliant, with ongoing work to share good practice across Kent and Medway continuing, a new mother and baby unit has been set up in Dartford that allows new mothers with mental health issues to stay with their babies whilst they receive treatment. Due to financial constraints, the Trust is unable to provide flu vaccination clinics for pregnant women but all pregnant women are advised to be vaccinated at their GP Surgery.
National Diabetes Audit – Adults Pregnancy in Diabetes	**Y**	**Report received 12 October 2017** The Trust is partially compliant, ongoing work on raising awareness with primary care teams of the benefits of all pregnant diabetic patients attending the combined multidisciplinary team clinic before ten weeks. A clear pregnancy pathway is being developed for GPs and Practice Nurses to ensure pregnant women with diabetes are referred early to the multidisciplinary Diabetes Service.
National Maternity and Perinatal Audit (NMPA)	**Y**	**Report received and distributed 10 November 2017** The Trust has worked hard to reduce the number of 3rd/4th degree tears by sharing and implementing good practice. All grades of tears are recorded on E3 (maternity electronic patient record system) and the statistics generated are closely monitored. A detailed review of postpartum haemorrhage >1500 ml has been completed and our PPH guideline has been updated and published.
Paediatric Inflammatory Bowel Disease; Biologics (IBD Programme)	**N**	MTW NHS Trust has not received the annual report as we do not subscribe to this service.
National Paediatric Diabetes Audit (NPDA**)**	**Y**	**Report received and distributed 10 October 2017** The Trust continues to have problems with data entry and is currently benchmarking their service against similar local services and this includes a review of other Trust's systems and how they manage the interface issues with Twinkle (electronic paediatric diabetes patient records system).
Neonatal Intensive and Special Care (NNAP)	**Y**	**Report received 31 October 2017** The Trust was partially compliant with some data entry

National Report Published April 2017 to March 2018	*Report received*	Date report due
		issues and some problems with the interface between Badger (neonatal unit electronic patient record system) and E3 (maternity electronic patient record system). Significant work has since been completed to improve these issues including making some fields on both systems mandatory. The Trust has been awarded Unicef Baby Friendly Initiative level 1 compliance.
Paediatric Intensive Care (PICANet)	**N/A**	The Trust does not provide this service
National BTS Paediatric Pneumonia Audit 2016	**Y**	**Reports received July 2017 and January 2018** Results showed that there had 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 all suspected community acquired pneumonia cases now start treatment without the need for x-rays. Oral antibiotics are used more often as the first line of treatment; those requiring IV antibiotics still continue to have blood cultures sent for testing as good practice.
Confidential Enquiries		
NCEPOD: Inspiring Change (Non-Invasive Ventilation)	**Y**	**Report received 13 July 2017** Trust was found to be largely compliant with clinical care and levels of staff training provided. The Trust needs to appoint a Consultant NIV Lead; the recruitment process for this is currently underway. All issues relating to NIV are reported and reviewed via the NIV Steering Group. NIV is delivered within 1 hour when blood gas measurements identify the need. A proforma for an NIV prescription chart is awaiting ratification and when in place will record all changes to ventilator settings. Vital signs are monitored via the use of the National Early Warning Score as recommended.
NCEPOD: Each and Every Need (Chronic Neurodisability)	**Y**	**Report received 8th March 2018** Report disseminated and with specialties for assessment.

Appendix C

Summary of local audits undertaken during 2018/19 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 CG110; Re-audit of the management of pregnancy & complex social factors	Fully compliant	All required standards for this audit were met with 100% compliance for the notes reviewed. Since this audit was last carried out in 2015, the Trust now has a Deputy Named Midwife for Safeguarding Children in post who reviews all concern and vulnerability forms completed and advise the midwives accordingly. There is also now the Maternity Safeguarding Hub which is held every month to discuss complex cases.
NICE NG81; Glaucoma Re-Audit	Fully compliant	Actions implemented from the previous audit were to ensure that patients receive an information leaflet at their first visit and/or verbal communication about their condition and treatment. All standards were met this round of the audit and no clinical concerns or risks identified.
NICE CG152; The rate of surgical recurrence in Crohn's disease	Fully compliant	This audit aimed to review the outcome from our Crohn's resections and specifically the 5 years surgical recurrence rate. The results confirm that our practice conforms to published data and patients received optimal medical therapy. Therefore no changes are required to our current practice.
NICE TA460; Use of Steroid Intravitreal implant (Ozurdex) for Uveitis	Fully compliant	The aim of this audit was to examine the outcomes following administration of Ozurdex implant to treat non-infectious uveitis. Whilst the clinical standards were fully met, the audit did identify that some patients were not attending or missing their follow up appointments. A protocol is being developed to set the postoperative expected time points for scheduling these follow-ups.
NG78 Cystic Fibrosis - Paediatric (QS168)	Fully compliant	This audit identifies good performance in the delivery of quality care (diagnosing and managing cystic fibrosis in infants, children, young people and adults) to our paediatric cystic fibrosis patients. We meet all standards relevant to our service listed in NICE QS168 Cystic Fibrosis.
NICE TA204 Osteoporosis Biologics (Denosumab) Criteria 2 only re-audit round 2	Fully compliant	This audit demonstrated that current practice in using denosumab for the secondary prevention of osteoporotic fractures in postmenopausal women was fully compliant with the NICE guidelines. No changes in practice were required.
TA495: Palbociclib use in ER1 and HER2 - locally advanced/ metastatic breast cancer audit.	Fully compliant	In summary, Kent Oncology Centre has followed the NICE Guideline TA495 correctly in the majority of cases since Palbociclib has been funded by NICE. There were some errors initially when Palbociclib w new, but these have become much less recently. Looking at the patients that were outside of the guidance, they were all within the firs months of the guidance being issued, meaning that Palbociclib is beir

		used appropriately as we have got used to prescribing it.
NICE TA305; All Anti VEGs for treating visual impairment caused by Macular oedema secondary to Central Retinal Vein Occlusion (CRVO)	Partially compliant	This audit has highlighted delays in initiating treatment which has the potential to cause a degree of irrecoverable visual loss which is a serious concern. Additionally, patients are not always being given the three doses of injections (94%) as per NICE Guidelines because they seem to show significant recovery without receiving the full three doses. Anti-Veg injections given as monthly doses was 94% and partially compliant with the guidelines. A business case is being produced to implement designated CRVO clinics and increase the number of injection clinics to reduce the length of waiting times for patients.
NICE CG174; Re- audit of the prescription of IV fluids - a trustwide audit	Partially compliant	Following an intervention of teaching sessions to healthcare professionals and publication of intravenous fluid guidelines, fluid prescription has improved. Further interventions are needed and will include additional teaching sessions, fluid therapy handouts / stickers, and online prescribing to automatically calculate how much electrolytes are being administered. Patients will receive the fluids required and aid a reduced length of stay.
NICE CG 124 A Clinical Audit to improve time to theatre for patients with Neck of Femur Fracture (#NOF)	Partially compliant	From the first round of the audit we identified the cause for delays to theatre in #NOF patients, generated a business case and through appointing a trauma fellow with a dedicated trauma list, rapidly improved time to theatre for these vulnerable patients. We will continue prioritising NOF's in list planning during trauma meetings to ensure that this group of patients receive early surgery as evidence indicates that this will lead to improvements in functional outcomes, reduce post-op complications and reduce length of stay.
NICE CG129 & QS46; Re-audit of Antenatal Care of Twin Pregnancies (Round 2)	Partially compliant	At present the Trust requires a more robust reporting system in order to provide evidence of compliance and a better method of relaying important information specific to multiple pregnancies to our patients. We intend to introduce specific standard documentation on E3 (Maternity Electronic record system), review our patient pathways and write a patient information leaflet to achieve a higher level of compliance
NICE CG190; Re-audit of Massive Obstetric Haemorrhage (PPH) - Incidence and Management	Partially compliant	Significant improvements have been made to the documented standard of care for major severe PPH. The introduction of a simplified escalation policy appears to have had a significant effect. We now also continuously monitor the monthly severe PPH rate (>1500 ml) via the Maternity dashboard. Recently, the Trust has introduced a new Maternity risk dashboard, which has adopted the National Maternity and Perinatal Audit standard for severe PPH of blood loss greater than 1500 ml. It has been agreed going forward that this will be the auditable standard used at the Trust. A formal documentation process for debriefing of severe PPH patients is required. Our recommendation is that this should be documented on the Euroking maternity system and re-audited once established.
NICE IPG104 - Re-audit of Impedance-controlled endometrial ablation for menorrhagia Novasure)	Partially compliant	The audit showed that Novasure endometrial ablation, with correct selection of patients, is an appropriate treatment for women with menorrhagia in MTW. There is a high patient satisfaction rate (100%). We are considering the possibility of Novasure being moved to the outpatient setting.
NICE CG94 & CG130 Management of patients with ACS (acute coronary syndrome).including Hyperglycaemia and GRACE Scoring re-audit	Partially compliant	Overall care was good in the majority of areas assessed. The audit found that all patients were appropriately treated with dual antiplatelet therapy and Fondaparinux on admission and all were appropriately treated with 12 months of DAPT therapy. The audit did find some areas of minimal documentation and risk stratification of patients being admitted with ACS (acute coronary syndrome). New processes are being put in place to improve documentation of GRACE scores for suspected ACS patients.
Audit to review NICE CG124 guidelines for day 0 mobility post elective TKR and THR surgery	Partially compliant	This audit looked at whether patients were mobilised on day 0 following elective total hip or total knee replacements. Multiple reasons were documented for not meeting this target (62%) including patients returning late to the ward from theatre, patients declined to stand and levels of pain. Results showed that when patients did stand on day 0 the average length of stay was between 2-3 days rather than an average of 5+ for the small group of patients that did not stand on day 0. The physiotherapy team

		plan to increase education on wards to encourage day 0 mobility for elective joint replacements.
NICE CG144 Appropriateness of adult CT pulmonary angiogram requests at Maidstone and Tunbridge Wells Hospitals.	Partially compliant	There is no direct patient risk identified by those standards not met in the audit; however appropriate use of the diagnostic tools available to the clinician and calculation of the pre-test probability may result in a decrease in the number of CTPA scans being performed. Radiologists have requested that all patients should have a Wells score calculated and documented on the electronic ordering system prior to CTPA discussion with a radiologist.
NICE TA305; All Anti VEGs for treating visual impairment caused by Macular oedema secondary to Central Retinal Vein Occlusion (CRVO)	Partially compliant	Central retinal vein occlusion (CRVO) is a common cause of reduced vision as a result of retinal vascular disease. This audit has highlighted delays in initiating treatment and 6% patients are not always being given the three doses of injections (94% received 3 doses) as per NICE Guidelines because they seem to show significant recovery without receiving the full three doses. The team plans to improve the service provided at our trust by making designated CRVO injection clinics to improve waiting times for patients and increasing the total number of injection clinics.
Audit to assess the outcomes of Gleason 7 prostate cancer treated with low-dose rate brachytherapy (IPG 132)	Partially compliant	This audit against NICE IPG132 found that we partially met one standard and fully met the other standard. The PSA nadir level is slightly lower than the standard as per NICE guidance (82% -v- 86%) IPG 132, however this has had no adverse outcome on overall survival or progression-free survival for the patients treated with low-dose rate brachytherapy. Therefore no clinical concern has been identified. The 5 year overall survival rate was 94.7% against a standard of 93%. No patients died due to their prostate cancer, but 9 patients died of unrelated causes. The team plans to continue to offer patients with prostate cancer, who are suitable to have low-dose rate brachytherapy, this treatment option.
NICE CG103: Re-audit - Delirium screen and prevention: A reflective practice.	Partially compliant	This audit has shown significant improvement. 100% of ICU pharmacists are now reviewing the patient's prescription charts and advise clinicians regarding the use of delirogenic drugs, the level of patients with moderate to severe pain scores has also decreased significantly which shows that pain is being better controlled. Compliance has improved across all standards audited except one - it was disappointing to find that that only 80% of patients are being screened for delirium which can cause delays in the early recognition and prompt intervention in this group of patients. The Intensive Care Delirium Screen checklist is to be disseminated to all members of the ICU staff and training sessions will be held for all new members of the team to ensure that staff know what is required of them regarding the delirium screening to ensure high levels of patient care.
NICE NG29; Intravenous (IV) fluid therapy in children & young people in hospital	Partially compliant	This audit found that five of the six standards were met. Clear evidence was provided (100%) on utilising the correct calculation for fluid replacement with children and young people having their electrolytes checked within 24 hours. The audit did show that there was poor documentation in the medical records of the initial dehydration status / assessment tool used. At the time of the audit the fluid charts used were not adapted to incorporate the new standards and the failings noted were lack of evidence for strict fluid output monitoring as not documented in mls / kg. New documentation of fluid management is being implemented to support this standard which will enable improved compliance with the standards.
NICE CG37; Re-audit of Management of routine postnatal care of women & their babies (Safeguarding Children) (QS37)	Partially compliant	This audit showed improvement in the level of compliance with 6 of the 9 standards now being fully met. Women and main carers of babies are now better being informed of symptoms and signs of potentially life-threatening conditions. Other information on risks of co-sleeping, programmes that encourage breast feeding, bottle feeding and emotional wellbeing showed high levels of compliance. Monthly audits will be undertaken using the E3 maternity database to continue to improve documentation and therefore consistent information being imparted to women.

NICE CG190; Re-audit of the management of Intra-partum care	Partially compliant	The audit reflects that there needs to be a general improvement in the documentation in the handheld notes and the data captured on E3 (maternity Database) to reflect the conversations midwives and obstetricians are having with women regarding birth planning. The audit identified that there needs to be a refocus on normal birth in the delivery suite setting. The relaunch of Take 5 at handovers can be used to inform the team of improvements in normalising care and remind the midwives to improve the accuracy of their documentation.
NICE CG50 (partial) - Audit of adherence to Trust Escalation Policy (Anaesthetics)	Not compliant	This audit has demonstrated that on a trust-wide basis, escalation for deteriorating patients only occurred in 67% of patients whose PAR score reached a level that should mandate a medical review. Only 45% of patients who triggered for escalation had their care escalated to an appropriate level of seniority as determined by the Trust Patient at Risk Score Algorithm. Planned actions are upgrading the current NerveCentre electronic observations system to enable clinical prompts. Improved recognition and escalation of deteriorating patients will improve the standard of patient care that staff provide
NICE NG89; Re-audit: VTE Thromboprophylaxis and AES stockings for Surgical Patients	Not compliant	VTE prophylaxis is important because it significantly reduces an element of risk associated with surgical admissions. The most deficient area of care assessed was completion of the second VTE risk assessment within 24 hours of admission. Compliance could be improved by making it the responsibility of the post taking team to ensure that a second assessment is completed. Actions are planned to Include a talk about VTE prophylaxis during the new F1s induction. Posters have been designed and displayed in the teams meeting rooms to remind juniors of their responsibility regarding VTE prophylaxis. The trust policy is to be updated to show that when a patient's care is taken over by a new team they should have a new VTE risk assessment carried out.
NICE NG38; Fractures (non-complex); Audit of management of distal radial fractures	Not compliant	The audit identified a good performance in documentation of clinical assessment at presentation, appropriate initial radiographic assessment, referral to fracture clinic and correct position of plaster application. Areas identified as requiring improvement: Use of regional anaesthesia rather than haematoma block when manipulation is indicated and inadequate assessment of bone health and falls risk. Additional teaching and training/simulation sessions have been implemented. A pathway has been developed to help doctors determine who is indicated for bone health assessment. This will help raise awareness of the importance of investigating bone health in fracture patients.
NICE CG124; Does access to pre-prepared equipment pack for Fascia Iliaca Nerve Block increase the provision of pre-operative nerve blocks for patients?	Not compliant	This audit found that although the Introduction of pre-prepared packs for Fascia Iliaca Nerve Block (FIB) did not appear to improve provision of nerve blocks for hip fracture patients, pre-operatively it did cut time from admission to block from an average of 1 hour 50mins to 42 mins. Notably, patients were twice as likely to receive a block if admitted during the day. It was decided to continue with pre-prepared FIB packs as they benefit admission-to-block time. Additional training courses have been implemented and the hip fracture proforma has been amended so that it will be quicker to indicate contraindications to nerve block. The overall aim is for patients to receive better pain relief for their #NOF.
NICE CG176; Re-audit of Paediatric Neurological Documentation (Round 3)	Not compliant	Although there was an improvement in performing, recording and documenting the correct neurological observations the standards were still not fully met. The team plans to create a proforma which should start with the patient when admitted and remain with the patient throughout their admission. Neuro observation charts are to be made available in A&E departments on both hospital sites and on Woodlands and Riverbank wards. Head injury/neuro observation procedures to be included in paediatric and A&E induction and teaching updates.

NICE CG137; Re-audit of the Use and Utility of EEG in the Diagnosis of Epilepsy in Children (Round 2)	Not compliant	This re-audit was carried out by the paediatric team following staff education in respect of ordering EEGs for this group of patients. The results showed that EEGs are often used as an exclusion tool rather than to support a diagnosis of epilepsy, this can lead to unnecessary investigations / interventions. The team will include EEGs in the department teaching programme to lead to a reduction in inappropriate referrals and the number of requests for EEG's.
NICE CG160; Re-audit of Paediatric Fluid Balance Charts – 2017	Not compliant	This audit found that fluid charts were not always being started on all paediatric patients who require a fluid chart upon their admission. A new fluid chart is in the process of being designed and trialled before introduction to the unit. Staff will find the new fluid chart more intuitive and therefore easier to complete. Improvement in patient care pathway.
NICE CG109 Syncope audit and re-audit	Not compliant	Following the last round of this audit a poster was designed to help prompt the initial medical clerking and assessment and details of investigations required. While improvements were identified in most criteria audited, the quality of history taking was overall sub-standard according to guidelines. There was an overall improvement in recording the clinical examination but still sub-standard. The team plan to insert the syncope flow chart into the Junior doctor's handbook and additional teaching sessions ad induction in order to improve the initial assessment of these patients.
NICE CG84; Re-audit of the management of Diarrhoea and Vomiting (D&V) in children	Not compliant	Results showed that we are effective at introducing oral rehydration therapy and encouraging parents to keep it going. We also perform well with sending only necessary investigations and keeping parents updated about the next steps of treatment. The team is working towards improving documentation of treatment provided and ensuring that the use of NG tube administration of oral fluid therapy is embedded in practice with all relevant staff completing the required competencies associated with NG enteral feeding tubes.
NICE CG75; Re-audit Metastatic spinal cord compression (MSCC) in adults: risk assessment, diagnosis and management	Not compliant	This audit highlighted that investigations and treatment took place outside the recommended time frames. It is not clear if this is due to a failure in the MSCC service or if the results reflect poor documentation. Initially the team want to prioritise improved documentation by developing a proforma for use with the medical department to facilitate compliance and to develop an electronic record to document MSCC in oncology records; they also plan to update local acute medicine guidelines on the management of MSCC.
NICE CG99, QS62; Audit of Constipation in Children	Not compliant	The results show that there is likely to be poor documention of the assessment of paediatric patients visiting our Trust for diagnosis and treatment of constipation. Only one patient out of eighteen being fully documented as having a full assessment before being diagnosed. However children diagnosed with constipation are appropriately treated as per the NICE guidelines. The audit did find that many of these patients are not being reviewed once their treatment plans have started at the appropriate time. Parents are also not being given the information that they need when the children start laxative treatment. The team have put in place information for parents by providing information leaflets on Riverbank and Woodlands. Follow up appointments are to be booked at the commencement of treatment for constipation. Teaching sessions are to be undertaken to improve the assessment of children with constipation

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 2018/19 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

We would like to thank Maidstone and Tunbridge Wells NHS Trust (MTW) for submitting their quality accounts and for working closely with the quality team within the CCG to support your quality improvement. As the main provider of acute NHS services for the population in West Kent, the CCG Quality Team is proud to support the trust in their aspirations and vision to provide safe, sustainable high quality care to their patients. Welcoming their endeavour to be improvement driven, and responsive, to the needs of their patients and staff.

We recognise and are encouraged by the good work that has gone into many areas within the trust in relation to sepsis management, CQC improvement plan, the 7 day standard, audit and research, Accident and Emergency targets, hospital@home service and CQUIN submission.

It has been delightful to see the trust have continued their work in their 'Best safety' work stream that focus's the importance of learning through incidents and improving the flow of this information to all staff. The new digital solutions and review of agenda's has supported the trust to gain insight into themes and trends. The CCG embraces their no blame culture and their vision of a 'just culture' initiative. We are heartened by their continued investment for the coming year into embracing the lessons learnt work stream and encouraging staff to share. We are also assured by their focus in the coming year in reviewing how they can improve their Infection Prevention and Control elements, which are supported by this year's CQUINS, as this has continued to be a challenge for the teams.

As the trust have alluded too, it is essential in any quality improvement that patient experience is central. It is encouraging to see that the trust has aligned improved patient outcomes with staff satisfaction. The CCG are confident that with the Best Quality strategy that includes the initiative 'make it personal', though at present in its infancy, will make a difference in the coming year. FFT responses in some areas have remained a challenge but the CCG are encouraged to note the continued work to improve this.

MTW continue to recognise and focus on the importance of patient flow and its relationship with delivery of safe and effective care. We are enthusiastic about the plan of new roles for staff within the trust to support the flow with enhancement of pathways and models of care. They continue to be challenged in the RTT and cancer pathways however the CCG are encouraged by the improved harm review process's and look forward to supporting the improvement in 19/20. The CCG are delighted that there has been a significant reduction in mortality rates for the trust that they are no longer classed as an outlier amongst their peers. This is a credit to the staffs hard work and resilience in mortality review and shared learning.

In conclusion the CCG are delighted with the improvement to patient care and outcomes in the previous year and encouraged by the continued commitment of the trust to learn from incidents and individualising the care their patients receive. The narrative in the report goes just a small way to show the commitment of the staff to ensure that they are able to provide safe and sustainable high quality care to all of its patients. We look forward to continue to build relationships, work collaboratively and continue the improvement to outcomes in the coming year.

Paula Wilkins
Chief Nurse for Medway, North and West Kent Clinical Commissioning Group

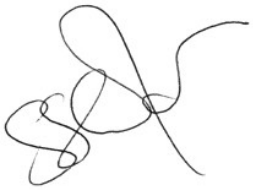
Health Overview and Scrutiny Committee – Kent County Council comments on the 2018/19 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on the Maidstone & Tunbridge Wells NHS Trust's Quality Account for 2018-19. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC's HOSC for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards



Sue Chandler
Chair, Health Overview and Scrutiny Committee Kent County Council

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

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'd like to support the Trust by setting out the areas we have worked together on in the past year:

- We met with the deputy Chief Nurse regularly to share the feedback we have heard.
- We regularly meet with patients within the hospitals to gather feedback about particular services including Outpatients, Oncology and Ophthalmology.
- We attend the Patient Experience Committee to share what the public have told us about services that the Trust provide
- Following our report detailing people's experience of being discharged from hospital we have worked with the Trust to capture the changes and improvements that have been made in response to our recommendations. Highlights include support being available for patients who need help to make space for medical equipment at home, more physiotherapy is provided within the hospital and more patients are being discharged before lunchtime.
- We have been working with the Trust to improve care for Parkinson's patients following an individual experience of a patient. This has meant that staff within the Trust have now been trained to be more aware of the support Parkinson's patients may need. We are currently working with the Trust to implement a new medicine box to enable patients to remain in charge of their own medication during a hospital stay.
- Together with colleagues at Healthwatch East Sussex we visited A&E at Tunbridge Wells Hospital to gather feedback from patients. A key recommendation includes not leaving patients for too long on bed pans and commodes.
- We visited Maidstone Hospital in partnership with The Kent Association for the Blind to understand what support was available for partially sighted patients. Our volunteers found a number of issues which we are working with the Trust to improve. Improvements so far include an audit of hearing loops across both hospitals and better training for staff on the needs of patients.
- We have been encouraging and supporting the Trust to develop a new strategy for involving and hearing from patients across West Kent.

We look forward to continuing our constructive working relationship with the Trust in the next year.

Healthwatch Kent May 2019

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

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 2019 ("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 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2019 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 1 April 2018 to 28 June 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 28 June 2019;
- feedback from commissioners dated 21 May 2019;
- feedback from local Healthwatch organisations dated 24 May 2019;
- feedback from the Overview and Scrutiny Committee dated 3 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services
- and National Health Service Complaints (England) Regulations 2009, dated 26 November 2018;
- the national patient survey dated 29 January 2019;
- the national staff survey dated December 2018
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 9 May 2019;
- the annual governance statement dated 23 May 2019;
- the Care Quality Commission's inspection report dated 9 March 2018;
- any other information obtained during our limited assurance engagement.

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 and is subject to separate terms and conditions. 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 2019:

- 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

Chartered Accountants
2nd Floor, St Johns House
Haslett Avenue West
Crawley
West Sussex
RH10 1HS
United Kingdom.

28 June 2019

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