NHS
Maidstone and Tunbridge Wells NHS Trust

Trust Board Meeting ('Part 1') - Formal meeting, which is open to members of the public (to observe)

23 July 2020, 09:45 to 12:00
Virtual meeting, via webconference

Agenda

Please note that members of the public will be able to observe the meeting, as it will be broadcast live on the internet, via the Trust's YouTube channel (www.youtube.com/channel/UCBV9L-3FLrluzYSc29211EQ).

07-8
To receive apologies for absence

David Highton

07-9
To declare interests relevant to agenda items

David Highton

07-10
To approve the minutes of the 'Part 1' Trust Board meeting of 25th June 2020

David Highton

Board minutes 25.06.20 (Part 1).pdf (9 pages)

07-11
To note progress with previous actions

David Highton

Board actions log (Part 1).pdf (2 pages)

07-12
Report from the Chair of the Trust Board

David Highton

Chair's report.pdf (1 pages)

07-13
Report from the Chief Executive

Miles Scott

Chief Executive's report.pdf (2 pages)

07-14
Integrated Performance Report (IPR) for June 2020, incorporating an update on the Trust's 'reset and recovery' programme and approval of revised objectives for 2020/21

Miles Scott and colleagues

IPR month 3 (incl. objectives for 2020-21).pdf (48 pages)

07-14.1
Update on Black, Asian, and Minority Ethnic (BAME) staff risk assessments

Simon Hart

Update on risk assessments for BAME staff.pdf (4 pages)

Quality items

07-15
Approval of Quality Accounts, 2019/20

Claire O'Brien

Quality Accounts, 2019-20.pdf (129 pages)

07-16
Findings of the national inpatient survey 2019

Claire O'Brien

Findings of the national inpatient survey 2019.pdf (27 pages)

07-17
Safeguarding Adults and Children update (Annual Report to Board, including Trust Board annual refresher training)

Claire O'Brien

Safeguarding Annual Report.pdf (20 pages)

Assurance and policy

07-18
Quarterly report from the Freedom to Speak Up Guardian

This item has been scheduled for 11.30am

Christian Lippiatt

FTSU Board Report July 2020.pdf (5 pages)

Reports from Trust Board sub-committees

07-19
Workforce Committee, 02/07/20 and 17/07/20

Please note that the report from the meeting on 17/07 will be given verbally.

Emma Pettitt-Mitchell

Summary of Workforce Cttee, 02.07.20.pdf (1 pages)

07-20
Quality Committee, 08/07/20

Sarah Dunnett

Summary of Quality C'ttee, 08.07.20.pdf (1 pages)

07-21
Finance and Performance Committee, 21/07/20

The report will be issued after the meeting on 21/07/20.

Neil Griffiths

07-22
Charitable Funds Committee, 21/07/20

This will be a verbal report.

David Morgan

07-23
To consider any other business

David Highton

07-24
To approve the motion (to enable the Board to convene its 'Part 2' meeting) that...

in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960,representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

David Highton

MINUTES OF THE TRUST BOARD MEETING ('PART 1') HELD ON THURSDAY 25th JUNE 2020, 9.45 A.M, VIA WEBCONFERENCE

NHS Maidstone and Tunbridge Wells NHS Trust

FOR APPROVAL

Present:	David Highton	Chair of the Trust Board	(DH)
	Sean Briggs	Chief Operating Officer	(SB)
	Maureen Choong	Non-Executive Director	(MC)
	Sarah Dunnett	Non-Executive Director	(SDu)
	Neil Griffiths	Non-Executive Director	(NG)
	Peter Maskell	Medical Director	(PM)
	David Morgan	Non-Executive Director	(DM)
	Claire O'Brien	Chief Nurse	(COB)
	Steve Orpin	Chief Finance Officer	(SO)
	Emma Pettitt-Mitchell	Non-Executive Director	(EPM)
	Miles Scott	Chief Executive	(MS)
In attendance:	Karen Cox	Associate Non-Executive Director (left during item 06-14)	(KC)
	Richard Finn	Associate Non-Executive Director	(RF)
	Simon Hart	Director of Workforce	(SH)
	Amanjit Jhund	Director of Strategy, Planning & Partnerships	(AJ)
	Sara Mumford	Director of Infection Prevention and Control (arrived during item 06-13)	(SM)
	Jo Webber	Associate Non-Executive Director	(JW)
	Kevin Rowan	Trust Secretary	(KR)
Observing:	The meeting was livestreamed on the Trust's YouTube channel.		

06-8 To receive apologies for absence

No apologies were received.

06-9 To declare interests relevant to agenda items

No interests were declared.

06-10 To approve the minutes of the 'Part 1' Trust Board meeting of 21st May and 18th June 2020

The minutes were approved as true and accurate records of the meetings, subject to the following amendment with regards to the meeting on 21/05/20:

- Item 05-8, page 4: Replace "COB then reported details of the latest position for patient falls, which had increased, and gave assurance that work was underway in response" with "COB then reported details of the latest position for patient falls, and noted that the falls rate had increased, but gave assurance that work was underway in response".

Action: Amend the 'Part 1' Trust Board minutes of 21/05/20 to reflect the amendment that was agreed at the meeting on 26/05/20 (Trust Secretary, June 2020 onwards)

SO then referred to the meeting on 18/06/20 and reported that the Trust's external auditors had provided their signed audit opinion and the Annual Report and Accounts for 2019/20 had been submitted to the regional and national offices.

06-11 To note progress with previous actions

The circulated report was noted. The following action was discussed in detail:

- **05-16a ("Arrange for the Trust's website and "MyMTW" App to be updated to reflect the latest available information").** AJ reported that the Communications team would update the "MyMTW" App and remove content that was no longer relevant. AJ added that the App was however always intended to be temporary, ahead of a new intranet being introduced, although

the Business Case for the new intranet had been paused as a result of the COVID-19 pandemic. DH therefore confirmed the action could be closed.

06-12 Report from the Chair of the Trust Board

DH referred to the relevant attachment and highlighted the following points:

- Thanks should continue to be given to the efforts of the staff during the last few weeks.
- It was important to maintain an inclusive approach to staff, whether Black, Asian, and Minority Ethnic (BAME), disabled, or LGBT+, and engagement with the three staff networks continued.
- Two consultant appointments had been made, and holding appointment panels by virtual means had gone well.

06-13 Report from the Chief Executive

MS referred to the relevant attachment and highlighted the following points:

- The BAME staff risk assessments and 'reset and recovery' programme would be covered in more detail during other items on the agenda.
- The Trust had received considerable amounts of charitable donations and the COVID-19 charitable fund was currently at circa £200k. £75k was from NHS Charities Together, with the remainder being donated by the local population. The rest of the significant NHS Charities Together fund would be issued in phases and the Trust had an opportunity to bid for up to £50k for the next phase. The Trust's bid would be managed by the Fundraising Manager, via the Charity Management Committee (the establishment of which had been paused as a result of the COVID-19 pandemic).
- The "Going the distance" charity campaign had currently raised £3k against its £10k target, and MS would run a marathon between the Trust's hospital sites on 15/07/20, to support the campaign. Trust Board members were welcome to join MS during his run, even if only for the finish, which would take place at Maidstone Hospital.
- The latest staff 'pulse' survey had had a good response rate, and the themes included positive comments on internal communications, and staff gratitude for the welfare facilities, although it was noted that some staff had difficulty in accessing these, so efforts would be made to improve access and the Associate Director of Organisational Development would liaise with the clinical Divisions regarding that issue. It was also apparent that the COVID-19 period had placed a significant strain on the Trust's middle managers so work was underway to support such staff.

[N.B. SM joined the meeting at this point]

- Medway NHS Foundation Trust (MFT) had asked for a temporary emergency transfer of its stroke services to the Trust and Dartford and Gravesham NHS Trust, in advance of the formal transfer that was intended once the Hyper Acute Stroke Units (HASUs) had been established. The Trust would start to accept acute stroke patients from Medway on 01/07/20.

PM referred to the last point and elaborated that the situation at MFT was not dissimilar to the situation previously faced by the stroke service at Tunbridge Wells Hospital, in that staffing issues had led to the need for an emergency temporary transfer of the service. PM gave further details of the arrangements that would be applied for the transfer from MFT, which included the addition of two MFT stroke consultants to the stroke rota, which would enable the Trust to develop a proper HASU rota ahead of the more controlled transfer at the conclusion of the Judicial Review. PM also noted that the Trust would establish a telemedicine system with South East Coast Ambulance Service NHS Foundation Trust, and that innovation may then be used for future care i.e. the process would act as a pilot for such future use. PM added that the additional stroke nurses that would follow from the transfer from MFT would also be beneficial.

MC commended the Trust's support for patient safety within the stroke service, but asked about the stroke rehabilitation pathway and in particular whether patients would be able to be rehabilitated closer to home. PM noted that the arrangements for the transfer from MFT did not affect the stroke rehabilitation service, but reported that the Trust had made it clear that it believed stroke rehabilitation should be undertaken closer to patients' homes.

JW referred to the donations made by the local population and asked how the Trust would ensure that the donations were used to benefit that population. JW also asked what feedback was provided. MS noted that all donors were thanked although he would have to check and confirm the arrangements for thanking persons making online donations.

Action: Check and confirm the arrangements for thanking persons making online donations to the Trust's charitable fund (Chief Executive, June 2020 onwards)

MS also stated that he would discuss with the Trust Board any proposals to use charitable funds for major projects, but he believed that much of the benefit to the local population would arise from having a contented workforce at their local hospitals, as many of donations would be used for staff welfare. MS added that he did not believe those donating would expect, for example, that their donations would be used to purchase lots of medical equipment SO added that the aforementioned "Going the distance" charity campaign had been specifically marketed to fund staff welfare.

RF then referred to the 'reset and recovery' programme and asked whether the Trust was prepared for a potential second wave of COVID-19 cases. MS gave assurance that was the case, but stated that the key priority over the next few weeks would be the reset of the Trust and the aim of returning activity levels to the pre-COVID-19 period, before focusing on planning for the forthcoming winter and issues such as the availability of Personal Protective Equipment (PPE). SB echoed MS' assurance regarding the planning for the second wave and added that the Trust had held its first meeting on winter planning on 24/06/20.

06-14 Integrated Performance Report (IPR) for May 2020, incorporating an update on the Trust's response to COVID-19 and review of the 'reset and recovery' project briefs

DH introduced the item by thanking the team for developing an IPR that included both 'normal' and COVID-19 measures, noting that a further development of the IPR would be submitted to the Trust Board in July 2020. MS then referred to the relevant attachment and highlighted that the underlying message was how strong the Trust's performance had been during the COVID-19 period, noting that the performance on the Emergency Department (ED) 4-hour waiting time target had been the best in the south east and south west every day for almost two months. MS added that the continued meeting of the cancer access targets, and the rapid response to meeting the costs associated with COVID-19 had been incredible, while PM and COB had been able to ensure that quality standards had not declined during the period.

MS then referred to the development of the IPR, and described some of the changes that were intended but noted that the IPR would remain focused on the five Care Quality Commission domains. MS suggested it would be beneficial to have a more detailed discussion of the new IPR format at the Trust Board meeting on 23/07/20.

COB then referred to the "Safe" domain and highlighted the following points:

- The number of falls had risen during the past month, and work was taking place with the Business Intelligence and falls teams to identify key themes.
- Pressure ulcers remained stable, as did the reporting of Serious Incidents (SIs).

SM also then referred to the "Safe" domain and highlighted that the Trust had two MRSA bacteraemia cases in the past month. MS added that the cases were both very complex although the Root Cause Analysis (RCA) for the second case had not yet been completed.

PM then referred to the "Effective" domain and highlighted that the data for the Best Practice Tariff (BPT) for stroke and from the Sentinel Stroke National Audit Programme (SSNAP) continued to be monitored and PM would update the Trust Board of any significant developments.

COB then referred to the "Caring" domain and highlighted that the national pause of the complaints process that had been applied during the COVID-19 period had now been lifted. COB added that the Trust's response rate had declined and a backlog had developed, so there would be a concerted focus on recovering the Trust's position.

SB then referred to the "Responsive" domain and highlighted the following points:

- Performance on the ED 4-hour waiting time target had regularly been at over 98%.
- The Trust was one of only two nationally who had achieved the 62-day cancer waiting time target for nine months in succession. The target was expected to be met in May too, while the performance for June also looked strong. Performance against the two week cancer waiting time target had also been very good. The cancer team had however been working very long hours during the COVID-19 period. SB was very proud of the ED and cancer teams.
- Performance on the Referral to Treatment (RTT) target had reduced to below 60% but this formed a major part of the Trust's 'reset and recovery' programme.

SH then referred to the "Well-Led" domain and highlighted the following points:
- There had been a focus on staff turnover in some areas.
- Workforce and recruitment plans would be reviewed with the divisions, in light of the changes to clinical pathways as a result of the response to COVID-19.
- The Trust's underlying sickness absence rate remained low, but circa 200 staff were shielding, so the latest government guidance would be reviewed, and the Human Resources department would work with line managers and Occupational Health to support such staff.

EPM asked whether there were any concerns regarding staff's annual leave (A/L) entitlement being back-loaded to the end of the 2020/21 year. SH explained that staff had been encouraged to take A/L during the COVID-19 period, and in particular to take one week's A/L by the end of June 2020, both as a health and safety issue, and to address the issue raised by EPM. MS added that the Trust was also trying to support staff who had family abroad, to enable them to travel and have their quarantine period covered once they returned.

SO then referred to the "Well-Led" domain and highlighted the following points:
- The national financial regime that had been applied during the COVID-19 period remained in place and would continue to at least the end of July 2020. That regime included a block contract and a retrospective 'top up' payment.
- The Trust had claimed for £1.4m of costs during May 2020 and the retrospective 'top up' payment for April 2020 had been received without challenge, which gave assurance that the Trust's costs claim had been appropriate.
- Factors affecting the position including backfilling of staff absence and PPE supply.
- The cash position was very strong, which had enabled the Trust to accelerate payments to its creditors.
- The Trust had not yet received confirmation of its capital funding for 2020/21, and the Trust was still in discussion with the NHS England (NHSE)/NHS Improvement (NHSI) regional team regarding COVID-19-related capital expenditure.

DH acknowledged that the current financial regime would operate until the end of July 2020 but asked whether SO knew what regime would be applied from August. SO replied that there had been no confirmation as yet and although some information had started to emerge, SO did not expect any certainty until at least July 2020, although he anticipated that a variation of the current regime would apply from August. DH noted that a realistic year-end forecast would not therefore be feasible for some time. SO confirmed that would be the case.

MS then proposed that the update on the 'reset and recovery' programme be given. DH agreed. KR therefore gave instructions to all Trust Board members on how to access the "How does MTW return to a new normal…" report that had been issued via the Admincontrol meetings portal on 24/06/20. SB then referred to that report and highlighted the following points:
- Many staff had worked incredibly hard, without any break, for the past five months, as the A/L they had planned to take in March had to be cancelled because of the COVID-19 pandemic.
- The Directorate and Divisional plans for 'reset and recovery' had now all been approved as being safe, which was a significant step.
- The "Outpatients – where are we now?" section outlined that the approach would focus on aiming to return to the elective activity levels that were in place before the COVID-19 period.
- Several Directorates & specialities were very close to their pre-COVID-19 activity levels. There were however challenges that prevented other specialities from achieving a similar position.
- All specialties were projected to return to their pre-COVID-19 activity levels by 20/07/20.

[N.B. KC left the meeting at this point.]

SB then elaborated on the challenges for recovering elective care activity, which included the need for patients to self-isolate for 14 days before their surgery, which limited the ability of the Trust to have patients on stand-by waiting lists and be scheduled for their surgery at short notice. SB added that there were also workforce challenges, as many anaesthetic staff and Operating Department Practitioners had worked extremely hard during the COVID-19 period.

SB then continued and highlighted the following aspects of the report

- The two main specialities with problems in returning to pre-COVID-19 activity levels were upper gastrointestinal and Ear, Nose and Throat (ENT), but the aim was to achieve pre-COVID-19 levels of activity by mid-August 2020.
- The main challenge facing diagnostic capacity was CT capacity and endoscopy, which had a large backlog of patients. More work was needed to address the situation.
- The content of the demand and capacity sections of the report illustrated the size of the significant challenge to return to compliance with the Referral to Treatment (RTT) waiting time standard. However, the Trust's position compared favourably with many others and the Trust's waiting list had reduced during the COVID-19 period.
- The Trust had a 'follow-up' waiting list and that was being managed.

SB then referred to the "Demand and Capacity – Next Steps" slide, and elaborated on the content, which included that discussions were needed with commissioners to understand their requirements for 2020/21. SB then concluded by highlighting the timetable for the 'New Normal', which included that the Executive Team Meeting on 30/03/20 would approve the 'reset and recovery' programme Project Initiation Documents (PIDs).

MC commended the plans regarding the 'reset and recovery' programme and echoed SB's commendation to staff for their hard work. MC then noted that circa 5000 patients had waited longer for treatment than they would have done, so asked about the process of clinical review and whether patients had been kept informed of their situation. SB confirmed that most of the clinical reviews had been undertaken at the 35 week waiting point and acknowledged the need for further work to communicate with patients whose waiting time had been extended, although all affected patients had been advised of the delays at the start of the COVID-19 period, and the Communications team had provided general updates via social media. SB added that consideration was however being given to referring patients who did not currently want to proceed with their treatment, because of their anxiety about entering hospitals, back to their GP, as they may be best placed to oversee their care during this time.

DM noted that the waiting list was probably artificially low at present and asked about the preparations for a surge of non-COVID-19 patients, should those who did not currently want to proceed with their surgery change their minds en masse. SDu commended SB for preparing the report but asked whether there had been any evaluation as to whether seeing patients in virtual outpatient clinics was as effective as seeing patients face-to-face. SB replied to DM's query by noting that some areas had already seen patient demand return to pre-COVID-19 levels, but it had been acknowledged that a further surge would likely occur, and this was a major aspect of the Trust's 'reset and recovery' programme. SB then replied to SDu's query by noting that some consultants had been cautious about having virtual outpatient appointments, but every such appointment had been subject to a clinical assessment.

NG also commended the plan and asked for a comment on the increase in ophthalmology activity. SB noted that the ophthalmology team had benefited from the attention the Finance and Performance Committee had given to the speciality before the COVID-19 period and the team had responded well to the challenges it had faced, both before and since the COVID-19 period.

RF then referred back to the approach and opined that there should be a "system" vertical, to take account of the system-wide factors that affected the 'reset and recovery' programme. RF also commented that he could not see any link with the Human Resources team in the work, which RF believed was of fundamental importance, given the support that line managers would need to implement the programme. RF therefore wondered whether that aspect had been incorporated

within the interdependencies. SB confirmed that the links with the Human Resources team was included within the interdependencies. SB also acknowledged the need to recognise the management capability needed to implement the 'reset and recovery' programme, and noted that he and SO had discussed that issue earlier that week. SB also gave assurance that the Trust was liaising with the wider system on demand and capacity and there were strong relationships with system partners on, for example, urgent care, although there was uncertainty at a system level about future demand. SB did however accept that that the system-wide factors that could affect the programme needed to be more evident in any future update reports.

Action: Ensure that any future update reports on the Trust's 'reset and recovery' programme reflected the system-wide factors that could affect the programme (Chief Operating Officer, June 2020 onwards)

MS referred to RF's comments regarding system factors and explained that the most pressing issue was workforce, not physical capacity, and additional physical capacity was not needed, particularly given the physical capacity that existed in the regional Independent Sector.

PM then referred back to SDu's query regarding virtual outpatient clinics and explained that he promoted local clinical decision-making regarding the use of such clinics, but corporate quality tools, such as incident and SI reporting, mortality reviews and Structured Judgement Review (SJRs) remained in place.

COB noted that the high-level descriptions of revised clinical pathways belied some of the subtleties that needed to be considered, such as patient consent and the protection of vulnerable patients. COB also noted that the need for patients to self-isolate for 14 days before surgery required support and she had discussed that with one of the Deputy Chief Nurses. The points were acknowledged.

06-14.1 Update on progress with the Perinatal Mortality Review Tool (PMRT)

COB referred to the relevant section of the attachment and highlighted the key points therein, which included that a larger review of the maternity service would be undertaken and presented at a future Quality Committee 'deep dive' meeting.

06-14.2 Planned and actual ward staffing for May 2020

COB referred to the relevant section of the attachment and highlighted the key points therein, which included that the national pause in the reporting of safe staffing data that had been introduced because of COVID-19 had now ceased, although the Trust had continued with the process, so was better placed than many other Trusts, who had to re-start their reporting.

COB then explained that she had no concerns regarding staffing levels, despite the content of the report, but she was keen to work with Allocate (the IT developer) and implement a system called SafeCare, which would enable more accurate, meaningful data to be reported. DH noted that he understood it was normal for staff rostering systems to have a patient acuity element and relayed his own experiences of Cerner's system, which linked with the Cerner Electronic Patient Record (EPR). DH therefore asked COB to consider whether the SafeCare system linked with the Allscripts EPR. COB confirmed she would bear DH's comments in mind.

06-14.3 Infection prevention and control board assurance framework

SM referred to the relevant attachment and highlighted the following points:

- The framework was a COVID-19-related extension to the Hygiene Code board assurance framework that had previously been submitted to the Trust Board. There had been several iterations of the framework.
- PPE usage and availability was being closely monitored and the Procurement team should be commended for their work on PPE over the past months.
- The cleaning teams should also be commended, as there had been very few incident reports regarding standards of cleaning being reduced.
- Antimicrobial stewardship audits had been suspended during the COVID-19 period but had now been reinstated.

DH referred to PPE, noted that the COVID-19 Ethics Committee had discussed placing a second order for re-usable face masks and asked whether an order had been placed. SM confirmed that several such orders had been placed and elaborated on the circumstances under which such masks would be used. SM added that the Trust had been notified that the national stockpile of FFP3 masks may be exhausted in the near future, so the Trust was taking mitigating actions.

06-14.4 Board Checklist - workforce risk factors linked to COVID‑19 and an update on BAME staff risk assessments

SH referred to the relevant attachment and highlighted the key points therein, which included that although the checklist had not been mandated, it had been strongly recommended, and had been useful in providing assurance to the Trust Board. SH added that he was grateful to Rantimi Ayodele and Mildred Johnson for their support, via the Cultural and Ethnic Minorities Network, in encouraging staff to engage in the risk assessment process for BAME staff.

SH continued that some key challenges were outstanding, which included the completion of BAME staff risk assessments by the required date. SH continued that compliance was 55% at the time of the report, but was 60% on 24/06/20, although a data issue in the Medicine & Emergency Care Division meant that the completion rate was likely to be 70%. SH acknowledged that more work was therefore needed to achieve 100% compliance, particularly in certain areas, such as medical staff in training, so work was taking place with such staff.

SH then noted that maintaining social distancing was also very challenging and efforts were being made to instil social distancing principles into staff consciousness.

RF remarked that he was interested in the differences between the document that SM had submitted under item 06-14.3 and the document that SH had submitted, as the latter did include details on the level of risk. RF therefore asked SH whether he had any plans to develop the document, to provide assurance that the associated risks had been mitigated and reduced. SH agreed to update the document to include reference to the evidence underlying the statements therein and provide assurance regarding the risks.

Action: Update the "Board Checklist - workforce risk factors linked to COVID-19" to include reference to the evidence underlying the statements in the report (and provide assurance that the associated risks had been mitigated and reduced) (Director of Workforce, June 2020 onwards)

MC asked whether the reasons for the 30% non-compliance with the BAME staff risk assessments were understood, and asked how BAME staff felt about working without such risk assessments being completed. SH replied that a number of factors were involved in the non-compliance, which included that a small number of individuals did not want to engage in the process due to concerns that they would be singled out from other staff. SH also reiterated his earlier comments regarding the difficult of engaging junior medical staff in the risk assessment process.

EPM stated that she was keen to see deadlines for the achievement of actions, including the completion of BAME staff risk assessments, so suggested it may be helpful to add deadline dates in the "Potential risk mitigation" or "Owner" columns in the report. EPM also asked for clarification that the Divisions were responsible for completing the BAME staff risk assessments and SH was just reporting such compliance. SH confirmed that line managers were responsible for completion of the BAME staff risk assessments & also confirmed that deadlines had been set for the actions.

JW asked whether line managers had considered making long-term adjustments for certain staff, including BAME staff. SH noted that the consideration of such long-term adjustments, including for staff being shielded, would be incorporated within the 'reset and recovery' programme. SH added that more detailed support would be required for certain frontline clinical staff, to allay their anxieties, and a more detailed risk assessment process would be applied.

SDu stated that one interpretation when reviewing the BAME staff risk assessment compliance status was that line managers had not taken the issue seriously enough, particularly given the

corporate message that had been issued in response to recent external events. SH acknowledged the point. MS added that the issue would be the main topic of discussion at the Executive Team Meeting on 30/06/20 and proposed that a further update be submitted to the next Trust Board meeting. This was agreed.

Action: Submit a further "Update on BAME staff risk assessments" report to the Trust Board meeting in July 2020 (Director of Workforce, July 2020)

MC noted the pressures on line managers and wondered whether they needed support to complete the risk assessments. MC also emphasised that the issue was related to a legal duty held by the Trust. The points were acknowledged.

Quality items

06-15 Quarterly mortality data

PM referred to the relevant attachment and highlighted the following points:

- The Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) remained low.
- PM had initially been concerned at the "HSMR by site" data but he had been assured.
- The Cumulative SUM (CUSUM) alerts did not give PM any cause for concern.
- There was a slight backlog in the completion of SJRs but this had been acknowledged by the Mortality Surveillance Group (MSG).
- The MSG had met on 24/06/20 and it had been confirmed that the standard mortality review process would be applied to all COVID-19 related deaths.

SM referred to the latter point and clarified that all COVID-19 deaths would be reviewed, but would not be subject to a full SJR.

Planning and strategy

06-16 Approval of Business Case for Point of Care Testing (POCT)

DH firstly highlighted that the Finance and Performance Committee had, at its meeting on 23/06/20, agreed to recommend that the Business Case be approved by the Trust Board. SB then referred to the relevant attachment and confirmed that the Business Case had been fully supported by the Executive Team Meeting prior to the Finance and Performance Committee.

COB confirmed her support for the Case but emphasised the significant work involved in implementation. The point was acknowledged.

MC asked whether the Business Case had taken into account the system-wide pathology changes that were planned, and would not conflict with such changes. SB confirmed that there would be no such conflict. NG noted that a similar question had been raised at the Finance and Performance Committee meeting on 23/06/20.

The Trust Board approved the Business Case for Point of Care Testing as submitted.

Reports from Trust Board sub-committees

06-17 Workforce Committee, 15/05/20 (incl. quarterly report from the Guardian of Safe Working Hours)

EPM referred to the relevant attachment and invited questions or comments. None were received.

06-18 Quality Committee, 02/06/20

SDu referred to the relevant attachment and invited questions or comments. None were received.

06-19 Patient Experience Committee, 11/06/20

MC referred to the relevant attachment and invited questions or comments. None were received.

06-20 Audit and Governance Committee, 18/06/20

DM referred to the relevant attachment and invited questions or comments. None were received.

06-21 Finance and Performance Committee, 18/06/20

NG referred to the relevant attachment and invited questions or comments. None were received.

Other matters

06-22 To consider any other business

There was no other business.

06-23 To approve the motion (to enable the Board to convene its 'Part 2' meeting) that in pursuance of Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest

The motion was approved, which enabled the 'Part 2' Trust Board meeting to be convened.

Log of outstanding actions from previous meetings **Chair of the Trust Board**

Actions due and still 'open'

Ref.	Action	Person responsible	Original timescale	Progress[1]
06-14.4a	Update the "Board Checklist - workforce risk factors linked to COVID-19" to include reference to the evidence underlying the statements in the report (and provide assurance that the associated risks had been mitigated and reduced)	Director of Workforce	June 2020 onwards	The document is being updated as per the Trust Board's request, and in light of the more recent guidance from NHS England (NHSE)/NHS Improvement (NHSI) relating to risk assessments for vulnerable adults, and the update will be completed w/c 20/07/20.

Actions due and 'closed'

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
06-10	Amend the 'Part 1' Trust Board minutes of 21/05/20 to reflect the amendment that was agreed at the meeting on 26/05/20	Trust Secretary	June 2020	The minutes were amended.
06-13	Check and confirm the arrangements for thanking persons making online donations to the Trust's charitable fund	Chief Executive	June 2020	The Trust's Fundraising Manager confirmed that: ▪ The vast majority of online donations are made via Just Giving. An automatic thank you email is sent by Just Giving to everyone on behalf of the charity, regardless of whether they have set up their own fundraising page of if they have donated to an appeal, friend's page etc. ▪ Online fundraisers who have set up their own page are thanked via letter or card and with a fundraising certificate as appropriate. The Trust has been using the Captain Tom Moore personalised cards, drawn by a member of staff, and these have been very popular. ▪ Other online platforms

[1] Not started | On track | Issue / delay | Decision required

Ref.	Action	Person responsible	Date completed	Action taken to 'close'
				include Much Loved (tribute funds) and a letter or email will be sent. However, sometimes donations are made via funeral directors, and the family involved may not want to provide their contact details (although the Trust makes enquiries in such circumstances).
06-14	Ensure that any future update reports on the Trust's 'reset and recovery' programme reflected the system-wide factors that could affect the programme	Chief Operating Officer	July 2020	The Project Briefs for the 'reset and recovery' programme workstreams identify the interdependencies (including any external interdependencies)
06-14.4b	Submit a further "Update on BAME staff risk assessments" report to the Trust Board meeting in July 2020	Director of Workforce	July 2020	A further update has been submitted to the Trust Board meeting in July 2020

Actions not yet due (and still 'open')

Ref.	Action	Person responsible	Original timescale	Progress
N/A	N/A	N/A	N/A	N/A
				N/A

Report from the Chair of the Trust Board **Chair of the Trust Board**

Consultant appointments

I and my Non-Executive colleagues are responsible for chairing Advisory Appointment Committees (AACs) for the appointment of new substantive Consultants, and the Trust follows the Good Practice Guidance issued by the Department of Health, in particular delegating the decision to appoint to the AAC, evidenced by the signature of the Chair of the AAC and two other Committee members. The delegated appointments made by the AAC since the previous report are shown below.

Date of AAC	Title	First name	Surname	Department	Potential / Actual Start date
16/07/2020	Dr	Graeme	Wallace	Care of the Elderly (Stroke Consultant)	To be confirmed

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Report from the Chief Executive **Chief Executive**

I wish to draw the points detailed below to the attention of the Board:

1. Now that the number of coronavirus cases has significantly reduced, we have fully opened all services to get back to delivering outstanding care to all patients, not just urgent and emergency cases. Our hospitals are safe with social distancing measures and additional infection prevention protocols in place to protect patients and staff. We have also eased our visiting restrictions with wards given a designated visiting hour, one visitor allowed per patient and people in labour can be accompanied by a partner from the time they're admitted. Our priority continues to focus on our reset and recovery plans. Highlights from this month include:
   - **Staff welfare** – building on the good work to provide a healthy working environment for all staff with access to wellbeing activity and psychological support as well measures to support vulnerable and shielding staff. Fostering the community partnerships that have developed during the pandemic to support staff is also a key focus.
   - **Homeworking and social distancing** – over 200 staff completed a homeworking survey in early July asking for feedback on what's working well and what could be improved. Homeworking forms a fundamental element of our plans to maintain social distancing measures and more of our staff will need to work from home going forwards.
   - **Outpatients** – to continue to deliver our services effectively, the outpatients department has moved from the Diagnostics and Clinical Services division to Cancer Services. Work is focused on maintaining 70% – 80% of all appointments across all specialties as virtual consultations to maintain social distancing measures and prevent the spread of infection.
   - **Surgery** – activity is being phased in over the next month to ensure we increase capacity safely and we'll be at normal levels by early August. We will continue to work with the independent sector for some orthopaedic, cancer and ophthalmology surgery. For orthopaedics we will be handling 80% of our capacity by 15 July and we'll be back to normal activity levels by August. Urology services will be running at 50% capacity by 20 July and back up to normal levels by early August. Lower gastrointestinal and gynaecology planned procedures will be running at full capacity by the end of next month.
   - **Diagnostics** - our immediate priority this month is to re-book those patients who had their CT or MRI scan postponed because of the pandemic. We are currently running at about 65% - 75% CT capacity but have introduced clinics at weekends and are using the independent sector to ensure patients are seen quickly. For MRI scans, we are also working with the independent sector and using mobile scanning machines to ensure we see patients promptly.

2. The Trust has put forward proposals for a series of organisational objectives for the year ahead. They outline an ambitious programme of developments and quality improvements, and provide the framework to deliver our vision of becoming an outstanding organisation. Overview highlights of our draft plans are:
   - **Clinical strategy** – reviewing how our current clinical services are configured to deliver improved patient experience as well as providing new clinical services so that patients have access to safe high quality care locally, reducing the need to travel to London. New service developments will be considered for cardiology and gastroenterology.
   - **Quality**– meeting our vision to provide outstanding, compassionate care to our patients with a focus on improving patient satisfaction levels and patient involvement in co-designing the new and reconfigured clinical services; timely and robust complaints handling; preventing hospital acquired infections; and excellent trust-wide sharing of learning from serious incidents.
   - **Organisational development** – implementing our ongoing Exceptional People Outstanding Care culture change programme to make MTW a great place to work, with a focus on nurturing all staff and encouraging everyone to get involved in shaping quality improvements to services / patient care.

- **Workforce** – recruiting and retaining talented staff and implementing a training and development programme for current and future leaders. Focus also on ensuring support measures are in place so that senior leaders are representative of our workforce.
- **Education** – working with the new Kent & Medway Medical School to establish an outstanding educational programme at MTW to help generate a sustainable medical workforce for the future.

3. Attendances to MTW's emergency departments are back to pre-Covid-19 levels. Despite this increase, MTW continues to remain in the top 10 best performing trusts for seeing, admitting or discharging patients within the four hour national standard. This is a fantastic effort and our outstanding performance is a result of the best practice we've embedded and excellent working with our external partners, in particular Kent Community Health NHS Foundation Trust and Kent County Council Social Services.

4. MTW recently welcomed Lieutenant Colonel EM Read (Mary), the commanding officer of 254 Medical Regiment, to our Trust to sign the Armed Forces Covenant to demonstrate MTW's ongoing commitment to forging closer links with the armed forces community, their families, reservists and veterans. Signing the covenant shows we are an armed forces-friendly organisation that actively supports the employment of armed forces, offering an access route into employment and career development opportunities.

5. A huge thank you to Tunbridge Wells resident Caroline May who raised more than £19,000 for the Intensive Care Unit at Tunbridge Wells Hospital during the pandemic as a way of thanking medical staff who saved her young son's life. Caroline May took the emergency number 999 and flipped it on its head to create the Reverse 999 Appeal which urged people to donate £9.99 to the hospital's ICU via the Maidstone and Tunbridge Wells NHS Trust Charitable Fund. The money raised has already improved the patient experience in ICU by funding a new rehabilitation chair, dementia clocks and Aerogens, a specialist piece of equipment which enables drugs to be delivered directly into patient's lungs to help them breathe.

6. A number of staff have been actively participating in our charity's new 'Go the distance' fundraising campaign to help raise money for staff welfare and wellbeing initiatives. Staff are running, walking or cycling a series of distances and receiving donations to complete the event. I got involved too as my way of saying thank you to staff for all their efforts during the pandemic. I ran a marathon between our hospital sites 15 July, which started at 8am at Crowborough Birthing Centre, via Tunbridge Wells Hospital and Paddock Wood, and crossed the finish line at Maidstone Hospital five hours later. So far the campaign has raised £6,000 in online donations alone.

7. The 2019 National Inpatient Survey results have just been published and demonstrate that MTW has continued to deliver good patient care, despite a backdrop of higher demand for our services over the past year. We are currently reviewing the survey feedback from our inpatients and are developing an action plan that's aligned to our staff welfare work, which builds on the good practice we've already put in place so that we can achieve our ambition of providing outstanding care.

8. We've now completed more than 85% of risk assessments of the 1,470 colleagues identifying as Black, Asian and Minority Ethnic. Around 10% have required some form of adjustment to their role to minimise their risk and keep them safe.

Which Committees have reviewed the information prior to Board submission?
N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Integrated Performance Report (IPR) for June 2020, incorporating an update on the Trust's 'reset and recovery' programme and approval of revised objectives for 2020/21	**Chief Executive / Members of the Executive Team**

The IPR for month 3, 2020/21, is enclosed, along with the monthly finance report and the latest 'planned vs actual' nurse staffing data. The IPR is in a revised format and Trust Board members' comments are invited.

The agenda item will also include a verbal update on the Trust's 'reset and recovery' programme.

A set of revised objectives are also enclosed, for consideration and approval. The enclosed objectives, which have been developed through the 'reset and recovery' programme, are intended to replace the objectives that the Trust Board approved at its meeting on 30/04/20.

Which Committees have reviewed the information prior to Board submission?

- Executive Team Meeting, 07/07/20 and 14/07/20 (revised objectives, which were included within the Project Briefs for the 'reset and recovery' programme)
- Finance and Performance Committee, 21/07/20 (IPR)

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

1. Review and discussion of the IPR and Planned V Actual nurse staffing
2. Approval of the revised objectives for 2020/21

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

NHS
Maidstone and Tunbridge Wells NHS Trust

Integrated Performance Report

June 2020

MTW
exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Contents

Appendices (Page 24 onwards)

Note: Detailed dashboards and a deep dive into each CQC Domain are available on request - mtw-tr.informationdepartment@nhs.net

MTW
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Key to KPI Variation and Assurance Icons

Variation			Assurance			
						
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Variation Indicates inconsistently (P)assing of the target	Variation Indicates inconsistently passing and falling short of the target	Variation Indicates inconsistently (F)alling short of the target	Data Currently Unavailable

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

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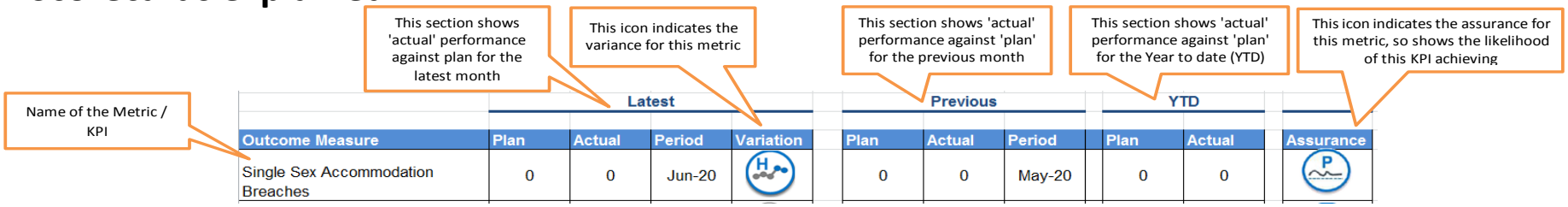
Maidstone and Tunbridge Wells NHS Trust

Escalation Rules:

Areas are escalated for reporting if:

- They have special cause variation (positive or negative) in their performance
- They have a change in their assurance rating (positive or negative)

Scorecards explained



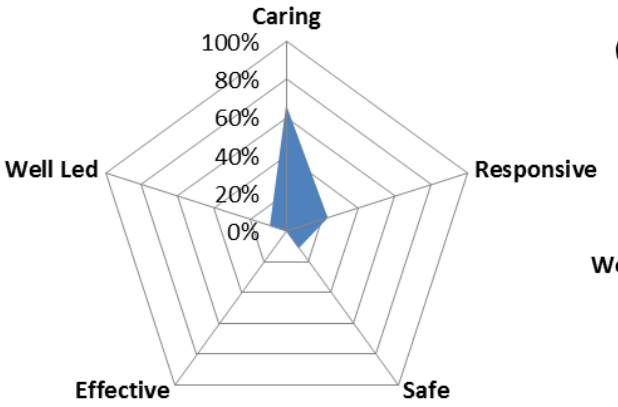
Further Reading / other resources

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

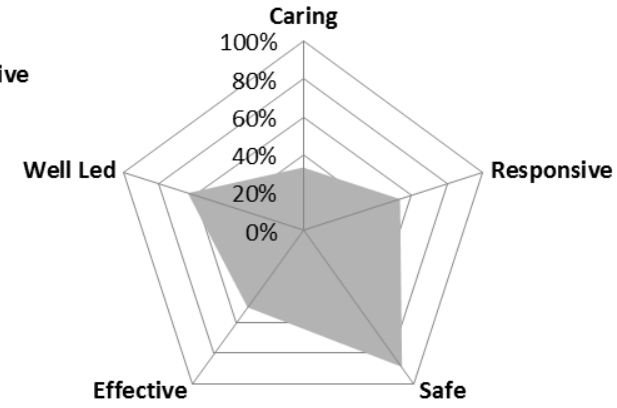
MTW exceptional people, outstanding care

Executive Summary

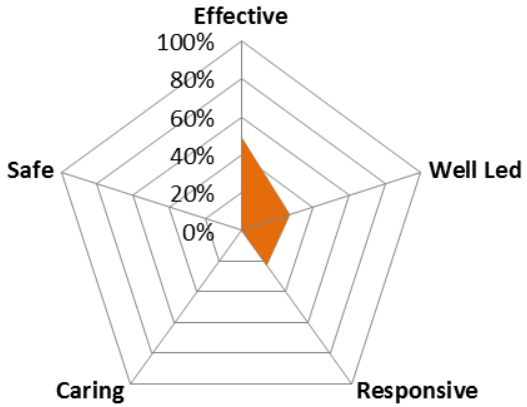
Favourable Assurance



Common Cause Assurance



Adverse Assurance



Favourable Assurance:
Trust Mortality (HMSR), Mixed Sex Accommodation Compliance, Rate of Complaints and Mandatory Training Compliance are consistently passing the target. The Cancer Waiting Times 2 week wait, 31 Day and 62 Day indicators are also now consistently passing the target. Both the 2 week wait and 62 Day first definitive cancer waiting times targets are now at a new mean which is higher than it was previously demonstrating the improvement in performance.

Common Cause Assurance:
All of the Safe and Caring Indicators are experiencing common cause variation and inconsistency (passing or falling short of target) indicating that the indicators are not stable with the exception of Mortality (HMSR) and Mixed Sex Accommodation Compliance. The rate of Hospital Acquired Pressure Ulcers is now at a new mean which is much closer to the limit, which is concerning. The number of infection control issues has remained similar to those reported prior to the COVID-19 pandemic, despite the lower level of occupied beddays. The majority of the Urgent Care and Flow Workstream indicators are experiencing special cause variation – data outside of control limits (in a positive way) and inconsistency (passing or falling short of target) due to the COVID-19 Pandemic.

All of the Workforce Indicators are experiencing common cause variation and inconsistency (passing or falling short of target) indicating that the indicators are not stable with the exception of the use of Agency Staff which is consistently failing the target. Readmissions within 30 Days of discharge indicators are experiencing common cause variation and inconsistency (passing or falling short of target).

Adverse Assurance:
Agency Staff used and Agency Spend are consistently failing the target. The majority of the efficiency indicators for the outpatient workstream are showing as consistently failing the target with the exception of the DNA Rates. The majority of the Elective Care workstream indicators are experiencing special cause variation – data outside of control limits and consistently failing the target due to the COVID-19 Pandemic. The 62 Day Cancer Backlog is experiencing special cause variation of an improving nature but is also showing as consistently failing the target now that the target has been set as to where the Trust aspires to be.

Executive Summary Scorecard

Current Month Overview of KPI Variation and Assurance Icons

	Variation					Assurance				Total
Trust Domains		L	H	L	H	P	F	?	No data	
CQC Domain Safe										
Infection Control	3							3	1	4
Harm Free Care	2							2		2
Incident Reporting	2							2		2
Safe Staffing	1							1	1	2
Mortality	1					1				1
Safe Total	***9***	***0***	***0***	***0***	***0***	***1***	***0***	***8***	***2***	***11***
CQC Domain Effective										
Outpatients		1	1	2	1		4	1	2	7
Quality & CQC	3							3	1	4
EPR									5	5
Strategy - Estates									5	5
Strategy - ICP / External									5	5
Effective Total	***3***	***1***	***1***	***2***	***1***	***0***	***4***	***4***	***18***	***26***
CQC Domain Caring										
Complaints	2					1		1		2
Admitted Care					1	1			2	3
ED Care									2	2
Maternity Care									2	2
Outpatient Care									1	1
Caring Total	***2***	***0***	***0***	***0***	***1***	***2***	***0***	***1***	***7***	***10***
CQC Domain Responsive										
Elective Access		2	2				2	2	1	5
Acute and Urgent Access				2	1			3	2	5
Cancer Access	3			1		3	1		1	5
Diagnostics Access		1						1		1
Bed Management				1				1		1
Responsive Total	***3***	***3***	***2***	***4***	***1***	***3***	***3***	***7***	***4***	***17***
CQC Domain Well-Led										
Staff Welfare		2			1		1	2	9	12
Finance and Contracts	1			1	1		1	2	3	6
Leadership and Education									9	9
Strategy - Clinical and ICC									9	9
Workforce	4			1		1	1	3		5
Well-Led Total	***5***	***2***	***0***	***2***	***2***	***1***	***3***	***7***	***30***	***41***
Trust Total	***22***	***6***	***3***	***8***	***5***	***7***	***10***	***27***	***61***	***105***

Corporate Scorecard by CQC Domain

Safe

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
S2	Number of cases C.Difficile (Hospital)	5.0	4.0		
S6	Rate of Total Patient Falls	5.80	6.88		
S7	Number of Never Events	0	0		
S8	Number of New SIs in month	11	7		
S10	Overall Safe staffing fill rate - Estimate	93.5%	90.0%		

Effective

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
E2	Standardised Mortality HSMR	Lower conf <100	93.4		
E3	% Total Readmissions	14.6%	15.8%		
E6	Stroke: Best Practice (BPT) Overall %	50.0%	No data	No Data	No Data
R11	Average LOS Non-Elective	6.80	5.75		
R12	Theatre Utilisation	90.0%	71.5%		

Caring

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
C1	Single Sex Accommodation Breaches	0	0		
C3	% complaints responded to within target	75.0%	68.4%		
C5	IP Friends & Family (FFT) % Positive	95.0%	No data due to COVID-19	No Data	No Data
C7	A&E Friends & Family (FFT) % Positive	87.0%		No Data	No Data
C10	OP Friends & Family (FFT) % Positive	84.0%		No Data	No Data

Responsive

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
R1	Emergency A&E 4hr Wait	91.2%	98.2%		
R4	RTT Incomplete Pathway - Estimate	84.8%	52.6%		
R6	% Diagnostics Tests WTimes <6wks	99.0%	59.3%		
R7	Cancer two week wait	93.0%	93.6%		
R10	Cancer 62 day wait - First Definitive	85.0%	85.7%		

Well-Led

ID	Key Performance Indicators	Plan	Actual	Variation	Assurance
W1	Surplus (Deficit) against B/E Duty	No data	No data	No Data	No Data
W2	CIP Savings	Suspended due to COVID-19		No Data	No Data
W7	Vacancy Rate (%)	9.0%	8.4%		
W8	Total Agency Spend	756	991		
W10	Sickness Absence	3.3%	4.2%		

Variation			Assurance			
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or higher pressure due to (H)igher or (L)ower values	Common cause - no significant change	Variation Indicates inconsistently (P)assing of the target	Variation Indicates inconsistently passing and falling short of the target	Variation Indicates inconsistently (F)alling short of the target	Data Currently Unavailable

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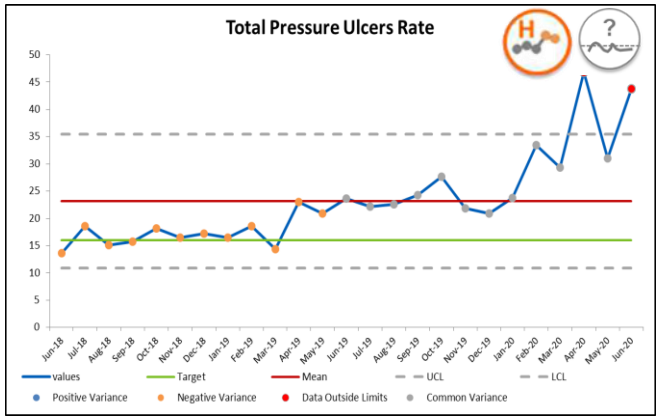
SAFE - CQC Domain Scorecard

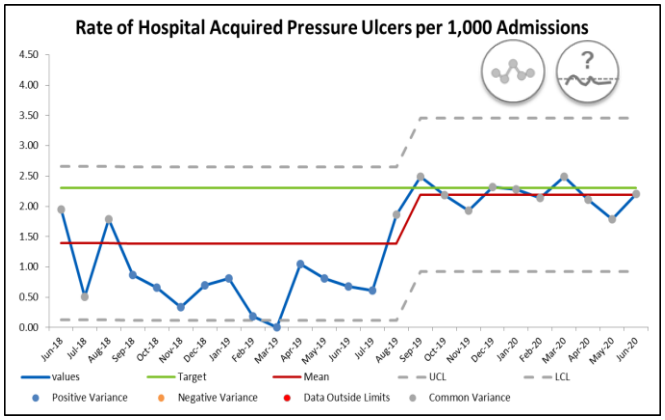
Reset and Recovery Programme: Patient and Staff Safety

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Safe Staffing Levels	93.5%	91.6%	Jun-20		93.5%	90.4%	May-20	93.5%	88.8%	
Sickness Rate - Covid / Non-Covid	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Infection Control - Number of Hospital acquired Covid	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Infection Control - Rate of Hospital C.Difficile per 100,000 occupied beddays	25.6	31.3	Jun-20		25.6	16.4	May-20	24.6	20.2	
Infection Control - Number of Hospital acquired MRSA	0	1	Jun-20		0	2	May-20	0	3	
Infection Control - Rate of Hospital E. Coli Bacteraemia	35.8	31.3	Jun-20		35.8	32.9	May-20	26.3	37.6	
Number of New SIs in month	11.0	7.0	Jun-20		11	9	May-20	33	21	
Rate of Total Patient Falls per 100,000 occupied beddays	5.8	6.9	Jun-20		5.8	8.0	May-20	5.8	7.5	
Rate of Hospital Acquired Pressure Ulcers per 1,000 admissions	2.3	2.8	Jun-20		2.3	2.5	May-20	2.3	2.9	
Standardised Mortality HSMR	100.0	93.4	Jun-20		100.0	92.3	May-20	100.0	93.4	P
Never Events	0	0	Jun-20		0	0	May-20	0	0	

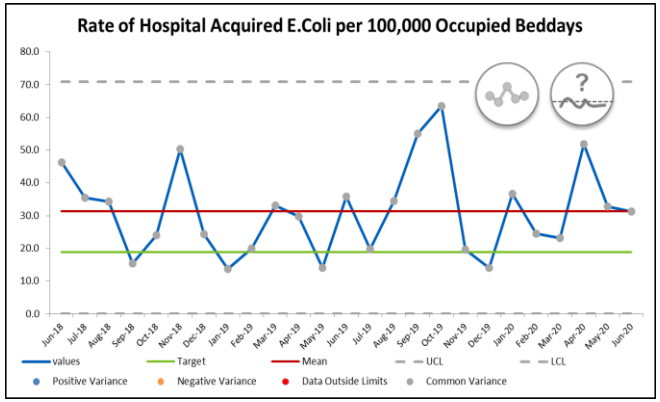
SAFE- Reset and Recovery Programme: Patient and Staff Safety



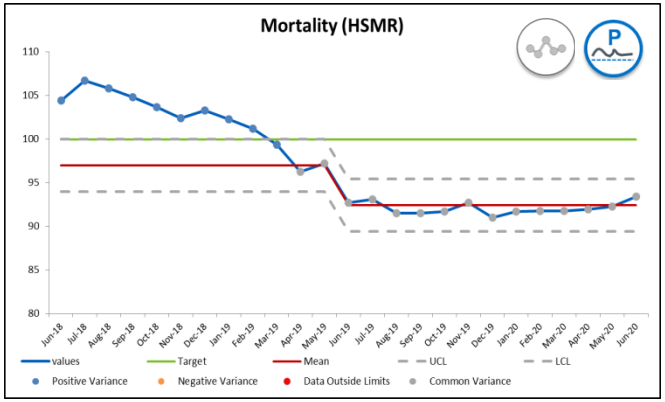
June-20
43.7
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
16.0
Target Achievement
Metric is experiencing variable achievement



June-20
2.8
Variance Type
Metric is currently experiencing common cause variation
Max Target (Internal)
2.3
Target Achievement
Metric is experiencing variable achievement



June-20
31.3
Variance Type
Metric is currently experiencing common cause variation
Max Target
22.7
Target Achievement
Metric is experiencing variable achievement



June-20
93.4
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
100
Target Achievement
Metric is consistently achieving the target

Summary:

Pressure Ulcers: The rate of Hospital Acquired Pressure Ulcers is experiencing common cause variation. However the confidence limits had to be reset as at September 2020 as the new mean is now at a higher level than it was previously, which is concerning. In addition the total rate of pressure ulcers (including those already having pressure ulcers on admission) is also high.

Infection control: Both the rate of E.Coli and the rate of C.Dfficile are experiencing variable achievement (sometimes passing and sometimes falling short of the target), however C.Difficile remains on trajectory YTD whereas E.Coli is above the maximum limit. There was a further case of MRSA reported in June (a relapse in a patient reported in May) and 4 cases of MSSA Bacteraemia.

Actions:

The Tissue Viability Service are monitoring the increased incidence of community acquired pressure damage. Nationwide discussions within the TVN society are hopeful that as the government relaxes its isolation rules, people that are currently declining support services will re-engage.

All new junior doctors receive infection control and antibiotic prescribing training.
Rehydration stations and UTI diagnosis educational resources rolled out across Trust.
Task and Finish group to implement control measures for gram negative blood stream infections.
Further trend analysis on E. coli is underway
Covid-19 Board assurance framework reported to IPCC and Board in June

Assurance:

We continue to triangulate pressure ulcer incidence in COVID positive patients alongside our requirements for data collection from NHS England.
We are working collaboratively with the PDN's and our industry colleagues to help provide pressure ulcer prevention training via Microsoft teams.

Routine cleaning Solution is Diff X across the Trust. HPV and UVC light cleaning remains in place for C diff cases, carriers and multi resistant organisms. Weekly C. difficile huddle held by DIPC and ICT. C. diff and MSSA review panels have been suspended for April and May. To be reinstated for June cases. The Trust will further promote the HOUDINI criteria through staff information cards.

EFFECTIVE - CQC Domain Scorecard

Reset and Recovery Programme: Outpatients

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Percentage of Non-face to face OP activity / Total activity	75.0%	54.8%	Jun-20	H	75.0%	55.8%	May-20	75.0%	14.8%	F
OP Utilisation	85.0%	46.7%	Jun-20	L	85.0%	42.5%	May-20	85.0%	44.2%	F
Outpatient DNA Rate	5.0%	5.2%	Jun-20	H	5.0%	4.6%	May-20	5.0%	4.7%	?
Outpatient Hospital Cancellation	20.0%	20.6%	Jun-20	L	20.0%	28.2%	May-20	20.0%	24.8%	F
Outpatient Cancellations < 6 weeks	10.0%	13.9%	Jun-20	L	10.0%	13.9%	Jun-20	10.0%	34.9%	F
Call time for patients	Coming Soon		Jun-20	No data	Coming Soon		Jun-20	Coming Soon		No data
Reduction in time in OP waiting areas	Coming Soon		Jun-20	No data	Coming Soon		Jun-20	Coming Soon		No data

Organisational Objectives: Quality and CQC

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Total Readmissions <30 days	14.6%	15.8%	Jun-20		14.6%	10.5%	May-20	14.6%	15.2%	?
Non-Elective Readmissions <30 days	15.2%	15.8%	Jun-20		15.2%	10.7%	May-20	15.2%	15.1%	?
Elective Readmissions < 30 Days	7.9%	6.6%	Jun-20		7.9%	7.0%	May-20	7.9%	7.6%	?
Stroke Best Practice Tariff	50.0%	30.0%	Jun-20	No data	50.0%	49.3%	May-20	50.0%	33.1%	No data

EFFECTIVE - CQC Domain Scorecard

Organisational Objectives: EPR

	Latest				Previous			YTD		Target
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Paper notes storage capacity (sqm)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Adverse drug events	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Data protection incidents	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Print costs	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Duplicate tests	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

Organisational Objectives: Strategy - Estates

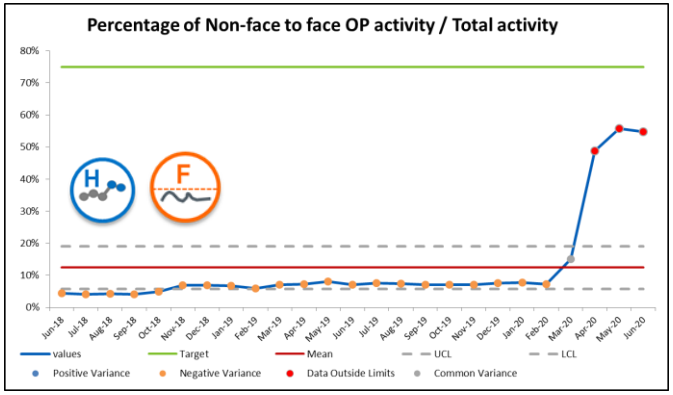
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Utilised and unutilised space ratio	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Footprint devoted to clinical care vs non clinical care ratio	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Admin and clerical office space in (sqm)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Number of people without allocated office space (excludes those allocated to hot desking space)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Aggregated cost per sqm of estate	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

EFFECTIVE - CQC Domain Scorecard

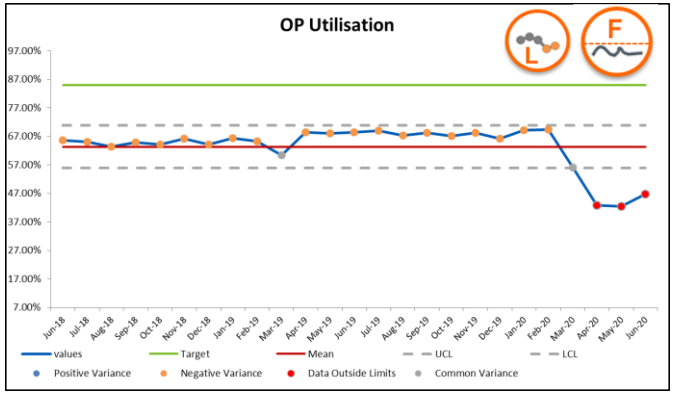
Organisational Objectives: Strategy – ICP/External

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Dementia rate	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Mental health – Children – Hospital admissions as a result of self harm (age 10-24)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Frailty – Admissions due to falls	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
System financial performance (£)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
West Kent estates footprint (sqm)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

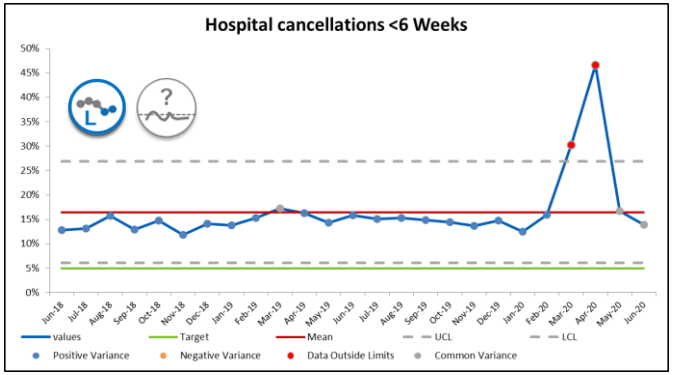
EFFECTIVE- Reset and Recovery Programme: Outpatients



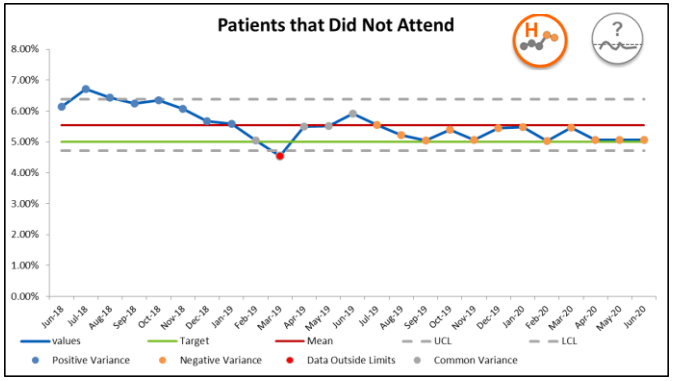
Jun-20
54.8%
Variance Type
Metric is currently experiencing special cause variation - positive performance outside limit
Max Target (Internal)
75%
Target Achievement
Metric is constantly failing the target



Jun-20
46.7%
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
85%
Target Achievement
Metric is constantly failing the target



Jun-20
13.9%
Variance Type
Metric is currently experiencing special cause variation – positive performance below mean
Max Target (Internal)
8%
Target Achievement
Metric is experiencing variable achievement



Jun-20
5.2%
Variance Type
Metric is currently experiencing special cause variation – negative performance above mean
Max Target (Internal)
5%
Target Achievement
Metric is experiencing variable achievement

Summary:	Actions:	Assurance:
As expected due to the COVID-19 pandemic outpatient utilisation levels have decreased. Additionally from the increased use of Attend Anywhere the non-face to face activity levels have increased. After a large increase in hospital cancelations within 6 weeks due to COVID they have reduced to around 14% but are still consistently failing the target.	Outpatient attendances have been impacted by COVID-19 but where clinically appropriate appointments have been moved to either a telephone or virtual appointment to avoid cancellations & DNAs. The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for Outpatients.	Outpatient recovery plan is being considered with the different speciality teams and will be implemented with support from PMO. The demand and capacity remodelling has been completed and shared with the divisions.

CARING - CQC Domain Scorecard

Organisational Objectives – Quality & CQC

	Latest				Previous			YTD		
Outcome Measure	**Plan**	**Actual**	**Period**	**Variation**	**Plan**	**Actual**	**Period**	**Plan**	**Actual**	**Assurance**
Single Sex Accommodation Breaches	0	0	Jun-20	H	0	0	May-20	0	0	P
Rate of New Complaints	3.9	2.4	Jun-20		3.9	1.4	May-20	3.0	1.7	P
% complaints responded to within target	75%	68%	Jun-20		75%	65%	May-20	75%	66%	?
IP Resp Rate Recmd to Friends & Family	25%	No data due to COVID-19	Jun-20	No data	25%	No data due to COVID-19	May-20	25%	No data due to COVID-19	No data
IP Friends & Family (FFT) % Positive	95%		Jun-20	No data	95%		May-20	95%		No data
A&E Resp Rate Recmd to Friends & Family	15%		Jun-20	No data	15%		May-20	15%		No data
A&E Friends & Family (FFT) % Positive	87%		Jun-20	No data	87%		May-20	87%		No data
Mat Resp Rate Recmd to Friends & Family	25%		Jun-20	No data	25%		May-20	25%		No data
Maternity Combined FFT % Positive	95%		Jun-20	No data	95%		May-20	95%		No data
OP Friends & Family (FFT) % Positive	84%		Jun-20	No data	84%		May-20	84%		No data

RESPONSIVE- CQC Domain Scorecard

Reset and Recovery Programme - Elective Care

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
RTT (Incomplete Pathways) performance against trajectory	84.8%	52.6%	Jun-20	L	84.8%	61.5%	May-20	84.8%	52.6%	F
Number of patients waiting over 40 weeks	0	1179	Jun-20	H	0	1060	May-20	0	1179	F
52 week breaches (new in month)	10	146	Jun-20	H	10	113	May-20	30	307	?
Average for new appointment	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Theatre Utilisation	90.0%	71.5%	Jun-20	L	90.0%	84.5%	May-20	90.0%	74.1%	?

Reset and Recovery Programme – Acute & Urgent Care

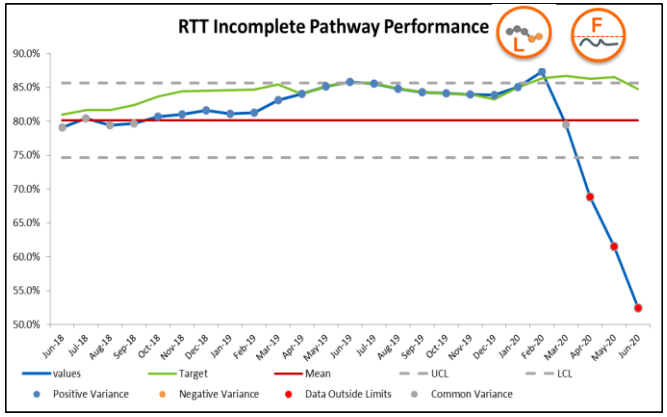
	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Referrals to ED from NHS 111	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
A&E 4 hr Performance	91.2%	98.2%	Jun-20	H	91.2%	98.1%	May-20	91.2%	98.2%	?
Super Stranded Patients	80	44.8	Jun-20	L	80	44.8	May-20	80	44.83	?
Delayed Transfers of Care	3.6%	No data	Jun-20	No data	3.6%	No data	May-20	3.5%	0.0%	No data
Bed Occupancy	90.0%	58.8%	Jun-20	L	90.0%	53.5%	May-20	90.0%	54.0%	?
NE LOS	6.8	5.8	Jun-20	L	6.8	5.3	May-20	6.8	5.8	?

RESPONSIVE- CQC Domain Scorecard

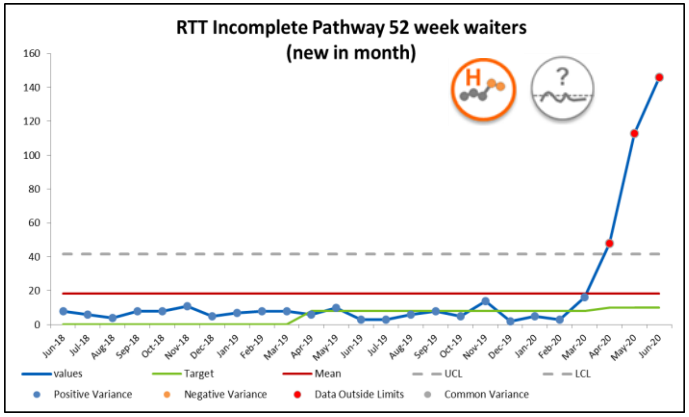
Reset and Recovery Programme – Cancer Services

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Cancer - 2 Week Wait	93.0%	93.6%	May-20		93.0%	93.6%	Apr-20	93.0%	93.6%	P
Cancer - 31 Day	96.0%	98.6%	May-20		96.0%	98.6%	Apr-20	96.0%	98.6%	P
Cancer - 62 Day	85.0%	85.7%	May-20		85.0%	85.7%	Apr-20	85.0%	85.7%	P
Size of backlog	Coming Soon		May-20	L	Coming Soon		Apr-20	Coming Soon		F
Access to Diagnostics (<6weeks standard)	99.0%	59.3%	Jun-20	L	99.0%	59.3%	May-20	99.0%	59.3%	?
28 day Target	Coming Soon		May-20	No data	Coming Soon		Apr-20	Coming Soon		No data

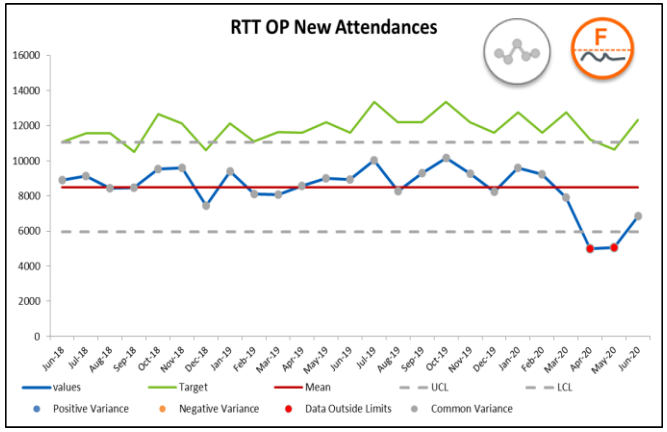
RESPONSIVE- Reset and Recovery Programme: Elective



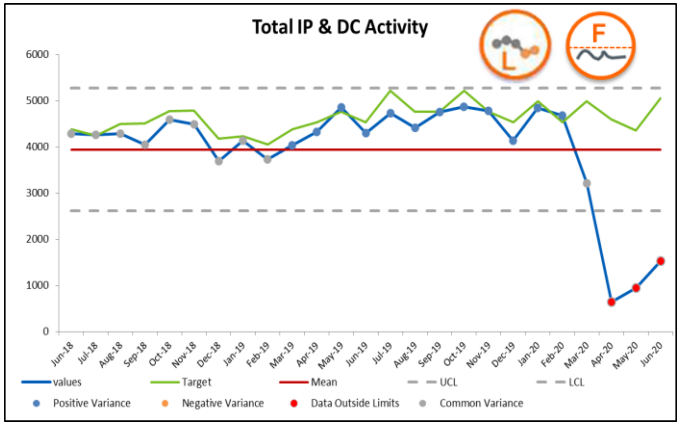
Jun-20
52.6%
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Target
86.3%
Target Achievement
Metric is consistently failing the target



Jun-20
146
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
8
Target Achievement
Metric is experiencing variable achievement



Jun-20
6,855
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
12,334
Target Achievement
Metric is consistently failing the target



Jun-20
1,533
Variance Type
Metric is currently experiencing special cause variation – negative performance outside limit
Max Target (Internal)
5,055
Target Achievement
Metric is consistently failing the target

Summary:

As expected due to the COVID-19 pandemic activity levels continue to remain low for both elective and outpatient appointments which have adversely impacted the RTT performance. June performance deteriorated further to 52.6% (still being finalised).

The activity levels have increased compared to May (+62% for elective and +29% for first outpatients). Large scale cancellations of elective activity has resulted in admitted electives & daycases reducing by 75-80% on normal levels YTD but with an improvement in June 2020. New Outpatient activity has reduced by around 40% and follow up by around 25% YTD with an improvement in June 2020.

Actions:

Due to the COVID response most of the elective activity has ceased apart from urgent cancers being undertaken internally, however some activity continues to be transferred and undertaken in the Independent Sector.

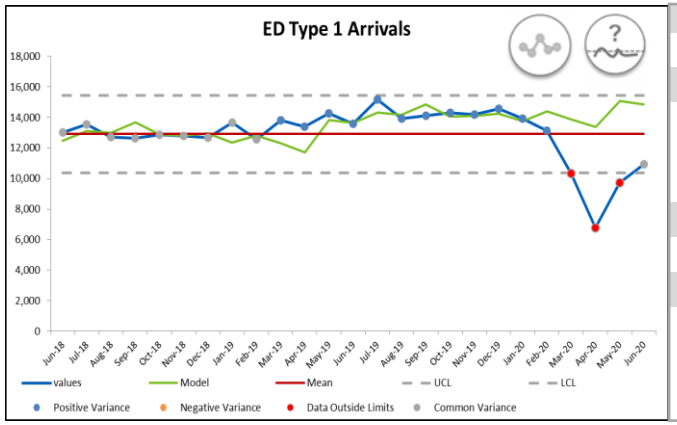
The Trust is reviewing the demand and capacity as part of the Reset and Recovery Programme for the Elective Pathway.

Assurance:

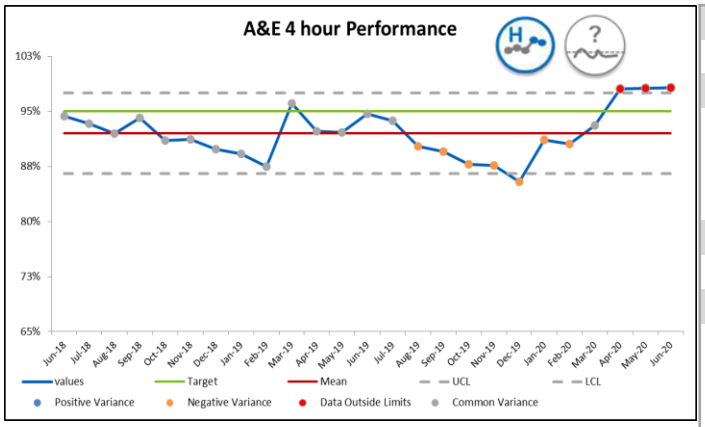
Plans are being implemented in conjunction with the de-escalation of intensive care provision to enable the Trust to increase some in-house theatre activity for cancer and urgent major surgical patients that may require HDU/ITU capacity following guidance from NHSEI.

Activity that has been transferred to the IS will continue.

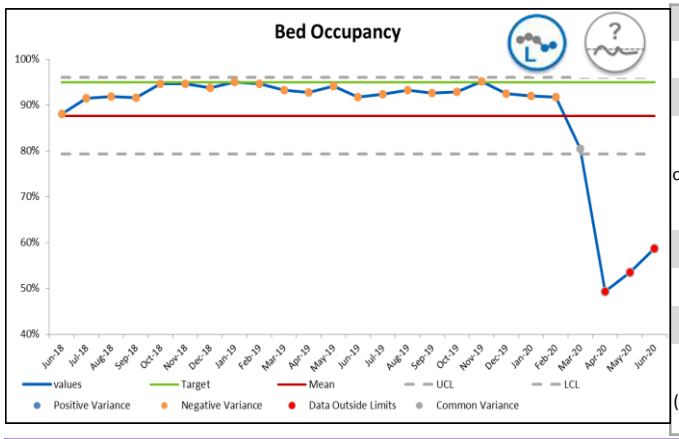
RESPONSIVE- Reset and Recovery Programme: Acute & Urgent Care



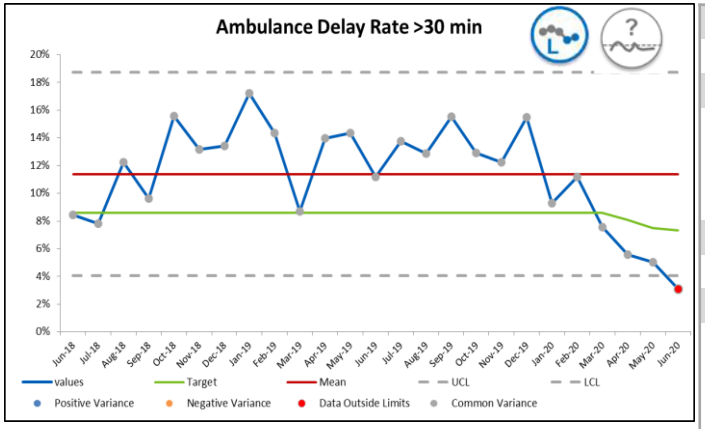
Jun-20
10,923
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
14,840
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Jun-20
98.23%
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Max Target
95.00%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Jun-20
59%
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Max Target
90%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)



Jun-20
3.1%
Variance Type
Metric is currently experiencing special cause variation – positive performance outside limit
Max Target
7.3%
Target Achievement
Metric is experiencing variable achievement (will achieve target some months and fail others)

Summary:

ED arrivals (Type 1) dropped by 55-60% at the height of the pandemic. June came in at 26.4% below model

ED 4hr performance (inc MIU) has now been above 98.0% for 3 months, and in June was a recent record of 98.23% Maintaining top 10 ED performance in the country consistently

Total bed occupancy dropped to under 50% during the pandemic, and is still very low at 59% in June. Greater bed availability has meant improved flow through the emergency pathways.

Ambulance delays have been generally improving since New Year, with a new low of 3.1% of all handovers delayed 30 mins or longer.

Actions:

SDEC running 7 days per week. Ambulance handover plan in place with increased SECAmb / CCG/ MTW working. Development of additional GP led minors clinic on both sites from Jan to support GP streaming.

Continued focus on staff provision and demand analysis. Winter escalation wards are open to support flow and maintain ED Performance. Regular site meetings/ winter huddles to support decision making.

COVID 19 Discharge P3 allowed rapid discharge, however this group of patients are still within the health economy , but are in care homes etc. This has significantly benefitted TWH. Reset requires conversation with social services and CCG

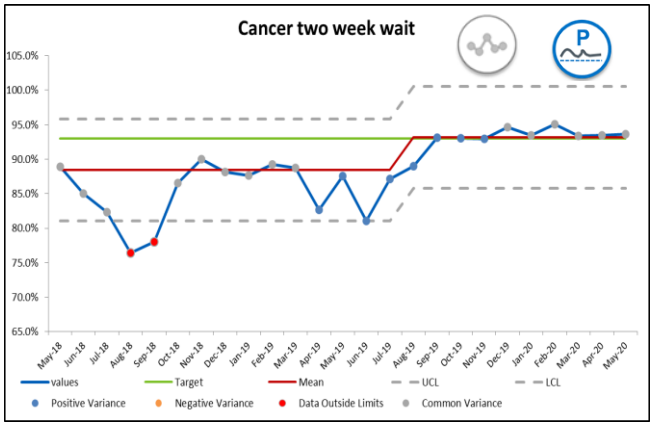
Assurance:

Work continuing to ensure all departments within Trust feel a part of the 4Hour Access Standard –Increased profile on ambulance handovers. Focused bed meetings on actions. System call put in on a daily basis where required when system is tight.

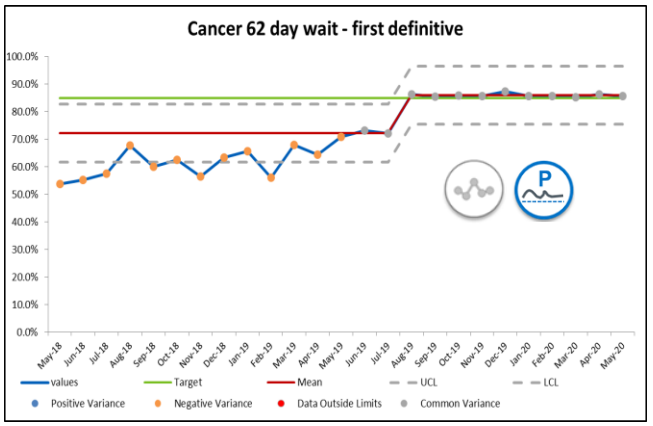
Audit run in both EDs to identify opportunity for GP flow. West Kent programmes suspended during pandemic but now restarting to reassess gaps to bid for implementation of Urgent Treatment Centre and increased appointment booking for non elective attendances.

Daily review of 21+ numbers . MFFD dramatically reduced and being carefully monitored. DTOC suspended.

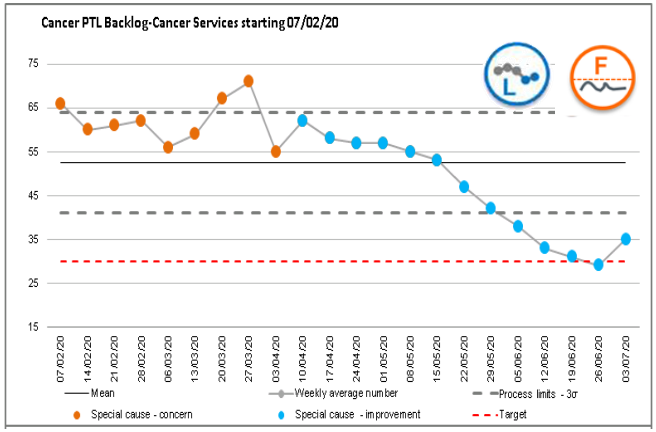
RESPONSIVE- Reset and Recovery Programme: Cancer



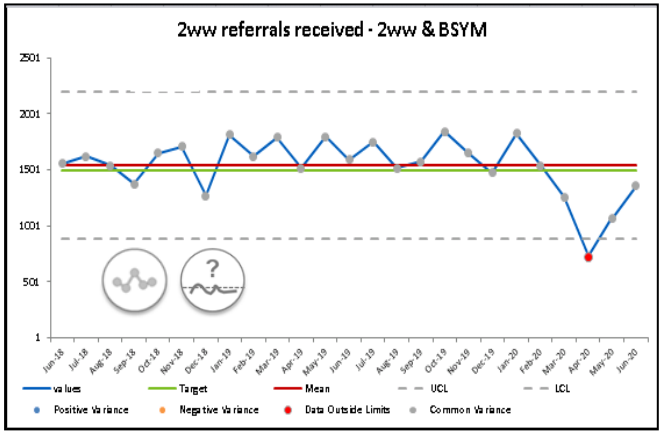
Mayr-20
93.6%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
93%
Target Achievement
Metric is consistently achieving the target



May-20
86%
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
85%
Target Achievement
Metric is consistently achieving the target



Jun-20
35
Variance Type
Metric is currently experiencing Special Cause Variation – positive performance above mean
Max Target
35
Target Achievement
Metric is consistently failing the target



Jun-20
1355
Variance Type
Metric is currently experiencing Common Cause Variation
Max Target (Internal)
1500
Target Achievement
Metric is experiencing variable achievement

Summary:

Continued achievement of the 2ww target with 93.6% in May and for the 62 day target with 85.7%

The number of incoming 2ww referrals dropped significantly in April 2020, with 731 referrals received in comparison to an average of 1355 over the previous months. The numbers increased again through May and June and is currently approx. 80% of the pre-Covid numbers

The overall size of the backlog has been steadily decreasing and with consistent focus, is now averaging around 35 patients passed day 62 on the PTL

Actions:

We have developed Green pathways to fit the Covid-19 requirements and integrated these to achieve the 28 day Faster Diagnosis and the 62 day targets

This is ongoing work and requires further engagement with all services to ensure both that the 28day FDS and 62d performance targets can be met

Services that were stopped during Covid -19 have recommenced (e.g endoscopy and major surgery)

Ongoing recruitment to nursing roles to support the new pathways developed during Covid-19

Assurance:

Daily huddles with each tumour site team are in place and daily PTLs to give oversight and hold services to account for patient next steps. Diagnostic services attend these huddles to escalate booking or reporting delays on the day

The weekly performance meetings now covers funding initiatives and quality assurance i.e. 104 day clinical harm reviews .

EFFECTIVE - CQC Domain Scorecard

Reset and Recovery Programme: Staff Welfare

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of staff adopting flexible / new ways of working post-covid-19 metrics	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Staff Friends and Family % recommended work	57.0%	72.2%	Jun-20	L	57.0%	72.2%	May-20	57.0%	72.2%	?
Staff Friends and Family % recommended care	80.0%	77.8%	Jun-20	H	80.0%	77.8%	May-20	80.0%	77.8%	?
Appraisal Completeness	95.0%	67.2%	Jun-20	L	95.0%	80.9%	May-20	95.0%	67.2%	F
Appraisal % Positive Feedback	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Take up of training and development opportunities – especially middle managers	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Health and Wellbeing metrics	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

Organisational Objectives: Workforce

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Sickness	3.3%	4.2%	Jun-20		3.3%	6.1%	May-20	3.3%	5.1%	?
Turnover	10.0%	11.6%	Jun-20	L	10.0%	11.8%	May-20	10.0%	11.6%	?
Vacancy Rates	9.0%	8.4%	Jun-20		9.0%	9.1%	May-20	9.0%	8.4%	?
Use of Agency	77	120	Jun-20		77	222	May-20	77	120	F
Stat and Mandatory Training	85.0%	85.2%	Jun-20		85.0%	85.3%	May-20	85.0%	85.4%	P

WELL LED - CQC Domain Scorecard

Reset and Recovery Programme: Finance & Contracts

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Surplus (Deficit) against B/E Duty	No data		Jun-20	No data	No data		May-20	No data		No data
CIP Savings	Suspended		Jun-20	No data	Suspended		May-20	Suspended		No data
Cash Balance	Not available	58,024	Jun-20	H	Not available	49,236	May-20	Not available	58,024	No data
Capital Expenditure	Not available	437	Jun-20		Not available	606	May-20	Not available	1,977	No data
Agency Spend	755,908	991,375	Jun-20	L	755,908	1,464,908	May-20	2,360,481	3,640,493	F
Use of Financial Resources	3	No data	Jun-20	No data	3	No data	May-20	No data		No data

Reset and Recovery Programme: Social Distancing / Home Working

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of staff home working against plan	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Staff swabbing compliance against guidelines	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Compliance with risk assessments e.g. BAME / at-risk staff / VDU	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Use of associated technology e.g. MS Teams	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Staff reporting having the equipment they need to comply with rules	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

WELL LED - CQC Domain Scorecard

Reset and Recovery Programme: ICC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Implementation of Teletracking	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
PPE availability	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Nursing vacancies	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Covid Positive - number of patients	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

Reset and Recovery Programme - Education / KMMS

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of medical students at Trust	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Number of clinical academic posts	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Number of non-medical educators	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
% of students reporting a good or better educational experience	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
% of medical students retained as FY1s	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

WELL LED - CQC Domain Scorecard

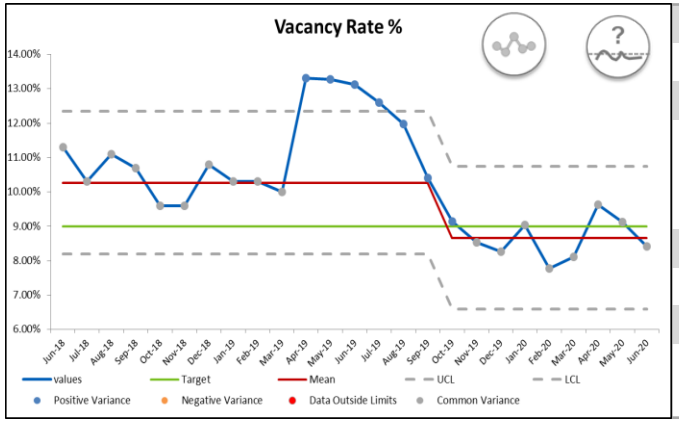
Organisational Objectives - Strategy – Clinical

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
Number of specialist services per directorate	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Volume of activity being sent to London	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Service contribution by division	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Research grants (£)	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Number of advanced practitioners	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

Organisational Objectives - OD / EPOC

	Latest				Previous			YTD		
Outcome Measure	Plan	Actual	Period	Variation	Plan	Actual	Period	Plan	Actual	Assurance
SLDP participation and feedback metrics	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Leadership & Talent Development Strategy Metrics	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Culture and Leadership Programme Phase 2 (discovery) intervention Metrics	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data
Equality, Diversity and Inclusion reducing inequalities metrics / dashboard	Coming Soon		Jun-20	No data	Coming Soon		May-20	Coming Soon		No data

WELL LED- Operational Objective: Workforce



June-20

8.42%

Variance Type

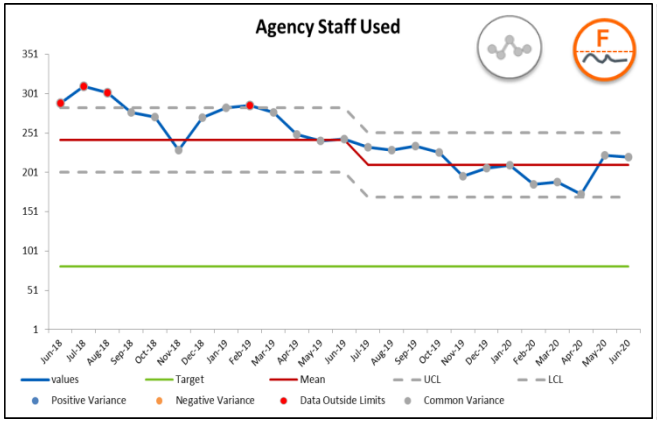
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

9%

Target Achievement

Metric is experiencing variable achievement



June-20

220

Variance Type

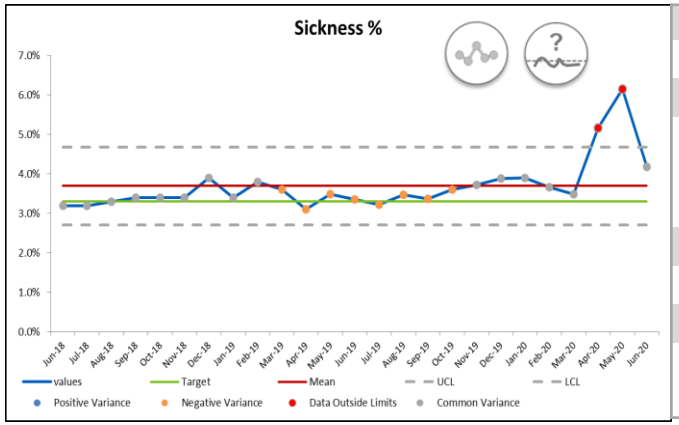
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

81

Target Achievement

Metric is constantly failing the target



June-20

4.2%

Variance Type

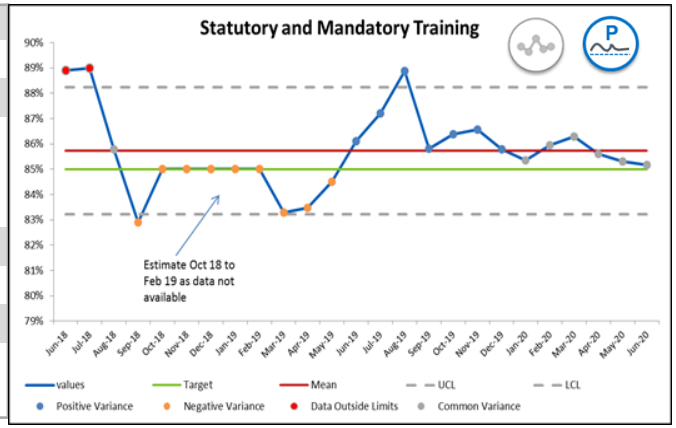
Metric is currently experiencing Common Cause Variation

Max Target (Internal)

3.3%

Target Achievement

Metric is experiencing variable achievement



June-20

85.2%

Variance Type

Metric is currently experiencing Common Cause Variation

Max Target (Internal)

85%

Target Achievement

Metric is consistently achieving the target

Summary:

The Vacancy rate is experiencing common cause variation now that the confidence limits have been reset from October 2019 as the new mean is now a lower vacancy rate than it was previously which shows the improvement that has been made. It rose above target in April due to the new posts being added as part of business planning . June achieved target. The level of Agency staff used is consistently higher than plan. Sickness levels have reduced in June and the metric is now experiencing common cause variation following the peak outside the control limits in April and May due to COVID-19. The rate went back within the control limits in June . The proportion that is due to COVID-19 has reduced to 1%.

Actions:

Analysis of the staff sickness rate shows: Non-Covid related sickness has continued to reduce during June and is achieving the target. The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply after the national lockdown on the 23rd March but has started to show a downward trend since mid-April.

Assurance:

Delivery of 2020/21 Workforce plans are supported by the HRBP and workforce information teams.

Divisions are reviewing existing workforce and recruitment plans in light of changes driven by COVID reset and recovery work.

Staff engagement and retention work is supported by divisional action plans for the national staff survey and local pulse checks. Progress against these action plans is reviewed in Divisional Performance reviews.

Appendices

Supporting Narrative

Executive Summary

The Trust has achieved the National Cancer 62 Day FDT Standard of 85% for ten consecutive months at 91.8%. The 2 week wait cancer waiting time target remained above target for the ninth consecutive month with Breast Symptoms also achieving the target following the dip in performance last month. In addition, June performance increased further to 98.23% for the A&E 4hr standard and the Trust remains one of the best performing Trusts in the UK. As expected due to the COVID-19 pandemic activity levels remained low in June for both elective and outpatient appointments , however the numbers have increased compared to May (+62% for elective and +29% for first outpatients). The low activity has adversely impacted the RTT performance in April, May and June and of the constitutional standards the RTT and Diagnostics standards are most at risk in future months due to the likely decrease in capacity (with the impact of social distancing and use of PPE) and the uncertainty as to the likely level of demand. Modelling the possible demand vs capacity has taken place as part of the Trust's Reset and Recovery Programme including some cancer and urgent activity continuing to be transferred and undertaken in the independent sector.

Key Performance Items:

- **Infection Control:** There was a further case of MRSA bacteraemia reported in June (a relapse in a patient reported in May). There were 4 cases of C.Diff reported in June, but the Trust remains on trajectory. Cases of Gram Negative Bacteraemia and MSSA have remained similar with the rate of E.Coli per 100,000 occupied beddays above the threshold.

- **Falls:** The level of Falls has reduced in June across both sites but remains above the mean. Maidstone Falls are now below the mean. The level of occupied beddays continues to be reduced in June due to COVID-19 (5% increase on May) which may have impacted the overall rate. Review of falls on wards with high number of falls (above threshold set)were located at TWH site. Ward managers to promote Falls Safety Huddle and focus on increased vigilance for patient at risk of falls.

- **Pressure Ulcers:** The level of hospital acquired pressure ulcers (HAPU) has increased further in June equating to a rate of 2.2 against a maximum limit of 2.3. Once again the level of admissions was reduced in June due to COVID-19 but was higher than in May 2020. The Trust continues to triangulate pressure ulcer incidence in COVID positive patients alongside our requirements for data collection from NHS England. We are working collaboratively with the PDN's and our industry colleagues to help provide pressure ulcer prevention training via Microsoft teams.

- **Stroke:** Due to a technical issue with the national reporting system the performance data for he Best Practice Indicators is currently unavailable.

- **A&E 4 hour Standard:** Performance in June improved further to 98.23% due to robust processes in place and excellent staff engagement as per the recent CQC report. While there have been lower attendance numbers, there have been considerable changes to working practices and patient pathways in response to the COVID-19 Pandemic. One of the key improvements is the assessment of all patients at the front door on both sites by the First Contact Practitioner to stream the patients effectively or redirect to MIUs. The Trust remains one of the best performing Trusts in the UK for the 4hr standard. The pandemic reduced A&E attendance to 55-60% of the normal levels in early April. They have since increased to around 75% of normal levels. Minor attendances have been reduced more than major attendances and ambulance arrivals are now around 5% lower than normal. Emergency Admissions are now around 20% to 25% lower than the normal levels, with the total bed occupancy increasing from around 42% in April to around 59% in June.

- **Ambulance Handover Delays**: The ambulance handover scores improved significantly in the weeks before the pandemic, and although they improved significantly during the pandemic, they have continued to improve as activity has been returning to normal. Ambulance handover delays are now at a new low of 3.1% of all handovers delayed 30 mins or longer. This is therefore outside of the lower confidence level.

Supporting Narrative Continued

- **Referral to Treatment (RTT) Incomplete Pathway:** As expected due to the COVID-19 pandemic activity levels continue to remain low for both elective and outpatient appointments, however the numbers have increased compared to May (+62% for elective and +29% for first outpatients). This has adversely impacted the RTT performance. June performance deteriorated further to 52.6% (still being finalised).

- **Outpatient Activity Face to Face vs Virtual:** The level of virtual outpatient activity for first (new) appointments is showing an increasing trend week on week form around 7.5% prior to the COVID-19 Pandemic to a high of around 43% in June. For follow up appointments this has also seen an increasing trend but at an even higher level from around 8% prior to Covid to around 62% in June The increased use of Virtual vs Face to Face outpatient appointments (where clinically appropriate) is part of the Trust's Reset and Recovery Programme.

- **Cancer 62 Day:** The Trust continues to report achievement of the 62 day standard with 85.7% for May 2020. This is the tenth consecutive month of achievement and a significant improvement over last year when only 64.5% of our patients were treated in 62 days. The current number of treatments is 80% of the average monthly totals from 2019-20.

- **Cancer 2weeks (2ww):** The Trust has maintained achievement of the 2ww standard from September 2019, reporting 93.6% for May 2020. Following the dip in performance seen last month Breast Symptoms achieved the target in June, reporting 94.1.

- **Cancer 2weeks (2ww) Referrals:** After the drop in referral numbers at the beginning of April due to COVID-19, the incoming referrals are increasing weekly and the numbers received are currently up to 81% of the average daily referrals from January / February 2020.

- **Diagnostics Waiting Times <6 weeks:** As expected performance since April has been adversely impacted by COVID-19. June performance increased but remains low at 59.3%.

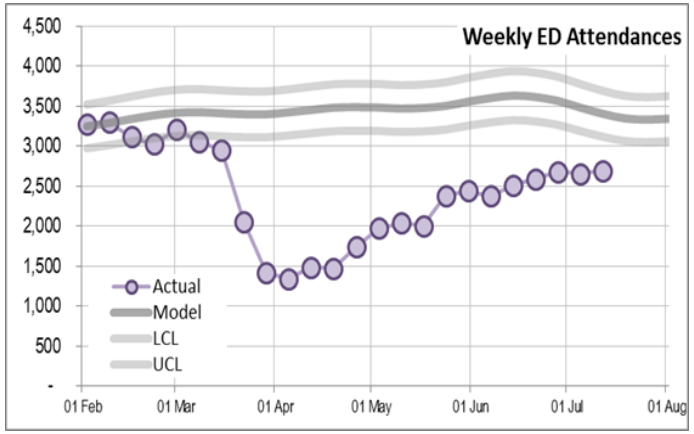
- **Finance:** The Trust has delivered a breakeven financial position which includes £5.5m retrospective top up income support. The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £9.7m, the Trust plan assumed £1.4m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £5.6m have been made to net down the impact to £5.5m. The key underspends to plan are: Drugs (£2.5m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£2.6m) mainly within Nursing (£0.9m), STT (£0.8m) and A&C (£0.6m) staff groups due to higher than planned vacancies, £1.4m underspend within clinical supplies due to reduction in elective activities and £0.4m underspend within independent sector usage. These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reserve), EPR project costs (£0.3m), increase in expected credit loss (£0.2m), income reductions within Diagnostics relating to independent sector activity (£0.2m), increase in reserves(£0.1m) and £0.1m 2019/20 clinical income contract settlement.

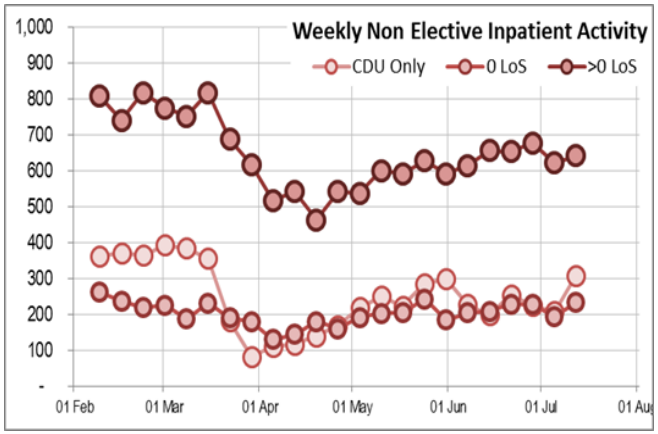
- **Workforce - Various:** The Safe Staffing Nursing Fill Rate remained similar in June but remains below usual levels which has impacted on the overall fill rate. There has not been any staffing level risk to wards. Agency staff usage has remained similar and above the desired levels. Sickness levels have reduced in June and the metric is now experiencing common cause variation following the peak outside the control limits in April and May due to COVID-19. The proportion that is due to COVID-19 has also reduced to 1% and therefore the non-covid sickness is achieving the target. June Vacancy rate decreased to 8.4%, therefore achieving the target.

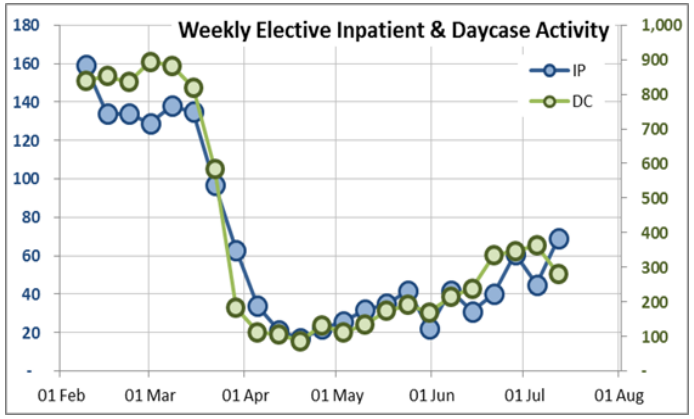
- **Staff and their Families Swabbing:** Capacity is higher than uptake with an average utilisation of 12% in June, although this was higher at weekends. The drive-through is less utilised than the two PODs at Maidstone and Tunbridge Wells Hospitals which is bringing down the overall utilisation rate.

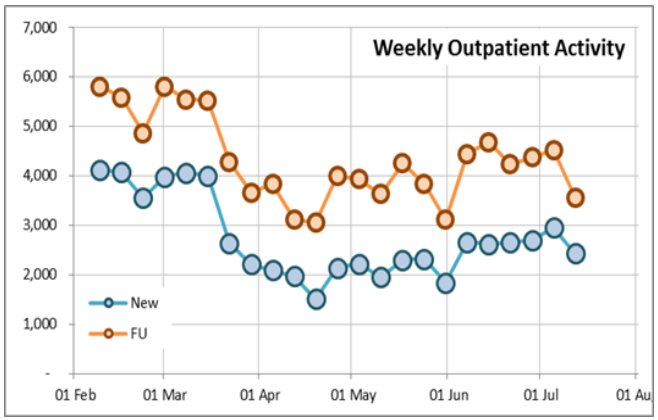
- **COVID-19 Tests:** There has been a gradual increase in the levels of testing and capacity has been increased to support the need. Total tests have now technically exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just under 600 total tests, and over 200 a day on staff. The percentage of tests showing positive has dropped to <1% The Trust has also been undertaking the antibody test.

Escalation: COVID-19









ED Attendances: Attendances fell by around 60% against model at the height of the pandemic, but have since been recovering steadily. June attendance were 31% down on model, and the week ending 12-July was 21% down. Ambulance arrivals dropped by around 30% at the height of the pandemic, and have recovered more strongly, with the last two weeks being only ~5% lower than average, and within normal ranges. Assessment at the door of ED is now occurring, which is preventing much of the lower end of the acuity scale from attending,

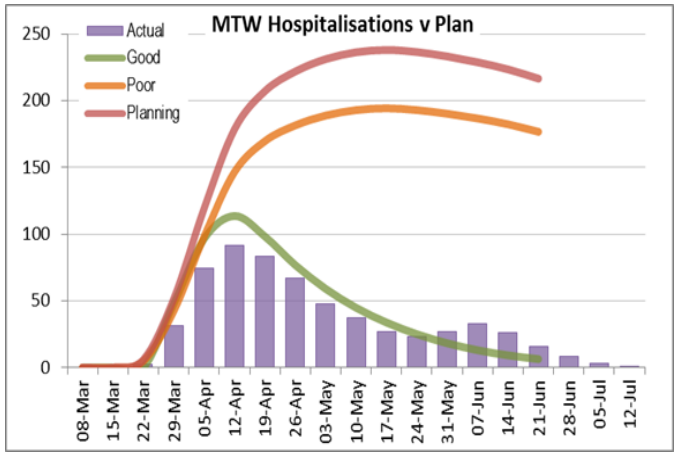
Emergency Admissions: Non-zero emergency admissions have been around 20% down on normal over the past 3 weeks, whilst zero LoS admissions are down around 5-10%. CDU Only remains down by ~30%, but this is due to a reduction in use of CDU in addition to the reduction seen in ED attendances.

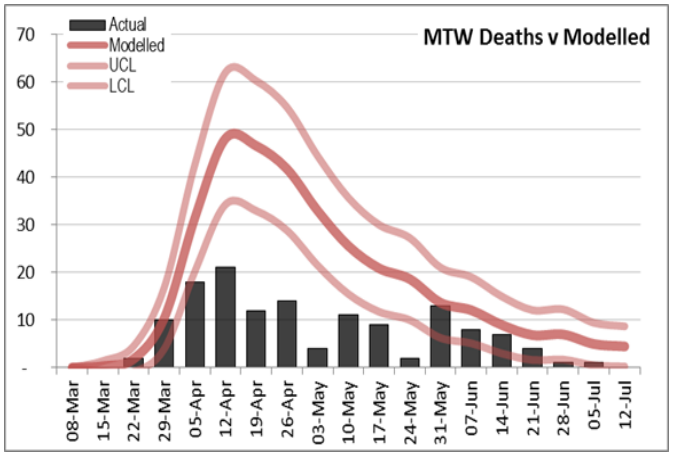
Elective / Daycase Activity: Large scale cancellations of elective activity has resulted in admitted electives reducing by 75-80% on normal levels, and daycases also 80-85%. They have both recovered steadily, and are currently sitting around 60% down on normal. Both these are expected to recover more strongly in the next few weeks as the trust restart programmes come into effect.

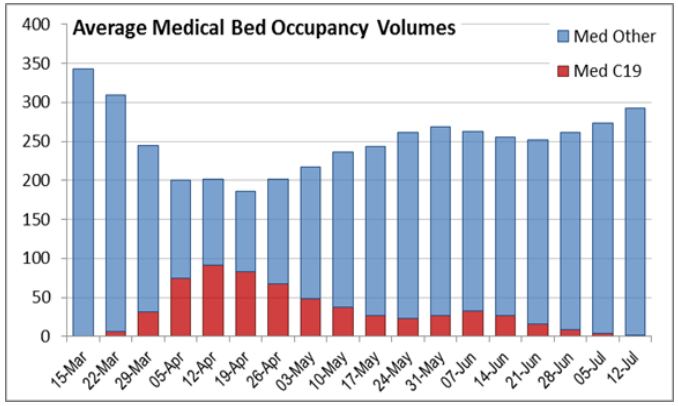
Outpatient Activity: New Outpatient activity is still 30-35% down, and follow up by around 25% down on normal, though the latest week is probably subject to an undercount, with some uncashed appointments still in the system. As with elective activity, the week-by-week reduction has been slower than seen in emergency activity.

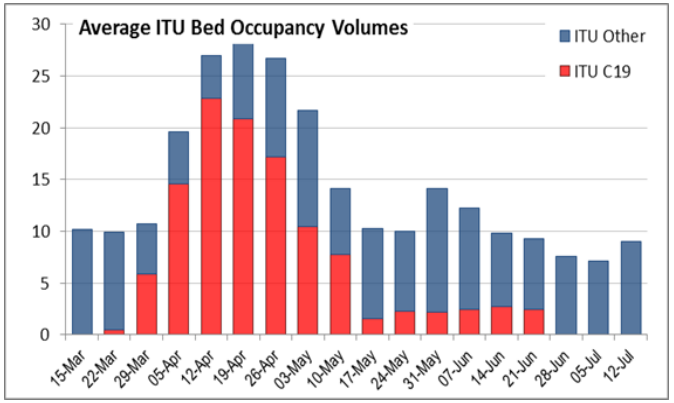
Summary : All activity is down, but recovering steadily
Minor ED attendances now 20-25% down, major down ~5%
Emergency admissions down around 20%
Daycase & elective activity down ~60%
Total Outpatient activity down 25-30%, with new down a little more than Follow Up

Escalation: COVID-19









Caseload v Planning: The bed planning figures only ran until 21-June. MTW saw a small resurgence in cases in early June, with numbers going back up into the 30s. This was not a reflection of the national trend, which has been falling fairly consistently despite relaxations to lockdown rules. Over the past 2 weeks, numbers have come down into single figures, and over the weekend 11th – 12th July, we actually had no cases

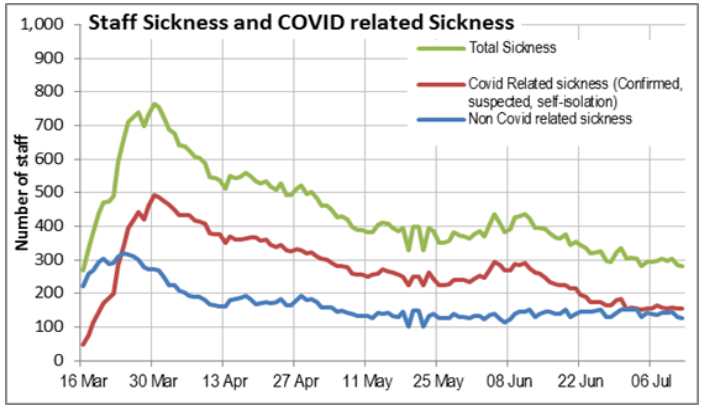
Deaths: The national total being quoted daily is hospital deaths. If deaths were spread evenly throughout the country, then by Sun 12-Jul, we would have expected our cumulative total to be 330-340. In reality it was less than half that at 137, and we have not seen a reportable death since 29-June.

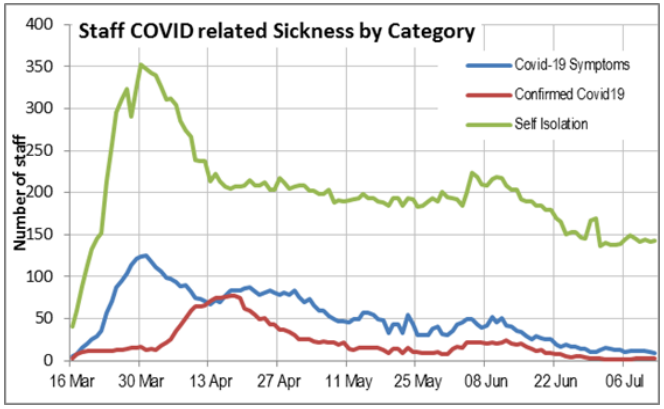
Bed Occupancy: Medical bed occupancy started to reduce from its normal level of 330-360 patients around 16-Mar, as a combination of reduced emergency demand, and the emergency plan to clear beds & reduce elective activity took effect. Occupancy was below 300 as the first cases came in, went down to 180-220 at the peak in early April, and is now back into the high 200s.

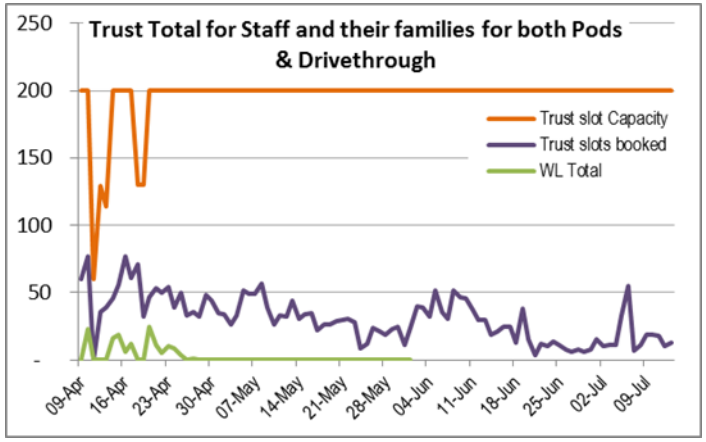
ITU Occupancy: This was around normal levels of 8-12 for the two weeks before the first patients arrived, before rising sharply to 25-30. ITU has now been Covid-free for 3 weeks.

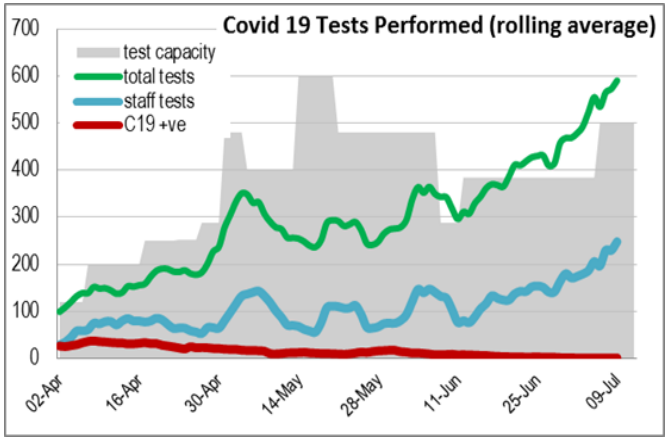
Summary : MTW caseloads & deaths have both been tracking well below what we would expect. In the past few weeks, C19 cases have been in single figures & deaths have approached zero.

Escalation: COVID-19









Staff Non-Covid related sickness peaked at just over 300 in late March, but have now come back down to normal levels of an average of under 130-150 per day

Covid-19 Related Sickness: The COVID-19 related sickness which includes; confirmed cases, suspected cases and self-isolation increased sharply at first, peaking at just under 500 at the end of March. This fell down below 250 in May, came up in June at the same time as the hospital saw an increase in admissions, but has since come back down into the 150-170 range. This is a combination of confirmed & unconfirmed symptomatic & self isolation

Self-Isolation: Similar to covid related sickness, this peaked in early April (~350), fell & stabilised in May (200-220), increased a little in June when our admissions came back up, and have since fallen back to 140-150 per day

Swabbing: Overall Trust slot capacity for staff and their families increased throughout April and is currently at 200 slots available per day (a slot could have 1 to 6 people attending depending how many in the family require swabbing). The number of tests booked has averaged just 16 over the last 4 weeks.

Pathology – COVID-19 Tests Performed: Total tests have now technically exceeded testing capacity, as we are now outsourcing some of our tests. We are currently averaging just under 600 total tests, and over 200 a day on our staff. The percentage of tests showing positive has dropped to <1%

Summary: Non-Covid related sickness is back to the sort of levels we expect, and both Covid related sickness & self isolation rose in early June along with hospital admissions, indicating a local infection hotspot around that time. Testing continues to rise, with totals approaching 600 per day, and 250 per day on staff

Review of latest financial position

- The Trust delivered the year to date and June's financial position by achieving a breakeven position. In line with national guidance this included retrospective top up income support from NHSE/I (£5.5m YTD, £0.5m in June). This funding is designed to cover the incremental step changes of COVID 19 above the baseline funding (November to January average) but is capped to the level of funding which is required for the Trust to breakeven.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £9.7m year to date (£2.4m in June). The Trust plan assumed a £1.4m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £5.6m have been made to net down the impact of COVID 19 costs to £5.5m.
- The key year to date variances to plan are as follows:
  - Drugs underspend mainly due to reduction in Oncology and Ophthalmology high cost drugs (£2.5m)
  - Pay underspends mainly within Nursing (£0.9m) A&C (£0.6m) and STT (£0.8m) staff groups due to higher than planned vacancies (£2.6m)
  - Clinical supplies underspend (£1.4m) due to reduction in elective activities.
  - Car Parking pressure (£0.3m)
  - Laundry increase in dilapidation reserve (£0.2m)
  - EPR project costs pressure (£0.3m)
  - Income reductions within Diagnostics relating to independent sector activity (£0.2m)
  - Increase in contingency reserves (£0.1m).
- The key current month variances are as follows:
  - Income excluding Top up income support and pass-through related costs is £0.7m adverse to plan. The main pressures related to the reduction in catering and car parking income (£0.3m) which has been included in the COVID impact schedule, £0.2m adverse variance relating to private patients, £0.1m underperformance associated with injury cost recovery and £0.1m reduction in Pathology independent sector charges.
  - Pay budgets adjusted for pass-through items underspent by £0.1m in June, the level of pay spend reduced by £1m between months to £25.2m, however this is still £0.6m higher than winter escalated levels. Medical staffing was the main staff group which reduced spend between months (£0.8m), this reduction was across all divisions with the largest reduction within Critical care (£0.2m) due to changes associated with ITU medical rota. The largest staff group underspent (£0.2m in month £0.6m YTD) relates to Scientific and Technical due to vacancies within Diagnostics (£75k) and Medicine (£75k). The level of nurse agency spend (£0.2m in June) is at record lows, this is £0.3m lower than the average for 2019/20.
  - Non Pay budgets adjusted for pass through items underspent by £0.4m in June which included £0.5m COVID related costs therefore a net £0.9m underspend within budgets. The key underspends to budget are: Drugs (£0.8m) mainly due to reduction in high cost Ophthalmology and Oncology drugs, clinical supplies (£0.3m) due to reduction in elective activity (mainly impacting pacemakers, pathology reagents and hearing aids) and £0.2m reduction in outsourcing costs (reduction in MRI and Endoscopy activity), these underspends were partly offset by £0.5m increase in expected credit losses associated with injury recovery income for 2014/15 and 2015/16.
- The closing cash balance at the end of June 2020 was £58m which is similar to the closing cash balance at the end of May. The slightly higher than normal balance is due to the Trust receiving an advance on SLA income within April.
- Capital spend by the end of month three is £1.98m of which £1.4m relates to Covid 19 equipment, ICT and estates costs – these costs have been submitted to NHSE/I as part of the funding claims and discussions remain ongoing. The main other area of cost is expenditure related to the ongoing EPR programme.
- The Trust re-submitted its capital plan in line with the STP/ICS level control total on the 17th June. If the overall plans are approved by DHSC then the Trust is expecting to be able to access the element of the local control totals that includes external PDC funding, in addition to its internally generated funds (which include the £2m of cash for asset sales brought forward from 2018/19).
- The Trust has received approval for £190k capital PDC to support the Kent & Medway Care Record system. The Trust was also notified that it is entitled to funding for replacement Breast Screening vans and units under phase 2 of the national Diagnostic Fund, and is working through the national Procurement process

Maidstone and Tunbridge Wells NHS

1. Dashboard

June 2020/21

	Current Month						Year to Date					
	Actual £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*	*Actual* £m	*Plan* £m	*Variance* £m	Pass-through £m	*Revised Variance* £m	*RAG*
Income	41.6	42.3	(0.7)	(0.1)	(0.6)		128.3	126.9	1.4	(0.3)	1.8	
Expenditure	(39.1)	(39.7)	0.6	0.1	0.5		(121.0)	(119.1)	(1.8)	0.3	(2.2)	
EBITDA (Income less Expenditure)	2.5	2.6	(0.1)	(0.0)	(0.1)		7.4	7.8	(0.4)	(0.0)	(0.4)	
Financing Costs	(2.5)	(2.6)	0.1	0.0	0.1		(7.5)	(7.8)	0.3	0.0	0.3	
Technical Adjustments	0.0	0.0	0.0	0.0	0.0		0.1	0.0	0.1	0.0	0.1	
Net Surplus / Deficit (Incl Top Up f	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**		**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**	
Cash Balance	58.0						58.0					
Capital Expenditure	0.4						2.0	3.2	1.2		1.2	

Summary Current Month:

- The Trust delivered the financial plan in June by achieving a breakeven position. In line with national guidance this included £0.55m retrospective top up income support from NHSI/E. This funding is designed to cover the incremental step changes of COVID 19 above the baseline funding (November to January average) but is capped to the level of funding which is required for the Trust to breakeven.
- The Trust in June has identified £2.4m of costs and income reductions associated with COVID 19 however this includes £0.3m of costs incurred in April and May which were previously not reported as COVID 19 therefore the actual impact in June is £2.1m. The Trust plan assumed £0.45m top up would be required to achieve a balanced position (before COVID costs) therefore underspends totalling £2m have been made to net the impact down to £0.55m. The key underspends against plan are: Pay budgets £1.4m which is across all staff groups, Drugs £0.8m due to reduction in high cost Cancer and Ophthalmology drugs, £0.3m clinical supplies due to reduction in elective activity, £0.2m underspend within independent sector usage, £0.1m depreciation less than planned. Overspends due to pressures associated with expected credit losses (£0.5m) mainly relating to 2014/15 and 2015/16 injury recovery income and £0.1m 2019/20 clinical income contract settlement.

Year to date overview:

- The Trust has delivered a breakeven financial position which includes £5.5m retrospective top up income support.
- The Trust has identified financial pressures (increase in costs and reduction in income) due to COVID 19 of £9.7m, the Trust plan assumed £1.4m top up would be required to achieve a balanced position (before COVID costs) therefore underspends within the plan of £5.6m have been made to net down the impact t o £5.5m. The key underspends to plan are: Drugs (£2.5m) mainly due to reduction in Oncology and Ophthalmology high cost drugs, pay underspends (£2.6m) mainly within Nursing (£0.9m), STT (£0.8m) and A&C (£0.6m) staff groups due to higher than planned vacancies, £1.4m underspend within clinical supplies due to reduction in elective activities and £ 0.4m underspend within independent sector usage. These underspends are partly offset by pressures associated with Car Parking (£0.3m), Laundry (£0.2m increase in dilapidation reser ve), EPR project costs (£0.3m), increase in expected credit loss (£0.2m), income reductions within Diagnostics relating to independent sector activity (£0.2m), increase in reserves(£0. 1m) and £0.1m 2019/20 clinical income contract settlement.

Key Points:

- In line with Mays funding assumption the Trust received £1.4m retrospective top-up income from NHSI/E on the 15th July.

Risks:

- The Trust won't be notified by NHSI/E of the final retrospective top up value for June until the 15th August

2. COVID 19 Expenditure and Income Impact

2020/21 Summary of Cost Reimbursement

Total Revenue (£000s):	8,408

Breakdown by Allowable Cost Type	£000s
Expanding medical / nursing / other workforce	238
Sick pay at full pay (all staff types)	0
COVID-19 virus testing (NHS laboratories)	980
Remote management of patients	0
Support for stay at home models	0
Direct Provision of Isolation Pod	0
Plans to release bed capacity	0
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	1,461
Segregation of patient pathways	1,281
Enhanced PTS	0
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0
Existing workforce additional shifts	728
Decontamination	0
Backfill for higher sickness absence	946
NHS 111 additional capacity	0
Remote working for non patient activites	224
National procurement areas	1,551
Other	1,000

Summary: Loss of income

Total (£000s):	1,265

Breakdown by income type	£s
Car parking income	422
Catering	107
Pathology Trade Income	120
Private Patient Income	300
Injury Recovery Income	54
Research and Development	154
Other	109

Grand Total

Total (£000s):	9,673

Commentary:
The Trust has identified the financial impact relating to COVID to be £9.7m, which includes £8.4m associated with additional expenditure and £1.3m due to lost income (mainly commercial income).

The main cost includes purchase of PPE, pathology testing, staff welfare such as providing meals, purchase of IT equipment and software licenses to enable staff working from home. Additional shifts required in ED, ITU areas, sickness cover, additional on calls and extended opening hours for support teams.

The Trust has received the funding relating to May 2020 retrospective top up funding (£1.4m). The Trust will be notified on the 15th July of the retrospective top up funding for June (£0.5m).

Planned Vs Actual staffing data

Jun-20		DAY				NIGHT				TEMPORARY STAFFING								Financial review		
Hospital Site name	Health Roster Name	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Average fill rate registered nurses/midwives (%)	Average fill rate care staff (%)	Average fill rate Nursing Associates (%)	Average fill rate Training Nursing Associates (%)	Bank/Agency Usage	Agency as a % of Temporary Staffing	Bank / Agency Demand: RN/M (number of shifts)	WTE Temporary demand RN/M	Temporary Demand Unfilled -RM/N (number of shifts)	Overall Care Hours per pt day	Falls	PU ward acquired	Comments	Budget £	Actual £	Variance £ (overspend)
MAIDSTONE	Stroke Unit (M) - NK551	121.9%	85.3%	-	100.0%	114.9%	96.1%	-	-	13.3%	12.5%	28	1.90	1	13.5	2	0		118,547	156,236	(37,689)
MAIDSTONE	Cornwallis (M) - NS959	91.3%	72.4%	-	100.0%	70.0%	90.9%	-	-	2.0%	0.0%	2	0.14	0	22.3	0	0		80,201	73,484	6,717
MAIDSTONE	Culpepper Ward (M) - NS551	91.4%	114.4%	-	-	100.9%	103.3%	-	-	10.8%	21.1%	36	2.45	3	10.2	0	0		101,835	112,734	(10,899)
MAIDSTONE	John Day Respiratory Ward (M) - NT151	108.6%	99.6%	-	-	110.7%	102.2%	-	-	30.5%	21.8%	79	5.45	8	13.3	1	0	Bed occupancy between 4 - 24. RMN requirements across 6 episodes	143,870	142,227	1,643
MAIDSTONE	Intensive Care (M) - NA251	95.5%	92.9%	-	-	92.6%	76.7%	-	-	13.2%	10.4%	93	5.62	11	84.1	0	0		163,807	179,194	(15,387)
MAIDSTONE	Pye Oliver (Medical) - NK259	93.1%	102.9%	-	-	110.0%	105.6%	-	-	21.3%	37.7%	94	6.26	13	7.5	3	1	Bed occupancy predominatly at 28 throughout the month	115,683	115,953	(270)
MAIDSTONE	Chaucer Ward (M) - NS951	76.2%	72.4%	-	-	78.8%	63.3%	-	-	18.9%	11.6%	60	4.10	5	52.3	0	0		95,723	87,990	7,733
MAIDSTONE	Whatman Ward - NK959	87.7%	91.8%	-	100.0%	155.0%	170.0%	-	-	39.9%	14.3%	90	6.06	4	11.1	4	0	Increased fill rate at night due to enhanced care requirements.	84,739	114,665	(29,926)
MAIDSTONE	Lord North Ward (M) - NF651	96.2%	97.8%	-	100.0%	82.2%	103.3%	-	-	4.0%	8.0%	6	0.44	0	10.6	2	0	Reduced fill rate in line with lower bed occupancy at times	94,903	93,464	1,439
MAIDSTONE	Mercer Ward (M) - NJ251	100.8%	120.1%	-	-	100.0%	103.3%	-	-	10.0%	9.9%	21	1.42	3	7.4	2	1	Bed occupancy at 26 throughout the month	106,119	113,443	(7,324)
MAIDSTONE	Edith Cavell (M) - NS459	105.7%	52.9%	-	100.0%	94.4%	96.7%	-	-	48.1%	46.7%	153	10.63	13	20.2	0	0	Bed occupancy between 2- 13. Staffing reflective of occupancy, acuity and dependency.	66,317	4,009	62,308
MAIDSTONE	Acute Medical Unit (M) - NG551	97.3%	118.8%	-	-	122.0%	191.2%	-	-	26.1%	22.7%	98	6.30	11	17.0	1	0	Bed occupancy between 8 - 20 throughout the month. Increased fill rate at night to cover ward escalation	151,755	130,662	21,093
TWH	Ward 22 (TW) - NG332	103.1%	89.6%	-	100.0%	116.8%	101.7%	-	-	31.5%	14.8%	92	6.45	11	7.6	15	0	8 falls above threshold. Reduced CSW fill rate at times due to lack of available temporary staff	101,813	111,921	(10,108)
TWH	Coronary Care Unit (TW) - NP301	105.1%	112.5%	-	-	100.0%	-	-	-	22.3%	2.0%	46	2.72	1	12.0	0	0		70,590	69,665	925
TWH	Ward 33 (Gynae) (TW) - ND302	95.9%	98.3%	-	-	100.0%	87.1%	-	-	16.7%	4.0%	46	2.59	6	16.3	0	0	Some staff sickness / self isolating reported during the month	112,501	108,785	3,716
TWH	Intensive Care (TW) - NA201	109.9%	105.8%	-	-	102.8%	93.1%	-	-	7.2%	0.0%	59	3.76	9	47.0	0	2		230,298	245,743	(15,445)
TWH	Acute Medical Unit (TW) - NA901	98.2%	91.5%	-	100.0%	100.6%	102.0%	-	-	21.1%	23.9%	117	7.61	9	13.9	9	0	3 falls above threshold Bed occupancy recorded between 12-23 throughout the month	213,340	183,528	29,812
TWH	Surgical Assessment Unit (TW) - NE701	100.0%	95.7%	-	-	100.0%	100.0%	-	-	11.0%	0.0%	6	0.42	0	163.1	0	0		64,955	62,934	2,021
TWH	Ward 32 (TW) - NG130	84.2%	104.0%	-	-	73.3%	76.7%	-	-	7.2%	0.0%	20	1.14	0	8.5	2	0		143,059	117,434	25,625
TWH	Ward 10 (TW) - NG131	85.5%	78.2%	-	100.0%	85.8%	103.3%	-	-	9.5%	28.2%	39	2.48	5	9.3	1	0		122,602	96,267	26,335
TWH	Ward 11 Winter Escalation 2019 TW	-	-	-	-	-	-	-	-	No Hours	No hours	No Demand	No Demand	No Demand		1	0	Ward 20 moved into the ward 11 area to faciliate a deep clean of ward 20 therefore reporting 1 fall during this relocation time.	0	2,595	(2,595)
TWH	Ward 12 (TW) - NG132	105.7%	102.0%	-	100.0%	111.1%	101.7%	-	-	15.5%	24.4%	42	2.94	5	7.0	14	0	8 falls above threshold	130,719	126,496	4,223
TWH	Ward 20 (TW) - NG230	88.3%	98.6%	-	-	120.2%	90.7%	-	-	61.2%	35.8%	197	13.42	31	8.5	7	1	Redcued RN fill rate with 31 unfilled shifts and enhanced care requirements reported throughout the month.	123,701	173,891	(50,190)
MAIDSTONE	Foster Clarke Ward - NR359	0.0%	0.0%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0.0	0	0		0	-276	276
TWH	Ward 21 (TW) - NG231	101.1%	99.0%	-	100.0%	106.7%	108.3%	-	-	29.1%	34.2%	122	8.14	13	9.0	6	0	Bed occupancy between 14 - 30	134,598	137,595	(2,997)
TWH	Ward 2 (TW) - NG442	118.3%	110.9%	-	100.0%	107.8%	125.5%	-	-	27.3%	9.7%	81	5.15	17	8.8	11	0	4 falls above threshold. Increased fill rate due to enhanced care requirements.	134,630	126,795	7,835
TWH	Ward 30 (TW) - NG330	99.1%	100.7%	-	-	104.4%	98.9%	-	-	21.7%	23.9%	60	3.80	8	7.8	3	0	Staffing supported by redeployed MOU staff	124,424	129,674	(5,250)
TWH	Ward 31 (TW) - NG331	107.3%	92.0%	-	100.0%	118.3%	101.1%	-	-	29.9%	38.8%	102	6.77	12	7.8	2	8	Bed occupancy between 19 - 30 . Staffing supported by redeployed MOU staff	129,079	152,684	(23,605)
Crowborough	Crowborough Birth Centre (CBC) - NP775	73.9%	104.1%	-	-	101.7%	100.0%	-	-	3.1%	0.0%	12	0.75	0			0		69,332	83,583	(14,251)
TWH	Midwifery (multiple rosters)	85.1%	53.1%	-	-	99.1%	71.8%	-	-	11.7%	1.0%	429	24.17	21	22.8	1	0	1 fall above threshold reported on PNU Reduced fill rate due to lack of available temporary staff. Delivery suite prioritised to ensure safe staffing levels.	672,354	625,564	46,790
TWH	Hedgehog Ward (TW) - ND702	92.6%	185.3%	-	-	85.4%	-	-	-	8.9%	61.9%	44	3.02	3	14.6	0	0	Bed occupancy between 5- 18. RMN requirements across 6 days	155,237	113,285	41,952
MAIDSTONE	Maidstone Birth Centre - NP751	103.2%	100.0%	-	-	98.2%	90.0%	-	-	10.9%	0.0%	22	1.39	0		0	0		72,755	73,771	(1,016)
TWH	SCBU (TW) - NA102	75.5%	604.5%	-	-	94.9%	-	-	-	12.3%	0.0%	82	4.40	2	18.3		0	Fill rate in line with bed occupancy which is reported between 5 - 13 throughout the month. 2 x amber days recorded otherwise remained green. Increased CSW fill rate as these numbers are inclusive of B4 Nursery Nurses which increase the fill rate of unregistered hours against a plan of 172.5. Roster to be realigned to reflect unregistered demand.	175,775	181,916	(6,141)
TWH	Short Stay Surgical Unit (TW) - NE901	89.8%	4.5%	-	-	127.3%	9.1%	-	-	1.6%	0.0%	4	0.26	0	6.2	0	0		46,531	54,062	(7,531)
MAIDSTONE	Short Stay Surgery Unit (M) - NE751	98.9%	84.2%	-	-	56.8%	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand		0	0		86,027	58,678	27,349
MAIDSTONE	Accident & Emergency (M) - NA351	106.9%	89.3%	-	-	126.7%	102.1%	-	-	32.8%	24.8%	227	15.05	11		2	0	MH - 2 falls above threshold. Increased fill rate to support COVID pathways TWH - Staff sickness reported in the team with 14 unfilled shifts reported during the month	199,158	252,936	(53,778)
TWH	Accident & Emergency (TW) - NA301	98.6%	119.4%	-	100.0%	104.0%	166.3%	-	-	34.1%	37.2%	304	21.13	14		0	0		335,142	365,581	(30,439)
MAIDSTONE	Maidstone Orthopaedic Unit (M) - NP951	52.3%	33.1%	-	-	0.0%	-	-	-	0.0%	No hours	No Demand	No Demand	No Demand		0	0		52,889	19,977	32,912
MAIDSTONE	Peale Ward COVID - ND451	0.0%	0.0%	-	-	0.0%	0.0%	-	-	0.0%	No hours	No Demand	No Demand	No Demand	0.0	1	0	low bed occupancy in June. Ward staffed from supporting areas in particular Edith Cavell to manage COVID pathway. Healthrosters still being aligned to map new pathways and staff on base wards.	0	74,452	(74,452)
																		Total Established Wards	**5,025,008**	**5,073,598**	**(48,590)**
																		Additional Capacity beds - Cath Labs	38,844	41,149	(2,305)
																		Whatman	0	0	0
																		Edith Cavell (M) - NS459	0	65,300	(65,300)
																		Ward 32 (Wells Suite) (TW) - PP010	0	-1,044	1,044
																		Other associated nursing costs	3,627,168	3,398,409	228,759
																			8,691,020	**8,577,412**	**113,608**

RAG Key

Under fill / Overfill

Green: Greater than 90% but less than 110%

Amber Less than 90% OR greater than 110%

Red Less than 80% OR greater than 130%

RAG Key

↓ Reduction of greater than 5

↑ Increase of greater than 5

↗→ Remains equal to Or less than a difference of 5

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Organisational Objectives

2020/21

MTW
exceptional people, outstanding care

The approach to the New Normal has segmented our work into reset and recovery and organisational objectives

Maidstone and Tunbridge Wells NHS Trust

		Cancer	Med & EC	C & W	Surgery	DCCS	Finance	MD	COO	CN	E & F	HR	Strategy
R&R Workstreams	Outpatients												
	Elective care												
	Acute & Urgent												
	Cancer												
	Social Distancing / Home Working												
	Staff Welfare												
	Patient and Staff Safety - RAG												
	ICC												
Organisational Objectives	Finance & Contacts (SO)												
	Operational Performance (SB)												
	Quality and CQC (COB + PM)												
	EPR (PM + SO)												
	Education / KMMS (PM)												
	Strategy – Estates (DW)												
	Strategy – Clinical (AJ)												
	OD / EPOC (SO)												
	ICP / External (AJ + PM)												
	Workforce (SH)												

Although summaries are shown for the organisational objectives Executive sponsors have created a detailed brief and in some cases full PID for each workstream

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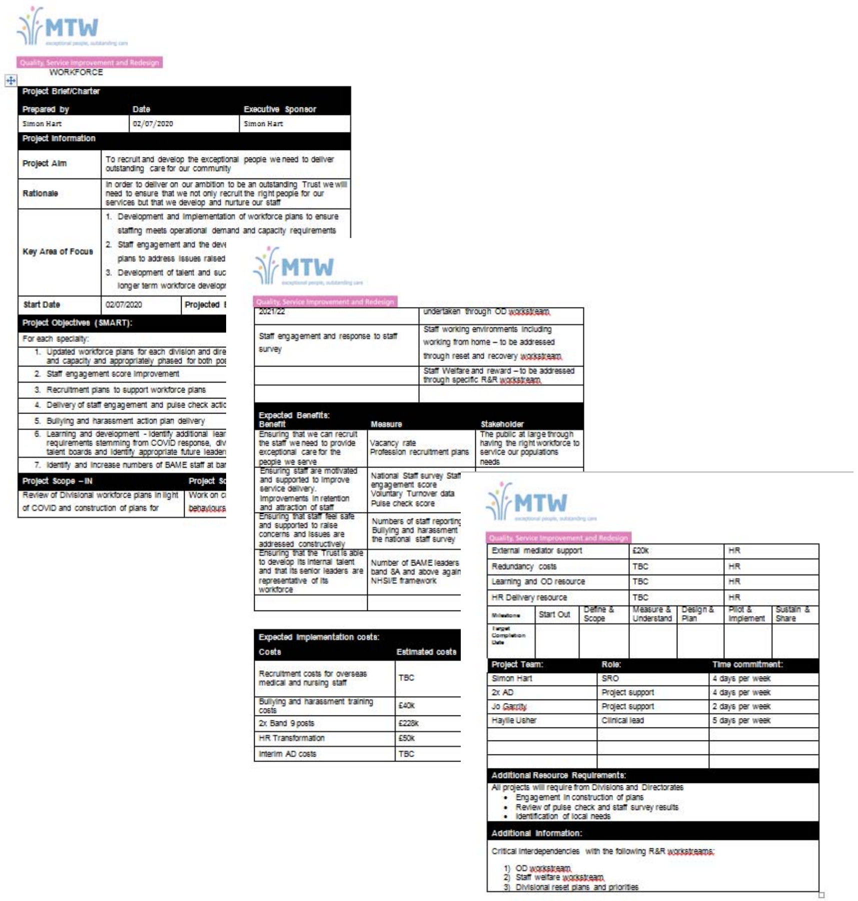

MTW
Quality, Service Improvement and Redesign
WORKFORCE

Project Brief/Charter		
Prepared by	Date	Executive Sponsor
Simon Hart	02/07/2020	Simon Hart
Project Information		
Project Aim	To recruit and develop the exceptional people we need to deliver outstanding care for our community	
Rationale	In order to deliver on our ambition to be an outstanding Trust we will need to ensure that we not only recruit the right people for our services but that we develop and nurture our staff	
Key Area of Focus	1. Development and implementation of workforce plans to ensure staffing meets operational demand and capacity requirements 2. Staff engagement and the deve… plans to address issues raised… 3. Development of talent and suc… longer term workforce develop…	
Start Date	02/07/2020	Projected …

Project Objectives (SMART):
For each specialty:
1. Updated workforce plans for each division and dire… and capacity and appropriately phased for both poi…
2. Staff engagement score improvement
3. Recruitment plans to support workforce plans
4. Delivery of staff engagement and pulse check actio…
5. Bullying and harassment action plan delivery
6. Learning and development - identify additional lear… requirements stemming from COVID response, div… talent boards and identify appropriate future leader…
7. Identify and increase numbers of BAME staff at bar…

Project Scope – IN	Project Sc…
Review of Divisional workforce plans in light of COVID and construction of plans for	Work on c… behaviours

2021/22	undertaken through OD workstream
Staff engagement and response to staff survey	Staff working environments including working from home – to be addressed through reset and recovery workstream Staff Welfare and reward – to be addressed through specific R&R workstream

Expected Benefits: Benefit	Measure	Stakeholder
Ensuring that we can recruit the staff we need to provide exceptional care for the people we serve	Vacancy rate Profession recruitment plans	The public at large through having the right workforce to service our populations needs
Ensuring staff are motivated and supported to improve service delivery. Improvements in retention and attraction of staff	National Staff survey Staff engagement score Voluntary Turnover data Pulse check score	
Ensuring that staff feel safe and supported to raise concerns and issues are addressed constructively	Numbers of staff reporting Bullying and harassment in the national staff survey	
Ensuring that the Trust is able to develop its internal talent and that its senior leaders are representative of its workforce	Number of BAME leaders band 8A and above again NHSIE framework	

Expected Implementation costs: Costs	Estimated costs
Recruitment costs for overseas medical and nursing staff	TBC
Bullying and harassment training costs	£40k
2x Band 9 posts	£228k
HR Transformation	£50k
Interim AD costs	TBC

MTW
Quality, Service Improvement and Redesign

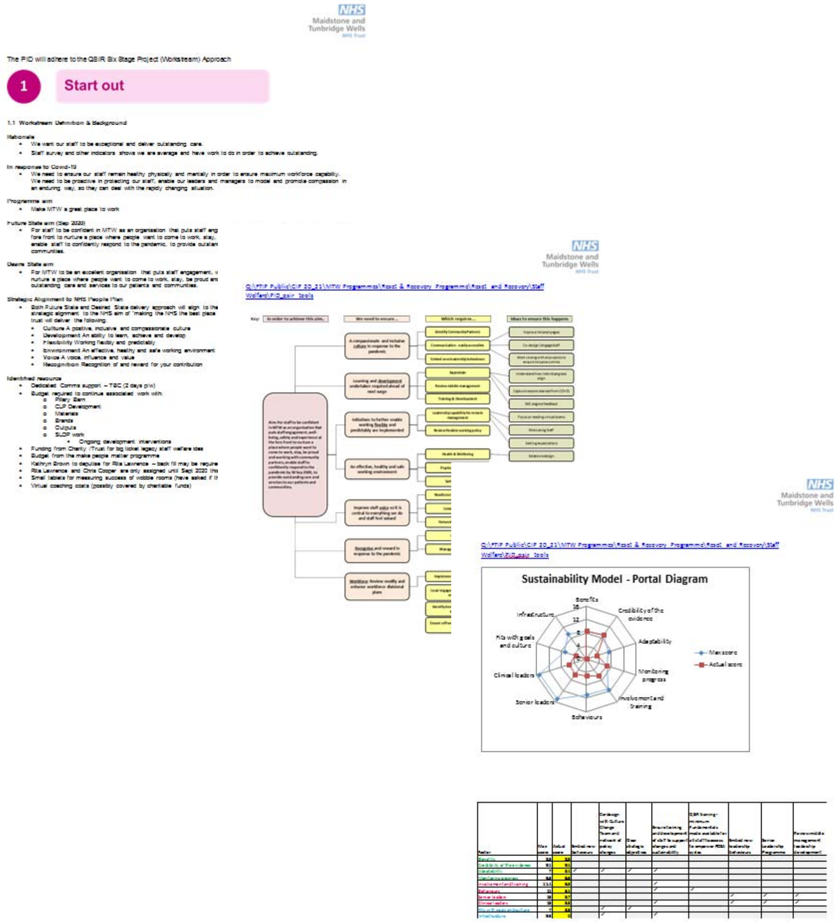
External mediator support	£20k	HR
Redundancy costs	TBC	HR
Learning and OD resource	TBC	HR
HR Delivery resource	TBC	HR

Milestone	Start Out	Define & Scope	Measure & Understand	Design & Plan	Pilot & Implement	Sustain & Share
Target Completion Date						

Project Team:	Role:	Time commitment:
Simon Hart	SRO	4 days per week
2x AD	Project support	4 days per week
Jo Garrity	Project support	2 days per week
Haylie Usher	Clinical lead	5 days per week

Additional Resource Requirements:
All projects will require from Divisions and Directorates
- Engagement in construction of plans
- Review of pulse check and staff survey results
- Identification of local needs

Additional Information:
Critical interdependencies with the following R&R workstreams:
1) OD workstream
2) Staff welfare workstream
3) Divisional reset plans and priorities



Finance and Contracts

NHS Maidstone and Tunbridge Wells Trust

SRO
Steve Orpin

Project Aim
To **deliver the Trust's financial plan**, which is set within the context of its financial strategy, and underpinned by a robust, sustainable recurrent surplus

Key areas of focus

- **Deliver financial plan** for 20/21
- **Complete Financial Strategy** and achieve Board Approval by end Q2
- Implement co-designed **Finance Directorate Improvement Plan** by end Q2
- **Agree and sign contracts for 21/22** in advance of the new year
- **Design and implement a new approach to efficiency management** to deliver aims of the financial strategy by end of Q2

Expected benefits	KPIs
Ability to manage and control our financial position to support our goals, and not be controlled by the position	• **Delivery of financial strategy and financial plan (Surplus/Deficit, CIP savings, Cash balance, Capital Expenditure)** • Change in regulatory banding • **Good or better CQC / NHSE/I Use of Resources**
Improved provision of financial advice and support within the organisation via a co-designed approach	• Undertake customer satisfaction surveys and improve scores • Delivery of Divisional Financial Plans
Improved Finance Directorate, that is rightly considered to be one of the best nationally	• Delivery of Finance Directorate Improvement Plan • Nomination, shortlisting and winning of awards (HFMA, HSJ, etc)

Operational Performance

Maidstone and Tunbridge Wells NHS Trust

SRO
Sean Briggs

Project Aim
To **improve the management of our patient journeys** through the utilisation of evidence-based practice to **ensure good quality care and achievement of the constitutional access standards** within agreed resources.

Key areas of focus
• **Delivery of Reset & Recovery** Programme • New **covid secure pathways** for inpatients and outpatients in place • Implementation of **Teletracking** • **Winter Plan for 20/21** agreed at Trust Board • Collaborative working across system partners to ensure **winter resilience in place** to secure **flow though inpatient beds** • **Development of NHS leading operational team**

Expected benefits	KPIs
Delivery of R&R will enable the Trust to emerge from the covid pandemic to deliver as much activity as possible	• Infection outbreaks within the Trust • Activity against post-covid plans
To manage inpatient and outpatient flow safely and appropriately, ensuring covid pathways are adhered to as necessary	• **Delivery of >95% ED performance each month for 20/21** • **Delivery of Cancer standards (2 week wait and 62 day)** • **Delivery of RTT performance against agreed plan** • **Delivery of diagnostic standard**
Securing sufficient external capacity will ensure timely discharge of patients once medically fit	• MFFD number • Escalated capacity • Cancelled elective procedures

Quality and CQC

NHS Maidstone and ells Trust

SRO
Claire O'Brien

Project Aim
To **deliver high quality care** to our patients and carers and be **recognised as an outstanding organisation.**

Key areas of focus

- **Patient Safety;** Implement the National Patient Safety Strategy, Implement the introductory Patient Safety Incident Response Framework (PSIRF)
- **Complaints;** Implement the National Complaints Strategy once finalised
- **Healthcare Associated Infections;** Ensure a system is in place for the prevention and control of covid 19 and compliance with the hygiene code
- **Mortality;** Implement the Medical Examiner process
- **Patient Experience;** Implement the Making It Personal Strategy
- **CQC;** Implement the Quality Improvement Committee work plan
- **Golden Thread and Learning;** Building on the work already achieved as part of the Lessons Learned workstream

Expected benefits	KPIs
Improved clinical outcomes	• **Mortality** • **Readmissions** • **Stroke Best Practice Tariff**
Recognition of the Trust as an outstanding organisation	• CQC inspection
Improvement in patient satisfaction	• FFT scores
Increased patient participation in projects – co-design.	• Patient involvement in project groups
Timely completion of SJRs and learning identified from these reviews	• Numbers completed • Timescale taken to complete SJR
Prevention of nosocomial infections	• Surveillance • Mandatory HCAI reporting
Timely and robust complaint investigations	• **Response time performance**
Increased levels of incident reporting	• **Number of incidents reported**

ding care

EPR

Maidstone and Tunbridge Wells NHS Trust

SRO
Pete Maskell

Project Aim
Delivery of Allscripts' EPR solution "Sunrise"; aligning and supporting the wider strategic objective of **digitally transforming MTW to improve patient outcomes** through providing safer and more efficient care.

Key areas of focus
• **Phase 1a** Go Live (EPR Enablers, Core Build, Order Comms, ED, Integration, Data Priming, Paediatrics, Outpatients, Reports): **April 2021** • **Phase 1b** Go Live (Core Clinical Documentation and eObservations, Therapies): **May 2021** • **Phase 2 Go Live** (EPMA and eDN): **October 2021** • **Phase 3: TBC**

Expected benefits	KPIs
Improved staff efficiency and improved patient outcomes	• **Adverse drug events** • Visibility of data • Time spent chasing notes
Less paper notes and a smaller footprint on the IT estate and for notes storage	• **Paper notes storage capacity (sqm)** • Legibility of notes • Accuracy of information
Reduction on print costs and improvement in governance	• **Print costs** • **Data protection incidents** • **Duplicate tests**

Education/KMMS

NHS
Maidstone and

SRO
Pete Maskell

Project Aim
To enable fulfilment of MTW's role in the delivery of an **integrated reputable, high quality educational programme and student experience** for KMMS students in line with the KMMS curriculum; provision of necessary student accommodation and teaching infrastructure at MH and TWH in time for the first intake of KMMS students on 01/09/22

Key areas of focus

- **To ensure Estates / Facilities infrastructure in place and operational by 1st September 2022**
- To ensure that MTW is at the forefront of KMMS engagement with Trusts
- To **agree allocation of student placements to MTW Departments and ensure necessary resources in place to allow delivery of KMMS curriculum and a high quality experience for the student** (Date TBC)
- To **maximise MTW research opportunities** arising from its relationship with KMMS
- To ensure necessary interface mechanisms in place with GP hubs and other trusts
- See individual workstream project briefs for full detail

Expected benefits	KPIs
Future workforce sustainability within MTW	• **% Recruitment and retention of KMMS graduates within MTW** • **Number of medical students at the Trust**
Establishment of quality educational placements with a local integrated educational programme at MTW	• Medical School quality visits • % of student retention • % of student attaintment • **Student feedback** • **Number of non medical educators**
Accommodation that meets medical school standards	• Medical School quality visits • Accreditation of accommodation by external medical education governing agencies
Established research programme with target for publication set	• % increase in MTW research activity and output • **Number of clinical academic posts at the Trust**

Strategy - Estates

NHS
Maidstone and
Tunbridge Wells
Trust

SRO
Doug Ward

Project Aim
To define an estates and facilities strategy and plan for MTW informed by both the clinical strategy and Reset and recovery workstreams

Key areas of focus

- **The primary area of focus will be the footprint of our 2 hospital sites with more detailed reconfiguration options worked up for the Maidstone Site given the PFI constraints at Tunbridge Wells**
- Production of an Estates and Facilities Strategy by the end of June 2020
- Production of Development Control Plan for both Hospital Sites by the end of August 2020

Expected benefits	KPIs
Optimized Estates and facilities footprint with prioritization of clinical care	• **% footprint dedicated to clinical care** • **Utilised and unutilized space ratio**
Reduction in space dedicated to admin and clerical workspace	• **Admin and clerical office space in sq ft**
Will allow for critical service co-adjacencies in line with clinical strategy	• Number of services with critical co-adjacencies(e.g. PPCI and HASU)
Reduction in overall cost of estates through more efficient use of space	• **Aggregated cost per sqft of estate**
Reduction in the number of people reporting that they do not have a workspace at the Trust	• **Number of people without allocated workspace (excluding those allocated to hotdesk facilities)**

ding care

Strategy – Clinical

NHS
Maidstone and

SRO
Amanjit Jhund

Project Aim
To define the future state (short medium and long term) configuration options for a range of clinical services with timelines and plans for implementation

Key areas of focus
• **Cardiology** • **Elective Orthopaedics** • **Imaging** • **Gastroenterology** • **Respiratory** • **Cancer (East Kent Cancer Centre)** • **Stroke (review of Maidstone estates only)**

Expected benefits	KPIs
More services with critical co-dependencies and adjacencies will be located together which will allow for the provision of more specialized care (e.g.in the formation of a digestive diseases unit)	• Number of services with critical co-adjacencies(e.g. PPCI and HASU)
Improved provision of services for the Trust (e.g. oesophageal manometry through DDU)	• **Number of specialist services per directorate**
Reduced volume of activity being sent to London through provision of specialist services in West Kent	• **Volume of activity sent to London**
Improvements to the Trusts financial position through the deployment of more cost effective financing options (e.g. a MES)	• **Service contribution**
Improvements to workforce models through clinical strategy work will improve the utilization of new roles across the Trust	• **Number of advanced practitioners**
Improvements to clinical strategy should also unlock additional opportunities for research and innovation across the Trust through specialization of services	• **Research Grants (£)**

OD/EPOC

NHS
Maidstone and
ells
rust

SRO
Steve Orpin

Project Aim
Make MTW a great place to work - For MTW to be an excellent organisation that puts staff engagement, well-being and experience at the fore front to nurture a place where people want to come to work, stay, be proud and enable staff to be exceptional, to provide outstanding care and services to our patients and communities.

Key areas of focus
• **Deliver Culture and Leadership Programme**
• **Deliver Senior Leadership Programme**
• Inclusive diverse leadership
• Support in place to **tackle long term effect of pandemic on mental health**
• Staff confident the trusts **act quickly and consistently on concerns raised to address negative behaviour, when raised formally or informally**
• **Maximise use of the apprenticeship levy** to develop our staff
• **Redesign workforce based on patient care activities** for a ward or pathway, including technology, processes, systems etc.

Expected benefits	KPIs
Participation in senior leadership programme	• **SLDP participation and feedback metrics**
Delivery of leadership and talent development programme	• **Leadership & Talent Development Strategy Metrics**
Delivery of phase 2 of culture and leadership programme	• **Culture and Leadership Programme Phase 2 (discovery)**
Reduction in inequalities and increase in diversity	• **Equality, Diversity and Inclusion reducing inequalities metrics**
Improved recruitment and retention	• **Vacancy Rate / Turnover metrics**

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ICP/External

NHS
Maidstone and

SRO
Amanjit Jhund

Project Aim
To oversee **and enable the ICP Development in West Kent** and ensure appropriate stakeholder engagement and participation in MTW's work (e.g. in clinical strategy development).

Key areas of focus
• **Revised ICP Governance with implementation by October 2020**
• Identification of **priority programmes of work for post COVID recovery** by 1st July 2020
• Identification of and **agreement on contractual mechanisms** for ICP by March 2021
• Consultation and engagement plan for all clinical strategy developments
• **Delivery of ICP Executive programs of work** (formerly West Kent Alliance programs)
• Implementation of **integrated frailty model**

Expected benefits	KPIs
Development of an ICP in West Kent will support integrated working and will have benefits in terms of the individual priority areas selected for focus	• Each program of work hasdetailed KPIs worked up as part of their development
Improvements to the key Population Health Measures across West Kent where we lag behind the rest of Kent and England through the ICP executive workstreams	• **Dementia screening rates** • **Hospital admissions due to falls** • **Hospital admissions as a result of self harm in the 10-24 age group**
Improvements to joint working and greater collaboration should improve the systems financial performance	• **System financial performance against West Kent aggregated control total**
Reduction in West Kent Estates footprint through improved joint working	• **West Kent Estates footprint (sqm)**

Workforce

NHS
Maidstone and Tunbridge Wells Trust

SRO
Simon Hart

Project Aim
To recruit and develop the exceptional people we need to deliver outstanding care for our community

Key areas of focus

- **Updated workforce plans for each division and directorate linked to their demand and capacity and appropriately phased for both post COVID and 2021/22**
- Staff engagement and the development of staff survey action plans to **address issues raised in the staff survey**
- Development of talent and succession planning to support longer term workforce development
  - Identify **additional learning and development requirements stemming from COVID response**, divisions to ensure they deliver local talent boards and **identify appropriate future leaders (8A plus)**
  - **Identify and increase numbers of BAME staff at band 8A and above**
- **Bullying and harassment action plan delivery**

Expected benefits	KPIs
Ensuring that we can recruit the staff we need to provide exceptional care for the people we serve	• **Vacancy rate** • **Sickness** • **Turnover** • **Use of agency**
Ensuring staff are motivated and supported to improve service delivery. Improvements in retention and attraction of staff	• National Staff survey Staff engagement score • Voluntary Turnover data • Pulse check score • **Stat and mandatory training**
Ensuring that staff feel safe and supported to raise concerns and issues are addressed constructively	• Numbers of staff reporting Bullying and harassment in the national staff survey
Ensuring that the Trust is able to develop its internal talent and that its senior leaders are representative of its workforce	• Number of BAME leaders band 8A and above against NHSI/E framework

ding care

The IPR that the board reviews is based on the KPIs within each workstream

Maidstone and Tunbridge Wells NHS Trust

	Workstream / Objective	Metric 1	Metric 2	Metric 3	Metric 4	Metric 5
Organisational Objectives	Finance & Contacts (SO)	Surplus (Deficit) against B/E Duty	CIP Savings	Cash Balance	Capital Expenditure	Use of Financial Resources
	Operational Performance (SB)	Cancer - 2 Week Wait	Cancer - 62 Day	A&E	RTT	Diagnostics
	Quality and CQC (COB + PM)	Mortality	Serious Incidents	Readmissions	Stroke Best Practice Tariff	Complaints
	EPR (PM + SO)	Paper notes storage capacity (sqm)	Adverse drug events	Data protection incidents	Print costs	Duplicate tests
	Education / KMMS (PM)	Number of medical students at Trust	Number of clinical academic posts	Number of non-medical educators	% of students reporting a good or better educational experience	% of medical students retained as FY1s
	Strategy – Estates (DW)	Utilised and unutilised space ratio	Footprint devoted to clinical care vs non clinical care ratio	Admin and clerical office space in (sqm)	Number of people without allocated office space (excludes	Aggregated cost per sqm of estate
	Strategy – Clinical (AJ)	Number of specialist services per directorate	Volume of activity being sent to London	Service contribution by division	Research grants (£)	Number of advanced practitioners
	OD / EPOC (SO)	SLDP participation and feedback metrics	Leadership & Talent Development Strategy Metrics	Culture and Leadership Programme Phase 2 (discovery)	Equality, Diversity and Inclusion reducing inequalities metrics /	Vacancy Rate / Turnover metrics
	ICP / External (AJ + PM)	Dementia rate	Mental health – Children – Hospital admissions as a result	Frailty – Admissions due to falls	System financial performance (£)	West Kent estates footprint (sqm)
	Workforce (SH)	Sickness	Turnover	Vacancy Rates	Use of Agency	Stat and Mandatory Training

Data available for reporting

Data source to be confirmed / put in place

MTW exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells NHS Trust

Update on Black, Asian, and Minority Ethnic (BAME) staff risk assessments — **Director of Workforce**

It was agreed at the Trust Board meeting on 25/06/20 that a further "Update on BAME staff risk assessments" report should be submitted to the Trust Board meeting in July 2020. The enclosed update has therefore been submitted in response

Which Committees have reviewed the information prior to Board submission?
- Workforce Committee, 17/07/20

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Review and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Risk Assessments for Staff in Vulnerable groups including BAME staff

Update as of 15th July 2020

National data has indicated that some staff are more likely to suffer negative outcomes as a result of contracting COVID-19. These include those with certain underlying health conditions, those over a certain age and staff from Black & minority ethnic groups (BAME). The Trust Risk assessment documentation has been developed in line with national guidance to ensure that the risks relating to these staff can be quantified and assessed and suitable action taken to minimise risk where indicated.

All managers were asked to risk assess staff who were in vulnerable groups or from a BAME background on 20th May 2020. On 25th June NHSE/I wrote to all NHS organisations informing them that risk assessments for all staff in at-risk groups must be completed within four weeks. NHSE have defined 'at risk groups' to include

- Black, Asian and minority ethnic staff (BAME), aged 55+, particularly those with co-morbidities
- White European ethnicity aged 60+
- Male
- Staff with underlying health conditions (Hypertension, CVD, DM, CKD, COPD, Obesity)
- Pregnancy

In line with NHSE/I guidance, uptake against the target is being published via the staff briefing each Friday.

1. Have you offered a risk assessment to all staff? Yes

What % of all your staff have you risk assessed?

Division	Not Completed	Completed	Total	%
359 Cancer Services (L3)	366	139	505	27.5%
359 Corporate and Support (L3)	415	273	688	39.7%
359 Diagnostic + Clinical Support (L3)	593	357	950	37.6%
359 Estates and Facilities (L3)	317	277	594	46.6%
359 Medical + Emergency Care (L3)	739	594	1,333	44.6%
359 Surgery (L3)	638	664	1,302	51.0%
359 Women, Children and Sexual Health (L3)	542	211	753	28.0%
Grand Total	**3,610**	**2,515**	**6,125**	41.1%

3. What % of risk assessments have been completed for staff who are known to be 'at-risk', with mitigating steps agreed where necessary?

Division	Not Completed	Completed	Total	%
359 Cancer Services (L3)	74	124	198	62.6%
359 Corporate and Support (L3)	107	167	274	60.9%
359 Diagnostic + Clinical Support (L3)	152	219	371	59.0%
359 Estates and Facilities (L3)	227	227	454	50.0%
359 Medical + Emergency Care (L3)	190	494	684	72.2%
359 Surgery (L3)	197	515	712	72.3%
359 Women, Children and Sexual Health (L3)	53	122	175	69.7%
Grand Total	**1,000**	**1,868**	**2,868**	65.1%

4. What % of risk assessments have been completed for staff who are known to be from a BAME background, with mitigating steps agreed where necessary?

Division	Completed	Not Completed	Total	% Completed
359 Cancer Services (L3)	71	5	76	93.4%
359 Corporate and Support (L3)	48	9	57	84.2%
359 Diagnostic + Clinical Support (L3)	125	2	127	98.4%
359 Estates and Facilities (L3)	167	34	201	83.1%
359 Medical + Emergency Care (L3)	443	26	469	94.5%
359 Surgery (L3)	412	21	433	95.2%
359 Women, Children and Sexual Health (L3)	95	12	107	88.8%
Grand Total	**1,361**	**109**	**1,470**	92.6%

Comparator with National and Regional completion rates

	% All Staff Completed	% At Risk Staff Completed	% BAME completed
National Average	35%	55%	64%
South East Region Average	34%	54%	65%
MTW	41%	65%	93%

Further Actions

- All shielded staff are being risk assessed by their line manager prior to 1st August to assess the safety issues of returning on site
- Divisional management teams are completing outstanding risk assessments with the support of their HR business partners and notifying ICC on completion
- Occupational Health continue to support individual line managers requiring guidance on completing the assessment and the potential options available for staff as a result
- Web ex support for completion of the assessment in a sensitive and supportive manner has been offered to line managers including support from the CEMN network & Occupational Health
- Medical Education, the Guardian for Safer Working are encouraging trainee medical staff within vulnerable groups to engage with their consultants to complete an assessment
- College tutors are being asked to engage with consultant colleagues to encourage juniors to complete the assessment with educational supervisors
- The CEMN network and staff side continue to encourage staff to talk with their line manager to complete an assessment
- Following feedback from the CEMN network, further guidance for managers has been issued in Trust Bulletins with a particular emphasis on completing the assessment in a sensitive and interactive fashion
- The final Trust position will be reported to NHSE/I south east region on 24th July

Approval of Quality Accounts, 2019/20 — Chief Nurse

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. The Trust's Quality Accounts for 2019/20 highlight the progress made against key priorities for the year to improve services for its patients and present those areas on which it will be focusing as priorities for 2020/21.

The draft Quality Accounts are enclosed for review and approval. The Quality Accounts were reviewed at the 'main' Quality Committee on 08/07/20, and the Committee recommended that they be submitted to the Trust Board for approval, as submitted. The Accounts are required to be published by the end of June each year; however due to COVID-19 the deadline for publication has been extended until December 2020 (although the Trust opted to proceed with finalising its Quality Accounts with only a one month delay).

Which Committees have reviewed the information prior to Board submission?

- 'main' Quality Committee, 08/07/20
- Trust Management Executive (TME), 15/07/20

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]

Review and approval (for publication)

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Maidstone and Tunbridge Wells NHS Trust

Quality Accounts

2019/20

Our Year on a Page

RESPECT

96.7%

of patients felt they were **TREATED WITH RESPECT AND DIGNITY** (National Inpatient Survey)

218

overseas nurses recruited to the Trust

DECREASE

The Trust declared

132

SERIOUS INCIDENTS in 2019/20 compared to 154 in 2018/19.

10%

REDUCTION in the number of hospital acquired pressure ulcers

CLEAN

97.6%

of patients felt their **HOSPITAL ROOM OR WARD WAS CLEAN** (National Inpatient Survey)

301

Staff completed QSIR training

7,000

ice creams provided to staff on hot weather days in summer 2019

83%

of frontline clinical staff received flu vaccination

MTW Trust has over

950,000

patient visits a year

Contents

Quality Accounts - Introduction

Maidstone and Tunbridge Wells NHS Trust aims to be a caring, sustainable and improvement-driven organisation. These objectives encompass the Trust's three core quality objectives to create a safety-focused culture, continuously improve patient and staff experience with clinically effective services and to learn lessons from our care delivery within a just culture. Providing safe, high quality health services to ensure the best overall experience for our patients, staff and public is at the heart of everything done at the Trust.

A requirement of the Health Act 2009 is for all NHS healthcare providers in England to produce an annual report that includes a review of the standard and quality of services from the last financial year and sets out the quality priorities for the coming year.

The Quality Accounts focuses on the quality of the Trust's services so that the public, patients and anyone with an interest in healthcare will be able to understand the following:

- Where the Trust is doing well
- Where improvements in service quality are needed and how we have prioritised these
- How the Trust Board has reviewed our challenges in improving the quality of care during the year and what we have prioritised for 2019/20

'High Quality Care for All' (2008) stated that quality within the context of the NHS should include three aspects. These are:

- Patient safety – we do no harm to patients and ensure all steps are taken to reduce avoidable harm and risks to individuals.
- Patient experience – seeking, analysing and understanding patient feedback to assess the compassion, dignity and respect with which patients are treated.
- Clinical effectiveness – understanding the success rates from different treatments and conditions via a range of measures of clinical improvement including the views of patients.

The three elements of quality within the NHS are used as a framework for this report.

High Quality Care for All. NHS Next Stage Review Final Report, June 2008, Department of Health

About Us

Maidstone and Tunbridge Wells NHS Trust is a large acute hospital trust in the south east of England. The Trust provides a full range of general hospital services to around 594,000 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 6,200 staff.

Along with the two main clinical sites at Maidstone Hospital and Tunbridge Wells Hospital at Pembury, the Trust also manages some services at the Kent and Canterbury Hospital and the Crowborough Community Hospital. The Trust provides outpatient clinics across a wide range of locations in Kent and East Sussex. It has over 950,000 patient visits a year, 165,000 of these coming through our Emergency Departments based on the two main sites. Maidstone Hospital has 281 overnight beds and Tunbridge Wells Hospital has 434 overnight beds.

Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital, providing mainly single bedded, en-suite accommodation for inpatients in a modern environment. This site hosts the Trust's designated Trauma Unit and is the base for Emergency Surgery, Orthopaedics, Women's Services and Children's Services.

Maidstone Hospital benefits from its central county location. The Kent Oncology Centre is based at the Maidstone site, providing specialist cancer services to around 2 million people across Kent and East Sussex. The first of the Trust's two Birthing Centres is on the Maidstone site, the other being at Crowborough.

An Academic Centre at Maidstone and an Education Centre at Tunbridge Wells enable the Trust to offer excellent clinical training. Both centres are well resourced and benefit from simulation suites. 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.

Part One

Chief Executive's Statement

Our Quality Accounts for 2019/20 outline the key actions we have taken to improve the experience we give our patients who receive care and treatment at Maidstone and Tunbridge Wells NHS Trust.

Over the past year, we have made significant progress in the quality and safety of our services and successfully delivered the patient-centred priorities we had identified in 2018/19.

In the coming 12 months, we will build on these successes and continue with our work to deliver our ambition of being an Outstanding provider of NHS care.

We know we still have more work to do to be outstanding. Key to our vision is putting quality improvement at the core of our organisation so that we can make a real difference for our patients.

Through our Best Care programme we have brought together all our quality plans in a focused and cohesive approach that allows us to continue to enhance patient care and safety, and move forward with our ongoing efforts to become a more caring, sustainable, and improvement driven organisation.

We have also implemented a dedicated Quality, Service Improvement and Redesign (QSIR) training programme for staff so that we can all use the same tools and methodologies to implement consistent quality improvements. QSIR forms the bedrock of how we are delivering quality and safety changes in our Trust.

In addition, we have put a real emphasis on boosting nurse recruitment and enhancing staff welfare and wellbeing in the last year. It is vital that we support our staff better as we know a workforce that feels valued delivers outstanding care and excellent services.

As a Trust we're doing more than ever to involve our patients, listen to their feedback and take action on what they tell us. We launched a new Patient Experience Strategy to help us meet our patient care goals. This sets out what we'll do over the next three years to improve their experience, from being better in our communication with patients to personalising their care and treating them as individuals with different needs, and facilitating patients to maintain independence and control over their lives.

As a result, a number of our patients and carers now participate in working groups to shape patient care and service improvement. We're growing this further so we move to a position where our patients help co-design our services right from the very start.

Your feedback and help in shaping our quality improvements over the next year to be even more of a patient-centred provider of personalised-care is critical in enabling us to do even better. So please do take every opportunity to get involved with our Trust and tell us how we're doing and what we could do better.

The information contained within this report represents an accurate reflection of our organisation's performance in 2019/20 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
Instagram:
LinkedIn
Facebook: www.facebook.com/mymtwhealthcare

Miles Scott
Chief Executive

Part Two

Quality Improvement Priorities for 2020/21

This section of the report will outline the quality improvement priorities we have identified for 2020/21 to further improve the quality of our services.

	SUMMARY		
	PATIENT SAFETY	**PATIENT EXPERIENCE**	**CLINICAL EFFECTIVENESS**
AIM	**To create reliable processes that will build a supportive environment that recognises and reduces avoidable harm.**	**To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.**	**To improve the management of our patient journeys through the utilisation of evidence-based practice.**
2020/21 Quality Priorities	Embracing all aspects of the National Patient Strategy to ensure that a safety culture is recognised as everyone's role and responsibility	Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'	Improving the flow of patients into and out of our wards and departments
	Continue to develop a downward trend in avoidable healthcare associated infections	The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process	
	Increased focus on reducing the number of hospital acquired deep tissue injuries (DTI) and Category 2 pressure ulcers	Sustain improvement in the timely completion of Duty of Candour* notifications as part of a wider commitment to improve patients and their carers' experience of adverse incidents and complaints.	The development of site-specific centres of excellence commencing with the centralisation of colorectal surgery, followed by the Hyper-Acute Stroke Unit (HASU), concentrating on new and improved ways of working which will support best practice and the opportunities for new roles.
	Improve the outcomes and experience of our expectant parents and their babies		
	Improve the recognition and escalation of the deteriorating patient with specific focus on sepsis and diabetes	Embedding safeguarding practices in all aspects of clinical care	

**The Duty of Candour is a statutory duty to be open and honest with patients or their families when something goes wrong that appears to have caused or could lead to significant harm in the future.*

Patient Safety

Maidstone and Tunbridge Wells NHS Trust are committed to providing safe, good quality and effective care. We are compassionate leaders and we strive to improve the patient safety service we provide to our colleagues and our patients by working as an inclusive team. Our staff need to feel empowered to raise concerns and report incidents. Our patients need to feel at ease to tell us about their experiences and if the care they receive falls short of their expectations.

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care. We will support our staff to minimise patient safety incidents and drive improvements in safety and quality. Patients should be treated in a safe environment and protected from avoidable harm.

In July 2019 NHS England and NHS Improvement published 'The NHS Patient Safety Strategy, Safer culture, safer systems, safer patients', which outlined several proposals relevant to the Trust. How these are embedded and sustained, in addition to continuous improvement in patient safety culture, is instrumental to the ongoing development in the quality of care we provide. The delivery of the Culture and Leadership programme, Exceptional People, Outstanding Care is therefore an essential component in making this happen.

Aim/goal

To create reliable processes that will build a supportive environment that recognises and reduces avoidable harm.

Areas for focus and improvement during 2020/21 **Key objectives will include: -**	
1) Embracing all aspects of the National Patient Strategy to ensure that a safety culture is recognised as everyone's role and responsibility	
a) Increasing the number of incidents that are reported to identify themes to support positive change and improvement	Increase in number of incidents* reported in 2020/21, based on 2019/20 numbers **There is evidence that a high level of incident reporting in NHS organisations is a reliable indicator of responsive, high quality care and a workplace where staff are confident that they will be listened to.*
	All relevant reporting about incidents will include: themes, actions in place to address these themes and tangible change as a result of learning from investigations
	Design qualitative process to evaluate staff experience of incident reporting
b) Improve the quality and timeliness of investigations to support the learning lessons agenda	Increase in achievement of 60 day** key performance indicator (KPI) in 2020/21, based on 2019/20 compliance figures ***Clinical Commissioning Groups (CCGs) require investigations of Serious Incidents (SIs) to be submitted to them in 60 days of the incident being declared.*
	Decrease in number of investigations with further queries returned from CCG, based on 2019/20 numbers

	Design qualitative process to evaluate patients and families experience of our Serious Incident process
c) Development of performance dashboards and reports that provides meaningful data to support departments and divisions	Every ward to have a performance dashboard in place on Datix (the Trust's incident reporting system)
	Decrease in numbers of incidents breaching 45 day closure timeline, based on 2019/20 numbers
d) Supporting all staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety	Plan in place to recognise World Patient Safety Day (17th September annually)
	Increase numbers of staff attending both Human Factors and Root Cause Analysis training
	Development of actions module (to monitor compliance with open actions from investigations) on Datix to drive performance
	Ensure every staff member has access to the final Serious Incident investigation report
	Design qualitative process to evaluate staff experience of being involved in our SI process
2) Continue to develop a downward trend in avoidable healthcare associated infections, in particular	
a) Gram negative bloodstream infections	21.5 cases per 100,000 bed days (whilst acknowledging national 5 year target of 50% reduction across the healthcare system by 2021)
b) Control of hospital acquired Covid-19	Systems in place for infection prevention and control of Covid-19 in line with the Hygiene Code
	Self-assessment undertaken of national framework
	Compliance of self-assessment to be monitored through the Infection Control Committee with periodic reports to Trust Board
3) Increased focus on reducing the number of hospital acquired deep tissue injuries (DTI) and Category 2 pressure ulcers	
10% decrease in number of hospital acquired avoidable DTIs and Category 2 pressure ulcers by year end, based on 2019/20 numbers	
4) Improve the outcomes and experience of our expectant parents and their babies through:	
a) Delivery of the ten key elements of the maternity transformation plan (one of which is the Continuity of Carer's	Each element of the plan in place

directive	
b) Engage with the Maternal & Neonatal Safety Collaborative (MatNeo) and implement the improvement plan on sepsis	Improvement plan for sepsis implemented and being monitored
5) Improve the recognition and escalation of the deteriorating patient with specific focus on:	
a) Sepsis	Undertake quarterly audit of 50 sets of notes to assess screening for and treatment of sepsis
	Report findings on a quarterly basis to the Sepsis Committee
	Committee to propose required actions as a result of audit findings
b) Diabetes	Audit of Blood Glucose Monitoring and Hypoglycaemia guideline to assess use of blood glucose monitoring form and algorithm
	Implementation of blood glucose monitoring connectivity meters and associated staff training
	Assessment of training levels for clinical staff in relation to diabetes and E-learning for safer use of insulin
	Quarterly audit of prescription chart focusing on insulin prescribing and administration

Executive Lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation Lead: Aoife Cavanagh, Deputy Director of Quality Governance
Monitoring: Patient Experience Committee

Patient Experience

Engaging with our patients and service users to gain feedback on their experiences and ensuring the patient's voice is heard when planning improvements and re-design to our services is central to the Trust's plans for becoming outstanding in delivery of care.

The quality priorities listed below are the areas we consider will result in maximum improvements to patient experience during 2020-21.

Aim/goal

To increase the opportunities available for patient involvement, interaction and gathering of views and feedback, which can then be utilised to improve services, pathways of care and the experience for all concerned.

Areas for focus and improvement during 2020/21 **Key objectives will include: -**	
1) **Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'**	
a) Re-establish the Patient Experience Lead role to lead on the strategy	
b) Monitor implementation and delivery of strategy quarterly at the Patient Experience Committee	
2) **The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process**	
a) Continue to undertake Trust bereavement survey and maintain consistently good results	
b) Improvement in the national End of Life Care survey results, based on most recent results	
c) Improvement in completion of individualised care plans for End of Life, based on last audit results	
d) To improve advance care planning in EoLC, through the increased use of the treatment escalation plan (audited as part of ICP audit and national EoLC audit)	
3) **Sustain improvement in the timely completion of Duty of Candour notifications as part of a wider commitment to improve patients and their carers' experience of adverse incidents and complaints**	
a) Refine reporting to capture all three elements of Duty of Candour – verbal notification, written notification and sharing the findings of the investigation	
b) Improved compliance, based on 2019/20 figures	
c) Develop Duty of Candour dashboard on Datix	
4) **Embedding safeguarding practices in all aspects of clinical care**	
a) Further develop tools to	Tool to be developed and co-designed with practitioners

enable practitioners to ensure that mental capacity assessments (MCA) are documented appropriately	MCA level 2 and 3 training package to be redesigned (including methodology of delivery)
b) Demonstrate the involvement of the patient and their representatives in decision making in relation to safeguarding	Audit to be undertaken assessing involvement of the patient and their representatives
	Results to be shared with relevant wards and any necessary actions put in place
	Results to be presented at the Safeguarding Committee
c) Ensure that all Deprivation of Liberty Safeguard applications are supported by a documented assessment of capacity	Audit to be undertaken assessing involvement of the patient and their representatives
	Results to be shared with relevant wards and any necessary actions put in place
	Results to be presented at the Safeguarding Committee

Executive Lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation Lead: Judy Durrant and Gemma Craig, Deputy Chief Nurses, Aoife Cavanagh, Deputy Director Quality Governance
Monitoring: Patient Experience Committee

Clinical Effectiveness

Efficient and effective clinical care drives improvements in both quality and performance. Ensuring our patient pathways throughout the organisation flow as effectively as possible is critical to the delivery of quality services; ensuring patients are cared for in the right environment, by the right staff at the right time. This needs to be applied from initial contact with our organisation through to discharge and beyond.

The quality priorities listed below are the areas we consider will have the greatest impact on delivery of quality patient care during 2020-21.

Aim/goal

To improve the management of our patient journeys through the utilisation of evidence-based practice.

<table>
<tr><th colspan="6">Areas for focus and improvement during 2020/21
Key objectives will include: -</th></tr>
<tr><td colspan="6">1) Improving the flow of patients into and out of our wards and departments by: -</td></tr>
<tr><td rowspan="3">a) Increasing the effectiveness of ambulance handovers</td><td></td><td>Maidstone Target</td><td>By Quarters</td><td>Tunbridge Wells Target</td><td>By Quarters</td></tr>
<tr><td>% of handovers exceeding 30 mins</td><td>5.0%</td><td>End Q1 6%
End Q2 5%
End Q3 5%
End Q4 5%</td><td>5.0%</td><td>End Q1 10 %
End Q2 7%
End Q3 5%
End Q4 5%</td></tr>
<tr><td>% of handovers exceeding 60 mins</td><td>0.1%</td><td>All quarters the same</td><td>0.2%</td><td>End Q1 0.4%
End Q2 0.4%
End Q3 0.3%
End Q4 0.2%</td></tr>
<tr><td rowspan="2">b) Improving the timeliness of discharge of patients from Intensive Care (ICU)</td><td colspan="5">Improve performance with regard to ward-based discharge (within 4 hours), based on 2019/20 numbers</td></tr>
<tr><td colspan="5">Decrease number of night-time discharges from the Intensive Care Unit (10pm-7am), based on 2019/20 numbers</td></tr>
<tr><td>c) Ensuring all necessary support is in place to allow patients to leave hospital when it is planned for them to do so</td><td colspan="5">Decrease in the numbers of patients with a length of stay of 7 days or more and 21 days or more respectively, based on 2019/20 numbers</td></tr>
<tr><td>d) Increasing the number of virtual clinics</td><td colspan="5">Transfer 50% of outpatient activity to virtual clinics, based on 2019/20 figures</td></tr>
</table>

2) The development of site-specific centres of excellence commencing with the centralisation of colorectal surgery, followed by the hyper-acute stroke unit (HASU), concentrating on new and improved ways of working which will support best practice and the opportunities for new roles.	
a) Development of colorectal surgery centre	
b) Development of Hyper-Acute Stroke Unit (HASU)	

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 Quality Committee and Trust Management Executive (TME).

Executive Lead: Sean Briggs, Chief Operating Officer
Board Sponsor: Sean Briggs, Chief Operating Officer
Implementation Lead: Lynn Gray, Deputy Chief Operating Officer
Monitoring: Patient Experience Committee

In the 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 the Maidstone and Tunbridge Wells NHS Trust Board has reviewed and engaged in national initiatives which link strongly to quality improvement.

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

The Trust is registered with the Care Quality Commission (CQC) 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 2019/20.

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

During 2019/20 the Trust provided and/or subcontracted acute and specialised services to NHS patients through our contracts with Clinical Commissioning Groups, Kent County Council and NHS England. The Trust has subcontracted more services to the Independent Sector Providers as part of the Prime Provider Model. The available data on the quality of care for all of these NHS services has been formally reviewed.

The income generated by the NHS services reviewed in 2019/20 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 consistently providing services to the required standards the Trust supported a number of reviews of its services undertaken by external organisations during 2019/20, including the following:

- Kent police – Counter Terrorism Crime and Security Act Annual Inspection – April 2019
- General Medical Council – Trainee & Trainer Survey – May 2019
- 2018/19 Annual Finance External Audit; Grant Thornton – completed May 2019

- CQC Engagement Event – 6th June 2019
- CQC Focus Groups with staff – 27th June 2019
- Health Education Kent Surrey and Sussex (HEKSS_ Surgery Programme Senior Led Conversation – June 2019
- National Cancer Peer Reviews - Annual rolling programme of internal validation – June 2019
- CQC Focus Groups with staff – 4th July 2019
- United Kingdom Accreditation Service (UKAS) accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – September 2019
- CQC Engagement Event – 5th September 2019
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – November 2019
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – November 2019
- Kings's College London (KCL) Quality Visit – November 2019
- CQC Engagement Event – 10th December 2019
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) - Blood Sciences – January 2020
- Caspe Healthcare Knowledge Systems (CHKS) (ISO 9001, CQC, Peer Review, TSR and Francis Rec.) Radiotherapy, Medical Physics, Chemotherapy, Clinical Trials, Oncology Outpatients, admin and clerical – February 2020
- International Organization for Standardization (ISO) accreditation 9001:2015 E.M.E. Services – February 2020
- Environmental Health – February 2020
- HM Revenue and Customs – VAT compliance review of contracted out services – not yet concluded

In addition our internal auditors, TIAA, undertook a range of audits to review the internal control environment at the Trust. TIAA undertook 16 assurance reviews, 13 of which provided reasonable assurance and 3 provided limited assurance.

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

- Internal assurance inspections (based on the CQC methodology) with participation from our patient representatives and Quality Leads from West Kent and Sussex Alliance CCG's
- Internal PLACE (Patient-Led Assessments of the Care Environment) reviews
- Infection control reviews, including hand hygiene audits
- Trust Board member "walkabouts"
- Matron's Quality Checks

The outcomes of these assessments are included within our triangulation process to review clinical areas and identify any areas where additional support and actions are required to maintain standards. Action plans are developed locally and, alongside the associated reports are scrutinised in the Quality Improvement Committee, within our governance structure and monitored accordingly.

Clinical Audit

Through the Trust's clinical audit activities, identified aspects of care are evaluated to ascertain compliance and quality against specific criteria. 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 2019/20, the Trust participated in 100% of relevant confidential enquiries and 96% of all relevant national clinical audits (2 were not submitted due to software issues). There were **378** audits registered on the 2019/20 Trust clinical audit programme. Of these **175** audits (local and national) were due to be completed to action plan stage by 31st March 2020. MTW staff successfully completed **167** clinical audits of the 175. 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 2019/20 are presented as follows:

National Clinical Audits for inclusion in Quality Accounts 2019/20	**Participation** Y, N or NA	**No of cases submitted**	**% cases submitted**	**Comments**
Acute Care				
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	MGH - 373 TWH - 504	100%	Continuous data collection.
Emergency Laparotomy Audit (NELA)	Y	MGH – 32 TWH - 215	100%	Continuous data collection.
Severe Trauma (Trauma Audit and Research Network) TARN	Y	MGH - 62 TWH - 355	69 – 87%	Continuous data collection
National Joint Registry (NJR)	Y	MGH - 570 TWH - 406	100%	Continuous data collection
Neurosurgical National Audit Programme	N/A			MTW does not provide this service
National Vascular	N/A			MTW does not

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
Registry				provide this service
RCEM Assessing Cognitive Impairment in Older People (care in the ED) 2019	Y	MGH – 50 TWH - 50	100%	
RCEM Mental Health Care in Emergency Departments (care in the ED) 2019	Y	MGH – 50 TWH - 50	100%	
RCEM Care of Children in Emergency Departments (care in the ED) 2019	Y	MGH – 50 TWH - 50	100%	
BAUS Urology Audits: Radical prostatectomy audit	Y	0	100%	Data collection currently suspended due to COVID-19
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	7	100%	
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNI)	Y	0	0%	Data collection currently suspended due to COVID-19
Specialist Rehabilitation for patients with complex needs following major injury (NCASRI)	N/A			MTW does not provide this service
Perioperative Quality Improvement Project (PQIP)	Y	2 patients recruited, 1 since withdrawn	100%	Research & Development Department study
Blood transfusion				

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
Serious Hazards of Transfusion 2019 (SHOT) UK. National haemovigilance scheme	Y	MTW - 10	100%	Reported 10 incidents, 3 of which were withdrawn by SHOT.
National Comparative Audit of Blood Transfusion Programme Re-audit of the medical use of blood.	Y	TWH – 20 MGH – 19	100%	
National Comparative Audit of Blood Transfusion Programme Audit of FFP and cryoprecipitate in children and neonates.	N/A			The Medical Director made the decision to not register or take part in this audit as there are no cases / too few to warrant inclusion and meaningful results.
Cancer				
Lung Cancer (NLCA)	Y	530	100%	Yearly rolling audit with continuous data collection. Projected figure provided for 2019-20 data.
Bowel Cancer (NBOCAP)	Y	351	100%	Continuous data collection. 2018/19 data submitted in June 2020. Data for 2019/20 to be submitted in September 2020.
National Prostate Cancer Audit (NPCA)	Y	525	100%	Yearly rolling audit with continuous data collection.
National Oesophago-gastric cancer (NOGCA)	Y	97	100%	MTW has not performed major upper gastrointestinal cancer surgery since 2013; however the

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
				Trust participates in the diagnostic pathway for this group of patients.
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.
Heart				
Myocardial Ischaemia National Audit Project (MINAP)	Y	MGH – 195 TWH - 192	100%	Data collection still open and data being submitted
National Heart Failure Audit	Y	MGH – 328 TWH - 280	100%	Data collection still open and data being submitted
National audit of Percutaneous Coronary Interventions (PCI) (Coronary angioplasty)	Y	MTW - 279	100%	Data collection still open and data being submitted
Cardiac Rhythm Management (CRM)	Y	0	0%	MTW unable to participate as we do not have access to the new software platform.
National audit of Cardiac Rehabilitation	Y	MGH - 444 TWH - 512	100%	

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
(NACR)				
National Cardiac Arrest Audit (NCAA)	Y	MGH - 63 TWH - 70	100%	Continuous data collection
Adult Cardiac surgery	N/A			MTW does not provide this service
National Congenital heart disease (CHD)	N/A			MTW does not provide this service
National Audit of Pulmonary Hypertension	N/A			MTW does not provide this service
Long Term Conditions				
National Adult Diabetes Inpatient Audit (NaDIA) 2019	Y	MGH – 54 TWH - 53		
National Diabetes Inpatient Audit – Harms	Y	MTW - 55	100%	
National Diabetes Foot Care Audit	Y	MGH - 17 TWH - 48	100%	
National Core Diabetes Audit (NDA) 2018-19	Y	MTW - 1699	100%	
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Pulmonary Rehabilitation	Y	MTW - 55	100%	
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD	Y	MTW - 33	100%	

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
Secondary Care				
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – Adult Asthma Secondary Care	Y	MTW - 109	100%	
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	Y	MTW - 235	100%	
National Early Inflammatory Arthritis Audit (NEIAA)	Y	MGH - 9 TWH - 4	100%	Data collection currently suspended due to COVID-19
National Audit of Anxiety and Depression	N/A			MTW does not provide this service
Older People				
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	Inpatient Falls (NAIF) MTW – 13	100%	Continuous data collection
	N/A	Fracture Liaison Service	N/A	MTW does not provide this service. This is a community service.
		National Hip		Continuous data

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
	Y	Fracture database (NHFD) MTW - 544	93.6%	collection
Sentinel Stroke National Audit Programme (SSNAP)	Y	MGH – 358 TWH – 176	100%	
Other				
Elective surgery (National PROMs Programme) Hip Replacement & Knee Replacement	Y	MTW: Hip: 108 Knee: 120	100%	
National Ophthalmology Adult Cataract Surgery Audit	N	MTW - 0	0%	MTW unable to participate as we do not have the software
National Audit of Care at the End of Life 2019 (NACEL)	Y	TWH - 20 MGH - 20	100%	
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
Mandatory Surveillance of bloodstream infections and Clostridium Difficile infection.	Y	C. Diff: 52 Bloodstream: 97	100%	
Mental Health				

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
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 - 444	100%	

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	Y	0	100%	The trust had no cases that met the criteria for this audit.
MBRRACE-UK; Perinatal Mortality Surveillance	Y	MTW Stillbirth: 17 Neonatal: 1 Extended Perinatal: 18	100%	
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	Y	0	100%	MTW 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: 17 Neonatal: 1 Extended Perinatal:18	100%	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	Y	49	100%	Continuous data collection
Paediatric Inflammatory	Y	24	100%	Data submitted

National Clinical Audits for inclusion in Quality Accounts 2019/20	Participation Y, N or NA	No of cases submitted	% cases submitted	Comments
Bowel Disease				quarterly
National Maternity and Perinatal Audit (NMPA)	Y	MTW - 5606	100%	Submitted monthly via Maternity Services Data Set.
National Pregnancy in Diabetes Audit	Y	49	100%	
Paediatric Intensive Care Audit Network (PICANet)	N/A			MTW does not provide this service
National Paediatric Diabetes Audit (NPDA)	Y	TWH: 108 MGH: 129	100%	Continuous data collection, final date for 2019/20 data submission is 29th May 2020.
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	Y	MTW - 112	100%	Continuous data collection
National Confidential Enquiries				
NCEPOD: Acute Bowel Obstruction	Y	6	66%	
NCEPOD: Out of Hospital Cardiac Arrest	Y	4	66%	
NCEPOD: Dysphagia in people with Parkinson's Disease study	Y	7	88%	
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 MTW.

51 national audits were published in 2019/2020 with actions taken to address areas of non- or partial compliance. A number of improvements have been made in line with national recommendations, including:

National Emergency Laparotomy Audit (NELA)

The Maidstone and Tunbridge Wells NHS Trust Emergency Laparotomy Team continues to go from strength to strength after again being named within the top performing teams in the UK. MTW is currently placed within the top 20 performing Trusts out of a total of 128. Within the top 20, the figures also show that the team at MTW was one of only two Trusts to carry out over 60 laparotomies complying with national targets for Best Practice, with many other organisations carrying out less than 10 of the procedures.

National Neonatal Audit Programme (NNAP) 2018

The Royal College of Paediatrics and Child Health who run the NNAP, identified The Tunbridge Wells Hospital as outstanding (three or more standard deviations above a zero rate of change) for change between 2016 and 2018 for the audit measure "Does a baby born at less than 30 weeks gestational age receive medical follow-up at two years corrected age (18-30 months gestationally corrected age)?" which is a notable improvement. When the full NNAP report was published, the Trust Neonatal Unit had performed above national averages in all but one category.

Royal College of Emergency Medicine VTE risk in lower limb immobilisation (care in the Emergency Department) 2018

This National Audit demonstrated excellent practice benchmarked against national outcomes, putting MTW among the highest achieving Trusts in the country. The Royal College recommendations state that compliance is achieved through measurement against the National Mean. Mean scores for the standards at Tunbridge Wells Hospital and Maidstone Hospital were 96% and 99% respectively with the national mean at 36%.

National Maternity and Perinatal Audit

The Trust is now fully compliant with all recommendations except one. In the previous report it was partially compliant for seven of the recommendations. Detailed reviews were carried out on 3rd and 4th degree tears, PPH >1500ml (postpartum haemorrhage) and instrumental deliveries. Actions were put in place to improve results and local monitoring and audits continued. The recommendation that we were partially compliant in the latest audit, "Maternity services, primary care and public health services should work together, with involvement of local service users, to ensure that there is appropriate provision to support weight management prior to, during and after

pregnancy", has resulted in a Transformation Lead Midwife being appointed to support Local Maternity System (LMS) collaboration.

Severe Trauma (Trauma Audit and Research Network) TARN

Every year across England and Wales, approximately 16,000 people die after injury. It is the leading cause of death among children and young adults of 44 years and under. In addition, there are many thousands who are left severely disabled for life. The Trust submits trauma data to TARN, with the vast majority of trauma cases seen in the two Emergency Departments being patients over 70 who have fallen. The TARN co-ordinator identifies areas where our performance could be improved via TARN reports and these areas are then flagged up and addressed at the quarterly Trauma Board meetings. Improvement measures are then put in place. For example to improve time to CT scan (computerised tomography) for head injury patients, measures for prompt CT requesting and dedicated porters have been implemented. The proportion of patients meeting NICE head injury guidelines that receive a CT scan within 60 minutes of arrival at the Trust is now at 67%, up from 50% in the last quarter's dashboard report. The national mean is 52%.

Please see Appendix A for full details of progress against each of the reported national audit results 2019/20.

Improvements to clinical practice from local audits

A number of improvements have been made as a result of the **116** completed local clinical audits, across all Directorates, in 2019/20. **64** 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 2019/2020	Trust Actions
Re-audit of sedation management in the ICU	It is sometimes observed in practice that patients are being kept more deeply sedated than necessary; Brattebo et al (2004) consider light sedation to include a RASS score of between +1 to -2. Maintenance of light sedation levels in stable ICU patients decreases the duration of mechanical ventilation and can reduce the rate of tracheostomy insertions. As a result of the previous audit, laminated copies of the RASS scoring system were placed in each patient room. The re-audit results indicate improvements have been made over the last year regarding minimising sedation when it is not clinically indicated (39% down to 23%). Further improvement may be achieved by optimising analgesia as opposed to sedation and training sessions about RASS scoring. *(Note: RASS score is a scale used to measure the agitation or sedation level of a patient)*
Documentation of emergency	The initial audit looked at the documentation of emergency (non-theatre) intubation for adults. The resulting action plan included staff education

Actions taken following local audits 2019/2020	Trust Actions
intubation	regarding current use of the trust emergency intubation proforma, where to find the proforma and when it is recommended to complete this form. An adequate supply was made available at both Maidstone and Tunbridge Wells ICU as well as ensuring paper copies are available with the crash bags. This re-audit reviewed notes of cases identified mainly from ICU admissions at both sites. There was a significant improvement in the documentation of emergency intubations with 100% of cases having some form of documentation in the medical notes compared to just 55.5% in the previous audit. There is room for further improvement as use of the Trust proforma is still below the level aimed for, with the largest barrier continuing to be awareness of the proforma.
Emergency Ophthalmology Admissions	The initial audit was conducted to review practice following the implementation of Trust guidelines on ophthalmology emergency admissions. It was noted that patients who had not been admitted under joint care but required a medical review were not escalated to the appropriate team. The auditors recommended that these patients' details should be updated and shared with the involved parties in the daily email handover. In the re-audit all patients received a regular ophthalmic review, their details were updated in the daily email handover, they received a medical review if they required it and they all received a Consultant review when required, ensuring patients receive adequate care and specialist input when needed.
Re-audit of Consent for Laparoscopic Cholecystectomy	Laparoscopic cholecystectomy is one of the most common elective operations; General Medical Council (GMC) guidance emphasises the importance of informed consent. After the initial audit, education sessions were held during surgical departmental meetings regarding the consent process including the importance of documentation of conversations with patients. The second round showed improvements in 11 of the 17 standards.
Re-audit of Consent for Open Inguinal Hernia Repair	The GMC guidelines advise that the principles of shared decision making state that patients must be informed of any serious adverse outcome, even if the likelihood is very small. Inguinal hernia repair is one of the most commonly performed surgical procedures. After the initial audit, education sessions were held during surgical departmental meetings regarding the consent process including the importance of documentation of conversations with patients. The second round showed improvements in 9 of the 14 standards.
Pre-operative Medications Administration	In 2015, a small group of junior doctors at Tunbridge Wells Hospital undertook an audit into the preoperative administration of medications of patients undergoing surgery. They followed the recommendations from

Actions taken following local audits 2019/2020	Trust Actions
(missed medications) Trauma and Orthopaedics – Re-audit	findings in a 2002 NCEPOD report. A poster was created highlighting which medications should be continued and which should be omitted pre-operatively and it was displayed on surgical wards. Re-audit showed patients not receiving drugs which should be stopped prior to surgery, improved from 75% in the first round to 94.4% in the second.
Improving follow up in Ward 2 patients, a closed loop audit	Ward 2 is an acute geriatric medical unit with a high turnover of patients every week. Patients admitted to Ward 2 should not stay more than 72 hours. To maintain high patient flow without compromising quality of care many patients are discharged with outstanding outpatient investigations. There was no formal system of tracking investigations that were outstanding as an outpatient at Tunbridge Wells Hospital. The first audit showed that a high percentage of outstanding investigations were being inappropriately referred to the GP. It also showed that, of the outstanding investigations requiring follow up, there was no evidence that these investigations were actually being followed up. In January 2019, Ward 2 introduced a colour coded spreadsheet system that automatically highlighted to the doctors which investigations were due to be followed up next, based on the expected date of investigation. On recollection of the data, the Ward 2 spreadsheet had improved rates of investigation followed up by the ward team by 50%, and decreased the rate of investigations inappropriately referred to the GP by 50%. It improved the rates of digitally documented evidence by nearly 80%.

NICE Guidelines

NICE
National Institute for Health and Care Excellence

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.

The Trust reviews 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 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 2019/20 a total of **1682** NICE guidance documents have been disseminated to Trust specialty leads since NICE guidance began to be published in 2005. Of those, **1618 (95%)** have

been evaluated. **666 (41%)** of the evaluated guidance are considered to be relevant to the Trust's activities. Each Directorate is regularly updated of the actions required to meet compliance.

Guidance published from 1 April 2019 to 31 March 2020.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (CG/NG)	**46**	**32**	**25**
Interventional Procedures (IPG)	**28**	**25**	**5**
Technology Appraisals (TA)	**50**	**38**	**22**
Others (DG, HST, MIB, MTG)	**17**	**15**	**6**
Totals	**141**	**110**	**58**

Please see Appendix B for full details of Trust compliance with NICE guidance that has been audited and completed during 2019/20.

Research

Maidstone and Tunbridge Wells NHS Trust recruited 3,267 participants to 85 research projects during 2019/20 that were approved by the Research Ethics Committee, against an annual plan of 1,306 participants. This plan was agreed with the Local Research Network and based on the predicted number of patients to be recruited to trials open at the start of the financial year.

The 2019/20 research year started with the Research and Development department (R&D) taking over the management of a number of sexual health studies. This followed the change in service provider for Sexual Health services across the region from the community to the Trust.

Meanwhile the Research Delivery team commenced the year preparing to vaccinate local students against Meningitis B as part of the 'Be-on-the-Team Teenagers Against Meningitis' study. Research nurses attended vaccination training and drafted in nursing support from other hospital departments to meet the challenge. By the end of the calendar year, the team had vaccinated 800 local sixth form students against the disease. This vaccination will provide some protection against the disease for students during the second most high risk stage of their lives.

Despite spending time preparing for Britain's exit from the European Union and addressing the impacts on research, research staff continued to ensure it was business as usual in delivering and promoting high quality research throughout the year.

The R&D department welcomed a number of new staff during the year, both from external organisations and from other Trust departments, including Research Nurses in Oncology research, Research Practitioners in Trauma & Orthopaedic and Ophthalmic research, and two part-time Research Midwives. Critical care research was boosted by the appointment of a full time

Critical Care Research Nurse, with a split role, providing ICU research support and leading on joint working with academia to create research studies to suit local health needs.

Research studies

85 studies were open and recruiting during the year, across a wide range of specialisms. Of the new studies opened at the Trust in-year, R&D staff managed to be the first hospital to recruit a patient nationally (and sometimes globally) to a record number of studies including in Ophthalmology, Trauma & Orthopaedics, Critical Care, Oncology and Rheumatology research. Ensuring patients are given an opportunity to participate in research in a timely manner is a key driver for the R&D department.

Hospital departments recruiting the largest number of patients to trials included Critical Care (100 patients), Oncology (over 200 patients) and Children's Services, who recruited over 1,000 young people to the national meningitis trial.

Promoting research

R&D staff took time out during the year to engage in local information sharing and promotion of research in general. In May, the Lead Research Nurse and the Critical Care Research Nurses attended a nursing student conference in May held at Christ Church University in Canterbury, Kent, to promote the work of research at the Trust and to encourage newly qualified nurses to become involved in research wherever they took their first jobs.

The Trust Lead Research Nurse was invited to be a judge for the 2019 National Nursing Times Awards.

The Research Governance team continued to run monthly 'Research Hubs' in the libraries on the two main hospital sites throughout the year. The hubs provide a space for Trust staff to discuss research and acted as a drop-in facility for staff to speak to members of the research team about their ideas.

New leadership posts

Research management staff were busy during the year contributing to a proposed new way of working collaboratively with other public sector providers and academia. The new initiative known as the Joint Research Office will pull together research ideas and projects from all over Kent and Medway to ensure the health needs of our region and the interests of local clinicians are addressed through research. This initiative will take shape in the New Year.

During the summer, the Trust and the new Kent and Medway Medical School agreed to fund two joint clinical academic posts. Facilitated by the Trust's Clinical Lead for Research, the posts help boost local research activity and capability across the region. Both new post holders were appointed in the autumn and took their positions late in 2019; Dr Catherine Harper-Wynne and Miss Karina Cox.

At this time, Miss Cox also took on the role of Clinical Lead for Research and Development. She said;

"*I am delighted to be Clinical Lead for R&D at the Trust. There are exciting times ahead as the research environment in Kent is improving with lots of new opportunities opening up. The University of Kent and Canterbury Christ Church University is full of talented and committed scientists, researchers and engineers, many of whom would jump at the chance to collaborate with clinical projects. I strongly believe that effective research is good for staff and patients and I hope to strengthen the existing research infrastructure to enable more staff to put together their own projects."*

Miss Karina Cox, Trust R&D Clinical Lead

These appointments support a wider initiative to attract research active clinicians to the Trust both at consultant level and in the longer term to bid for academic clinical fellows and externally funded Trust research posts. The aim is to integrate Trust research activity with that of the Kent, Surrey and Sussex Applied Research Collaboration (KSSARC) and the Kent and Medway Medical School (KMMS).

Keeping research staff up to date with new information

2019/20 was another year where MTW research staff were given every opportunity to advance their research learning and capability. Two research nurses and a research physiotherapist joined the Integrated Clinical Academic Programme, funded by the National Institute for Health Research (NIHR). The programme provides research training for healthcare professionals, allowing them to develop their research careers and research leadership with continued clinical practice. The Trust's Lead Research Midwife was also successful at securing a place on the NIHR Advanced Leadership Programme.

At the end of the year, the R&D Team were delighted to be nominated for awards in 11 categories of the Trust's Annual Staff Awards, taking runner-up in the Staff Innovation category. The outstanding work of one of our Research Practitioner staff was voted as 'highly commended' by the Local Research Network for her work in local and national promotion of research.

Patient and Public Involvement in research

Patient and Public Involvement (PPI) in research is very active at the Trust. Over the last year, research volunteers have been instrumental in supporting the set up and delivery of research studies, such as writing research proposals, putting research documents into a format that is easy to read, and providing hands-on support to clinical staff in study delivery.

The team bring a wealth of wider expertise to the department and is central to the research function at the Trust. Their contribution was recognised at the end of the year by the Kent Surrey and Sussex Clinical Research Network, who awarded them with two awards for their positive impact on research.

Covid-19 Research

ITU Research Nurse

Like other R&D departments across the country, the Trust's R&D department swiftly adapted to the Covid-19 outbreak at the start of 2020. The team successfully recruited patients to five high profile public health Covid-19 studies, and worked with colleagues across Kent, Surrey and Sussex to devise studies designed to look at the impact of Covid-19 on the local population.

All clinical and non-clinical research staff worked tirelessly to ensure Covid-19 studies were opened as soon as possible to provide treatment opportunities to as many patients as possible. Research staff from the local mental health Trust also stepped up to support the running of Covid-19 trials at the hospital, using their transferable skills to support data collection.

For most of the R&D team, the critical care environment and critical care studies were not something they were used to.

An MTW Research Practitioner supporting data collection for the Covid-19 studies

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 2019/20, 1.25% of the contract value was dependent on achieving the CQUIN targets for CCGs and 0.75% was for NHS England in line with the CQUIN payment framework. However Maidstone and 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 percentage achievement. This does not detract from the main intention or purpose of CQUINs, which are to improve the quality of care provided to our patients; as such delivery of these remains a high priority for the Trust.

Due to COVID-19, in March 2020, CQUIN submissions were suspended, and therefore achievement relates to quarter three achievements, except where data was already available for the entire year.

Within the commissioning payment framework for 2019/20 quality improvement and innovation goals were set and achieved as indicated in the table below.

CQUINs	Target	Achieved (local data)	RAG Rating
National CQUINS (CCGs)			
Improving the uptake of flu vaccinations for frontline clinical staff.	80% uptake achieved by 29th February	83%	Green
Preventing ill health through risky behaviours. This focussed on screening a number of patients for tobacco	Screening 80%	20% 100%	Amber

CQUINs	Target	Achieved (local data)	RAG Rating
and alcohol misuse, and referring to cessation services, or offering advice for 90% of those who triggered a positive response to the screen. Documentation on this was limited, and in Q3 onwards the focus was on undertaking this in pre-operative assessment. All patients that receive a pre-op are screened and the opportunity for referral and advice is embedded into the assessment. This accounted for 20% of activity	Referral/ advice 90%		
Antimicrobial Resistance: Lower Urinary Tract Infections in Older People. This CQUIN focussed on the diagnostic method for UTI's (urinary tract infections) in patients aged over 65, and achievement is attained by excluding the use of a dip stick for diagnosis.	80%	89%	Green
Antimicrobial Resistance: Antibiotic Prophylaxis in colorectal surgery. This CQUIN focused on reducing the number of antibiotic doses prescribed after colorectal surgery.	90%	87%	Green
Three High Impact Actions to Prevent Hospital Falls. This CQUIN focussed on three areas to reduce the number of falls in inpatients. A) Recording a lying and standing blood pressure (BP). B) No hypnotics, antipsychotics, or anxiolytics given during stay. C) Mobility assessment and walking aid provision.	50	46%	Amber
Same Day Emergency Care. This CQUIN aimed to reduce unnecessary hospital admission by encouraging providers to develop ambulatory pathways for three conditions: 1. Pulmonary Embolus	75%	91%	Green
2. Tachycardia with Atrial Fibrillation	75%	95%	Green
3. Community Acquired Pneumonia	75%	89%	Green
NHS England Specialist CQUINs			
Clinical Utilisation Review (CUR) – optimising patient flows and move out of acute settings	Data submission, daily use of CUR, reduction in % of NQ* patients	75%	Amber

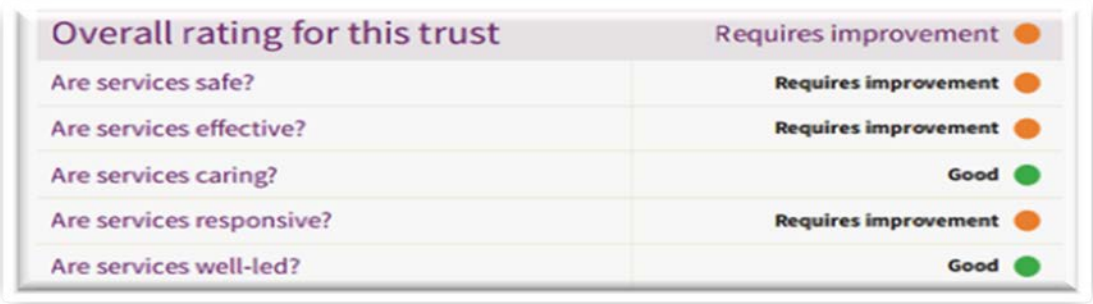
CQUINs	Target	Achieved (local data)	RAG Rating
Hospital Medicines Optimisation has 5 elements: 1. Improving efficiency in the IV chemotherapy pathway from pharmacy to patient – reducing chemotherapy waste. 2. Managed access agreement compliance - ensuring data requirements are met so that the real-life value of these medicines can be assessed. 3. Supporting national treatment criteria through accurate completion of prior approval proformas (Blueteq) - reducing unwarranted clinical variation between centres. 4. Faster adoption of prioritised best value medicines and treatment – improving the rate of adoption at a local level. 5. Anti-Fungal Stewardship- Reduce inappropriate use of anti-fungal agents and prevent the development of resistance to antifungals through the development of anti-fungal stewardship teams.	Trigger 1 Trigger 2 Trigger 3 Trigger 4 Trigger 5	100% 100% 100% 100% 100%	Green

***** Delivery against the agreed KPI for the reduction in non-qualified (unmet) patients throughout the period of CUR operation, where patients do not meet clinical criteria for admission, continued stay or treatment at the current level of care. The CQUIN payment should be determined by measuring the reduction in the % of CUR assessments that do not meet CUR criteria for the current level of care against those beds / services implemented in 2018/19.

Statements from the CQC

The Trust has not been inspected since the update provided in the Quality Accounts 2018/19.

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'.



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 were hugely encouraged that the inspectors recognised that we put quality at the heart of everything we do, and that we had 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 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. Each of these recommendations have been addressed, with ongoing checks in place to ensure that the actions have been embedded.

The Trust's preparations and planning for CQC inspections are fully integrated and embedded as part of the Trust's business as usual (BAU) quality improvement agenda. The Trust monitors compliance with CQC registration requirements itself, primarily through a programme of in-house assurance visits/inspections. Such inspections, which are managed by the Quality Governance and Corporate Nursing teams, include patient representatives and representatives from NHS Kent and Medway Clinical Commissioning Group, the main commissioner of the Trust's services. The outcomes of the inspections are used to identify areas for improvement, which are then acted upon. The Quality Improvement Committee provides the governance and oversight of this programme of work.

This committee, which is chaired by the Chief Nurse and reports to the Best Quality work stream, has been pivotal in overseeing timely delivery of the recommendations for the most recent CQC inspection.

Quarterly engagement events have taken place with the CQC during 2019/20. Although such engagement events do not affect the Trust's formal assessment rating, the CQC have provided positive feedback on the areas that have been visited during these events.

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

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

Improving data quality

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 12):

- 99.7% (99.6% 18/19) for Admitted Patient Care;
- 99.9% (99.8% 18/19) for Outpatient Care; and
- 98.6% (98.1% 18/19) for Accident and Emergency Care.

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

- 99.9% (100% 18/19) for Admitted Patient Care;
- 99.9% (99.9% 18/19) for Outpatient Care; and
- 99.9% (100% 18/19) for Accident and Emergency Care.

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

Data Security and Protection Toolkit (DSPT)

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.

Due to COVID-19 the deadline for DSPT submission was pushed back by NHSX to 30 September 2020. The Trust continues with its preparations for submission and has requested TIAA to complete an audit of evidence posted to support the submission. The review tested a sample of four of the ten Data Security Standards for completeness and validity of evidence and statements supporting the assertions and mandatory evidence items associated with those standards. These standards address modern data security threats as well as inherent information governance processes operated at NHS organisations. As at 11 March 2020 the Trust received 'Reasonable Assurance' from the audit report. At that time two mandatory evidence items were still outstanding.

It is the Trust's intention to submit a 'Standards Met' toolkit in September 2020.

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

The 2019/20 clinical coding and process review was undertaken by Maxwell Stanley Ltd in March 2020. The audit scored the Trust to the equivalent of Level 3. The recommendations from the previous year were reviewed and it was demonstrated that progress had been made in all four areas highlighted.

Audit results summary

	Primary diagnosis correct %	Secondary diagnosis correct %	Primary procedure correct %	Secondary procedure correct %	Unsafe to audit
IG audit 2019/20	99.50 %	99.14 %	98.63 %	98.70 %	2
IG audit 2018/19	98.00 %	97.38 %	96.40 %	97.27 %	0
Break down of errors	Total from audited FCEs	Coder error	Non-coder error	Total incorrect	% correct
Primary diagnosis	200	1	0	1	99.50 %
Secondary diagnosis	812	6	1	7	99.14 %
Primary procedure	146	2	0	2	98. 63 %
Secondary procedure	230	3	0	3	98.70 %

The findings of the audit demonstrated a high standard of coding accuracy.

The recommendations made were:

- Provide additional training to all clinical coding staff to aide extraction from the clinical case notes of all relevant conditions and mandatory comorbidities.
- Provide additional training to all clinical coding staff to ensure all relevant imaging procedures are correctly captured and coded.
- Coding department to continue to liaise with relevant departments in order to continue improvements in the filing of case notes.
- Coding staff to search all relevant documentation and additional systems within the timeframe of the inpatient spell to ensure all relevant conditions are captured.

These recommendations have been built into the work plan for the Clinical Coding service for 2020/21.

Part Three

Results and achievements against the 2019/20 quality priorities

The table below summarises the quality improvement priorities we set out to achieve during 2019/20. We have made significant progress in all areas resulting in improved outcomes for patients.

	SUMMARY		
	PATIENT SAFETY	**PATIENT EXPERIENCE**	**CLINICAL EFFECTIVENESS**
Aim	To create reliable processes that will build and sustain a supportive environment to reduce avoidable harm.	To improve the use of current feedback mechanisms and provide more innovative ways to receive and act upon feedback.	To improve patient flow through the delivery of safe and effective care for patients by whichever pathway of care best meets those needs.
2020/21 Quality Priorities	Creating a safety culture that embraces 'lessons learned'.	Embed and deliver the Quality Improvement plan.	Improving the delivery of clinical quality standards and therefore timely treatment for our patients accessing care through both our emergency and planned pathways.
	Reducing healthcare associated infections.	Improving End of Life Care (EoLC) in the acute Trust.	Improving patient flow through the development of alternative care models/pathways.
	Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.	To recognise and respond to the specific needs of our patients with complex needs.	Reduction in cancelled operations.
	Improve the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation.		Development of new and enhanced roles to improve pathways of care and raise staff morale.

This section will describe the results and achievements in greater detail against each of the quality priorities. Later in this section other significant improvements in patient care and quality initiatives are outlined to provide further examples of the implementation of the quality agenda within the Trust.

Patient Safety

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

1) Creating a safety culture that embraces 'lessons learned'

a) Increasing the number of incidents that are reported to identify themes to support positive change and improvement

This quality priority has been achieved as the number of reported incidents has continued to rise in 2019/20**.** Please see comparison tables below demonstrating a rise of 853 more incidents reported.

	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	Total
Total reported in quarter	2742	3038	2911	2978	**11669**
Total reported in quarter still open awaiting investigation / closure	12	14	26	18	**132**
Total reported in quarter that were investigated and closed	2730	3024	2885	2898	**11537**
Total number of all incidents investigated and closed during time period*	2059	2494	3364	2644	**10561**
	19/20 Q1	**19/20 Q2**	**19/20 Q3**	**19/20 Q4**	**Total**
Total reported in quarter	2787	2867	3531	3337	**12522**
Total reported in quarter still open awaiting investigation / closure	144	195	356	425	**1120**
Total reported in quarter that were investigated and closed	2643	2672	3175	2912	**11402**
Total number of all incidents investigated and closed during time period*	3422	1613	4963	4370	**14368**

*This figure includes total number of incidents finally approved with a closed date during this quarter and will contain incidents reported outside of this quarter

Additionally, over 3,800 more incidents were investigated and closed in 2019/20 than the previous year. These improvements were, in part, the result of the expansion of the Patient Safety team.

An interim Datix Project Manager was appointed and facilitated the following:

- Weekly key performance indicators (KPIs) to be produced for number of incidents reported and closed,
- Support of directorate staff to close down open incidents >45 days and
- Changes to the Datix incident reporting form to improve ease of use

The Patient Safety team recruited two Serious Incident Investigators to ensure timely and robust investigation of serious incidents and a Deputy Patient Safety Manager, who will lead on education. The SI investigator role includes establishing good communication processes and support to all parties involved in incidents / serious incidents – patients, family members and staff.

Two Patient Safety administrators were appointed to support the management of incident reporting, review and closure. Being able to review, investigate and identify learning from incidents in a timely manner ensures measures can be implemented promptly. These measures should be planned carefully to eliminate where possible, and if not then to reduce risks to patients.

b) Continued focus on reducing our Trust-level mortality figures in line with the national average (HSMR/SHMI) through learning from mortality reviews

Learning from Deaths and Mortality Reviews are covered in more detail in a separate section on page 77. The Trust has continued to see mortality rates reduce during 2019/20. Work continues to implement the Mortality Datix module to further support the mortality review process. The module will improve the Trust's ability to identify trends and learning from mortality reviews.

The Trust has recruited to Medical Examiner and Medical Examiner Officer posts to enable implementation of the Medical Examiner System during 2020. The purpose of this system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data

NHS Improvement, Establishing Medical Examiner System, 2019

This system will further support the learning from deaths and mortality reviews process at the Trust and an ongoing reduction in our Trust-level mortality figures was anticipated for 2020/21. This position may now be affected by the COVID-19 pandemic.

c) Supporting staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety.

A range of initiatives have been developed / continued to meet this quality priority. The Trust recognises the importance of:

- Supporting staff involved in patient safety incidents and

- Providing training and development to staff to embed a patient safety culture in all corners of the organisation.

The introduction of a Deputy Patient Safety Manager and Education Lead has enabled the progression of the Learning Lessons agenda for the Trust. This includes Trust-wide learning events, the roll out of Datix Incident Management training and Duty of Candour training for all staff.

Unfortunately due to the COVID-19 pandemic the Timothy Mason Learning Lessons launch event scheduled for 31st March 2020 and subsequent events have had to be cancelled for the foreseeable future. However, the Trust is considering virtual technology and/or socially distanced events to ensure these can safely take place in the future.

Joint Root Cause Analysis Training with Kent and Medway NHS and Social Care Partnership Trust (KMPT) was introduced in 2019/20. This has the benefit of enabling cross-organisational learning, whilst equipping staff with the tools and support to competently and confidently undertake incident investigations, identify root causes and develop robust action plans.

The Trust continues with a comprehensive programme of Human Factors training to improve patient safety. A previous review of 'near miss' incidents reported from Theatres has evidenced a rise of almost 30% since the inception of Human Factors training. The categories that have seen the biggest rise include consent, patient information and treatment/procedure. This increase may be attributed to this training as its aim is to enhance clinical performance through fostering an understanding of the effects that teamwork, tasks, culture, equipment, environment, etc. may have on human behaviour. This understanding therefore has an impact on patient safety; staff may be able to identify risks more quickly and work to stop incidents happening.

Schwarz rounds were introduced in the Trust in 2019 to provide a forum for staff to share experiences in a safe environment. Rounds were held on both of the main hospital sites and attracted audiences from a range of staff groups, both clinical and non-clinical.

d) Embed a safety culture within all departments undertaking invasive procedures which complies with the WHO surgical safety methodology.

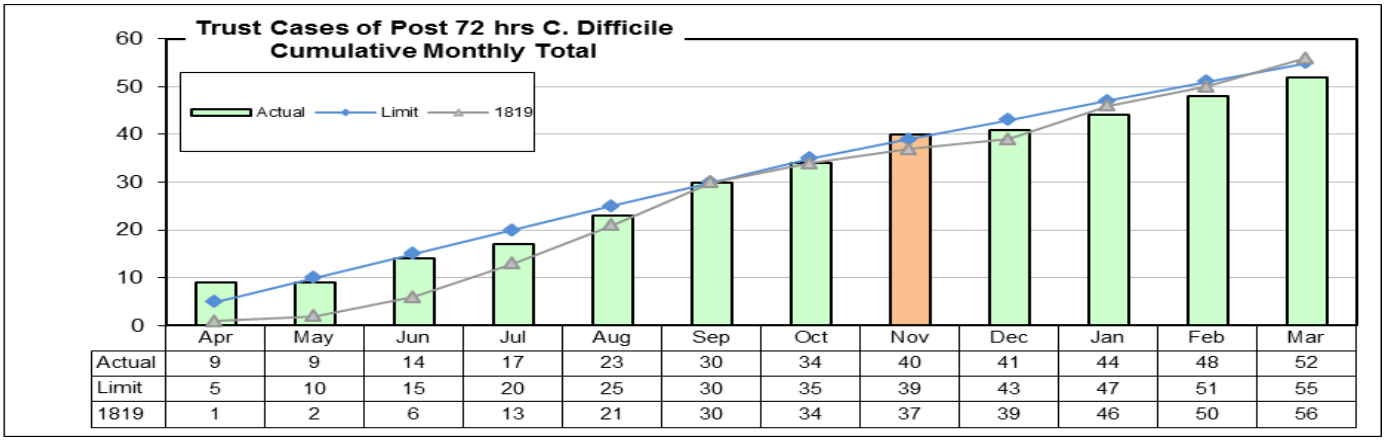
A Safety Standards for Interventional Procedures Working Group was re-launched in November 2018 to focus on the standardisation and implementation of Local Safety Standards for Invasive Procedures (LocSSIPs – previously known as the WHO checklist) across the Trust.

- An audit has been undertaken to identify all clinical departments using some form of safety checklist for procedures
- A new template for LocSSIPs has been devised and approved through the Health Records Committee
- A process for developing and approving LocSSIPs has been established
- Directorate representatives have identified procedures that require application of the revised methodology
- The majority of specialities have developed LocSSIPs for their procedures and submitted these for approval to the Working Group.
- A Trust policy for LocSSIPs is in development

2) Reducing healthcare associated infections, in particular

a) Clostridium Difficile (C diff)

The Trust achieved this with 52 cases of Clostridium Difficile (C diff) against a limit of 55. Cases of C diff were attributed differently during 2019/20 as both community onset – health care associated and hospital onset – health care associated were attributed to the Trust. This change was reflected in an increase in our limit from 26 to 55. The Trust's rate for C diff was 21.4 cases per 100, 000 bed days.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	9	9	14	17	23	30	34	40	41	44	48	52
Limit	5	10	15	20	25	30	35	39	43	47	51	55
1819	1	2	6	13	21	30	34	37	39	46	50	56

b) Gram negative bloodstream infections

There is an expectation to reduce gram negative infections by 50% by 2021 across the system. Gram negative bloodstream infections include Escherichia coli (E. coli), Klebsiella and Pseudomonas aeruginosa. There was a mixed picture for the Trust during 2019/20.

The Trust had 75 cases of E. coli, which represents an increase from the 2018/19 figure of 69 cases. The Trust's rate for E.coli was 30.8 per 100,000 bed days. However Klebsiella cases over halved from 28 in 2018/19 to 13 in 2019/20. Pseudomonas also decreased over 50% from 16 in 2018/19 to 7 cases in 2019/20.

c) MRSA/MSSA bloodstream infections

There is no national target for MRSA (Methicillin-resistant Staphylococcus aureus) bacteraemia however there is an expectation that there should be no avoidable infections. The Trust did not achieve with two cases of post 48 hour MRSA bacteraemia in the year. This does represent a decrease from three cases reported in 2018/19. Following investigation the two MRSA cases were classed as one avoidable (contaminant) and one unavoidable.

There is no national target for MSSA (Methicillin-sensitive Staphylococcus aureus) bloodstream infections. The Trust had 27 cases of MSSA representing an increase from 2018/19 (19 cases).

3) Improvement in outcomes for expectant mothers and their babies in line with 'Better Births' and the National Maternity Transformation work.

Please see below the Trust's data for 2019/20 for maternity metrics.

Metric	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Unanticipated admissions to NNU >37 wks	14.3	14	10.3	11
Number of Stillbirths >24wks	1.6	1.6	1	3.3
Number of 3rd/4th degree tears	8.6	7.6	6.6	7
Unexpected number of Postnatal Readmissions	7	10	12	6

The National Maternity Transformation work has confirmed the agenda of projects to improve outcomes for mothers and babies in a systematic approach across the region.

The Trust is working with the Local Maternity System (LMS) and NHS Improvement Maternal and 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 maternal and neonatal learning system". Through this work projects have been identified and are moving forward, these include:

- Reducing the number of stillbirths by introducing a new post of Fetal Wellbeing Midwife to help implement the Saving Babies Lives Care Bundle version 2.
- Continue with the aim to increase the number of women on a Continuity of Carer pathway. Currently the Trust is at 10% but further investment is required to increase this to national expectations.
- Continue a cycle of self-improvement through weekly benchmarking in clinical areas against the CQC standards.
- Embed actions from risk into practice by having an integrated seamless wheel from risk identification to learning. A strengthened Risk and Governance team will aid this.

To support the delivery of the above projects the Maternity Governance Team has been re-invigorated to include a wider range of posts including a Project Midwife, Fetal Wellbeing Midwife, Risk Lead, Guideline Lead and Practice Development Midwifery posts.

4) Improve the care of the deteriorating patient through the promotion of early recognition, response and appropriate escalation.

The National Early Warning Score (NEWS2) is the latest version of a tool used to improve the detection and response to clinical deterioration in adult patients. NEWS2 has been embedded into practice at this Trust. A baseline clinical audit was completed on escalation and review of patients in line with the Trust's Escalation policy and an action plan was developed and completed in response to the audit findings.

During 2019/20 the Trust achieved the 90% target for screening and treating red flag sepsis within one hour for both inpatients and patients on an emergency pathway. The target for screening inpatients for sepsis was narrowly missed (achieved 80% versus a target of 90%).

Targeted work continues to promote sepsis recognition within the Trust through the Trust Sepsis Committee. All staff continue to receive mandatory sepsis training every two years and clinical staff are trained on induction on deteriorating patient escalation and NEWS 2. This is further supported by SIM training. The sepsis screening tool is in place in the Emergency Department and planned for incorporation in Electronic Patient Record (EPR).

Ensuring that appropriate escalation of patients admitted to Intensive Care from ward areas is a CQUIN for 2020/21. This will ensure that patients are cared for in the most appropriate clinical setting.

A Task and Finish Group was established to implement a trust-wide action plan on Diabetes with the aim of improving the care of a patient with diabetes. The action plan included a range of measures that focused on the identification of a deteriorating patient including:

- Revision and launch of the clinical guideline for the monitoring of capillary blood glucose and the Blood Glucose Monitoring chart with combined algorithm
- Series of Blood Glucose monitoring training sessions for both medical and nursing staff have been provided by the Diabetes Consultants and Nurse specialists (this is ongoing)
- Regular, specific review of all incidents reported on Datix that relate to diabetes care to identify trends requiring action
- Review and revision of e-learning modules relating to diabetes management / insulin prescribing for staff to access

Patient Experience

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

1) Embed and deliver the Quality Improvement plan.

Major progress has been made with this quality priority. The Quality Improvement Committee (QIC) is fully established and continues to meet monthly. The QIC actively reviews internal assurance visits, CQC Insight reports alongside outcomes and monitoring implementation of agreed actions.

Following successful CQC engagement events throughout 2019/20, the Trust's final event was scheduled to take place on 30th March 2020. This event would focus on surgery reconfiguration, ophthalmology and the Trust's links with the Integrated Care Partnerships. Due to the COVID-19 pandemic, this event was deferred. However, the Trust continues to actively engage with the CQC and CQC engagement events are now mapped throughout 2020/21.

The Trust's "Plan to Outstanding" continues with agreed forward planning and monitoring through the QIC. The Trust-wide communication of our 'Plan to Outstanding' continues with a monthly focus on the Key Lines of Enquiry (KLOE) which has covered the Effective, Safe, Caring, Responsive, and Well-Led domains to date.

The QIC are increasing preparedness for a formal CQC inspection. Self-assessment of services has been mapped against the KLOE's and peer reviews have been completed to support with ratings, evidence and action planning. On completion of the peer review, the monitoring of action plans is agreed.

2) Improving End of Life Care (EoLC) in the acute Trust.

A wide range of initiatives have been progressed during 2019/20 to improve EoLC in the Trust. These are detailed below.

- SWAN is a model of care used to improve the way patients and their loved one spend their last days together. Phase one of the SWAN initiative has been completed and funding has been secured to launch phase two. This was due to launch in April 2020 but is currently on hold due to COVID-19.

- A business proposal was agreed for implementation of the AMBER care bundle at the Cancer Divisional Board in November 2019 with a plan for the full business case to be completed by February 2020. This is currently on hold due to COVID-19.

- An ongoing patient survey on experiences of bereavement is in place. The results are shared with Matrons and Ward Managers and a presentation was given at the Nursing, Midwifery and Allied Health Professional Steering Group (NMAHPG). An action plan was developed and completed in response to the survey findings and will be presented to the Patient Experience Committee in June 2020.

- Because of low attendance at previous EoLC training days the team has changed the format to half-day sessions and as a result seen an increase in attendance.

- As there was poor utilization of the individualised care plans for the dying patient and other EoLC documents, the Palliative Care team took every opportunity to actively promote tools and educate clinicians in the use of the documents. Further action to improve utilisation was addressed through the revised EoLC Strategy. The team also shared this learning in the February and March editions of the Governance Gazette.

- The Care of the Dying and Deceased Policy and Procedure has been ratified and is pending upload to the Trust intranet.

- The Trust has introduced annual memorial services. The next service was planned for May 2020 but is currently on hold due to COVID-19.

- The mortuary process for viewing the deceased patient has been reviewed and changes were implemented to improve the process for relatives. A workshop with all relevant departments was held in March 2020 and the pathway refined to reflect the changes. This will be kept under review.

- EoLC hubs commenced in January 2020 and are held concurrently in the Academic Centres, on both sites, to discuss any issues or concerns pertaining to EoLC as well as ideas on how to improve EoLC within the Trust.

- Parking exemptions have been implemented for relatives of patients who are in the last days of life.

- A review of EoLC, using the CQC Key Lines of Enquiry (KLOES), identified that although some areas required improvement, overall the self-assessment rating was good, with some aspects deemed outstanding. The internal assurance inspection in August 2019 of the Palliative Care team in relation to EoLC was also rated as good.

- The Treatment Escalation Plan (TEP) was developed and piloted during 2019 and is now being rolled out across the Trust. The TEP is completed on admission to set goals of care, including ceilings of treatment, and a DNACPR discussion.

- The Trust continues to maintain excellent working relationships with local hospices. During 2019 Hospice in the Weald started to attend board rounds on key wards for the early identification of patients who were in the last year of life. Earlier referral to the Hospice is expected to improve the patient's quality of life and may reduce some inappropriate hospital admissions through advance care planning.

- The Trust's Lead Nurse for Palliative and End of Life Care initiated and chairs an EoLC Forum, with representation from local acute trusts. The aim of the Forum is to share good practice and explore joint Palliative and EoLC initiatives.

- Advance care planning banners will soon be displayed within the Trust.

The focus of EoLC during March 2020 has been on developing documents and information to support clinicians during the COVID-19 period. The following documents have been approved and uploaded to the Trust intranet:

- COVID-19 Palliative Care Guidelines – the document provides pharmacological and non-pharmacological advice for palliating symptoms that are commonly experienced by patients with COVID-19, advice on how to approach discussions regarding goals of care and guidance on use of syringe drivers and conversion of opioids.
- Clinical Guidelines for Symptom Control for dying with COVID-19 – a one-page summary of prescribing advice for managing the common and acute COVID-19 symptoms for imminently dying patients.
- COVID-19 Individualised Care Plan (ICP) for the adult dying patient – the document is a condensed version of the Trust's existing ICP for use in the organisation during the pandemic. It is a communication tool that provides guidance and prompts for areas that need to be addressed when a patient is dying.
- Chaplaincy and Spiritual Care – guidance on how to access spiritual care.
- Communicating with patients that are acutely dying **–** guidance on how to approach difficult conversations has been developed. The guidance provides advice on how to have face to face conversations with patients to assist healthcare practitioners in communicating with patients when they are deteriorating and death is expected.
- Talking to relatives by telephone – the document provides guidance on how to talk to relatives over the telephone.

3) To recognise and respond to the specific needs of our patients with complex needs including:

a) Working with our partner organisations to deliver all aspects of the Accessible Information Standard (AIS)

The AIS Working Group continues to meet monthly to ensure the Trust is meeting the standard,

working to review improvements in the way patients and their carers understand the information they are given and to share best practice.

There is a network of AIS Champions throughout the Trust in both clinical and non-clinical areas. Training sessions have been provided to the Champions; these have included sight and hearing impairment and a focus on Learning Disability training.

A3 posters were developed in collaboration with Kent Community Health NHS Foundation Trust (KCHFT) and are now in place around the Trust sites to raise awareness of the AIS standard for service users and staff.

We continue to work in partnership with external organisations such as HealthWatch to audit our services and take forward any recommendations.

b) Development of training strategies to support our staff in delivering care appropriate to their patients' needs

<u>Patients with Learning Disabilities</u>

There is consistent engagement with the AIS Working Group to implement actions to support people with learning disabilities to access mainstream hospital services. As stated above the Learning Disability Liaison Nurse (LDLN) has provided training to AIS Champions on Learning Disability. This is part of a range of training delivered by the LDLN across the Trust during 2019/20. Training is both formal and informal, classroom based or bespoke to a specific patient need.

The LDLN has been actively involved in the NHSI&E Transition project, delivering a transition workshop for young people and their families. The LDLN supported the transition team to make reasonable adjustments for people with learning disabilities and devised a patient survey in an accessible format (easy read).

The number of patients recorded using the Trust's flagging system as having a diagnosis of learning disability has more than doubled in this past year: in April 2019 there were 260 patients and in April 2020 there are 542 patients.

<u>Mental Capacity Assessment (MCA) project</u>

Focused work is ongoing in training sessions and in clinical areas to support all clinical staff to improve how they evidence their assessments of mental capacity for patients with impaired decision making ability.

The assessment of mental capacity document has been pre-printed and is now readily available for practitioners to use in clinical areas.

A consultant has been recruited to champion and support medical colleagues with the application of the Mental Capacity Act (MCA). Applying the MCA is part of the consent process, and so the effective application of this Act will uphold patients' rights to autonomy and promote improvements to their individual patient experience.

Patients with a diagnosis of dementia

The Dementia team provide a range of training and dementia workshops throughout the year to educate staff across the Trust on caring for patients with a diagnosis of dementia.

Reducing the number of ward moves to reduce confusion and improve patient experience and outcomes continues to be a focus for the Dementia team. Other work completed over the last year includes:

- A pathway for reducing emergency admissions for people with dementia was launched working with the Emergency Medicine directorate and the operational site team.
- The operational policy and procedure for Dementia and Carers was revised and updated.
- Guidance for Nutrition and Hydration for Dementia was revised.

Along with all the developments laid out above other improvements implemented in 2019/20 in relation to patient experience include:

- Establishment of a lead role for Patient Experience to fully support the launch, delivery and embedding of the 'Making it Personal' strategy
- Set up the concept of a community lounge
- Reviewed the external engagement strategy with a plan for the Trust to outreach to existing patient representative groups already established in the wider community
- Initiated a pilot of a new way of working with volunteers and patient representatives with the objective of embedding patient experience in core Trust business through a patient-partner approach
- Initiated a review of the function of the Patient Experience Committee with the objective of embedding patient experience across the organisation
- Piloted 'Always Events' on the Acute Medical Unit (AMU) at the Tunbridge Wells Hospital and on Peale Ward at the Maidstone Hospital with a view to roll-out 'Always Events' Trust-wide.

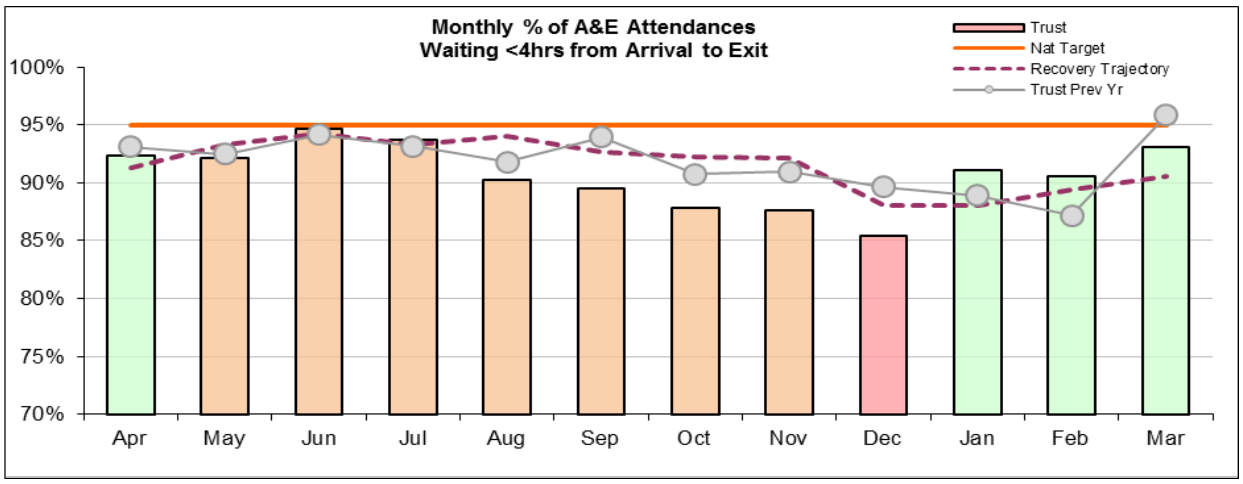
Clinical Effectiveness

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.

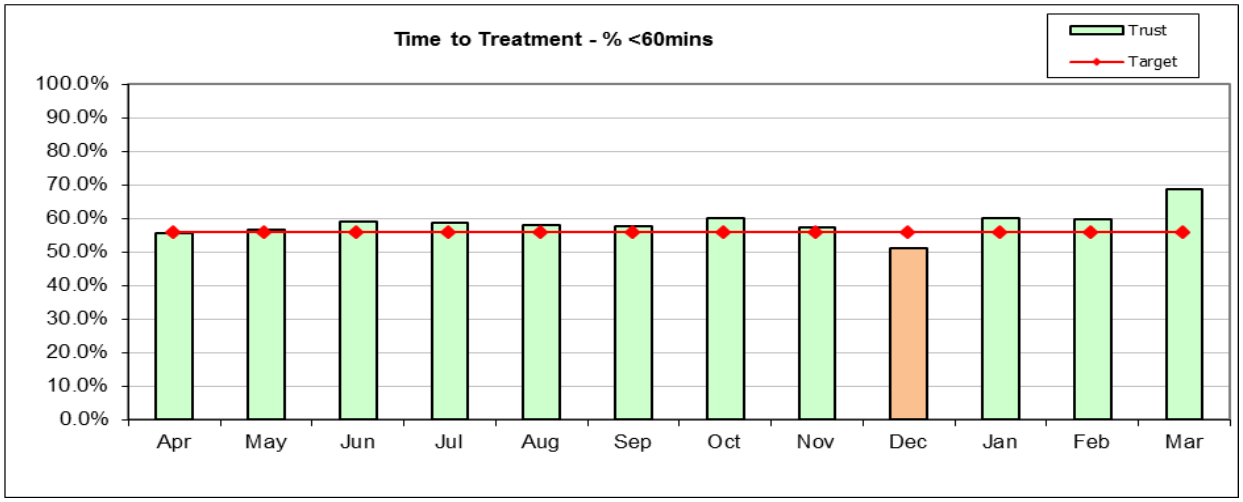
These options should include a variety of routes including; support for the self-management of patients with long-term conditions; speciality-led assessment units; ambulatory care pathways; onward referral to other provider organisations who are better able to meet the patients' care needs and for those 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 Emergency Department (ED) 4-hour quality standard, 18 week referral to treatment and the cancer quality standards.

1)	**Improving the delivery of clinical quality standards and therefore timely treatment for our patients accessing care through both our emergency and planned pathways.**
a)	To ensure that an increasing number of patients are promptly seen and treated through our emergency departments

Emergency Department 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 Emergency Departments (ED) in 2019/20 and was slightly below the Trust recovery trajectory for the year at 90.6% against the target of 91.7%. There was a 6% increase in Type 1 ED attendances compared to 2018/19, despite the drop in attendances in March due to the COVID-19 Pandemic.

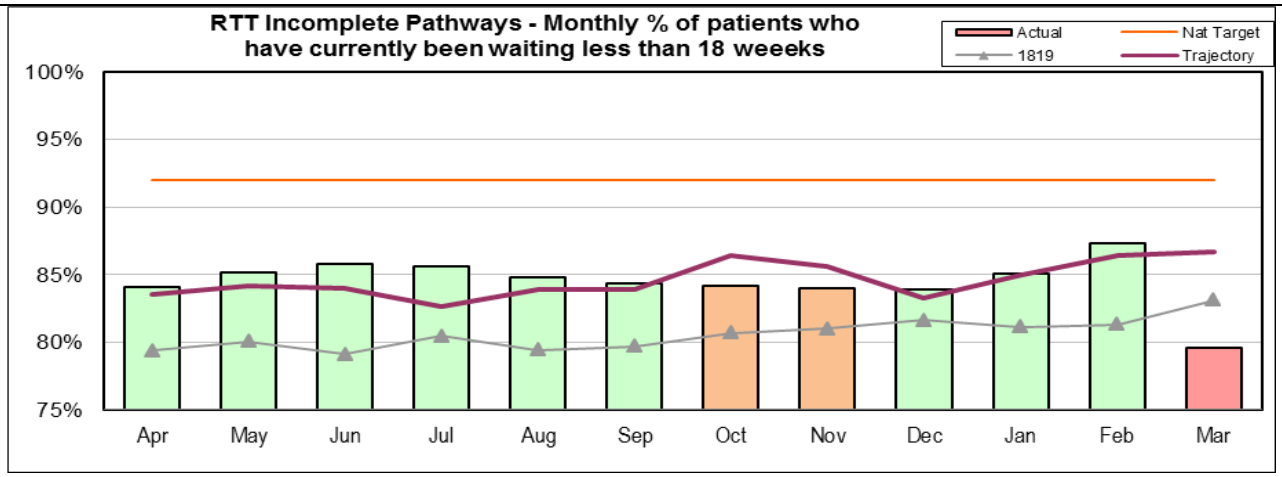


Emergency Department Time to Treatment <60 minutes – the Trust achieved this standard of 55.9% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 58.3%. This is an improvement on last year's figure of 55.9%.



b) To reduce the number of patients waiting for their procedures on our elective waiting list whilst ensuring that they do not come to harm

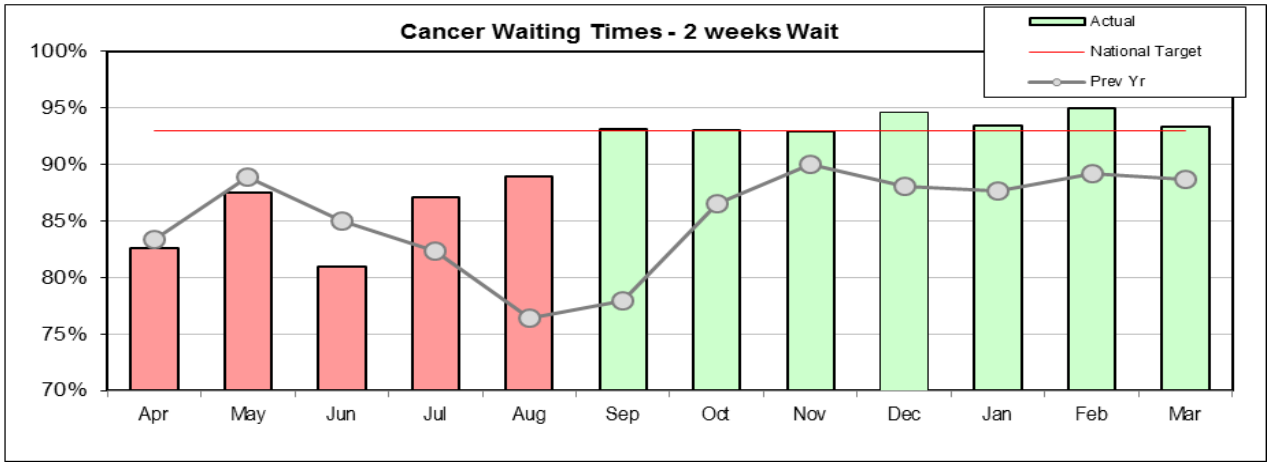
18 weeks standard – the Trust did not achieve the national standard of 92% of patients on an Incomplete Pathway being treated within 18 weeks due to some of the improvement initiatives in the speciality business plans not being funded. The Trust did achieve the year end recovery trajectory set at 86.7%, with a performance of 87.3% in February 2020, a waiting list size at 30,412 and a backlog of 3,861. The waiting list and backlog figures are a considerable decrease compared to March 2019. Performance fell in March due to the cancellation of activity in response to the COVID-19 pandemic.



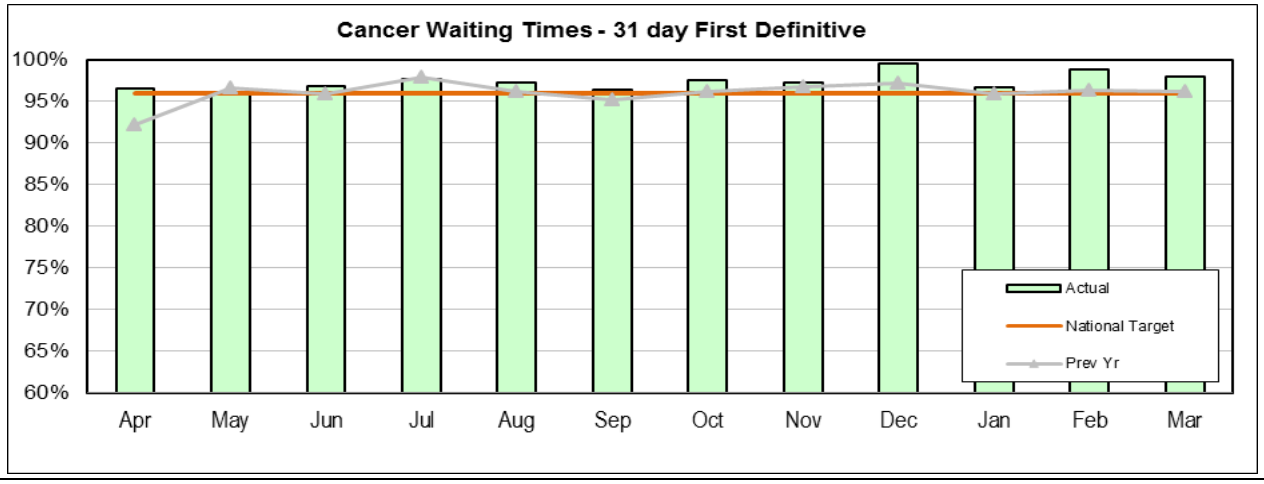
A process has been established to review patients on waiting lists to ensure they do not come to harm whilst waiting for procedures / treatment.

c) Improvements in timeliness of diagnosis, decision making and treatment for our cancer patients

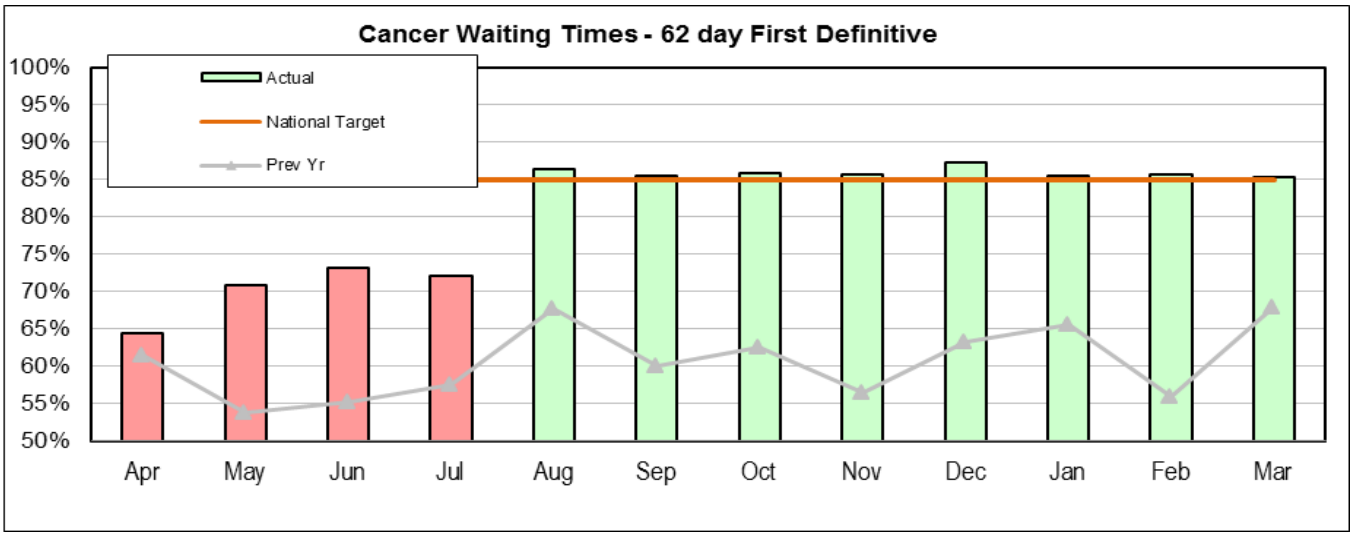
Cancer Waiting Time Targets: 2 weeks from referral – the Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks throughout 2019/20 at 90.2%. However, this has significantly improved from the previous year and the target has been consistently achieved since September 2019.



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 throughout 2019/20 at 80.4%. However, this has significantly improved from the previous year and the target has been consistently achieved since August 2019.



Whilst two of the three cancer targets were not met as the graphs demonstrate there has been significant improvement in the second part of 2019/20. This is a picture the Trust is committed to continuing to deliver during 2020/21.

2) Improving patient flow through the development of alternative care models/pathways.

The Trust has implemented a range of new / adapted care pathways and initiatives to improve patient flow. These include:

- The Trust has developed direct GP admissions and direct Southeast Coast Ambulance (SECamb) conveyance to the appropriate unit within the hospital i.e. Ambulatory Emergency Care (AEC) or Frailty Units.

- The Hospital@Home service was launched to support patients with their care needs in their own homes. These patients continue their treatment at home under the care of a medical practitioner provided by KCHFT.

- The GP streaming model continues to develop with increased numbers of patients being directed through this model, although there has been a reduction since the start of the COVID-19 pandemic. This paves the way for the implementation of an Urgent Treatment Centre (UTC) which (pending approval) may be piloted in ED.

- The Same Day Emergency Care (SDEC) model has been in operation seven days a week on both Trust sites since last autumn and continues to develop.

- The Clinical Utilisation Review (CUR) programme continues to support patient flow using the 'Beautiful Information' tool to display demand in real time and an escalation tool to identify bottlenecks that reduce patient flow. The Trust's work on using these electronic tools was presented last summer in London to other NHS organisations from across the country.

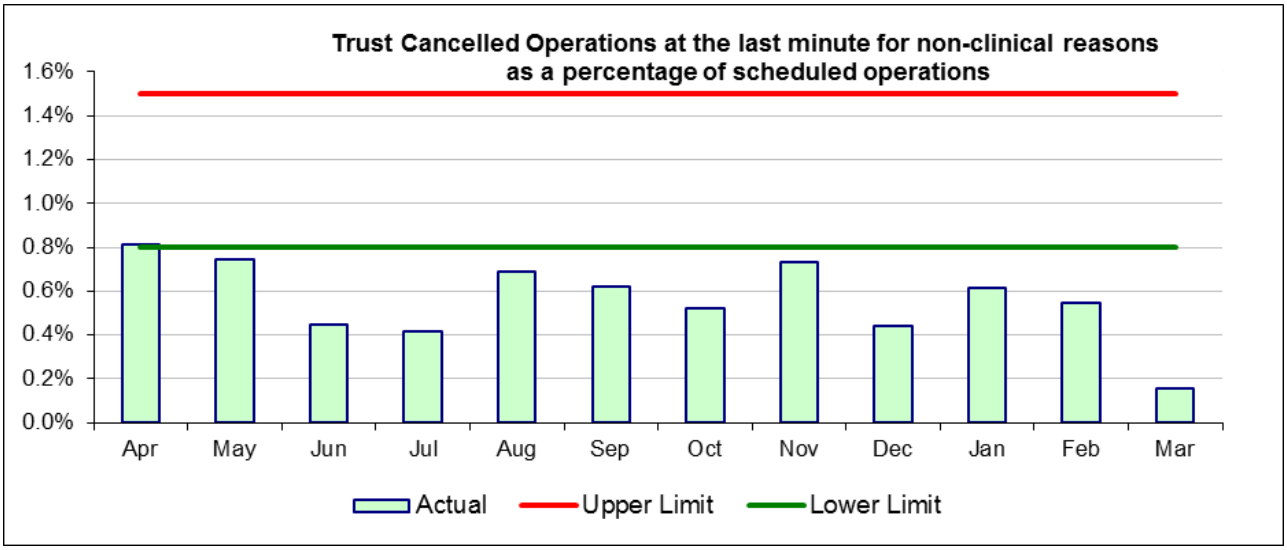
- Delayed Transfers of Care (DTOC): during COVID-19 it has been necessary to reduce the patients who were medically fit for discharge in order to create capacity. Therefore the number of DTOC patients has reduced considerably, with increased funding for additional non-hospital placements.

- Streaming – new pathways have been put in place to support improved flow as well as patient and staff safety during the COVID pandemic. This means that both ED departments have increased their footprint through working with other clinical directorates in order to provide areas for both possibly COVID and non-COVID patients.

- In March 2020 a new Rapid Assessment Point (RAP) at Maidstone was built to increase the capacity of the existing RAP from three to seven trolleys. This improves flow and supports faster ambulance handovers ensuring the Trust is providing urgent treatment to patients at the right time and in the right place.

3) Reduction in cancelled operations.

Cancelled operations – the Trust achieved this standard with 0.6% of operations cancelled at the last minute against the national maximum limit of 0.8%. In order to achieve this a Task and Finish group was established, which focused on monitoring cancellations in order to rectify trends that occurred.



4) Development of new and enhanced roles to improve pathways of care and raise staff morale.

The West Kent Nursing Associate (NA) Consortium, hosted and chaired by the Trust continues. The first cohort of Trainee Nursing Associates (TNA) will be due to qualify as Nursing Associate (NA) in January 2021. The second cohort commenced in September 2019 through the Nursing Midwifery Council (NMC) validated training programme. The Consortium has been recognised and praised for its approach. Presentations on the work of the consortium were delivered at the Kent and Medway Senior Leader Forum (June 2019) and Health Education England's (HEE) Kent and Medway Deployment Workshop (October 2019). The consortium has continued to work collaboratively to manage the academic programme and placements for all TNAs during the COVID-19 pandemic.

The Advanced Practice Assurance Group (APAG) is established with an agreed policy (pending ratification), which has been widely consulted upon. The Advanced Clinical Practice Working Group

continues to build on the initial scoping project and has refined the methodology to complete the scoping work across all registered health care professionals practicing beyond their level of initial registration. Resource has been allocated to support an Advanced Clinical Practitioner (ACP) lead to carry forward this work. The job description is being worked up prior to submission to the recruitment team. The Trust actively participated in the HEE National ACP Survey.

Physician Associate roles continue to be supported with an agreed six placements for September 2020. The Trust Board received a presentation of this role in December 2019 focusing on the experience of embedding a new role, the benefits and impact on the current chosen areas of care delivery.

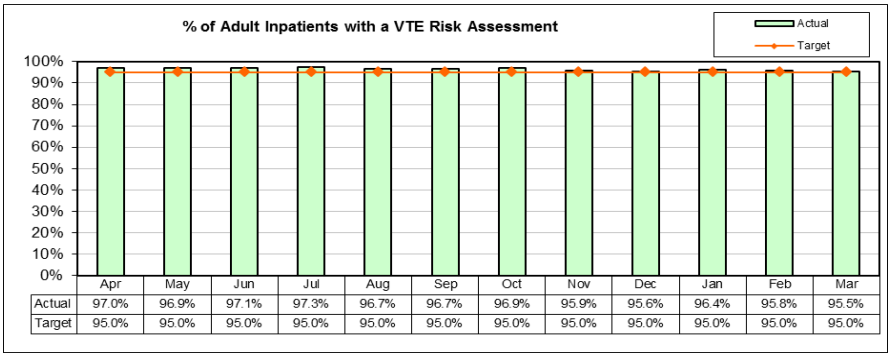
In light of the COVID-19 pandemic, the Trust has proactively reviewed ways of working and the development of new roles, such as Personal Protective Equipment (PPE) Safety Officers, to support the delivery of high quality, safe, effective care.

Further Review of Quality Performance

In addition to the information and tables provided in the above section reviewing progress against the 2019/20 quality priorities, other measures of quality performance are displayed below.

Prevention of venous thromboembolism (VTE)

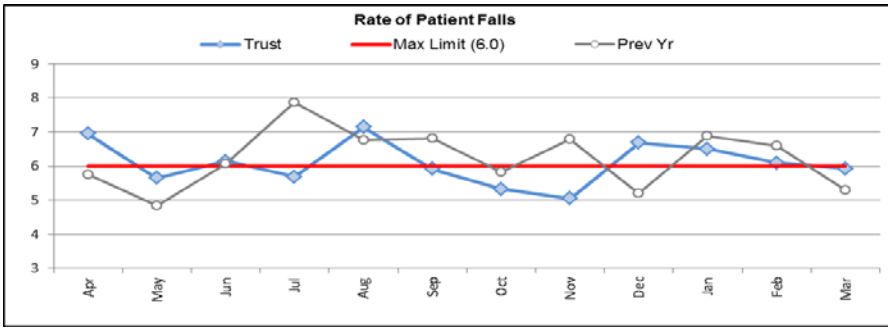
The Trust ensured that 95% of patients had a VTE Risk Assessment completed on admission to hospital in 2019-20 with an overall score of 96.5%.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	97.0%	96.9%	97.1%	97.3%	96.7%	96.7%	96.9%	95.9%	95.6%	96.4%	95.8%	95.5%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

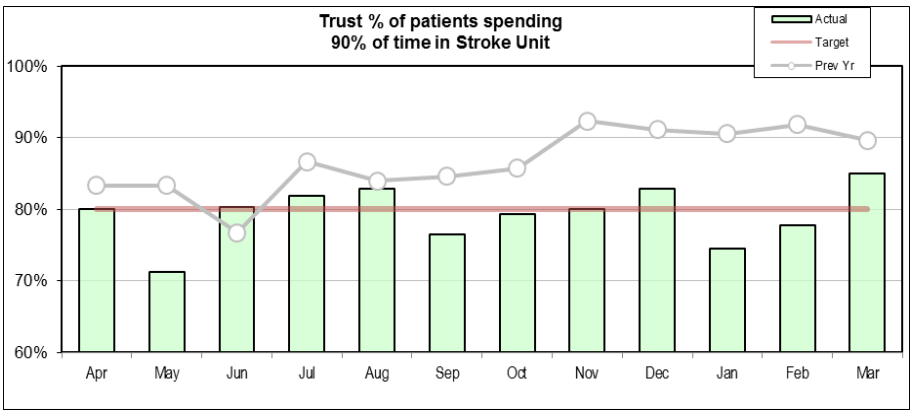
Reducing the number of patient falls

The Trust's rate of falls per 1,000 Occupied Bed days is slightly above the Trust maximum limit of 6.0 at 6.09 at year end (6.10 for the previous year).



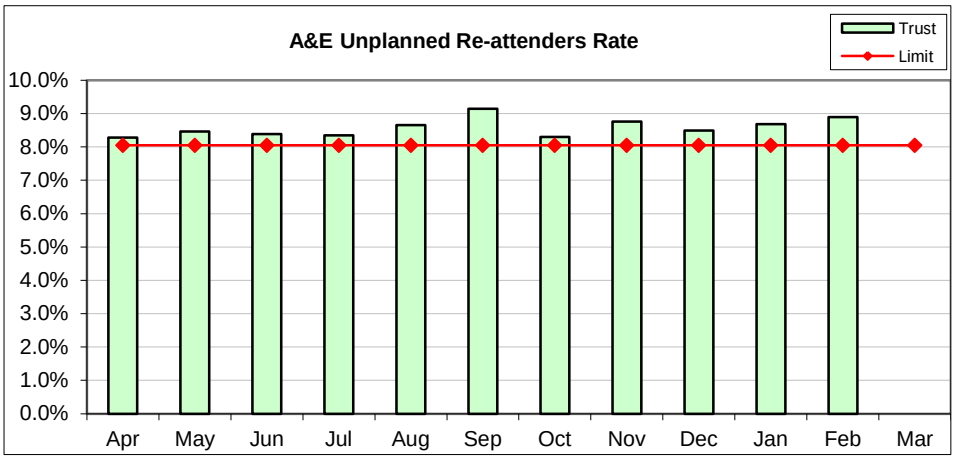
Improving care for patients who have had a stroke

The Trust did not achieve the standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2019-20 at 75.9% compared to 91.66% in 2018-19.



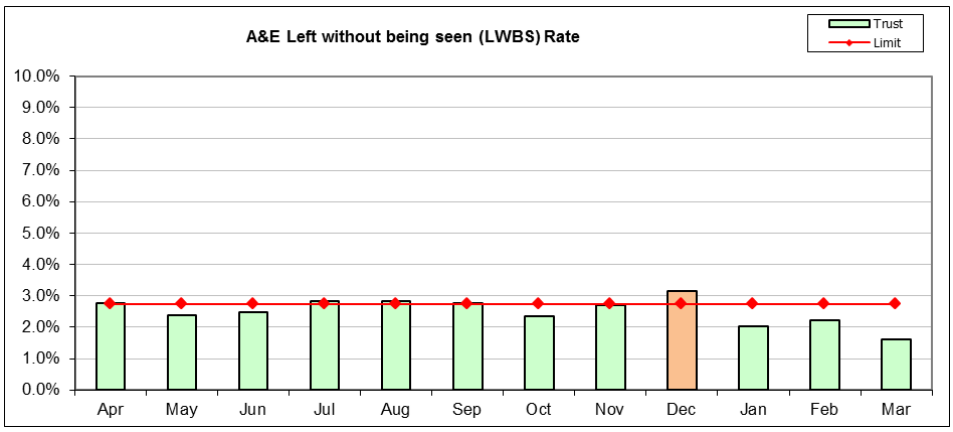
Emergency Department Unplanned Re-attendance Rate

The Trust achieved this standard of less than 8% unplanned re-attendance rate at 8% (data for March not available yet as data runs one month behind).



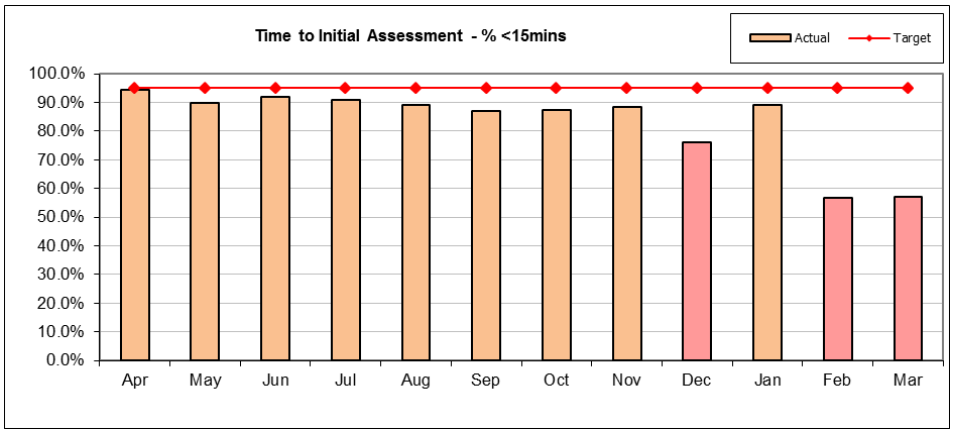
Emergency Department Left without being Seen Rate

The Trust achieved this standard of less than 5% of patients leaving the Emergency Departments without being seen at 2.5%.



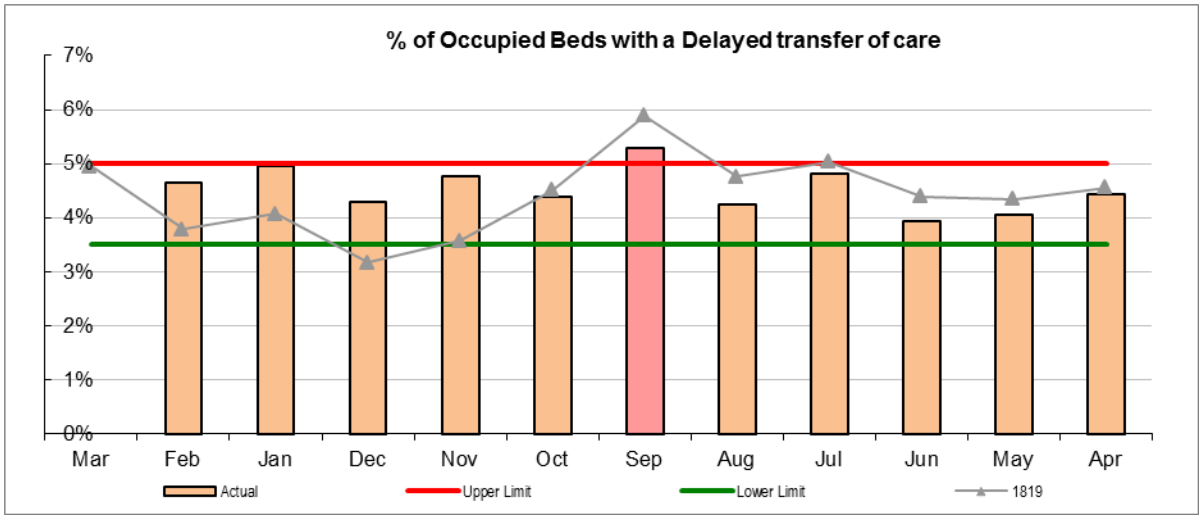
Emergency Department Time to Initial Assessment <15 minutes

The Trust did not achieve this standard of 95% of patients arriving in the Emergency Departments being assessed within 15 minutes of arrival at 81.7%.



Delayed Transfers of Care (DTOC)

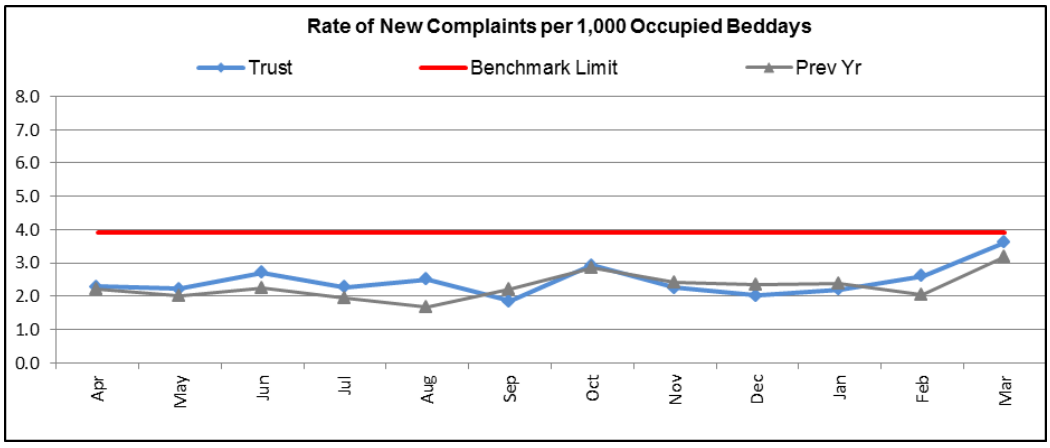
The Trust did not achieve this standard of delayed transfers of care remaining below the national limit of 3.5% for the year at 4.53%, which is similar to the previous year.



Complaints

Maidstone and Tunbridge Wells NHS Trust has 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.

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 2.40 for the year (2.30 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 patient focused and striving for continuous improvement. Whilst complaints are often considered to have a negative connotation, we recognise that they are also a valued method 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.

During 2019/20 we received 562 new complaints, compared to 550 in 2018/19. The rate of complaints per 1000 occupied bed days was 2.40 for the year. We aim to investigate and provide a full response to all formal complaints within an agreed timeframe of either 25 or 60 working days of receipt, depending on the severity of the complaint. We achieved performance of 67.8% for the year, against a target of 75%. Meeting this target proved challenging in the first part of the year due to vacancies within the central complaints team. Vacancies were filled during the year, culminating in full establishment by February 2020. Sustained improvements with performance have been seen since November 2019.

An annual report on Complaints and PALS (Patient Advice and Liaison Service) activity including learning and outcomes is produced and presented to the Patient Experience and Quality Committees. Quarterly reports are provided to the Patient Experience Committee on activity and actions taken in response to complaints and an interim update report is provided to the Quality Committee in January on the same. The Trust was recognised by HealthWatch England for the publication of information and outcomes from complaints on the public website and we have received a number of enquiries from other Trusts looking to model our practice. Case studies and key messages from complaints are regularly included in the Trust's monthly Governance Gazette.

Quote from a complainant:

'Thank you for your November letter which sets out a full and thorough response to my email and evidence of a strong desire to learn from my Grandmother's experience at Maidstone and make the appropriate changes.'

Patient Surveys

The Trust employs a range of methods to gather feedback from patients including three different forms of patient surveys:

- National patient experience surveys
- The Friends and Family Test (FFT)
- Local patient surveys

These each provide a different insight into the experience of our patients and enable us to develop services to meet the needs of our patients and their loved ones.

National Patient Surveys

The Trust participates with the national annual patient experience survey programme and undertakes all national surveys stipulated by the Care Quality Commission (CQC) each year.

During 2019/20 the Trust participated in four national patient surveys. The Maternity survey and the Adult Inpatient survey were undertaken in house:

The Maternity survey data was submitted in September 2019 and the results were published on the CQC website on the 29th January 2020.

2019 National Maternity Survey		
Respondents & Response Rate		
The Trust had 199 respondents giving a response rate of 48%. The national response rate was 37%.		
Comparisons with last year's survey		
We were worse than last year for two questions and the remaining questions scored about the same. The two worse were:		
	2019	2018
B14 During your pregnancy, did you have a telephone number for a member of the midwifery team that you could contact?	9.3	9.9
F17 If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	6.4	8.0
Actions		
An action plan was developed to address all aspects of the national maternity survey results. The survey results and action plan were presented to the Patient Experience Committee and the implementation of the plan will be overseen by the Trust's Maternity Board.		

The Adult Inpatient Survey data was submitted to CQC/Pickers Europe in January 2020 and the embargoed results were received in June 2020. Our response rate was 51.76%.

The Trust was approached and was happy to support a pilot of a new survey format for the Children and Young Persons Survey in 2019/20. The pilot used a range of methods to obtain feedback as opposed to relying solely on a paper mail out system. The results have yet to be shared with the Trust.

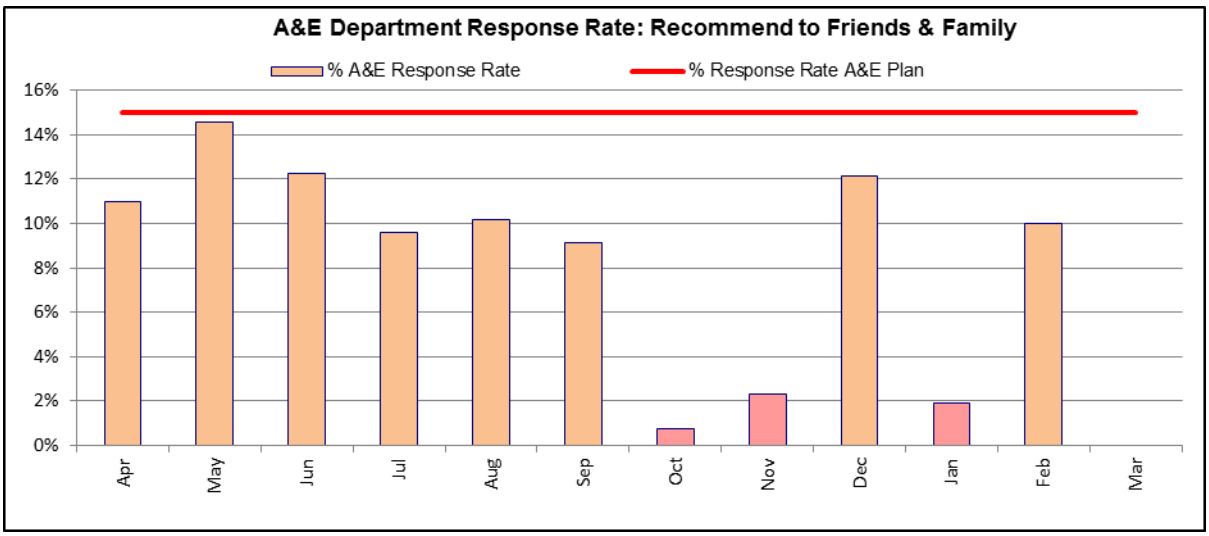
The Trust also participated in the National Cancer Patient Experience Survey. In 2019/20 this survey was undertaken by the Picker Institute and we are awaiting the report.

Friends and Family Test (FFT)

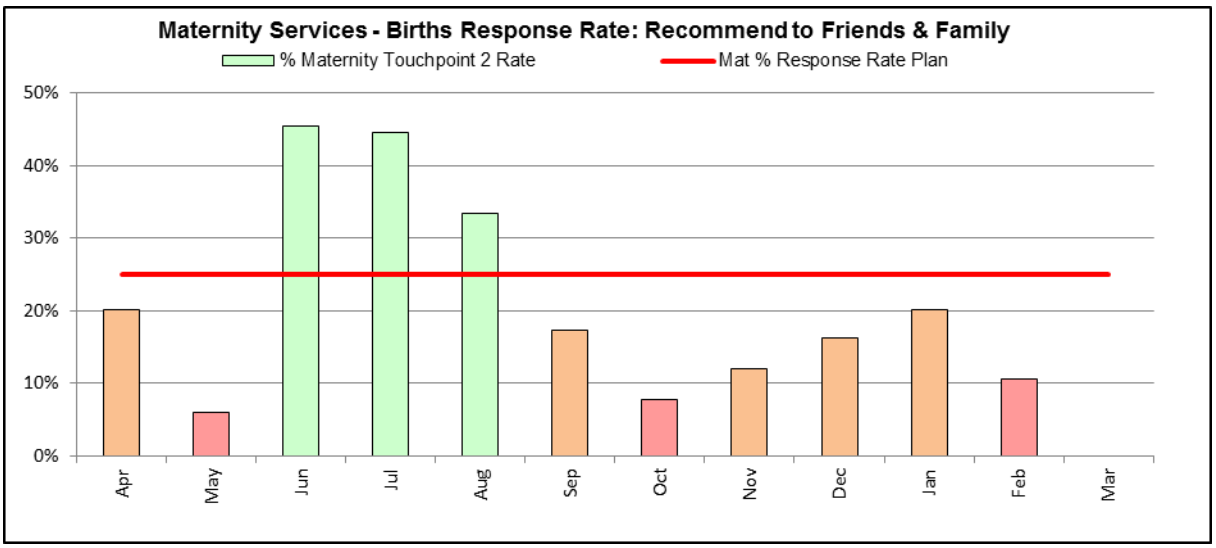
Part-way through 2019 the Trust changed service provider for the Friends and Family Test. End of

contract with the previous service provider enabled the Trust to explore opportunities to widen methods of obtaining patient feedback. The intention is to move to different formats of data collection to increase overall response rates as opposed to relying on paper. The changeover in September 2019 did result, initially, in a dip in responses as the Trust adapted to the new system.

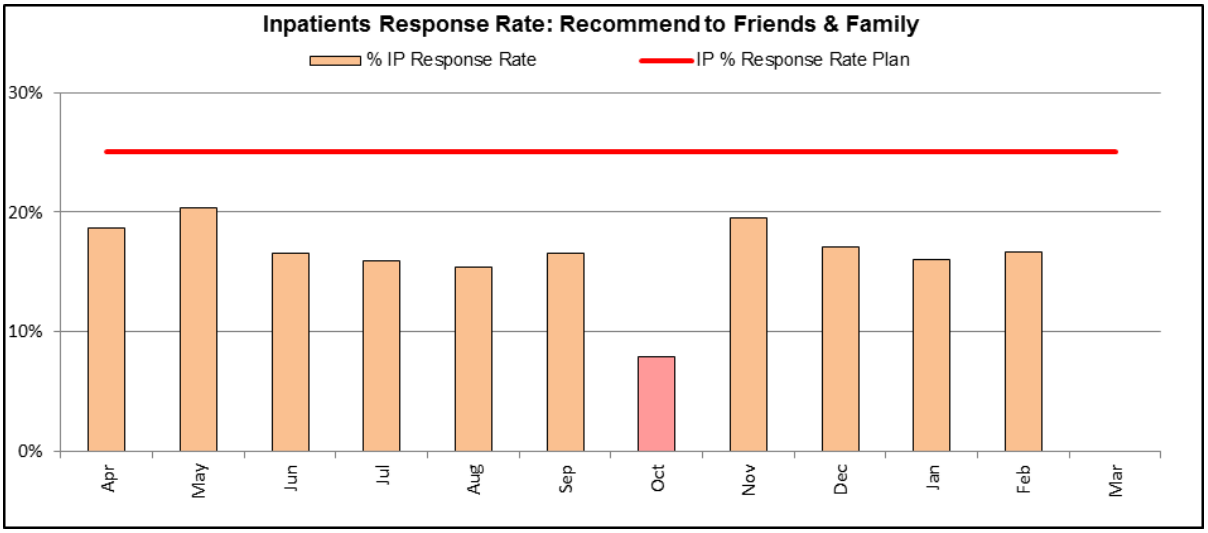
The Trust did not achieve the target of 15% response rate for the Friends and Family Test given to patients in the Emergency Departments with a result of 8.5%. Of the responses received 87.7% were positive. Data was not collected for March 2020 due to the COVID-19 pandemic.



The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to patients after giving birth with a result of 21.2%. Of all the responses received for patients accessing Maternity Services 95.5% were positive. Data was not collected for March 2020 due to the COVID-19 pandemic.



The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients with a result of 16.4%. Of the responses received 95.7% were positive. Data was not collected for March 2020 due to the COVID-19 pandemic.

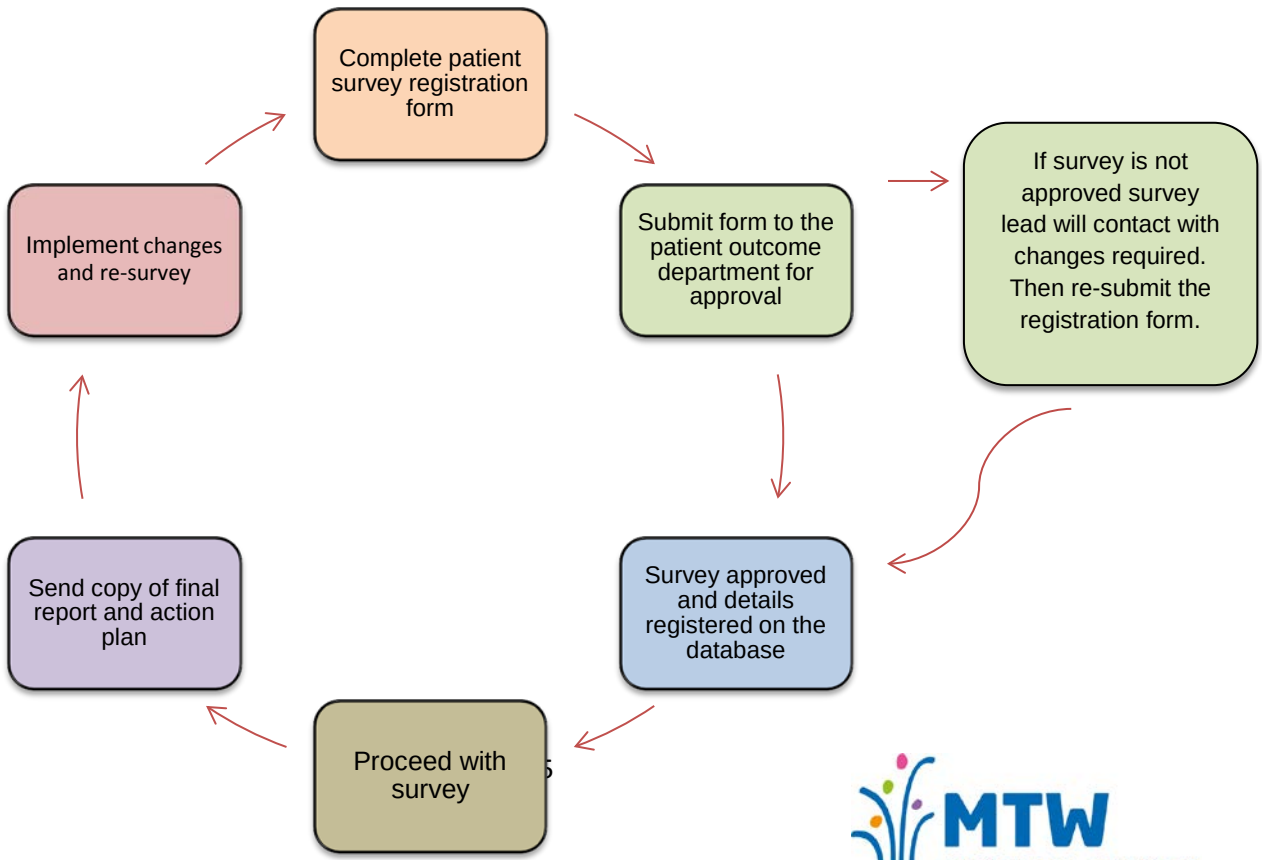


Local Patient Surveys

In June 2019 the Patient Outcomes team re-launched the process for undertaking in-house local patient surveys. The process was laid out in a standard operating procedure (SOP) and a diagrammatic pathway (please see below). The process was supported by a formal registration form and a report template. All local surveys registered are entered into a database and progress followed up to monitor completion. Over 25 local patient surveys were registered between quarter 2 – quarter 4 2019/20. Final reports with action plans have been submitted to the Patient Outcomes team for a small proportion of the registered surveys.

During 2020/21 this process will be monitored more closely with quarterly reports produced on local patient survey activity and outcomes. An action plan database will be populated to monitor implementation of actions arising from the surveys to evidence the developments to improve patient experience.

Pathway for completing a patient survey



Staff Survey / WRES

This section outlines our most recent staff survey results from 2019 for percentages of staff experiencing harassment, bullying or abuse at work from staff, percentage of staff believing that the organisation provides equal opportunities for career progression or promotion and percentage of staff experiencing discrimination at work from manager/team leader or other colleagues for the Workforce Race Equality Standard (WRES).

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
White staff: 25.8% (2018 findings 26.9%) – national average for acute Trusts is 25.8%
BAME staff: 26.9% (2018 findings 25.7%) – national average for acute Trusts is 28.8%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
White staff: 86.4% (2018 findings 83.9%) – national average for acute Trusts is 86.7%
BAME staff: 74.2% (2018 findings 67.0%) – national average for acute Trusts is 74.4%
Percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months
White staff: 6.4% (2018 findings 6.8%) – national average for acute Trusts is 6.0%
BAME staff: 13.3% (2018 findings 13.3%) – national average for acute Trusts is 13.8%

Whilst the Trust has made improvements in all indicators since the first WRES report published in 2016, there are areas which require continued focus.

It is encouraging to note that the relative likelihood of white staff being appointed from shortlisting compared to Black and Minority Ethnic (BAME) staff has reduced since 2018. We can, however, see an increase in the relative likelihood of BAME staff entering the formal disciplinary process compared to white staff in 2018. There is also with a noticeable difference in the relative likelihood of white staff accessing non mandatory training compared to BAME staff.

The 2018 National NHS Staff Survey shows that BAME and white staff experience similar harassment, bullying or abuse from staff. There has been an increase in the number of BAME staff who believe that the Trust provides equal career development opportunities. The number of BAME people experiencing discrimination at work from managers and colleagues remains nearly double that of white staff; this is similar to the national average.

Cultural and Ethnic Minority Network (CEMN)

Since submission of the 2018 WRES data, the most noticeable improvement at the Trust has been the re-invigoration of the Cultural and Ethnic Minorities Network (CEMN). Chaired by Ms Rantimi Ayodele, Consultant Paediatric Orthopaedic Surgeon, the network has been driven by the ambitions of Rantimi to support ethnic minority staff; to encourage and work towards a culture of inclusion; to spearhead and develop the Trust's diversity and inclusion work; to advise staff and

managers across the Trust in the development and maintenance of diverse teams and to leading the Trust in celebrating our diversity.

Activities undertaken under the leadership of Ms Ayodele include:

- The creation of a committee within the network to lead on communications and marketing, advocate for pastoral care of international staff and to develop diversity events
- The updating of the name and associated logo of the network
- The production of posters and postcards to promote the network
- The increase of the network membership by 100% with committee members actively going out and talking to staff about the support being offered
- The update of the equality statement that accompanies all job adverts
- The delivery of "The Power of Me" – a half day development programme aimed at supporting staff with both their career development and in breaking down barriers
- Collaborative working with staff side, HR and other diversity networks to review disciplinary and bullying and harassment cases and specifically asking the question – given the nature of the allegation was the investigation appropriate given the nature of the allegation and was the outcome appropriate?
- Provision of support to our international staff by attending Meet and Greet sessions for international nurse cohorts and taking part in International Staff Drop-in sessions to provide advice, guidance and faith support
- The securement of a small budget for the promotion of the network and diversity events
- The arrangement of diversity events including Meet and Greet sessions and steel bands playing at main sites to celebrate both Black History Month as well as Diwali Meet and Greet activities
- The attendance of "Addressing the Barriers for BAME representation in the workplace" conference
- The securement of funds to pilot "Recruiting for Difference" in quarter four of 2019/20

Focus for 2020/21

1)	**To increase the understanding of why promoting diversity in the workforce is a business and asset argument to help the Trust develop the culture of inclusion that will promote the actual aims and objectives for patient care.**
a)	Leading the Executives in a workshop/review of its goals around diversity to be able to articulate how this work will lead to a better achievement of the Trusts aims and objectives.
2)	**To increase the percentage of BAME staff in each of the Agenda for Change bands 1- 9 as well as within very senior management and increase the percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion.**
a)	Deliver "The Power of Me" actively targeting BAME staff to attend.
b)	Provide job interview skills workshops for BAME staff.
c)	CEMN chair to mentor a member of the CEMN to lead to wider mentorship programme being established.
d)	Develop Talent Boards within each Division working in collaboration with HR Business Partners to set up to identify and support talent management and succession planning ensuring that assessment of BME staff is identified and supported.

	e) Pilot a reverse mentoring programme for Executive Board Members.
	f) Create a central repository of BME talent within the Trust.
3)	**Increase the relative likelihood of BAME staff being appointed from shortlisting compared to white staff.**
	a) Pilot "Recruiting for Difference" with Chief Operating Officer.
4)	**Reduce the percentage of BME staff experiencing harassment, bullying or abuse from staff.**
	a) Implement 'Safe Space Champions' (SSC) to support the Freedom to Speak Up (FTSU) Guardian in the provision of first port of call service to staff –to listen and signpost to relevant support.
	b) Develop and implement a robust communications plan to ensure that staff are aware of the role of the SSC.
	c) Continue to review bullying and harassment and disciplinary cases on an annual basis with other diversity network representatives, Human Resources and staff side representatives.
	d) Undertake quarterly reviews of bullying and harassment and discrimination incidents recorded on Datix.
	e) Hold engagement/drop-in sessions allowing staff to discuss bullying and harassment issues.
5)	**Develop a Trust-wide, cross-diversity network campaign to combat bullying and harassment more generally, which centres on behaviours and expectations. This will be linked to the culture and leadership work.**

Freedom to Speak Up (FTSU)

The Freedom to Speak Up (FTSU) agenda is to:

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that:

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

The tables below display the numbers of contacts with the FTSU Guardian during 2019/20 broken down by month, staff group and theme. There are also comparison tables for numbers of contacts with the FTSU Guardian by quarter during 2018/19 to 2019/20. These demonstrate an increase in contacts by 28 indicating a growing awareness of the role of the FTSU Guardian. The intention is to further grow the FTSU agenda and the role of the FTSU Guardian. A business case is in development to secure further investment for the FTSU role.

Number of contacts with the FTSU Guardian 2019/20

2019/20 Month	Number of contacts	Anonymous	All open cases
April	4	1	0
May	6	2	0
June	5	2	0
July	5	4	0
August	6	2	0
September	5	0	0
October	1	0	0
November	0	0	0
December	0	0	0
January	1	0	0
February	1	1	1
March	4	2	2
Total	**38**	**14**	**3**

Quarter	No. of contacts 2019/20	No. of contacts 2018/19
Quarter 1	15	0
Quarter 2	16	0
Quarter 3	1	2
Quarter 4	6	8
Total	**38**	**10**

2019/2020 FTSU contacts by staff group and theme

Staff Group	Number
Estates and Facilities	3
Nursing	4
Midwifery	0
Medical	1
Allied Health Professionals	1
Clinical Support	10
Administrative and Clerical	9
Unknown	10
Total	**38**

Theme	Number
Patient Safety	5
Bullying/ Harassment	18
Fraud	1
Health and Safety	5
Other	9
Total	**38**

Themes and issues

The main issue raised relates to bullying and harassment but there have also been cases of concern relating to safe staffing levels and more specifically safe skill mix.

The Trust has undertaken a significant recruitment drive of overseas nurses. Some areas have experienced a relatively large intake of nurses into their team; all of whom have needed support, training and supervision. This has caused additional pressure on staff already struggling to cope due to previously low staff numbers. Whilst this was only one formal concern that was raised through the FTSU route, it appears to be a concern, which has been discussed and mentioned by staff in general. It is anticipated that these concerns should now be resolved through recruitment within the Practice Development Nurse team to support the new overseas nurses as well as the newly appointed nurses having settled into their new roles on the wards and clinical areas.

Networking

The FTSU Guardian continues to attend regional and local network meetings as well as Trust staff network meetings, inductions and events. There were national and regional meetings due to take place earlier this year but due to COVID-19 these were either cancelled or the Trust's FTSU was unable to attend.

Rota Gaps

In August 2019 there were no gaps identified at Foundation Year 1 (FY1) level and six additional FY1 posts were secured. We identified six rota gaps at Foundation Year 2 level and with the continuing proactive approach by Medical Staffing in the early advertising of these roles, we were able to recruit to four of these locally. Overall the fill rate was very good across all specialties.

In addition, we have a number of key initiatives supported by our Medical Education Department:

- Clinical Fellowship Programmes: The Emergency Medicine Department continue to develop their Clinical Fellowship Programme. They successfully appointed individuals into two Fellow posts (Education and Simulation) in August 2019. Funding was secured to enable the Fellows to undertake Post Graduate Certificates with Canterbury Christ Church University.
- Following the success of Simulation Fellow appointments in the Anaesthetic Department, ongoing recruitment into this role continues.
- Senior Clinical Fellows: The Emergency Medicine Department appointed four Senior Clinical Fellows from August 2019 to commence a four year Certificate of Eligibility for Specialist Registration programme. The programme entails undertaking essential secondments in Anaesthetics, Intensive Care, Paediatrics and Acute Medicine to complete the curriculum requirements for Emergency Medicine.
- The Widening Access to Specialty Training (WAST): This is a 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. Four WAST doctors joined the Trust in August 2019 and they were invited to join the FY1 Induction programme, which gave them an extended and comprehensive induction and introduction to the Trust. Three of the WAST doctors continue in their Medicine placements until August 2020. A further WAST doctor joined the Emergency Medicine Department in February 2020 on a one year placement.

- The Trust's first two Chief Medical Registrars were appointed in October 2019, one on each site, under the Royal College of Physicians programme. The role is 50% clinical and 50% management.
- Medical Training Initiative (MIT): Anaesthetics, Paediatrics and Obstetrics & Gynaecology have recruited overseas doctors through this training initiative.
- Physicians Associate and Advanced Practitioner roles continue to be recruited to and provide multi-professional support to our services and rotas.

This approach is ongoing and will continue for the medical intake in August 2020, updates are provided to the Trust's Workforce Committee.

Learning from Serious Incidents and Never Events

Serious Incidents

To ensure that there is a system of learning from serious incidents and never events we have a robust reporting, investigation and learning process in place. All serious incidents (SIs) are reported on StEIS (Strategic Executive Information System – the system which supports the monitoring of investigations between NHS providers and commissioners) and this has to be done within 48 hours of the SI being identified. The Patient Safety team identify themes and trends to help reduce risks going forward and learning is shared with

the directorates, both by sharing the final investigation report and a monthly learning report.

All SIs are assigned a lead investigator outside of the service where the incident happened and also a directorate link from the service involved in the incident. A root cause analysis (RCA) is completed using recognised investigative tools (e.g. five whys, fishbone, human factors). Action plans are developed to share learning across the Trust to prevent recurrence of the same incident. In March 2020 the Trust updated the incident reporting management system (Datix) to a fully web-based system, which now enables actions to be monitored on the system.

The Trust declared 132 SIs in 2019/20 compared to 154 in 2018/19.

Of the 132 SIs, 5 were discussed with the West Kent Clinical Commissioning Group Quality Leads who agreed with our findings that these cases no longer met the SI criteria and were subsequently downgraded. Therefore the total of our serious incidents reported reduced to 127.

In addition the Trust's Serious Incident policy has been further revised to include the impact of human factors and to encourage a just culture and open and transparent investigations and learning. The Trust also agreed a business case in February 2019 to increase the staff in the Patient Safety team to include a Deputy Patient Safety Manager with a focus on Education, a second Patient Safety Lead and two SI Investigators.

Actions and learning from SI's are key to improving safe, effective and high quality patient care. In 2019/2020 learning and actions included:

- Introduction of competencies that allow extended roles for experienced nurses
- Human factors training to help change the culture to enable junior staff to challenge senior staff effectively
- Introduction of Pressure Ulcer Champions and Link Nurses
- Review, implementation and dissemination of revised Terms of Reference for the Slips, Trips and Falls Group

Never Events

"Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective factors are available at a national level and should have been implemented by all healthcare providers." *NHS Improvement, 2018*

Three 'Never Events' were declared at the Trust in 2019/20. Full RCA investigations were undertaken for two of the events and presented to the Executive-led SI Panel. The findings were shared with NHS Improvement to ensure wider learning. The incidents were subject to scrutiny through the serious incident investigation process and the aim is to

ensure that lessons were learnt to prevent recurrence. The third Never Event investigation is currently ongoing and remains open. This Never Event involved a patient receiving treatment to the wrong eye for Diabetic Macular Oedema (DMO). The patient received three intravitreal injections to the left eye not the right before the error was identified.

Postcards are produced and disseminated across the organisation to share learning following Never Event investigations. Please see below the two postcards for the completed investigations.

Never Event: Incorrect Procedure (June 2019)

What is a Never Event? Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. (NHS Improvement)

What Happened? A Lumbar Puncture (LP) was performed on the wrong baby.

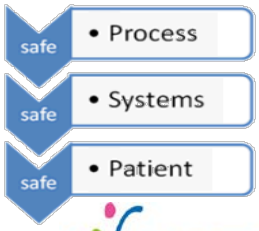
The staff member spoke to the parents informing them that a raised blood marker indicated a need for a Lumbar Puncture to be undertaken. Verbal consent only was taken and noted in the case notes.

Why did it happen? No formal clarification of the baby's identity was made at this point.

Following on from the Lumbar Puncture the staff member went to verify patient details and realised that it was not the baby he thought. Therefore the ***wrong*** baby was brought from the post-natal ward for the Lumbar Puncture.

What lessons have we learnt and actions taken? The department has written and put in place a Clinical Guideline on Lumbar Punctures in the Neonatal Unit. A parent information leaflet has also been written and has been approved by the neo-natal unit's guideline group.

How does this relate to me? We all work in teams throughout the organisation so it is important that we all fully participate in ensuring processes are followed and the required checks are undertaken to maintain our patients' safety. Staff should feel empowered to advocate for our patients and challenge decisions and actions made on their behalf without their awareness.



MTW
exceptional people, outstanding care

Patient Safety Alert

MTW Governance Team
exceptional people, outstanding care

Never Event: Administration of medication by the wrong route

(January 2020)

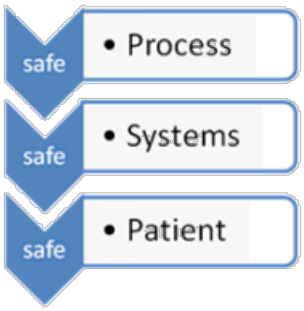
What is a Never Event: Never Events are '*serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'* (DoH).

What Happened: A post-operative patient was administered an oral preparation of oxycodone (opiate based preparation for pain relief) intravenously instead of orally. Thankfully on this occasion there was no significant harm to the patient.

Why did it happen: The initial report is that the patient had been prescribed the medication to be administered either orally or intravenously. There are different formulations for each route of administration and they are not interchangeable. Whilst the full root cause of this incident is under investigation we know on this occasion that the purple plunger oral syringe was not used.

What lessons have we learnt and actions taken: All oral liquid medicines **must** be drawn up with purple oral syringes, as per Trust "purple plunger" policy. Medication errors often occur due to human factors such as fatigue, poor environmental conditions or staff shortages that affect prescribing, transcribing, dispensing, administration and monitoring practices

How does this relate to me: Are you aware of best practice in medicines management?



Duty of Candour

127 Serious Incidents (SIs) were declared at the Trust in 2019/20.

During 2019/20, we have demonstrated an improvement in compliance with Duty of Candour for patients involved in a Serious Incident. Current data demonstrates that 9.9% of patients involved in an SI did not receive an initial Duty of Candour letter in 2019/20 in comparison to 5.19% the previous year.

At the time of this report 26.7% of the declared SI's remain open and under investigation. Of the 73.3% that were completed, 52.6% of patients/families have been sent the final outcome of the investigation. This is compared to 54.5% compliance during 2018/19.

Next steps:

- Review and strengthen processes for following up outstanding Duty of Candour notifications
- Review and strengthen how Duty of Candour is recorded on Datix
- Review feasibility of creating Duty of Candour dashboards for Divisions to easily identify outstanding incidents
- Consider making this a mandatory field on Datix
- Consider creation of a validation field for completion of Duty of Candour at the point of closure by the Patient Safety Team to ensure adequate evidence is recorded within the record prior to final approval
- To continue to report on monthly KPIs
- Complete quarterly compliance audits
- To deliver regular Duty of Candour training sessions Trust-wide

Actions for 2020/21:

- A training schedule for joint root cause analysis (RCA) training with Kent and Medway NHS and Social Care Partnership Trust (KMPT) is in place (*due to the current COVID pandemic the training has been on hold since March 2020*)
- Roll out of Trust-wide learning lessons events
- Roll out of the new Performance Dashboard module on Datix, to be led by the Deputy Patient Safety Manager
- Roll out the revised Duty of Candour training schedule to be delivered by the Patient Safety team to all clinical staff
- Deliver Datix training Trust-wide
- Establish the Patient Safety Strategy Working Group to implement the revised Patient Safety strategy
- Write and present a briefing paper for the introduction of the Patient Safety Incident Response Framework (PSIRF)
- Nominate a Patient Safety Specialist to represent the Trust in the delivery of the NHS Patient Safety Strategy

Seven Day Services

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. Full compliance is being achieved against the four 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, General Surgery). This occurs during part of the weekend when these Consultants are not currently routinely job planned to be resident (between mid to late afternoon on a Saturday and 08.00 hours 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, 5 and 6 but there is a significant Consultant workforce challenge in respect of standard 8 and thus, these services did not achieve full compliance by the March 2020 deadline.

Compliance Status

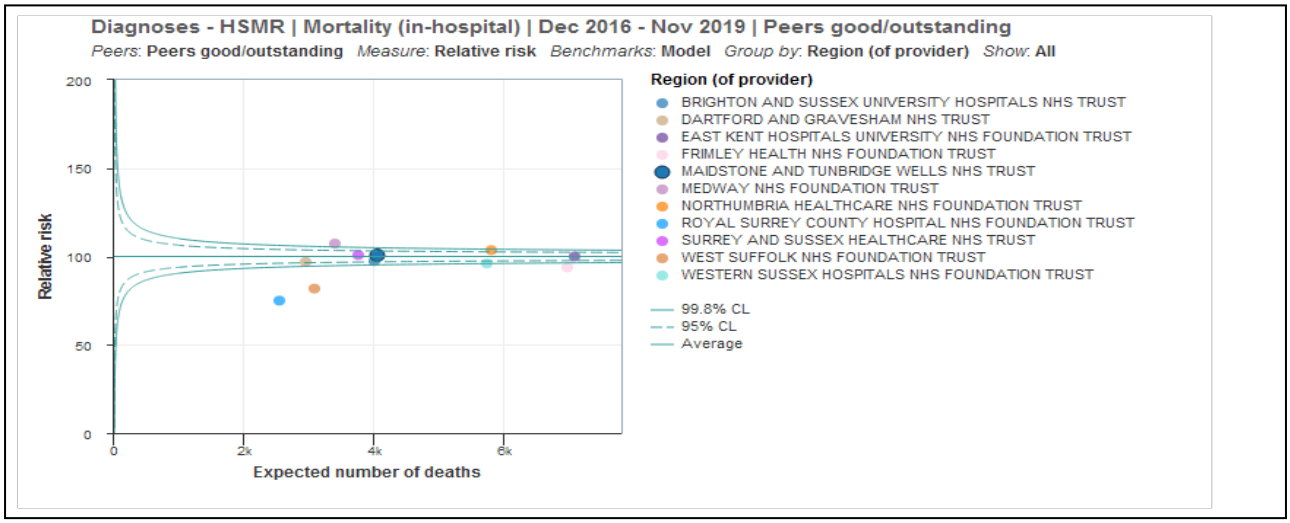
'Exempt' relates to services that do not have non-elective (NEL) patients under the direct care of the specialty consultant, but are under the primary care of another service (normally a physician due to co-morbidities).

Service	Std 2	Std 5	Std 6	Std 8	Comment/Actions in progress
Surgery	✓ (w/day) X (w/end)	✓	✓	✓	The directorate continues to work on a plan to be compliant during the second quarter of 2020. The current status is that virtual Saturday and Sunday evening ward rounds in place, 6pm face to face wards rounds at TWH, job plans updated to support, audit of standard 2 is in place and continues, feedback is discussed at clinical governance meetings and is used as a driver for cross site changes to clinical services.
Urology	✓)	*N/A	✓	✓	Compliant
Women's Health	✓)	✓	*N/A	✓	Compliant
T&O	✓	*N/A	✓	✓/X	Compliant
ENT	X	*N/A	N/A	X	Consultants are undertaking daily weekday board rounds each morning and are seeing the medically active patients daily. Virtual ward rounds occur daily at 7pm and at weekends.
Acute and Geriatric Care and Specialist Medicine	✓	✓ (Endos-copy)	✓ (Interventional Endos-copy)	X	There is a significant Consultant workforce challenge in respect of standard 8, a significant investment in resources is required to achieve compliance and a plan is in place.
Paediatrics	✓	*N/A	✓	✓	Compliant
Critical Care	✓	*N/A	✓	✓	Compliant
Ophthalmology	Exempt	*N/A	*N/A	Exempt	Exempt: All medically activity patients are under the care of a Physician.
Clinical Haematology	✓	*N/A	*N/A	Exempt	Nature of case mix – 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 2019/20 the Trust has continued to see mortality rates reduce in line with the reduction we previously evidenced in 2018/19. As we were achieving well against our peers in the region we made the decision to challenge ourselves further and are now benchmarking against NHS Acute Trusts who are recognised as being 'Good' or 'Outstanding' by the Care Quality Commission. This continues to demonstrate that we remain in a favourable position amongst our peers and compliance is at a sustained acceptable level.



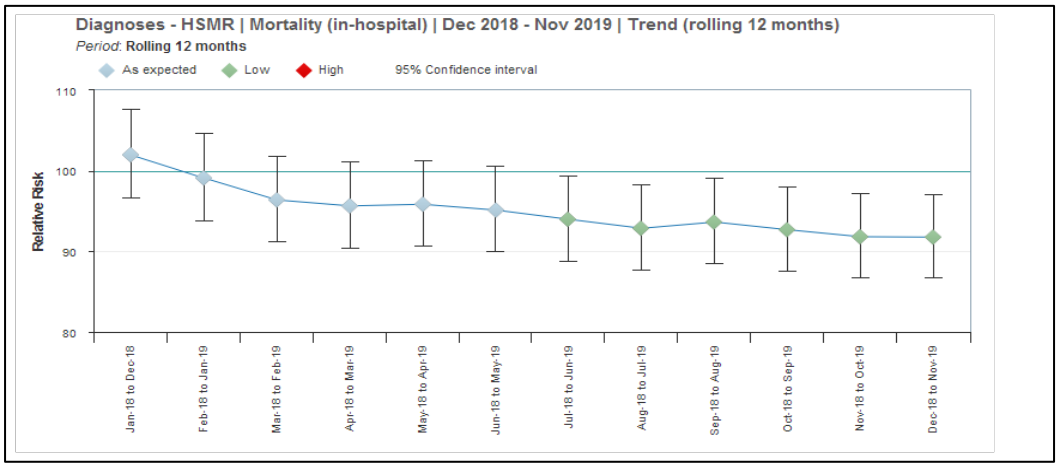
The Trust Mortality Surveillance Group (MSG) has been operational since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning. This group reports directly to both the Quality Committee and the Trust Board. The chair of this Group is the Chief of Service for the Medicine and Emergency Care Division.

The MSG closely monitors both local and national data in an effort to identify themes and trends that may impact on the care our patients receive. The MSG uses both the Hospital Standardised Mortality Rate (HSMR) and Standardised Hospital Mortality Indicator (SHMI), which support us to benchmark amongst our peers but more importantly to look for any unusual trends or themes against particular diagnosis codes.

Both the HSMR and SHMI when tracked over time are also indicative of how successful a hospital has been in managing their deaths and improving upon the care provided.

In April 2019 our HSMR was recorded as 99.4 (a ratio of the actual number of deaths to the expected number of deaths), in March 2020 we reported HSMR at 91.8 which continues to evidence the downward trend of actual deaths at the Trust, the expected rate is 100 or below.

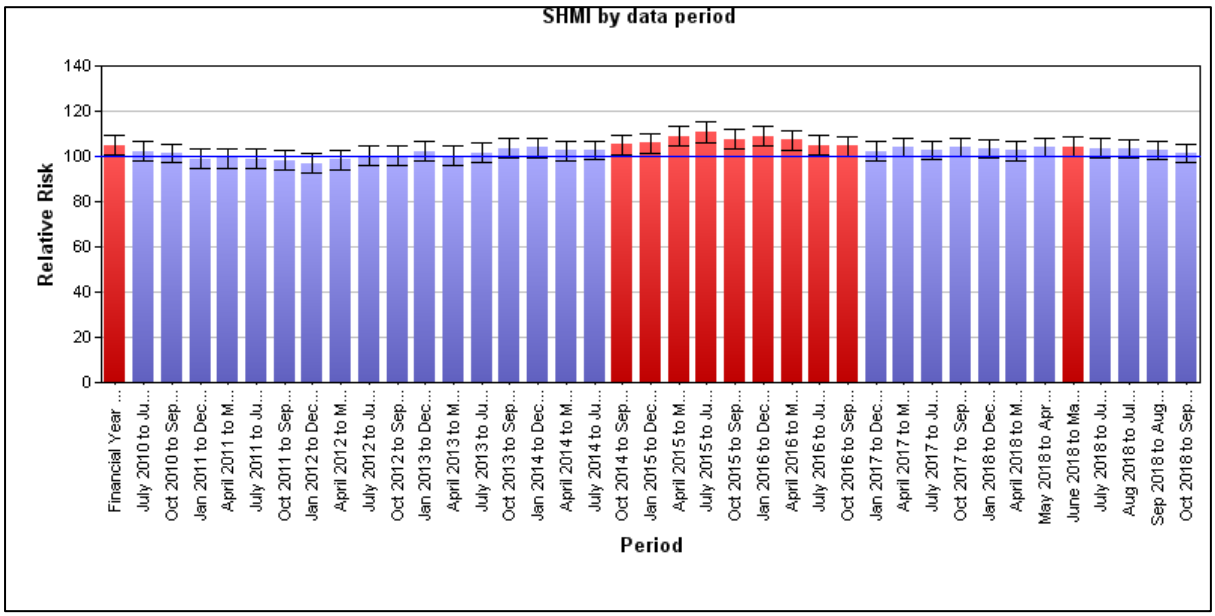
Data from December 2018 – November 2019 (rolling 12-month view)



Further evidence of improvement in mortality at the Trust is seen in the 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 and Social Care Information Centre (HSCIC) for the period January to December 2018 showed the Trust's SHMI as 1.0492, which was banded as level 2 'as expected'. In March 2020 this is now at 1.0080 (banded as level 2 'as expected').

Publication of the next data series for the period January – December 2019 will be in May 2020.



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. In this Trust 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 2019/20 the Trust recorded 1,607 patients who had died: 1,494 inpatient deaths and 113 in the Emergency Department (ED). The current mortality review process was recognised as being labour intensive with learning having to be manually extracted. Funding has been approved to purchase the Mortality Datix IQ Cloud module and at present negotiations are taking place between our Information Technology team and DatixRL to make this operational. Once this is in place the process will be automated and will enhance our ability to analyse our themes and trends to support the 'Lessons Learned' agenda.

The purpose of the mortality review is to determine any death where 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 2019 – March 2020

Trust	Q1	Q2	Q3	Q4	Total
No of Deaths	358	377	411	461	1607
No of Completed Reviews	305	326	354	367	1352
%age completed reviews	**85.2%**	**86.5%**	**86.1%**	**79.6%**	**84.1%**
SJRs Requested	31	18	21	9	79
SJRs Completed	6	9	11	9	35
%age SJRs requested of all deaths	8.66%	4.77%	5.11%	1.95%	4.92%

79 structured judgement reviews representing 4.92% of the 1,607 patient deaths that have occurred during 2019/20 were requested during this time frame. Of these 44.30% have been completed to date equating to 2.18% 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 35 reviews undertaken the judgements in regard to care provided were:

- Very poor care 5
- Poor care 12
- Adequate care 3
- Good care 14
- Excellent care 1

Learning identified from Mortality Reviews during 2019/20 includes:

- Use of the Amber care bundle is currently being trialled. When it is unknown whether the patient will survive or not, this guides staff through the difficult conversation with the relatives regarding treatment options, resuscitation wishes and ceilings of care.
- Prompt senior oversight of decision making regarding End of Life Care (EoLC) is needed, to include review of DNACPR (do not attempt cardiopulmonary resuscitation) form signed by Consultant lead.
- Sensitive DNACPR discussions with relatives should be carried out by senior members of the medical team who are responsible for making the decision and not delegated to juniors.
- When a patient is considered for End of Life Care the requirement is to use the end of life plan of care.

- Consent for high risk surgical procedures must include the risk of death and the content of this discussion must be documented.
- Importance of contemporaneous and legibility of documentation, including best interests discussions.
- Improved documentation with particular records of thought processes leading to decision making, including elimination of possible diagnoses.

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.

The NHS Outcomes Framework has five 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 —	2019/20 local and national data	2018/19 local and national data	National average

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 —	2019/20 local and national data	2018/19 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	1.0203 (Band 2 – "As Expected")	1.0391 (Band 2 – "As Expected")	Best 0.6909 Band 3 Worst 1.1957 Band 1
	(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.	43% Dec 2018 – Nov 2019	30.7 Oct 2017 – Sept 2018	Lowest 11% Highest 58% Mean 36% Dec 2018 – Nov 2019
3	PROMS			
	i) groin hernia surgery	No data	0.18	0.086
	ii) varicose vein surgery	No data	No data	No data
	iii) hip replacement surgery	0.444	0.463	0.437
	iv) knee replacement surgery	0.337	0.298	0.323
	during the reporting period (*See below for explanation of reporting data)*		(Apr 16 - Mar 17)	
3	the percentage of patients aged— i) 0 to 15; and	**Elective** 5% *1 **Non-Elective** 5.2% *1	**Elective** 3.1% *1 **Non-Elective** 4.8% *1	**Elective** 4.1% **Non-Elective** 9.4%

Domain	Prescribed data requirements The data made available to the National Health Service Trust or NHS foundation Trust by the Health and Social Care Information Centre with regard to —	2019/20 local and national data	2018/19 local and national data	National average
	(ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	**Elective** 8.2% *1 **Non-Elective** 17.1% *1	**Elective** 7.2% *1 **Non-Elective** 16.7% *1	**Elective** 3.8% **Non-Elective** 14.0%
4	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	74%*2	78.2%*2	69.93% 2017
5	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96.5%*3 Q3 2019-20 96.67% Risk assessed 34,148 Total admission 35,326	96.7%*3 Q4 2018-19 97.10%	95.33% Q3 2019-20 Lowest 71.59% Highest 100%
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.	21.4 *4	16.3 *4 2018/19 Rate 41.5 Mean 34.9	13.85 2017/18 tbc

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 —	2019/20 local and national data	2018/19 local and national data	National average
			Low 0.0 High 168.0	
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	12,491 28.55 per 1,000 bed days (April – Sept 2019 only) 302 (0.46%)	8,113 80 (0.98%)	 1.23%

*1 2019/20 data is Apr-19 – Feb- 20 as March not currently available. Data taken from local tables and readmissions within 30 days (not 28 days)
*2 Based on Quarter 3
*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 two surgical procedures for which PROMs data is captured; Hip and Knee replacements. Up to three measures are used to assess the outcomes of these procedures. Results are uploaded on the NHS Digital website from which the graphs below are provided.

Data published in February 2020 (based on April 2018 to March 2019) shows an improvement in health gain following an operation for both surgical procedures.

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

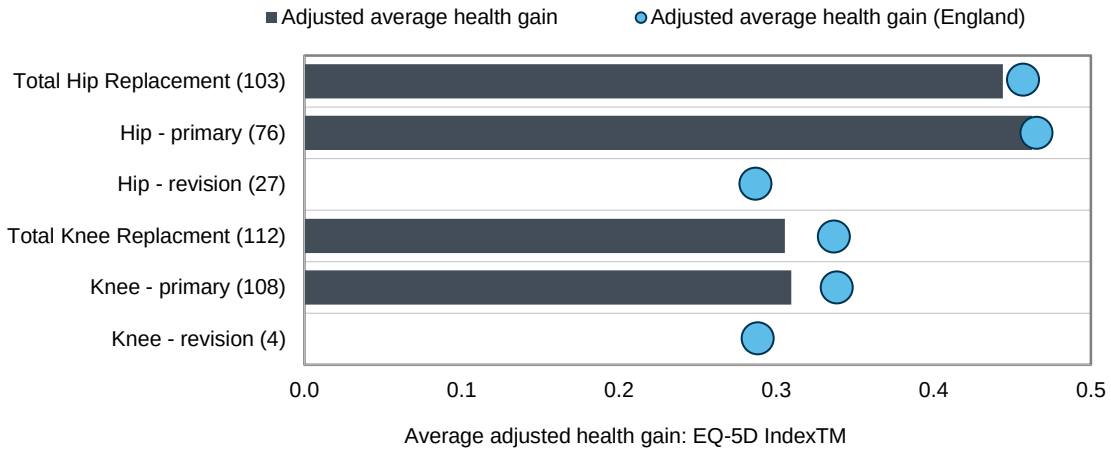


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

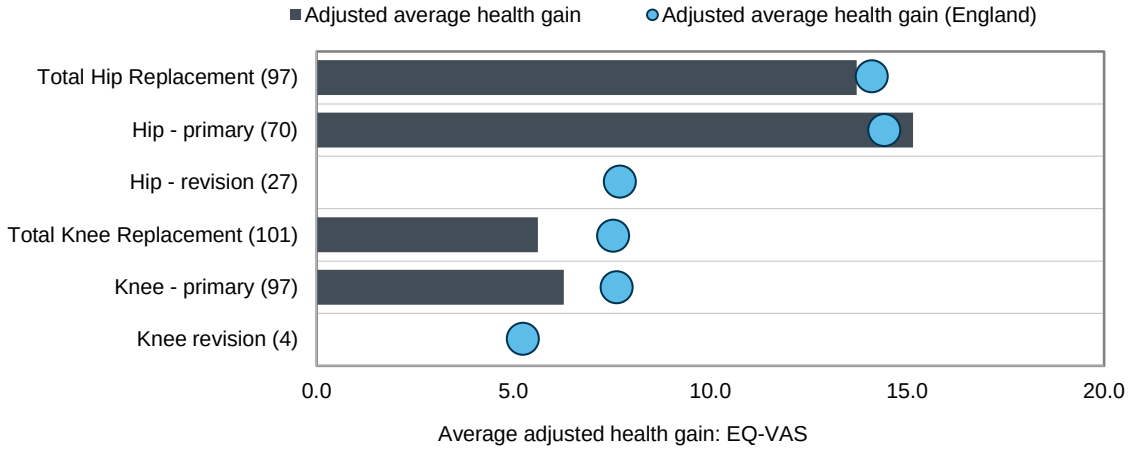
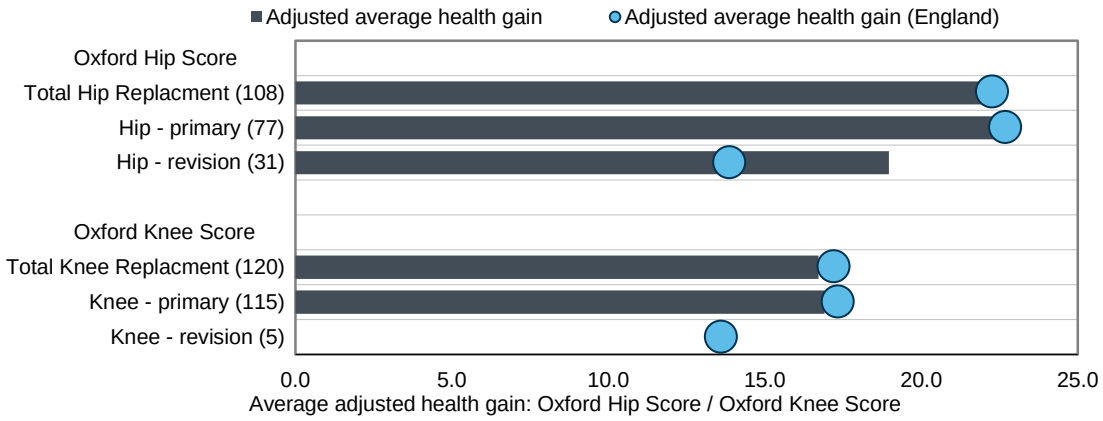
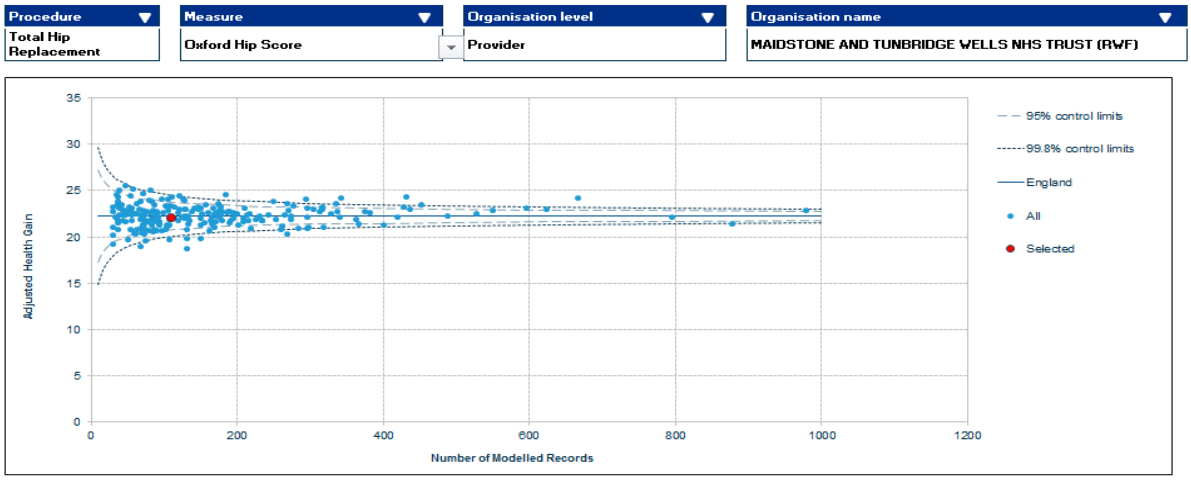


Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

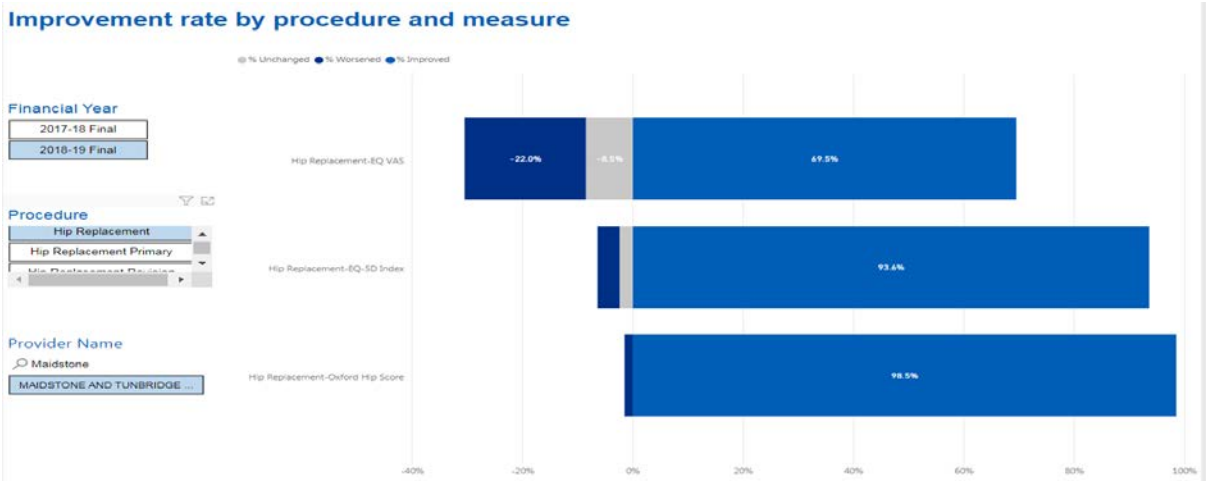


As can be seen the Trust scored below the national average for all three measures for Total Hip and Knee replacements; although most patients reported an improvement following surgery.

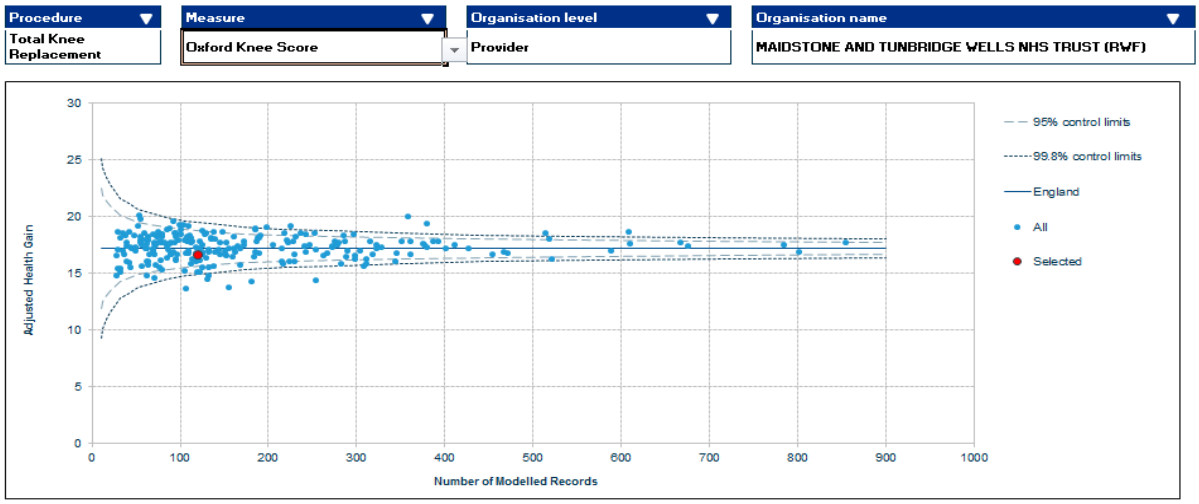
Total Hip Replacement – 108 returns of which 106 reported an improvement in health following the procedure (using the Oxford Hip Score PROMS Measure).



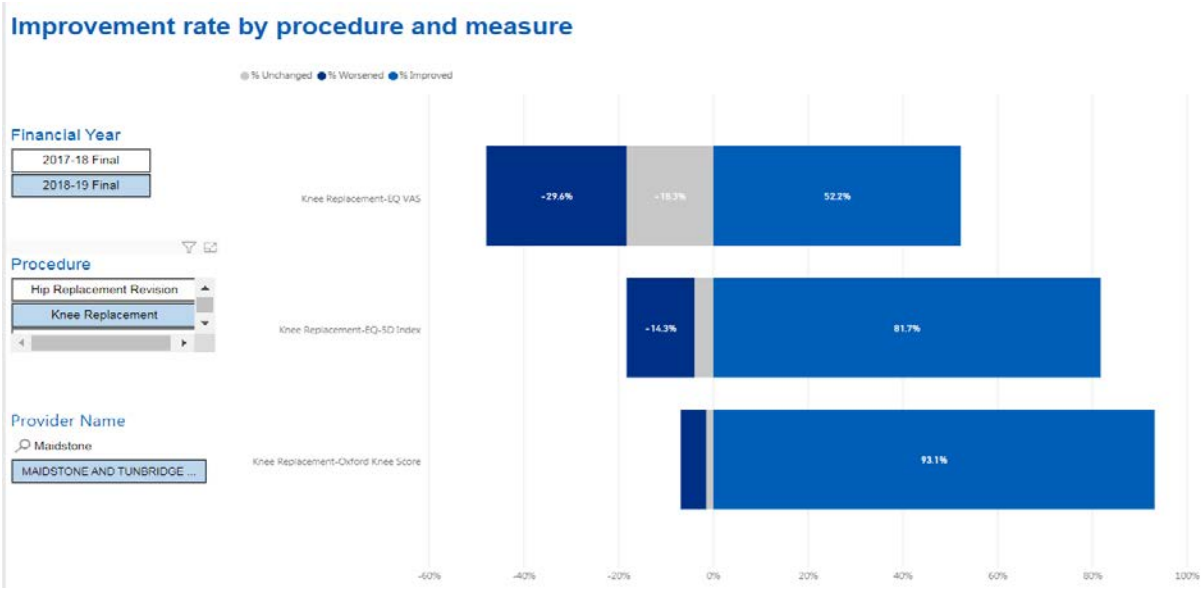
The Improvement Rate for all measures relating to Hip Replacements is shown below.



Knee Replacement – 120 returns of which 112 reported an improvement in health following the procedure (using the Oxford Knee Score PROMS measure).



The Improvement Rate for all measures relating to Knee Replacements are shown below.



Additional areas of significant improvement during 2019/20

Corporate Services - International Nurses Recruitment Programme

During 2019/20, the Trust recruited 218 international nurses from Ghana, India, Kenya, Nepal, Nigeria, The Philippines and Zimbabwe.

The Professional Standards Team successfully prepared 180 of these nurses to take the Nursing and Midwifery Council's (NMC) Objective Structured Clinical Examination (OSCE) at the University of Northampton, Oxford-Brookes University and Ulster University, in order for them to be Registered Nurses in the UK. The nurses had to pass four stations covering Assessment, Planning, Implementation and Evaluation, plus two clinical skills stations, e.g. Basic Life Support, Aseptic Non-Touch Technique.

The Trust has also worked with a company in India, Aryavrat, to pilot the recruitment of OSCE-ready nurses. Thirty-eight nurses completed their OSCE training in India and then undertook their OSCE within a week of arriving in the UK. They are now Registered Nurses in our workforce. Going forward, Aryavrat will be providing the Trust with approximately five Registered Nurses per month. As part of their induction the international nurses attended a study day covering UK culture, the NHS, the NMC Code, the role of the Registered Nurse in the UK and patient and family expectations.

Corporate Services - Emergency Planning

In December the new Maidstone helipad was officially opened by HRH The Princess Royal.

The new pad funded by the HELP appeal charity replaced the grass landing site that frequently became waterlogged in bad weather. Its design makes it fully compliant and is usable 24 hours a day; both to receive patients and transfer out. The helipad was also designed to allow the helicopter to meet a road ambulance so a patient can be moved direct to the aircraft for onward transfers to specialist units such as major trauma centres. The main user of the helipad will be the Kent, Surrey and Sussex Air Ambulance but it will also be available to other operators such as the Children's Air Ambulance.

The helipad's first emergency use was just three days after it opened.

Corporate Services – Dementia Care

The Trust was recognised for its work in the fight against Dementia after winning an award at the Dementia Friendly Kent Awards 2019.

Along with our fellow partners in the West Kent Emergency Services Dementia Group, including Kent Police, South East Coast Ambulance Service and Kent Fire & Rescue, the group took home the Community & Partnership award at the ceremony on Friday 11 October 2019.

The partnership was recognised for its hard work helping people with dementia in the community and helping reduce unnecessary hospital admissions.

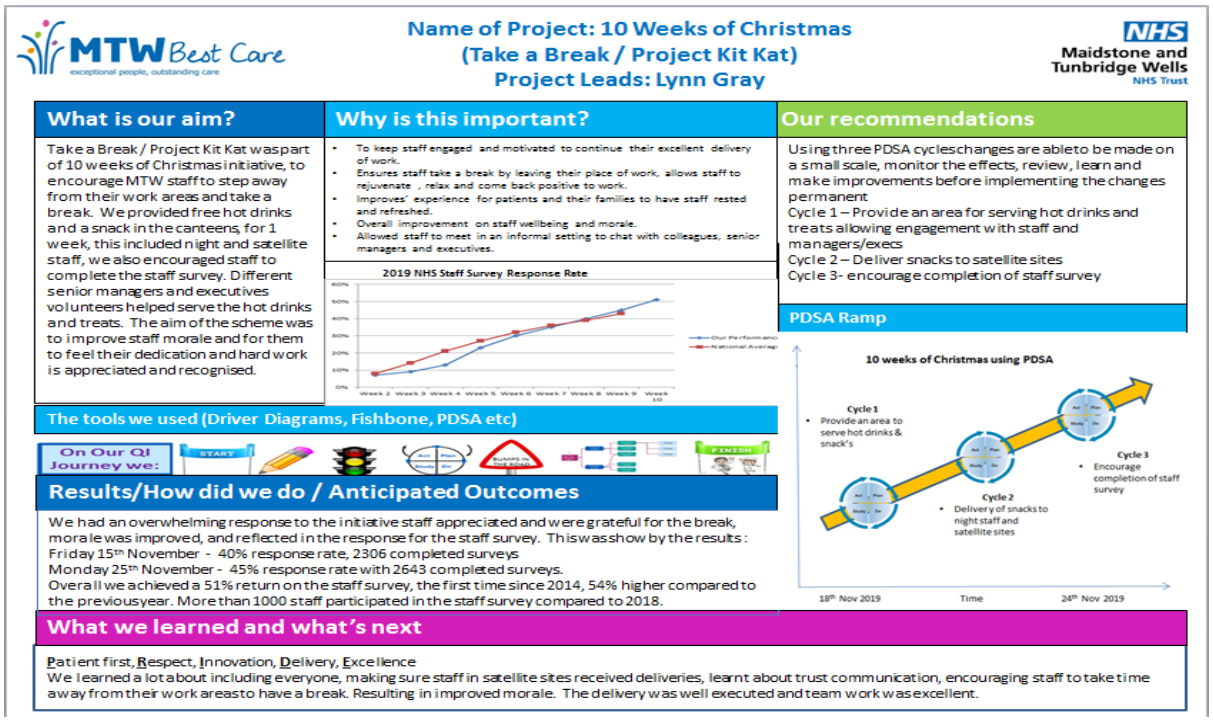
This is just part of the ongoing work within the Trust to improve the care of our patients with dementia.

Corporate Services - QSIR

During 2018-2019, six staff undertook their formal Quality, Service Improvements and Redesign (QSIR) training to graduate as QSIR College Associates. This enabled the Trust to create a local Quality Improvement Faculty. The first QSIR Practitioner training started on 13th May 2019, with the 4-day training course undertaken over 4 months covering all 8 QSIR modules.

The first QSIR Practitioner cohort consisted of the Trust Executive team and other senior members of both clinical and non-clinical divisions, and graduated on 15th July 2019.

Each cohort must undertake a number of projects, utilising the QSIR tools and resources throughout their training, one of these projects was titled ‘Project KitKat – Take a Break’. The project on a page below shows the QSIR tools used and the direct impact this played in the Trust achieving the **Best Staff Survey response** rate since 2014.



The Trust thanked the staff with the 'Thank you' film, which can be seen on the link below.
https://www.youtube.com/watch?v=f1j-QN5DdCg

The Trust's Quality Improvement (QI) Faculty delivered the QSIR training and achieved significantly above the planned staff trained numbers. In year 1 the Trust's QI Faculty planned to train 90 staff on QSIR Practitioner training and 50 staff on QSIR Fundamental training, which is the one day introduction training. The actual numbers trained, by workforce group, can be seen below. The number of staff who have pre-booked to attend QSIR training is also shown.

Workforce/staff group	Practitioner Trained	Fundamental Trained	Practitioner Registered	Fundamental Registered
Administration and Clerical	113	78	37	24
Allied Health Professional	12	18	1	2
Clinical Services	0	0	1	0
Healthcare Scientists	1	0	1	0
Medical and Dental	7	19	10	1
Nursing and Midwifery	19	33	13	24
Unknown/blank	1	0	4	7
TOTAL TRAINED	**153**	**148**	**67**	**58**

The National QSIR team wanted to celebrate the success of the Trust's adoption and application of QSIR. They commissioned a film specifically to understand the importance of Quality Improvements to the Trust to promote a **Culture of Continuous Improvements.** The film can be seen on the link below.

https://www.youtube.com/watch?v=pSaKmgY9yUA

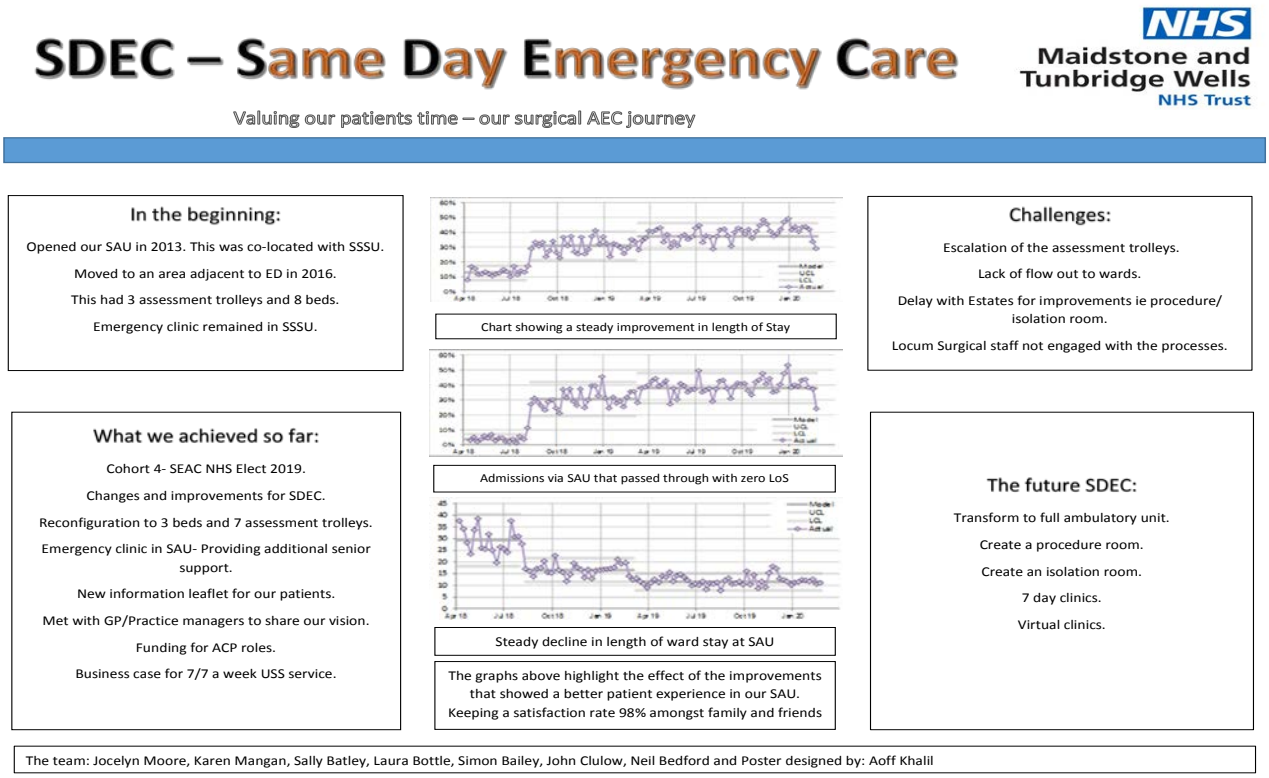
Surgical Services - My Pre-op

During the last year we have reviewed our pre-operative assessment process within the Trust. There was a need to focus on our sickest patients to comprehensively prepare them for their elective procedure and make the pathway as efficient as possible for fit, healthy patients.

In order to identify our fit, healthy patients we adopted the My Preop on line system. A walk-in Pre-Operative Assessment (POA) system was put in place where patients are able to submit a completed health questionnaire on line. The questionnaires are reviewed remotely with fit, healthy patients not needing to return to the hospital prior to surgery. Face-to-face pre-operative appointments are utilised for major surgery patients or those with significant co-morbidities. This has also allowed for the prompt screening of cancer patients to reduce delays in their pathways.

https://www.ultramed.co/mypreop

Surgical Services - SDEC



Medical and Emergency Care – Patient Flow

The Trust was shortlisted for the Acute or Specialist Service Redesign Initiative – London and the South, at this year's HSJ Awards.

The judging panel shortlisted our Improving Patient Flow project based on the ambition, visionary spirit and the demonstrable positive impact it has had on patient and staff experiences within the healthcare sector.

Thanks to significant improvements made over the past year to improve how we care for and treat our patients using our emergency care services, we are now one of the top 10 performing Trusts in the country.

Innovative measures introduced include extending the use of our ambulatory services and frailty units, securing beds in the community to care for patients waiting for social services support, working collaboratively with our partners to support suitable patients to return home to finish their acute care via the new Hospital @ Home scheme and improving the efficiency of our operating theatres and outpatient clinics.

Women's Services

During the past year, Women's Services has implemented several innovations with a focus on quality and safety.

In January 2019 a rolling Quality Improvement Programme was initiated with spot checks and audits of quality measures. Topics include documentation and medicines management. Each clinical area is audited weekly and topics revisited on a monthly cycle. Sessions are chaired by the Head of Midwifery with Matrons, Ward Managers and

specialist roles all attending with a phone-in facility enabling community and Birth Centre staff to participate remotely. Actions are agreed each week with the programme supported by an action plan log, audit tools and a poster generated at the meeting to provide immediate feedback to staff in all areas.

The introduction of a multidisciplinary lead staff 'Huddle' at 10.00 hours every week day has enabled increased awareness of issues throughout the Women's Directorate and significantly improved staff communication.

It is important that all our patient-facing digital information is accurate and up to date as this is the most utilised mode of information gathering for childbearing women. The new maternity website acts as a resource that staff can signpost women to, ensuring that all women are given equitable information.

Continuity of Carer, when women are cared for by the same midwife or team throughout all stages of pregnancy, labour and birth, is a nationally recommended model of care for women accessing maternity services and is currently being implemented within our maternity service. Evidence suggests that this model of care improves clinical outcomes for both mothers and babies.

The Maternity Triage service has been changed to incorporate the South East Coast Ambulance Service NHS Foundation Trust (SECAMB) labour line model used by other Trusts in the country. This initiative aims to take the 8,000+ phone calls per month out of the main Triage department to improve flow and quality of telephone contacts. Senior midwives now operate a dedicated telephone Triage service away from the busy unit and early findings indicate success in improving service flow and quality of care.

Diagnostics Services – Interventional Radiology

Interventional Radiology (IR) is a growing specialist field within Radiology. We are extremely lucky to have some expert Consultant Radiologists in this field on both sites in the Trust but we were still finding it difficult to allocate the correct priority and time to all the requests we were seeing, especially in the light of meeting the 28 day FDS for biopsies.

We decided to employ an Interventional Coordinator to align all requests across both hospital sites to maximise capacity. This had resulted in reduced waiting times and provided opportunities for developing our Advanced Practice Radiographers by diverting some interventional work to them. To this end, we have begun a training program for our Consultant Radiographer and IR Superintendent to be able to perform ascitic drain insertion.

These initiatives have already begun to help improve patient experience by being able to offer both diagnostic and palliative treatments in a much more efficient and timely way.

Virtual Outpatients

The Transformation Programme Director has been actively working with NHS E/I on the virtual platform referred to as 'Attend Anywhere' to convert face to face outpatients to virtual outpatients, where clinically appropriate and where patient appropriate.

The Trust has proactively converted face to face to virtual outpatients, which allowed us to be in a strong position to accelerate the programme due to COVID-19 and continue outpatients in this new way. The Trust was also the first Trust to trial running a clinic from a Consultant's home so allowing that Consultant to maintain their service, whilst at home. All the necessary information governance was approved prior to the trial and our lessons learned have been shared with NHS E/I and other Trusts. The infographics below show at

a point in time the number of clinics and waiting rooms created virtually. This project is ongoing.

Cancer Services – Mentoring Success

Staff at the Kent Oncology Centre, which is based on the Maidstone Hospital site, have been passing on their knowledge to help cancer patients across the country by mentoring NHS staff from fellow Trusts to undertake prostate brachytherapy.

Brachytherapy treats localised prostate cancer with the aim of cure by implanting the prostate with tiny radioactive ‘seeds’ under ultrasound guidance. The Trust is one of the largest centres in the UK to provide the treatment, performing over 750 implants since 2006.

The Royal Marsden have recently converted to the technique and visited the Trust twice before successfully carrying out their own procedure alongside our team. The knowledge of the team is in huge demand after they recently hosted colleagues from as far as the Netherlands.

Part Four - Appendices

Appendix A

51 national clinical audit reports were published where the topic under review was relevant to the Trust in 2019/20 with action to be taken in 2019/20.

National report published April 2019 to March 2020	Report received	Date report due or date received
Acute Care		
National Cardiac Arrest Audit (NCAA)	**Y**	**Report published June 2019:** There were 71 cardiac arrests at TWH that met the criteria for inclusion in the NCAA. The survival rates for the in-hospital only cardiac arrest was 43.5% with a survival to discharge of 24.2%. This demonstrates a slightly above average survival for shockable and an average survival for non-shockable rhythms in comparison to other hospitals. There were 75 cardiac arrests at MGH that met the criteria for inclusion in the NCAA. The survival rate for the in-hospital only cardiac arrest is 43.7% with a survival to discharge of 11.3%. This demonstrates a below average survival for shockable and an average survival for non-shockable rhythms in comparison to other hospitals. **Action:** Improve compliance with policy for completing the audit forms by adding as a standard agenda item at Clinical Governance meetings.
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	**Y**	**Report published July 2019:** ICNARC reports are published quarterly and reviewed at Critical Care cross site meetings in which they are a standing item. MTW performance remains comparable to the national picture of similar units. MTW is fully compliant with

National report published April 2019 to March 2020	Report received	Date report due or date received
		data submission. The reports are currently not showing any major areas of concern and in particular, mortality levels are better than average across all quarters. **Action:** Continue monitoring of ICNARC outcome parameters in a timely fashion.
Emergency Laparotomy Audit (NELA)	**Y**	**Report published in December 2019:** The report is with the Anaesthetics Team for review and action plan development.
Severe Trauma (Trauma Audit & Research Network) TARN	**Y**	**Report published November 2019**: MTW's submission rate to TARN and its quality has increased quarter on quarter in the last year. The vast majority of trauma cases seen in our two emergency departments are patients over 70 who have fallen. We now record our data by admission date to bring us in line with the TARN reports. The use of systems such as TheatreMan has enabled us to improve our data quality. The TARN co-ordinator records data on areas where we fall down in performance and these areas are then flagged to the trauma team through quarterly newsletters and addressed at the quarterly Trauma Board meetings, where improvement measures are put into place. An example is time to CT for head injury patients (Trust at 67%, although national mean is 52%). Measures for prompt requesting and portering have been implemented. The care of all patients with a high injury severity score (ISS greater than 15) is reviewed quarterly.
National Joint Registry (NJR)	**Y**	**Report published October 2019** Review of the NJR is a standing item at the Trauma and Orthopaedic department

National report published April 2019 to March 2020	Report received	Date report due or date received
		Clinical Governance and directorate meetings. 701 procedures were recorded on the 2019 annual report (2018 data) with a consent rate of 100% for Maidstone submissions, which is above the national average. The report showed the Trust is not an outlier in any of the reported areas. The overall level of assurance was 3, fully compliant therefore there were no actions recommended. This is an ongoing national audit which our Trust participates in continuously with a dedicated administrator
RCEM Feverish Children (care in the ED) 2018	**Y**	**Report published in July 2019:** Overall this National Audit demonstrated excellent practice benchmarked against national outcomes, putting MTW among the highest achieving Trusts in the country in 5 out of the 6 standards. **Action:** The Paediatric pathways are fundamentally different cross-site: at TWH there is a dedicated Paediatric ED; whereas at MGH these patients are transferred to the Riverbank Unit. A dedicated Paediatric-trained nursing team has now been introduced at Maidstone ED for the assessment/observations and triage of children presenting with febrile illness in order to follow the same pathway as TWH.
RCEM Vital Signs in Adults (care in the ED) 2018	**Y**	**Report published in July 2019:** This National Audit demonstrated excellent practice benchmarked against national outcomes, putting MTW among the highest achieving Trusts in the country. The Royal College recommendations state that compliance is achieved through measurement against the National Mean. Mean scores for the standards at Tunbridge Wells Hospital, Maidstone Hospital and nationally were

National report published April 2019 to March 2020	Report received	Date report due or date received
		94%, 86% and 63% respectively. Fully compliant, no actions required at this time.
RCEM VTE risk in lower limb immobilisation (care in the ED) 2018	**Y**	**Report published in July 2019:** This National Audit demonstrated excellent practice when benchmarked against national outcomes, putting MTW among the highest achieving Trusts in England. The Royal College recommendations state that compliance is achieved through measurement against the National Mean. Mean scores for the standards at Tunbridge Wells Hospital, Maidstone Hospital and nationally were 96%, 99% and 36% respectively. Fully compliant, no actions are required at this time.
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
Blood Transfusion Programme		
Serious Hazards of transfer (SHOT) UK. National haemovigilane scheme	**Y**	**Report published in July 2019:** MTW reported 27 incidents to SHOT in 2018. Of these, 8 were reactions to blood components. All except the reactions were deemed to be errors, which meant that 71% of our reported incidents were errors. This is below the national average. 57.9% of the errors occurred in the clinical area and 42.1% of the errors occurred in the laboratory. The Trust was partially compliant with an action to implement Electronic Issue to improve compliance.

National report published April 2019 to March 2020	Report received	Date report due or date received
Cancers		
National audit of Breast Cancer in Older People (NABCOP)	**Y**	**Report published May 2019** The report covers patients diagnosed between January 2014 and December 2017. Results showed the Trust is not an outlier and met all recommended criteria. The data is input by separate individuals; all of the mandatory fields were completed but optional fields were sometimes missed resulting in lower than expected completeness of data. Triple Diagnostic Assessment and Involvement of a Breast Clinical Nurse Specialist scores were above national average. **The action plan** highlights the need for a designated administrator to input the data for NABCOP to improve data completeness.
National Audit of Lung Cancer (NLCA)	**Y**	**Report published January 2020:** The report is with Cancer Services for review and action plan development.
National Audit of Bowel Cancer (NBOCAP)	**Y**	**Report published January 2020:** The report is with Cancer Services for review and action plan development.
National Prostate Cancer Audit 2017	**Y**	**Report published in January 2020:** Nationally 42,668 men were diagnosed with prostate cancer in England and Wales between 1st April 2017 and 31st March 2018. The number of Cancer Registry Records submitted to this audit by our Trust was 520. Action agreed to improve data capturing by reviewing the data completeness reports. Radiotherapy centre specialist gastrointestinal services are being considered to offer advice to people with bowel- related side effects of

National report published April 2019 to March 2020	Report received	Date report due or date received
		radiotherapy.
Oesophago-gastric cancer (NAOCG)	**Y**	**Report published in December 2019:** The report is with Cancer Services for review and action plan development.
National Ophthalmology Database Audit Project	**N/A**	The Trust was unable to submit data to this national audit due to software issues.
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 in October 2019** The report showed the Trust is fully compliant and is not an outlier in any reported areas. BAUS is discussed at Urology team meetings.
BAUS Urology Audits: Cystectomy	**N/A**	The Trust does not provide this service
BAUS Urology Audits: Nephrectomy Audit	**Y**	**Report published in October 2019** The report showed the Trust is not an outlier in any reported areas and is partially compliant as the Trust transfusion rate and complication rate had both increased marginally from the previous year. Both rates were within acceptable ranges. BAUS is discussed at Urology team meetings.
BAUS Urology Audits: Percutaneous Nephrolithotomy (PCNL)	**Y**	**Report published in October 2019** The report showed the Trust is not an outlier in any reported areas. The average patient risk profile was higher for the Trust than the national average which resulted in the Trust length of stay being above the national average. The report is with the Urology Team for review and action plan

National report published April 2019 to March 2020	Report received	Date report due or date received
		development.
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	**Y**	**Report Published in July 2019** The national audit collects continuous data on patients of all ages that are prone to heart rhythm disturbances. Complete data was not submitted in 2016/17 due to staffing constraints. **Action:** A business case has been put together including the provision for Admin support which should ensure improved transparency for future audits.
Coronary Angioplasty / PCI 2017-18	**Y**	**Report Published in October 2019** The report is with the Cardiology team for review and action plan development.
MINAP 2017-18	**Y**	**Report Published in October 2019** The report is with the Cardiology team for review and action plan development.
Heart Failure 2017-18	**Y**	**Report Published in October 2019** The report is with the Cardiology team for review and action plan development.
Cardiac Rehabilitation 2017-18	**Y**	**Report Published in October 2019** The report is with the Cardiology team for review and action plan development.
Adult Cardiac surgery	**N/A**	The Trust does not provide this service

National report published April 2019 to March 2020	Report received	Date report due or date received
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	**Y**	**Report Published December 2019** The report is with the Diabetes team for review and action plan development.
National Adult Diabetes Inpatient Audit (NaDIA) 2018 (Hospital Characteristics only)	**Y**	**Report Published May 2019** The audit was a snapshot audit of hospital characteristics in England and Wales. The two main priorities identified from the audit findings were Staffing Levels and Health Technology. **Action:** The Trust has put together a business case to increase the provision of Diabetes Inpatient Specialist Nurses (DISN) and discussions are taking place with Kent Community Healthcare Trust to revise the current service level agreement (SLA) in order to increase inpatient podiatry. In line with the NHS Long Term Plan, MTW is in the process of implementing Sunrise for Electronic Patient Records and electronic prescribing for detecting, recording and avoiding insulin and oral hypoglycaemic agent prescribing errors. The Point of Care Team has submitted a business case for web linked meters. These allow for remote blood glucose monitoring.
National Adult Diabetes Inpatient Audit – Harms (NaDIA-Harms) 2018	**Y**	**Report Published May 2019** The report is with the Diabetes team for review and action plan development.

National report published April 2019 to March 2020	Report received	Date report due or date received
National Diabetes Foot Care Audit (NDFA) 2014-18	**Y**	**Report Published May 2019** The report is with the Diabetes team for review and action plan development.
National UK IBD Biologics 2018/19	**Y**	**Report Published October 2019** The report is with the Gastroenterology team for review and action plan development.
Neurosurgical National Audit Programme	**N/A**	Trust does not provide this service
Falls and Fragility Fractures Audit Programme (FFFAP)	**Y**	1. National Audit of Inpatient Falls (NAIF). **Report published March 2020** The report is with the Falls team for review and action plan development.
	N/A	2.Fracture Liaison Service MTW does not provide this service. This is a community service.
	Y	**3.** National Hip Fracture database (NHFD) **Report published December 2019** The report shows the percentage of patients meeting best practice for 2018 was 49%, below the national average of 58.3%. The Trust is not an outlier in any of the reported areas. Recommendations include adopting a NICE compliant surgical approach to manage patients considered eligible for total hip replacement. A further recommendation was to ensure patients are seen by an Ortho-Geriatrician to ensure pre and post-operative treatments meet best practice.
National audit of Dementia (NAD) Round 4 2018	**Y**	**Report Published July 2019** The Trust is fully compliant in staffing and

National report published April 2019 to March 2020	Report received	Date report due or date received
		training. The Trust is partially compliant in the remaining 5 areas. **Action:** The Trust Dementia Nurse Facilitator is providing bespoke training to wards for completion of 'This is Me' documentation with patients in order to identify factors that cause stress and agitation and those which calm. There is a push to complete the 'Occurrence of Delirium' fields in the electronic patient notes to increase compliance. A business case for a dedicated delirium team is currently awaiting Executive approval.
BTS Adult Community Acquired Pneumonia (CAP) 2018-19	**Y**	**Report Published February 2020** The report is with the Respiratory team for review and action plan development.
National COPD Secondary Care audit Sept 2017- Sept 18	**Y**	**Report Published May 2019** The report is with the Respiratory team for review and action plan development.
National Adult Asthma 2018-19	**Y**	**Report Published December 2019** The report is with the Respiratory team for review and action plan development.
National Adult Asthma and COPD organisational audit 2019	**Y**	**Report Published March 2020** The report is with the Respiratory team for review and action plan development.
National Early Inflammatory Arthritis audit (NEIAA) (8 May 18 - 7 May 19)	**Y**	**Report Published October 2019** The Trust is partially compliant, but has been identified as an outlier for the standard "People with suspected persistent synovitis are assessed in a rheumatology service within three weeks of referral". **Action:** To ensure all team members were submitting data for the audit as poor data entry figures were considered to be a factor of the low score. Increase in clinic capacity with a Referral

National report published April 2019 to March 2020	Report received	Date report due or date received
		Assessment Service for these patients.
National Patient Reported Outcome Measures (PROMs) Programme Elective surgery Hip Replacement, Knee Replacement, Groin Hernia, Varicose Vein* (* not performed at MTW)	**Y**	**Report published February 2020** The report shows the Trust had a total of 582 eligible hospital procedures .The adjusted average health gain for the trust is slightly below the national average. The report is with the Divisional Director of Nursing and Quality for review and action plan development.
Older People		
UK Parkinson's 2019 (Elderly Care)	**Y**	**Report Published February 2020** The report is with the Care of Elderly team for review and action plan development.
UK Parkinson's 2019 (Neurology)	**Y**	**Report Published February 2020** The report is with the Neurology team for review and action plan development.
National Sentinel Stroke Audit Programme (SSNAP) 2019 Organisational	**Y**	**Report Published December 2019** The report is with the Stroke team for review and action plan development.
National Sentinel Stroke Audit Programme (SSNAP) 2018-19	**Y**	**Report Published December 2019** The report is with the Stroke team for review and action plan development.
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	**N/A**	The Trust does not provide this service

National report published April 2019 to March 2020	Report received	Date report due or date received
patients prescribed lithium		
Women and Children		
MBRRACE-UK Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance	**Y**	**Report published in October 2019** There were 5,883 births in 2017 within our Trust with 27 extended perinatal deaths. The Trust is partially compliant with the recommendations. **Action:** Business case to be written for a dedicated pre-term clinic and training to ensure doctors are equipped to offer unbiased post-mortem consent counselling.
MBRRACE-UK; Saving Lives, Improving Mothers' Care; Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17	**Y**	**Report published in December 2019** The report is with the Midwifery team for review and action plan development.
MBRRACE-UK; Serious Maternal Morbidity - Saving Lives, Breast Cancer in Pregnancy (2015-2017)	**Y**	**Report published in December 2019** The report is with the Midwifery team for review and action plan development.
National Perinatal Mortality Review Tool	**Y**	**Report published October 2019.** The report is with the Midwifery Team for review and action plan development.
National Maternity and Perinatal Audit (NMPA)	**Y**	**Report published September 2019** The Trust is fully compliant with all recommendations except for the recommendation "Maternity services, primary care and public health services should work together, with involvement of local service users, to ensure that there is appropriate provision to support weight management prior to, during and after pregnancy" where we are partially compliant. A Transformation Lead Midwife has now been appointed to support Local Maternity System collaboration on this

National report published April 2019 to March 2020	Report received	Date report due or date received
		recommendation.
National Pregnancy in Diabetes Audit (NPID) 2016-2018	**Y**	**Report published October 2019.** The Trust is partially compliant with the recommendations. Work continues on improving early referral of type 2 diabetics onto the pathway by primary care. **Actions** include meeting with the Community Midwife Team Leads and the Diabetes Specialist Nurses.
Paediatric Inflammatory Bowel Disease; Biologics Round 2 (IBD Programme)	**Y**	**Report published October 2019.** The Trust is one of just 11 sites nationally that submitted paediatric data to the Registry in January 2019. The report is with the Paediatric Gastroenterology team for review and action plan development.
National Paediatric Diabetes Audit 2018-19 (NPDA**)**	**Y**	**Report published 12th March 2020.** The report is with the Paediatric Diabetes team for review and action plan development.
National Paediatric Diabetes Audit 2017-18 (NPDA**)**	**Y**	**Report published May 2019** The Trust is partially compliant with the recommendations. A comprehensive action plan has been developed to address the issues identified including setting up annual review clinics and analysing the clinic day rotas to identify the optimum clinic schedule. A structured diabetes system has also been implemented.
Neonatal Intensive and Special Care (NNAP)	**Y**	**Report published 13th December 2019** The Trust is partially compliant. There have been ongoing issues with data entry although there has been some improvement from the previous year. The Trust results compare favourably with the national rates, performing above average

National report published April 2019 to March 2020	Report received	Date report due or date received
		in all standards except for administering antenatal steroids for mothers delivering their babies between 23 and 33 weeks gestation. **Action:** Improve data entry further and review submitted business case to increase outpatient clinic times for follow-up after discharge.
Paediatric Intensive Care (PICANet)	**N/A**	The Trust does not provide this service
Confidential Enquiries		
NCEPOD Balancing the Pressures - Child Health – Long-term Ventilation	**N/A**	The Trust does not provide this service
NCEPOD Delay in Transit - Acute Bowel Obstruction Report	Y	Report published January 2020. Assessment of recommendations to be prepared and distributed.
NCEPOD Know the Score - Medical & Surgical Review Programme: Pulmonary Embolism Report 2019	Y	Report published October 2019. The report is with Medical Specialties for review and action plan development.

Appendix B

Summary of local audits undertaken during 2019/20 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 clinical 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 then undertaken to identify whether the changes have led to improvements in clinical 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

Key:

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
CG122: Re-audit - Ovarian cancer: recognition and initial management.	Fully compliant	This audit was conducted retrospectively by review of oncology notes and main hospital notes of patients diagnosed with stage 1 ovarian cancer between January 2017 and January 2019. The standards were evaluated for each of the patients identified with true stage 1 invasive ovarian cancer and the remaining higher grade cancers for intraperitoneal chemotherapy. We were fully compliant with all standards. No recommendations made as no changes were required.
NICE CG179: Prevalence Audit May 2019	Partially compliant	The prevalence audit took place on 15 May 2019. A total of 30 wards across the two trust sites took part in the data collection. Data was collected only on patients who were identified as having pressure ulcers and moisture associated skin damage. Hospital acquired pressure ulcers have increased to 3.5% which is slightly above the trust target of 3.0%.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG151; Re-audit of Febrile Neutropenia Patients (Round 4)	Partially compliant	Delay in treatment of suspected neutropenic sepsis can cause rapid deterioration and can potentially cause overwhelming sepsis and death. **The actions** from the 2017 re-audit included continuing use of the oncology admission proforma and continuing ward-based education for the immediate care of an unwell child receiving chemotherapy. Further improvement was noted with 100% of children being seen by a nurse within 30 minutes of arrival and 100% of children being medically reviewed within 1 hour.
NICE GC65; Hypothermia prevention and management in adults having surgery	Partially compliant	This audit has highlighted a lack of adequate documentation in particular to recording timings and temperatures of patient warming. We are failing to meet the standard of giving patients or their families / carers written information about the risks of hypothermia, and the action of developing a patient leaflet was not implemented following the previous recommendations. **Action:** Patient information leaflet explaining the risks of hypothermia to be developed, the surgical proforma will be amended to include sections to address this issue.
NICE NG45; Preoperative laboratory investigations audit	Partially compliant	This audit was conducted due to concerns that we may have been over-investigating fit and healthy patients having minor and intermediate level elective surgical procedures. Audit findings have shown a low level of documented indications for blood tests causing a lack of patient satisfaction due to undergoing unnecessary tests and increased workload for the pre-assessment clinic.
Re-audit: Central venous access device and peripheral venous access device insertion and ongoing care documentation annual audit (NICE CG139)	Partially compliant	The High Impact Interventions (HII) incorporate care bundles based on best-identified practice and care process and actions associated with quality patient care. Organisations that have succeeded in reducing infections have implemented HIIs as part of organisation-wide infection prevention and control strategies and part of robust systems to monitor the effectiveness of clinical processes. This round we improved in all areas except two. **Action:** Improve regular and persistent education concerning cannula insertion record-keeping.

NICE Guidance	Level of Compliance	Summary results and Actions
Audit of night time sedation (NICE: CG22 and TA77)	Partially compliant	Fewer patients than had been expected were found to have been prescribed night time sedation. There is still a concern that patients who have an increased falls risk are being prescribed night time sedation. **Action:** The prescribing of sedation in primary care should be reviewed due to patients being admitted with regular or long term use of night time sedation; report to be shared with West Kent CCG.
Re-audit assessing the appropriate use and prescribing of Lidocaine 5% patches at MTW. (NICE CG173)	Partially compliant	Lidocaine 5% patches are licensed only for use in the management of Post-Herpetic Neuralgia. This audit showed decreased compliance relating to the initiation of patches by or on the advice of the pain team. **Action:** create clinical information sheet for pharmacists explaining approved indications for use of Lidocaine patches.
NICE CG32 (criterion 1.7.17); Use of Nasogastric Tubes for Enteral Feeding re-audit round 3	Partially compliant	The incorrect placement of nasogastric feeding tubes (NGTs) can result in serious complications including death and is considered a 'never' event in the NHS. This audit demonstrates that the standards for the appropriate use of x-rays to confirm the correct placement of NGTs (87.5%) and for the use of gastric aspirates as an initial check for the correct placement of NGTs (84.6%) are both partially met within the Trust. **Action:** Education sessions developed or adapted plus memorandums circulated to educate nurses and doctors on documentation and the need for fine bore NGTs in enteral feeding.
NICE CG141 (partial); Management of Upper Gastrointestinal Bleeds re-audit round 3 -	Partially compliant	Acute upper gastrointestinal (GI) bleeds are a medical emergency, they make up about 70-80,000 hospital admissions in the UK per year. The audit demonstrates that there has been an improvement in the therapeutic endoscopy service offered, particularly with the introduction of the weekend GI bleed service meaning no patients are required transfer to a tertiary centre for intervention out of hours. The out of hours bleeds were stable enough to wait for upper GI endoscopy on local lists running Monday to Sunday. 82% (9/11) of GI bleeds referred on a weekend had an endoscopy within 24 hours. **Action:** Implementation of an upper gastrointestinal bleed care bundle and teaching on GI Bleeds using available teaching sessions.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG175; Quality of information provided on MRI prostate request forms and the subsequent effect of an intervention (A closed loop audit).	Partially compliant	Magnetic Resonance Imaging (MRI) of the prostate plays an important role in the diagnosis and management of prostate cancer. It is an evolving imaging modality for detecting and ruling out clinically significant prostate cancer. After the first audit, we introduced a sticker on the request forms detailing the criteria for this MRI scan. Prior to the intervention, the clinical information met the criteria on 62% of scans, whereas after the intervention, compliance had improved to 84%. This represented an improvement of 22%.
NICE CG32; Re-audit: Insertion and ongoing care of nasogastric tubes at Maidstone Hospital Intensive Care Unit: Auditing and documentation and Saving Lives forms	Partially compliant	Incorrect placement of nasogastric feeding tubes can result in serious complications including death and is considered a “never event” in the NHS. There has been an improvement or no change in 7 of the 13 standards since the last time this audit was completed in 2018, but we are still failing to meet the expected standards of care as set out by NPSA, NHS Improvement and Trust policy in relation to nasogastric tubes. **Action:** Regular training sessions held for both medical and nursing staff on hospital policy via monthly CG sessions.
NICE NG143, NG51, QS64; Re-Audit of the Paediatric Early Warning Score (PEWS) Charts	Partially compliant	The PEWS chart audit has highlighted that staff are utilising the PEWS charts for patients of different ages appropriately. However it can be identified that staff still require further education into remembering to total/score PEWS at every occasion and always sign their entries. **Action:** All staff to be reminded of the importance of taking a full set of observations and accurately maintaining PEWs charts, recording appropriately, scoring, signing and escalating concerns.
NICE CG144 partial and TA287; Diagnosis, management and follow-up of patients with PE (pulmonary emboli) at TWH re-audit round 3 (	Partially compliant	The Pulmonary Emboli (PE) audit reviewed the standard of care provided to patients with PE at the Trust. Management was optimised for the majority of patients as per Trust guidance; however the Wells score was not being utilised in order to stratify the likelihood of PEs. Only 14% of patients had a documented Wells score in their healthcare record. **Action:** Teaching sessions at Clinical Governance, AMU teaching and AMU inductions.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG30, QS129; Audit on the Early Removal of Long-acting Reversible Contraceptive Implants	Partially compliant	There has been an increase in the number of patients attending the Trust requesting removal of their LARC (Long-Acting Reversible Contraceptives) implant less than a year after it was inserted. There are financial implications for the Trust if the implant is removed before one year after insertion and the patient may be having unnecessary procedures. We did not meet the standard to provide the FPA leaflet advising patients at the fitting. **Action:** As we are moving away from paper leaflets, implement text-link to FPA website.
NICE NG76; Child Abuse and Neglect (safeguarding children)	Partially compliant	This audit set out to assess whether children who may have been abused or neglected were recognised, assessed and treated according to NICE guidance. It was found that different standards of record keeping were observed across the patients' healthcare records. This was discussed within the Multi-Disciplinary Team (MDT) and agreed that professionals would continue to use safeguarding proformas during the safeguarding assessment and, when using this to complete the report to ensure all relevant information was included. **Action:** To include completion of safeguarding documentation in doctor training sessions.
NICE NG18, NG19; Diabetes (type 1 and type 2) in children and young people: diagnosis and management including diabetic foot problems	Partially compliant	This audit was first undertaken in 2018 and assessed the care delivered to children attending Maidstone and Tunbridge Wells NHS Trust Diabetes Clinics against NICE guidance. This was re-audited in 2019 where improvement in results and compliance across most domains was recorded. Poor documentation still remains the leading cause for sub-optimal results. **Action:** Develop a new approach to the perpetual DNA's (Did Not Attend) and to improve documentation, develop a pink annual review form including a check list to prompt the person holding the clinic not to miss any sections.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE MPG2; Re-audit of the use of PGDs for Sexual Health conditions in the hub GU Clinic at MTW	Partially compliant	Patient Group Directions (PGDs) are a way of supplying or administering medication without the need for a prescription from a doctor. It is believed that patients are being given all the information that they require and that medicines are being prescribed under the PGD appropriately, however these details are not being documented as required by the PGD process. **Action:** One to one review of PGD training with all PGD trained staff and all staff to have their own PGD file to refer to for supply of medications.
NICE CG132; Trust audit of caesarean section mothers returning to theatre post procedure	Partially compliant	This audit looked at the care that maternity patients receive after a caesarean section. It found that there was an appropriate level and standard of staffing to provide 1:1 care post operatively, however the documentation was not always complete and sometimes absent in paper notes, including observation charts. **Action:** Review all aspects of care of post-operative patients and improve documentation of observations by commencement of weekly quality rounds and monitoring of compliance of documentation to appropriate standards.
NICE CG68; Carotid Doppler Ultrasound audit	Partially compliant	Carotid artery disease is a common cause of ischaemic stroke, accounting for approximately 25% of all cases in the UK. Carotid artery disease is usually diagnosed after an acute stroke or a transient ischaemic attack (TIA). Only 18% of the patients who required the Doppler scan had it completed within the recommended timeframe. In most cases (83%), the request for scan was made at an appropriate time; however, the delays were potentially due to the limited number of scanning slots available. These in turn are reliant on availability of ultrasonographers. **Action:** Increase the number of slots available for Carotid Doppler, separate from the TIA slots. This reduces the time constraint and ensures that the patients are scanned at the earliest convenience.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE NG23; Menopause: diagnosis and management	Partially compliant	The audit set out to review the care received by patients for the diagnosis and management of the menopause. Approximately half the patients had a documented pre-operative discussion about postoperative Hormone Replacement Therapy or hormonal treatment. The remaining patients may have had a preoperative discussion, but it was not documented. **Action:** Patient information leaflets to be developed or appropriate preoperative advice to be identified on websites to which patients can be directed. Results to be shared with all gynaecologists and the gynae-oncology team.
NICE CG62; An audit of the management of Antenatal Care Screening within the Trust (Criteria 5-7 only) (Safeguarding Children)	Partially compliant	This audit was a snapshot of 34 patients booked on a given day by various midwives across the Trust. This was the first time that this information had been audited. The results of this audit indicate that pregnant people were consistently being offered appropriate antenatal screening for infectious diseases and haemoglobinopathies. The offer and acceptance or decline of the offer was captured on E3 for 100% of the people in the audit. The documentation of results onto the E3 system was achieved in 85% (29/34) cases within ten working days. **Action:** Submit data quarterly to Public Health England for antenatal and newborn national audit protocol 2019-22 to ensure no abnormal screening result is missed.
NICE CG49; Faecal incontinence in adults: how does our trust manage them?	Partially compliant	Faecal incontinence (FI) is a frequent and debilitating symptom, which has many causes. The audit found that the majority of patients seen in the Pelvic Floor Clinic underwent a full set of specialist investigations as per NICE guidelines for FI. Conservative management was found to be the mainstay of treatment, with surgery playing a small role. **Action:** Ensure regular pelvic floor Multidisciplinary Team meetings continue to take place.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG144; Re-audit: Imaging waiting times for the diagnosis of deep vein thrombosis.	Non-compliance	NICE guideline specifies that the Trust should aim to complete all US Doppler scans for suspected DVT within 24 hours of the request or within 4 hours if anticoagulation cannot be given. The standards set by NICE guidance are very high. The very low positivity rates (6.5%) mean that delay in positive diagnosis affects very few patients. Patients are generally treated prospectively so that a delayed positive diagnosis should not have a negative clinical impact. There is a small risk associated with unnecessary anticoagulation in patients without a DVT but the risk of 1 or 2 additional days should be minimal. Delay in inpatient scanning could have a negative impact on patient flow/discharge but currently 92% of inpatients receive a scan by the next working day. **Action:** Develop business case for resources/funding for Sonographer service over the weekend. This will allow allocated ultrasound slots over the weekend for inpatient, ambulatory care or urgent outpatient scanning.
NICE CG169 (partial);TWH Acute Frailty Unit (AFU) Acute kidney injury (AKI) round 1 (	Non-compliance	NICE guidelines on acute kidney injury have stated that acute kidney injury is seen in 13-18% of all people admitted to hospital with older adults being particularly affected. Therefore, it is important to assess for acute kidney injury in those presenting to hospital. Ideally, all patients admitted to hospital should be screened for risk of developing AKI. The detection of acute kidney injury, regular creatinine measurements and urine output on the Acute Frailty Unit (AFU) at TWH did not meet NICE guidelines. **Action:** Create a section within the comprehensive geriatric assessment proforma that states the risk factors for acute kidney injury and AKI guidelines to be presented during departmental teaching. This will be done every 4 months to coincide with doctors' rotation.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG69, QS61(partial); Use of Co-amoxiclav in the Emergency Department: compliance with the MTW Guidelines	Non-compliance	Inappropriate use of the broad-spectrum antibiotic Co-amoxiclav can lead to increased risk of antimicrobial resistance, increased risk of hospital acquired infections, especially Clostridium difficile diarrhoea, and other adverse effects. This audit has shown areas in need of significant improvement in the appropriate use of Co-amoxiclav. Areas of particular concern are treatment of skin/soft tissue infections and treatment of lower respiratory tract infection (without pneumonia). **Action:** Increase awareness of the Trust's Antimicrobial Guidelines in the Emergency Department and when it is appropriate to prescribe Co-amoxiclav.
NICE NG41; ED Cervical Spine CT Audit	Non-compliance	All patients referred for CT cervical spine are presumed to be at risk of having a cervical spine fracture. This provides the justification for the scan. All patients sent for CT cervical spine are referred under the Canadian C Spine rules. The requirement for imaging is also a requirement for full immobilisation under NICE Guidelines (logically since they are at risk of unstable fracture). The audit found that very few patients were arriving for the scan with a hard collar despite no contraindication; there was a clinical suspicion of a neck fracture, and therefore a potentially unstable neck fracture**. Action:** Radiology Clinical Lead to escalate findings. Report distributed to all Emergency Department Consultants.
NICE CG166; Management of Acute Severe Ulcerative Colitis	Non-compliance	Ulcerative Colitis is a long-term condition where the colon and rectum become inflamed. This audit assessed the care of patients with acute severe colitis at the Trust. Several standards were not met, suggesting variations in care. Lack of adherence to guidelines may reflect in a prolonged length of stay, less timely intervention with colectomy and therein an increased risk of an out of hours surgical intervention or toxic dilatation / perforation. However, regionally our colectomy rate remains one of the lowest. **Action:** Ideally move towards a Digestive Disease Unit with these patients managed jointly between Gastroenterology and Surgery.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE NG1 & QS112; Re-audit of Diagnosis & Management of Gastro-oesophageal reflux (GOR) in children	Non-compliance	Gastro-oesophageal reflux (GOR) and Infantile reflux are common diagnoses made in children. Major improvements were made in the accuracy of diagnosis in GOR/GORD when compared to the previous audit. Quality standards were partially met for the use of acid-suppressing agents, but there was a tendency to start alginate therapy in infants before adequate documentation of the step-wise approach to managing reflux in infants. This may have been already addressed in the community, but without adequate documentation, we have to assume that this was not the case. **Action:** Signposting of the NICE guidance and Trust guidance to doctors working in paediatrics. This will allow for appropriate documentation of referral criteria, a guide to the "step-wise approach" to managing patients and for the diagnosis criteria for GOR vs. GORD. Also improve general standard of record keeping by training at inductions and requesting that the new Sunrise paediatric forms are designed to invite good record-keeping.
NICE NG108; Mental Capacity Assessment for Dementia Patients at MTW	Non-compliance	The Mental Capacity Act (2005) (MCA) was introduced to protect individuals who lack capacity. The primary aim of the audit was to identify whether patients with a known diagnosis of dementia were having their capacity assessed and documented for serious medical interventions and also a change in residence documented as per the MCA. After reviewing the results of the audit, existing concerns in relation to patients having interventions without their capacity being fully assessed and therefore consent for these interventions not being valid remain. **Action:** Redesign MCA training Trust-wide to include every day and complex decisions and onward referral to specialist teams. Staff to be made aware of the role of Safeguarding Champions and how to contact them.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG111; Re-audit of the management of Bedwetting in Children and Young People	Non-compliance	This re-audit was carried out to evaluate to what extent the NICE guidelines for management of enuresis in children are being implemented. It was found that the detailed history from the parents and children was not documented as mentioned in NICE guidance. Alarms were not offered in a considerable number of cases before trying drug treatment and response to alarms or Desmopressin were not assessed at 4 weeks in the majority of cases as there were no follow up appointments at 4 weeks. **Action:** Add history taking/ documentation and consent training into junior doctors induction training and Clinical Governance. Bedwetting proforma to be developed to include advice on accessing alarms so doctors can give details of ERIC (Enuresis Resource & Information Centre) website in clinic to families and document that the information has been provided.
NICE CG100, CG115; Alcohol Withdrawal: Are we treating it?	Non-compliance	Alcohol abuse remains a significant socio-economic and health problem for the country, with an estimated 12% of A&E attendances directly related to drinking. When patients are recognised to be withdrawing, they are twice as likely to be managed appropriately and hence this is a crucial stage in the patient's admission. Once they are started on Clinical Institute Withdrawal Assessment for Alcohol (CIWA), there is unfortunately a high variation in their ongoing care. Upon discharge, few patients were referred to community alcohol services for ongoing abstinence support. Considering the expense of an inpatient withdrawal, this represents an enormous wasted opportunity to prevent future admissions. **Action:** Redesign CIWA chart and through shared learning, adopt same practice as St Thomas's Hospital.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE QS138; Adults who are expected to have moderate blood loss are offered Tranexamic Acid. Audit to check our compliance.	Non-compliance	Adults who are having surgery and are expected to have moderate blood loss (>500mls) should be offered Tranexamic Acid in order to minimise risk. The trust did not meet an expected standard of 100% compliance. The difficulties in obtaining this data arose mainly due to poor documentation (i.e. WHO checklist not being completed; actual blood loss during the procedure not recorded accurately) and missing sections of healthcare records. **Action:** Create laminated operation list for display in all anaesthetic rooms and add as a standing item on the morning huddle. All theatre documentation should be hole-punched prior to use, and placed in the correct section in the patient's healthcare record at the earliest opportunity/immediately post-operative.
NICE CG76; Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence re-audit.	Non-compliance	None of the standards for this audit have been met; this means that patients are not always involved in all decisions regarding their medicine, do not always understand their disease/condition and are not always aware of possible side effects of their medication. The potential clinical risks are that patients do not understand the importance of medicines adherence and may not take their medicines as recommended, which may result in ill-health to patients and financial loss to the NHS. **Action:** Raise the awareness amongst Health Care Professionals to explain how medicines might help patients and be more open to discuss the pros and cons of taking medicines, as well as side effects.
NICE CG50 (partial); Re-audit of adherence to Trust Escalation Policy	Non-compliance	In this re-audit a concerning number of patients who met the criteria for escalation were not escalated. In addition, when patients were escalated it was often the case that the patients were not escalated to an appropriate level of seniority and reviews were often not conducted in a timely fashion. **Action:** Trust wide education to highlight the importance of the recognition and appropriate escalation of deteriorating patients. NEWS2 should be publicised by articles in the Governance Gazette and in the Safety Calendar. The Sunrise system will provide prompts for acutely unwell/ deteriorating patients.

NICE Guidance	Level of Compliance	Summary results and Actions
NICE CG169 (partial); MGH Acute Frailty Unit (AFU) Acute Kidney Injury (AKI) re-audit	Non-compliance	There was an improvement in regular creatinine and daily urine output monitoring although still short of the standard. Only one out of ten of the standards were met, 3 were partially met. Poor documentation was noted in several of the standards that were not met. **Action:** Educational sessions planned on the ward to highlight areas for improvement.
NICE CG 83; Re-audit Rehabilitation After Critical Illness.	Non-compliance	Early and structured rehabilitation in critical care, through to and beyond hospital discharge has been shown to improve quality of life, reduce the length of hospital stay and assist in returning patients to their previous level of function. MTW recognises the need for ongoing rehabilitation for critical care patients from the point of ICU admission throughout a patient's hospital stay, to discharge and follow up. Processes have been put in place but standards have still not been met due to a variety of constraints. No major concerns to patient care have been identified; no areas of clinical risk to patients have been identified. **Action:** Identify service needs in order to set up new rehabilitation service (funding restraints may apply).

Part Five

Stakeholder feedback

1. West Kent Clinical Commissioning Group
2. Health Overview and Scrutiny Committee – Kent County Council
3. Healthwatch Kent
4. 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.

The quality team welcome that MTW continue to create a safety-focused culture, strive to continuously improve patient and staff experience with clinically effective services and to learn lessons from care delivery within a just culture. Key to this, the trust has launches a new Patient Experience Strategy to help meet patient goals. This is welcomed by the quality team to improve the care and experience that people receive.

MTW continue to recognise quality improvement and demonstrate this by clearly identifying their priorities for 2021 based on three key areas; patient safety, patient experience and clinical effectiveness. Ensuring these key factors are the basis of all improvements ensures focus and learning. The CCG are pleased that patient safety is at the forefront of the priorities and that the trust strives to build a supportive environment that recognises and reduces harm. The CCG are especially pleased that the trust continues to embrace all aspects of the Patient Safety Strategy and continues to work on embedding a reporting culture that encourages and empowers staff to speak up through a no blame culture to ensure patient safety.

The CCG are assured that the trust are focussed in the coming year to continue to develop a downward trend in avoidable healthcare associated infections including gram negative bloodstream infections and the through the control of hospital acquired Covid-19 and look forward to seeing these work streams develop.

MTW continue to work against their maternity transformation plan including continuity of carer so that they are able to improve the outcomes and experiences of expectant parents and their babies. The CCG is please that there is continual engagement with the Maternal and Neonatal Safety Collaborative (MatNeo) and are implementing the improvement plan on sepsis.

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 continued relationship between the trust and the CCG has allowed collaborative working and continued improvements, of which the CCG are looking forward to seeing the outcomes within the next year.

Yours sincerely,

Paula Wilkins
Chief Nurse – Kent and Medway CCG

Health Overview and Scrutiny Committee – Kent County Council comments on the 2019/20 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 2019-20. 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

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council

kent.gov.uk

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 have a strong and constructive relationship directly with the Chief & Deputy Chief Nurses at the Trust and meet them regularly to share the feedback we have heard from the public.
- We've worked well to resolve individual issues that patients have raised with us.
- We attend the Trust's Patient Experience Committee to share what the public have told us about services that the Trust provide.
- We organised and facilitated a discussion about the value of patient experience and how Trusts could improve the way they capture and act upon patient feedback. MTW hosted these meetings.
- We have actively supported the Trust in developing their Patient Experience Strategy and they have been open and willing to listen to our advice.
- Following our report detailing the experience of a partially sighted person accessing Maidstone hospital we spoke to the Trust about what improvements had been made. These included changes to patient letters, staff training and making sure all hearing loops are working.
- The Trust proactively contacted us to test improvements pharmacy had made in response to this report. We had planned to return to see for ourselves what improvements have been made but we had to postpone due to Covid.
- Together with the Motor Neurone Association, we have been working with the Trust to make improvements for people who use communication aids following a visit and subsequent recommendations.

You can read all the reports relating to our work with MTW on our website. www.healthwatchkent.co.uk

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

Healthwatch Kent June 2020

Statement of Directors' responsibilities

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

Findings of the national inpatient survey 2019 **Chief Nurse**

The enclosed report give details of the findings of the national inpatient survey 2019, which was published in July 2020. The first part of the report contains an in-house analysis, while the second part contains the Trust's official benchmarking report, which is publicly available.

Which Committees have reviewed the information prior to Board submission?

- Trust Management Executive (TME), 15/07/20

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]

Review and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Introduction:

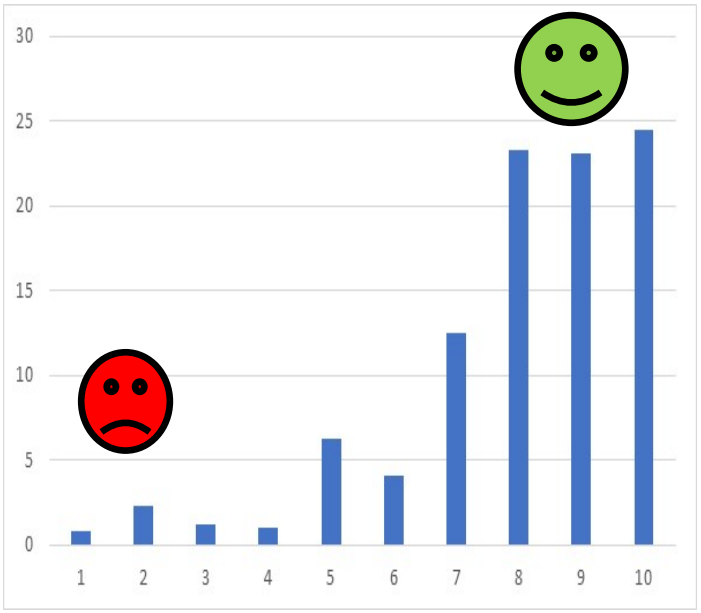
- Comparison is made from the 143 NHS acute Trusts across England who took part in the Adult inpatient Survey. Each trust has been assigned one of five bands: ‘much worse than expected’, ‘worse than expected’, ‘about the same, ‘better than expected’ or ‘much better than expected’.

- MTW is not contained in the ‘Identification of Outliers within Trust Level Results’ and has received the overall rating ‘**about the same’.**

- As we start to think about the focus of attention for possible actions for this survey we have also referenced the findings from the recent Culture work and pulse results to identify any common themes.

Key Facts:

- For the 2019 National Inpatient Survey, the month sample was fixed to July and will remain fixed for all future surveys. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital during July 20191 and were not admitted to maternity or psychiatric units.
- 72 core questions
- Results reflect views from patients who had an inpatient stay at either site of the Trust.
- Sent to a data sample of 1250 adult inpatients (aged 16+)
- 632 returned equating to a 51.76% response rate.
- 47.8% male patients and 52.2% female patients
- The youngest patient in the data sample was 16 years old and the oldest was 102
- 73.5% of patients were emergency or urgent admissions
- 23.1% of patients were waiting list or planned in advance



Overall…
0 = I had a very poor experience
10 = I had a very good experience

9/10 patients felt they were treated with respect and dignity

9.1/10 of patients felt their hospital room or ward was clean

6.7/10 of patients felt they were involved in their discharge from hospital

Banding:

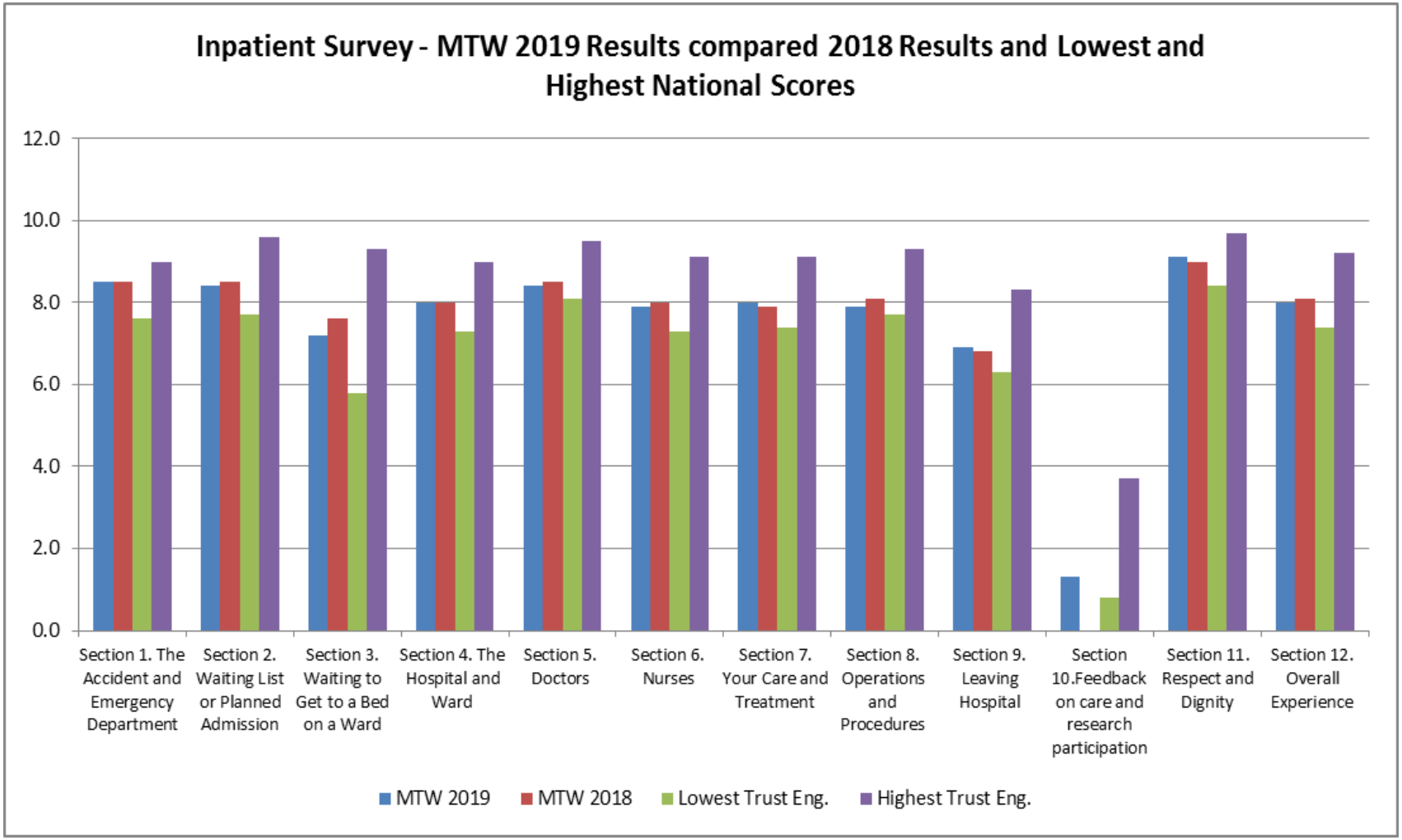
- MTW's results were better than most trusts for **0** question
- MTW's results were worse than most trusts for **1** questions:

  Q47 After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- MTW's results were significantly higher this year for **1** questions.

  Q20 Were you offered a choice of food?
- MTW's results were significantly lower this year for **1** questions:

  Q15 Were you ever bothered by noise at night from hospital staff?
- The were no statistically significant differences between last year's and this year's results for **60** questions.
- MTW's results were about the same as other trusts for **62** questions.

Inpatient Survey - MTW 2019 Results compared 2018 Results and Lowest and Highest National Scores



Section Score:	2019	2018	LTS**	HTS**
Section 1. The Accident and Emergency Department	8.5	8.5	7.6	9.0
Section 2. Waiting List or Planned Admission	8.4	8.5	7.7	9.6
Section 3. Waiting to Get to a Bed on a Ward	7.2	7.6	5.8	9.3
Section 4. The Hospital and Ward	8.0	8.0	7.3	9.0
Section 5. Doctors	8.4	8.5	8.1	9.5
Section 6. Nurses	7.9	8.0	7.3	9.1
Section 7. Your Care and Treatment	8.0	7.9	7.4	9.1
Section 8. Operations and Procedures	7.9	8.1	7.7	9.3
Section 9. Leaving Hospital	6.9	6.8	6.3	8.3
Section 10.Feedback on care and research participation	1.3	-	0.8	3.7
Section 11. Respect and Dignity	9.1	9.0	8.4	9.7
Section 12. Overall Experience	8.0	8.1	7.4	9.2

**LTS Lowest Trust Score in England
**HTS Highest Trust Score in England

Recommendations/ Next steps:

Key Focus areas for improvement for Section 8, Section 9 and Section 10 where MTW scored lower:

- Operations and Procedures 7.9
- Leaving Hospital 6.9
- Feedback on care and research participation 1.3

Continuous commitment of focus:

- Overall Experience 8.0

Key Work streams for focus:

- Information and communication and utilising the findings from the CLP work to join up efforts to improve communication with patients; who was in charge, who was undertaking their care and consistency across services.
- Discharge process
- Patient Experience Strategy matches the current survey outputs
- Patient and public experience feedback.
- Agreeing expected metrics for next survey – how can we achieve better than expected ?

Patient survey report 2019

Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

NHS Patient Survey Programme
Adult Inpatient Survey 2019

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve. Our role is to register care providers, and to monitor, inspect and rate services. If a service needs to improve, we take action to make sure this happens. We speak with an independent voice, publishing regional and national views of the major quality issues in health and social care.

Adult Inpatient Survey 2019

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used health services to tell us about their experiences.

The 2019 survey of adult inpatients (the seventeenth iteration of the survey) involved 143 acute and specialist NHS trusts. 76,915 people responded to the survey, yielding an adjusted response rate of 45%.

Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts sampled patients discharged during July 2019[1]. Trusts counted back from the last day of July 2019, including every consecutive discharge, until they had selected 1,250 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2019). Fieldwork took place between August 2019 and January 2020.

Surveys of adult inpatients were also carried out in 2002 and annually from 2004 to 2018. Although questionnaire redevelopments took place over the years, the survey results for this year are largely comparable to those from previous iterations.

The Adult Inpatient Survey is part of a wider programme of NHS patient surveys which covers a range of topics, including children and young people's services, community mental health services, urgent and emergency care services and maternity services. To find out more about the programme and to see the results from previous surveys, please see the links in the 'Further information' section.

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England. We will use data from the survey in our system of CQC Insight, which provides inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections. NHS England and NHS Improvement will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health and Social Care will hold providers to account for the outcomes they achieve.

This research was carried out in accordance with the international standard for organisations conducting social research (accreditation to ISO20252:2012; certificate number GB08/74322).

Interpreting the report

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the '**expected range**' to determine if your trust is performing 'about the same', 'better' or 'worse' compared with most other trusts. For more information on the expected range, please see the 'methodology' section below. This approach is designed to help understand the performance of individual trusts, and to identify areas for improvement.

[1] 31 trusts sampled additional months because of small patient throughputs.

This report shows the same data as published on the CQC website (https://www.cqc.org.uk/surveys). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better', 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

People's characteristics, such as age and gender, can influence their experience of care and the way they report it. For example, research shows that men tend to report more positive experiences than women, and older people more so than younger people. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of patients.

To account for this, we 'standardise' the data, which means we apply a weight to individual responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by age, gender and method of admission (emergency or elective) of respondents to reflect the 'national' age-gender-admission type distribution (based on all respondents to the survey). This helps to ensure that no trust will appear better or worse than another because of its respondent profile. It therefore enables a more accurate comparison of results from trusts with different population profiles. In most cases this standardisation will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of 0 the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all the questions in the questionnaire. For example, some questions are descriptive, such as Q1, which asks respondents if their inpatient stay was planned or an emergency. Other questions are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply. An example of a routing question is Q44 "During your stay in hospital, did you have an operation or procedure?". For full details of question scoring please see the technical document (see 'Further information' section).

Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Graphs

The graphs in this report show how the score for the trust compares to the range of scores achieved by all trusts taking part in the survey. The black diamond shows the score for your trust. The graph is divided into three sections:

- If your trust's score lies in the grey section of the graph, its result is 'about the same' as most other trusts in the survey.
- If your trust's score lies in the orange section of the graph, its result is 'worse' compared with most other trusts in the survey.
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph states whether the score for your trust is 'better' or 'worse' compared with most other trusts. If there is no text, the score is 'about the same.' These groupings are based on a rigorous statistical analysis of the data, as described in the following 'Methodology' section.

Methodology

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the '**expected range**' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust

and the scores for all other trusts. If the trust's performance is outside of this range, it means that it performs significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'. Where a trust is identified as performing 'better' or 'worse' than the majority of other trusts, the result is unlikely to have occurred by chance.

In some cases, there will be no orange and / or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and / or a lot of variation in their answers.

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (and the corresponding section the question contributes to[2]). This is because the uncertainty around the result is too great.

A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see 'Further information' section).

Tables

At the end of the report you will find tables containing the data used to create the graphs, the response rate for your trust and background information about the people that responded.

Scores from last year's survey are also displayed where available. The column called 'Change from 2018' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2018. A statistically significant difference means that the change in the result is very unlikely to have occurred by chance. Significance is tested using a two-sample t-test with a significance level of 0.05.

Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Where a result for 2018 is not shown, this is either because the question was new this year, or the question wording and / or the response categories have been changed. Where the question wording or response options were modified, it is not possible to compare the results because any score change could be caused by alterations in the survey instrument, rather than variation in a trust's performance.

Comparisons are also not able to be shown if a trust has merged with other trusts since the 2018 survey, or if a trust committed a sampling error in 2018.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to some trusts.

All trusts

Q50 and Q51: The information collected by Q50 "On the day you left hospital, was your discharge delayed for any reason?" and Q51 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital.

The combined question in this report is labelled as Q51 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/hospital transport."

Q52: Information from Q50 and Q51 has been used to score Q52 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q53 and Q56: Respondents who answered Q53 "Where did you go after leaving hospital?" with "I was transferred to another hospital" were excluded from the scoring of Q56 ("Before you left

[2]The section score is not displayed as it would include fewer questions compared with other trusts.

hospital, were you given any written or printed information about what you should or should not do after leaving hospital?").

Trusts with female patients only

Q11: If your trust offers services to women only, the score for Q11 "While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" is not shown.

Trusts without an A&E department

Q3 and Q4: The results to these questions are not shown for trusts that do not have an A&E department.

Notes on question comparability

The following questions do not have historical comparisons because they were substantially modified for the 2019 questionnaire:

Q51: "What was the main reason for the delay", where the third response option was modified from "I had to wait for an ambulance" to "I had to wait for hospital transport".

Q66: "After being discharged, was the care and support you expected available when you needed it?" where the stem "after being discharged" was added.

For more information on questionnaire redevelopment and the reasons for modifying questions please see the Survey Development Report, available here:
https://nhssurveys.org/wp-content/surveys/02-adults-inpatients/01-design-development/2019/Survey%20development%20report.pdf

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
https://www.cqc.org.uk/inpatientsurvey

The results for the adult inpatient surveys from 2015 to 2018 can be found at:
https://nhssurveys.org/data-library/

Full details of the methodology for the survey, including questionnaires, letters sent to patients, instructions for trusts and contractors to carry out the survey, and the survey development report, are available at:
https://nhssurveys.org/surveys/survey/02-adults-inpatients/

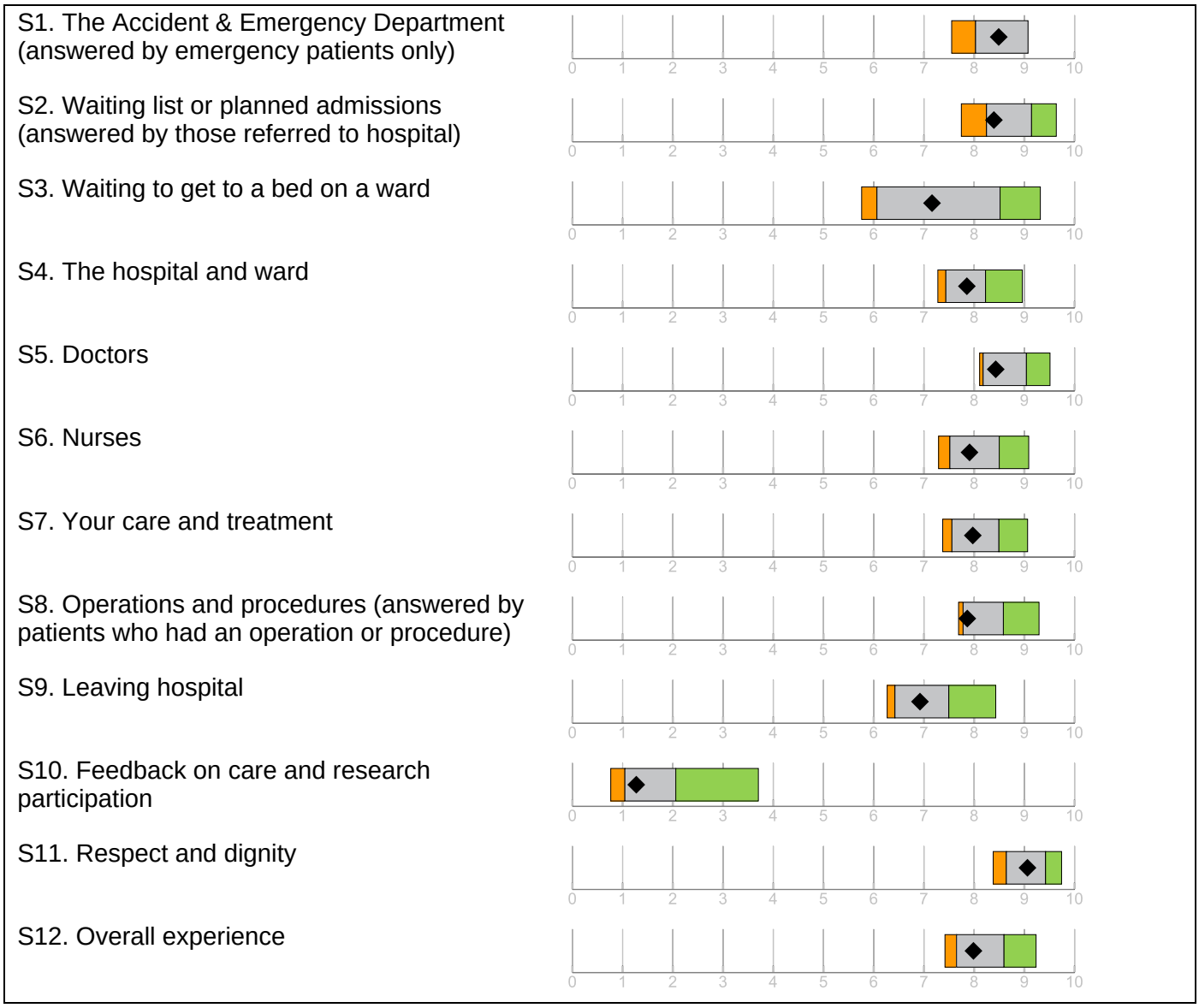
More information on the NHS Patient Survey Programme, including results from other surveys and a schedule of current and forthcoming surveys can be found at:
https://www.cqc.org.uk/content/surveys

More information about how CQC monitors hospitals is available on the CQC website at:
https://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-nhs-acute-hospitals

Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

Section scores



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

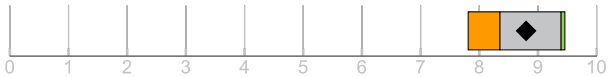
Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

The Accident & Emergency Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

Q4. Were you given enough privacy when being examined or treated in the A&E Department?



Waiting list or planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?

Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

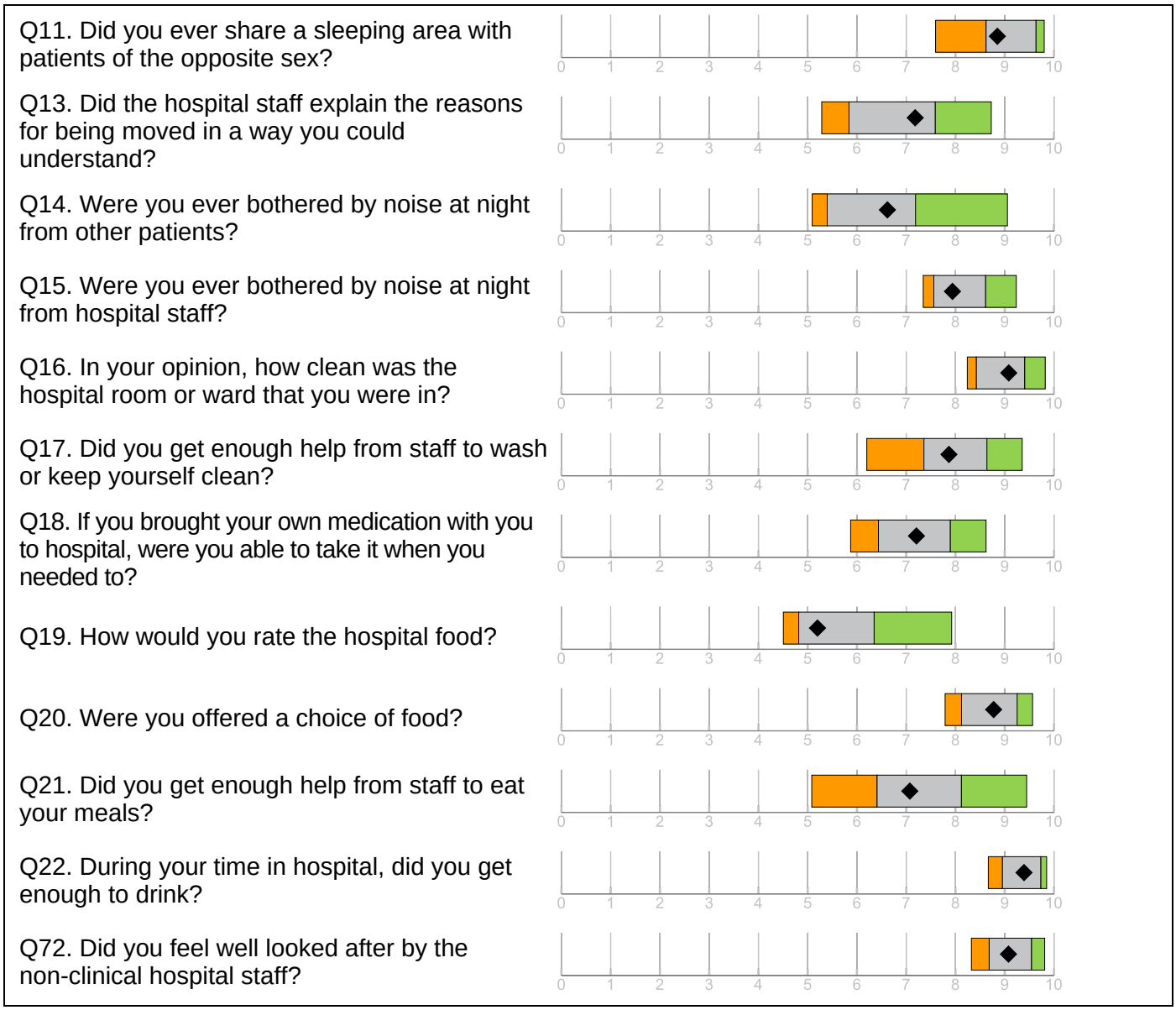
Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

Best performing trusts	‘Better/Worse’	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

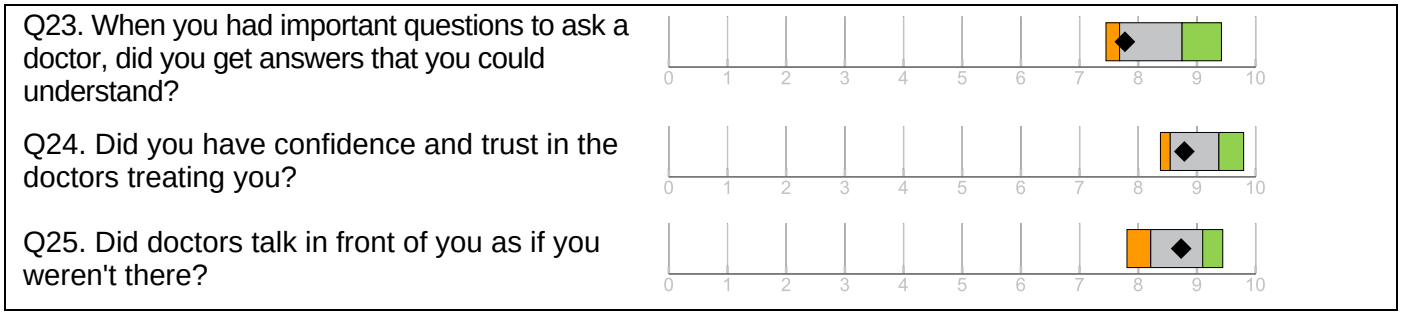
Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

The hospital and ward



Doctors



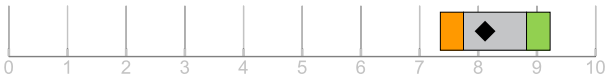
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2019

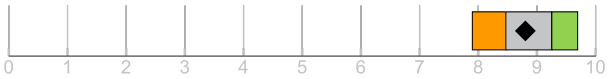
Maidstone and Tunbridge Wells NHS Trust

Nurses

Q26. When you had important questions to ask a nurse, did you get answers that you could understand?



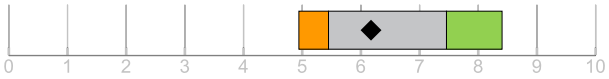
Q27. Did you have confidence and trust in the nurses treating you?



Q28. Did nurses talk in front of you as if you weren't there?

Q29. In your opinion, were there enough nurses on duty to care for you in hospital?

Q30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

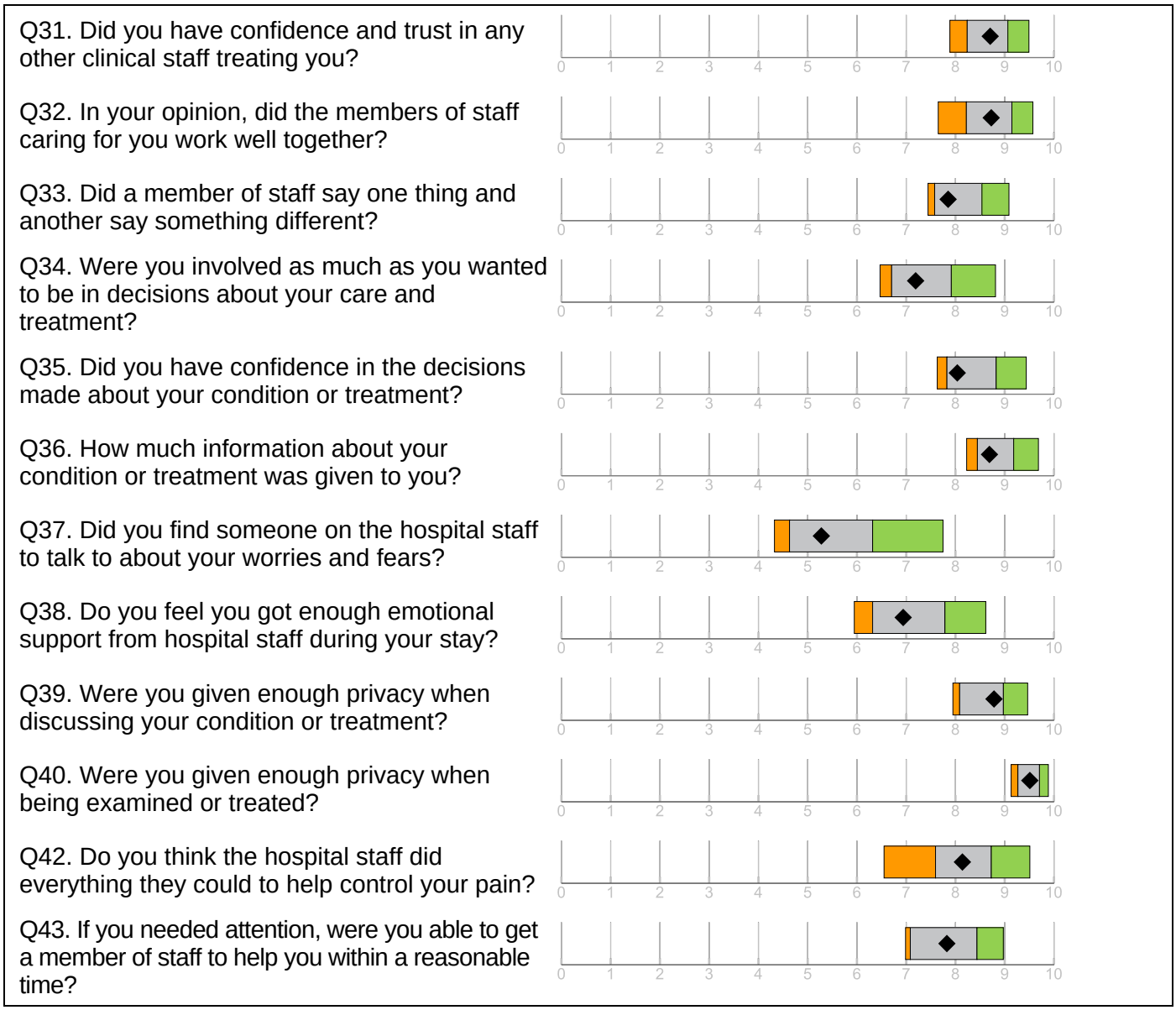


Best performing trusts	‘Better/Worse’	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

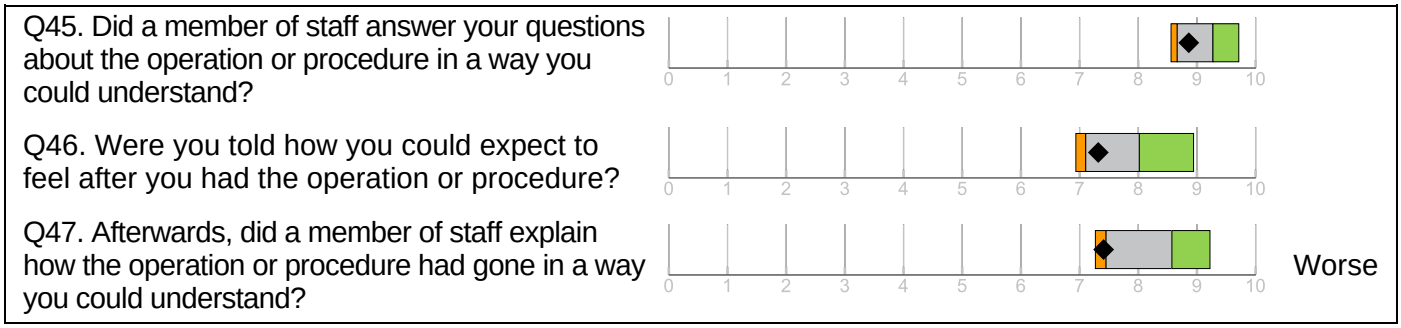
Adult Inpatient Survey 2019

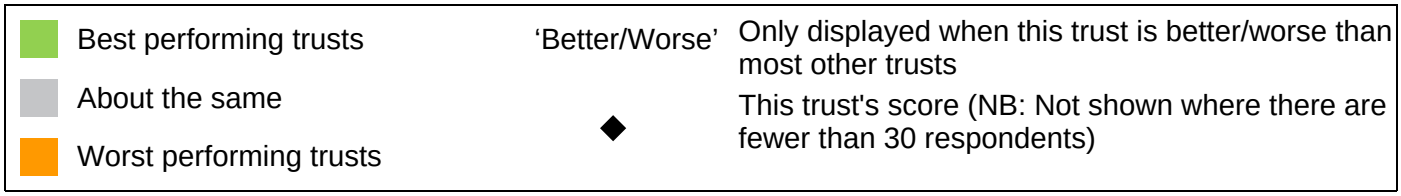
Maidstone and Tunbridge Wells NHS Trust

Your care and treatment



Operations and procedures (answered by patients who had an operation or procedure)

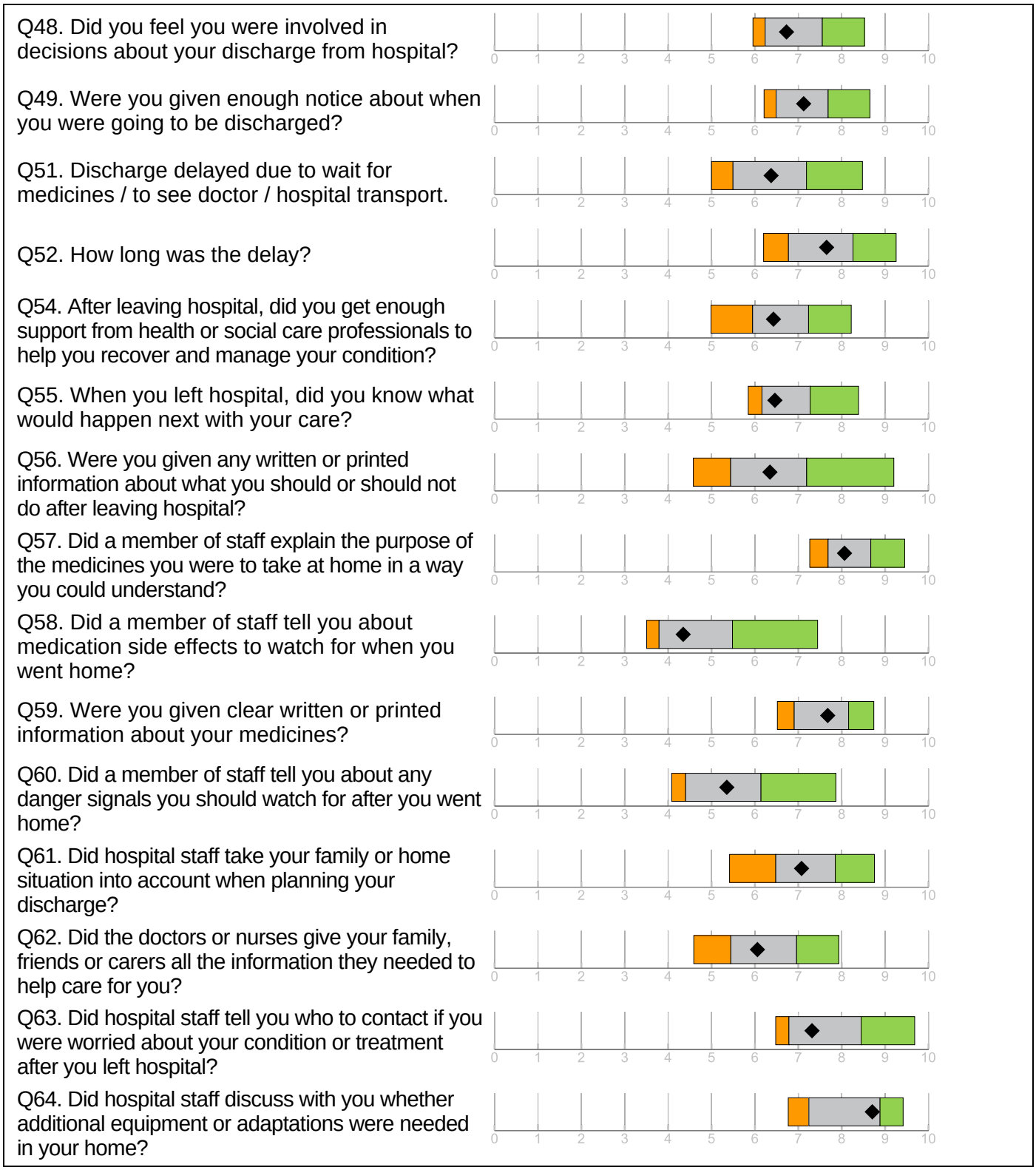




Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

Leaving hospital



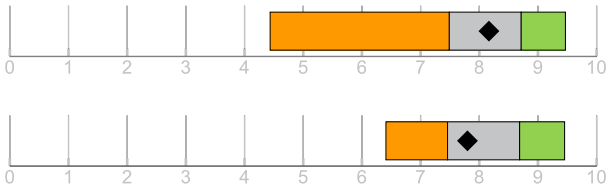
Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

Q65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?

Q66. After being discharged, was the care and support you expected available when you needed it?

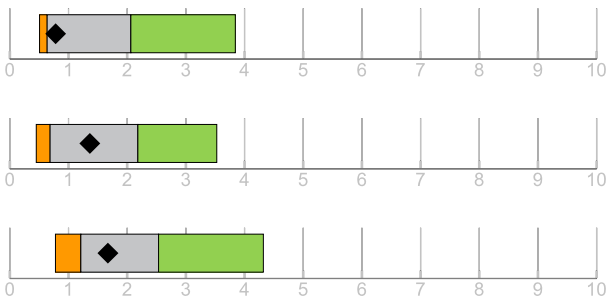


Feedback on care and research participation

Q69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

Q70. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

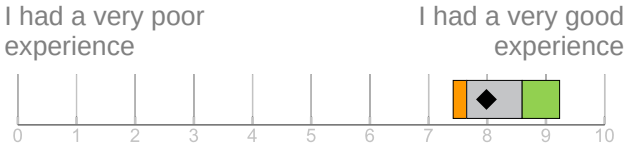


Respect and dignity

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Overall experience

Q68. Overall...



Best performing trusts	'Better/Worse'	Only displayed when this trust is better/worse than most other trusts
About the same	◆	This trust's score (NB: Not shown where there are fewer than 30 respondents)
Worst performing trusts		

Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2018 scores for this NHS trust	Change from 2018
The Accident & Emergency Department (answered by emergency patients only)							
S1	Section score	8.5	7.6	9.0			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.2	6.8	9.0	379	7.9	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.8	7.8	9.5	419	9.1	
Waiting list or planned admissions (answered by those referred to hospital)							
S2	Section score	8.4	7.7	9.6			
Q6	How do you feel about the length of time you were on the waiting list?	7.4	6.3	9.6	157	7.1	
Q7	Was your admission date changed by the hospital?	9.2	8.0	9.8	160	9.1	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	8.7	8.2	9.5	157	9.1	
Waiting to get to a bed on a ward							
S3	Section score	7.2	5.8	9.3			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.2	5.8	9.3	610	7.6	

↑ or ↓	Indicates where 2019 score is significantly higher or lower than 2018 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2018 data is available.

Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2018 scores for this NHS trust	Change from 2018
The hospital and ward							
S4	Section score	7.9	7.3	9.0			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	8.9	7.6	9.8	614	9.1	
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	7.2	5.3	8.7	119	6.4	
Q14	Were you ever bothered by noise at night from other patients?	6.6	5.1	9.1	612	7.2	
Q15	Were you ever bothered by noise at night from hospital staff?	7.9	7.3	9.2	611	8.5	↓
Q16	In your opinion, how clean was the hospital room or ward that you were in?	9.1	8.2	9.8	617	9.1	
Q17	Did you get enough help from staff to wash or keep yourself clean?	7.9	6.2	9.4	335	8.1	
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.2	5.9	8.6	346	7.5	
Q19	How would you rate the hospital food?	5.2	4.5	7.9	579	5.3	
Q20	Were you offered a choice of food?	8.8	7.8	9.6	592	8.7	
Q21	Did you get enough help from staff to eat your meals?	7.1	5.1	9.4	122	7.4	
Q22	During your time in hospital, did you get enough to drink?	9.4	8.7	9.9	579	9.3	
Q72	Did you feel well looked after by the non-clinical hospital staff?	9.1	8.3	9.8	553	9.1	
Doctors							
S5	Section score	8.4	8.1	9.5			
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	7.8	7.4	9.4	533	7.9	
Q24	Did you have confidence and trust in the doctors treating you?	8.8	8.4	9.8	600	8.9	
Q25	Did doctors talk in front of you as if you weren't there?	8.7	7.8	9.4	595	8.8	

↑ or ↓	Indicates where 2019 score is significantly higher or lower than 2018 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2018 data is available.

Adult Inpatient Survey 2019

Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2018 scores for this NHS trust	Change from 2018
Nurses							
S6	Section score	7.9	7.3	9.1			
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	8.1	7.4	9.2	516	8.1	
Q27	Did you have confidence and trust in the nurses treating you?	8.8	7.9	9.7	599	8.8	
Q28	Did nurses talk in front of you as if you weren't there?	9.0	8.0	9.6	597	9.1	
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	7.5	6.2	9.0	596	7.6	
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.2	4.9	8.4	597	6.3	

↑ or ↓	Indicates where 2019 score is significantly higher or lower than 2018 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2018 data is available.

Adult Inpatient Survey 2019
Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2018 scores for this NHS trust	Change from 2018
Your care and treatment							
S7	Section score	8.0	7.4	9.1			
Q31	Did you have confidence and trust in any other clinical staff treating you?	8.7	7.9	9.5	334	8.5	
Q32	In your opinion, did the members of staff caring for you work well together?	8.7	7.7	9.6	558	8.5	
Q33	Did a member of staff say one thing and another say something different?	7.9	7.4	9.1	597	8.0	
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.2	6.5	8.8	594	7.1	
Q35	Did you have confidence in the decisions made about your condition or treatment?	8.0	7.6	9.4	603	8.1	
Q36	How much information about your condition or treatment was given to you?	8.7	8.2	9.7	566	8.6	
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	5.3	4.3	7.7	360	5.4	
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	6.9	5.9	8.6	353	6.9	
Q39	Were you given enough privacy when discussing your condition or treatment?	8.8	7.9	9.5	591	8.7	
Q40	Were you given enough privacy when being examined or treated?	9.5	9.1	9.9	599	9.5	
Q42	Do you think the hospital staff did everything they could to help control your pain?	8.1	6.6	9.5	372	8.1	
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	7.8	7.0	9.0	536	7.7	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	7.9	7.7	9.3			
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.9	8.6	9.7	298	9.0	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	7.3	6.9	8.9	315	7.4	
Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.4	7.3	9.2	312	7.8	

↑ or ↓	Indicates where 2019 score is significantly higher or lower than 2018 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2018 data is available.

Adult Inpatient Survey 2019
Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2018 scores for this NHS trust	Change from 2018
Leaving hospital							
S9	Section score	6.9	6.3	8.4			
Q48	Did you feel you were involved in decisions about your discharge from hospital?	6.7	6.0	8.5	580	6.7	
Q49	Were you given enough notice about when you were going to be discharged?	7.1	6.2	8.7	600	6.7	
Q51	Discharge delayed due to wait for medicines / to see doctor / hospital transport.	6.4	5.0	8.5	566		
Q52	How long was the delay?	7.7	6.2	9.3	564	7.5	
Q54	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	6.4	5.0	8.2	320	6.4	
Q55	When you left hospital, did you know what would happen next with your care?	6.5	5.8	8.4	512	6.6	
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.3	4.6	9.2	576	6.4	
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.1	7.3	9.5	411	8.1	
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	4.3	3.5	7.4	350	4.1	
Q59	Were you given clear written or printed information about your medicines?	7.7	6.5	8.7	391	7.6	
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.4	4.1	7.9	448	5.0	
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	7.1	5.4	8.8	380	7.0	
Q62	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	6.1	4.6	7.9	402	5.8	
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.3	6.5	9.7	519	7.1	
Q64	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	8.7	6.8	9.4	190	8.3	
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.2	4.4	9.5	317	8.2	
Q66	After being discharged, was the care and support you expected available when you needed it?	7.8	6.4	9.5	338		

↑ or ↓	Indicates where 2019 score is significantly higher or lower than 2018 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2018 data is available.

Adult Inpatient Survey 2019
Maidstone and Tunbridge Wells NHS Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2018 scores for this NHS trust	Change from 2018
Feedback on care and research participation							
S10	Section score	1.3	0.8	3.7			
Q69	During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	0.8	0.5	3.8	516	0.9	
Q70	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.4	0.5	3.5	522	1.4	
Q71	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.7	0.8	4.3	494	1.8	
Respect and dignity							
S11	Section score	9.1	8.4	9.7			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.1	8.4	9.7	611	9.0	
Overall experience							
S12	Section score	8.0	7.4	9.2			
Q68	Overall...	8.0	7.4	9.2	601	8.1	

↑ or ↓	Indicates where 2019 score is significantly higher or lower than 2018 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2018 data is available.

Adult Inpatient Survey 2019
Maidstone and Tunbridge Wells NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	632	76915
Response Rate (percentage)	52	45

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	48	48
Female	52	52
Age group (percentage)	(%)	(%)
Aged 16-35	6	5
Aged 36-50	10	8
Aged 51-65	17	22
Aged 66 and older	68	65
Ethnic group (percentage)	(%)	(%)
White	95	92
Multiple ethnic groups	1	1
Asian or Asian British	1	2
Black or Black British	0	1
Arab or other ethnic group	0	0
Not known	3	3
Religion (percentage)	(%)	(%)
No religion	20	18
Buddhist	0	0
Christian	76	74
Hindu	0	1
Jewish	0	0
Muslim	0	2
Sikh	0	0
Other religion	1	1
Prefer not to say	3	3
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	96	93
Gay/lesbian	0	1
Bisexual	0	1
Other	0	1
Prefer not to say	3	4

NHS
Maidstone and Tunbridge Wells NHS Trust

Safeguarding Adults and Children update (Annual Report to Board, including Trust Board annual refresher training) — **Chief Nurse**

This is the first joint Safeguarding Children and Adults Annual Report for the Trust Board to consider covering the year 2019/20. This report provides the Trust Board with an overview of all safeguarding activities within Maidstone and Tunbridge Wells NHS Trust (MTW).

The purpose is to inform the Trust Board and the Quality Committee on how the Trust is meeting its statutory duties to safeguard adults and children by preventing and responding to concerns of abuse, harm or neglect of patients, visitors and staff from April 2019 to March 2020.

All individuals working for the Trust, or engaged by the Trust, have a responsibility for the safety and wellbeing of all ages of patients, colleagues and visitors to the Trust. This is a statutory responsibility enshrined in the 'Safeguarding is Everyone's Responsibility' agendas.

The report has been prepared jointly by the Safeguarding Adults Matron and Named Nurse for Safeguarding Children and has had oversight from the newly formed Safeguarding Committee.

Which Committees have reviewed the information prior to Board submission?

- Safeguarding Committee
- Quality Committee, 08/07/20

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Information & assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Safeguarding Children and Adults Annual Report 2019/20

Summary / Key points

This is the first joint Safeguarding Children and Adults Annual Report for the Trust Board to consider covering the year 2019/20. This report provides the Trust Board with an overview of all safeguarding activities within Maidstone and Tunbridge Wells NHS Trust (MTW).

This report identifies the extent to which the Trust Board can be assured that they, in partnership with the local authority and other agencies are effectively discharging their statutory safeguarding functions for both children and adults.

It highlights areas where improvements ~~are~~ may be required for the Trust to gain assurance that there are effective systems in place to safeguard both children and adults in the future.

Where there are joint areas of interest this will be reported upon jointly where there are specific requirements for each subject matter, these will be separated out in the report accordingly.

The Trust has a named person at Board level (the Chief Nurse) with executive responsibility for both safeguarding agendas.

The day to day delivery of the safeguarding adults' agenda is delivered by the Matron for Safeguarding Adults with oversight provided by the Deputy Chief Nurse (DCN).

The day to day delivery of the safeguarding children's agenda is delivered by the Named Nurse for Safeguarding Children and Named Midwife, with oversight provided by the Divisional Director of Midwifery and Nursing Services (DDMNQ).

The Trust is an active participant with the Kent & Medway Safeguarding Adults Board (KMSAB) and the Kent Safeguarding Children Multi-agency Partnership (KSCMP) and their constituted working groups.

The Trusts Children and Adults Committees have now joined to form one Safeguarding Committee, which has been designed as a strategic committee to consider emerging themes and trends, along with national/regional updates in relation to both safeguarding agendas. It will also provide assurance to the Trust Board that the Trust fulfils its statutory responsibilities, highlighting any areas of risk.

The Clinical Commissioning Group (CCG) Designated Safeguarding Nurses for both children and adults are represented on this committee along with Trust senior nurses/matrons, AHP's and medical leads in the Trust.

The committee has a named Non-Executive Director to champion, support and challenge both safeguarding agendas.

Safeguarding activity is underpinned by a suite of learning and development opportunities, in line with national and local guidance. The Trust has access to multi-agency training via the KMSAB and KSCMP's.

Safeguarding supervision is provided to the Safeguarding Leads via the local Safeguarding Adults professional network. Managerial supervision for the Matron for Safeguarding Adults is provided by the Deputy Chief Nurse. For the Named Nurse for Safeguarding Children managerial oversight is currently provided by the DDMNQ.

Supervision is provided to front line staff involved in significant or complex cases by the Named Professionals for Safeguarding.

1. Purpose

This Safeguarding Annual Report for 2019/20 provides the Trust Board with an overview of safeguarding activities within MTW.

This report identifies the extent to which the Trust Board can be assured that they, in partnership with the local authority are effectively discharging their safeguarding functions for both children and adults.

It highlights areas where improvements are required for the Trust to better ensure that there are effective systems in place for safeguarding activities in the future.

2. Introduction

This annual report is to inform the Trust Board and the Quality Committee on how the Trust is meeting its statutory duties to safeguard adults and children by preventing and responding to concerns of abuse, harm or neglect of patients, visitors and staff from April 2019 to March 2020.

All individuals working for the Trust, or engaged by the Trust, have a responsibility for the safety and wellbeing of all ages of patients, colleagues and visitors to the Trust. This is a statutory responsibility enshrined in the 'Safeguarding is Everyone's Responsibility' agendas.

The NHS Accountability and Assurance Framework (019) sets out that NHS Trusts are required to ensure that they have appropriate systems in place for discharging their responsibilities in respect of safeguarding. This report forms part of the Maidstone and Tunbridge Wells NHS Trust Boards assurance processes in respect to its statutory duties and responsibility around safeguarding.

The Statutory requirements for Safeguarding; The Care Act 2014, Children's Act (2004), Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and PREVENT (under the Counter-Terrorism and Security Act 2015).

3. Governance & Safeguarding Structures

The Trust is accountable to the West Kent Clinical Commissioning Group (CCG), and reports to the Performance & Quality Committee. Additionally, quality and monitoring for East Sussex CCG, is captured on the jointly completed West Kent CCG quarterly report and shared with East Sussex accordingly.

The Designated Nurses for Safeguarding are members of the Trust's internal Safeguarding Committee. The Adult Designated Nurse attends the Safeguarding Learning and Improvement Panels (sub-panel to the Serious Incident panel) in an advisory capacity.

The Trust Executive Lead for Safeguarding is the Chief Nurse, who delegates responsibilities to the DCN in relation to adults and the DDMNQ in relation to children.

Operational oversight of safeguarding adults is delegated to the Matron for Safeguarding Adults (MSGA), with operational oversight of the Safeguarding Children's agenda delegated to the Named Nurse for Safeguarding Children (NNSC).

The Trust Board has a responsibility to ensure that there is a policy and process in place that details the processes to protect adults and at risk.

The Trust has separate Safeguarding Policies and Procedures for Children and Adults Safeguarding Policy are both up to date and robust and reviewed on a regular basis,

ultimately by the Trust Board. All policies and procedures are available to staff via the staff intranet.

The Domestic Abuse Policy is under review and will be consulted upon in due course.

The Board receives assurance via the Trust Quality Committee, which receives reports, risks and plans to mitigate via the Trust's Safeguarding Committee

The separate children and adults safeguarding committees were combined in October 2019 to enable the consolidation of the two agendas, to promote a more streamlined approach to safeguarding and advance the 'think family' agenda within the Trust.

The Trust Safeguarding Committee is a constituted sub-committee of the Trust Quality Committee. It is chaired by the Chief Nurse and has core representation from senior leaders from the directorates, therapies, Lead Nurse for Dementia Care, Hospital Learning Disability Liaison Nurse, Learning & Development and the CCG Designated Safeguarding Nurses.

The Committee has a Named Non-Executive Director (NED) to support and champion both safeguarding agendas.

The committee is scheduled to meet quarterly, in line with the required Safeguarding Quality quarterly reporting mechanisms to the CCG. New Terms of reference (TORS) have been agreed and the joint committee has met twice in the last reporting year. (The two committees had met before the start of the combined committee on four occasions separately).

The purpose of the joint committee is to implement and monitor the Safeguarding Frameworks and agendas, to ensure training provision is available to equip staff with the knowledge and skills required for the identification of adults and children at risk, to identify patients who need to be safeguarded, to ensure appropriate steps have been taken when staff are responding to referrals/concerns, and to ensure that enquiries and investigations are carried out with learning outcomes identified.

The Trust Safeguarding Committee draws its work plan and objectives from both the KMSAB, KSCMP along with emerging themes resulting from safeguarding incidents, investigations, Safeguarding Adults Reviews, Domestic Homicide Reviews and Serious Case Reviews.

The committee also provides a forum for the review of practice, to provide practical advice and support and to facilitate feedback and discussion between directorates, commissioners and the Trusts Safeguarding Leads.

The Matron for Safeguarding Adults leads on the key areas of work necessary to safeguard adults at risk. These include:

- Design & delivery of training including the principles of the Care Act (2014), the role of the lead agency, application of the Mental Capacity Act (2005), Domestic Abuse, PREVENT (under the Counter-Terrorism and Security Act 2015)
- Policy and procedure development and review, ensuring that Trust policies are in line with both the Care Act 2014 and Kent & Medway Policy and Procedures, MCA, DOLS Physical Restraint.
- Mental Capacity Act lead for the Trust, which includes the Deprivation of Liberty Safeguards agenda.
- PREVENT Lead and Home Office approved trainer for the PREVENT agenda.
- Domestic Abuse Lead, working closely with staff in key areas including:
    - Links have also been established with Human Resource Business Partners to develop strategies to support and manage staff for which domestic violence is a personal issue.

    - The new Domestic Abuse Policy recognises that visitors to the Trust can be victims too.
- Internal Management Review (IMRs): author of IMRs in response to requests for the preparation of Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs)
- Represents the Trust at KMSAB sub-groups; Policy & Procedures, Learning & Development and the Quality Assurance Working Group.
- Attends and chairs the Health Providers Leads Forum
- The Matron attends the Mental Capacity Act Local Implementation Network (MCA LIN).
- Safeguarding supervision: provides supervision to staff involved in complex or serious safeguarding cases. The Matron receives managerial supervision from the Deputy Chief Nurse. Specialist safeguarding supervision for named individuals and safeguarding leads is provided by an appropriately qualified supervision facilitator external to the trust.
- Line manages the Hospital Learning Disability Hospital Liaison Nurse.

The Named Nurse for Safeguarding Children leads on the key areas of work necessary to safeguard children at risk. These include:

- Design and delivery of training
- Policy and procedure development and review in line with Children's law and KCSMP policy and procedure
- Author for IMR's in relation Serious Case Reviews for children
- Co-shares lead for Domestic Abuse, developing strong links with
    - Emergency Departments and Women's services
    - Independent Domestic Violence Advocates (IDVA's)
- Co-shares lead for Prevent as above
- Represents the Trust at (amongst others) Kent and Medway Exploitation Group, Health Reference Group, KCSMP Serious Case Review Action Plan Forum, and the West Kent Adolescent Risk Management Panel.
- Safeguarding supervision: provides mandatory supervision to those staff identified as requiring it (e.g., Midwifery staff, NICU and ED staff); also provides supervision and debriefs to staff involved in complex or serious safeguarding cases. Receives external safeguarding supervision from a suitably qualified practitioner.
- Ensures that all processes for reviewing Child Death are adhered to (in conjunction with the Named Doctor for Child Death)
- Line manages the children's safeguarding practitioners and deputy named midwife

4. Interagency partnership working

The Local Authority, Kent County Council (KCC) provides the statutory service for leading and managing Safeguarding investigations and plans.

The Kent and Medway Safeguarding Adults Board (KMSAB) is a statutory board which exists to make sure that all member agencies are working together to help keep Kent and Medway's adults safe from harm and protect their rights. The Chief Nurse and Executive lead for Adult Safeguarding attends the board or will delegate responsibilities to the Deputy Chief Nurse.

The KMSAB has a number of sub-groups to ensure a consistent approach across Kent in relation of quality assurance, learning & development, practice, policy & procedure and Safeguarding Adults Reviews (SARs).

Health services have a separate group to enable debate and information sharing, which also acts a conduit for communication between organisations and the board, which is attended by the Chief Nurses from across Kent.

The Local Authority has an escalation process available on their website which enables practitioners at any and every level to escalate a concern or query if they feel the response to a request for a Section 42 Enquiry has been inappropriate or untimely.

The Named Nurses liaise with safeguarding professionals in East Sussex. Where there are concerns for adults, the Trust staff are encouraged to raise safeguarding alerts for community investigations for East Sussex to consider, East Sussex Adults Social Care accept the Kent Safeguarding Alert form, which the Trust staff are confident to complete. In relation to East Sussex residents who have been an inpatient in our hospitals, where allegations are raised in relation to hospital care these are dealt with using the Kent and Medway procedures.

Any resident of East Sussex who requires a DOLS to be applied for; Trust staff are clear that the DOLS application needs to be sent to the East Sussex Local Authority DOLS Office.

The Safeguarding Children team has a close relationship with professionals in East Sussex. The Trust makes approximately thirty five referrals to East Sussex Children's Social Services per year; these are mainly from ED and the Midwifery service. We provide advice, support and supervision to the Trust teams in East Sussex; we will attend Child Protection Conference's as needed. We have not been involved in any Serious Case Reviews for East Sussex in the last 12 months.

5. Oversight and scrutiny

5.1. Disclosure and Barring (DBS) checks.
The Trust meets its statutory requirements in relation to Disclosure and Barring (DBS) checks – all staff employed at the Trust undergo a DBS check prior to employment and those working with adults at risk and with children undergo an enhanced level of assessment.

5.2. Self-Assessment Framework (SAF)
The Trust undertakes a self-assessment against the core standards on an annual basis. The SAF has been developed by the KMSAB and includes a mechanism of peer review to validate the assessment outcomes. The peer review is then reported to the Quality Assurance Group, a sub- group of the SAB. The Trust scored positively overall in the 2019 exercise.

5.3. Section 11 Audit – this was last submitted in 2018 and reviewed in 2019. All actions have been signed off by the KSCMP. A new audit will be commissioned in late 2020.

5.4. Was Not Brought
The Trust has a process in place for following up children who are not bought to outpatient appointments within any speciality to ensure their care and health is not affected in any way.

5.5. Flagging Systems in Place for:

- Children who are subject to a child protection plan. The Trust has implemented the national Child Protection Information Sharing System (CP-IS) in the ED and will follow this in both Paediatrics and Maternity. The trust has further implemented the national FGM-IS.
- Children who are designated as a Child in Care
- People with a Learning Disability
- People with a diagnosed dementia

5.6. Training Design and Delivery
All eligible staff are required to undertake relevant Safeguarding training and this is regularly reviewed to ensure it is up to date. The Trust has a training strategy in place with regard to delivering safeguarding training. All Safeguarding Children training is in

line with the current Intercollegiate Document (2019) and highlights emerging themes in safeguarding as set out by the NHSE.
The safeguarding training offer is currently under review for 2020-21. This to ensure the correct staff are allocated to attend the pertinent level of training and also to consolidate the training delivery between the adults and children's agendas, emphasising the 'Think Family' agenda and all crossover agendas. It is anticipated that a majority of the training will be completed on line and/or jointly, with specialist training (at Level 3) remaining separate.

The key message from both teams is that Safeguarding Adults and Children is everyone's responsibility within the Trust.

5.7. Care Quality Commission

There is regular liaison with the CQC Liaison Officer on a monthly basis, where any safeguarding concerns may be addressed. To date, the Trust has always been able to answer any external question in a timely manner having already initiated an investigation or having completed the investigation and awaiting final closure with the Local Authority.

There has not been a formal CQC Inspection during 2019-20.

6. Quality and Safeguarding

6.1. Projects

Safeguarding Adults is a recognised priority in the Trust and staff demonstrate good knowledge about how and when to raise a Kent Adult Safeguarding Alert Form (KASAF) with the Local Authority. Safeguarding Adults and MCA sit within the Trusts Best Quality work stream.

When we deliver patient care safely, in the right place and in the correct manner, at all times, this safeguards patients from being harmed in the first place.

Whether we're looking after our patients, or supporting our staff, we want everyone to have the best possible experience with us.

The lead for the Mental Capacity Act (MCA) within the Trust is the Matron for Safeguarding Adults.

Mental Capacity Act project work is underway to develop strategies and tools for staff to be able to document their assessments of capacity undertaken when working with patients who have a cognitive decline.

There is now a consultant who has agreed to support this ongoing work across the Trust with his consultant and medical colleagues.

The Safeguarding Children agenda has been highlighted in the Best Care Programme. A project to ensure that children transitioning to adult services from Paediatric services has been on-going; this ensures that all children are transitioned safely with their needs being met. It is anticipated that the majority of children will move to adult services at 18 years (16 previously).

A Transition Workshop was held in March 2020. Young people and their parents were invited to meet some of the adult services available to them and to see what the adult areas (ITU, ED and Ward 12) looked like (in comparison the Paediatric areas).

Trust staff from both paediatric and adult areas worked alongside voluntary services to showcase a variety of support measures, including sexual health, mental health and a drug and alcohol charity that would be available to the young people as they moved out of Paediatric services. Fourteen young people and twenty six parents attended and gave very positive feedback; they particularly appreciated visiting the adult areas.

Unfortunately the Trust Transition team have not been able to undertake the final NHSI Transition Collaborative presentation in London due to COVID restrictions. The Trust is considering how support for YP transitioning to adults will continue alongside the normal transition pathways already in place for children under the specialist nursing teams.

Following the CQC inspection in 2018 attention was drawn to 16 and 17 year olds who are not routinely admitted to Paediatric areas. A Policy and Procedure Document entitled 'Policy and Procedure for the Admission of 16 and 17 year olds Adult Areas' is in the final stages of ratification. It is recognised that these young people are children and deserve high quality care that meets their unique needs as young people and not adults.

6.2 Safeguarding Referrals and Investigations

ADULTS

Staff are aware that they do not need permission to raise a Kent Adult Safeguarding Alert Form (KASAF), but will raise one using their professional judgement to ensure that Section 42 Enquiry requirements are notified to the Local Authority. All KASAFs raised, are requested to be copied into the Matron for Safeguarding Adults.

Trust staff raise safeguarding alerts for hospital related incidents, complaints and disciplinary issues and also for issues of concern noted to have arisen in the community. (These are to notify the Local Authority where Trust staff assess that a concern meets the threshold for a Section 42 Enquiry to be undertaken by the Local Authority).

Directorate Matrons support the safeguarding agenda and either undertake or oversee the hospital safeguarding related investigation.

The Trust holds Safeguarding Learning and Improvement panel meetings, every month, to review all hospital KASAF alerts and the subsequent investigation with ward managers and matrons, in partnership with the Local Authority and CCG Designated Nurse.

The Matron for Safeguarding Adults coordinates this panel and liaises with the directorate level investigators to ensure appropriate support is offered.

This multi-agency approach to review the investigation, allows for open debate with the opportunity to agree the best way to involve the individual and to feedback on findings. It is also considered to be an effective learning opportunity for staff to fully understand the requirements from the Local Authority when carrying out a Section 42 Enquiry.

This approach allows for prompt closure of hospital KASAF's with the Local Authority and ensures a robust level of oversight by both the Deputy Chief Nurse and the Local Authority Safeguarding Adults Coordinator.

Trust practitioners are keen to learn lessons when the patient journey has not been as event free as it should have been. Following all investigations staff will usually find areas where practice could have been improved and will share that learning across the Trust so that practice can be improved. These lessons are shared quickly and widely through the Trust.

Day to day safeguarding activity is primarily overseen by the Directorate Matrons, and front-line clinical staff with guidance, advice and support provided by the Matron for Safeguarding Adults.

Supervision for staff involved in complex or serious safeguarding cases is provided by the Matron for Safeguarding Adults

The total number of KASAFs raised in relation to MTW provided care (Hospital KASAF's) during this reporting period is 83.

This year 2019–20, 24 of these alerts have been raised by Trust staff; this is 28.92% of hospital incidents relating to safeguarding and a reduction from 39.5 % in 2018-19 demonstrating ongoing confidence that staff are open and transparent in their practice, by raising safeguarding alerts about their own practice.

71.08% of KASAFs raised about Trust practice are raised by a variety of practitioners, patients, family and friends from outside of the Trust – all of which are investigated when the Local Authority deem that they meet the requirement for a Section 42 Enquiry.

Of the 83 KASAFs raised about practice in MTW outcomes of investigations are noted as:

- 60 (72.3%) not upheld
- 5 (6.02%) upheld or partially upheld
- 5 (6.02%) insufficient evidence
- 13 (15.66%) are still to be heard either at panel or via an alternative process

Trust staff raised 120 KASAFs for community investigations, Section 42 Enquiries, to be carried out and completed by the Local Authority. Only 1 of these in the last year was felt to be inappropriate and feedback was given to the practitioner who raised it.

6.3 CHILDREN

Maidstone and Tunbridge Wells NHS Trust submitted 294 referrals to Children's Specialist Services in the 12 months from April 2019-20. This number is higher (20+) than the 2018/19 period. More noticeable is the increase in referral rates during the Q4 period in 2020. This shows that the Trust made 98 referrals, in comparison to 71 in the same 2019 period. The data highlights an increase in reporting around Mental Health needs (both adult and children), Domestic Abuse and Substance misuse. The majority of referrals are made by ED or Paediatric staff with Midwife's being the next group.

As a team the quality of the referrals are reviewed. We provide training on 'how to make a quality referral' and staff are encouraged to get referrals reviewed by safeguarding practitioners prior to submission.

The Safeguarding Children team work closely with Children's Specialist Services; the Named Nurse regularly meets with Children's Specialist Services colleagues in both the Maidstone and Tunbridge Well's areas. These forums provide an excellent opportunity for joint working, information sharing and developing new working relationships. The Named Nurse sits on a number of Safeguarding Children Partnership committees including the Joint Exploitation Board. The Named Nurse also takes part in multi-agency Safeguarding audits based on the JTAI model.

The Safeguarding Children Nurses attend Child Protection Conference's for high risk children known to Maidstone and Tunbridge Wells NHS Trust to support staff whose experience in Safeguarding may be limited. The Safeguarding Children Nurses support staff to provide high quality reports for Child Protection Conference's; the Named Nurse will also attend conferences as time permits.

Currently the Local Authority has 1338 children subject to a Child Protection Plan – the Trust flags these children on our IT systems. We also flag known Children in Care and other high risk children, including those that are frequently missing or display high risk behaviours.

The Trust raised one SI in relation to Safeguarding Children in 2019. This was investigated and learning around when to escalate for senior opinion, and, recognising the significance of non-weight-bearing in a 2 year old has been disseminated.

6.4 Children with Mental Health needs

Within this Trust it is apparent that an increasing number of children are being admitted with Deliberate Self-Harm (DSH) and overdoses. Staff are ill-prepared for the risk that these children pose to themselves and struggle with the limited services provided by CAMHS. There are some challenges in supporting admission to a tier 4 Mental Health bed, often this can take up to 4 weeks; this leaves very vulnerable children on an acute Paediatric ward receiving Mental Health care from agency RMN staff.

The Trust has a robust care pathway and risk assessments for these children. Staff are supported by both the Paediatric Matron and the Named Nurse Safeguarding Children. Both work closely with the CCG, CAMHS, NHSE (as the 'bed manager' for tier 4 beds) and Children's Social Care to ensure appropriate care for these children is given.

7. Mental Capacity Act (MCA) 2005

Mental Capacity is the ability to make a decision. Capacity can vary over time, and according to the decision to be made.

The MCA sets out statutory responsibilities which apply to everyone who works in health and social care who are involved in the care and treatment or support of people over the age of 16 years In England or Wales.

8. Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) form part of the MCA 2005.

If a patient in the Trust lacks capacity to make the decision to be in hospital and meets the Acid Test then a DoLS application will need to be made to the Local Authority who will then authorise the application.

Acid Test

The Supreme Court clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

- The person is under continuous supervision and control **and**
- Is not free to leave, **and**
- The person lacks capacity to consent to these arrangements

The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind being in hospital.

The DoLS Office for the Local Authority triages all requests and should take action within specified time frames. However, it continues to be unclear how many applications are converted to authorised DoLS. This issue has been raised with the KMSAB and has become a standing agenda item.

The Trust is achieving a good compliance with MCA training uptake, but resulting from audits undertaken during which highlighted that the application of the Mental Capacity Act (MCA), into practitioners practice could not always be evidenced. A Best Quality Work-stream project has been focusing on Mental Capacity Assessments, to ensure that practitioners are involved and motivated to improve the application of the MCA and DOLS into every practitioners practice and will continue to be an area of focus for the Trust.

This does not necessarily mean that MCA principles are not being applied, rather a failure to explicitly evidence the approached used to determine capacity within the health care records.

A Consultant has now taken an interest in furthering this work with the Consultant body and this input is valued.

The Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure has been separated into two stand-alone policies and procedures, this was in preparation for the upcoming changes emanating from the Mental Capacity Act (Amendment) Bill and the expected development of the Liberty Protection Safeguards.
The Trust has made a total of 300 DoLS applications in the year April 2019-20 this is a 12% increase on last year's figures. The 300 are made up of 134 at Maidstone Hospital and 166 at Tunbridge Wells Hospital. Rarely are these assessed by the Local Authority due to the rise over the years of applications made to them.

Best Interest Meetings following the MCA take place across the Trust and the most complex of these are chaired by the Matron for Safeguarding Adults. When a person with Learning Disability is involved these are chaired by the Learning Disability Liaison Nurse. Less complex Best Interest Meetings are chaired by a senior member of the team with the appropriate level of knowledge and skills. Trust staff needs to improve how they document whether a patient has got capacity for a particular decision or not.

9.0 Midwifery Safeguarding

The Safeguarding Midwife continues to provide robust support for the community and hospital based Midwifery teams. The Midwife teams have submitted 71 requests for Support in the 12 months to 31.4.20.

The Safeguarding Supervision Policy is now embedded in practice. Compliance is >70% with some Community Midwife teams achieving 100% compliance for safeguarding supervision.

The focus for 2020 remains increasing the compliance for L3 Safeguarding Children as it currently sits at 70%.

10.0 Domestic Abuse

Domestic Abuse continues to be a cause for concern and the Trust is clear about its responsibilities to staff, patients and visitors. A new Domestic Abuse policy will be ratified in mid-2020.

The safeguarding team attend the local MARAC meetings as appropriate.

The Trust has been approached by Kent County Council Commissioners regarding a Hospital Based IDVA (independent Domestic Violence Advisor) Service to be based in ED and support victims of Domestic Abuse. Both EKUHFT and Medway Maritime Hospital have

this service and evaluation has shown it to be valuable to both victims and staff. It is to be hoped that [at some time] resources can be found to enable this project to go ahead.

11.0 PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities.

PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation.

The Trust has met the PREVENT training standard for Basic Awareness and achieved 93.5%. Face to face WRAP Training has not been delivered to staff in the last year.

The Trust made one CHANNEL Panel referral during 2019-20.

12.0 Safeguarding Adults Review (SAR), Serious Case Reviews (Children) & Domestic Homicide Reviews (DHR)

12.1 A Safeguarding Adults Review (SAR) is requested by the Safeguarding Adults Board when certain criteria or thresholds are met. These include

- An adult at risk dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in their death.
- An adult at risk has sustained any of the following:
  A life threatening injury through abuse or neglect
- Serious sexual abuse
  Serious or permanent impairment of development through abuse or neglect

  And

- The case(s) give rise to concerns about the way in which local professionals and services worked together to protect and safeguard adult (s) at risk.

The Trust has responded to all requests for information with regards to SAR's, but as yet there have not been any published SAR's this year.

12.2 Serious Case Reviews (Children)

In September 2019 the Kent Safeguarding Children Multi-Agency Partnership published an overview of Serious Case Reviews commissioned in Kent. It found 9 common or recurring themes that it considered professionals should have due regard for –

- Undertaking assessments and the use of historic information – use of chronologies to give practitioners a timeline of concerns about a family; a combined chronology can be even more useful
- Inquisitive practice and meaningful engagement – 'inquisitive practice' is about asking the right questions at the right time; it's also about working with other agencies in a meaningful way to engage the family
- Engaging with fathers and new adults in the family – who lives in the family home? What role does this male have in the home?
- Information sharing and record keeping – effective information sharing safeguards children; all professionals to be clear about when to share information and with whom
- Working with neglectful families and understanding sustained change – what does the change/improvements in the household mean? Are they sustainable or sustained? Are services staying with a family even if change is evidenced?

- Children's attendance at appointments – what is the impact on the child of not being brought to an appointment; moving away from DNA (Did Not Attend) to Was Not Brought;
- Multi-Agency Challenge and Escalation – having the confidence to challenge other professionals decisions; understanding the challenge and escalation process
- Working with children where the parents have additional needs – this may include substance misuse, Domestic Abuse or Learning Difficulty/Disability
- Vulnerability of small children and babies – patterns of injuries; the most 'at 'risk' children

The Trust has not contributed to any Serious Case Review's in the previous 12 months.

The Serious Case Review library can be found via the following link –

https://www.kscmp.org.uk/about-kscb/kscb/kent-scrs

12.3 A Domestic Homicide Review (DHR) is a review undertaken when an adult dies as a result of domestic abuse. This is led by the Police and is a multi-agency review in a similar format to that of a SAR.

In 2019-20, 2 IMRs were provided for DHRs and none requested for SARS. These DHR's are not as yet published.

The outcomes of published SARs are monitored by the Trusts Safeguarding Adults Committee with any pertinent learning for the Trust disseminated out further to practitioners.

13.0 Learning Disability

Over the past year the Learning Disability Hospital Liaison Nurse (LDLN) has consolidated the good links made with a multitude of professionals both internally within the Trust and externally within the community teams.

The LDLN has implemented a range of reasonable adjustments with individual patients, which has positively impacted on their individual patient experience, and their ability to access health services.

The LDLN is in discussion with the Open University and Dynamic Training to produce a joint tender for the Mandatory Learning Disability training.

The LDLN has made progress in setting up an electronic referral system to which staff from inpatient areas have responded positively. The Trust learning disability flagging system now holds a total of 520 patients.

The LDLN continues to engage with people with learning disabilities in service improvement projects.

The LDLN has been actively involved in the Paediatric Transition Best Quality project. NHS Improvement and NHS England visited the Trust on 03.02.2020; this was an opportunity to show case the transition work already completed.

On 29.02.2020 the Trust hosted a transition workshop, this was an opportunity for young people to meet with adult teams and visit adult wards. The LDLN ensured the workshop was accessible for all by producing an easy read survey and offering to provide additional

support on the day for young people with learning disabilities. The Safeguarding Adult's Matron and Named Nurse for Safeguarding Children supported the workshop by holding a Safeguarding Adults & Children, Mental Capacity Act and Consent stand.

Guidance for community support worker's supporting people with learning disabilities in the Acute Trust setting. This work has now been completed and the consultation period has finished. Once it is in the correct Trust template it will be completed and be published. This will assist the Trust in relation to lessening the expenditure on specialist agency staff and will ensure continuity of care for people with learning disability when they are in-patients.
The LDLN has been working closely with coding to develop a local agreement policy for coding learning disability; this policy is completed and pending approval. Prior to the policy learning disability was being incorrectly coded as learning difficulty, this policy aims to ensure learning disability is coded as such. This will mean data is more accurate.

For the next year the LDLN plans to focus on the NHS Improvement benchmarking standards to ensure these standards are implemented throughout the trust.

14.0 Learning Disability Mortality Review (LeDeR)

The Learning Disability Mortality Review (LeDeR) process was established in April 2018. This national process has been commissioned by NHS England as result of the Confidential Inquiry into Premature Deaths of People with Learning Disability (CIPOLD).

All deaths of adults and children with learning disability must be reported to the LeDeR programme. Reviews are allocated by the CCG Local area coordinator to reviewers, to undertake a review of all care from all the care providers involved with the deceased leading up to their death.

The Trust has 2 individuals who have undertaken the LeDeR review training (Matron for Safeguarding Adults, and Learning Disability Hospital Liaison Nurse). In the past year the LDLN has assisted external LeDeR reviewers to complete their reviews when the person with LD has been a patient in our hospitals.

All patients with a learning disability, who have died following care in the trust, have a structured mortality review of the care and clinical management within the Trust.

15.0 Dementia Strategy

The Dementia Strategy Group reports into the Safeguarding Committee on a quarterly basis. Basic Dementia Awareness training uptake is at 92% and Intermediate Dementia Awareness sits at 90%.

The Dementia Policy and Procedure and Carers Policy and Procedure have both been reviewed and updated.

The Dementia Strategy Group reports into the Joint safeguarding committee on a quarterly basis.

15.1 Summary / Key points for 2019/20

- Achieved most of the Dementia Strategy objectives for 2017-2020.
  - Ongoing work includes continue quarterly audits for evidence of pathways of care being followed with appropriate documentation.

    Unachieved objectives were the development of a training programme for staff in identifying end-of life care for people with dementia incorporating advance care

planning. Exceeded standard (85%) set for Basic (Tier 1) and Intermediate (Tier 2) dementia Training for staff. Achieving 92% and 90% respectively.

  - Continued reduction in incidents related to inpatients with dementia.
  - 3 main categories of incidents are falls; pressure damage and aggression and 'other' are recorded to identify themes and trends.

- Are fully compliant with 10/14 recommendations of the National Audit of Dementia Round 4 and partially compliant with 4/14.
  - Partially compliant areas relate to delirium and a business case for a delirium nurse facilitator pilot on the TWH site is currently with the executive committee.

- Revised policies and procedures and guidance and written new guidance.
  - Revised – Operational Policy and Procedure for Dementia
    - Carers Policy
    - Guidance on Nutrition and Hydration in Dementia

- New Guidance – Administration of covert medication.

- Reduced length of stay for patients with dementia.
- Average length of stay for elective patients is 2.6 days – non-dementia is 3.4 days.
  - Average length of stay for non-elective patients is 8.7 days – non-dementia is 6.9 days.

Monitoring the number of ward moves for people with dementia.

- This piece of work commenced through Best Quality programme this year and there is further work to be done.
  - Pathway for dementia patients for A&E and Site teams to assist in preventing admissions where appropriate and also to ensure admission to appropriate bed first time developed.

- Established the West Kent Emergency Services Dementia Partnership with MTW; West Kent Police; SECAmb and KFRS. Actively supported the Dementia-Friendly Hospital Charter.
- Continue to work collaboratively with Involve Kent in the organisation to help support all carers'.
- Mental Capacity assessments for people with dementia and best interest meetings where appropriate is an area that still requires further work and we represent and support the work being done on Best Quality work stream for MCA.

16.0 Serious Incidents

A Serious Incident (SI) is defined by NHS England as an event in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Whilst there is no definitive list of events or incidents that constitute an SI there are a number of descriptors that contribute to the classification of an incident as an SI; this includes

Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery, all of which were: healthcare did not take appropriate action / intervention to safeguard against such abuse occurring; or abuse occurred during the provision of NHS-funded care

The Trust reported 4 SI's related to safeguarding adults between April 2019 & March 2020.
The Trust reported 0 SI's related to safeguarding children between April 2019 & March 2020.

Key learning from these cases includes the management of expectations whilst minimising anxiety during the consent process and also ensuring that staff use the Mental Capacity Act appropriately prior to an intervention where required.

17.0 Education & Training

The Trust provides a range of education and training opportunities for safeguarding adults, in line with the draft intercollegiate documents and Kent County Council training requirements.

The Matron for Safeguarding Adults oversees the internal training content and provides much of the training in relation to MCA and PREVENT.

The Matron for Safeguarding Adults works closely with the Named Nurse for Safeguarding Children in both the development and delivery of training. Training is offered in a variety of ways including e-learning, group sessions and bespoke to wards and departments.

The Trust can also access multi-agency training via the KMSAB team. The KMSAB run a number of learning events throughout the year to enable practitioners to hear and discuss the learning from both local and national SARs.

The table shows the Trust training update and compliance as at Quarter 3:

Division	Mental Capacity Act (once only)	Prevent Basic (3 Year Update)	Prevent Wrap (3 Year Update)	Safeguarding Children Level 1 (3 Year Update)	Safeguarding Children Level 2 (3 Year Update)	Safeguarding Children Level 3 (3 Year Update)	Safeguarding Vulnerable Adults Level 1 (3 Year Update)	Safeguarding Vulnerable Adults Level 2 (3 Year Update)
Total December	92.2%	93.5%	78.8%	91.3%	80.8%	69.2%	93.7%	84.4%

Due to the redeployment of some staff during the Covid-19 Pandemic it has proven difficult to gain the Q4 figures. There is also cognisance that staff have been encouraged to complete e-learning in quarter 4 as a number of face to face sessions had to be cancelled.

18.0 Priorities for 2019/20

18.1 Best Care: MCA & Consent

As noted earlier, there is a need to be able to 'evidence' the approach taken to ascertain capacity. The Trusts transformation programme 'Best Care' has adopted MCA under the Best Quality work stream. The Best Safety work stream is also undertaking a piece of work to strengthen the evidence around informed consent.

As MCA is a corner stone of informed consent these two work streams will be closely aligned. It anticipated that this work will also identify further MCA champions from the clinical areas to support embedding this work.

18.2 Learning Disabilities

The Trust will explore with the CCG how to contribute effectively to LeDeR reviews.
The LDLN plans to continue to focus on the NHS Improvement benchmarking standards to ensure these standards are implemented throughout the trust.

18.3 Education & Training

Safeguarding training remains under review against the published Adult Safeguarding Intercollegiate Document. A variety of methods to deliver the training has been suggested and work is underway to establish the best way to provide this training in the Trust. There is an appetite to have a joint approach to safeguarding children and adults training to lessen crossover, and repetition of subject matter. The new system means that the way that Safeguarding training in the Trust is delivered will change substantially and this will take time to organise and develop. The new system of delivery is expected to be in place commencing January 2021.

18.4 Safeguarding Children

The priorities for the Safeguarding Children service in the next 12 months are –

- Improve compliance with Level 3 over the Trust – the training offer is in the process of being redesigned and will be a combination of face-to-face, on-line and Masterclasses
- Introduce a Safeguarding 'Duty Rota' to allow staff a 7 day access to Safeguarding Children advice and support

18.4 Review of Safeguarding Service

It is anticipated that the Trust Safeguarding service as a whole will be combined and brought within the aegis of Corporate Nursing.

19. Addendum

The safeguarding leads have responded to the Covid-19 pandemic and in April 2020 advertised out to staff the following:-

- Advised Command Centre of the Safeguarding Covid-19 Plan for escalation of issues for both children and adults
- Advised staff about the Single Point of Contact details for each ward – wards were shared between the available practitioners
- Poster about the Safeguarding Offer and the Think Family agenda
- Information about accessing various appropriate E-Learning for staff
- Contact details for team members.

Appendix 1: Statutory duties for Safeguarding Adults

National & Local Policy

National policy pertaining to Safeguarding adults is underpinned by the Care Act 2014, along with a number of other acts or policies including (but not limited to) the Mental Capacity Act and Deprivation of Liberty Safeguards, Counter-Terrorism and Security Act (including CONTEST the UK's counter-terrorism strategy).

1. The Care Act 2014

The Care Act 2014 puts adult safeguarding on a statutory footing. The guidance states that safeguarding 'is about people and organisations working together to prevent and stop both the risks and experiences of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, there appropriate, having regard to their views, wishes, feelings and beliefs in the deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about the personal circumstances'

Making Safeguarding Personal, a multi-agency approach led and supported by the Association of Directors of Adult Social Care, seeks to achieve:

- A personalised approach that enables safeguarding to be done with, not to, people.
- Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation and conclusion'
- An approach that utilises social work (and health care) skills rather than just 'putting people through a process'
- An approach that enables practitioners, families, teams and Safeguarding Adults Boards (SABs) to know that difference has been made

Safeguarding practice is, therefore, underpinned by six principles of

- Empowerment
- Prevention
- Proportionate
- Protection
- Partnership
- Accountable

NHS England and the Local Authority have in place and Accountability and Assurance Framework (2015) that sets out the expectations of role, duty and responsibility including: .

- Staff are suitably skilled and supported
- Safeguarding leadership and commitment at all levels of the organisation
- Fully engaged with and support local accountability and assurance structures, in particularly via the SABs and their commissioners
- Have effective arrangements in place to safeguard adults
- A named lead for adult safeguarding

2. Children's Act 2004

The Children Act 2004 states that the interests of children and young people are paramount in all considerations of welfare and safeguarding and that safeguarding children is everyone's responsibility.

Safeguarding in the broadest sense can only be achieved by improving a wide range of outcomes for children and young people, including their health, education and development, safety, and economic circumstances.
This can only be delivered and sustained when key people and bodies work together to design and deliver more integrated services around the needs of children and young people.

The Children Act provides a legislative spine for the wider strategy for improving children's lives. This covers the universal services which every child accesses, and more targeted services for those with additional needs.

3. Mental Capacity Act (MCA) 2005

Mental Capacity is the ability to make a decision. Capacity can vary over time, and according to the decision to be made. Lack of capacity may be due to either a permanent condition such as stroke or temporary due to a mental health problem or unconsciousness because of illness or the treatment for the illness (e.g.: ICU admission).
The MCA sets out statutory responsibilities which apply to everyone who works in health and social care who are involved in the care and treatment or support of people over the age of 16 years In England or Wales.

The MCA is underpinned by 5 principles:

- Assume Capacity, unless it is established otherwise
- Practical steps taken to maximise decision making capacity (e.g.: use of non-verbal communication)
- Unwise decisions: a person has the right to make an unwise or eccentric decision
- Best Interest: any act or decision must in the person's best interest (not the practitioner or organisation).
- Least restrictive: alternative acts or decisions must be considered with regard to the purpose for which it is needed and whether it can be achieved in a way that is less restrictive for the person's rights and freedom to act.

3.1 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) form part of the MCA 2005. The DoLS provide a mechanism to ensure that appropriate safeguards and least restrictive options are in place for a person lacking mental capacity where it is considered to be in the person's best interest to keep them in a hospital or care home.

The 'acid test' from previous Supreme Court Judgements (P&Q vs Surrey Council and P vs Cheshire West) remains in place. The 'acid test' criteria are applicable if the person is assessed as lacking mental capacity and is:

- Under continuous supervision and control **AND**
- They would not be free to leave

The process requires an application to be made to the Local Authority who will then approve the application.

The DoLS Office for the Local Authority will triage all requests and should action with specified time frames. However, it continues to be unclear how many applications are converted to authorised DoLS. This issue has been raised with the K&MSAB and has become a standing agenda item. DoLS applications for individuals within acute care settings are often seen as a lower priority for the Local Authority

4. PREVENT

The Prevent Duty is a set of definitions and responsibilities approved under the Counter-terrorism and Security Act 2015 which sets out duties for specific authorities.

Key responsibilities for health are:

- Partnership: working with regional safeguarding forums to have oversight of compliance with the duty.
- Organisations should have a lead and access to networks for advice and support to make referrals to Channel
- Risk Assessment; all Trusts should have a Prevent Lead who acts as a single point of contact within their organisation
- Staff Training, relevant to role in safeguarding adults and children.

PREVENT training focuses on the identification of vulnerable people who are (or maybe) at risk of radicalisation.

The Safeguarding Children, Young People and Adults at Risk in the NHS – Accountability and Assurance Framework (*SAAF*) (NHSE 2019) sets out the statutory duties and roles required of NHS providers.

Kent Safeguarding Children Multiagency Partnership (KSCMP)

On 17.9.19 the Kent Safeguarding Children Multi-Agency Partnership was formed – this has replaced the previous Kent Safeguarding Children Board.
The arrangements for the Partnership can be found via the following link –
https://www.kscmp.org.uk/about-kscb/kscmp
The Kent Safeguarding Children Multiagency Partnership (KSCMP) has overall responsibility for Safeguarding Children policy in Kent. The arrangements set out the vision that the Kent Safeguarding Children Multiagency Partnership has for children in Kent and how they will be safeguarded and their welfare promoted. It has established a tripartite partnership between health, the police and the Local Authority with each partner having equal status. This recognises the importance of the role that health has to play in safeguarding children and will enable the 'voice of health' to be heard. The Executive Lead for Safeguarding in the Trust sits on the Health Providers Safeguarding Partnership.

Child Deaths
The new Child Death Review Guidance set out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements set out in Working Together Guidelines (2018) and clarifies how individual professionals and organisations across all sectors involved in the child death review should contribute to reviews. The guidelines place a responsibility on all organisations to improve the experience of bereaved families, and professionals involved in caring for children. They also ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths. The new arrangements are in place in Kent.

Kent and Medway Safeguarding Children's procedures
The above procedures were updated in October 2019 to include new guidance on responding to Abuse and Neglect and children not attending school. New chapters on the safeguarding partnership arrangements, Child Death Reviews and Safeguarding Children Practice Reviews are now included.

Kent and Medway Adults Board Multi-agency Safeguarding Adults Policy, Procedures and Practitioner Guidance
This was updated within this year and published in November 2019. This was a total re-write and as a result the Trusts Adults Safeguarding Policy and Procedure is under review.

Quarterly report from the Freedom to Speak Up Guardian Freedom to Speak Up Guardian

The latest quarterly report from the Freedom to Speak Up Guardian is enclosed.

Which Committees have reviewed the information prior to Board submission?
- N/A

Reason for submission to the Board (decision, discussion, information, assurance etc.) [1]
Review and discussion

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Board of Directors (Public)

Freedom To Speak Up Guardian Report

Action Requested / Recommendation

The Trust Board is asked to read the report and discuss the content and recommendations.

Summary

This is the second report to the Board by the Freedom To Speak Up Guardian (FTSUG) which now outlines and identifies trends, issues and the resource requirement to move the FTSU agenda forward.

Author; Christian Lippiatt, Freedom To Speak Up (FTSU) Guardian

Date; 15th July 2020

Freedom To Speak Up Non-Executive Director	Maureen Choong
Freedom To Speak Up Executive Lead	Simon Hart
Freedom To Speak Up Guardian	Christian Lippiatt

Introduction

The FTSU Agenda is to;

- Protect patient safety and the quality of care
- Improve the experience of workers
- Promote learning and improvement

By ensuring that;

- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

National Guardians Office (NGO)_Case Reviews

June 2020; Whittington Health NHS Trust (WHT). Two workers referred the handling of two speaking up cases to the National Guardian. The referrals were in relation to a reported failure to follow Trust policy.

The review identified a number of areas of good practice and areas for learning and improvement. Below are the areas where MTW may need to look more closely to provide assurance in these practices;

- WHT employs 4,000 staff. They increased their FTSU Guardian from 1.5 days a week to full time and this was acknowledge as good practice. MTW is in the process of increasing its resource of 1 day per week to 5 days per week in the form of a Guardian (2 days) and Deputy (3 days).
- WHT Guardian has regular meetings with HR BP's to promote joint working and understanding of each of their roles. This is an area that MTW will need to improve on and a recent external review of the Workforce Directorate and subsequent action plan supports this need.
- WHT Speaking Up / Whistle blowing policy was not in accordance with the national standard published in 2016. The review noted an upcoming review of national standard in 2020 and MTW will need to review its own policy (which is based on national standard) in line with any new publication and revision once they are released.
- WHT had good promotion / publicity of speaking up, however the scope and remit / extent of authority the Guardian has was not well understood within the wider organisation, though the Guardian them self knew. MTW will need to increase and improve its publicity of speaking up and the extent of the Guardian role.
- WHT had undertaken a combined audit of complaints and speaking up. Some matters relating to speaking up were not addressed and a speaking up only audit was recommended. The MTW Guardian should engage with the Trust Audit function to set out the scope of an audit and frequency.
- Reference was made to not being offered an exit interview and the opportunity to speak up at that point about the culture and emotional distress experienced by the employee. Exit interviews at MTW are an area for interest in relation to information gathering, trend identification and actions taken. This is an area being looked at by the Staff Welfare project stream which the FTSU Guardian is involved in.

Themes / Issues

There have been five concerns raised in the last quarter, all of which were on the Maidstone site and in relation to bullying /harassment, one of which has a second classification of potential fraud.

In the last quarter the concerns of bullying have all followed the same pattern as in previous months whereby staff have felt unable to approach HR for support to address the concerns they have. Three of those cases have resulted in significant interventions including formal investigations and mediation. The case involving a concern of fraud has naturally been escalated through the Deputy CEO/ Director of Finance and for reasons of on-going investigation cannot be reported further at this point. 4 of the 6 concerns raised in the last quarter are still open and being progressed and again for that reason further reporting / outcomes cannot yet be reported. The two closed concerns were for advice and support on how to address and approach issues of bullying and were happy to close the case and progress themselves with the option to open the case again should they wish further support. 3 of the concerns

are within clinical areas and whilst not directly related to patient safety, will inevitably have an effect on patient care due to the psychological impact it has upon the clinicians.

The concerns all have similar impact upon the staff members irrespective of level of seniority / banding;

- Issues of being ignored when others are greeted / acknowledged
- Issues of being spoken to in a disrespectful manor, particularly in public
- Being made to feel worthless or treated like a child

Three of the staff members reported having previously raised concerns with managers / management and these cases are all now receiving some form of intervention to help resolve and address the concern.

All of the staff members raising concerns were suffering a heightened level of stress, anxiety and in some cases the extent of this resulted in presenteeism.

Over the last year there have been 30 reported cases, of which 18 were raised from the Maidstone site. Whilst this may appear to be a trend over and above TWH site, it should also be noted that staff on the Maidstone site are generally more vocal in other aspects of engagement. To that extent, once a Deputy Guardian has been appointed we will focus some initial promotion of the speaking up agenda on the TWH site to help establish if it is simply a "general" lower level of engagement or a genuine issue on the Maidstone site. The split of concerns is shown below with the highest number of concerns being bullying.

Theme	Maidstone	Tunbridge Wells	Unknown
Patient Safety	6	0	0
Bullying/ Harassment	10	2	3
Fraud	1	1	0
Health & Safety	1	2	0
Other	0	2	2
Total	18	7	5

Growing the Speaking Up Agenda

A business case for a 0.6 whole time equivalent Deputy FTSU Guardian has been presented to the Business Case Review Panel and is anticipated to be formally approved this month. Advertising and recruitment to this additional post will take place as soon as approval has been received and will be undertaken through the "recruiting for diversity" process.

Networking

The FTSU Guardian continues to attend regional and local network meetings. These are currently virtual meetings due to the pandemic.

During this pandemic period, existing and new staff network meetings have been set up virtually and are being attended by the FTSU Guardian/ Head of Occupational Health in that dual role to help extend the reach and awareness of speaking up and enabling concerns to be discussed in real time as many clinical practices and services have been rapidly changed. Any form of rapid change within a clinical setting carries increased risk of patient safety being compromised. Due to this fast paced environment and real time approach, discussions, actions and resolutions that have been taken have not been recorded as FTSU concerns. If however, any of those concerns raised were to be unresolved / raised again, they would be formally recorded as a FTSU concern.

It is possible that this "real time" and virtual approach has resolved many concerns before they would otherwise have been escalated as a formal concern. It is anticipated that even post pandemic many of these network / staff engagement sessions will continue to be offered as a virtual meeting and would form part of a new and planned approach to expand and address the speaking up agenda – and ultimately rapid intervention and resolution.

Data Collection; Concerns Raised

2020/21

20/21 Month	No. of contacts	Anonymous	All Open Cases
April	3	0	1
May	1	0	1
June	2	0	2
July			
August			
September			
October			
November			
December			
January			
February			
March			
Total	**6**	**0**	**4**

Staff Group	
Estates & Facilities	2
Nursing	
Midwifery	
Medical	2
AHP's	1
Clinical Support	
A&C	1
Unknown	
Total	6

Theme	
Patient Safety	0
Bullying/ Harassment	5
Fraud	1
Health & Safety	0
Other	0
Total	5

2019/2020 Details

Quarter	Month/Year	No. of Contacts	Open Cases
Q1	April-June '19	15	0
Q2	July-September '19	16	0
Q3	October-December '19	1	0
Q4	January-March '20	6	1
Total	**2019/20**	**39**	**1**

Staff Group	Number
Estates & Facilities	3
Nursing	4
Midwifery	0
Medical	1
AHP's	1
Clinical Support	10
A&C	10
Unknown	10
Total	**39**

Theme	Number
Patient Safety	6
Bullying/ Harassment	18
Fraud	1
Health & Safety	5
Other	9
Total	**39**

NHS Maidstone and Tunbridge Wells NHS Trust

Summary report from Workforce Committee, 02/07/20 and 17/07/20	Committee Chair (Non-Exec. Director)

The Workforce Committee met on 2nd July 2020 and 17th July 2020.

- **The key matters considered at the meeting on 2nd July were as follows:**
  - At the start of the meeting the Committee was informed by the Chair that it would generally meet monthly as agreed at the Trust Board on 25th June 2020
  - The Committee reviewed **the national NHS Staff Survey 2019 - Findings & Key Implications** wherein the Director of Workforce noted the Board Assurance Framework (BAF) objective for 2019/20 of "Achieve staff engagement score of ≥ 7.2 within 2019/20" had not been achieved but there had been a statistically significantly improve.
  - The Head of Staff Engagement and Equality provided a report on **the national NHS Staff Survey 2019 - Divisional Action Plans** wherein it was agreed that the Chair of the Workforce Committee should liaise with the Vice Chair of the Workforce Committee, Head of Staff Engagement and Equality and Director of Workforce to develop an "Engagement" area for action within the corporate national NHS staff survey action plan. The following actions were also agreed for the Head of Staff Engagement and Equality:
    - Arrange for each Division to develop a "plan on a page" in response to the findings from the National NHS staff survey and the June 2020 staff pulse survey
    - Collate the Divisional "Plan on a pages" in response to the findings from the National NHS staff survey and the June 2020 staff pulse survey into a corporate action plan and circulate to Committee members ahead of the 17th July meeting
    - Ensure that the Divisional national NHS staff survey action plans included the relevant Divisional labels for the purpose of identify which Division the action plan corresponded to
    - Liaise with the relevant leads for those divisions with national NHS staff survey action plans that required further development, to support the addition of further details to the actions therein
    - Develop a proposed approach to the National NHS Staff survey 2020; (that was expected to take place in October 2020); and circulate to Committee members for review
  - The Committee undertook a **review of the June 2020 COVID-19 Staff Pulse Survey Results,** wherein it was agreed that the Associate Director of Organisational Development should circulate the action plans from the Chiefs of Service in response to the findings from the June 2020 staff pulse survey to all Committee members once available
  - Under **any other business** the Director of Workforce informed the Committee that staff had been commended for their response during COVID-19 via Staff Side

The key points from the meeting on 17th July will be reported to the Trust Board verbally in July, and a written summary report will be submitted to the Trust Board's meeting in September.

The issues from the meeting that need to be drawn to the Board 's attention as follows: N/A

Which Committees have reviewed the information prior to Board submission? N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.)[1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance

Summary report from Quality Committee, 08/07/20 | **Committee Chair (Non-Executive Director)**

The Quality Committee met on 8th July (a 'main' meeting), via virtual means. The meeting reverted to its usual format, following the revised format used for the meeting in May, due to COVID-19.

1. **The key matters considered at the meeting were as follows:**
   - The Deputy Director of Quality Governance **reported the outcome of the review of the Never Events that had occurred at the Trust** (in light of the seeming common themes involved in some of the Events).
   - The issues raised from the **reports from the clinical Divisions** included the challenges faced as part of the 'reset and recovery' programme. The report from Medicine & Emergency Care included an update on quality in the stroke service and the adverse impact of therapy staffing issues was noted, particularly with regards to the reduction in Sentinel Stroke National Audit Programme rating. It was agreed to bring that issue to the Board's attention.
   - The Medical Director reported on the **output from the COVID-19 Ethics Committee**.
   - The Committee received details of the **complaints that had been received during the COVID-19 period** as well as the **Complaints Annual Report for 2019/20**
   - The **update on the 'MTW new normal'/'reset and recovery' programme** that was reported to the Trust Board in June 2020 was noted.
   - The **draft Quality Accounts for 2019/20** were reviewed and it was agreed to recommend their approval to the Trust Board (these have been submitted under a separate agenda item)
   - The Chief of Service, Medicine & Emergency Care gave the latest **update on mortality** and the Deputy Medical Director reported the **latest position on Serious Incidents (SIs)**
   - The latest **annual review of Quality Impact Assessments (QIAs)** was considered.
   - The Safeguarding Adults Matron, Named Nurse Safeguarding Children and Deputy Chief Nurse attended for review of the **Joint Safeguarding Annual Report, 2019/20**. The Committee commended the report, but asked for it to be amended, to include details of the Trust's involvement with safeguarding issues in East Sussex. It was also agreed that the Deputy Medical Director should Invite the Safeguarding Adults Matron to attend a meeting of the Clinical Directors and Chiefs of Service Committee, to raise awareness of the Kent Adult Safeguarding Alert Form (KASAF) process (and allay any anxieties regarding that process). The report has also been submitted to the Trust Board under a separate agenda item.
   - A brief **update on the relevant aspects of the Board Assurance Framework** was given
   - Reports were received from the **Committee's sub-committees** (the Complaints, Legal, Incidents, PALS, Audit and Mortality (CLIPAM) group; the Infection Prevention and Control Committee; and the Drugs, and Therapeutics and Medicines Management Committee).
   - A **summary report from the Patient Experience Committee**, 11/06/20, was noted

2. **In addition to the agreements referred to above, the meeting agreed that:**
   - The Chief of Service for Diagnostics & Clinical Support should provide further details of the "Omitted Doses- For medication Safety incident across the Trust" that were referred to in the "Themes from new Incidents" section of the Division's report
   - The Chief of Service for Medicine & Emergency Care should check and confirm how many of the five Kent Adult Safeguarding Alert Forms that were reported in the Division's report
   - The Deputy Chief Nurse agreed to consider what action should be taken in response to the "increase in abusive and racial behaviour towards staff" that was reported by the Women's, Children's & Sexual Health Division

The issues from the meeting that need to be drawn to the Board's attention are:
- The therapy staffing issues that had adversely affected the Trust's stroke service (and the reduction in Sentinel Stroke National Audit Programme rating in particular)

Which Committees have reviewed the information prior to Board submission? N/A

Reason for receipt at the Board (decision, discussion, information, assurance etc.) [1]
Information and assurance

[1] All information received by the Board should pass at least one of the tests from 'The Intelligent Board' & 'Safe in the knowledge: How do NHS Trust Boards ensure safe care for their patients': the information prompts relevant & constructive challenge; the information supports informed decision-making; the information is effective in providing early warning of potential problems; the information reflects the experiences of users & services; the information develops Directors' understanding of the Trust & its performance