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

MTW exceptional people, outstanding care

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
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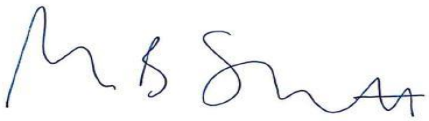


Miles Scott
Chief Executive

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

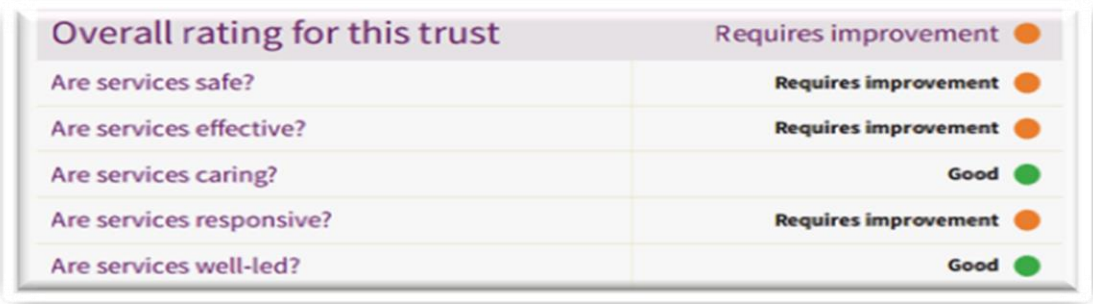
CQUINs	Target	Achieved (local data)	RAG Rating
Hospital Medicines Optimisation has 5 elements: 1. Improving efficiency in the IV chemotherapy pathway from pharmacy to patient – reducing chemotherapy waste. 2. Managed access agreement compliance - ensuring data requirements are met so that the real-life 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.

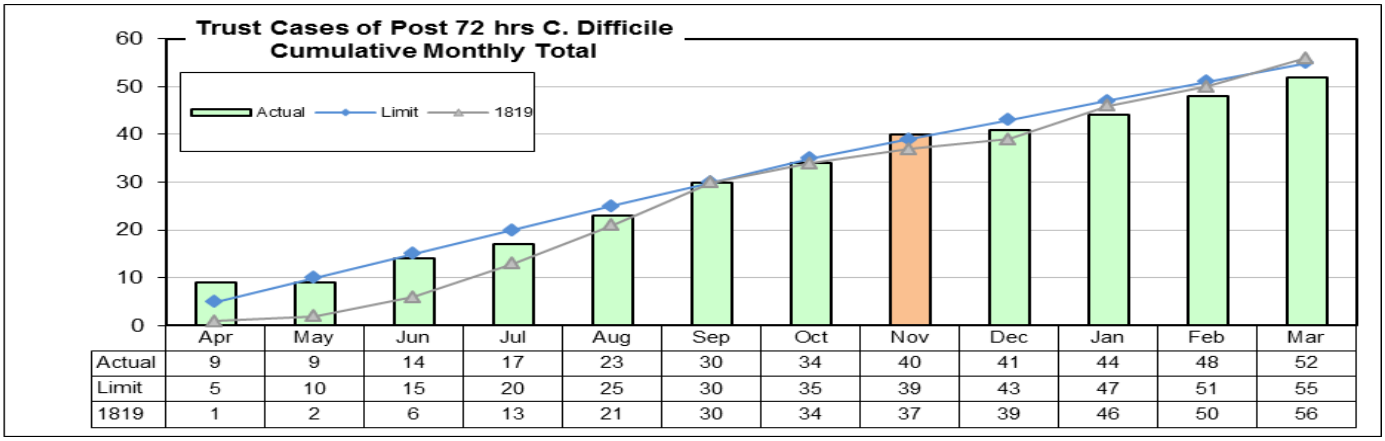
A Safety Standards for Interventional Procedures Working Group was re-launched in November 2018 to focus on the standardisation and implementation of Local Safety Standards for Invasive Procedures (LocSSIPs – previously known as the WHO checklist) across the Trust.

- 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

Patients with Learning Disabilities

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.

Mental Capacity Assessment (MCA) project

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.

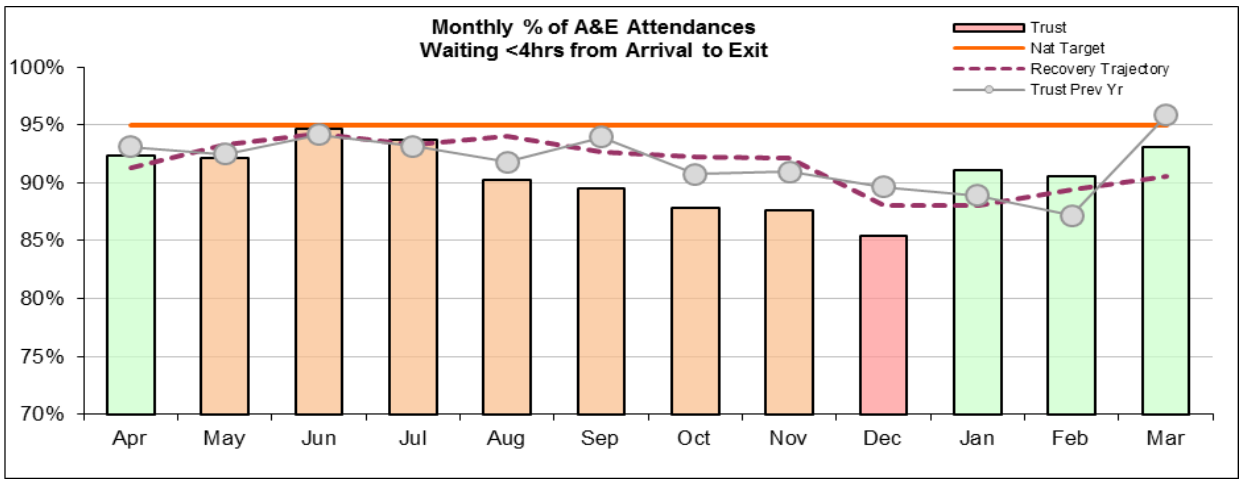
Clinical Effectiveness

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.

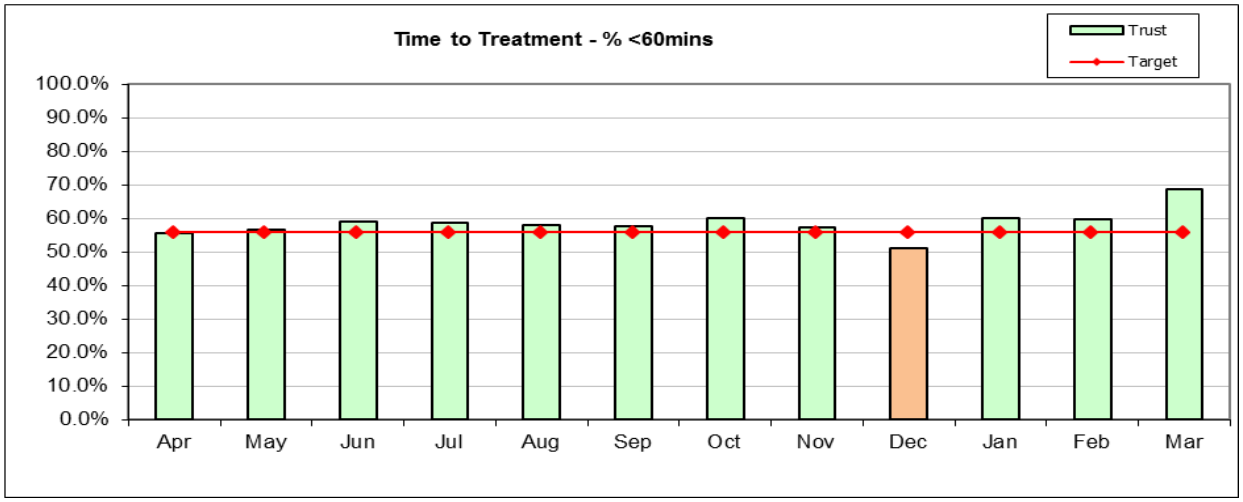
These options should include a variety of routes including; support for the self-management of patients with long-term conditions; speciality-led assessment units; ambulatory care pathways; onward referral to other provider organisations who are better able to meet the patients' care needs and for those 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.

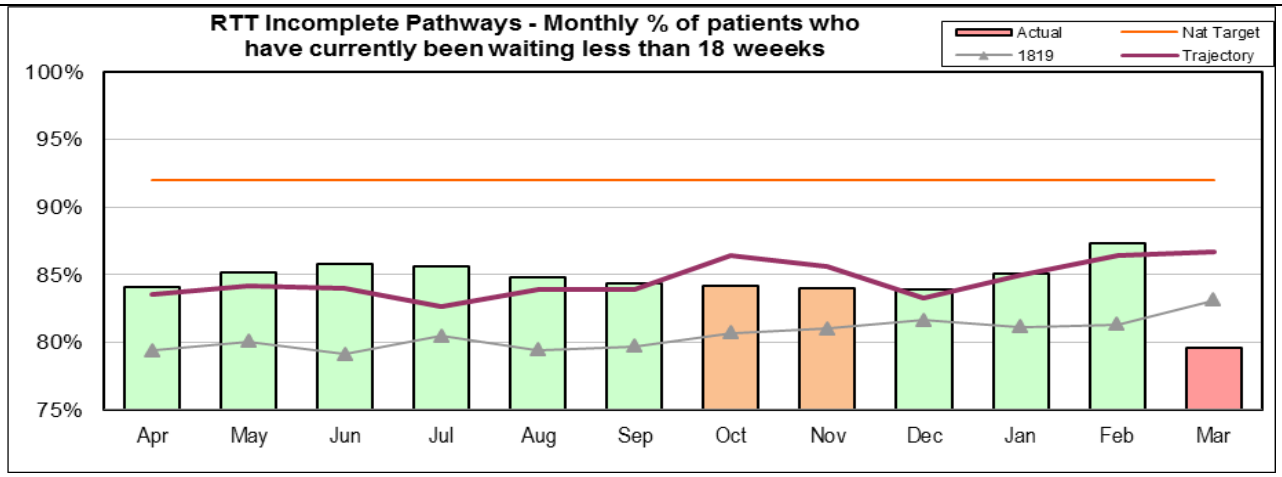


Emergency Department Time to Treatment <60 minutes – the Trust achieved this standard of 55.9% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 58.3%. This is an improvement on last year's figure of 55.9%.



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

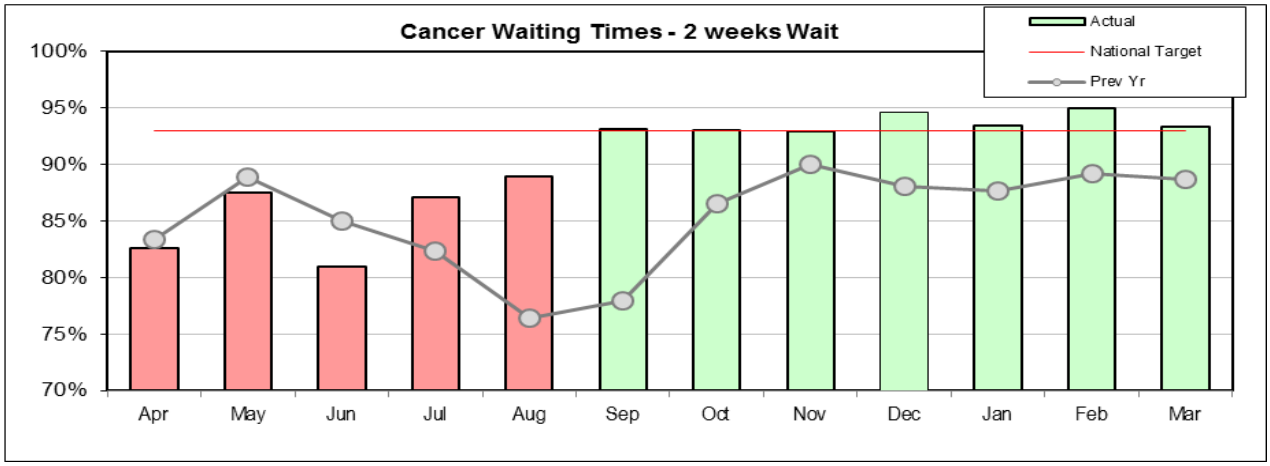
18 weeks standard – the Trust did not achieve the national standard of 92% of patients on an Incomplete Pathway being treated within 18 weeks due to some of the improvement initiatives in the speciality business plans not being funded. The Trust did achieve the year end recovery trajectory set at 86.7%, 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.



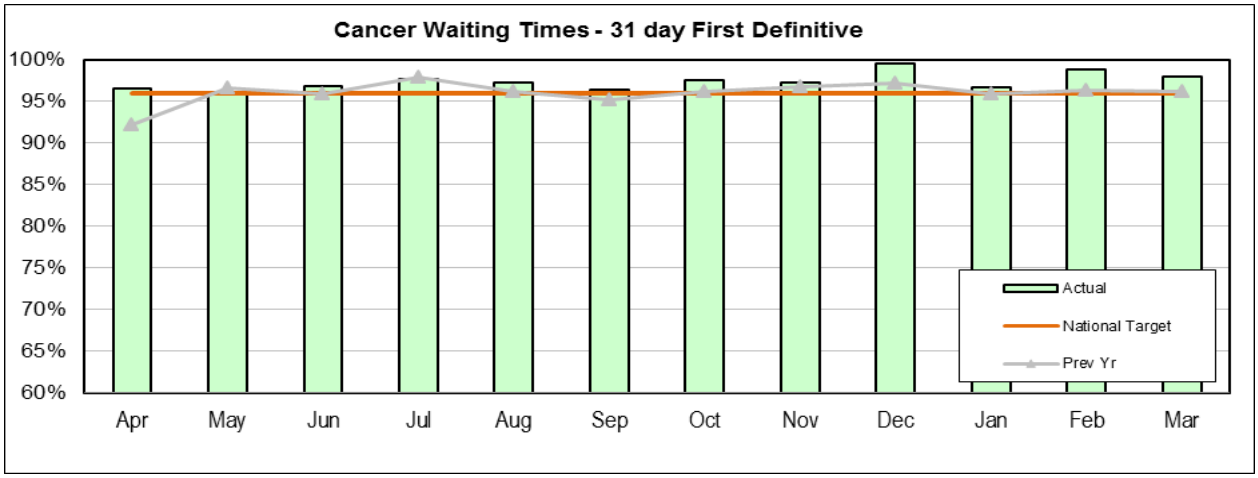
A process has been established to review patients on waiting lists to ensure they do not come to harm whilst waiting for procedures / treatment.

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

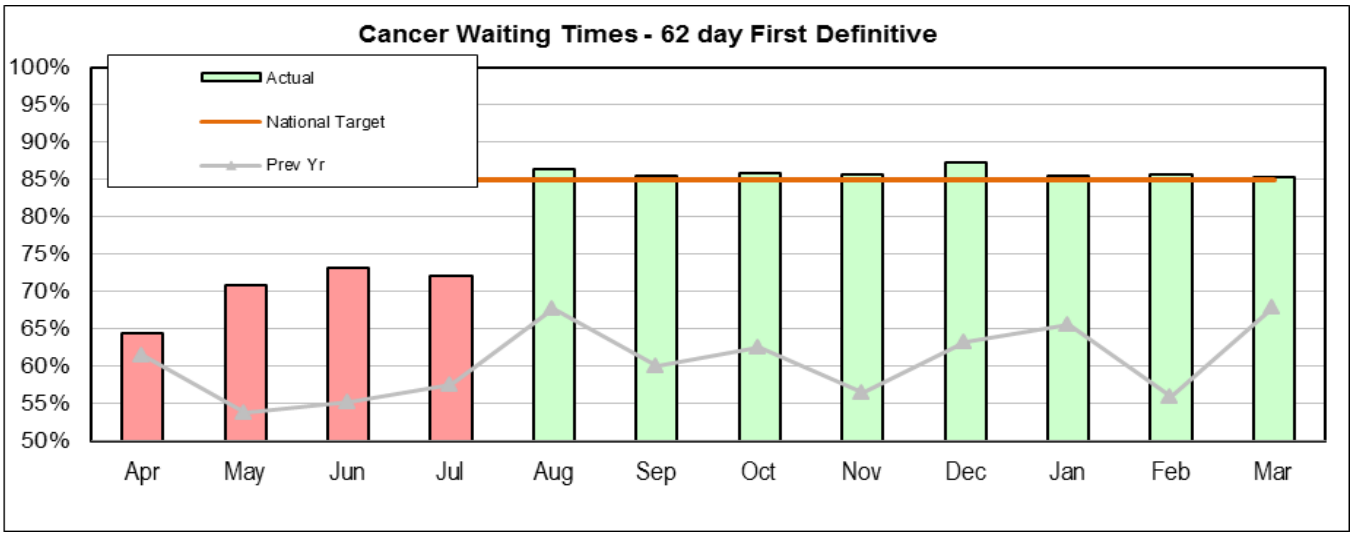
Cancer Waiting Time Targets: 2 weeks from referral – the Trust did not achieve this standard of ensuring that 93% of patients with suspected cancer were seen within two weeks throughout 2019/20 at 90.2%. However, this has significantly improved from the previous year and the target has been consistently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

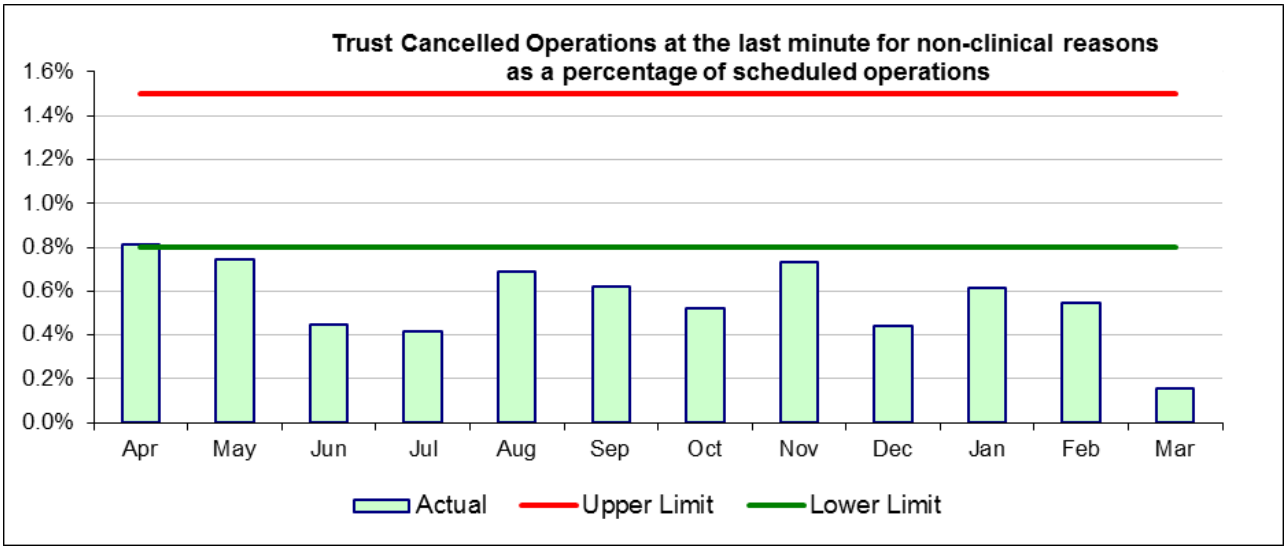
- Delayed Transfers of Care (DTOC): during COVID-19 it has been necessary to reduce the patients who were medically fit for discharge in order to create capacity. Therefore the number of DTOC patients has reduced considerably, with increased funding for additional non-hospital placements.

- 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.

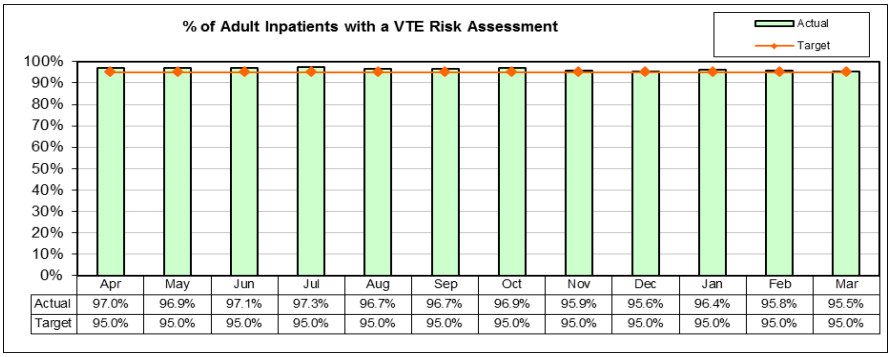
In light of the COVID-19 pandemic, the Trust has proactively reviewed ways of working and the development of new roles, such as Personal Protective Equipment (PPE) Safety Officers, to support the delivery of high quality, safe, effective care.

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)

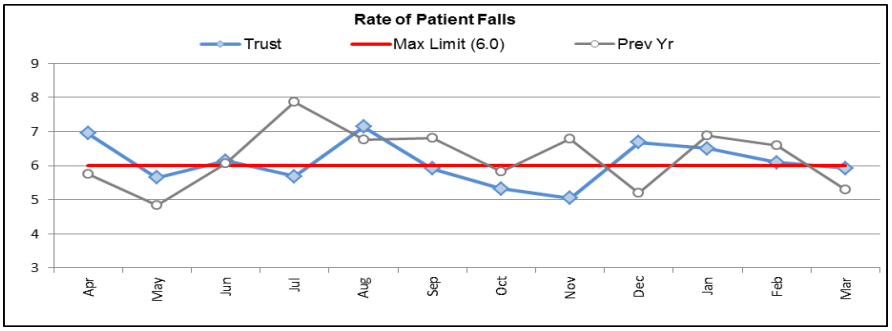
The Trust ensured that 95% of patients had a VTE Risk Assessment completed on admission to hospital in 2019-20 with an overall score of 96.5%.



	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%

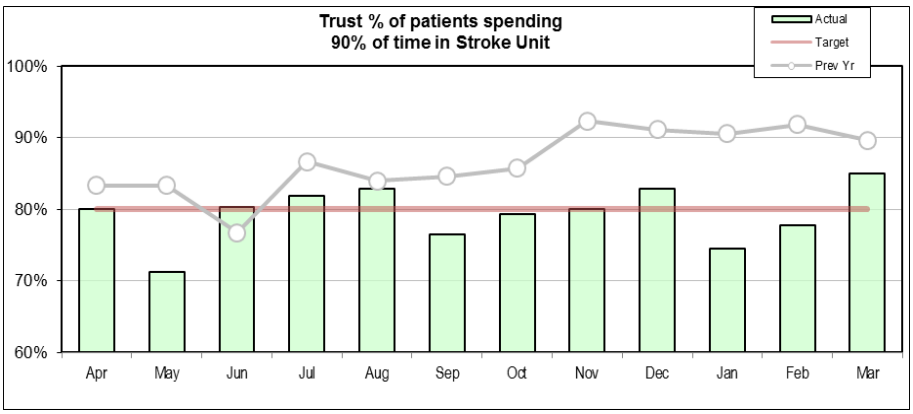
Reducing the number of patient falls

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).



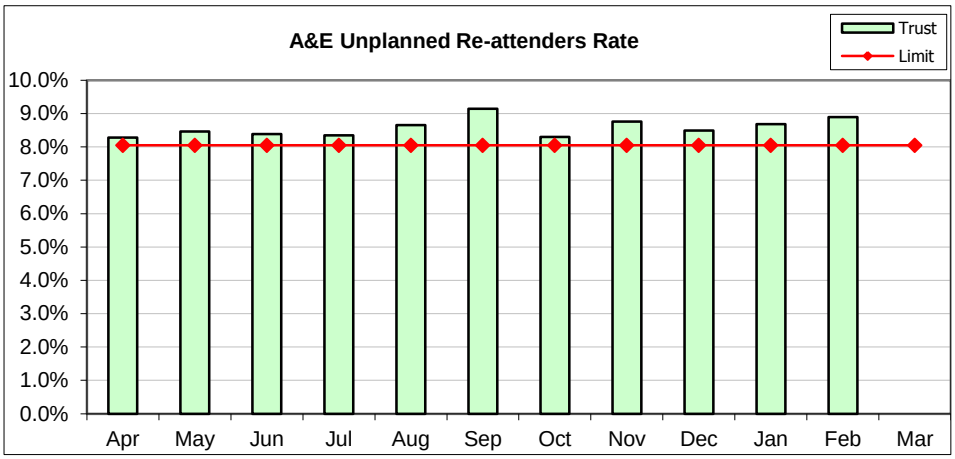
Improving care for patients who have had a stroke

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.



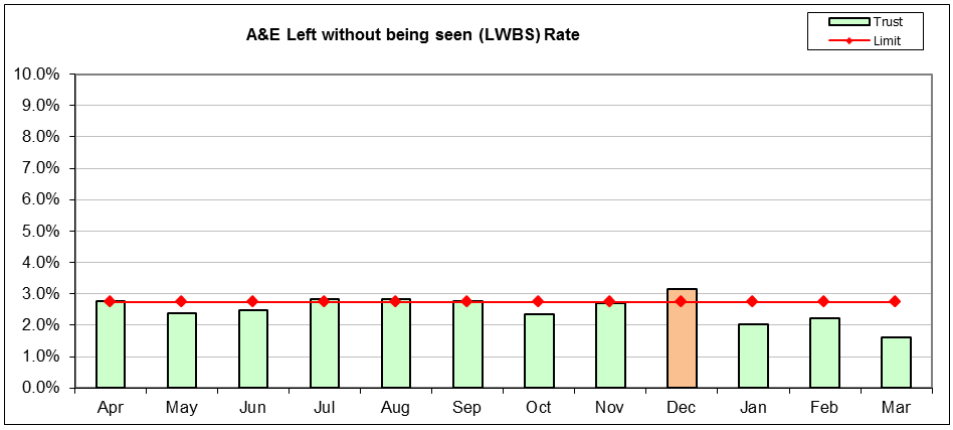
Emergency Department Unplanned Re-attendance Rate

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).



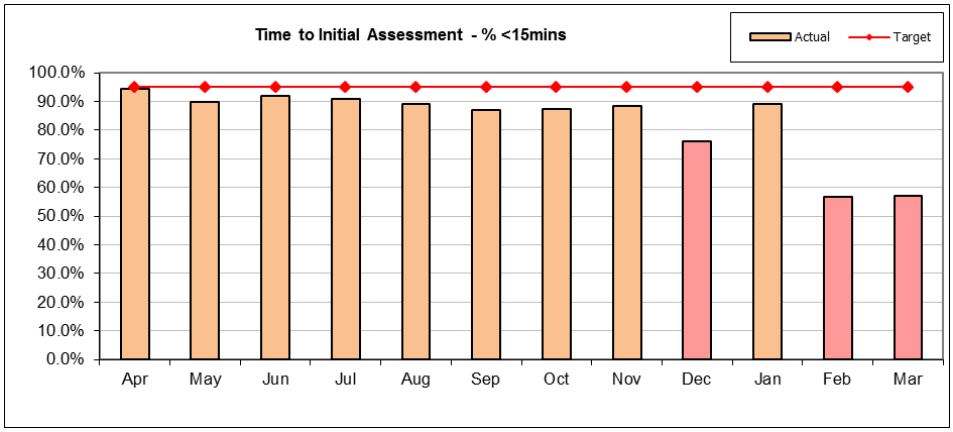
Emergency Department Left without being Seen Rate

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



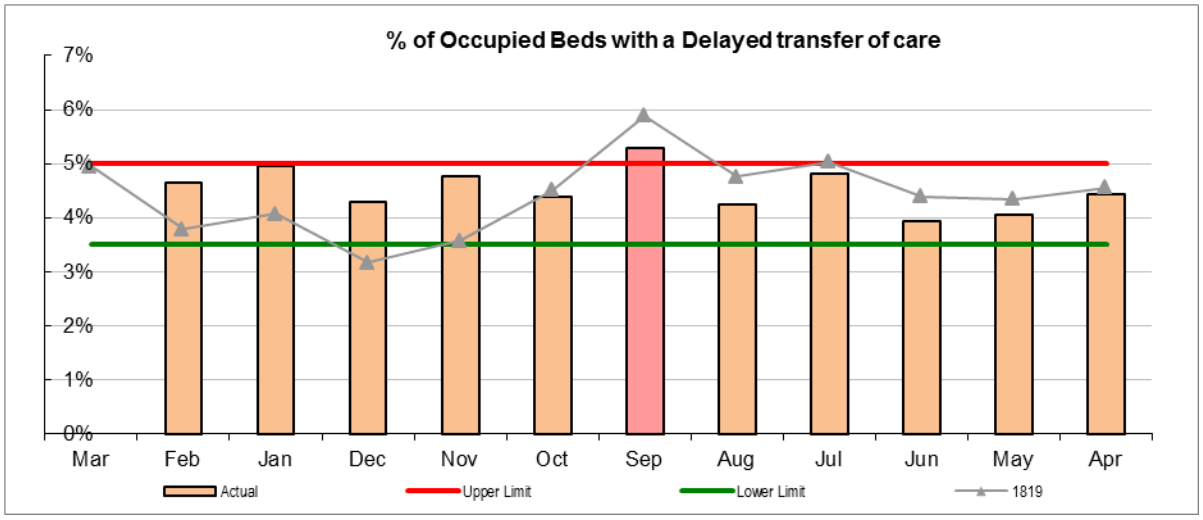
Emergency Department Time to Initial Assessment <15 minutes

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)

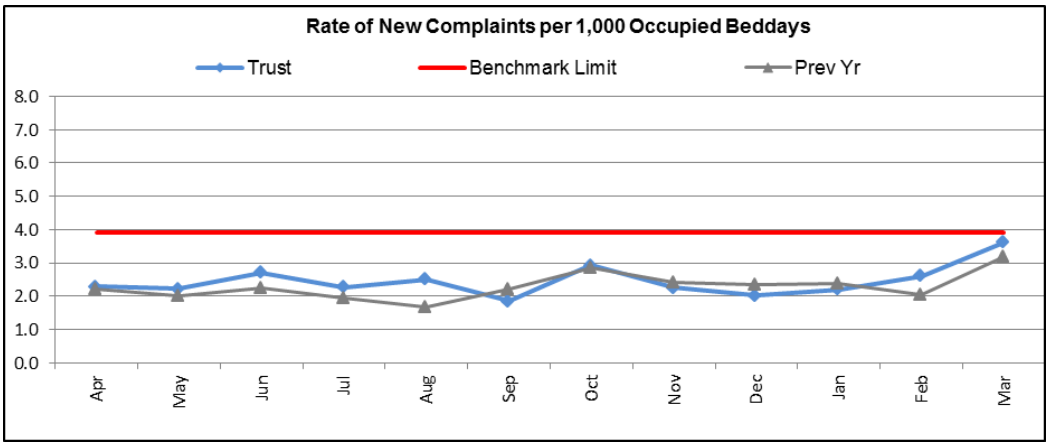
The Trust did not achieve this standard of delayed transfers of care remaining below the national limit of 3.5% for the year at 4.53%, which is similar to the previous year.



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.

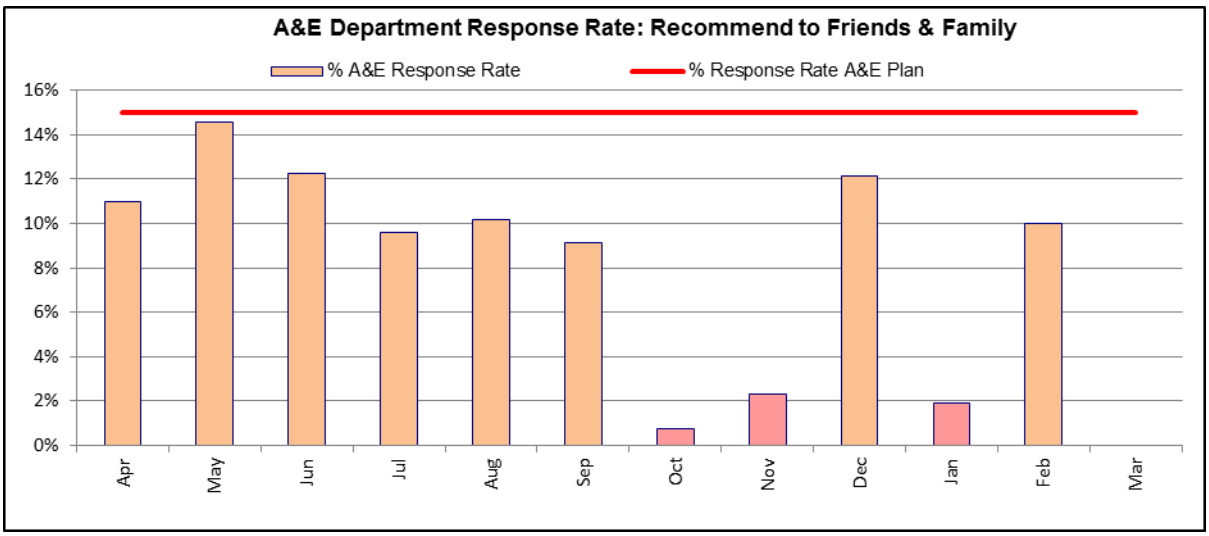
The Trust also participated in the National Cancer Patient Experience Survey. In 2019/20 this survey was undertaken by the Picker Institute and we are awaiting the report.

Friends and Family Test (FFT)

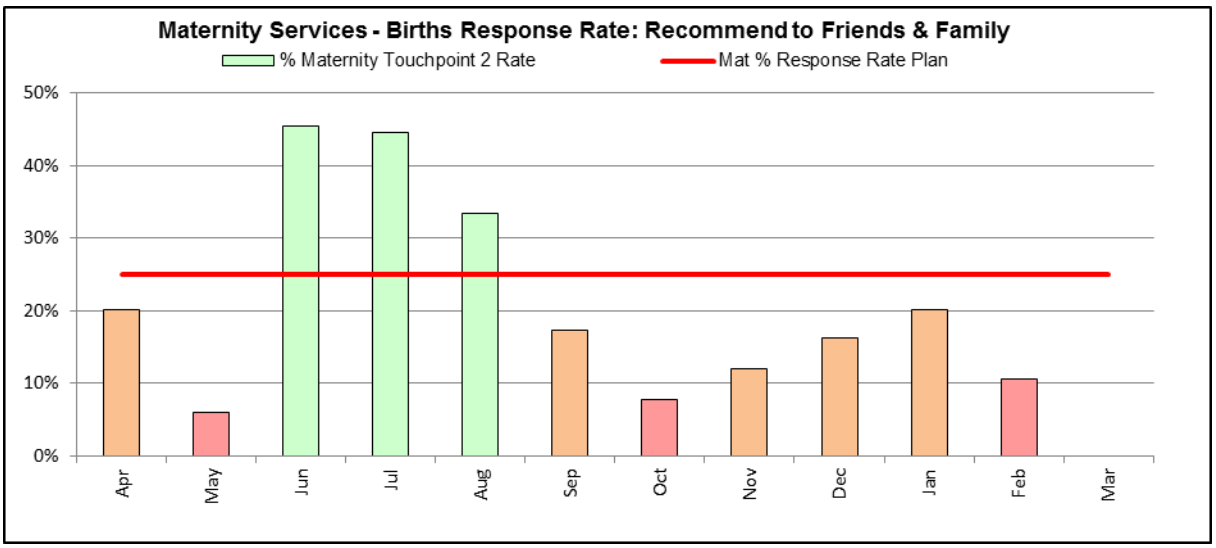
Part-way through 2019 the Trust changed service provider for the Friends and Family Test. End of

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.

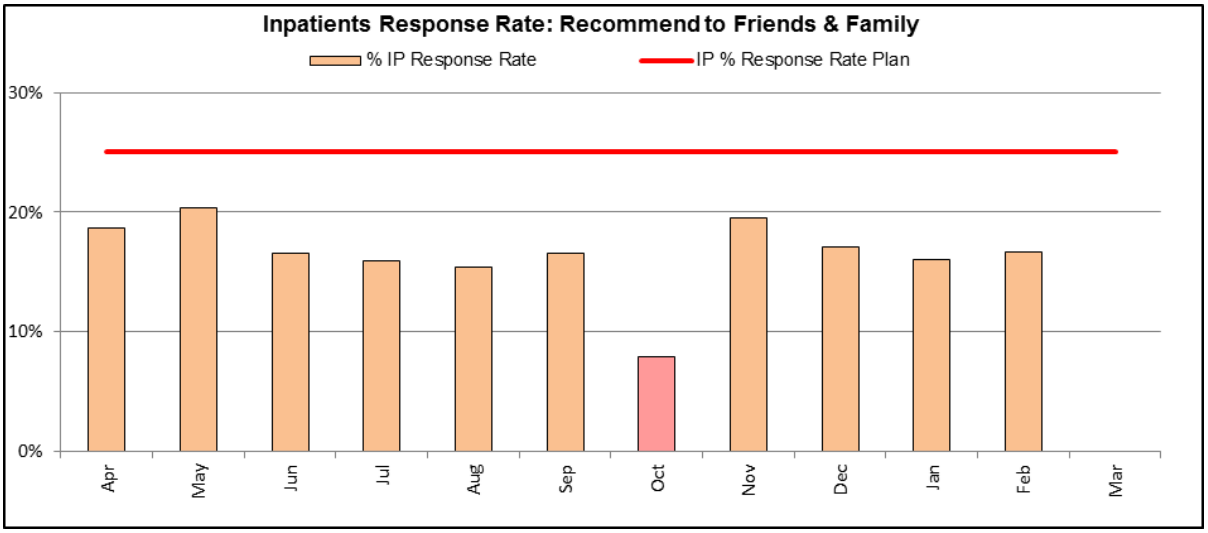
The Trust did not achieve the target of 15% response rate for the Friends and Family Test given to patients in the Emergency Departments with a result of 8.5%. Of the responses received 87.7% were positive. Data was not collected for March 2020 due to the COVID-19 pandemic.



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.

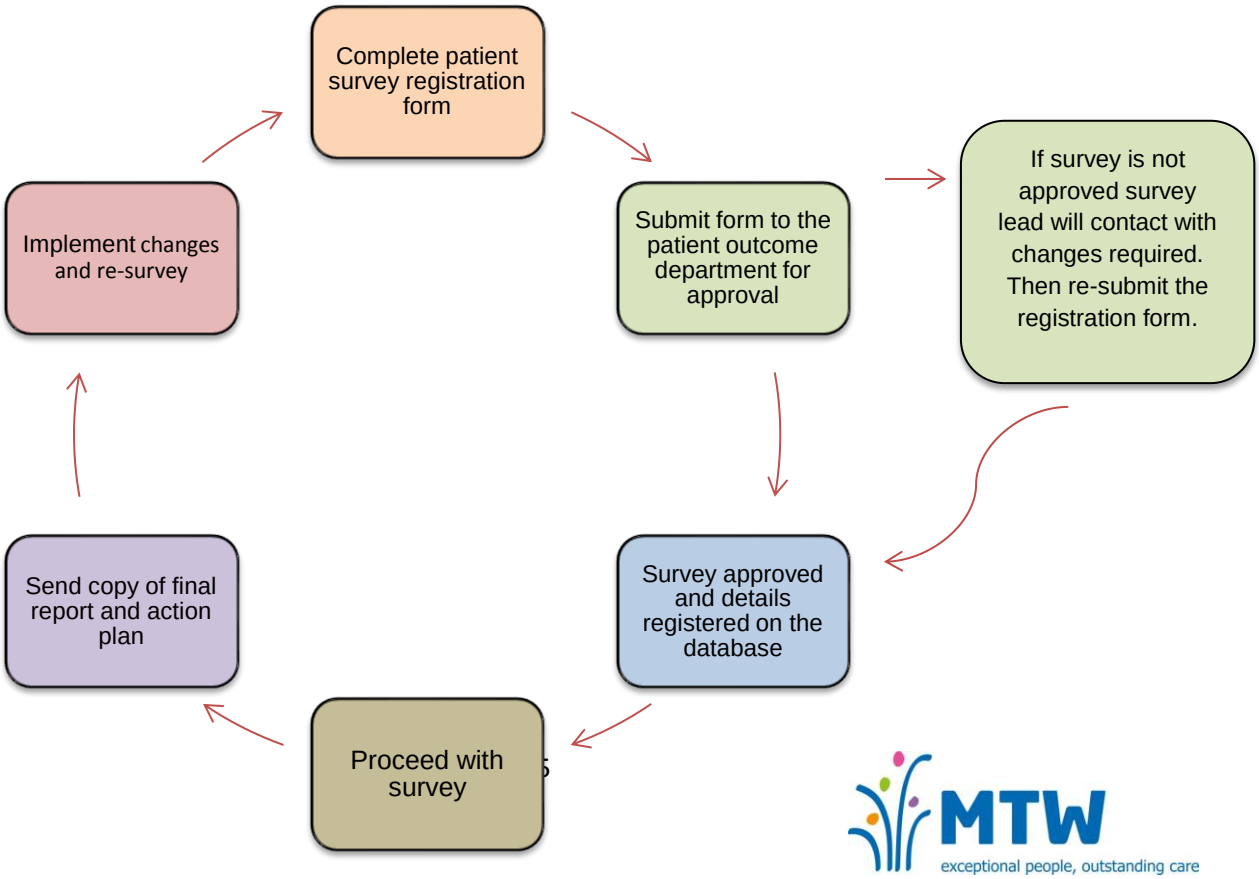


Local Patient Surveys

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



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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.

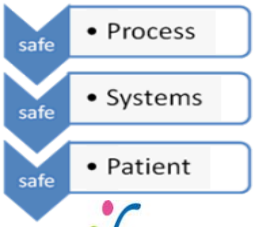
The staff member spoke to the parents informing them that a raised blood marker indicated a need for a Lumbar Puncture to be undertaken. Verbal consent only was taken and noted in the case notes.

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

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).

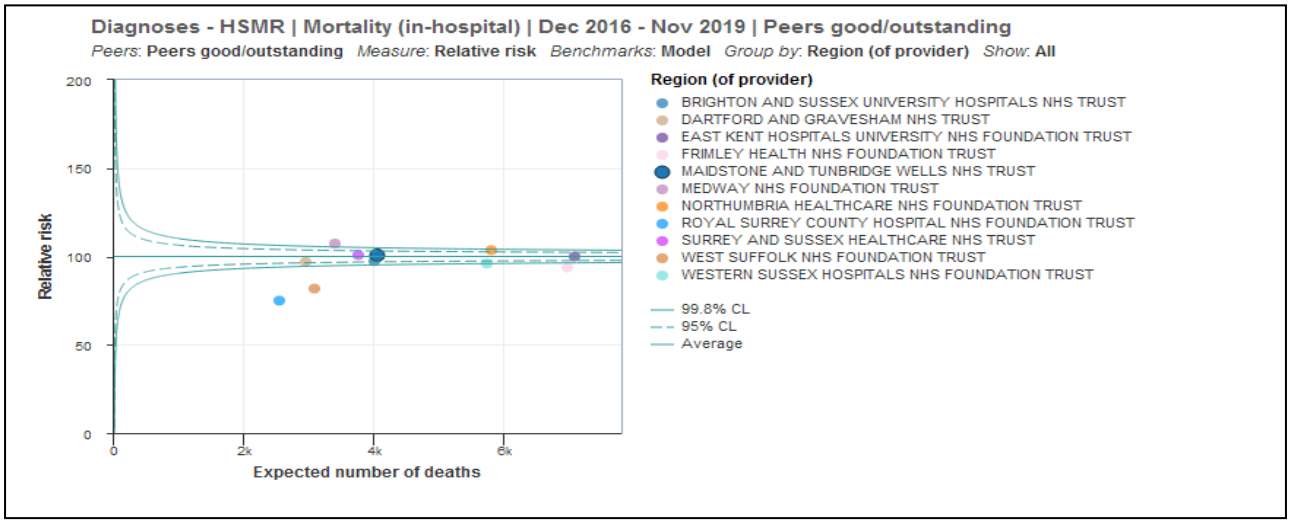
Service	Std 2	Std 5	Std 6	Std 8	Comment/Actions in progress
Surgery	✓	✓	✓	✓	The directorate continues to work on a plan to be

	(w/day) X (w/end)				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.



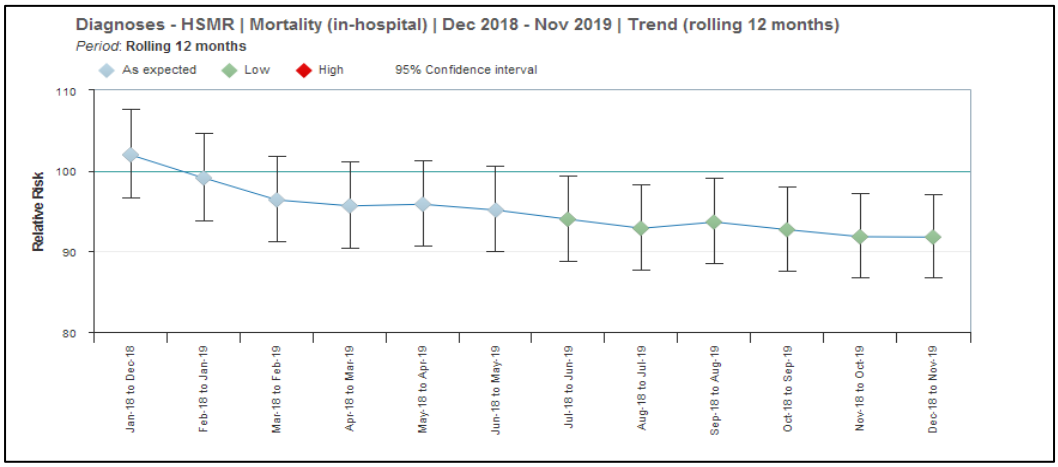
The Trust Mortality Surveillance Group (MSG) has been operational since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning. This group reports directly to both the Quality Committee and the Trust Board. The chair of this Group is the Chief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

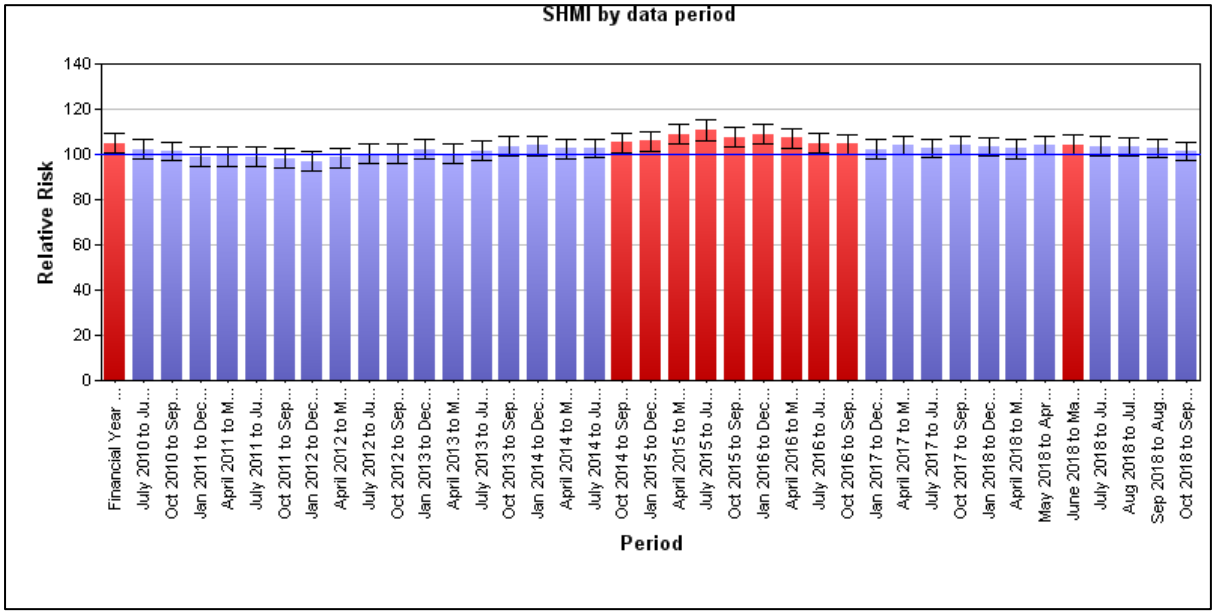
Data from December 2018 – November 2019 (rolling 12-month view)



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

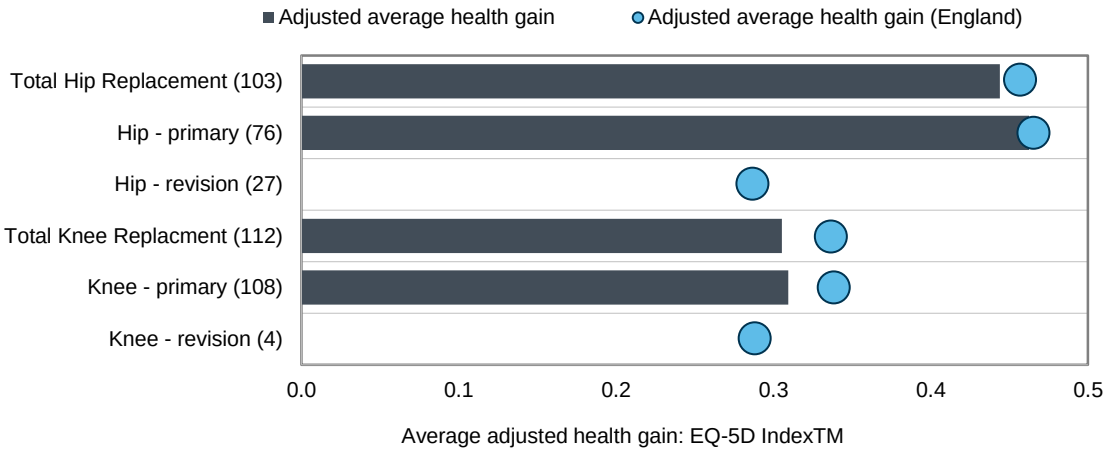


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

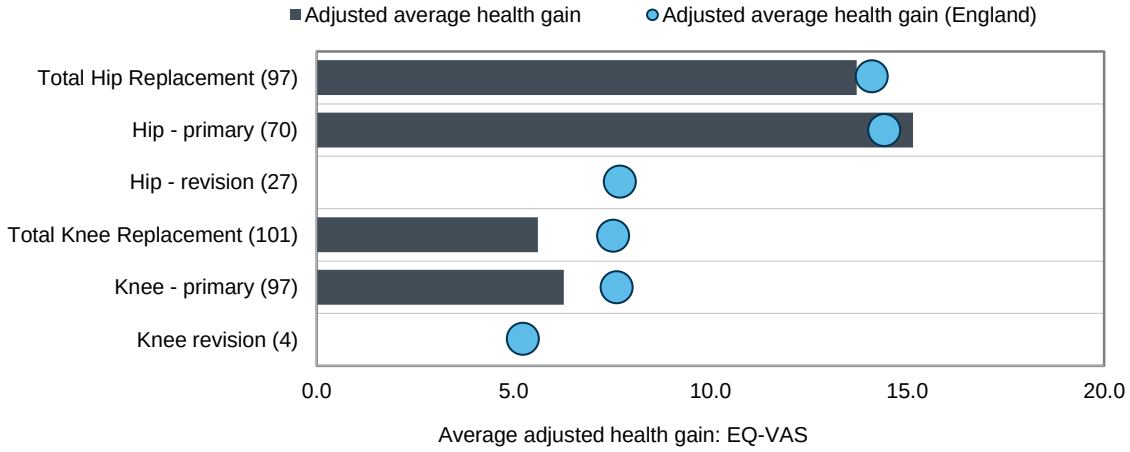
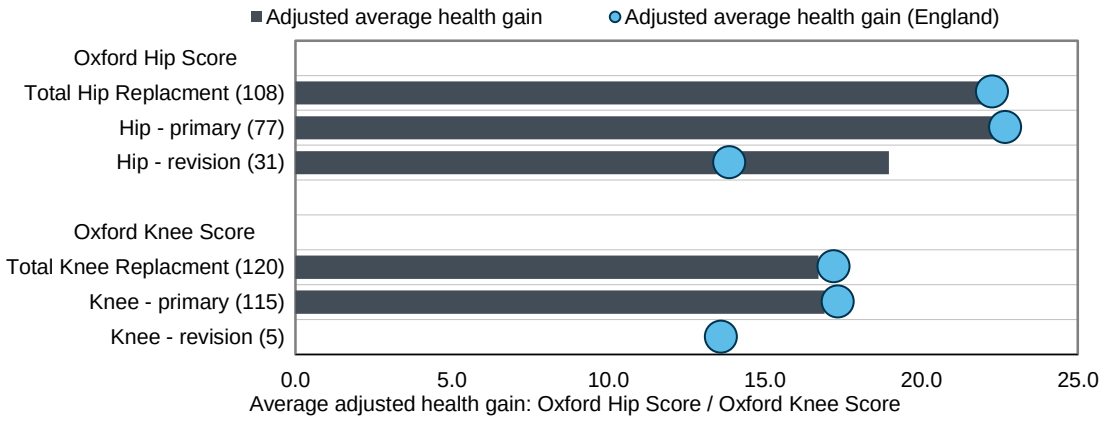
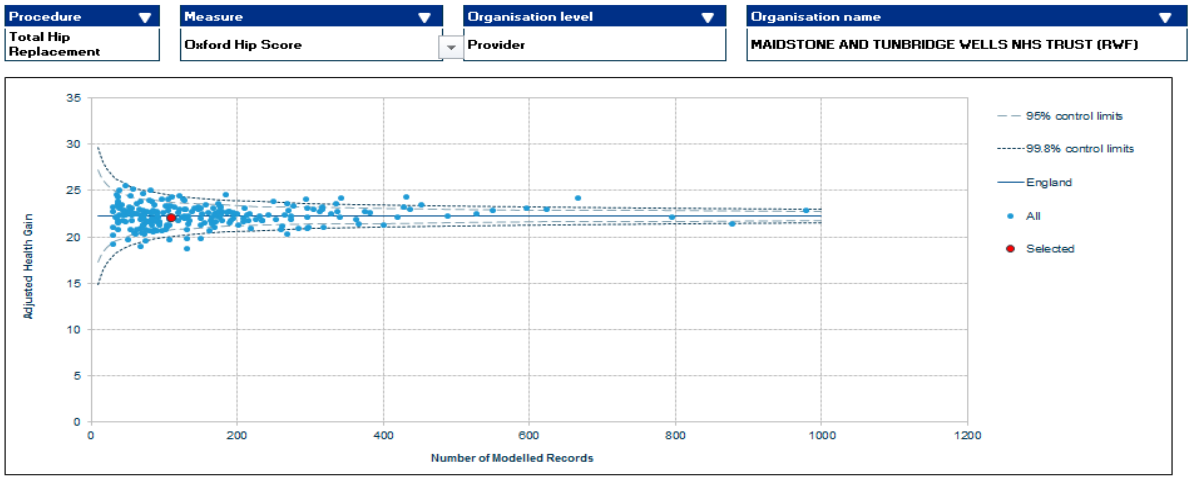


Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

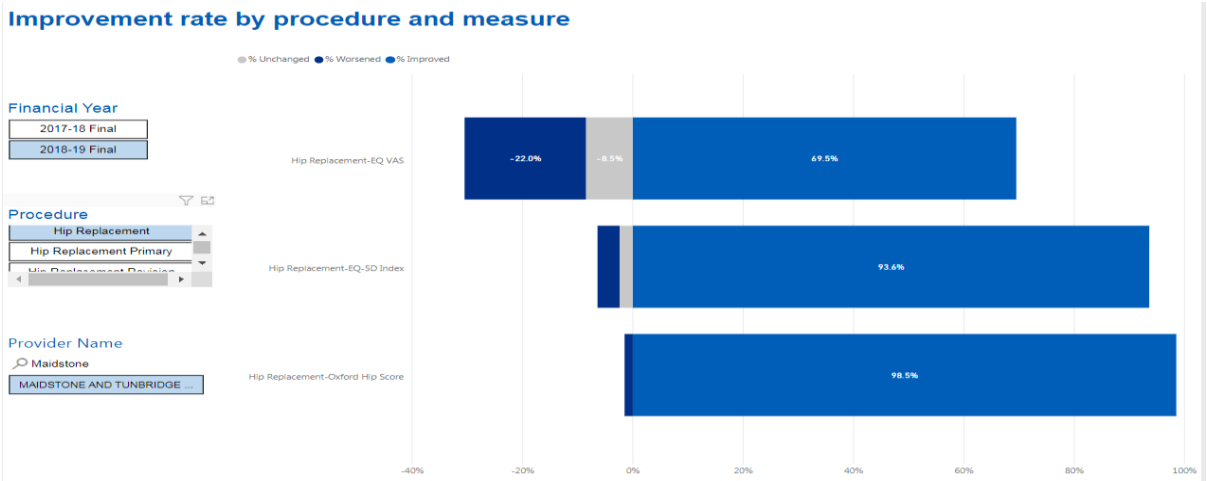


As can be seen the Trust scored below the national average for all three measures for Total Hip and Knee replacements; although most patients reported an improvement following surgery.

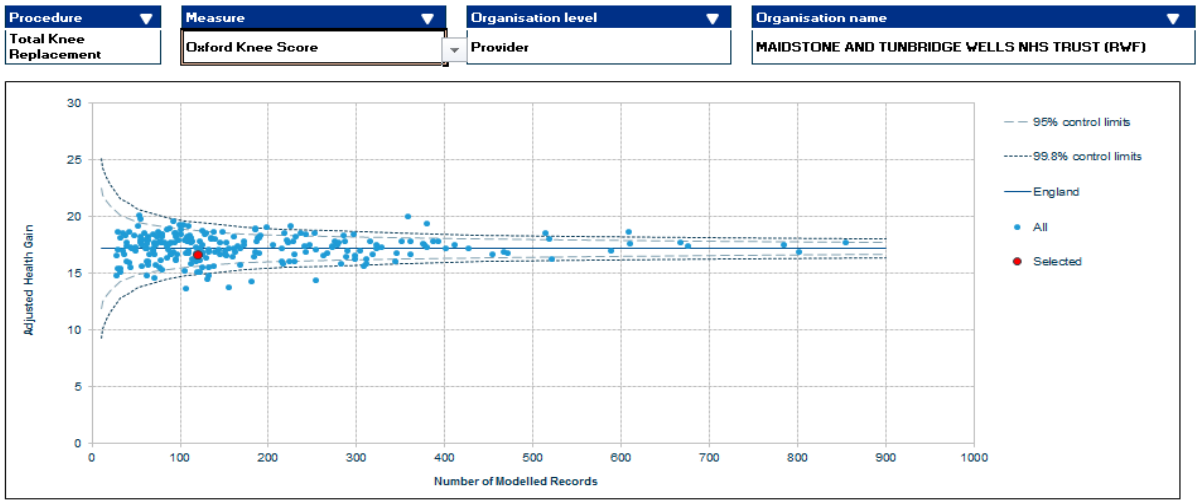
Total Hip Replacement – 108 returns of which 106 reported an improvement in health following the procedure (using the Oxford Hip Score PROMS Measure).



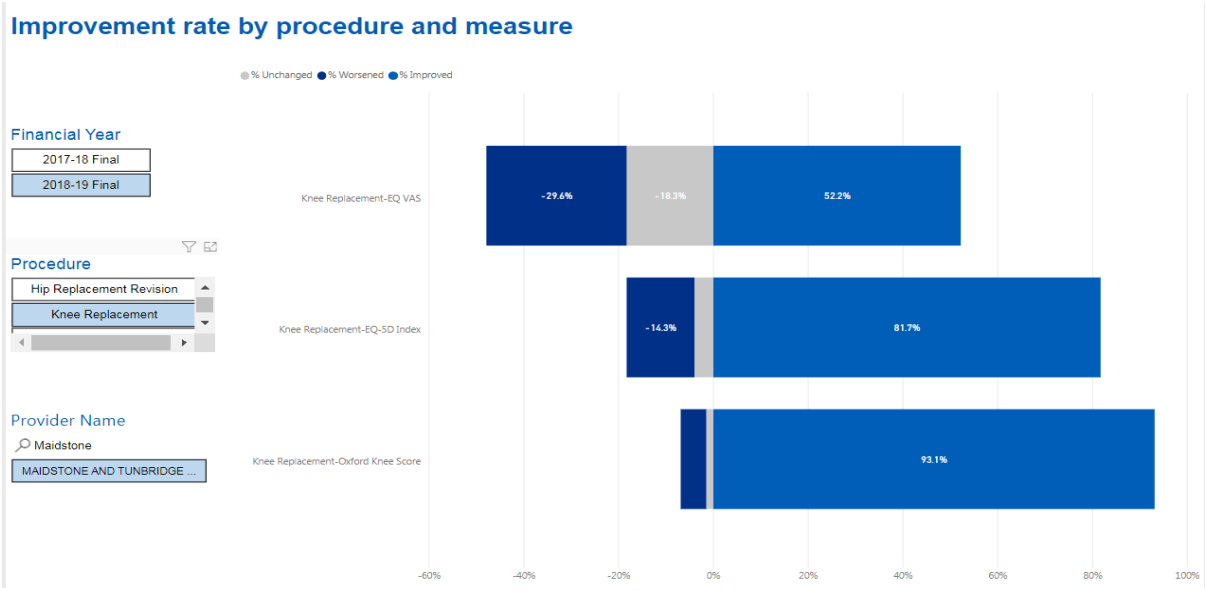
The Improvement Rate for all measures relating to Hip Replacements is shown below.



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.

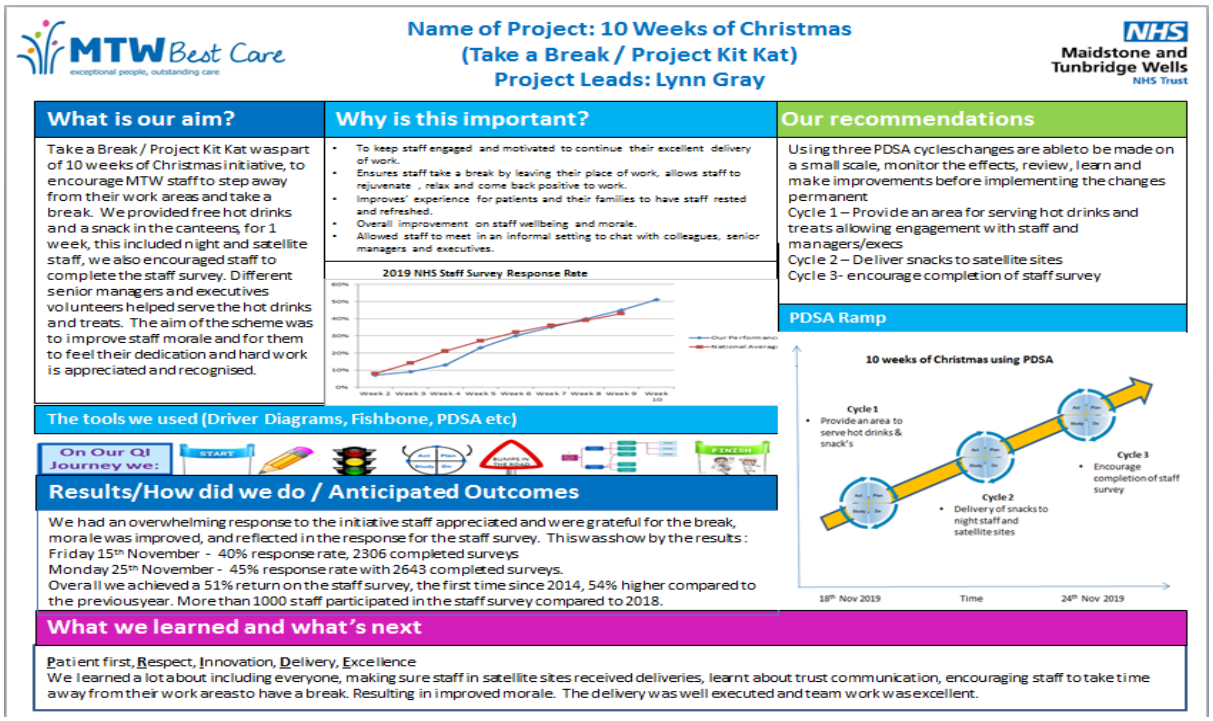
This is just part of the ongoing work within the Trust to improve the care of our patients with dementia.

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

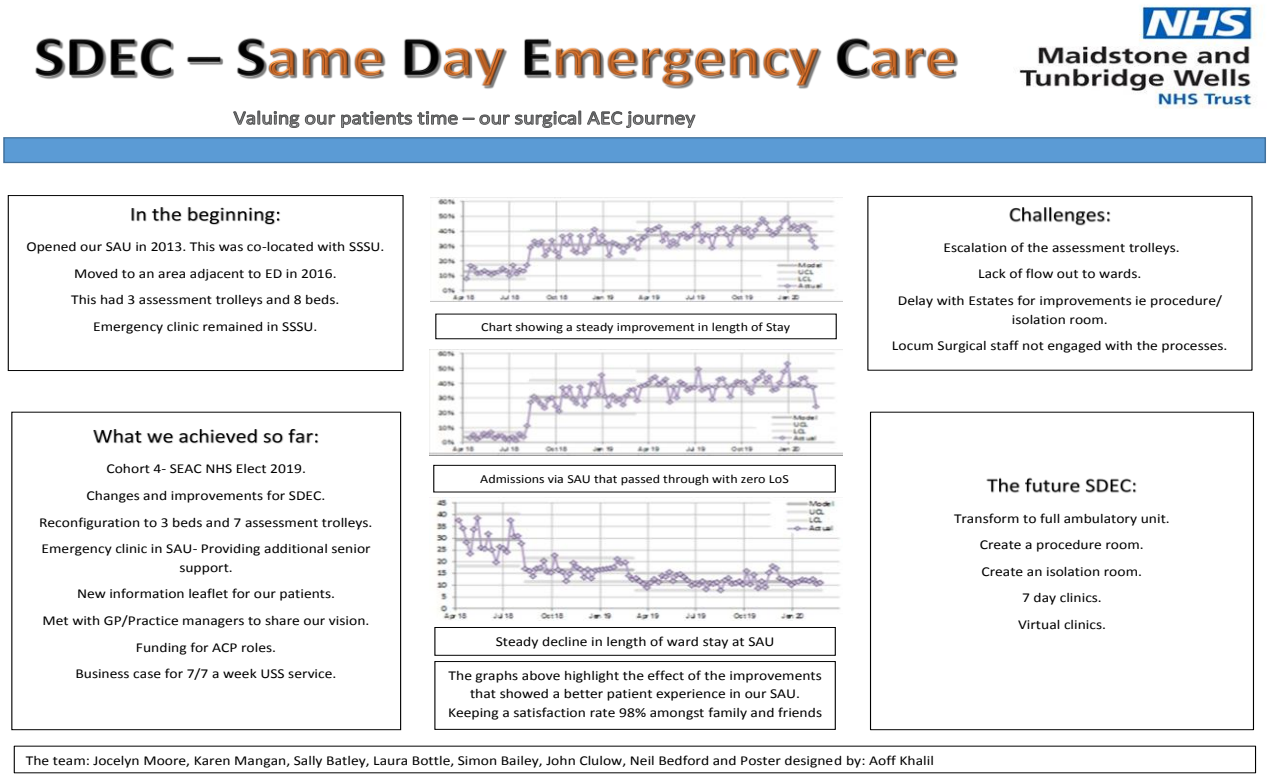
Surgical Services - My Pre-op

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



MTW exceptional people, outstanding care

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

NHS West Kent Clinical Commissioning Group

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

MTW
exceptional people, outstanding care

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