MTW
Exceptional people, outstanding care

NHS
Maidstone and Tunbridge Wells
NHS Trust

Quality accounts

2020-2021

Part **one**

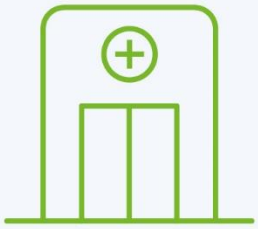
Our year on a page

108

different nationalities are represented in our diverse staff

520,000

outpatient attendances – **40%+ delivered virtually**



10

Our emergency departments are consistently in the **top 10 performing Trusts**

18,314

operations carried out

5547

babies born

165,290

lab processed PCR **Covid-19 swabs**

3,580

participants recruited to **76 research projects**

3

All three national **cancer performance targets met**

30,300+

Covid-19 **vaccinations administered**

Contents

Quality Accounts - Introduction

Maidstone and Tunbridge Wells NHS Trust aims to be a caring, sustainable and improvement-driven organisation. These aims encompass the Trust's three core quality objectives to create a safety-focused culture, to 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 we do 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 focus 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 these have been prioritised
- How the Trust Board has reviewed our improvement in the quality of care during the year and what we have prioritised for 2021/22.

'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.

Department of Health. (2008*) High Quality Care for All. NHS Next Stage Review Final Report. Available at:*

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About Us

Maidstone and Tunbridge Wells NHS Trust (MTW) is a large acute hospital Trust in the South East of England. We provide a full range of general hospital services and some aspects of specialist complex care to around 590,000 people living in the south of West Kent and the north of East Sussex. The Tunbridge Wells Hospital is a Private Finance Initiative (PFI) hospital and provides a large number of single-bedded en suite accommodation. We provide specialist cancer services to around 1.8 million people across Kent and East Sussex via the Kent Oncology Centre, which is sited at Maidstone Hospital. We also provide outpatient clinics across a wide range of locations in Kent and East Sussex. We have a team of nearly 6,000 full and part-time staff.

The Tunbridge Wells Hospital at Pembury is the first NHS hospital in England to provide en suite, single rooms for all inpatients; most of which have woodland views. The hospital provides a range of complex and routine surgical and medical services. It has a Trauma Centre, an Emergency Department, Orthopaedic Centre and Women and Children's Centre; all of which provide care for patients from across Maidstone and Tunbridge Wells. The hospital is seen, nationally, as an example of best practice in the design of patient-safe facilities and has attracted widespread international interest.

Maidstone Hospital provides a wide range of complex and routine surgical and medical services. It also has the latest in diagnostic facilities. Maidstone Hospital is the base for the Kent Oncology Centre, which provides complex radiotherapy and chemotherapy for patients throughout Kent and North East Sussex.

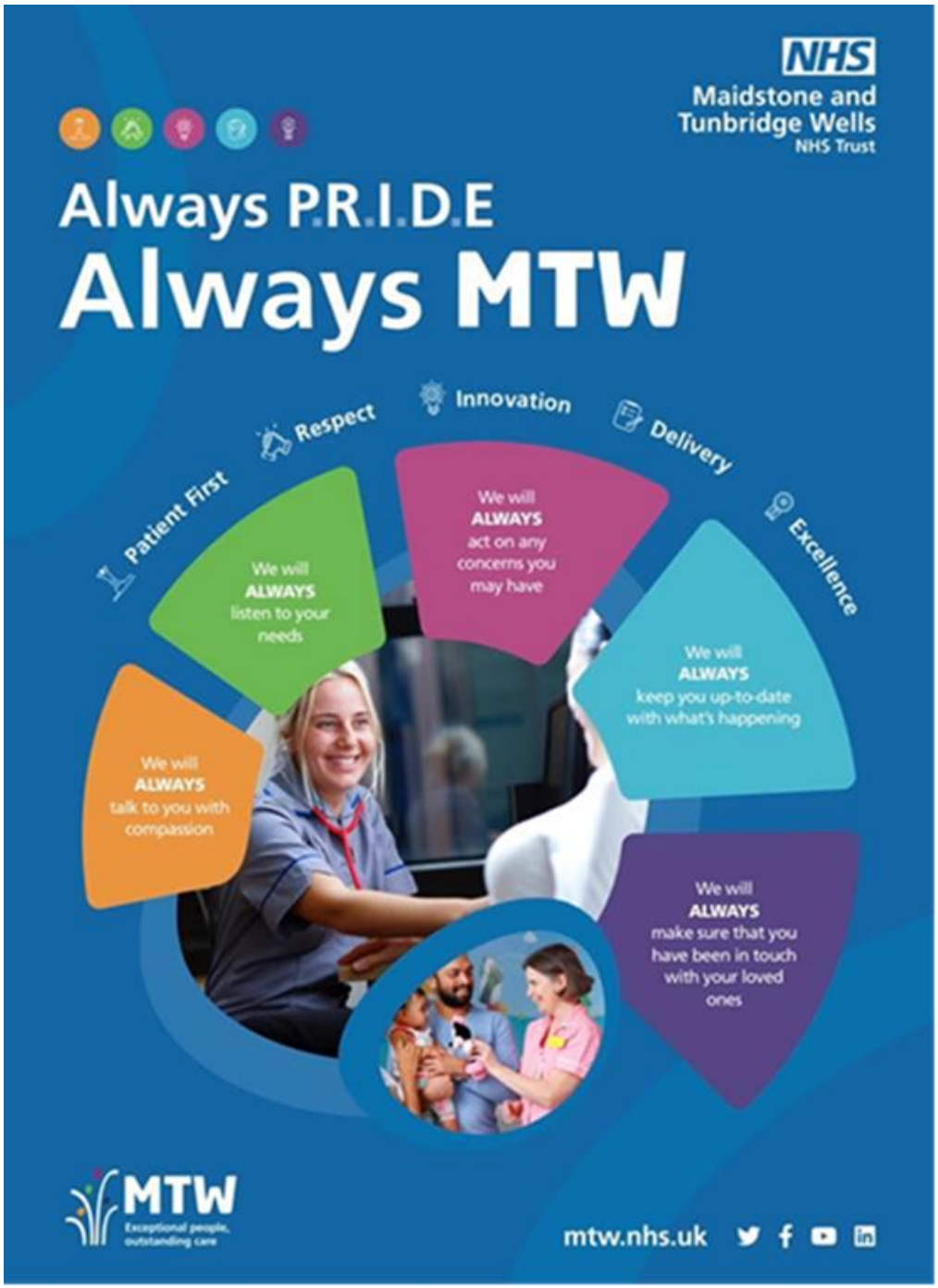
MTW
exceptional people, outstanding care

Our Mission, Vision and Objectives

The Trust's mission is:
To be there for our patients and their families in their time of need and to empower our staff so that they can feel proud and fulfilled in delivering the best care for our community.

The vision of the Trust is:
Outstanding hospital services delivered by exceptional people – 'Exceptional People, Outstanding Care'.

The objectives of the Trust are:
• To be recognised as a caring organisation
• To provide sustainable services
• To be improvement-driven across all areas



MTW exceptional people, outstanding care

Working with Others

Maidstone and Tunbridge Wells is part of the Kent-wide Integrated Care System (ICS). The ICS brings health and social care together across Kent, so that we are providing the best possible care for our population in the most appropriate place. This will mean working more closely than ever with our colleagues from the county, district and borough councils to ensure that we are working holistically across Kent.

There are four Integrated Care Partnerships (ICPs) in the Kent-wide ICS; MTW is within the West Kent ICP. We are working towards a model of integrated care based on population health needs and holistic, individual personal care. This model will cover both planned and unplanned care for physical and mental illness via integrated pathways across primary, secondary and social care. The emphasis will be on prevention and care in the community.

Chief Executive's Statement

On behalf of the Trust Board and staff working at Maidstone and Tunbridge Wells NHS Trust welcome to our Quality Accounts for 2020/21.

The Quality Accounts give us an opportunity to reflect on our achievements, share our performance and learning, and look forward to the next year.

MTW is a family of exceptional people providing outstanding care and I hope that as you read this account it is clear that our patients are at the heart of everything our staff do.

Their dedication has led to some significant achievements but the Covid-19 pandemic has had a major impact on our services, led to different and innovative ways of working and changes to patient pathways. This has also meant we were unable to deliver all our quality priorities for 2020-21 and a number of these are included in our priorities for 2021-22.

Quality improvement continues to drive our work and despite all the challenges of the last year there were a number of key achievements. The Trust tripled intensive care capacity, has continued to deliver the 62 days cancer access standard and is consistently one of the top performing Trusts in the country for Emergency Department performance.

Our ambitious reset and recovery programme continues at pace and significant progress has been made on reducing the number of our patients who have been waiting for treatment , increasing theatre and outpatient activity, and maximising new technology to support patient and staff safety and improve flow around our hospitals.

Staff welfare has been a priority over the last 12 months and the annual staff survey, carried out in the middle of the pandemic, showed increased staff engagement rates. The successful 'One Team Runners' and 'Tele-tracking' schemes were introduced and additional support for staff was provided by a host of initiatives, the 'Wobble Rooms' and Project Wingman being two examples of these.

Over the next year we are implementing an ambitious Exceptional Leaders training programme and rolling out Strategy Deployment and Divisional Objective Setting. This will enable our staff to build and own the goals of the organisation, making quality improvement everyone's business, with the continual aim of delivering outstanding care to our patients.

We continue to work within our Integrated Care System (ICS) on the formation of a system quality group to engage and share intelligence on quality across the ICS and developing an agreed way to measure quality, using key quality indicators.

As we continue to safely restore our services and care for our patients and staff, our goal is to take MTW to Outstanding. We know we have more work to do but with the hard work and dedication of our teams I am confident we will achieve this.

We welcome your feedback and will use it to shape our quality improvements over the next year. So please do share your thoughts and tell us how we are doing and what we can do better.

Thank you for taking the time to read our Quality Accounts. If you have any comments or suggestions you can contact us in the following ways:

Follow us on
Twitter: www.twitter.com/mtwnhs
Instagram:
LinkedIn
Facebook: www.facebook.com/mymtwhealthcare

Miles Scott
Chief Executive

Part **two**

Quality Improvement Priorities for 2021/22

This section of the report will outline the quality improvement priorities we have identified for 2021/22 to further develop the quality of our services.

	SUMMARY		
	PATIENT SAFETY	**PATIENT EXPERIENCE**	**CLINICAL EFFECTIVENESS**
AIM	**To sustain and further enhance robust processes to provide 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.**
2021/22 Quality Priorities	Embedding a safety culture within the Trust through ongoing implementation of the National Patient Safety Strategy. Continue to develop a downward trend in avoidable healthcare associated infections. Increased focus on reducing the number of hospital-acquired deep tissue injuries (DTI) and Category 2 pressure ulcers. Focus on reducing the number of inpatient falls resulting in harm. Improve the outcomes of our expectant parents and their babies. Improve the recognition and escalation of the deteriorating patient with specific focus on NEWS2, sepsis and diabetes.	Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'. The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process. 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. Embedding safeguarding practices in all aspects of clinical care. Implementation of the Dementia Strategy 2021-2024. Implementation of the Delirium agenda. Improving communications with community pharmacies to improve access to medicines for patients. Improve the experience of our expectant parents and their babies.	Improving the flow of patients into and out of our wards and departments.

**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. Our patients need to feel at ease to tell us about their experiences and if the care they receive falls short of their expectations. MTW staff need to feel empowered to raise concerns and report incidents. By providing our colleagues and patients with a compassionate and inclusive patient safety service we can encourage open and honest reporting.

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of health care. We 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 sustain and further enhance robust processes to provide a supportive environment that recognises and reduces avoidable harm.

Areas for focus and improvement during 2021/22 **Key objectives will include: -**	
1) Embedding a safety culture within the Trust through ongoing implementation of the National Patient Safety Strategy.	
a) Further improve the quality and timeliness of incident investigations to support the learning lessons agenda.	Increase in achievement of 60-day key performance indicator (KPI) in 2021/22 based on 2020/21 compliance figures
	Decrease in numbers of incidents breaching 45-day closure timeline, based on 2020/21 numbers
b) Development of performance dashboards and reports that provide meaningful data to support departments and divisions.	Every ward to have a performance dashboard in place on Datix (the Trust's incident reporting system)
	Development of actions module (to monitor compliance with open actions from investigations) on Datix to drive performance and timely learning
c) Supporting all staff to share their patient safety experiences and to encourage their development of skills and practices to support patient safety.	Develop virtual root cause analysis (RCA) training
	Design a qualitative process to evaluate staff experience of incident reporting and being involved in the Serious Incident process

2) Continue to develop a downward trend in avoidable healthcare associated infections, in particular.	
a) To continue excellent practice in infection prevention and control (IPC) measures during the remobilisation of services as we move out of the COVID-19 pandemic.	Flexible and responsive systems in place for infection prevention and control of COVID-19 in line with national guidance
	Performance against the national IPC board assurance framework is reviewed with evidence made available to the Trust Board
	Compliance of self-assessment with the Code of Practice of the Health and Social Care Act 2015 (the Hygiene Code) to be monitored through the Infection Prevention and Control Committee with periodic reports to Trust Board
b) Gram negative bloodstream infections.	To achieve a year on year reduction of gram negative bacteraemia (whilst acknowledging national 5 year target of 50% reduction across the healthcare system by 2024/25)
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 2020/21 numbers.	
4) Focus on reducing the number of inpatient falls resulting in harm.	
5% reduction in number of falls resulting in harm (moderate, serious and death) compared with 2020/21 figures.	
5) Improve the outcomes of our expectant parents and their babies through:	
a) Delivery of the ten key elements of the maternity transformation plan, with specific focus on the Continuity of Carer's directive.	Continue to implement and embed the maternity transformation plan.
b) Aim to make measurable improvements in safety outcomes for women, their new-borns and families in maternity and neonatal services, as set out in Better Births, the Ockenden report and the Transforming Perinatal Safety publication.	Aim to reduce the rate of stillbirths, maternal and neonatal deaths and neonatal brain injuries occurring during or soon after birth by 50% by 2025 through benchmarking against Saving Lives Care Bundle v2, ATAIN and Maternal and Neonatal Safety Collaborative (MatNeo).
	To achieve the 'halve it' ambition we need to improve care for the populations more at risk of poor outcomes and safety champions can help drive this.
	Effective use of Perinatal Mortality Review Tool (PMRT) process in all eligible cases.
6) Improve the recognition and escalation of the deteriorating patient with specific focus on:	
a) The correct use of NEWS2 and escalation algorithm.	To achieve 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+ having a NEWS 2 score, time of escalation and time of clinical response recorded. 90% of data recorded meeting Trust policy for escalation and clinical response timeframes.

b) 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
c) Diabetes.	Undertake an audit of Blood Glucose Monitoring and Hypoglycaemia guideline to assess use of blood glucose monitoring form and algorithm
	Complete the 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
	Continue quarterly audits of prescription charts focusing on insulin prescribing and administration with identification of learning and action plans

Executive Lead: Claire O'Brien, Chief Nurse
Board Sponsor: Claire O'Brien, Chief Nurse
Implementation Lead: Aoife Cavanagh, Deputy Director Quality Governance
Monitoring: Quality 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 2021/22.

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 2021/22 **Key objectives will include: -**
1) **Implementation of the Patient Engagement and Experience Strategy 'Making it Personal'**
a) Make the Patient Experience Lead role a substantive post to lead on the strategy.
b) Review the Patient Engagement and Experience Strategy in light of learning from the pandemic and amend if indicated.
c) Monitor implementation and delivery of the strategy quarterly at the Patient Experience Committee (PEC).

d) Design a qualitative process to evaluate patients' and families' experience of our Serious Incident Process.	
e) Re-design and re-launch the complaints satisfaction survey to enable improved understanding of the experience of making a complaint and assess effectiveness in meeting the needs of complainants.	
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 the 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) Implementation of the AMBER Care Bundle across adult wards to improve communication (among clinicians, patients and their families) where recovery is uncertain and facilitate advance care planning and increased use of the treatment escalation plan (TEP), (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 2020/21 figures.	
c) Develop Duty of Candour dashboard on Datix.	
4) **Embedding safeguarding practices in all aspects of clinical care**	
a) Embed use of the tool developed last year to enable practitioners to ensure that mental capacity assessments are documented appropriately.	Audit use of the tool at a minimum annually
	Report uptake of redesigned MCA level 2 and 3 training to the Safeguarding Committee on a quarterly basis
b) Demonstrate the involvement of the patient and their representatives in decision making in relation to safeguarding.	Annual re-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
	Audit results, learning and action plans 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
	Audit results, learning and action plans to be presented at the Safeguarding Committee

5) **Implementation of the Dementia Strategy 2021-2024**	
a) Monitor ward moves for people with dementia to ensure appropriate admission to the most appropriate bed first time where possible.	Monitor via dashboard and results to be reviewed at Dementia Strategy Group and actions identified
b) Develop Patient Partners for people with dementia in collaboration with the Patient Experience Lead, to enable the ability to receive feedback directly from people with dementia.	Patient Partners for people with dementia to be developed and feedback reviewed
c) Develop a proposal / business case for a multi-disciplinary peripatetic team to provide an activity programme for people with dementia.	Proposal / business case to be developed in collaboration with multi-disciplinary team
6) **Implementation of the Delirium agenda**	
a) Recruit a Delirium Nurse Facilitator for 1-year pilot.	Monitor business case KPIs once post holder recruited and report to Dementia Strategy Group
7) **Improving communication with community pharmacies to improve access to medicines for patients.**	
a) Introduce remote dispensing of outpatient prescriptions.	
8) **Improve the experience of our expectant parents and their babies**	
a) The Patient Experience Midwife and Maternity Voices Partnership (MVP) working together to co-produce local maternity services.	
b) Employing the use of patient advocates where appropriate.	

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 2021/22.

Aim/goal

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

Areas for focus and improvement during 2021/22 **Key objectives will include: -**	
1) Improving the flow of patients into and out of our wards and departments by: -	
a) Increasing the effectiveness of ambulance handovers.	Ambulance handover targets Over 60 mins = 0 Over 30 mins = 3% Over 15 mins = 25% by end Sept (phased approach to decrease by 5% each month from 45% in May)
b) Early assessment of patients attending the Emergency Department	(*To be determined as local targets for the national ED standards have not yet been set*)
c) Improving the timeliness of discharge of patients from Intensive Care (ICU).	Improve performance with regard to ward-based discharge (within 4 hours), based on 2020/21 numbers
	Decrease number of night-time discharges from the Intensive Care Unit (10pm-7am), based on 2020/21 numbers
d) Ensuring all necessary support is in place to allow patients to leave hospital when it is planned for them to do so.	Improved communication with patients and families, measured by a reduction in complaints and PALS contacts
	Improve processes for discharge medications by the use of computers on wheels (COWs) and Omnicell (automated pharmacy management system) to expedite ward based dispensing
e) Increasing the number of video clinics (currently using the Attend Anywhere platform).	10% of all outpatient activity to be carried out as video appointments
f) Ensure there is sufficient MRI capacity to cater for rapid diagnostics for our emergency, cancer and elective patients.	Develop and progress a fully managed MRI Service in line with the broader Trust needs linking in with external partners Ensuring high quality service provision and reporting in a timely manner

g) Work to consolidate a high quality, timely and effective therapies service supporting both inpatient and outpatient activity.	Review and consider the changing needs of the Trust patient-base and expectations in terms of delivery of service Ensure all patients are seen within required timeframe and receive high quality and consistent support
2) Working towards the development of site-specific centres of excellence for Digestive Diseases and Stroke; concentrating on new and improved ways of working, which will support best practice and the opportunities for new roles.	
a) Work to review the best practice diagnostic pathway for colorectal cancer patients in line with broader directional change.	Work with surgery and cancer teams to ensure robust diagnostic radiological pathway for cancer pathway patients in line with national changes to avoid unnecessary delays
b) Development of a Digestives Diseases Unit on the TWH site.	
c) Development of stroke services in preparation for the Hyper-Acute Stroke Unit (HASU) focusing specifically on the provision of stroke rehabilitation.	

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

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 regularly throughout 2021/22 at Quality Committee and Trust Management Executive (TME).

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 2020/21.

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

During 2020/21 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 services to the Independent Sector Providers as part of the Prime Provider Model for elective care and in response to the COVID-19 pandemic for emergency admissions. 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 for quality purposes in 2020/21 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 usually supports a number of external reviews of its services. The COVID-19 pandemic has changed the way in which certain external visits are undertaken, with an increase in those carried out remotely or virtually. The following reviews took place in 2020-21:

- 2019/20 Annual Finance External Audit; Grant Thornton – completed May 2020
- Virtual engagement event with the CQC – 10th June 2020
- General Medical Council – Trainee and Trainer Survey – July 2020

- Counter Terrorism Security Advisers inspection on management of radiation safety - September 2020
- Environment Agency inspection on management of radiation safety – September 2020
- United Kingdom Accreditation Service (UKAS) accreditation (Clinical Pathology accreditation (CPA/ ISO 17043) – SE England General Histopathology EQA scheme – remote visit September 2020
- Virtual engagement event with the CQC – 9th September 2020
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Histology and cytology – remote visit November 2020
- Virtual engagement event with the CQC – 2nd November 2020
- Virtual engagement event with the CQC – 21st December 2020
- HM Revenue and Customs – VAT compliance review of contracted out services – concluded January 2021
- Caspe Healthcare Knowledge Systems (CHKS) (ISO 9001, CQC, Peer Review, TSR and Francis Rec.) Radiotherapy, Medical Physics (including E.M.E. Services), Chemotherapy, Clinical Trials, Oncology Outpatients, Clinical Haematology, admin and clerical – February 2021
- Environmental Health, Maidstone Hospital kitchen – February 2021 (the review of the Tunbridge Wells Hospital kitchen is due in August 2021)
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) – Microbiology – a visit was due in November 2020 but has been postponed to May 2021
- UKAS accreditation (Clinical Pathology accreditation (CPA/ ISO 15189) - Blood Sciences – a visit was due in January 2021 but has been postponed to July 2021

In addition our internal auditors, TIAA, undertook a range of audits to review the internal control environment at the Trust. TIAA undertook 14 assurance reviews, 10 of which provided reasonable assurance and 4 provided limited assurance. There were no reviews with substantial assurance or no assurance. TIAA made 88 recommendations following the reviews – 11 urgent, 39 important and 38 routine.

Internally we have a range of reviews to assess the quality of service provision within MTW. However, the impact of the COVID-19 pandemic meant these reviews had to either be suspended or adapted:

- 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 – these inspections were suspended due to the pandemic and the need to reduce footfall in our clinical areas.
- Internal PLACE (Patient-Led Assessments of the Care Environment) reviews – these reviews were also suspended due to the pandemic and the need to reduce footfalls in our clinical areas.

- Infection control reviews, including hand hygiene audits – these reviews were partially undertaken. The Infection Prevention and Control team also undertook regular observations of practice in clinical areas and provided support to clinical teams in terms of feedback and advice.
- Trust Board member "walkabouts" – these were suspended due to the pandemic and the need to reduce footfall in clinical areas.
- Matron's Quality Checks – these continued where possible but were briefly stood down in the critical phase of the second COVID-19 wave.

Usually 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.

During 2020/21 the results of the Matron Quality Checks and other intelligence from sources such as management teams, PALS and patient safety incidents were used to identify any areas where additional support and actions were required in clinical areas during the pandemic. A 'Heat Map' was also developed during the year to assist in identifying areas requiring support or intervention in the absence of the other reviews and inspections. The 'Heat Map' displays in one spreadsheet data from a range of sources for all inpatient clinical areas. The data is grouped under four themes – patient safety, infection control, patient experience and staff management. Some but not all of the elements of the 'Heat Map' are colour coded (RAG – red, amber, green) and the colours have scores, which lead to an overall score for each clinical area.

Clinical areas were visited throughout the pandemic by members of the Corporate Nursing and Quality Governance teams to provide support, listen to staff and patients and to identify where any further actions were indicated.

Clinical Audit

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

COVID-19 has had a major impact on the Trust's 2020/21 Clinical Audit Programme. Whilst participation in data submission to National Audits has not been mandated during 2020/21, local clinical audits have also been scaled down to allow our clinical colleagues to focus on front line clinical care.

In spite of COVID-19, MTW still participated in **100%** of relevant confidential enquiries and **82%** (45/55) of all relevant national clinical audits in 2020/21 (data for 2 audits was not submitted due to software issues; data for another audit was not submitted following a Directorate decision; data for 7 audits was not submitted due to COVID-19). During the same period, MTW staff successfully completed **114** clinical audits of the **144** due to be completed (local and national) to action plan stage of the **334** audits on the programme to be undertaken during the year. The

remaining audits are at various stages of completeness and will be monitored through to completion.

In response to COVID-19, Clinical Audit registered and supported 12 clinical audits that addressed both COVID-19 care pathways as well as the impact of COVID-19 on the standard of care of patients with other conditions. These were a mixture of local, national and international studies.

We also registered and supported 23 COVID-19 service evaluations that looked at a wide range of topics connected to COVID-19. Although local studies dominated, the Trust also participated in several national and international service evaluations.

Many of these national and international studies are now publishing their findings and some local study reports have also been received. Taking part in these important studies on COVID-19 will help the Trust to learn from the pandemic and plan for the future.

Some of the national and local clinical audits and COVID-19 studies that Maidstone and Tunbridge Wells NHS Trust worked on during 2020/21 to improve the quality of patient care are outlined below:-

Theatres and Critical Care: National Emergency Laparotomy Audit (NELA)

The Maidstone and Tunbridge Wells NHS Trust Emergency Laparotomy Team continues to deliver excellent care. The team assesses all patients' risk of death and morbidity prior to sending the patient into theatre, with Consultant Surgeon and Consultant Anaesthetist presence and almost all patients go to our Intensive Care Unit postoperatively. Our mortality (9.7%) and length of stay (12 days) figures are in line with our Academic Health Services Network and national results. The NELA Team continues to work on maintaining their high level of compliance with national standards.

Children's Services: The National Paediatric Diabetes Audit (NPDA) report received in March 2020 showed that Tunbridge Wells Hospital was an outlier for the adjusted mean HbA1c. "HbA1c is a marker of overall diabetes blood glucose levels over the preceding six to eight weeks and is associated with lifetime risk of microvascular complications... good diabetes management in childhood tracks into adulthood with a lower risk of developing vascular complications and early mortality in the future" - NPDA core report: Care Processes and Outcomes 2018/19.

A set of robust and comprehensive actions were developed to address the outlier status including:

1. Increasing support for technology-led monitoring such as Libre Flash Glucose monitoring by identifying the patients who would most benefit from the system due to impact of diabetes on quality of life.
2. Building a new amber alert pathway to include clinic appointments every 2 months and individualised plans in the High HbA1c policy.

In March 2021, we were advised that Tunbridge Wells Hospital is no longer an outlier for the adjusted mean HbA1c, which should result in a better outlook for our paediatric patients as they transition to adult services.

Rheumatology: The National Early Inflammatory Arthritis Audit's first national report was published in October 2019 (NEIAA). Maidstone and Tunbridge Wells NHS Trust was identified as a negative outlier for quality statement (2) "People with suspected persistent synovitis are assessed in a rheumatology service within three weeks of referral".

The Rheumatology Team reviewed the service and developed a set of actions to increase clinic capacity to enable patients with early synovitis to be seen on time including:

1. Obtain approval from the General Manager to add extra clinics slots.
2. Ensure extra clinic slots are reserved for early synovitis patients.
3. Add a new weekly synovitis clinic run by a Consultant to the clinic schedule.

In January 2021, the NEIAA published its second report and Maidstone and Tunbridge Wells NHS Trust is no longer identified as an outlier for quality statement (2) meaning that patients presenting with early synovitis are now seen in a timely manner.

Pharmacy: Are new, stopped or changed medications clearly documented on discharge summaries? In 2017, the Pharmacy Team conducted an audit with the aim to assess if new, stopped or changed medications have been documented clearly on discharge summaries generated by Maidstone and Tunbridge Wells NHS Trust to aid in continuity of care post-discharge. The results were disappointing with three of the four standards not being met and the fourth standard being partially met. Two recommendations were made:

1. Include more precise directions around documenting medications on the discharge summary in the MTW Clinical Procedures Policy.
2. Develop a learning initiative such as “learning at lunch” to ensure all staff are informed of the changes to the policy.

In September 2020, the re-audit was completed. Significant improvements were noted for all standards with only one standard remaining as “not met”; two standards are now “partially met” and one standard is now “fully met”. Additional actions have been developed to improve results further including protected time for Pharmacy staff to read the Standard Operating Procedure “Discharge Medication Preparation and Standard Practice” so that individual clinical staff can improve their compliance.

Breast Care Team: B-MaP C study (a national audit) Breast Cancer Management Pathways during the COVID-19 pandemic. Our Breast Care Team submitted data into this important study aiming to determine alterations to breast cancer management during the peak transmission period of the UK COVID-19 pandemic, and the potential impact of these treatment decisions. The study group published their findings in the British Journal of Cancer[1] in March 2021, which concluded that “The majority of ‘COVID-19 altered’ management decisions were largely in line with pre-COVID-19 evidence-based guidelines, implying that breast cancer survival outcomes are unlikely to be negatively impacted by the pandemic. However, in this study, the potential impact of delays to breast cancer presentation or diagnosis remains unknown[1].”

Neurology: A qualitative and quantitative study to explore the impact of COVID-19 on community-dwelling adults with Parkinson’s Disease. This local service evaluation looked at how the COVID-19 pandemic had disproportionally affected and distorted the lives of people living with long term conditions, including Parkinson’s disease (PD). The study explored the impacts of the pandemic and what matters the most to PD patients.

The study observed a trend of deterioration including anxiety, social isolation, fear of contracting COVID-19 and physical deterioration. This had a profound negative impact on our patients’ wellbeing as well as an exponential effect on carer burden. Many PD patients felt that human interactions within medical consultations are very important and were very much missed during

the pandemic. This study again reinforces the benefits of exercise groups on wellbeing and delaying disease progression in Parkinson's disease.

The national clinical audits and national confidential enquiries relevant to Maidstone and Tunbridge Wells NHS Trust are listed in the table below and our participation in these clinical audits during 2020/21 is also presented:

National Clinical Audits for inclusion in Quality Accounts 2020/21	***Participation*** Y or N	***No. of cases submitted***	***% cases submitted***
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	MGH - 270 TWH - 479	100%
Antenatal and newborn national audit protocol 2019 to 2022	Y	2	100%
BAUs Urology Audits: Renal Colic Audit (Snapshot)	Y	27	100%
BAUs Urology Audits: Cytoreductive Radical Nephrectomy Audit	Y	0	100%
BAUs Urology Audits: Female Stress Urinary Incontinence Audit	Y	0	100%
Cardiac Rhythm Management (CRM)	Y	MGH - 248 TWH - 143	100%
Cardiac Rhythm Management (CRM) – Cardiac Electrophysiology	Y	MGH - 31	100%
Elective surgery (National PROMs Programme) Hip Replacement, Knee Replacement	Y		Submission data not yet available
Emergency Laparotomy Audit (NELA)	Y	MGH - 16 TWH - 141	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	MGH - 4 TWH - 11	100%
National Hip Fracture Database (NHFD)	Y	464	88%
Inflammatory Bowel Disease (IBD) Programme /IBD Registry	N		Directorate decision
Mandatory Surveillance of bloodstream infections and Clostridium Difficile infection	Y	149	100%
MBRRACE-UK; Maternal Mortality surveillance and mortality confidential enquiries	Y	0	100%

National Clinical Audits for inclusion in Quality Accounts 2020/21	***Participation*** Y or N	***No. of cases submitted***	***% cases submitted***
MBRRACE-UK; Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiries	Y	0	100%
MBRRACE-UK; Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	Y	Stillbirth: 11 Neonatal: 2 Extended Perinatal: 0	100%
MBRRACE-UK; Perinatal Mortality Surveillance	*Y*	Stillbirth: 11 Neonatal: 2 Extended Perinatal: 0	100%
Myocardial Ischaemia National Audit Project (MINAP)	Y	MGH - 132 TWH - 158	>91%
National Adult Diabetes Inpatient Audit (NaDIA)	N		Data not submitted - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Pulmonary Rehabilitation	Y	MGH - 3 TWH - 14	21.25% Limited data submission - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Secondary Care	Y	MGH - 21 TWH - 47	Limited data submission - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – Adult Asthma Secondary Care	N		Data submission optional - COVID-19
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) – COPD Secondary Care (Paediatric Asthma)	Y	64	100%
National audit of Breast Cancer in Older people (NABCOP)	Y		Submission data not yet available
National audit of Cardiac Rehabilitation (NACR)	Y	MGH - 284 TWH - 437	100%
National Audit of Care at the End of Life 2020 (NACEL)	N		Data submission postponed - COVID-19

National Clinical Audits for inclusion in Quality Accounts 2020/21	***Participation*** Y or N	***No. of cases submitted***	***% cases submitted***
National Audit of Dementia (NAD)	N		Data collection suspended - COVID-19
National audit of Percutaneous Coronary Interventions (PCI) (Coronary angioplasty)	Y	267	100%
National Audit of Seizure and Epilepsies in Children and Young Adults (Epilepsy 12)	Y	99	100%
National Bowel Cancer Audit (NBOCA)	Y	333	100%
National Cardiac Arrest Audit (NCAA)	Y	MGH - 33 TWH - 50	100%
National Comparative Audit of Blood Transfusion Programme - 2020 Audit of the management of perioperative paediatric anaemia	N		Data submission postponed - COVID-19
National Core Diabetes Audit (NDA)	Y	MGH - 627 TWH - 668	100%
National Diabetes Foot Care Audit	Y	MGH - 6 TWH - 8	100%
National Diabetes Inpatient Audit – Harms	Y	MGH - 12 TWH - 4	100%
National Early Inflammatory Arthritis Audit (NEIAA)	N		Data not submitted - COVID-19
National Heart Failure Audit	Y	MGH - 192 TWH - 216	>88%
National Joint Registry (NJR)	Y	MGH - 250 TWH - 211	100%
National Lung Cancer Audit (NLCA)	Y	255	100%
National Maternity and Perinatal Audit (NMPA)	Y	5626	100%
National Oesophago-Gastric Cancer Audit (NOGCA)	Y	88	100%
National Ophthalmology Database Audit	N		Data not submitted - software issues

National Clinical Audits for inclusion in Quality Accounts 2020/21	***Participation*** Y or N	***No. of cases submitted***	***% cases submitted***
National Paediatric Diabetes Audit (NPDA)	Y	TWH - 100 MGH - 143	100%
National Pregnancy in Diabetes Audit	Y	34	100%
National Prostate Cancer Audit (NPCA)	Y	394	100%
NCEPOD: Dysphagia in people with Parkinson's Disease study	Y	7	88%
NCEPOD: Physical Health in Mental Health Hospitals	Y	0	100%
Neonatal Intensive and Special Care (NNAP)	Y	650	100%
Paediatric Inflammatory Bowel Disease	Y	31	100%
Perioperative Quality Improvement Project (PQIP)	N		Patient recruitment optional -COVID-19
RCEM Fractured Neck of Femur (care in emergency departments)	N		Data not submitted - COVID-19
RCEM Infection Control (Care In Emergency Departments)	N		Data not submitted - COVID-19
RCEM Pain in Children (Care in emergency departments)	N		Data not submitted - COVID-19
Sentinel Stroke National Audit Programme (SSNAP)	Y	601	April 2020 – Dec 2020, ongoing data submission
Serious Hazards of Transfusion 2020 (SHOT) UK. National haemovigilance scheme	Y	22	100%
Society for Acute Medicine Benchmarking Audit	N		Data collection postponed - COVID-19
Surgical Site Infection Surveillance	Y	4	Incomplete data submission, to be entered retrospectively
The Trauma Audit and Research Network (TARN)	Y	647	83-100%

National Clinical Audits for inclusion in Quality Accounts 2020/21	*Participation* Y or N	*No. of cases submitted*	*% cases submitted*
UK Registry of Endocrine and Thyroid Surgery (BAETS)	N		No access to the data entry platform

In 2020/21, 41 national clinical audits and confidential enquiries published reports that covered the relevant health services provided by Maidstone and Tunbridge Wells NHS Trust. 41 were reviewed by the Trust and a full list of these national clinical audits and the key actions developed in response to the reports published can be found in **Appendix A**.

In 2020/21, 71 local clinical audits were completed at Maidstone and Tunbridge Wells NHS Trust. A full list of these local clinical audits and the key actions developed in response to the findings of the clinical audits can be found in **Appendix B**.

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. The role of NICE is to improve outcomes for people using the NHS by producing evidence-based guidance and advice to 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 2020/21 a total of **1857** NICE guidance documents have been disseminated to Trust specialty leads since NICE guidance began to be published in 2005. Of those, **1698 (91%)** have been evaluated. **706 (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.

The impact of the COVID-19 pandemic led to changes in priorities for clinicians and evaluation of guidelines not linked to COVID-19 were deferred. This has led to a backlog that will be addressed in 2021.

Guidance published from 1 April 2020 to 31 March 2021.

Guidance Type	Published	Evaluated	Relevant
Clinical Guidelines (CG/NG)	34	18	12
Interventional Procedures (IPG)	18	2	0
Technology Appraisals (TA)	60	8	2
Others other types of guidance	22	7	3
Totals	**134**	**35**	**17**

Please see Appendix B for full details of Trust compliance with NICE guidance that has been audited and completed during 2020/21.

Research

Maidstone and Tunbridge Wells NHS Trust recruited 3,580 participants to 76 research projects during 2020/21 that were approved by the Research Ethics Committee, against an annual plan of 1556 participants. This plan was agreed with the Clinical Research Network for Kent, Surrey and Sussex and based on the predicted number of patients to be recruited to trials open at the start of the financial year. 2020/21 saw the highest number of patients recruited to trials at MTW on record.

The 2020/21 research year started with the Research and Development department involved in delivering a number of COVID-19 clinical trials.

Delivering research during a pandemic

Many MTW research delivery staff were ring-fenced throughout the year to ensure important treatment trials continued where possible and where safe to do so as 'normal' NHS service provision had to scale down. This also ensured there were research staff ready to open and deliver the new, high profile COVID-19 studies that were commenced in response to the pandemic.

It usually takes around four to six weeks to set up a clinical trial within the organisation. We were tasked with setting up COVID-19 trials within just 9 days during the pandemic.

The urgency of the situation required staff to ready themselves for the unexpected. Used to delivering a set programme of research studies, the team were now tasked with opening one new COVID-19 study every 4 weeks, in record time, within existing resources.

Staff regularly worked over-time, during unsociable hours, and at weekends, to ensure studies were set up safely and on time. With no known treatments or cure for COVID-19, the clinical trials were patients' only hope. Hospital teams such as Pharmacy and Pathology also worked over and above to support the trials and were key to delivering the studies safely and accurately.

Our successful delivery of COVID-19 research was in part thanks to the establishment of very capable and engaged research teams who, even before the pandemic, had made a name for themselves as excellent researchers.

To support our existing research staff, we also welcomed a number of new staff to the team during the year, both from external organisations and from within the Trust, including Research Nurses and Clinical Trial Co-ordinators. The appointments followed a number of research staff moving on to the next stage in their careers to take promotions in other areas of healthcare.

Nursing and administrative support was also drafted in from neighbouring healthcare providers to help the Trust research team deliver our ever-growing number of COVID-19 trials. Research nurses, practitioners, data managers and administrative staff joined our research team between August and December in what was a truly collaborative effort between health provider organisations.

"The UK's research response to the COVID-19 pandemic was unparalleled. It triggered a system-wide, collaborative approach that enabled unprecedented speed and efficiency in clinical trial approvals, set-up and recruitment. As a result, the UK has been able to rapidly answer questions of global importance about the safety and efficacy of COVID-19 treatments and vaccines." (National Institute for Health Research, 2021)

COVID-19 trials

A total of 17 COVID-19 studies were opened by the end of the year, including all studies of national importance badged as Urgent (to) Public Health. Notable studies include:-

The RECOVERY Trial

MTW is one of 181 UK sites delivering this national research study that recruited almost 40,000 patients during the year. The RECOVERY trial is currently the world's largest trial of potential COVID-19 treatments. The study was successful in identifying Dexamethasone as being an effective treatment for some patients with COVID-19, showed that Hydroxychloroquine and convalescent plasma gave no benefit to patients and found that some anti-inflammatory drugs are beneficial to patients.

Recruitment to this trial at MTW is delivered by a small team of clinicians, led by Dr Matt Szeto, Consultant Physician and Rheumatologist. Over 150 patients have been recruited to date.

SIREN Study

210 members of MTW staff signed up to take part in the SIREN study during 2020. The SIREN study, led by Public Health England was set up in over 130 hospitals across the country to measure antibody levels in healthcare workers such as doctors and nurses, porters and cleaners. The purpose of this study was to understand whether prior infection with the virus that causes COVID-19 protects against future infection with the same virus. The research team performed swab and blood tests on staff and sent them to laboratories for analysis.

In February 2021, SIREN published findings that healthcare workers were 72% less likely to develop infection after one dose of the vaccine, rising to 86% after the second dose based on nearly 50,000 NHS staff test results.

Psychological impact of COVID-19

Led by Southern Health NHS Foundation Trust, MTW was one of 55 sites in the UK promoting the global study, which was open to the general population. Over 250 people took part from MTW. Early results show that one third of all respondents identified worsening levels of stress, anger and loneliness due to the pandemic, with women more likely to report than men. The study is currently continuing across the globe.

REMAP-CAP study

The REMAP study was already open at MTW before the pandemic and is designed to evaluate treatments for Community Acquired Pneumonia in patients admitted to intensive care units. It was adapted early last year to include patients admitted to intensive care with COVID-19. The study is open at 300 hospitals across 21 countries to provide truly global findings relating to COVID-19 treatments. The study is ongoing and looks at the effectiveness of treatments such as antibiotics, antivirals and steroids in helping patients recover. 185 patients were recruited to the study last year, contributing to nearly 7,000 patients recruited nationally. REMAP-CAP has been named by the Chief Medical Officers of the United Kingdom as a key clinical trial for COVID-19.

Novavax COVID-19 Vaccine trial

The research team was very happy to be accepted as a participating site on the international Novavax vaccine trial in September 2020. Over 100 people from the local population were consented to join the blinded trial at Maidstone hospital with 50% of participants receiving the Novavax trial vaccine and the other 50% receiving a placebo. This study allowed some of our local population to receive a COVID-19 vaccine months before the national vaccine roll out, so people were very keen to take part. Study findings released in January 2021 found the vaccine to be

89.3% effective during what was a period of high transmission and with a new UK variant strain of the virus emerging and circulating widely. The study was led at MTW by Dr Arabella Waller, Consultant Physician and Rheumatologist.

Impact of the pandemic on research delivery

76 studies were open and recruiting during the year (including COVID-19 studies), across a wide range of specialisms. During March and April 2020, 56 studies were paused in response to the pandemic. Studies were paused as patient services were halted or changed to reduce the infection risk at the hospital. Many study-specific processes had to stop as they did not match the new way of providing services during the first months of the pandemic. The Trust made every effort to ensure as many studies as possible remained open (if safe to do so) to ensure patients on treatment trials did not miss out on receiving their medication. Many studies in oncology and haematology in particular, remained open over the year. We ensured the oncology and haematology research nurses remained ring-fenced throughout the year to continue caring for their patients.

Hospital departments recruiting the largest number of patients to trials during 2020/21 remained the same as the previous year - Critical Care (281 patients), Oncology (114 patients) and Women's services who recruited over 1,500 expectant mothers to the POOL water-birth study.

Research collaboration

Working in research during a pandemic has been challenging but has also facilitated the benefits of working collaboratively with others. Over the year, the Trust worked closely with the Kent Surrey and Sussex Clinical Research Network to share important information on new COVID-19 research studies as they became available and to plan how these would be delivered across the region. Research staff also came together to set up the Kent and Medway Project Review Group in response to the pandemic. The Project Review Group, hosted by Medway NHS Foundation Trust with research representation from across Kent and Medway met on a weekly basis to support clinicians from all healthcare providers to collect data, design studies and collaborate across organisations to address clinical issues and questions relating to COVID-19. From this collaboration MTW's first long-COVID-19 study was developed by Consultant Respiratory Physician, Dr Loke.

Research staff feel very proud to have actively supported critical care and ward-based colleagues in offering trial drugs to COVID-19 patients to help save lives in what has been an unprecedented period of research provision.

Goals agreed with commissioners

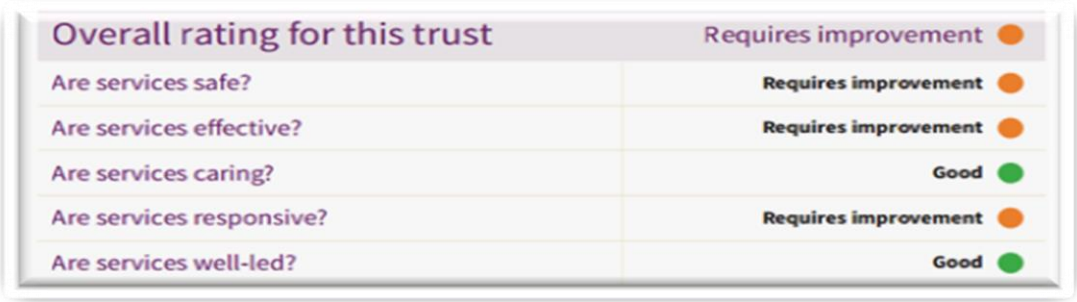
This section usually describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The intention of the CQUIN framework when it was initially introduced was to support the cultural shift within the NHS to ensure that quality is the organising principle for all 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.

Due to COVID-19, the CQUIN programme was suspended for 2020/21. This meant that there was no agreed programme or targets for 2020/21. However, the Trust still continued its work in vital areas which formed part of last year's CQUIN programme such as Sepsis, Falls and staff receiving the flu jab.

Statements from the CQC

The Trust has not been inspected since the update provided in the Quality Accounts 2019/20.

The most recent inspection undertaken of the Trust took place during the period 18th October, 2017 to the 1st February, 2018 with the report published in March 2018. The overall rating for the Trust was 'Requires Improvement'.



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

The CQC reported that they had seen significant improvements since our previous inspection three years ago and although we have been rated as 'Requires Improvement', they acknowledged that significant and sustained improvements had been made and we were moving towards a 'Good' rating.

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

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. These were paused during 2020/21 due to COVID-19 and will be reinstated in 2021/22. In addition to these, the Trust will be working with neighbouring Trusts to consider a programme of peer review to monitor compliance with CQC requirements.

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 Quality Committee, was pivotal in overseeing timely delivery of the recommendations from the last CQC inspection and is responsible for the ongoing prioritisation of key areas for focus.

A bi-monthly operational working group chaired by the Chief Nurse is also in place, which facilitates progress against key priorities and supports divisions with their continuous improvement plans.

Quarterly engagement events have taken place with the CQC during 2020/21. 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 Trust also ensured that they submitted feedback on the strategy consultation launched by the CQC in January 2021.

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

TIAA Audit

The core purpose of the audit undertaken by TIAA was to assess the Trust's position against the original 17 'Should Dos' resulting from the last CQC inspection of 2017. The audit reviewed how the Trust has addressed the recommendations and how we continue to monitor the position and deliver ongoing improvement against them. All action plans, trackers and evidence were reviewed alongside the work to achieve an 'Outstanding' CQC rating governance structure.

Whilst the final report is pending (expected May 2021), the post audit exit interview and draft report indicate a very positive outcome. The feedback acknowledged successful completion of the 17 'Should Dos' and the subsequent iterative approach required to achieve an outstanding rating by the CQC.

The TIAA draft report has commented on a "reasonable level of assurance" and suggest the following key strategic findings:

- Consider the need for a putting a process in place to ensure clear linkages to CQC fundamental standards are referenced in Trust policies, procedures and guidance. This would help to raise awareness and improve compliance with the embedding of standards.
- Consider implementing a document management system or process for CQC supporting evidence. Create a central repository to which supporting evidence could be regularly uploaded to facilitate effective monitoring by the CQC Project Team and improve processes.
- An effective Quality Framework with a sound governance structure is in place, which includes reporting to the Trust Board through the Integrated Performance Report and monitoring through the Board Assurance Framework (BAF).

Additional positive findings include:

- The Trust's relationship with the CQC is good having proactively engaged with them through virtual CQC engagement events. These have been well received and valued by both the CQC and Trust Divisions, who have been enthusiastic to demonstrate their progress through the Trust's journey to Outstanding.
- Testing confirmed that the Trust has implemented the "Should Dos" resulting from the last CQC inspection. The Trust has continued to make progress and have stretched objectives in their journey to Outstanding.

The draft report suggests 3 key actions; 1 rated as important and 2 as routine.

The CQC programme group are developing a proposed management response to these recommendations.

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 10):

- 99.8% (99.7% 19/20) for Admitted Patient Care
- 99.9% (99.9% 19/20) for Outpatient Care
- 99.0% (98.6% 19/20) for Accident and Emergency Care

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

- 100% (99.9% 19/20) for Admitted Patient Care
- 99.9% (99.9% 19/20) for Outpatient Care
- 99.9% (99.9% 19/20) 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 an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. Organisations must make an annual submission supported by appropriate evidence to demonstrate that they are working towards or meeting the required standards.

Due to COVID-19 the deadline for the DSPT 20/21 submission was pushed back by NHSX to 30 June 2021. The Trust continues with its preparations for submission and has requested TIAA to complete an audit of mandatory evidence posted against 13 assertions across the 10 standards as selected by NHS Digital for 2020/21. The review will test the evidence for completeness and validity.

In September 2020, the submission date for 2019/20, the Trust submitted a 'Standards Met' return.

In addition to completing the toolkit, the Trust reviews its Information Governance Management Framework on an annual basis. This document details the governance arrangements concerning the obtaining, recording, holding, using, sharing and destruction of all data and records held or used by the Trust in accordance with the law and best practice.

An action plan is developed each year to address any areas of weakness identified. 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.

Clinical Coding

The table below provides the results of the 2020/21 clinical coding audit scores.

Code Type	Percentage Correct	Data Quality section of Data Security Standard 1 Level of Attainment	
		Standards met	Standards exceeded
Primary Diagnosis	98.5%	90% or above	**95% or above**
Secondary Diagnosis	99.02%	80% or above	**90% or above**
Primary Procedure	99.29%	90% or above	**95% or above**
Secondary Procedure	97.28%	80% or above	**90% or above**

The 2019/20 audit recommendations for clinical coding were all implemented and are detailed below.

R1	Provide additional training to all clinical coding staff to aide extraction from the clinical case notes of all relevant conditions and mandatory comorbidities (immediate and ongoing)
R2	Provide additional training to all clinical coding staff to ensure all relevant imaging procedures are correctly captured and coded (immediate and ongoing)
R3	Coding department to continue to liaise with relevant departments in order to continue to improve the filing of case notes
R4	Coding staff to search all relevant documentation and additional systems within the timeframe of the inpatient spell to ensure all relevant conditions are captured (immediate and ongoing)

During the COVID-19 pandemic the clinical coding source documents and access to these were greatly affected due to the coders having to work remotely. The Trust is working towards full implementation of an electronic patient record (EPR) and in the interim the coding department had to use the electronic source documentation that was available. There were some exceptions to this, which included the coding of deceased patients, implementation of an electronic patient record (EPR) and in the interim the coding department had to use the electronic source documentation that was available. There were some exceptions to this, which included the coding of deceased patients.

Part **three**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Results and achievements against the 2020/21 quality priorities

The table below summarises the quality improvement priorities MTW set out to achieve during 2020/21. We have made progress in many areas resulting in improved outcomes for patients but delivery of these quality priorities has been affected by the COVID-19 pandemic.

	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 Continue to develop a downward trend in avoidable healthcare associated infections Increased focus on reducing the number of hospital acquired deep tissue injuries (DTI) and Category 2 pressure ulcers 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	Implementation of the Patient Engagement and Experience Strategy 'Making it Personal' The delivery of excellent care for patients at End of Life (EoL) including the experience of the bereaved/families in the bereavement process 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 Embedding safeguarding practices in all aspects of clinical care	Improving the flow of patients into and out of our wards and departments 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.

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 a supportive environment that recognises and reduces avoidable harm.

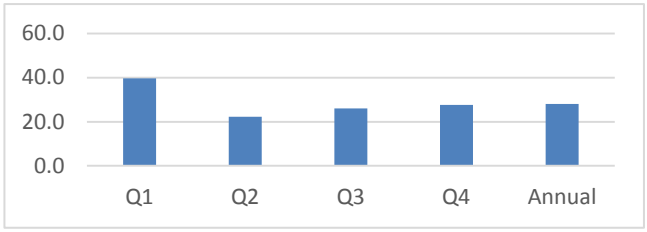
Objective	Criteria	Progress
1) Embracing all aspects of the National Patient Strategy to ensure that a safety culture is recognised as everyone's role and responsibility		
a) Increasing the number of incidents that are reported to identify themes to support positive change and improvement	Increase in number of incidents* reported in 2020/21, based on 2019/20 numbers	**This criterion was achieved.** Patient safety incidents reported in 2019/20: 10,261 Patient safety incidents reported in 2020/21: 10,361
	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	**This criterion was achieved.** Themes, actions, changes and learning are included in the monthly Serious Incident (SI) Update report for the Executive team meetings and bi-monthly for the Quality Committee. In relation to SIs both the recommendations and learning are captured in the Root Cause Analysis (RCA) reports and used as case studies in the Governance Gazette.
	Design qualitative process to evaluate staff experience of incident reporting	**This criterion was achieved.** In March 2021 the Patient Safety team re-launched the Staff Safety Culture Survey, which is an evaluative exercise to include incident reporting. The data has been analysed and preliminary recommendations identified based on those results.
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	**This criterion was not achieved** as the majority of serious incident investigations were undertaken by the Patient Safety Team to ensure clinicians could focus on patient care during COVID-19. This impacted on investigation timelines. An increase in achievement was reported in the first three quarters compared to 2019/20 but then decreased in Q4. The Patient Safety Team continue to work to improve the 60-day compliance and this is a quality priority for 2021/22.

Objective	Criteria	Progress
	Decrease in number of investigations with further queries returned from CCG, based on 2019/20 numbers	**This criterion was achieved.** There has been a significant decrease in the number of Non-Closures issued by the CCG. The Patient Safety Manager (PSM) meets monthly with the PSM at the CCG to review outstanding cases and ways to streamline the process. MTW PSM is now a member of the CCG SI panel, which facilitates timely processing and sign-off of investigations.
	Design qualitative process to evaluate patients and families' experience of our Serious Incident process	**This criterion was not achieved** and is a quality priority for 2021/22. Due to pressures from the COVID-19 pandemic, this has not yet been implemented. However, through the SI process, the corporate and clinical teams have worked with a number of families regarding their experience of the SI process to enable learning and improve future experiences for patients and their families.
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)	**This criterion was partially achieved.** Due to COVID-19 pressures this has not yet been fully implemented. The implementation is ongoing and is monitored through the monthly Datix Implementation Group meetings. The plan is to launch the dashboards in 2021/22. The dashboards have been designed and created. Access has been given to the key leads in the directorates which allows them to see a snapshot of current incident, SI and Duty of Candour performance.
	Decrease in numbers of incidents breaching 45 day closure timeline, based on 2019/20 numbers	**This criterion was not achieved** and is a quality priority for 2021/22.
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 Health Organisation (WHO) - World Patient Safety Day (17th September annually)	**This criterion was achieved** and events took place to recognise the World Patient Safety day in September 2020. The theme for 2020 was "Health Worker Safety, Safe health workers, Safe patients". Members of the Patient Safety Team spoke with over 70 Trust staff about what staff and patient safety means to them and how to improve safety at MTW.
	Increase numbers of staff attending both Human Factors and Root Cause Analysis	**This criterion was partially achieved.** Human factors training was reinstated in July 2020, providing two full day sessions a month. Due to demand this was then increased (pre 2nd surge of COVID-19) to four full day sessions a month. Face to face RCA training did not

<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td></td><td>(RCA)training</td><td>take place in 2020/21 but has been reinstated in May 2021.</td></tr>
<tr><td></td><td>Development of actions module (to monitor compliance with open actions from investigations) on Datix to drive performance</td><td>This criterion has been partially achieved.

The actions module has been developed and will be rolled out and embedded in 2021/22.</td></tr>
<tr><td></td><td>Ensure every staff member has access to the final Serious Incident (SI) investigation report</td><td>This criterion has been achieved.

Currently all staff involved in the investigation and the relevant Divisional Director for Nursing and Quality (DDNQ) and Clinical Leads are sent the final SI report. SI reports are now also being attached to the original Datix incident, which will make them accessible to all staff.</td></tr>
<tr><td></td><td>Design qualitative process to evaluate staff experience of being involved in our SI process</td><td>This criterion was not achieved and is a quality priority for 2021/22.</td></tr>
<tr><td colspan="3">2) Continue to develop a downward trend in avoidable healthcare associated infections, in particular</td></tr>
<tr><td>a) Gram negative bloodstream infections</td><td>21.5 cases per 100,000 bed days (whilst acknowledging national 5 year target of 50% reduction across the healthcare system by 2021)</td><td>This criterion was not achieved.

The rate of E.coli blood stream infections is per 100,000 bed days, results per quarter and annual are shown below.
<table><tr><td>Q1</td><td>39.6</td></tr><tr><td>Q2</td><td>22.3</td></tr><tr><td>Q3</td><td>26.0</td></tr><tr><td>Q4</td><td>27.6</td></tr></table> 
Annual = 28.0</td></tr>
<tr><td>b) Control of hospital acquired COVID-19</td><td>Systems in place for infection prevention and control of COVID-19 in line with the Hygiene Code</td><td>This criterion was achieved.

Infection prevention guidelines for COVID-19 follow PHE guidelines and are in line with the Hygiene Code.</td></tr>
</table>

Objective	Criteria	Progress
	Self-assessment undertaken of national framework	**This criterion was achieved.** Self-assessment undertaken and presented to Trust Board in December 2020 within the infection prevention and control board assurance framework (BAF). The BAF has been presented at Board monthly since Dec.
	Compliance of self-assessment to be monitored through the Infection Control Committee with periodic reports to Trust Board	**This criterion was achieved.** Completed and ongoing.
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		**This criterion was not achieved.** Q4 saw the highest rate of hospital acquired (HA) pressure ulcers for the year. The acuity and dependency of the patients and the higher levels of unfilled shifts during the second wave of the pandemic are thought to be the main contributory factors. Q4 saw a reduction in HA Cat 2 pressure ulcers of 39%, but an increase in DTIs of 30% for the same quarter in the previous year. 2020 / 2021 saw an overall reduction in HA Cat 2 pressure ulcers of 3%, but an increase in HA DTIs of 38%. It is important to note that there has been ongoing national and international research into COVID-19 related skin changes. The evidence suggests small vessel changes with COVID-19 have caused skin damage that presents in identical discolouration and similar shaping as a DTI caused by pressure. Therefore, some skin damage declared as DTIs in COVID-19 positive patients may have been COVID-19 related skin changes.
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 directive)	Each element of the plan in place	**This criterion was not achieved.** Due to pandemic pressures, the focus is currently on the continuity of carer's directive, maintaining quality and safety and the digital strategy. Progress is tracked monthly at the Maternity Board.

Objective	Criteria	Progress
b) Engage with the Maternal & Neonatal Safety Collaborative (MatNeo) and implement the improvement plan on sepsis	Improvement plan for sepsis implemented and being monitored	**This criterion was achieved.** This is being implemented and is monitored through the monthly Maternity Board. Review of the Sepsis policy forms part of the improvement plan and this is underway.
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	**This criterion was partially achieved.** Data collection for this audit was severely impacted due to critical care staff redeployed to clinical work during both COVID-19 waves. Q3 audit results - sepsis screening of eligible patients with raised NEWS 2 scores = 77.3% and IV antibiotic treatment of red flag patients within 1 hour remains at 100%. No data collected during Q4 but a separate audit undertaken by medical team on Acute Medical Unit produced similar results to Q3.
	Report findings on a quarterly basis to the Sepsis Committee	**This criterion was partially achieved.** Sepsis Committee met on the 14th October 2020. Q1 audit data was reported, discussed and captured in the minutes. Sepsis Committee met on the 17th February, results of AMU audit discussed and captured in the minutes.
	Committee to propose required actions as a result of audit findings	**This criterion was achieved.** Main issues identified, which include continuing sepsis education and raising awareness of the sepsis proforma. Sepsis is a mandatory training requirement for clinical staff. Plan to update the sepsis e-learning module. Sepsis competencies for all registered healthcare professionals ready for roll-out. 43 sepsis trolleys have been purchased and will be distributed to clinical areas in May 2021. Each trolley will have six sections containing everything required to implement sepsis screening and an action plan. Having everything to hand will support the prompt treatment/management of sepsis, improve patient safety and enhance the quality of care delivered. Need to review resources for sepsis audit data collection.

Objective	Criteria	Progress
b) Diabetes	Audit of Blood Glucose Monitoring and Hypoglycaemia guideline to assess use of blood glucose monitoring form and algorithm	**This criterion was not achieved.** It was not possible to undertake this audit during the COVID-19 pandemic due to staffing pressures within the diabetes team. A Diabetes Inpatient Specialist Nurse (DISN) has been recruited to however the start date is yet to be confirmed. Secured confirmation within the new financial year to go out to advert for the second agreed DISN role. Connectivity meter roll out has been successful in the Trust and connection to the EPR is pending. With these successful steps forward we will be in a position to start this priority audit over the next few months.
	Implementation of blood glucose monitoring connectivity meters and associated staff training	**This criterion has been achieved.** All connectivity meters are now distributed and in place across the Trust. Trust targets for clinical staff training have been achieved.
	Assessment of training levels for clinical staff in relation to diabetes and e-learning for Safer Use of Insulin	**This criterion was partially achieved.** The e-learning for 'Safer use of insulin' module was launched on the MTW Learning site in 2020. 2356 Trust staff identified as needing to complete the module, so far 75% of these staff have undertaken the module. The remaining 25% will be targeted this year. The Diabetes Educator post has been recruited to and this role will monitor and ensure compliance with the e-learning module on insulin. The post holder will also carry out a wider review of diabetes training needs cross-site to inform strategic planning of diabetes education.
	Quarterly audit of prescription chart focusing on insulin prescribing and administration	**This criterion was partially achieved.** Pharmacy team commenced this audit in Q1 with 1 day per month screening of prescription charts against audit criteria. Data received and shared with Diabetes team. Analysis of data and sharing of learning limited due to current pandemic situation.

Patient Experience

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.

Objective	Criteria	Progress
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		**This criterion has been achieved.** The interim Patient Experience Lead is now full time since the 01/12/20. This role has been recruited to substantively in May 2021.
b) Monitor implementation and delivery of the strategy quarterly at the Patient Experience Committee (PEC)		**This criterion has been achieved.** A progress update on delivery against the Patient and Carer Strategy, including a specific focus on a review of learning in regards to communications with patients during COVID-19 and the steps implemented to improve communication were presented to the PEC in Dec 2020. In addition, further work was completed to present an update to the Committee in March 2021 to share how MTW are ensuring the optimum experience of patients and their families in the COVID-19 environment. Key initiatives, which have been implemented and are ongoing include: volunteer hubs at each main entrance to assist with signposting and prompt delivery of patient's belongings, patient welfare calls to discharge patients established and ongoing, photo badges which show staff faces behind face masks have been successfully trialled in paediatrics, 'Always' checklist refined and relaunched as our pledge to all patients and carers and service users. Ward quality rounds are underway. As a direct result of the quality rounds, the

Objective	Criteria	Progress
		"One Team Runner" role was established; focusing on releasing time to care for patients.
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		**This criterion has been achieved.** The Bereaved Carers Survey 2019/20 has maintained consistently good results and has demonstrated an increase in patients accessing spiritual care at the end of life. The survey was temporarily halted during the first wave of the pandemic due to restricted visiting and changes in processing of the death certificates. However the survey was resumed during September and will be reported on in May 2021.
b) Improvement in the National End of Life Care (NACEL) survey results, based on most recent results		**This criterion has been partially achieved.** The NACEL audit was halted for 2020, due to the COVID-19 pandemic. The NACEL audit is planned to go ahead for 2021, and details of the audit have now been provided to the Trust. Data collection will now also include a staff survey and data collection will commence June 2021. The Palliative care team are currently undertaking an audit of the COVID-19 deaths that occurred during the first wave to review processes. This audit has now been adapted to incorporate data from the second wave for comparison and incorporates many of the realms of the NACEL audit.
c) Improvement in completion of individualised care plans for End of Life, based on last audit results		**This criterion has been partially achieved.** The audit has now been completed and identified that although mandated, the use of the ICP document remains low. However, its use has increased since the last audit and it is now used in 36% of cases in this sample, compared to 14% in 2019. Some form of End of Life care plan (be that ICP or a written narrative in the medical notes) was present in over half (58%) of all patients in this audit; however, this is a decrease from last year's figure, which identified that two-thirds of patients had a plan. When looking at all deaths it will not be possible to ever achieve 100% compliance, as death remains a possibility even when active treatment is being undertaken in unwell hospitalised patients; and in this context an End of Life plan is unlikely to be completed. An action plan has been developed in response and is being

Objective	Criteria	Progress
		monitored through the EoLC Steering Committee.
d) To improve advance care planning in EoLC, through the increased use of the treatment escalation plan (TEP), (audited as part of ICP audit and national EoLC audit)		**This criterion has been partially achieved.** The use of the TEP was also audited as part of the ICP audit. The TEP document was poorly used and only 2 patients from the medical records audited had a completed TEP. The results were shared with the Medical Director at the COVID-19 Ethics meeting in October 2020 for consideration of further action required. The current COVID-19 audit being undertaken also collects data on the use of TEP.
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		**This criterion has been achieved** (albeit in April 2021 and not in 2020/21 as planned). As of 1st April 2021, the reporting elements have been amended to capture all three elements and the incident reporting system has been reconfigured to capture this, whilst also linking to the Directorate dashboards.
b) Improved compliance, based on 2019/20 figures		**This criterion has been achieved.** However there is further room for improvement in 2021/22 which is why this will continue to be a quality priority.
c) Develop Duty of Candour dashboard on Datix		**This criterion has been achieved.** Dashboards are now in place for every division. This will be further developed in 2021/22 for each ward.
4) Embedding safeguarding practices in all aspects of clinical care		
a) Further develop tools to enable practitioners to ensure that mental capacity assessments (MCA) are documented appropriately enable practitioners to ensure	Tool to be developed and co-designed with practitioners	**This criterion has been achieved.** The tool has been developed and co-designed with practitioners and is now in place on the wards.
	MCA level 2 and 3 training package to be redesigned (including methodology of delivery)	**This criterion has been achieved.** The training package has been redesigned and is currently being delivered as e-learning due to the pandemic.

Objective	Criteria	Progress
that mental capacity assessments (MCA) are documented appropriately		
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	**This criterion has been partially achieved.** Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be shared with relevant wards and any necessary actions put in place	**This criterion has been partially achieved.** Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be presented at the Safeguarding Committee	**This criterion has been achieved.** A progress update was presented to the Safeguarding Committee in January 2021.
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	**This criterion has been partially achieved**. Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be shared with relevant wards and any necessary actions put in place	**This criterion has been partially achieved.** Not every clinical area has been audited due to competing clinical demands but progress has been made in some areas.
	Results to be presented at the Safeguarding Committee	**This criterion has been achieved.** A progress update was presented to the Safeguarding Committee in January 2021.

Clinical Effectiveness

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

<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td colspan="3">1) Improving the flow of patients into and out of our wards and departments by: -</td></tr>
<tr><td>a) Increasing the effectiveness of ambulance handovers</td><td>See below</td><td>
This criterion has been achieved.

The Emergency Department staff worked hard over the year to swiftly admit patients from ambulances to the departments despite the increased pressures of the COVID-19 pandemic. Data from October to March is displayed below.

Ambulances waiting over 30 mins to handover patient

<table>
<tr><th></th><th>Target</th><th>Actual</th></tr>
<tr><td>Oct</td><td>5.9%</td><td>3.5%</td></tr>
<tr><td>Nov</td><td>5.9%</td><td>0.4%</td></tr>
<tr><td>Dec</td><td>5.6%</td><td>7.7%</td></tr>
<tr><td>Jan</td><td>5.3%</td><td>6.8%</td></tr>
<tr><td>Feb</td><td>5.3%</td><td>4.8%</td></tr>
<tr><td>Mar</td><td>5.0%</td><td>4.5%</td></tr>
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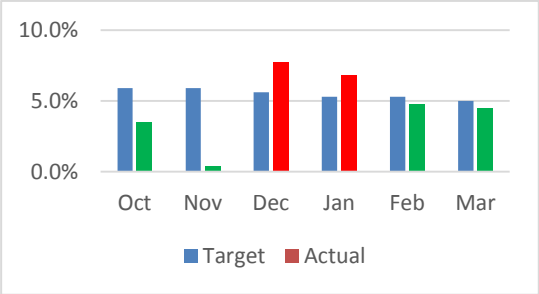
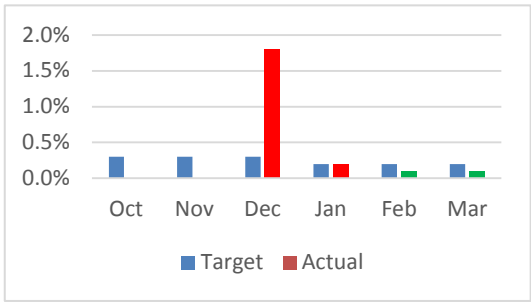


Ambulances waiting over 60 mins to handover patient

<table>
<tr><th></th><th>Target</th><th>Actual</th></tr>
<tr><td>Oct</td><td>0.3%</td><td>0.0%</td></tr>
<tr><td>Nov</td><td>0.3%</td><td>0.0%</td></tr>
<tr><td>Dec</td><td>0.3%</td><td>1.8%</td></tr>
<tr><td>Jan</td><td>0.2%</td><td>0.2%</td></tr>
<tr><td>Feb</td><td>0.2%</td><td>0.1%</td></tr>
<tr><td>Mar</td><td>0.2%</td><td>0.1%</td></tr>
</table>


</td></tr>
<tr><td>b) Improving the timeliness of discharge of patients from Intensive Care (ICU)</td><td>Improve performance with regard to ward-based discharge (within 4 hours), based on 2019/20 numbers</td><td>
This criterion was partially achieved.

The COVID-19 pandemic led to many changes and challenges within critical care. ICU capacity was expanded on both sites during the 2 waves of the pandemic. An increase in performance for timely discharge from ICU occurred for periods but was not fully sustained throughout the year.
</td></tr>
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<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td></td><td>Decrease number of night-time discharges from the Intensive Care Unit (10pm-7am), based on 2019/20 numbers</td><td>This criterion was partially achieved.

The increase in ICU beds in response to the COVID-19 pandemic led to some reduction in discharges at night-time from ICU for some periods. Comparison with 2019/20 figures is difficult due to the impact of the pandemic.</td></tr>
<tr><td>c) Ensuring the necessary support is in place to allow patients to leave hospital when it is planned for them to do so</td><td>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><td>This criterion has been achieved.

There have been significant reductions for both 7-day and 21-day length of stay figures each month in 2020-21 compared to 2019-20 data. Each month throughout the year the figures are lower than for each respective month in the previous year for both 7 day and 21 day LOS. Please see table below showing the full data for both years.
<table>
<tr><th></th><th colspan="3">7 day LOS</th><th colspan="3">21 day LOS</th></tr>
<tr><th></th><th>Maid</th><th>TWH</th><th>Trust</th><th>Maid</th><th>TWH</th><th>Trust</th></tr>
<tr><td>Apr-19</td><td>131.1</td><td>179.8</td><td>310.9</td><td>51.0</td><td>64.5</td><td>115.5</td></tr>
<tr><td>May-19</td><td>129.3</td><td>183.7</td><td>313.0</td><td>49.6</td><td>69.4</td><td>118.9</td></tr>
<tr><td>Jun-19</td><td>123.4</td><td>178.2</td><td>301.6</td><td>40.8</td><td>66.4</td><td>107.2</td></tr>
<tr><td>Jul-19</td><td>125.5</td><td>174.0</td><td>299.5</td><td>47.5</td><td>66.5</td><td>114.0</td></tr>
<tr><td>Aug-19</td><td>130.0</td><td>169.3</td><td>299.3</td><td>41.7</td><td>66.8</td><td>108.5</td></tr>
<tr><td>Sep-19</td><td>137.9</td><td>172.5</td><td>310.4</td><td>53.7</td><td>64.4</td><td>118.0</td></tr>
<tr><td>Oct-19</td><td>133.5</td><td>159.1</td><td>292.7</td><td>49.6</td><td>56.4</td><td>106.0</td></tr>
<tr><td>Nov-19</td><td>142.0</td><td>159.3</td><td>301.3</td><td>54.7</td><td>52.3</td><td>107.0</td></tr>
<tr><td>Dec-19</td><td>145.5</td><td>173.1</td><td>318.7</td><td>55.9</td><td>54.3</td><td>110.2</td></tr>
<tr><td>Jan-20</td><td>161.1</td><td>180.6</td><td>341.7</td><td>69.5</td><td>66.4</td><td>135.9</td></tr>
<tr><td>Feb-20</td><td>161.8</td><td>166.6</td><td>328.4</td><td>61.8</td><td>54.5</td><td>116.2</td></tr>
<tr><td>Mar-20</td><td>130.2</td><td>137.9</td><td>268.1</td><td>53.6</td><td>43.5</td><td>97.2</td></tr>
<tr><td>Apr-20</td><td>68.6</td><td>68.1</td><td>136.8</td><td>15.3</td><td>16.1</td><td>31.4</td></tr>
<tr><td>May-20</td><td>69.1</td><td>81.1</td><td>150.1</td><td>22.5</td><td>20.8</td><td>43.3</td></tr>
<tr><td>Jun-20</td><td>67.7</td><td>98.4</td><td>166.0</td><td>21.7</td><td>23.1</td><td>44.8</td></tr>
<tr><td>Jul-20</td><td>78.5</td><td>91.8</td><td>170.3</td><td>22.7</td><td>18.3</td><td>41.1</td></tr>
<tr><td>Aug-20</td><td>94.6</td><td>116.5</td><td>211.0</td><td>27.4</td><td>26.2</td><td>53.6</td></tr>
</table></td></tr>
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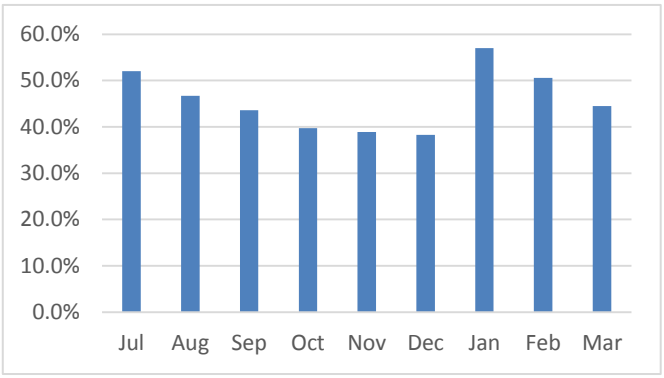
<table>
<tr><th>Objective</th><th>Criteria</th><th>Progress</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Sep-20</td><td>113.9</td><td>113.5</td><td>227.4</td><td>37.3</td><td>25.9</td><td>63.2</td></tr>
<tr><td>Oct-20</td><td>126.6</td><td>120.2</td><td>246.8</td><td>45.8</td><td>23.6</td><td>69.5</td></tr>
<tr><td>Nov-20</td><td>141.1</td><td>120.6</td><td>261.7</td><td>45.7</td><td>29.3</td><td>75.0</td></tr>
<tr><td>Dec-20</td><td>150.4</td><td>150.5</td><td>300.9</td><td>52.2</td><td>35.4</td><td>87.6</td></tr>
<tr><td>Jan-21</td><td>161.6</td><td>163.8</td><td>325.4</td><td>54.4</td><td>46.9</td><td>101.3</td></tr>
<tr><td>Feb-21</td><td>126.4</td><td>136.4</td><td>262.8</td><td>38.6</td><td>43.7</td><td>82.3</td></tr>
<tr><td>Mar-21</td><td>108.6</td><td>113.0</td><td>221.6</td><td>34.6</td><td>26.1</td><td>60.7</td></tr>
</table>
</td></tr>
<tr><td>d) Increasing the number of virtual clinics</td><td>Transfer 50% of outpatient activity to virtual clinics, based on 2019/20 figures</td><td>
This criterion has been partially achieved.

Data for Q2, Q3 & Q4 for percentage of outpatient activity which was delivered virtually, not face-to-face, is shown below:

<table>
<tr><th>Month</th><th>Number</th></tr>
<tr><td>Jul</td><td>52.3%</td></tr>
<tr><td>Aug</td><td>46.7%</td></tr>
<tr><td>Sep</td><td>43.6%</td></tr>
<tr><td>Oct</td><td>39.7%</td></tr>
<tr><td>Nov</td><td>38.9%</td></tr>
<tr><td>Dec</td><td>38.3%</td></tr>
<tr><td>Jan</td><td>57.0%</td></tr>
<tr><td>Feb</td><td>50.6%</td></tr>
<tr><td>Mar</td><td>44.5%</td></tr>
</table>


January was the highest month at 57.0% and the Trust was meeting this Quality Priority in Q1 during the first wave of the pandemic.

Video conferencing technology is now being used by various departments across the Trust to host virtual appointments with patients. Currently, there are 114 users across 11 specialities using the facility. Initial feedback has revealed that 67% of patients say the video appointments are equivalent or better than a face to face appointment. The software is being used by teams in Diabetes and Endocrinology; Neurology; Paediatrics; Cardiology; Sexual Health; Ophthalmology and Oncology and will soon be rolled out to Trauma and Orthopaedics, Physiotherapy Outpatients and Respiratory Services. Benefits of the service include reduced travel times and associated expenses for patients as well as reduced footfall at our sites as patients can attend their appointment from the comfort of their own home or any other appropriate location. In addition, it is also helping to improve patient care between teams.

For example, the Emergency Department can show an Ophthalmologist a patient's eye injury. Using a camera attached to a slit lamp, the attending clinician can shine the light into the patient's eye and send the video images directly to the
</td></tr>
</table>

Objective	Criteria	Progress
		Ophthalmologist allowing them to view it from where they are and make a diagnosis meaning the patient is treated quickly and their length of stay is reduced. Work began last summer to start rolling out video conferencing technology in identified specialities as part of a pilot project but the outbreak of COVID-19 pushed the value of the service to the forefront and as a result it was implemented in other departments ahead of schedule. The pandemic has certainly demonstrated how we need to work differently and as we return to normal levels of activity; the Trust's forthcoming digital transformation strategy aims to continue to utilise this form of technology by default for outpatient care. As a result we anticipate up to 60% of future outpatient appointments will be done via the phone or video conferencing. This will enable us to comply with social distancing recommendations, to maintain safety for patients, and help us ensure we have sufficient staff for those patients who need to come into hospital for a face to face consultation.
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		**This criterion has been partially achieved.** Phase one surgical reconfiguration is embedded from an emergency and elective perspective (pending pandemic reductions). Further changes have been made to move the Consultant body to a 24 hour on call rostering pattern and an associate Registrar rostering pattern that will move with their paired Consultants' job plan. This has taken effect as of the 29/03/21. Discussions continue in regards to the formation of a Digestive Diseases Unit (DDU) and the required movement of Gastroenterology to the Pembury site, which continues to be delayed due to the second wave of the COVID-19 Pandemic. The Upper GI service is continuing to increase its portfolio of services. Discussions are continuing with our relevant CCG partners in regards to the commissioning of Bariatric Surgery at Tunbridge Wells. Furthermore, the department is looking to insource support for the restart of PH Manometry and Bravo Capsules with a view to providing this service for the Kent area. Finally, AR Manometry and our Pelvic Floor clinic offering will be restarting by the end of April 2021, following an equipment upgrade.

Objective	Criteria	Progress
b) Development of a Hyper-Acute Stroke Unit (HASU)		**This criterion has not been achieved due to reasons stated below.** The implementation plan for three hyper-acute stroke units (HASUs); one of which will be at Maidstone Hospital has not progressed due to: a) Lack of feedback from the Secretary of State for Health on the appeal made by Medway Council for a review of the decision-making process on the three HASU sites. b) Delays due to the OBC approval process. c) COVID-19 pandemic impact leading to delays. In response to the COVID-19 challenges MTW put in place two stroke rehabilitation initiatives - home rehabilitation with Hilton Nursing Partners and stroke rehabilitation beds at Sevenoaks Hospital. It is imperative stroke rehabilitation is working effectively for the successful functioning of the HASU/ASUs. In response to the delays and a lack of confirmation of the capital development timeline MTW have: a) Consolidated stroke inpatient services on the Maidstone site. b) Developed 46 acute beds to cope with the increase in activity as a result of the Medway stroke unit closure. c) Increased staffing levels to ASU national guideline levels. d) Developed the specialist stroke rehabilitation pathways. e) Improved the flow through the ASU. f) Implemented an assessment bay to improve patient care and facilitate patient flow through the Emergency Department (ED) g) Implemented a telephone and video triage process with SECAMB to ensure the right patients are transported to the right care setting. The outcome of implementing all of the above actions is that despite the COVID-19 pandemic and resulting challenges, the Trust achieved a 'B' SSNAP rating, the majority of stroke staff posts are recruited to and staff training and development continues. The first four months of the remote triage with SECAMB resulted in 140 patients being diverted away from Maidstone ED. Due to the delays with the stroke unit build, a review of the stroke flow has been undertaken and low-level works are being recommended to continue to improve the service. This will be

Objective	Criteria	Progress
		progressed through May 2021.

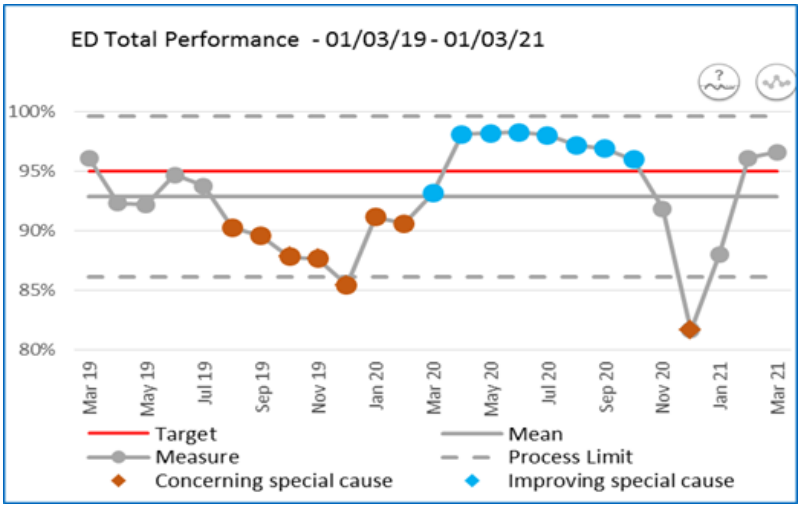
Ambulance handover targets

	Maidstone Target	By Quarters	Tunbridge Wells Target	By Quarters
% of handovers exceeding 30 mins	5.00%	End Q1 6%	5.00%	End Q1 10 %
		End Q2 5%		End Q2 7%
		End Q3 5%		End Q3 5%
		End Q4 5%		End Q4 5%
% of handovers exceeding 60 mins	0.10%	All quarters the same	0.20%	End Q1 0.4%
				End Q2 0.4%
				End Q3 0.3%
				End Q4 0.2%

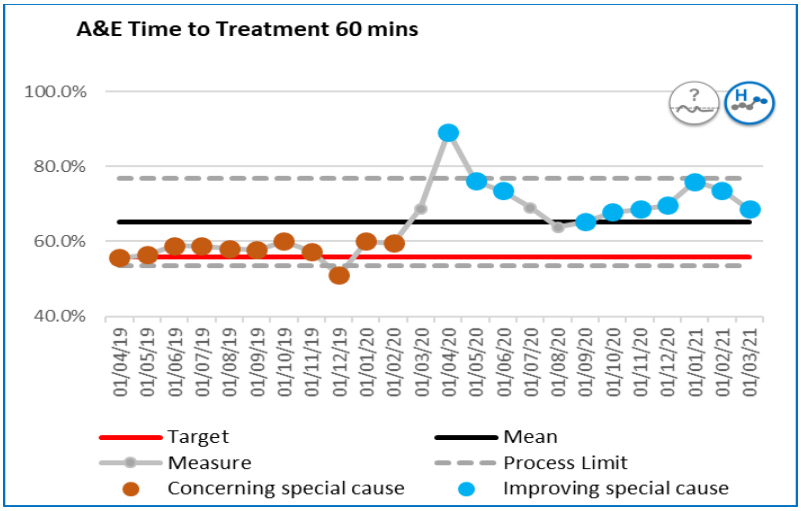
Further Review of Quality Performance

In addition to the information and tables provided in the above section reviewing progress against the 2020/21 quality priorities, other measures of quality performance are displayed below.

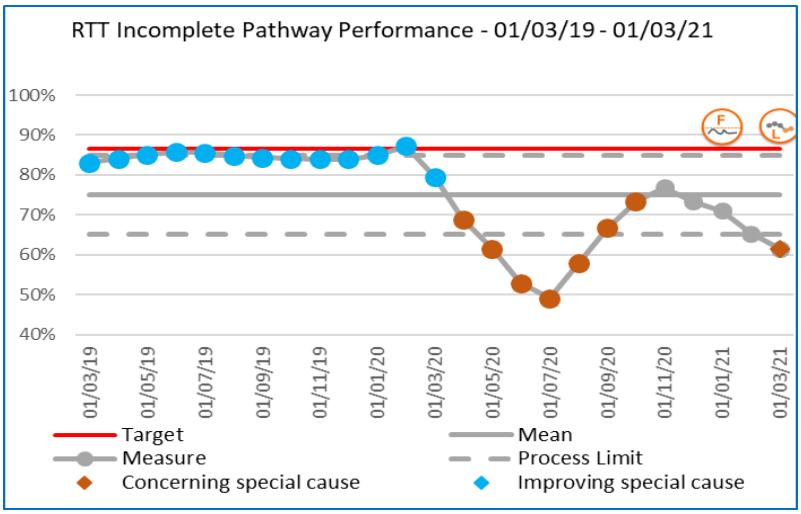
Emergency Department (ED) 4-hour access – the Trust did not achieve this standard of 95% of patients being seen, treated, admitted or discharged within 4 hours of arrival in its Emergency Departments in 2020/21. The Trust was above the Trust's planned recovery trajectory for the year at 94.7% against the target of 88.0%. There was a significant drop in Type 1 ED Attenders of 21.9%, driven by the COVID-19 pandemic.



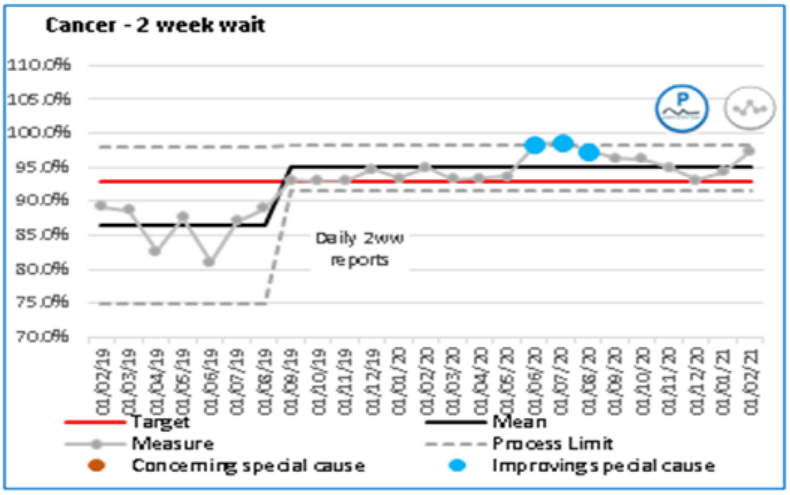
Emergency Department Time to Treatment <60 minutes – the Trust achieved this standard of 55.9% of patients arriving in its Emergency Departments being treated within 60 minutes of arrival at 71.8%. This is a significant improvement on last year's figure of 58.5%.



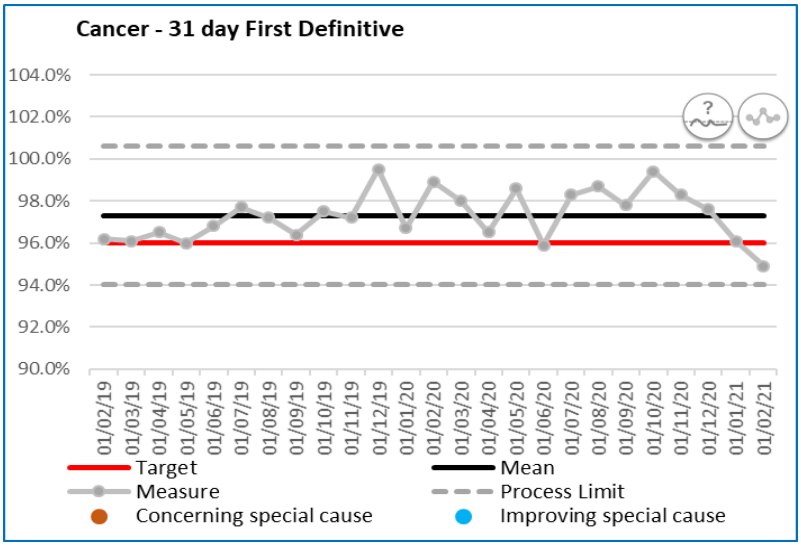
18 weeks standard – the Trust did not achieve the national standard of 92% of patients on an Incomplete Pathway being treated within 18 weeks, predominantly driven by the COVID-19 pandemic. A process has been established to review patients on waiting lists to ensure they do not come to harm whilst waiting for procedures / treatment.



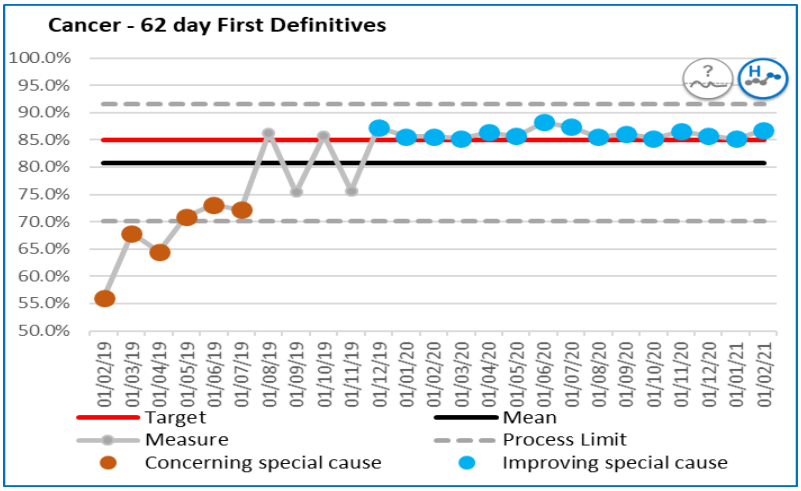
Cancer Waiting Time Targets: 2 weeks from referral – the Trust has consistently achieved this standard of ensuring that 93% of patients with suspected cancer are seen within two weeks throughout 2020/21 at 95.8%. This is a significant achievement both against the previous year and throughout the COVID-19 pandemic.



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.

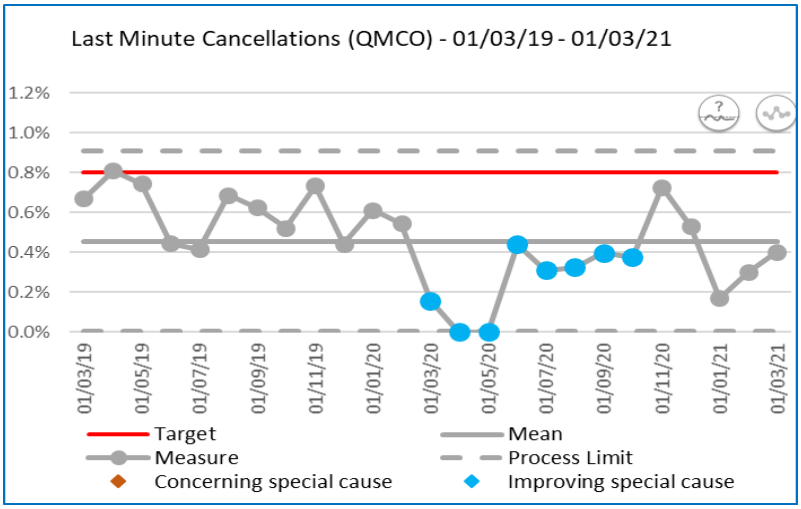


Cancer Waiting Time Targets: 62 day first definitive treatment – the Trust achieved this standard of 85% of patients who needed to start their first definitive treatment within 62 days throughout 2020/21 at 86.3%. This is a significant achievement both against the previous year and throughout the COVID-19 pandemic.



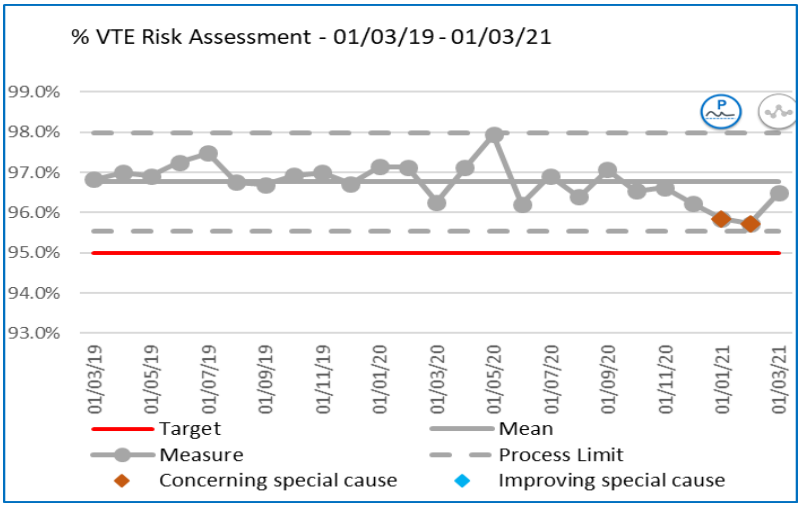
All three of the cancer targets were met in 2020/21, a significant achievement compared to 2019/20. This is a picture the Trust is committed to continuing to deliver during 2021/22.

Cancelled operations – the Trust achieved this standard with 0.3% 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.



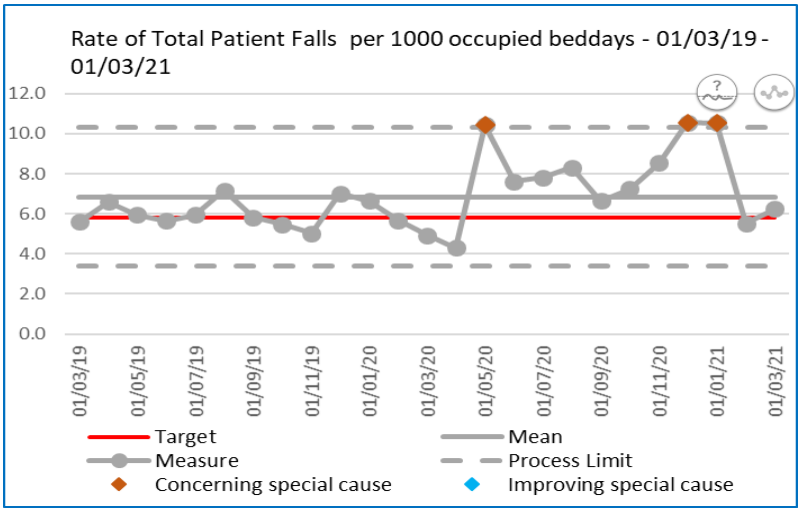
Prevention of Venous Thromboembolism (VTE)

The Trust ensured that the national target of 95% of patients had a VTE Risk Assessment completed on admission to hospital in 2020/21 with an overall score of 96.6%.



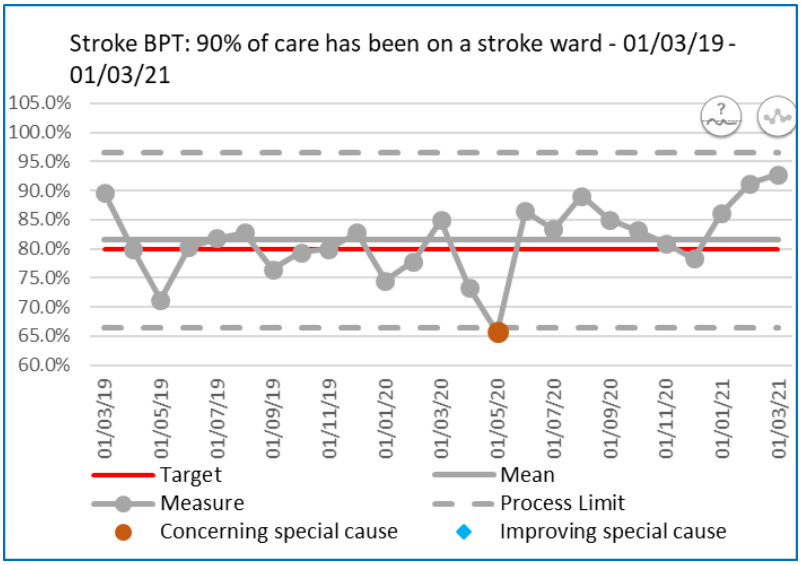
Reducing the number of patient falls

The Trust's rate of falls per 1,000 Occupied Bed days is above the Trust maximum limit of 6.0 at 7.8 at year end (6.9 for the previous year). Fall rates increased considerably during wave 2 of the COVID-19 pandemic, but have subsequently improved.



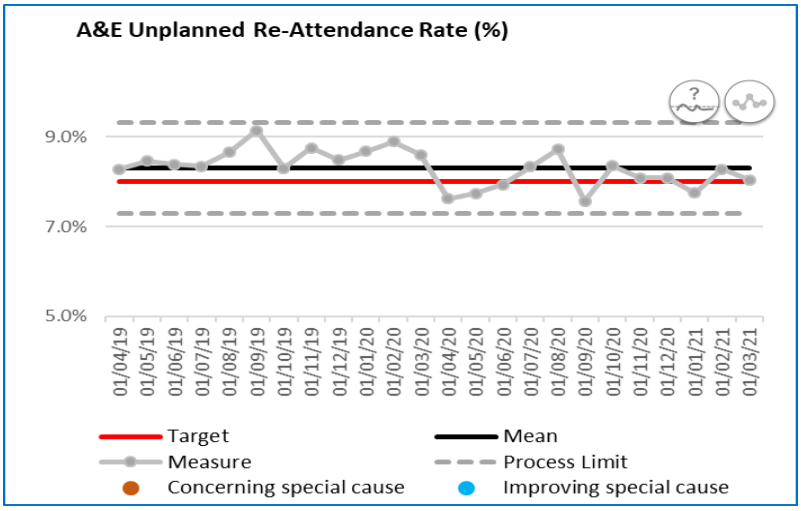
Improving care for patients who have had a stroke

The Trust achieved the standard of 80% of stroke patients to spend 90% of their time on a dedicated stroke ward in 2020/21 at 92.8%, compared to 77.8% in 2019/20.



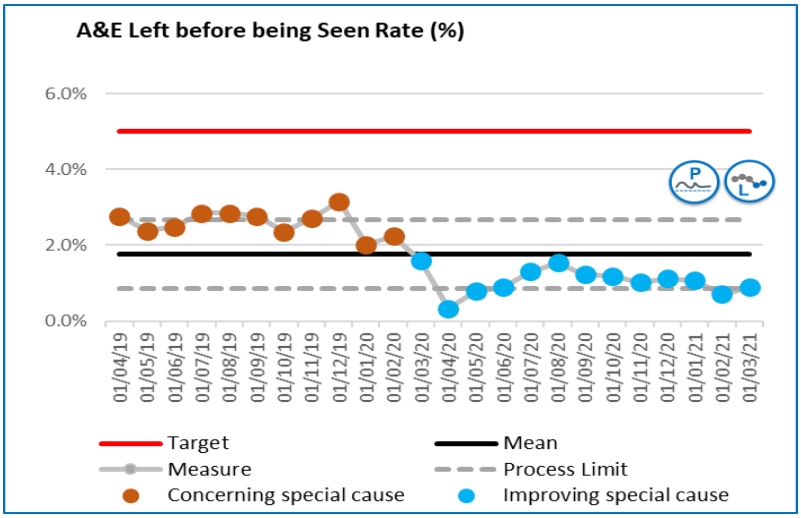
Emergency Department Unplanned Re-attendance Rate

The Trust achieved this standard of less than 8% unplanned re-attendance rate at 8%.



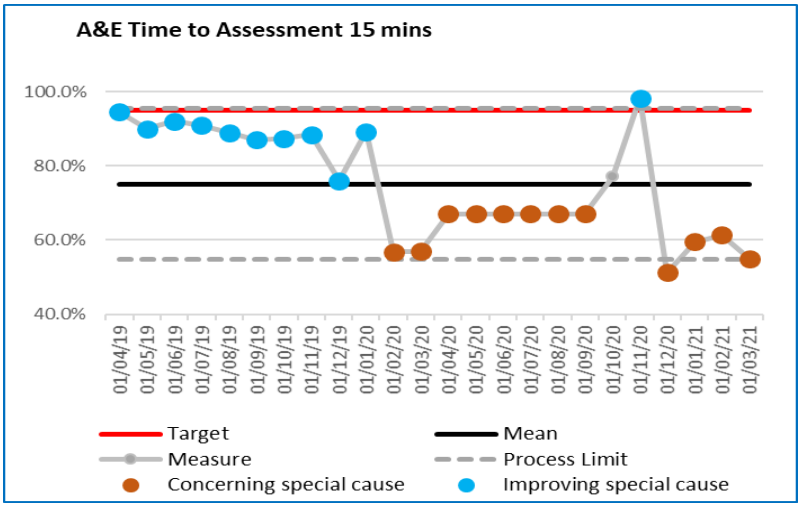
Emergency Department Left without being seen rate

The Trust achieved this standard of less than 5% of patients leaving the Emergency Departments without being seen at 1%. This is an improvement compared to 2.5% in 2019/20



Emergency Department Time to Initial Assessment <15 minutes

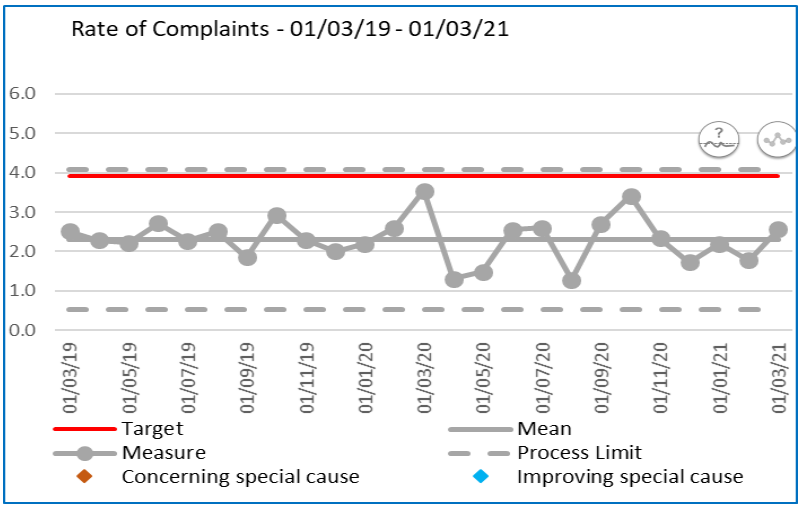
The Trust did not achieve this standard of 95% of patients arriving in the Emergency Departments being assessed within 15 minutes of arrival at 67.1%.



Complaints

The number of formal complaints received by Maidstone and Tunbridge Wells NHS Trust in 2020/21 significantly decreased. This was a direct result of the COVID-19 pandemic, which saw a reduction in clinical activity for periods during the year, coupled with an assumed increase in support for the NHS by the public.

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 2.20 for the year (2.40 for the previous year).



On 31 March 2020, NHS Improvement/England issued guidance to all NHS healthcare providers, recommending that the complaints system be 'paused' for an initial three-month period. Emphasis was placed on the need to continue to maintain any Patient Advice and Liaison Service (PALS, or equivalent) to ensure that any incoming complaints/concerns could be

triaged on receipt. Triaging would ensure all immediate appropriate action could be taken should the complaint/concern identify a serious incident, safeguarding or competency issue.

All complaints open at that time were reviewed by the Complaints and PALS Manager to identify which could be completed with no or minimal input from the patient facing clinical teams. Those complaints, which could not be progressed without moderate/significant input from the front-facing clinical teams were 'paused' in line with the recommendations. All affected complainants were contacted to advise them of the situation.

At the same time, all face to face services offered by PALS and complaints were suspended. This was to support the national lockdown, government instruction to 'stay home' and to ensure the safety of staff. The PALS offices were closed to personal callers (attending the actual office in person), but remained accessible to the public via telephone and email. Any complainant awaiting a local resolution meeting was contacted and advised that this would be postponed indefinitely at that time and they were offered the opportunity to receive a further written response instead. In mid-May, the complaints leads were issued with laptops and the team began to organise virtual local resolution meetings using WebEx.

The 'pause' ended on 30 June 2020. A full complaints service resumed, although local resolution meetings continue to be held virtually. The PALS offices have remained closed to personal callers, in order to maintain COVID-19 secure environments. Going forward, this will be reviewed in line with the national roadmap and local arrangements.

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.

Quote from a complainant:

'I wanted to acknowledge how thorough and personal the response was – it addressed elements of our complaint in a pragmatic and understanding way and I am pleased that the overall complaint was upheld……The written response has gone a long way in addressing our concerns and it is encouraging to hear of the specific actions taken as a result.'

During 2020/21 we received 389 new complaints, compared to 562 in 2019/20. 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 71.3% for the year, against a target of 75%. As might be expected, performance has varied during the year in line with activity levels linked to the management of the COVID-19 pandemic. However, the Trust achieved or exceeded 75% for seven months of the year, peaking at 96.8% in August.

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. Case studies and key messages from complaints are regularly included in the Trust's monthly Governance Gazette. The Gazette is an electronic newsletter used as a tool for sharing learning and other information from the Quality Governance team.

COMMUNICATION CORNER

We recently responded to a complaint from a patient with a hearing impairment, who had a poor experience when attending an outpatient clinic. The patient received no support in terms of her hearing loss, despite her informing the clinic receptionist on arrival that she was profoundly deaf and lip reads. The only seat in the waiting area was positioned somewhere the patient could not see the staff. After an hour, the patient enquired and was told that her name had not been called, but a short while later, the patient was collected by a nurse who told her that she "hadn't been listening" and her name had been called an hour ago.

On investigation, one of the points that was identified was that there was no flag on Allscripts to alert staff to this patient's hearing impairment and this was not identified by staff on her arrival at the clinic.

This case is a good example of the importance of us meeting the **Accessible Information Standard**. This is a statutory requirement placed upon us to ensure that service users receive information in a format that is accessible for them.

How you can help

- **ASK** if people have any information or communication needs and find out how to meet those needs.
- **RECORD** those needs and consent in a way that is highly visible on the electronic and / or paper record.
- **FLAG** on the person's electronic record and put a communications need sticker on their paper record
- **SHARE** information about the person's needs with other teams, services, agencies and providers during referral, discharge or handover.
- **ACT** to make sure people get their information in the way they have requested and have their communication needs met.

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

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 Experience Surveys

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

During 2020/21 the Trust participated in three national patient surveys: Urgent and Emergency Care (UEC) Survey, Inpatient Survey and Children and Young People's Survey. The surveys were undertaken by Quality Health for our Trust. At the time of writing the results for the Urgent and Emergency Care (UEC) Survey had been released to the Trust but these are embargoed

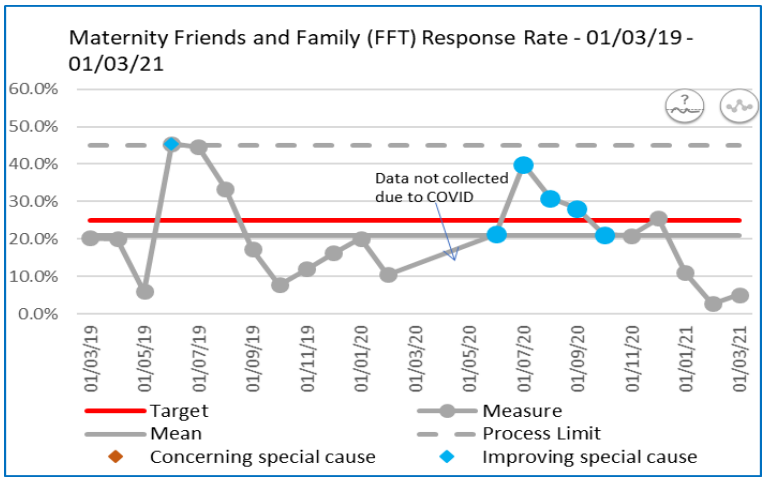
until they are released nationally later in the year. The Trust awaits the results for the Inpatient Survey and the Children and Young People's Survey.
Due to the COVID-19 pandemic the Maternity survey was cancelled and the Trust chose not to participate in the National Cancer Patient Experience Survey, which became voluntary to undertake. The Trust will be taking part in the Maternity Survey in 2021.

Friends and Family Test (FFT)

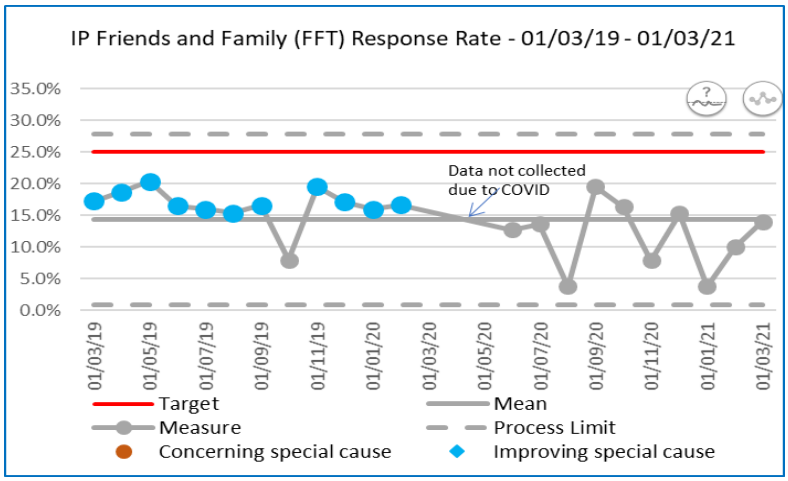
Friends and family feedback submission was stopped temporarily during the first wave of the COVID-19 pandemic. The data submission discontinued in accordance with NHSE/I guidelines. The organisation received instruction to recommence submission of December's data for the January reporting period; this was during the second peak of the pandemic. Due to these circumstances, submission was not as expected in the same reporting period for the previous years.

Submission of feedback increased significantly in the month of March 2021 when the peak of the pandemic had subsided. We are working towards a higher rate of submission to capture larger feedback in order to evidence and action future change. We have moved towards electronic submission, which provides immediate capture and analysis.

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 20.7%. Of all the responses received for patients accessing Maternity Services 97.6% were positive. Data was not collected for April and May 2020 due to the COVID-19 pandemic.



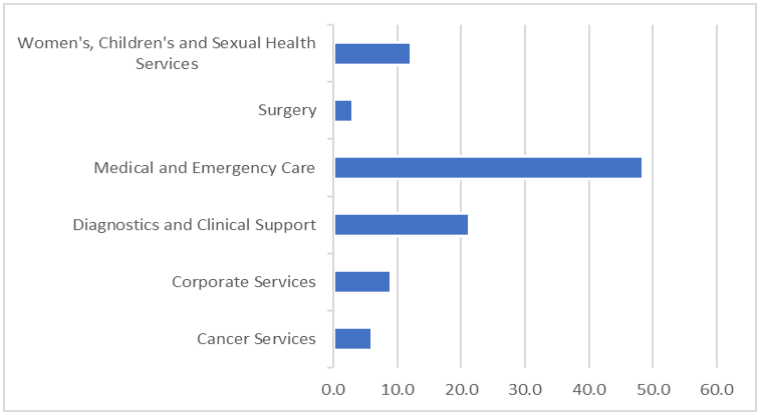
The Trust did not achieve the target of 25% response rate for the Friends and Family Test given to inpatients with a result of 14%. Of the responses received 96.1% were positive. Data was not collected for April and May 2020 due to the COVID-19 pandemic.



Local Patient Surveys

All local surveys that are registered with the Patient Outcomes team are entered into a database and their progress is followed up to monitor completion. 33 local patient surveys were registered with the Patient Outcomes Team during 2020/21. Final reports with action plans were submitted to the Patient Outcomes team for 9 (27%) surveys. There were a high number of surveys that were put on hold due to the COVID-19 pandemic and staff being redeployed.

Directorate	No	%
Women's, Children's and Sexual Health Services	4	12.1
Surgery	1	3.0
Medical and Emergency Care	16	48.5
Diagnostics and Clinical Support	7	21.2
Corporate Services	3	9.1
Cancer Services	2	6.1
	33	



An action plan database has been populated to monitor implementation of actions arising from the local patient surveys. This will capture evidence of developments to improve patient experience.

Staff Survey / WRES

Staff Survey 2020, WRES 2020, WDES 2020

This section outlines our most recent staff survey results from 2020 with a focus on the experiences of staff regarding harassment, bullying, abuse and discrimination; equal opportunities in terms of career progression and reasonable adjustments for staff with disabilities.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
White staff: 20.0% (2019 findings 25.8%) – national average for acute Trusts is 24.4%

BAME staff: 27.4% (2019 findings 26.9%) – national average for acute Trusts is 29.1%

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

White staff: 87.2% (2019 findings 86.4%) – national average for acute Trusts is 87.7%

BAME staff: 75.1% (2019 findings 74.2%) – national average for acute Trusts is 72.5%

Percentage of staff experiencing discrimination at work from a manager/team leader or other colleagues in the last 12 months

White staff: 5.8% (2019 findings 6.4%) – national average for acute Trusts is 6.1%

BAME staff: 16.5% (2019 findings 13.3%) – national average for acute Trusts is 16.8%

Very little has changed since 2019 but we have seen a 3.2% increase in the number of BAME staff who have experienced discrimination from staff. This is also reflected in the average national increase of 2.6%.

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

	2019	2020
MTW: staff with a LTC or illness	23.8%	20.6%
MTW: staff without a LTC or illness	10.3%	10.7%
Average: staff with a LTC or illness	18.5%	19.3%
Average: staff without a LTC or illness	10.8%	10.8%

*LTC – long term condition

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

	2019	2020
MTW: staff with a LTC or illness	28.7%	26.3%
MTW: staff without a LTC or illness	18.6%	18.4%
Average: staff with a LTC or illness	27.7%	26.9%
Average: staff without a LTC or illness	17.5%	17.8%

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

	2019	2020
MTW : staff with a LTC or illness	74.4%	77.6%
MTW : staff without a LTC or illness	86.0%	86.2%
Average : staff with a LTC or illness	79.3%	79.6%
Average : staff without a LTC or illness	86.1%	86.3%

Percentage of staff agreeing that they have had reasonable adjustments made to enable them to carry out their work

	2019	2020
MTW : staff with a LTC or illness	68.3%	76.3%
Average : staff with a LTC or illness	73.4%	75.5%

There has been little change from the 2019 results with the exception of a 7% increase in the number of staff receiving reasonable adjustments to help them undertake their role. All results are in line with the national average of acute Trusts in England.

Staff Networks

The Cultural and Ethnic Minorities Network have provided additional support to our BAME staff over the last year by hosting twice monthly meetings. These meetings enabled our BAME staff to discuss the issues affecting them by COVID-19 and the killing of George Floyd. Over time the meetings have evolved into learning sessions with speakers from MTW and outside the Trust, including our local MP Helen Grant. The sessions have been open to all MTW staff.

The LGBT+ Network have struggled to move their usual activities and celebrations during the year to the virtual environment and are very much looking forward to returning to a face to face environment in the coming months.

The Disability Network was re-launched at the end of 2020 and is in the early stages of forming the committee. They are dedicated to supporting the learning and development of staff and managers to aid their support of staff who have disabilities or have long term health conditions.

Focus for 2021/22

- **Safe Space Champions Network** – developing a network of staff who are trained and supported to provide a listening ear to staff with worries and concerns. Developing staff confidence to tackle issues or signpost to alternative support.
- **Mediation provision** – developing a robust mediation process, which provides facilitated conversations and mediation to help resolve workplace issues and concerns.

- **EDI Recruitment Champions** – developing a network of staff who are trained in how to provide challenge within the recruitment process to ensure fairness and equity.
- **BAME Mentoring Programme** – developing opportunities to train staff in mentoring skills to provide support to BAME staff in bands 5 – 7 to help develop their career within MTW.
- **Reverse Mentoring Programme –** launch first cohort of the programme with a focus on the lived experiences of BAME staff paired with members from the Trust Board, including all Executives and Non-Executive Directors.
- **White Ally Programme –** developing a programme of learning to support white staff to become active allies for our BAME colleagues.
- **Talent Boards** – creating talent boards with effective stretch assignments, with a focus on BAME staff in bands 5 – 8A.
- **Reasonable Adjustments Passport** – design and launch a reasonable adjustments passport that supports discussions with managers for staff with long term health conditions to ensure that adjustments are made and reviewed regularly.
- **Disability Leave Policy** – introduce a policy that reflects the differences between disability related sickness and disability leave.

Freedom to Speak Up (FTSU)

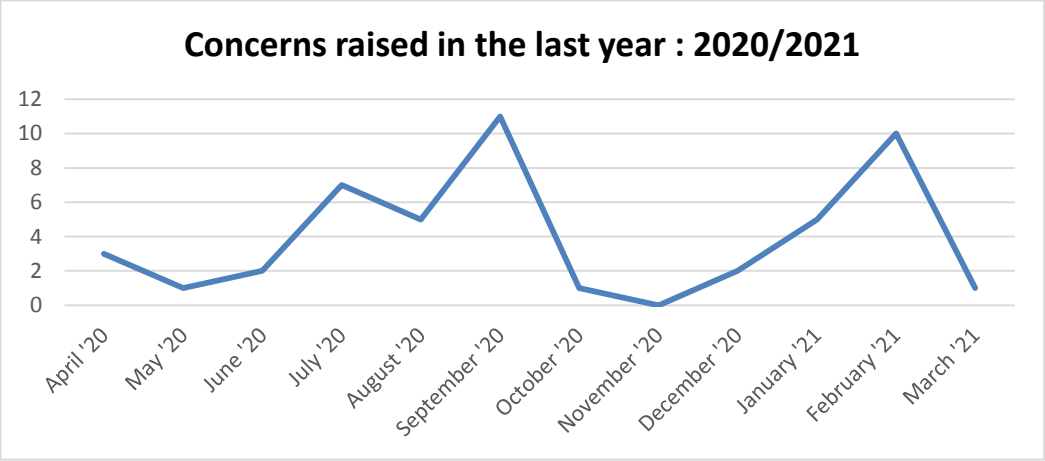
The Freedom to Speak Up (FTSU) agenda is to:

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

By ensuring that:

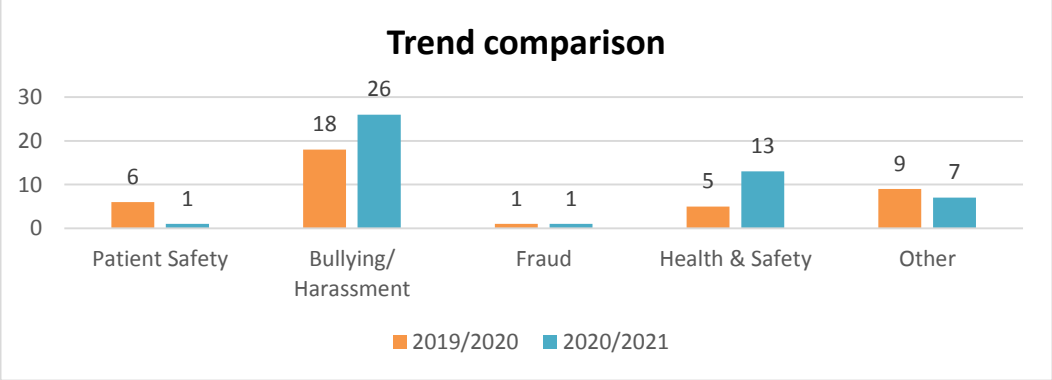
- Workers are supported in speaking up
- Barriers to speaking up are addressed
- A positive culture of speaking up is fostered
- Issues raised are used as opportunities for learning and improvement

During 2020/21 49 cases were raised through FTSU, an increase of 10 cases compared to 2019/20. As the lockdown started to ease in June 2020 and more staff were returning to work on site there was a significant increase in cases. September had the highest recorded number of cases raised. As the number of COVID-19 cases began to increase for the second wave across the UK and in the Trust with new lockdown rules being introduced, the number of concerns raised through FTSU decreased initially but began to gain traction in January/February 2021.



Trends comparison

In comparison to 2019/20, the highest number of concerns raised through FTSU were concerns around bullying/harassment and health and safety, an increase of eight concerns for each. In regards to patient safety, there was a huge decline, with only one concern raised in 2020/21, compared to six concerns in 2019/20.



Progress in implementing the FTSU strategy

In addition to the number of concerns raised and in spite of the vaccine roll out during the previous quarter, the following actions have been successfully achieved by the FTSU guardians to further promote the agenda:

- FTSU Guardians continue to attend various network meetings and provide support to staff who raise concerns through the networks
- Materials /screensavers for publicising the FTSU agenda are now available and have been put up in staff areas on both sites
- An interview was held with Peter Maskell, Medical Director, in January to promote the FTSU agenda
- BAME lived experience session was held with the BAME allies in January and a follow up meeting was held to discuss action plans, which are currently been implemented
- A Freedom to Speak Up presentation and facilitated conversation took place on 25th February during the Cultural and Ethnic Minority Network meeting; this enabled BAME staff to share some of their experiences and the support they receive
- The FTSU guardians, in partnership with the Learning and Development team, have worked closely in embedding the FTSU agenda in Trust inductions
- The process of recruiting Safe Space Champions to work closely with EDI and FTSU team is ongoing. In March, a pilot training to review the content of the presentation was

conducted with representatives from various networks. The Learning and Development team were also in attendance.

Growing the Speaking Up Agenda

The National Guardian office, in partnership with Health Education England, has launched two 'Speaking up' themed e-learning packages for all workers and line managers. This training will be very useful for promoting the FTSU agenda. The first module, ***Speak Up***, is for all workers while the second module***, Listen Up***, is for managers. Both modules focus on listening and understanding the barriers to speaking up. A final module, ***Follow Up***, for senior leaders, will be launched later in the year to support the development of FTSU as part of the strategic vision for organisations and systems.

Work is being undertaken with the Learning and Development team to include these modules in the MTW e-learning system with the recommendation that this should be a mandatory course for all MTW staff with subsequent refresher training every three years.

Rota Gaps

In August 2020 there were no gaps identified at Foundation Year 1 (FY1) level or at Foundation Year 2 (FY2) level. In addition, we were allocated three additional F2s for August 2020 in order to support the increased intake into GP training programmes in line with the People Plan. Due to the continuing proactive approach by Medical Staffing in the early advertising for prospective gaps we did however recruit three supernumerary FY2s locally. This helped reduce the reliance on agency doctors for gaps through sickness absence, etc. The few gaps at a senior level did not cause a detrimental impact. Overall the fill rate was very good across all specialties, including an additional training post in Clinical Radiology.

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

- Clinical Fellowship Programmes: There are a number of established Fellowship Programmes in the Trust, particularly in the Emergency Medicine Department and the Anaesthetic Department.
- Senior Clinical Fellows: The Emergency Medicine Department has an ongoing four year Senior Clinical Fellow Certificate of Eligibility for Specialist Registration (CESR) programme. The programme entails undertaking essential secondments in Anaesthetics, ITU, Paediatrics and Acute Medicine to complete the Curriculum requirements.
- 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. Trust post numbers were increased; however in the event only one WAST doctor joined the Emergency Medicine Department on a year's placement. This doctor has remained in the Trust in the Acute Medicine Department.
- One Chief Medical Registrar was appointed in October 2020, at Tunbridge Wells Hospital, under the Royal College of Physicians programme. The Chief Registrar undertakes this 50% clinical and 50% management role whilst in their training programme.

- 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 2021; updates are provided to the Trust's Workforce Committee.

The Trust followed Health Education England directives during the peak periods of the COVID-19 pandemic. In line with this guidance Trainee rotations that were due to take place in April 2020 did not occur, with Trainees remaining in their original placements. However, for operational reasons a number of Trainees were redeployed and F2 doctors in GP Practice and F1s in Community Psychiatry were brought back to the Acute Trust to support Emergency Medicine and Medicine. During the second wave, the directive was that training should continue and planned rotations took place. During the peak of the second wave it was necessary to seek Postgraduate Dean approval to bring some Trainees back to the Trust from their GP community placements; however this was only for a 2-4 week maximum period.

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. Due to the COVID-19 pandemic, the face to face Trust-wide learning events were postponed. The Patient Safety team plan to launch "virtual" Learning Events in 2021/22 where staff and stakeholders will be invited to attend.

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 129 SIs in 2020/21; compared to 131 in 2019/20, which decreased to 113 following 18 downgrades granted by the Clinical Commissioning Group. The number of downgrades for 2020/21 is awaiting validation so the figure of 129 may reduce.

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

Two ‘Never Events’ were declared at the Trust in 2020/21. Full RCA investigations were undertaken for the two 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 with the aim of ensuring that lessons are learnt to prevent recurrence.

Actions and learning from SIs are key to improving safe, effective and high-quality patient care. In 2020/21 learning and actions included:

- Introduction of competencies that allow extended roles for experienced nurses.
- Human factors training in place 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.
- Robust Standard Operating Procedure for security officers working in the Emergency Department to be written, agreed and disseminated across the teams.
- New interim local protocol implemented, identifying that any chest x-rays requested for confirmation of NG tube placement should be reviewed by reporting radiographers, consultant radiologists and consultant anaesthetists to confirm safe placement prior to commencing feed.
- Immediate review of e-learning package against national patient safety alert for enteral feeding and implementation of a working group to establish and implement competencies to run alongside the e-learning package.
- Clarification of roles and responsibilities and education on the new Tele-tracking system.

Actions completed by the Patient Safety Team in 2020/21:

- A training package and schedule was put in place for joint root cause analysis (RCA) with Kent and Medway NHS and Social Care Partnership Trust (due to the pandemic the training was put on hold in March 2020).
- Created and launched the new Performance Dashboard module on Datix.
- Delivered revised Duty of Candour training.
- Delivered Datix training Trust-wide.
- Established the Patient Safety Strategy Working Group to implement the revised Patient Safety strategy (established but postponed due to the pandemic).
- Wrote a briefing paper in preparation for the introduction of the Patient Safety Incident Response Framework (PSIRF) (implementation now on hold until Spring 2022).
- Nominated two Patient Safety Specialists to represent the Trust in the delivery of the NHS Patient Safety Strategy and PSIRF.
- Recruited two Serious Incident Investigators to the team to lead on investigations and identify learning and actions to improve patient safety.
- Launched the culture survey in March 2021 to ascertain feedback from staff around the incident reporting process
- Reviewed and strengthen processes for following up outstanding Duty of Candour notifications.
- Reviewed and strengthen how Duty of Candour is recorded on Datix.
- Implemented and embedded Duty of Candour dashboards for Divisions to easily identify outstanding incidents.

Next steps for the Patient Safety Team:

- To continue to report on monthly Key Performance Indicators.
- Complete quarterly compliance audits for Duty of Candour.
- To continue to deliver regular Duty of Candour training sessions Trust-wide.
- To increase support for staff having Duty of Candour conversations with patients and/or families in order to improve patients'/families' experiences.
- Implement the action plan developed in relation to the culture survey
- Recruit to substantive Governance Systems (Datix) expert role. This role will be the subject matter expert and will work with staff to make the system as user friendly as possible, therefor having a positive impact on incident reporting.
- Reinvigorate the working group set up in response to the National Patient Safety Strategy and accompanying action plan.
- Prepare for the rollout of PSIRF (currently planned for Spring 2022).
- Expand the pool of both incident and SI lead investigators in the Trust.
- Support clinicians through training sessions to investigate incidents robustly and in a timely way, with the patient/family at the centre of the investigation.
- Explore closer working with the Medical Examiner Service to ensure bereaved families have a positive experience of both Patient Safety and Medical Examiner services.

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: Ongoing review in high dependency areas**
- Standard 9: Transfer to primary, community and social care
- Standard 10: Quality Improvement.

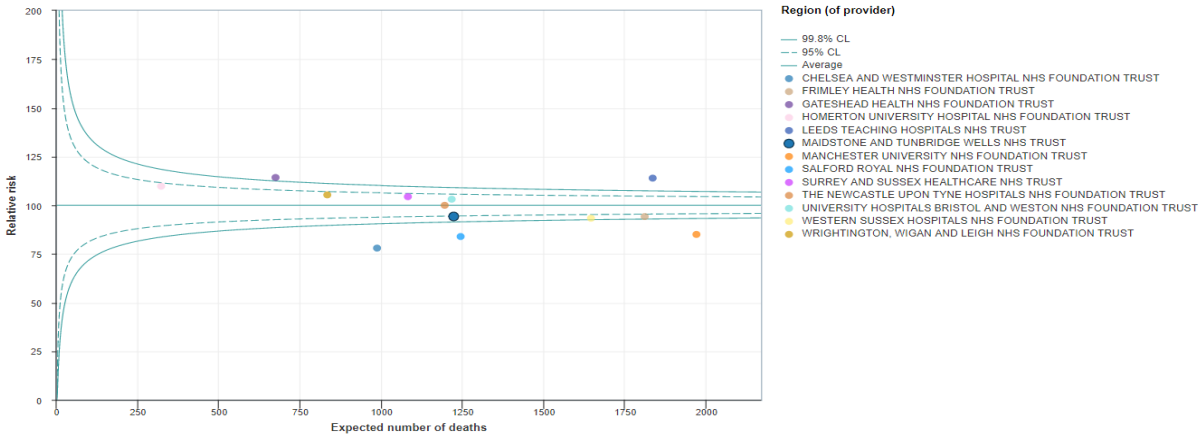
Those highlighted in **bold are the priority standards.*

Reviews against these standards were paused during 2020/21 due to the COVID-19 pandemic and will be re-established during 2021/22.

Learning from Deaths (Mortality Reviews)

During 2020/21 the Trust has continued to see mortality rates reduce overall in line with the reduction we previously evidenced in 2019/20. A slight increase has been seen in the most recent reporting period, which will be monitored closely at the monthly Mortality Surveillance Group and will be considered in the context of the second wave of COVID-19 experienced in November 2020 – January 2021. However, we are still performing below the expected rate of 100 (expected number of deaths). 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.

HSMR Benchmarking – Good and Outstanding Trusts



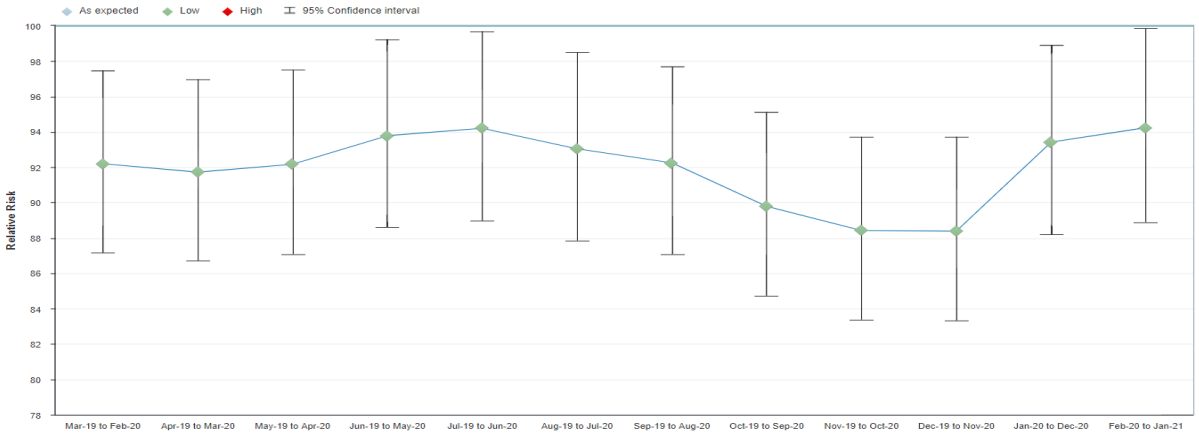
The Trust Mortality Surveillance Group (MSG) has been operational since January 2016 and meets monthly to review all hospital related mortality data, identify trends and share learning. This group reports directly to both the Quality Committee and the Trust Board. The chair of this Group is the Chief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

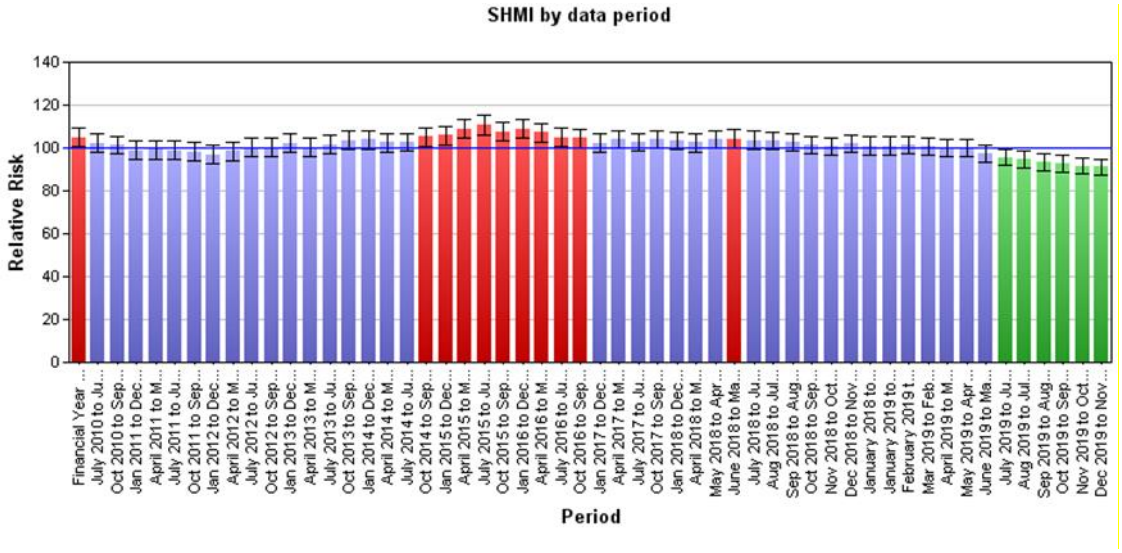
In March 2020 our HSMR was recorded as just below 92 (a ratio of the actual number of deaths to the expected number of deaths); in January 2021 we reported HSMR at 94.2. The expected rate is 100 or below.

HSMR Data from February 2020 – January 2021 (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.

The most recent SHMI data published by the Health and Social Care Information Centre (HSCIC) for the period December 2019 to November 2020 showed the Trust's SHMI as 0.9106, which was banded at level 2 'as expected'. As a Trust, our SHMI continues to improve, with 6 months consecutively as a positive outlier.



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, SJR).

During 2020/21 the Trust recorded 1,905 patients who had died: 1,871 inpatient deaths and 34 in the Emergency Department (ED). The current mortality review process had already been identified as being labour intensive with learning having to be manually extracted. Funding had been approved to purchase the Mortality Datix IQ Cloud module; however, work to progress this was paused due to COVID-19. The module will be implemented in 2021/22. 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.

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.

TIAA undertook an internal audit of the mortality review process in Maidstone and Tunbridge Wells and published their findings in February 2021. Their overall assessment of the process found "reasonable assurance". An action plan has been developed in response to the findings and this is being reported to and monitored by the MSG.

Reporting Period April 2020 – March 2021

Trust	Q1	Q2	Q3	Q4	Total
No of Deaths	387	313	576	629	1905
No of Completed Reviews	281	194	484	619	1578
% completed reviews	**72.6%**	**61.9%**	**84%**	**98.4%**	**82.8%**

In relation to the 1,905 patient deaths that occurred during 2020/21, 34 structured judgment reviews have been completed to date, equating to 1.78% 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 34 reviews undertaken the judgements in regard to care provided were:

Very poor care	1
Poor care	3
Adequate care	8
Good care	12
Excellent care	10
Total received	34

Learning identified from Mortality Reviews during 2020/21 includes:

- The need for clear and comprehensive documentation in the patient's healthcare record.
- The need for prompt assessment of our patients' pressure areas on admission and the delivery of timely treatment if indicated.
- The need for prompt Venous Thromboembolism (VTE) assessment and timely preventative measures if these are indicated.
- The need for comprehensive and clear documentation around VTE assessment.
- The need for thorough assessment of our patients prior to discharge from the Emergency Department.
- The need for prompt recognition of patients who are at end of life so that they can be cared for appropriately and so that timely and clear communication can take place with patients and their families.

Medical Examiner Service

There is a requirement for all Acute Trusts in England to establish a Medical Examiner Office.

The purpose of the Medical Examiner System is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- To 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.

Maidstone and Tunbridge Wells implemented this service in September 2020 and it is now well embedded in the Trust. Since September, the service has been working to scrutinise all deaths that happen in the hospital. This involves reviewing the patient's healthcare record and speaking with a medical member of the team who looked after the patient. The Medical Examiner will also speak to the family to provide them with an opportunity to talk to a doctor who wasn't involved in the care of their loved one and raise any concerns they may have.

The scrutiny may prompt a number of different actions such as a referral to the Coroner, signposting the family to our Patient Advice and Liaison Service or a further, more in-depth review such as an SJR. Where it is detected that sub-optimal care may have been provided, the service requests that the Serious Incident process is considered and Duty of Candour is instigated where indicated. This is an opportunity to then review Trust processes and procedures to make the necessary changes as a result of lessons learned.

The Medical Examiner Service provides monthly updates to the Mortality Surveillance Group so that any learning the service has identified in their scrutiny and from talking to bereaved families can be shared and addressed.

The Trust is now working with key external stakeholders such as the local community Trust, the local hospice, GPs and the CCG to plan for and implement the rollout of the Medical Examiner Service to the community in 2021/22.

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 carrying out 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	2020/21 local and national data	2019/20 local and national data	National average
1 & 2	(a) the value and banding of the Summary Hospital-level Mortality Indicator ("SHMI") for the Trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. *The palliative care indicator is a contextual indicator.	91.63 (Band 2 – "As Expected") 36% Nov 2019 – October 2020	102.03 (Band 2 – "As Expected") 43% Dec 2018 – Nov 2019	Best 73.22 Band 3 Worst 112.74 Band 1 Lowest 8% Highest 59% Mean 36% Nov 2019 – October 2020
3	PROMS			
	i) groin hernia surgery ii) varicose vein surgery iii) hip replacement surgery iv) knee replacement surgery during the reporting period (*See below for explanation of reporting data)*	No data No data 0.50 0.340	No data No data 0.44 0.337 (Apr 16 - Mar 17)	No data No data 0.437 0.323
3	the percentage of patients aged (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital, which forms part of the Trust during the reporting period.	**Elective** 5.7% *1 **Non-Elective** 6.2% *1 **Elective** 10.9% *1 **Non-Elective** 18.5% *1	**Elective** 5% *1 **Non-Elective** 5.2% *1 **Elective** 8.2% *1 **Non-Elective** 17.1% *1	**Elective** 4.1% **Non-Elective** 9.4% **Elective** 3.8% **Non-Elective** 14.0%
4	The percentage of staff employed by, or under contract to, the Trust	81.4%*2	74%*2	

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	2020/21 local and national data	2019/20 local and national data	National average
	during the reporting period who would recommend the Trust as a provider of care to their family or friends.			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.	96.6%*3	96.7%*3	95.33% 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.	27.4 *4	21.4 *4 2019/20	13.85 2017/18 tbc
5	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, The number and percentage of such patient safety incidents that resulted in severe harm or death. *(See below for explanation of reporting data)*	12,470 14.62 per 1,000 bed days 129 (0.44%)	12,491 302 (0.46%)	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 2021 (based on April 2019 to March 2020) shows an improvement in health gain following an operation for both surgical procedures.

Adjusted average health gain

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

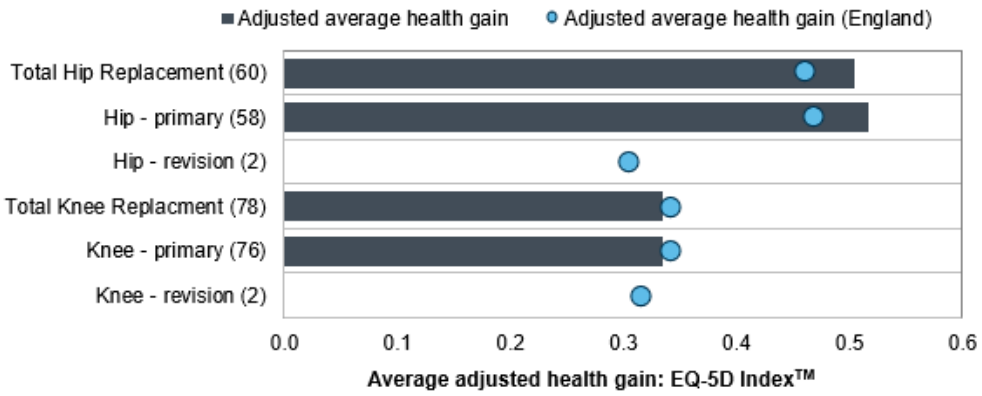


Figure 2: Adjusted average health gain on the EQ-VAS by procedure

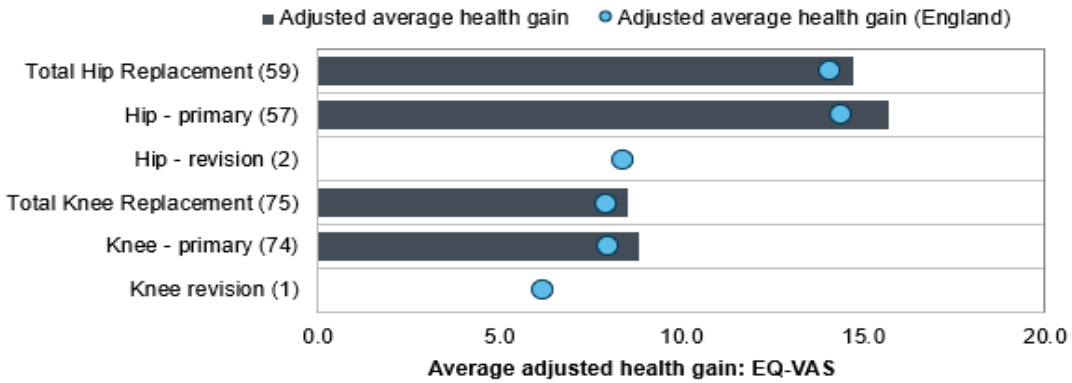
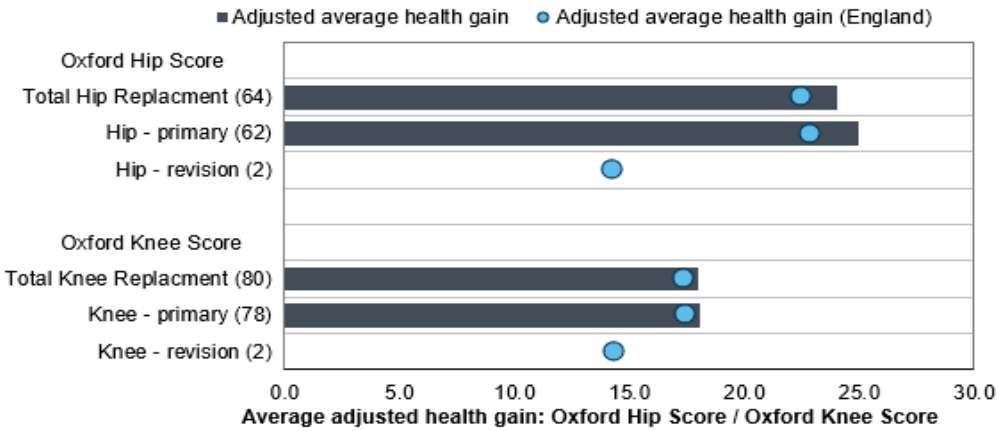
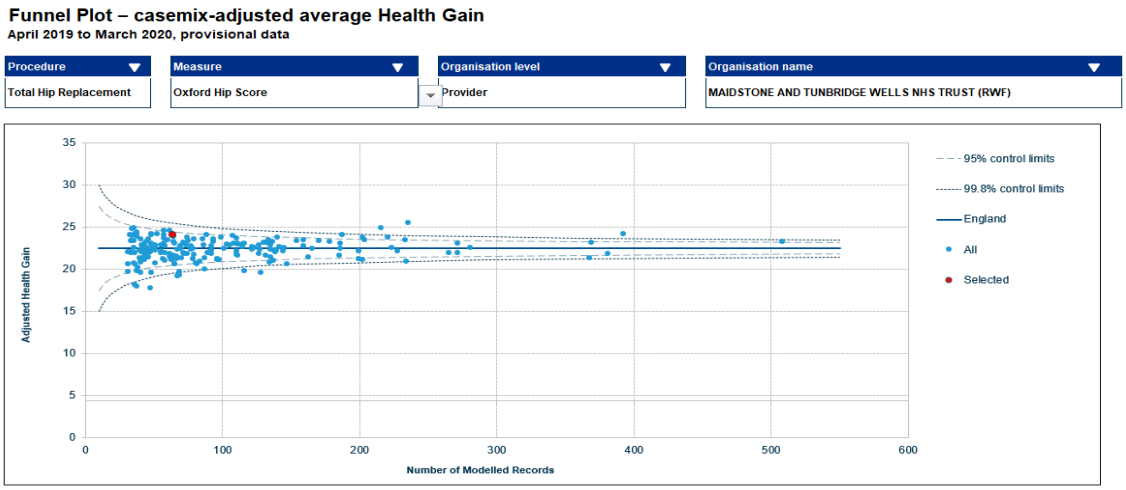


Figure 3: Adjusted average health gain on the Oxford Hip Score / Oxford Knee Score by procedure

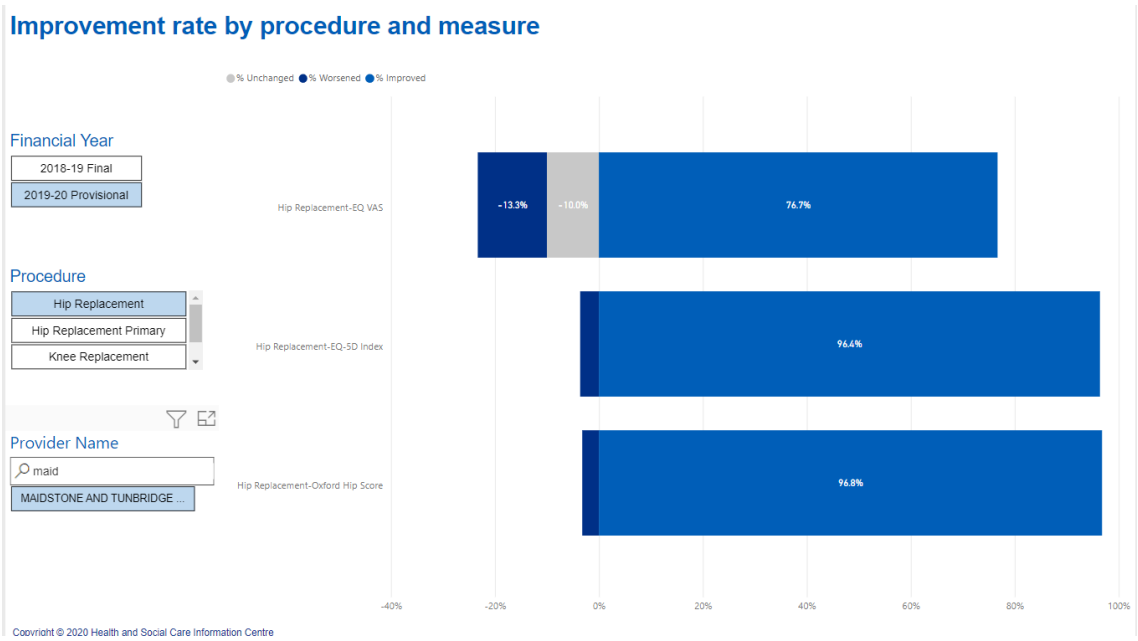


As can be seen the Trust scored above the national average for all three measures for Total Hip and Knee replacements, with most patients reporting an improvement following surgery.

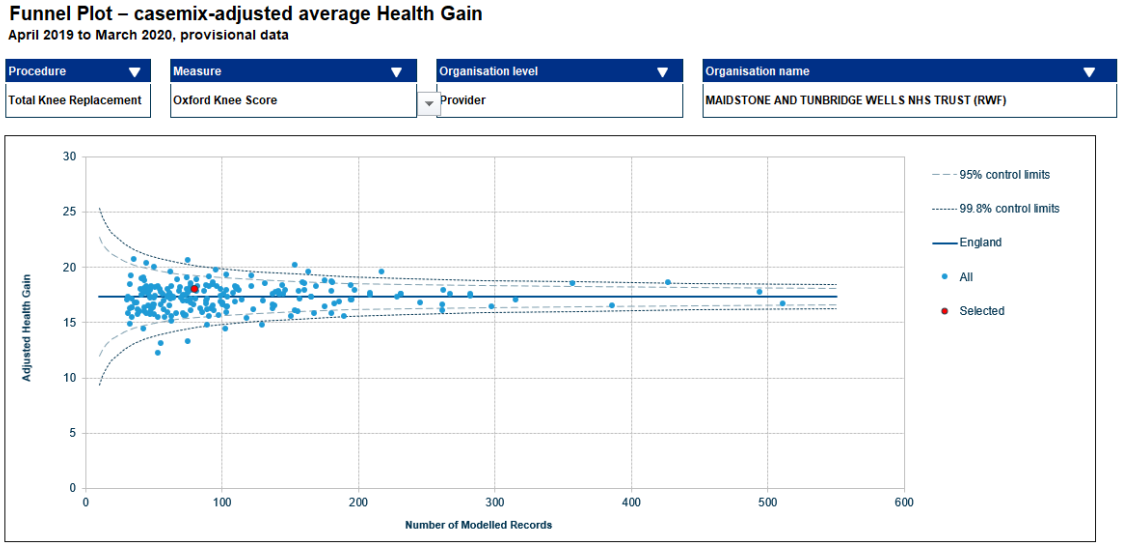
Total Hip Replacement – 64 returns of which 63 reported an improvement in health following the procedure (using the Oxford Hip Score PROMS Measure).



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

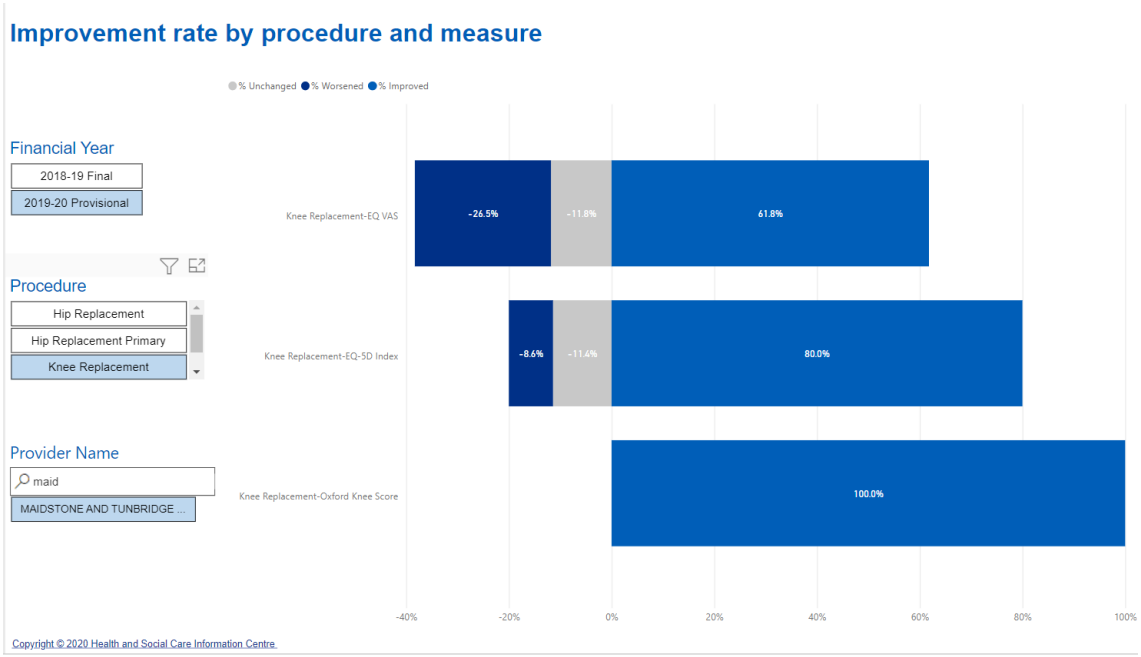


Total Knee Replacement – 80 returns of which 79 reported an improvement in health following the procedure (using the Oxford Knee Score PROMS measure).



MTW exceptional people, outstanding care

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



Additional areas of significant improvement during 2020/21

1. Response to COVID-19 Pandemic

MTW Vaccination Centre

The Academic Centre at Maidstone was converted into a vaccination centre in December 2020 to provide Covid-19 vaccinations to MTW staff. A portal system was set up for booking slots and a range of staff from across the organisation worked together to deliver an efficient and effective vaccination roll-out. Non-clinical staff were redeployed to provide the administration support needed, pharmacy staff ensured a ready supply of the vaccines and clinical staff undertook the vaccine administration. The Trust worked with colleagues from South East Coast Ambulance Service (SECAmb) and local hospices to include their staff in the vaccination programme. The Centre also managed to vaccinate some of our high risk patients with cancer. In total 30,300 vaccinations were administered.

Respiratory Enhance Care Unit (RECU)

A 12-bed respiratory unit was set up within 24 hours at Maidstone hospital to meet the needs of clinically unwell patients with COVID-19 that required enhanced respiratory care but not intensive care. General Managers, Doctors and Matrons worked with teams from Estates and Facilities, Emergency Planning, IT and Programme Management Office (PMO) to create the unit in space freed up by ITU. This was possible because ITU vacated this location, moving into an alternate space to create more ITU capacity. The unit was staffed by seven specialist respiratory nurses providing care to patients requiring this non-invasive type of ventilation. The specialist respiratory nurses were supported by seven Clinical Support Workers (CSWs) and one Nursing Associate, working alongside respiratory doctors and physiotherapists.

COVID-19 Virtual Ward

Joint working between the Respiratory Team, Clinical Systems and the Transformation Team led to the establishment of a COVID-19 Virtual Ward, with the first patient being admitted just three weeks from the first discussion. The virtual ward allowed patients who no longer require in-hospital care for coronavirus, to monitor their condition from the comfort of their own home, safe in the knowledge that they were still under the care of MTW. The patients had regular telephone calls from the virtual ward team to check on their condition.

Drive through pharmacy for patients with cancer

A drive through pharmacy was set up so patients with cancer could receive vital medication without the need to enter Maidstone Hospital during the COVID-19 pandemic.

The cabin, known as a Medicines Pick Up Pod, was set up in car park B next to the Kent Oncology Centre so patients, or a relative or carer, could drive up or arrive on foot to collect their prescribed medicines. These were issued by one of the two members of staff from the Trust's Oncology Pharmacy Team. The drive-through pharmacy helped to 'shield' patients with cancer from COVID-19 as they are at high risk of contracting the virus due to having a weakened immune system.

Connecting patients with their families virtually

iPads helped inpatients stay connected with their loved ones whilst on our wards. More than ever inpatients needed to be able to stay in contact with their family and friends. Being able to stay in touch with their loved ones is not only good for our patient's wellbeing but also their recovery.

To help them stay connected with their nearest and dearest during the pandemic the Trust provided 55 iPads to wards at both hospital sites so patients could see and speak to those closest to them via video messaging services, such as FaceTime or Skype. A total of 42 iPads were introduced initially in April 2020 after visiting restrictions were put in place to help protect both patients and staff from the virus but as the weeks passed more iPads were allocated, including 10 to the Intensive Treatment Units (ITU) at both hospital sites.

Heart-warming stories shared by staff about how patients have used the iPads include a patient on ITU being able to wish their son a happy birthday from their hospital bed and another patient

being able to see his wife, children and dog for the first time in five weeks. Due to the visiting restrictions, having the iPads on ITU meant staff could also help relatives who sadly need to say their final goodbyes to their loved one before they pass away. In line with infection prevention control policies, the iPads are wiped down before and after each use.

As well as providing patients with technology solutions so they can communicate with their loved ones, policies have also been put in place by the Trust so relatives, carers and friends can still get essential items to inpatients during the pandemic.

One Team Runners

A project was set up to recruit staff members, working at all levels across the Trust, to volunteer to help and support clinical areas during the pandemic. The project was called 'One Team Runners' and was an outstanding success. The volunteers were paid on the staff bank to work extra hours over and above their normal MTW role. Tasks undertaken by the runners differed from ward to ward and included the following:

- Ensuring staff get a cup of tea and something to eat
- Passing items required into bays / rooms for clinical staff i.e. linen, washing items, sundries, meals and drinks
- Answering the phone and taking messages
- Running errands such as collecting medication from pharmacy or delivering notes
- Collecting patient property and making sure it gets to the patient
- Co-ordinating and assisting with communicating with families i.e. Facetime – ensuring equipment is charged and connecting to Wi-Fi
- Supporting patient surveys and feedback
- Receiving handover from clinical staff in order to be able to make a pro-active call to the patient's family and update them on any non-clinical aspect of care
- Receiving messages from family to pass onto the clinical support volunteer / nurse / patient / CSW
- Restocking the wards
- Monitoring hand hygiene.

This is me - the face behind the mask

Staff working on the Woodlands Unit at Tunbridge Wells Hospital developed a novel way of letting the children they treat see their faces without the need to remove their mask - they each wear a badge showing their faces normally. This helps to create a more patient focused environment and is also proving to be a conversation starter for the children with many of them commenting on what the nurse really looks like underneath their mask.

Woodland themed visors for paediatric staff

More than 450 woodland themed visors were developed and donated to paediatric staff working on Woodlands Unit and Hedgehog Ward at Tunbridge Wells Hospital and the Riverbank Unit at Maidstone Hospital. The reusable, polycarbonate, child-friendly visors can be worn by the Paediatric Team whilst carrying out procedures on children, which involve them having to cough or having throat swabs or bloods taken.

PPE Safety Officers

The importance of using, donning and doffing Personal Protective Equipment (PPE) correctly led to the creation of a PPE Safety Officer role within MTW. The PPE Safety Officers were introduced across both sites providing a 7 day service from 08.00 to 16.00 / 21.00hrs. The PPE Safety Officer's purpose is to ensure staff are safe and feel safe wearing PPE. They routinely visit all wards and departments offering advice on the correct use of PPE and answer any questions the staff have. This role is one of many developed in response to the COVID-19 pandemic including a team providing FIT-testing of FFP masks, staff undertaking COVID-19 swabbing and a team rolling out the lateral flow testing kits to staff.

2. Awards

Finalist for the Acute or Specialist Trust of the Year Award

17 March 2021 marked the virtual awards ceremony of the HSJ Awards and MTW was one of four finalists to be shortlisted for the Acute or Specialist Trust of the Year Award. It was a great achievement to make it through to the final stages of this prestigious competition as it recognised the achievements of staff across the organisation and their focus on delivering outstanding patient care. As a result of everyone's efforts, MTW is now one of the best performing Trusts in the country for emergency care and cancer services. The Trust has introduced a wide range of patient and staff-centred initiatives – all focused around its 'Exceptional People, Outstanding Care' programme. Not only improving the care and services it provides but also making MTW a great place to work. MTW has also invested in new facilities and staff development and welfare, brought in new talent locally and from overseas thanks to successful recruitment campaigns, and introduced innovative ways of working to ensure patients get skilled, compassionate care quickly.

National award for Infant Feeding Team

A film made by the Trust's Infant Feeding Team has won JOHNSON'S® Excellence in Maternity Care and Innovation Award in the Royal College of Midwives (RCM) Annual Awards. The video Colostrum Collection in Pregnancy: 'When to start and how to do it', shows those who are pregnant how to express their first breast milk (colostrum) by hand in the late stages of pregnancy, collect it using a syringe and then label and store it in a freezer at home ready to take to the hospital when they go into labour.

This practice is recommended if it is anticipated that the baby may experience difficulties with feeding or maintaining their blood sugar levels after birth, as the previously collected colostrum can then be used. This is especially important for babies at risk of being born prematurely, if the parent has diabetes, or it is a twin pregnancy. It is also recommended in other circumstances, such as if the person is taking certain medications, has a raised BMI, has a breast abnormality or has had breast surgery, or found breastfeeding challenging in the past.

Known as 'liquid gold' due to its golden yellow colour, colostrum is the perfect food for new born babies because it is full of antibodies which help protect them from infections and also contains the perfect balance of carbohydrates, fats and proteins.

HSJ Value Awards

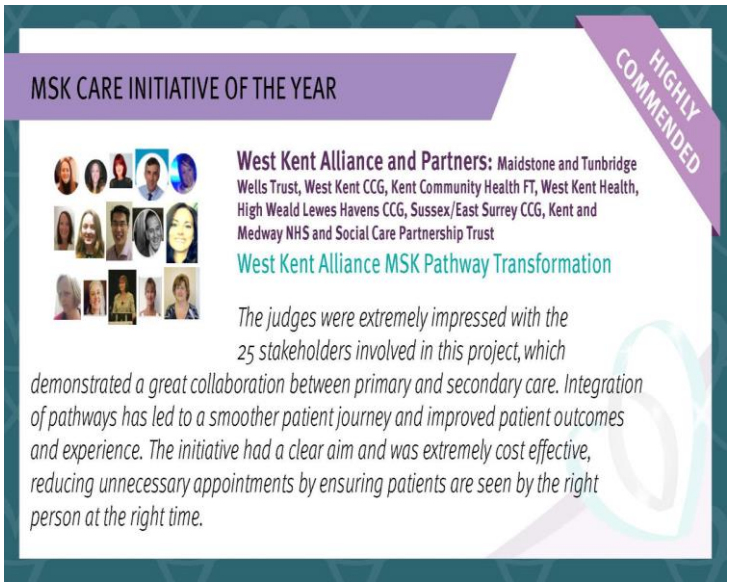
The Finance Team received a highly commended award after it put itself forward for Finance Team of the Year in the Operational and Corporate Category. The five shortlisted NHS teams were asked to showcase the most efficient and innovative projects they are working on that are helping their wider organisations deliver better services and improved outcomes.

The MTW team was recognised for supporting the Trust's Outstanding Care, Exceptional People commitment; supporting the Trust from Financial Special Measures to recurrent surplus within 3 years, as well as the links it has developed with industry, research and national bodies.

The West Kent Alliance (WKA) Musculoskeletal (MSK) Pathway Transformation Team, which MTW's Transformation Team is part of, received a highly commended award for the Musculoskeletal (MSK) Care Initiative of the Year in the Clinical and Medical Services category.

The WKA is made up of six NHS partners, including MTW NHS Trust, which all work together with the support of a Joint Programme Management Office (JPMO) to transform and deliver system wide treatment pathways for patients.

It is through this joint approach that the alliance has managed to improve waiting times for MSK patients by ensuring they get patients to the right place first time for MSK services in West Kent acute and community services. This was done by creating a single point of access and clinical decision making unit all of which has resulted in good patient and staff feedback. The changes also resulted in a £1million saving.



Finalists in the Dementia Care Awards
MTW made it through to the finals of the Best Dementia Friendly Hospital category in the National Dementia Care Awards 2020 hosted by the Journal of Dementia Care.

3. New developments

New Patient Experience Midwife

A six-month pilot was undertaken to test the concept of a Patient Experience Midwife role that enabled us to hear from parents about their first-hand experience of our maternity services. The midwife listened to many new parents describing their experiences of maternity care at Tunbridge Wells Hospital. Gathering peoples' experiences, will help us understand what we can do to make everybody's experience the best it can possibly be and ultimately hopefully reduce complaints.

Video messaging service on the Neonatal Unit

Parents of premature and sick babies being cared for on the Neonatal Unit at Tunbridge Wells Hospital can see their baby via video when they're unable to be with their child. The secure video messaging application vCreate, which has been rolled out on the Neonatal Unit permanently following a successful three month pilot, is now more important than ever for bringing babies and parents together. The technology, which allows clinical teams to send video updates to parents when they're not able to be at the hospital, was made possible thanks to the Morrisons' Foundation. The Foundation, part of the national supermarket chain, donated £9,600 to Maidstone and Tunbridge Wells NHS Trust Charitable Fund, which will fund the service for two years.

vCreate aims to minimise separation anxiety and bring comfort to worried parents who haven't been able to take their baby home with them as planned. Parents can login to the vCreate App at any time to see how their child is progressing and can leave notes and feedback for the nursing team. Once their baby has been discharged from hospital, parents are able to download the videos and keep them forever.

John Allen and partner Allison Woods (pictured) used the app when they couldn't physically be with their son Rafferty whilst he was being cared for on the Neonatal Unit at Tunbridge Wells Hospital.

Rafferty, who was born at 26 weeks weighing just 900 grams, spent a total of 102 days in three different hospitals – 65 of which were spent on the Neonatal Unit at Tunbridge Wells Hospital – following his birth on 19 December 2019. He was eventually discharged from the unit on 30 March 2020 – six days after his original due date. Dad of two John, from Kings Hill, said the video messaging service gave the family a boost because it meant they were able to see Rafferty was doing ok in between hospital visits.

Launch of Mental Capacity Act Hub

As part of the ongoing work to improve compliance with the Mental Capacity Act and safeguard our patients the Trust launched a Mental Capacity Act (MCA) E-Hub in 2021. The hub is an electronic resource for staff with access to detailed information, videos and the MCA Directory from the Social Care Institute for Excellence (SCIE).

Maidstone Acute Frailty Unit

Building work to extend the Acute Frailty Unit (AFU) at Maidstone Hospital has now been completed. Former office space at the front of Whatman ward, where the unit is located, has been converted to accommodate four assessment chairs which now sit alongside the existing five trolleys in an adjoining bay. AFUs, which have been running for two years at both the Maidstone

and Tunbridge Wells sites, provide specialist care to patients over the age of 70 from 8am to 8pm, Monday to Friday and from 10am to 6pm, on weekends and Bank Holidays. Patients are currently referred to the unit either via the Emergency Departments or the Acute Assessment Units on each site. By expanding the unit at Maidstone, the plan is for GPs to be able to refer patients directly to the unit and for South East Coast Ambulance Service (SECAmb) to be able bring patients straight to the unit on a more regular basis in the near future with the aim of reducing admissions, decreasing the patient's length of stay and improving patient outcomes. Not only will this help with patient flow but also provide our patients with a better experience during their time on the unit. Increasing the size of the unit also means there is more room for the consultant, three registrar doctors, two nurses and a personal assistant who are based there to work in.

Expansion of Maidstone Rapid Assessment Point

An assessment area for patients brought by ambulance to Maidstone Hospital's Emergency Department (ED) was doubled in size to help ensure patients receive rapid access to the right care and treatment by the right people in the right place. Opened on Monday, 8 June 2020 as part of the Trust's plans to improve patient care, the number of bays in the Rapid Assessment Point (RAP) has increased from three to seven after the service was moved to the front entrance which is used by South East Coast Ambulance Service (SECAmb).

In order to create the clinical area, several offices were relocated to the new Acute Assessment Unit (AAU) which opened at the beginning of March and is sited next to, and accessed via ED. The total cost of the RAP expansion project, which was overseen by the Trust's Estates Department, was £400,000. Included in the cost are plans to convert the former RAP area into further clinical space.

RAP is a national best practice tool designed to support best patient care. Patients who arrive by ambulance are taken to RAP where they are assessed by a senior clinical decision maker, such as an emergency medicine registrar or consultant. That person can then either refer the patient to a speciality such as the medical or surgical teams or order tests or images to help diagnose a patient so those investigations are ready when they are assessed by the next emergency clinician, speeding up their visit to the department. Increasing RAP's capacity allows rapid handover of the patient's care from SECAmb to our staff, which then allows SECAmb crews to get back on the road and respond to the next emergency call in the community.

New Surgical Assessment Unit

A new Surgical Assessment Unit (SAU) at Tunbridge Wells Hospital was opened on 21 December 2020.The SAU, which was previously based inside the hospital, is now located in a new modular building adjacent to the Emergency Department (ED). The move forms part of the Trust's plans to enhance its Same Day Emergency Care (SDEC) pathway so that more patients can benefit. The acute unit, which is operational 24-hours a day seven days a week, houses a waiting area, a clinic room, and a procedure room complete with an ultrasound machine. It is staffed by a Senior Surgical Doctor, who is based on the unit at all times, Nurses and Clinical Support Workers (CSWs). A receptionist will staff the desk Monday to Friday between the hours of 8-6pm.

Part **four**

Appendices

Appendix A

41 national audit reports were published where the topic under review was relevant to the Trust in 2020/21. These national reports are listed below with the key actions developed in response to the recommendations stated in the reports to improve the quality of healthcare provided.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
Adult Critical Care Case Mix Programme (ICNARC) (CMP)	Y	Report summaries published in February 2021. The report is with Theatres and Critical Care for review and action plan development.
BAUS Urology Audits: Nephrectomy Audit 2017-19	Y	Report published 30th September 2020: The trust is not an outlier in any of the reported areas. No actions required.
BAUS Urology Audits: Radical Prostatectomy Audit	Y	Report published 30th September 2020: Fully compliant, no actions required.
Cardiac Rhythm Management (CRM) 2017/18 & 2018/19	Y	Report published 10th December 2020: A business case has been approved for a Band 4 coordinator to provide administrative support for NICOR audit data submissions
Coronary Angioplasty / PCI 2018-19	Y	Report Published 10th December 2020: The report is with Cardiology for review and action plan development.
Emergency Laparotomy Audit (NELA)	Y	Report published 12th November 2020: The report is with Theatres and Critical Care for review and action plan development.
Epilepsy12 National Clinical Audit of Seizures and Epilepsies for Children and Young People	Y	Report published 10th September 2020: Mental health provision for children with epilepsy at the Trust to be reviewed. The outcome may result in a business case for in house CAMHS input for epilepsy and other paediatric subspecialty patients.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
Falls and Fragility Fractures Audit Programme (FFFAP) - National Audit of Inpatient Falls (NAIF).	Y	Report published 12th March 2020: 1. Laminated hard copies of falls guidance for older people to be provided to all wards and units 2. Trust-wide communication on the availability of the scoop stretchers and their locations
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture database (NHFD)	Y	Report published 14th January 2021: The report is with Trauma and Orthopaedics for review and action plan development.
Heart Failure 2018-19	Y	Report Published 10th December 2020: The report is with Cardiology for review and action plan development.
MBRRACE-UK Maternal, New-born and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance 2018	Y	Report published in 10th December 2020: The report is with Women's Services for review and action plan development.
MBRRACE-UK Perinatal Confidential Enquiry Stillbirths and neonatal deaths in twin pregnancies	Y	Report published 14th January 2021: The report is with Women's Services for review and action plan development.
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 2016-18	Y	Report published 14th January 2021: The report is with Women's Services for review and action plan development.
MINAP 2018-19	Y	Report Published 10th December 2020: The report is with Cardiology for review and action plan development.
NACAP Adult Asthma National Clinical Audit Report 2019-2020	Y	Report published 14th January 2021: The report is with Respiratory for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
NACAP Pulmonary rehabilitation 2019	Y	Report published 10th December 2020: Fully compliant with recommendations, no actions required.
National Adult Asthma and COPD clinical audit 2018/19	Y	Report Published 9th July 2020: The Trust is undertaking service reviews and formulating business plans to increase staff resource, including the appointment of an Asthma and Non-Invasive Ventilation Consultant Lead.
National Adult Diabetes Inpatient Audit – Harms (NaDIA-Harms) 2019	Y	Report Published 13th November 2020: The report is with Medical Specialties for review and action plan development.
National Adult Diabetes Inpatient Audit (NaDIA) 2019	Y	Report Published 13th November 2020: The report is with Medical Specialties for review and action plan development.
National Audit of Bowel Cancer (NBOCAP)	Y	Report published 10th December 2020: The report is with Cancer Services for review and action plan development.
National audit of Breast Cancer in Older People (NABCOP)	Y	Report published 9th July 2020: The Trust is fully compliant with all criteria, no actions required.
National Audit of Care at the End of Life	Y	Report published 9th July 2020: 1. Business plan for a 7-day service to be submitted 2. Develop a medications information leaflet 3. Introduce advance care planning tool for end of life care i.e. AMBER Care Bundle.
National Audit of Lung Cancer (NLCA)	Y	Report published 13th August 2020: The report is with Cancer Services for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
National Comparative Audit of the Management of Maternal Anaemia	Y	Report published 6th August 2020: Develop "Management of Anaemia in Pregnancy" guidelines which will incorporate British Society for Haematology guidance.
National Confidential Enquiries into Patient Outcome and Deaths – Time Matters	Y	Report published 11th February 2021: Critical Care Department to review and update Percutaneous Coronary Intervention referral policy with Cardiology Department.
National Diabetes Audit (NDA) Core audit 2017-18	Y	Report Published 10th December 2020 The report is with Medical Specialties for review and action plan development.
National Early Inflammatory Arthritis Audit – Second Annual Report	Y	Report published 14th January 2021 The report is with Rheumatology for review and action plan development.
National Joint Registry (NJR)	Y	Report published 15th September 2020: Fully compliant with recommendations, no actions required.
National Maternity and Perinatal Audit (NMPA)	Y	Sprint Multiple Births Report published 13th August 2020: The report is with Women's Services for review and action plan development.
National Oesophago-gastric cancer (NAOCG) 2020	Y	Report published 10th December 2020: The report is with Cancer Services for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
National Paediatric Diabetes Audit 2018-19 (NPDA) (1193)	Y	Report published 12th March 2020: 1. Increase support for technology led monitoring such as Libre Flash Glucose monitoring by identifying the patients who would most benefit from the system due to impact of diabetes on quality of life 2. Create an amber alert point for high HbA1c patients at 64 mmol/mol and build a new amber alert pathway to include clinic appointments every 2 months and individualised plans in High HbA1c policy.
National Paediatric Diabetes Audit – parent and patient reported experiences (PREMS) 2019	Y	Report published 12th November 2020: The report is with Children's Services for review and action plan development.
National Perinatal Mortality Review Tool	Y	Report published 10th December 2020: The report is with Women's Services for review and action plan development.
National Prostate Cancer Audit 2020	Y	Report published 14th January 2021: 1. Where appropriate offer combined systemic therapy, either with docetaxel or novel anti-androgenic therapy to people with newly diagnosed metastatic disease 2. Submit a business case for a late radiotherapy toxicity clinic 3. Submit a business case for a local High dose-rate Brachytherapy Service.
National UK Inflammatory Bowel Disease Biologics Registry	N	Decision made by IBD Registry to postpone the IBD annual report for 2019/20 due to COVID-19.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
Neonatal Intensive and Special Care (NNAP)	Y	Report published 12th November 2020: 1. Continue to encourage parents to be present on ward rounds as partners in care or use video calls for parents unable to visit. 2. Work towards UNICEF Baby Friendly Initiative Stage 2 award and accreditation. 3. Submit business case for increased outpatient time for physio to complete Bayley scoring system.
National UK Paediatric Inflammatory Bowel Disease Biologics Registry	N	Decision made by IBD Registry to postpone the IBD annual report for 2019/20 due to COVID-19.
RCEM Assessing Cognitive Impairment in Older People (care in the ED) 2019	Y	Report published 9th February 2021: The report is with Emergency Medicine for review and action plan development.
RCEM Care of Children in Emergency Departments 2019	Y	Report published 25th January 2021: The report is with Emergency Medicine for review and action plan development.
RCEM Mental Health Care in Emergency Departments 2019	Y	Report published March 2021: The report is with Emergency Medicine for review and action plan development.
Sentinel Stroke National Audit Programme – Annual Report 2019-20	Y	Report published 14th January 2021: The report is with Stroke Team for review and action plan development.
Serious Hazards of transfer (SHOT) UK. National Haemovigilane Scheme	Y	Report published 17th July 2020: The report is with Pathology for review and action plan development.

National audit report published April 2020 to March 2021	Report received	Date report published and key actions
The Trauma Audit and Research Network (TARN)	Y	Report published April 2020: 1. Emergency Department consultant to be informed of trauma patient with Injury Severity Score (ISS) >15 on arrival in the emergency department to enable assessment within 5 minutes of arrival. 2. Trauma Fellow to review patients and identify any delays to CT to improve trauma pathway for patients with head injuries.

Appendix B

71 local clinical audits were completed during 2020/21. These local clinical audits are listed below with the key actions developed in response to the recommendations in the reports to improve the quality of healthcare provided.

Clinical Audit Title	Key Actions
Documentation Audit – General Surgery 2020	Include “Good record keeping” in General Surgery Junior Doctor Induction Programmes. Patient ID stickers and self-inking name pads introduced to save time.
Pressure Ulcer Prevalence Clinical Audit August 2020	Meetings with Tissue Viability Champions to assist with staff education to be rescheduled post COVID-19.
Re-audit of the accuracy of intraoperative frozen pelvic sections	This audit has shown a continued high accuracy rate of the frozen section service, but a persistent need to more evenly distribute the caseload between team members. To be discussed at Gynaecology Pathology Governance meeting.
Colorectal Cancer Audit for lymph node harvest, incidence of vascular invasion and serosal involvement: re-audit	Good compliance with standards, no actions recommended at this time.
Re-audit of compliance with the policy and procedure for the assessment of patients presenting with diarrhoea	1. Audit report to be included on Infection Prevention and Control Committee (IPCC) agenda (August 2020). 2. Audit report to be disseminated to ward managers and link workers.

Clinical Audit Title	Key Actions
Re-audit of catheter associated urinary tract infections and compliance with the HOUDINI criteria	1. Audit report to be presented to the Infection Prevention and Control Committee (IPCC), Ward Managers and Matrons. 2. Findings of the audit to be shared at the Link Workers meeting 3. Share the findings of the audit with the Gram Negative Reduction UTI Working Group.
Monitoring compliance and effectiveness of antimicrobial prescribing for patients on Ward 20 at Tunbridge Wells Hospital	1. Provide training for prescribing members of the healthcare team emphasising the key points of antimicrobial stewardship and what they should be doing in their clinical practice. 2. Create handouts and posters for the ward and staff with reminders of the standards.
An audit to assess the rate of high-grade dysplastic adenomas for individual pathologists who report for the West Kent & Medway Faecal Occult Blood Tests BCSP (Bowel Cancer Screening Programme) during 2017	1. Audit results to be presented at the Medway and West Kent BCSP clinical meeting. 2. The audit will be presented at the GI pathology governance meeting.
Critical Care Pain Observation Tool (CPOT) Compliance Audit	Continue to disseminate the use of CPOT and reiterate the importance of pain assessment/ management for patients overall experience and outcomes by: 1. Ensuring that all patients have a CPOT baseline assessment completed. 2. All non-verbal patients will have at least one CPOT assessment per shift (non-baseline).
Compliance with spontaneous breathing trials in mechanically ventilated patients – Guideline for the Provision of Intensive Care Services standards	1. Increase ICU staff awareness of the need for daily respiratory function evaluations and that this is clearly documented within the patients' healthcare record at ICU staff meeting. 2. Display poster with audit results, findings and recommendations on the ICU.
Avoidance of gaps in the radiotherapy treatment schedule for all category 1 patients	Category 1 patients that have a gap in treatment schedule due to unrelated illness should have Biologically Effective Dose Calculations if hyper fraction is not possible (for discussion at Consultant's meeting post COVID-19).
Re-audit: are new, stopped or changed medications clearly documented on discharge summaries?	1. Clinical Audit report findings to be shared with clinical teams as a reminder about good record-keeping of medications in patient healthcare records. 2. Identify clinical pharmacy staff members who have not yet read the updated SOP C8 Discharge Medication Preparation and give them protected time to read it. 3. All new members of the clinical pharmacy team to read SOP C8 Discharge Medication Preparation as part of their induction programme.

Clinical Audit Title	Key Actions
Re-audit of Operation Note Completeness and Legibility: The Writing's on the Wall	Development of quick reference template sheet for all Trauma and Orthopaedic theatre staff for operation notes. Also provide instructions on using typed operation notes, with a check list.
A re-audit of compliance to the policy for the use of purple plunger oral /enteral syringes for the administration of liquid medicines and enteral feeds	1. Trust procurement to be contacted to ensure adequate levels of oral/ enteral syringes are available on the wards. 2. Pharmacy to check stocks of oral / enteral syringes on wards every 6 months. 3. Open oxycodone bottles on wards to be checked every 6 months, when undertaking controlled drug (CD) checks to ensure an ENFit bung is in situ.
Audit of fine needle aspiration cytology diagnosis in solid lesions of the pancreas at Maidstone and Tunbridge Wells NHS Trust over a 3-year period (2016-28)	Continue current reporting practices which include double reporting of malignant and suspicious EUS-FNA samples and correlation with concurrent pancreatic biopsies.
Endoscopy re-audit on the manual cleaning of flexible endoscopes prior to decontamination through an Automated Endoscope Re-processor	1. Maintain annual competency assessment of all endoscopy staff who will be involved in endoscope decontamination. 2. Maintain annual refresher training for all endoscopy staff. 3. All endoscopy departments should conduct internal audits on decontamination to ensure that standards are being maintained.
Audit of management outcome of stage 1 ovarian cancer in Maidstone Hospital NICE CG122	Fully compliant with standards. Consider carrying out an audit of frozen section evaluation of complex ovarian cyst/ masses in patients.
Re-audit: accuracy of bronchial brushing/ washing cytology diagnosis via correlation with histology at Maidstone Hospital	Findings of audit to be disseminated to lead respiratory physicians by email and presentation in lung TSSG meeting (concurrent bronchial washings/ brushings and bronchial biopsies should be reserved for cases where biopsy is difficult or contraindicated).
Audit of the management of moderate or severe hyperkalaemia	1. Present findings of audit at the Medical Grand Round in January 2020 at both hospitals. 2. Design and display hyperkalaemia flowchart that can be printed and left on wards to be filled out.
Adequacy of endobronchial ultrasound-guided trans-bronchial needle aspiration for diagnosis and molecular analysis	Fully compliant with standards, no actions required.

Clinical Audit Title	Key Actions
An audit to assess the value of deeper histological levels in Bowel Cancer Screening Programme (BCSP) negative polyps	Six further histological levels should be examined on BCSP negative polyps: • Inform all BCSP reporting pathologists. • Presentation of audit to West Kent & Medway Bowel Cancer clinical meeting. • Presentation at cellular pathology clinical governance. • Add recommendation to BCSP reporting SOP (Standard Operating Procedure).
Management of Appendicitis during COVID-19	Develop a criterion for patients booked for diagnostic laparoscopies to reduce the number of negative diagnostic laparoscopies and patient stay.
Re-Audit to check accuracy of Tumour Site Identification during Colonoscopy 2019	Purchase scope guides to improve the accuracy of tumour localisation (position) which will help when developing the patient's surgical management plan.
A re-audit assessing the quality of Surgical handovers	To improve multidisciplinary team approach to patient care:- 1. During the handover all mobile telephones and bleeps to be silenced to avoid any potential delay or disruption during the handover. 2. A weekly register of those expected to attend handovers will be distributed at the beginning of each week.
A re-audit of analysis of efficiency of emergency incision and drainage of abscesses under General Surgery	An abscess pathway has been implemented to direct patients to allocated emergency theatre sessions which are available three times per week.
NICE CG176 & 161; Management of Head Injuries Audit	A Computed Tomography (CT) cervical spine protocol has been developed to increase the number of patients having a CT cervical spine scan when they have a CT Head scan for trauma.
NICE NG 89 Re-audit Thromboprophylaxis and AES in Surgical patients	Continue to include a talk on VTE prophylaxis and documentation of risks and benefits during junior doctors' Inductions. Poster displayed on surgical wards to remind junior doctors and nursing staff of thromboprophylaxis guidelines.
NICE CG188; Audit of gallstone pancreatitis management	Develop a clear and agreed protocol between the surgery and radiology departments regarding the indication of magnetic resonance cholangiopancreatography (MRCP) in gall bladder disease.
Timing of laparoscopic cholecystectomy following percutaneous cholecystostomy	All patients who are managed with percutaneous cholecystostomy to be offered a follow up appointment within 4 weeks following discharge from hospital unless the patient is deemed unfit for any further management.

Clinical Audit Title	Key Actions
NICE CG188; Hot gall bladder pathway in emergency General Surgery - are we following the guidelines?	An algorithm of the management of patients admitted with a diagnosis of acute cholecystitis/biliary pancreatitis to be available to all doctors in the surgical team. A specific booking form for hot gall bladder pathway to be added to Allscripts to enable online booking and reduce surgical cancellations.
Re-audit: Assessing ENT department medical record keeping compliance using CRABEL scoring	Educate new doctors joining the ENT department during their induction on the importance of a high standard of record keeping; documentation of investigations, diagnosis and management plan. The utilisation of name stamps and patient stickers introduced.
Laser Precision: Checking Accuracy of YAG Laser Consent	1. Patients will be sent a patient information leaflet along with their appointment letter for the laser clinic. 2. To produce procedure specific complication stickers to be used on the consent form.
Re-audit: Number of Hemiarthroplasties that have Pre-Operative Templates	1. Training for those undertaking templating to ensure adequate ability to template. 2. Formal guidance to be developed and included in the patient pathway for templating patients undergoing hemiarthroplasties.
Re-audit of the management of supracondylar fractures of the humerus in children at TWH against BOAST 11 National guidelines	1. Teaching for Junior Doctors during induction on the importance of these fractures and the appropriate assessment and management. 2. Improve wire removal time by encouraging removal in clinic in the first instance.
Montgomery and Informed Consent in Trauma and Orthopaedics; audit of practice at MTW Trust	1. Leaflets to be produced for all procedures and given to patients prior to consent. 2. Jargon free clinic letters to be provided to all patients.
Re-audit: Documentation of medical records in fracture clinic	Reintroduction of the “Fracture clinic pro-forma” at the Trust to improve documentation and ensure that the documented plan is available for the doctor to review at the follow up visit.
Audit on the assessment and investigation of suspected Cauda Equina Syndrome (CES)	A protocol to be developed to prioritise patients with suspected CES in order to reduce the time from presentation to MRI scan and report.
Paediatric forearm fracture management in the children's Emergency Department: Audit and new guideline for manipulation with intra-nasal diamorphine and Entonox	Junior Doctors and Registrars educated at induction sessions on the management of paediatric forearm fractures in the Emergency Department.

Clinical Audit Title	Key Actions
NICE NG12; Assessing the appropriateness of GP referrals to breast clinics	Provide up to date information to West Kent GPs regarding the NICE criteria for 2 week wait referrals to breast clinic and the alternative non-urgent route for patients aged under 30 with an unexplained breast lump with or without pain to reduce inappropriate referrals.
NICE NG118 Acute Management of Renal and Ureteric Stones at MTW	Develop an ambulatory pathway for the management and treatment of renal and ureteric stones. Teaching to Emergency Department doctors and Urology junior doctors to raise awareness of the treatment pathway.
Breast Implant Loss Audit	1. Use of two surgical teams for bilateral cases to reduce operating time 2. Use of skin glue after subcuticular suturing to create an extra layer of protection to pathogens. 3. Business case to introduce medical photography service
NICE CG97 Comparison of the effectiveness of different techniques of prostate enucleation during HoLEP operation	Fully compliant with standards, no actions required.
Early Management of Sepsis re-audit	1. The funding for Sepsis trolleys on wards has been approved. Trolleys to be set up to improve management of sepsis. 2. Sepsis proforma added to the Sunrise Electronic Patient Record (EPR) with mandatory fields for patient reassessments.
Thromboprophylaxis Re-Audit	VTE risk assessment to be added to the Sunrise EPR to ensure compliance and electronic medication prescription service to reduce errors in prescribing.
NICE CG16 - Management of Deliberate self-harm in children who present to the Emergency Department re-audit	1. Electronic Emergency Department proforma to be used for all Deliberate Self Harm. 2. Education of all Emergency Department staff regarding paediatric self-harm and taking an effective psychiatric history
Pacing and DC cardioversion re-audit	Fully compliant with standards, no actions required.
NICE CG 32 Use of the MUST Screening for Malnutrition at Maidstone and Tunbridge Wells NHS Trust - 2019	1. E-Learning set up on Trust Learning Management System and continuation of MUST training on the wards. 2. Dieticians to ensure all wards have a laminated copy of BAPEN (British Association for Parenteral and Enteral Nutrition) MUST guide.
Therapy management of post distal radius fractures re-audit	Online tutorials set up on Trust Learning Management System to ensure efficient recording of data to maximise treatment plan

Clinical Audit Title	Key Actions
NICE CG124 criteria 1.7 Are fractured neck of femur patients receiving daily physiotherapy totalling a minimum of 2 hours in the first 7 days post-surgery?	1. Neck of Femur patients highlighted in written handover and on Nerve Centre to ensure that they are easily identified and prioritised for daily physiotherapy sessions to reduce their length of stay. 2. Amendment of physiotherapy prioritisation matrix
Medical Clerking Proforma Initial Audit	1. Audit findings presented at Clinical Governance and teaching sessions to emphasize the importance of accurate and complete documentation. 2. Current proforma updated for upload to Sunrise Electronic Patient Records.
Quality of Consent in Cardiac Procedures re-audit round 2	1. Circulation of recommendations for consent in the Catheter Laboratory sent to laboratory staff by way of an aide-memoire. 2. Pre-printed labels to be used for patient identification and cross-site procedure specific information to improve legibility of consent forms.
An audit to determine whether exercises are being provided to stroke patients with muscle weakness	1. Review of standardised exercise sheets to ensure that evidence-based advice is provided to patients. 2. Update of discharge checklist to include tick box to provide exercise sheets. 3. Provision of standardised exercise sheet to community services to improve flow and communication between the Acute and Community teams.
Acute Stroke Swallow Assessment	Change of the format of the swallow assessment tool to ensure correct nutrition and lower the risk of aspiration pneumonia
Concordance of Clinical and Imaging Coding with expected and actual Cancer Rates in the Symptomatic Breast Clinic	1. Email audit results to all staff who use clinical and imaging coding for the Symptomatic Breast Clinic 2. Write new SOP using audit findings titled “Clinical Examination of Breast Patients”
An Audit to Evaluate the Diagnostic Adequacy and Safety of Percutaneous Image Guided Liver Biopsy	Fully compliant with standards, no actions required.
Diagnostic Yield of Spinal Disc Biopsies for Malignancy or Infection at MTW Trust	Endeavour to have doctors hold off antibiotics until the disc biopsies are complete by distributing the report to key teams within Trust and advisory email to GPs.
Creating a new local CT Urogram protocol by retrospectively auditing the renal collecting system’s opacification.	Creation of a new CTU protocol to improve the efficacy of scans.
Temporal Artery Biopsy Audit	Clinicians to be made aware of the potential for tissue shrinkage after biopsy sample is taken and fixed in formalin.

Clinical Audit Title	Key Actions
NICE NG157; Guidance for elective shoulder replacements	1. The information leaflet for patients for elective Total Shoulder Replacement to be reviewed and updated. 2. Departmental discussion and consensus regarding the routine in-wound use of Tranexamic Acid and subsequent documentation of its use.
Re-audit of NICE CG98: the management of Neonatal Jaundice	Increase the use of transcutaneous bilirubinometer in Children's Services: 1. Add training in the use of transcutaneous bilirubinometer to induction sessions 2. Purchase additional transcutaneous bilirubinometers.
Safeguarding reports: are we doing it well? Completion of the audit cycle	1. Create a new template for safeguarding reports based on RCPCH's reports template. 2. Weight and height measuring equipment to be available at all required locations. 3. Update proforma to include parental discussion box on Sunrise Electronic Patient Records.
Hepatitis B&C - ways to promote and offer testing (NICE PH43 Criteria 7 only)	1. Improve team knowledge and documentation of Hepatitis B&C including "At Risk Groups" by reviewing case studies in Clinical Governance session. 2. Staff to revisit e-learning for health on Hepatitis B&C.
Re-audit of the Management of Urinary Tract Infections (UTIs) in the sexual health clinic	1. Training for staff on the core symptoms and urine analysis results to diagnose a UTI. 2. Develop UTI clinical diagnosis sheet for Clinical Management Summary on UTIs.
The use of condoms as the sole method of contraception.	1. Teaching session for staff within next three months regarding improving documentation. 2. Raise awareness of the facility to quickly and easily send links to leaflets via text whilst in the consultation (SMS templates).
Audit to assess documentation of recommended data and health parameters when providing Depo-Provera.	1. Develop the B.O.S.S. assessment (B = bones; O = observations; S = smoking status; S = smear test) and implement it. 2. Training session for all staff about the B.O.S.S assessment.
NICE NG 126, QS 69; Re-audit of Diagnosis & Management of Pregnancy of Unknown Location (PUL)	1. Improve communication regarding PUL within the team by updating the clerking proforma. 2. Ensure team is aware of updated NICE guidance and Trust guideline and when to escalate to Consultants by including in induction training session.
NICE NG133, QS35 Re-audit of Hypertension in Pregnancy	Use of mandatory risk assessment question on E3 (electronic patient records) to prompt Midwives and Obstetricians to risk assess patients for pre-eclampsia.
Re-audit of Clinical Outcomes of Obstetric ITU Admissions in 2018 & 2019 at TWH	Fully compliant with standards, no actions required.

Clinical Audit Title	Key Actions
Re-audit of compliance to the swab counting policy in the Obstetric Unit	Review and update the policy to reflect the move to recording SNI counts on the electronic E3 system. Update the departmental guideline. To be included in E3 training.
Audit of management of Obstetric Cholestasis	1. Disseminate the audit recommendations to all the maternity staff and publish it in Women's Echo newsletter. 2. Distribute guideline to all clinicians via email and ask for email confirmation that they have read and understood the guideline.

Part **five**


Exceptional people,
outstanding care
We put patients first!
62 DAY CANCER
STANDARD MET
FOR A YEAR
MTW

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 2020/21 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

NHS
Kent and Medway
Clinical Commissioning Group

Ref: **Maidstone and Tonbridge Wells NHS Foundation Trust Quality Account**

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Sent via email

27th May 2021

Kent and Medway CCGs MTW Quality Account Comments 20/21

Dear Claire,

We welcome the Quality Account for Maidstone and Tunbridge Wells NHS Trust (MTW). The CCG has a responsibility to review the Quality Accounts of the organisation each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document and the CCG confirms that the Quality Account has been developed in line with the national requirements with all of the required areas included.

Your report clearly sets out your key areas of quality focus for the coming year, by identifying priorities for 2021 for each of the three key quality domains; patient safety, patient experience and clinical effectiveness.

MTW
exceptional people, outstanding care

It is evident that Quality Improvement continues to drive your work and although the pandemic has had a major impact on your services, it has resulted in innovative ways of working and positive changes to patient pathways.

Staff at MTW are referred to in the account as a 'family of exceptional people' and their dedication has resulted in some key achievements during the pandemic by; increasing critical care capacity, delivering the 62 cancer access standard and consistent good performance for Emergency Department performance indicators. The culture of the staff is reflected in the response to the staff survey, carried out in the middle of the pandemic, which showed increased staff engagement rates. It is important to note the significant amount of work the Trust has put into supporting staff well-being during this time, alongside innovative ways of engaging with patients and their visitors. This includes the use of video messaging services for patient visitor interactions and the use of video messaging app on the neonatal unit. In addition, the awards the Trust and its staff have been nominated for and received confirms that patients are at the heart of everything you all do.

We would like to thank all of the staff at the trust for their hard work during this unprecedented time.

There is a thorough overview of the work that you have all undertaken this year with a focus on quality. Although the Trust's clinical audit plan was affected, it is noted that audits continued and were prioritised on those relating to clinical care. The Trust contributed to national and international studies relating to the pandemic to support service evaluations. There is a clear commentary on audits which were carried out and how they affected patient experience and outcomes. The research which has continued through the pandemic is noted in particular the responsiveness to which the team enabled delivery of COVID-19 research.

The continued relationship between the Trust and the CCG has allowed collaborative working which will develop into working together within our Integrated Care System (ICS). 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 vision to provide: 'Outstanding hospital services delivered by exceptional people' with the Trust's objectives; To be recognised as a caring organisation, To provide sustainable services and To be improvement-driven across all areas.
Throughout the report you have provided clear and measurable objectives for the coming year, and have maintained the focus within the three clear domains, which gave the report a clear flow, that would be easy to follow for members of the public who may have an interest in reading this report.
In conclusion, the report is well structured and highlights that the quality of patient care remains a clear focus for the organisation and at the forefront of service provision. The CCG thanks the organisation for the opportunity to comment on these accounts and looks forward to further strengthening the relationships with the organisation through continued collaborative working in the future.

Yours sincerely,

Paula Wilkins
Executive Chief Nurse for NHS Kent and Medway Clinical Commissioning Group

Health Overview and Scrutiny Committee – Kent County Council comments on the 2020/21 Quality Accounts for Maidstone and Tunbridge Wells NHS Trust

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Date: 11 June 2021

Dear Sarah,

Maidstone & Tunbridge Wells NHS Trust Quality Accounts 2020-21

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. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trust which will be looking to KCC's HOSC for a response, and the short window 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 services delivered by your organisation and as part of it's ongoing overview function, the

Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council

kent.gov.uk

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

Healthwatch Kent 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 into 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 Trust. We meet regularly with the Chief Nurse, Deputy Chief Nurse and the Patient Experience Lead. We share the feedback we hear from the public directly with them.

MTW exceptional people, outstanding care

- On some occasions we have escalated individual cases to them for immediate action and we're pleased to report that these are picked up and resolved swiftly.
- We are regular attendees as the Patient Experience Committee where we have a standing agenda item to update and discuss our joint work.
- We helped the Trust to organise a session with stroke patients and their families and carers as part of the Trust's plans to develop a new hyper acute stroke unit (HASU). The feedback from people that day has already been used to inform the new unit.
- More recently, we wanted to hear from Medway residents who were being treated on the stroke ward at Maidstone. The Trust willingly helped us to reach stroke patients because we were unable to visit ourselves during the pandemic. The feedback from that exercise will be shared shortly.
- Most encouragingly this year, the Trust have talked to us about their desire to hear from more patients across a range of communities. We offered to develop a Facebook group to enable them to hear directly from people who had been inpatients with Covid. The group, which is a pilot, has been established and is enabling the Trust to hear from and communicate with people about their experience.
- As always, we have continued to review the Trust's communication and engagement materials offering advice and suggestions about how they could be improved. In addition, we provide advice about how best to meet the Trust's statutory requirements to engage and involve people around any changes to services.
- Following our reports looking at the Accessible Information Standard, the Trust have made improvements including Makaton and BSL training being delivered to AIS champions and Recite me software has now been signed off for their new website.

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 year ahead.

Healthwatch Kent June 2021

Statement of Directors' responsibilities

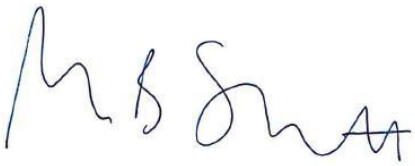
The directors are required under the Health Act 2009 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality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

MTW
Exceptional people, outstanding care

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