Quality Account
2017-18
### QUALITY ACCOUNT 2017-2018

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**Independent auditors opinion and testing of indicators**
Part One

Welcome to the 2017/18 Trust Quality Account. I am pleased to be able to tell you how the Trust has performed this year in key areas of responsibility.

- The Trust has an acceptable mortality rate compared to other acute Trusts in the country measured by the Hospital Standardised Mortality Ratio (Dr Foster Healthcare Ltd) of 96 and the Summary Hospital Mortality Index (NHS Digital) of 1.11.
- The Trust had seven assigned MRSA cases in 2017/18, an increase on the five cases seen in 2016/17. The NHS objective for cases of MRSA bacteraemia is zero cases.
- The Trust had 16 C-difficile cases in 2017/18 against a baseline of 19 cases in 2016/17. The NHS set a maximum tolerance of 24 cases for the Trust, for the year.
- The 62 day cancer target has been met in ten out of twelve months and averages 86% against a target of 85%. The NHS nationally achieved 82.3%.
- The Trust achieved 90.99% of patients waiting less than four hours in A&E with over 104,247 attendances in 2017/18, an increase of 2.3% on 2016/17 when there were 101,868 attendances. The national performance target is 95%.
- In the annual NHS Staff Survey the Trust is in the top 20% of trusts for staff engagement as shown by staff recommending the Trust as a place to work or receive treatment. The Trust scored 3.9 out of a possible 5.0, compared to 3.88 in 2016/17.

In part two of this report we detail the outcomes and achievements of the last year and the priorities we set ourselves for 2017/18. We have achieved the priority of learning from patient safety incidents and achieved our patient experience priority to seek feedback from patients and parents on their experiences of the Vanguard project. We have partially achieved our patient experience priority of increasing patients’ awareness of plans for their discharge. For clinical effectiveness we have achieved our priorities on the management of sepsis in the Emergency Department and improving mandatory staff training rates. Reducing the number of avoidable healthcare acquired infections has proved more challenging and we did not achieve this priority; neither have we achieved the priority set for the full adoption of national safety standards for invasive procedures (NatSSIPs). The Trust will continue to prioritise work to improve our performance in respect of the prevention of hospital acquired infections as we have not been successful in embedding the necessary changes trust-wide.

Following an unannounced inspection visit in November, the Trust completed its Care Quality Commission (CQC) inspection on the 6th and 7th of December with a set of interviews with the Trust’s leadership team. This was part of the ‘Well Led’ component of the CQC assessment process. The inspection report was published in early April and the CQC rated the Trust overall as ‘requiring improvement’, but ‘good’ at Queen Mary’s and I was particularly pleased with one part of the CQC’s feedback following the final part of their visit which was how they “found staff at all levels wanting to provide great care to patients”. Whilst it is disappointing not to achieve a ‘good’ rating overall the Trust Board welcomed the independent assessment of Trust services and acknowledged the observations of the CQC inspection team. We have now produced an Improvement Plan which is designed to ensure patients consistently receive the very best standard of care.

The imbalance between our admissions and discharges continues to be a key risk for the organisation. To mitigate this we have delivered on our plans to put additional beds into the Darent Valley site and continued to develop in patient elective beds at Queen Mary’s Hospital so that the Darent Valley site can better concentrate on urgent, unscheduled and emergency work. However, whilst this approach supported our response plan to deal with winter pressures, it was a particularly difficult time for our staff. Elective work had to be reduced with the Trust maintaining urgent and priority cases at Darent Valley and deploying staff from our Queen Mary’s Hospital site to support these emergency demands.

The experience of our patients when using Trust services is equally as important as providing safe and effective care. I was pleased to receive the national Cancer Patient Survey results which showed a significant improvement over the previous year’s figures. At a Board meeting we heard how patients...
were being supported after their acute care had come to an end and in particular patients were delighted with the improved access to the clinical nurse specialist and other supportive care staff.

The Trust clinical research and audit competition was held in June and the judges noted the excellent quality of the presentations from Pharmacy, Orthopaedics Urology, Gynaecology and the Emergency Department. The winner of the audit competition was Ageing and Health with an excellent audit on falls and the risk of falls presented by two junior doctor colleagues.

The NHS has engaged with a National quality programme called ‘Getting it Right First Time’ (GIRFT), and in July GIRFT appointed clinician came to discuss the results of a detailed examination of the Trust’s specialty data. Within the GIRFT programme orthopaedics has been examined twice, and urology and obstetrics and gynaecology once. Our data was very good with the Trust appearing to be extremely well-balanced in its coverage of all of the things it must achieve.

Laboratory services at Medway Maritime and Darent Valley hospitals have succeeded in an integration plan which will create a blood science and microbiology hub in the north of Kent to rival any in the area. The modern laboratory here at Darent Valley has the capacity to cope with more work and staff have moved their work base to develop the efficient and ever-ready service needed by a modern NHS.

Our relationship with Guy’s and St Thomas’ hospital has moved to the next stage with the formation of a Group. The feedback from service users has been positive with more patients able to have care and treatment locally without having to travel to London. We have been looking at the health, care and education needs of the new town at Ebbsfleet and the Group is an important part of the design and delivery of a health and care solution for this new population.

I am extremely pleased to let you know that the NHS Staff Survey results were recently published and show that staff continued to give Dartford and Gravesham NHS Trust the best and most positive feedback within Kent and Medway. We were positioned in the top 20% of all acute Trusts in 20 out of 32 key indicators and scored better than average in six indicators.

As the year concludes we are waiting for the outcome of the proposal to establish three new ‘Hyper Acute’ Stroke Units in Kent and Medway following a ten week public consultation period. The Trust is included in three of the five options under consultation.

In part two of this Quality Account you will find the priorities set by the Trust Board for the year 2018/19, together with the results and achievements in respect of the 2017/18 priorities. For 2018/19 there are three priorities set in each of these areas – Patient Safety, Patient Experience and Clinical Effectiveness.

For Patient Safety the priorities will be (a) to continue work to reduce MRSA bacteraemias and gram negative bacteraemias; (b) to improve safeguarding provision for vulnerable groups by increasing numbers of staff trained in awareness of the Mental Capacity Act (MCA) to support the care and safeguarding of vulnerable patients; and (c) to achieve a reduction in mortality from fractured neck of femur.

For Patient Experience our priorities will be (a) to improve patient experience and promote better privacy and dignity by reducing the occurrence of avoidable mixed sex breaches; (b) to improve telephone responses to patient calls regarding appointments in the Outpatients Department; and (c) to increase use of the Birth Centre, in line with women’s feedback through the experience and engagement strategy.

For Clinical Effectiveness we will (a) evaluate the outcomes from the proactive care of older people having surgery (POPS) project; (b) demonstrate as per the national Learning from Deaths priority that we have responded to findings from mortality reviews; and (c) transfer the obstetric scrub nurse role to main theatres via a collaborative partnership between maternity services and surgical services.
but will also tell you about the services we provide, improvements we have made this year and the plans we have for the future.

Finally, on behalf of the Board my sincere thanks go to all Trust staff, wherever they work in the organisation, for their contributions to the achievements of the year. Their hard work is recognised in that the Trust is well thought of and valued by the people who use our services.

To the best of my knowledge the information in this report is accurate.

Gerard Sammon

Acting Chief Executive
Dartford and Gravesham NHS Trust
Part Two
Priorities for improvement and statements of assurance from the Trust Board for the 2017/18 Quality Account

In the previous Quality Account the priorities were set for 2017/18 on the basis of feedback from staff, Governors, patients and commissioners.

The themes decided by the Board were:
- Patient safety
- Patient experience
- Clinical effectiveness

These were linked to the Commissioning for Quality and Innovation (CQUIN) payment framework and other contractual quality mechanisms, the priority being to ensure that no patient suffers avoidable harm or complications whilst in our care.

The 2017/18 priorities were selected by the Trust Board having reviewed information from many sources; for example, incidents reported by staff, letters and complaints from patients and/or their carers, comments placed by service users on the NHS Choices website and other social media, internal audit outcomes and data published by NHS Digital.

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Results and achievements for the 2017/18 Quality Account priorities

A) PATIENT SAFETY

Priority 1: To reduce the number of avoidable healthcare acquired infections in the Trust.

Background
Healthcare associated infections (HCAIs) are infections that are associated with care within healthcare settings, for example, hospitals and care homes. They may be acquired as a result of healthcare interventions, surgery or other invasive procedures. NICE estimates that in England, around 300,000 patients a year acquire an HCAI as a result of care within the NHS. Common types of HCAI are respiratory infections (including pneumonia), urinary tract infections, bloodstream infections and surgical site infections.

Why was this a priority?
Approximately 30% of HCAIs are avoidable and if these occur patients may have a longer hospital stay and be subject to additional diagnostic tests and treatment. One of the major problems with HCAIs is they can be resistant to antibiotics. Which makes preventing HCAIs is an important aspect of work to tackle antimicrobial resistance as reducing the occurrence of infections would also reduce the number that are resistant to antibiotics.

What was our aim?
To reduce the number of patients acquiring an HCAI whilst in our care and to demonstrate this by monitoring the number of Trust assigned MRSA bacteraemia (bloodstream infection) and C.difficile cases identified by the laboratory and incident forms submitted by staff to the Datix incident management system.

Baseline
MRSA - the baseline was the number of MRSA bacteraemias assigned to the Trust in 2016/17 (i.e. five cases).
C- difficile – the baseline was the number of C-difficile cases allocated to the Trust in 2016/17, (i.e. 19 cases).

Did we achieve this priority?
This priority for MRSA has not been achieved. There were seven Trust assigned cases in 2017/18, an increase on the five cases seen in 2016/17. The NHS objective for cases of MRSA bacteraemia is zero tolerance.
The C-difficile priority was achieved with 16 cases in 2017/18 against a baseline of 19 cases in 2016/17 (fig 3). NHS England has set a maximum of 24 cases allowable for the year.
The trend for C-Difficile HCAIs is rising over the last six months, both in the raw numbers and the number of cases per 1,000 bed days (fig 4).

**How have we improved our performance?**
Hospital acquired infections are a multi-faceted problem and the Trust has taken several actions to improve IP&C performance / compliance in order to reduce HCAIs. These have included:

- A standardised approach to infection prevention and control training, which is now delivered via e-learning with compliance reported to the Directorates each month.
- Infection prevention and control Link Practitioners trained in hand hygiene, and trained to undertake annual hand hygiene competency assessments for staff in their wards and departments.
- All patients screened for MRSA on admission and then weekly (every 7 days) until discharge (some patient categories are exempt), with results collated and reported to the wards.
- Infection prevention and control Specialist Nurses undertake patient clinical reviews in order to ensure appropriate infection prevention and control management.
- Infection control and antimicrobial stewardship rounds, led by the Consultant Microbiologist and Infection Control Doctor.
- Robust completion of MRSA bacteraemia post infection review (PIR) and C.difficile root cause analysis (RCA), led by the infection prevention and control team, in order to ensure that learning is identified and shared across the organisation.
- New audit and monitoring tools.

**How did we measure and monitor our improvement?**
By monitoring the number of MRSA bacteraemia and C-Difficile cases identified by the Laboratory and incident forms submitted by staff to the Datix incident management system.

**How was progress reported?**
The Director of Infection Prevention and Control submits a monthly report to the Trust Quality and Safety Committee, and a monthly MRSA Report to the Trust Board. HCAI updates are
also agenda items at the operational the strategic infection prevention and control committees.

The lead for infection prevention and control is the Director of Infection Prevention and Control reporting to the Chief Executive.

**Priority 2: The adoption of National Safety Standards for Invasive Procedures (NatSSIPs) across the Trust.**

**Why was this a priority?**
This high level alert was developed by the NHS England ‘Surgical Never Events Taskforce’ following examination of the reasons for persistence of these Never Events. The resultant national standard for all invasive procedures is a five step process similar to the World Health Organisation (WHO) Surgical Checklist used in theatres. The five steps to safer surgery are: briefing, sign in, time out, sign out, debriefing.

The Trust made this a safety priority following the issue the national patient safety alert and had good compliance in some areas but wanted to see this extended to all areas which carry out invasive procedures during 2017/18.

**What was our aim?**
To identify all procedures undertaken across clinical settings in the Trust to which the five steps to safer surgery are applicable and to develop and test local safety procedures.

**Baseline**
The baseline before the alert was issued was that the Trust did not have a database of procedures to which the five steps should apply and for those procedures where a local safety standard was in operation a copy of the standard was not held outside the practice area.

**Did we achieve this priority?**
This priority was partially achieved and a survey completed of all areas which carry out invasive procedures. Relevant teams in each directorate have confirmed that a local safety checklist is in use and an audit of compliance commenced in October 2017 in Radiology, the Heart Centre, Respiratory laboratories, and Endoscopy at DVH. The continuing assurance around embedding pf practice has not been achieved yet and will be the focus of the next stage of this work.

**How have we improved our performance?**
The Trust has a clear position that the use of checklists and safety techniques is not a personal option, but is mandated as a core function of professional surgical performance. Compliance with safety checklists is audited.
Human Factors training is part of the teaching offered in the simulation suite and provided by skilled trainers.
Debrief and learning events following a surgical Never Event in theatre which included making a video to support learning.
How did we measure and monitor our improvement?
Progress to achieve this priority was measured and monitored by developing a database of areas using invasive procedures and including the local safety standards in place. Local audit has begun to confirm safety standards are being used, but is not rolled out to all areas in consistent fashion yet.

How was progress reported?
Progress was reported to the Trust Quality and Safety Committee and Trust Board on the Quality Account priorities.

The Executive Lead for clinical services is the Medical Director.

Priority 3: To demonstrate effective learning from patient safety incidents by monitoring implementation of action plans and reviewing the impact.

Why was this a priority?
Trust staff reported a number of pressure ulcer, falls and medication related incidents in 2016/17 which showed patterns of contributory causes.

- The pressure ulcer report to the Quality and Safety Committee (April 2017) noted an increase in grade 2 pressure ulcers, with 60% of these developing within 3-14 days of admission to hospital, indicating the need to focus on the early stages of a patient’s admission.
- Falls resulting in a fracture shown an upward trend in 2016/17 and often occurred when accessing the bathroom and were unwatched.
- The Serious Incident Declaration Group noted a number of cases involving medication errors both in the inpatient setting and in medications to be taken home on discharge.

What was our aim?
The aim was to review action plans and recommendations from incident investigations, tracking the implementation of changes and measuring the number of incidents subsequently. If the measures were appropriate and effective it would be expected that the number of incidents would be reduced.

Baseline
The baseline was the number of grade 2 pressure ulcers, falls resulting in a fracture and medication errors in 2017/18 compared to 2016/17.

Did we achieve this priority?
This priority has been partially achieved as shown in the graphs below.

- There was a reduction in grade 2 pressure ulcers was achieved and the learning from action plans included. This was achieved.
- Initially there was a downward trajectory in inpatient falls resulting in a fracture between January and December 2017. However, in quarter four the number of falls resulting in a fracture increased. The reason for the increase is unclear but may be related to the admission of more patients who were frail and/or elderly and so more prone to falling. The priority was partially achieved and the main learning points from action plans are listed below.
• Medication errors have not reduced neither have these increased despite a significant increase in activity in the latter part of the year 2017/18. This was not achieved.

**How have we improved our performance?**

**(a) Grade 2 pressure ulcers**

![Avoidable Grade 2 hospital acquired pressure ulcers per 1000 bed day - Apr 2016 to Mar 2018](image)

**Actions from learning points**

- A weekly clinical huddle and discussion for all new pressure ulcers identified.
- An evaluation of hybrid mattresses on Cherry ward and additional foam mattresses added to the stock.
- Skin checks prior to transfer from areas such as recovery, heart centre, and endoscopy.
- Increased Tissue Viability Nurse (TVN) visits to Elm Court a facility for Elm Court staff to upload wound photographs, for TVN assessment–this facilitates triage and advice promptly.
- Monthly tissue viability study days with attendance of 15 -20 persons each time, and a link nurse day held on the 29th June 2017.
- Consistency of staffing levels identified as a contributory factor
- Early assessment of capacity and better documentation of body mapping.
- Communication and involvement with carers regarding care planning for patients with challenging needs
- Prompt multidisciplinary team (MDT) care planning meetings to meet the needs of the individual whilst an inpatient.
(b) Inpatient falls with fracture

Fig 6

**Inpatient falls with fracture per 1,000 bed days**

| Time line: Apr 2016 to Apr 2018 |
|---------------------|-----------------|-----------------|
| Q1                  | Q2              | Q3              |
| Bed days            | Falls with fracture per 1000 bed days | Trend |
| 20000               | 0.0             | 0.0             |
| 25000               | 0.0             | 0.0             |
| 30000               | 0.0             | 0.0             |
| 35000               | 0.0             | 0.0             |
| 40000               | 0.0             | 0.0             |
| 45000               | 0.0             | 0.0             |
| 50000               | 0.0             | 0.0             |

**Actions from learning points**

- Introduction of Multifactorial Falls Risk Assessment and management plan, available on all wards.
- Ward mapping to identify areas which have a particular risk for patients on the ward
- Implementation of a daily MDT providing person centred plan of care
- Input from the frailty team working alongside the ward nursing staff to support education and awareness of likelihood of falls.
- Equipment training (crash mats, bed rails, low rise beds) and use of anti-slip red socks
- Staffing kept under review in areas with high numbers of vulnerable patients.
- Additional input from Therapy staff for patients likely to fall.
- Introduction of the inpatient post fall check-list sticker and increased awareness of the ‘falls’ stickers, supporting early medical review.
(c) Medication errors

The data relates to incidents reported during the administration or supply of medications from a clinical area and does not include incidents related to medication security, advice, the preparation of medicines or dispensing of medications in pharmacy, prescribing errors made during the writing of a drug chart or prescription.

Fig 7

![Medication errors per 1,000 bed days (administration or supply of a medication from a clinical area).]

**Actions from learning points**

- This Medication Safety and Learning Group (MSLG) work around insulin safety and e-learning module available to staff.
- Antimicrobial prescribing safety – following a national safety alert around the risks of using a syringe to withdraw insulin from pre-filled pens and cartridges, an audit of practice identified that this practice was occurring – information on the risks of this has been shared with clinical teams.
- MicroGuide (online resource) has been regularly updated to communicate guideline changes during a period of significant antimicrobial shortages.
- All new FY1 doctors starting with the Trust in August 2017 were allocated a ‘buddy’ pharmacist. The pairs meet at regular intervals, and through semi-structured meetings, the pharmacist will provide support on general high-risk prescribing areas.
- Following a medication incident involving the prescribing of aminophylline, the Medication Safety Education and Training group undertook to develop a prescribing and administration guideline.

**How did we measure and monitor our improvement?**

Progress to achieve this priority was monitored and measured by recording the number of incidents received on the Datix system per 1,000 bed days of clinical activity.

**How was progress reported?**

Progress was reported in the Pressure Ulcer report, the Falls Report and the Medication Safety Report and the update on the Quality Account priorities made to the Trust Quality and Safety Committee.

The Executive Lead for Patient Safety is the Director of Nursing and Quality.
B) PATIENT EXPERIENCE

Priority 1: To improve patient experience by increasing patients’ awareness of discharge plans as reported in the inpatient survey.

Why was this a priority?
Poor communication regarding plans for discharge leads to an increase in patients reporting dissatisfaction with the process. Results from the NHS Adult Inpatient Survey, published in May 2017, showed a decline and patients were less likely to report positive experiences of leaving hospital than in the previous year’s survey.

What was our aim?
To demonstrate that we better involve patients in arrangements for their discharge from hospital, that:

- They feel involved in decisions about discharge from hospital.
- They think the family and home situation are sufficiently considered.
- Family are given enough information to help care when they go home.
- Patients are given written information about what they should and shouldn’t do after leaving hospital.
- Medications are explained with written information given about purpose, dosage and side effects.

Baseline
The score for the questions listed above on 'leaving hospital' in the 2013 Inpatient Survey as seen in the data provided by Picker for the Care Quality Commission (CQC).

Did we achieve this priority?
This priority has been partially achieved as can be seen in the graphs below. The CQC survey is conducted annually by sending a survey form to between 800-900 patients who were inpatients in the Trust in quarter two. The response rate varied between 40 and 48% for the years included here.

![Fig 8](image1)
**Fig 8**
*Did not feel involved in decisions about discharge from hospital*

![Fig 9](image2)
**Fig 9**
*Family or home situation not sufficiently considered*
Narrative:

Fig 8 – Improved as fewer patients said they were not involved in decisions about discharge from hospital.

Fig 9 – Not improved as more patients said their home situation was not considered in 2016 and in 2017.

Fig 10 – Not improved as more patients said their family was not given enough information to help care in 2016 and in 2017.

Fig 11 – Improved as fewer patients said they did not receive written information about medicines.

Fig 12 – Improved as fewer patients said they did not receive written information about what they should and shouldn’t do after leaving hospital.

Note: the inpatient activity figures are significantly higher in 2016 and 2017 indicating the Trust was very busy.

How have we improved our performance?

- Wards have introduced a daily huddle which improves communication and safety within the ward team and also aids consistent messages to patients and families.
- Surgical Admissions Lounge to increase the delivery of personal property to the receiving wards from once per day to twice in order that patients receive their property in a more timely fashion
- Better communication and involvement with carers regarding care planning for patients with more challenging needs
- Reviewing pathways for ‘medically fit for discharge’ patients to support better planning of discharge.
- All new FY1 doctors starting with the Trust in August 17 were allocated a ‘buddy’ pharmacist. The pairs meet at regular intervals, and the pharmacist will provide support on general high-risk prescribing areas. This includes prescriptions to take home and advice given to patients.
How did we measure and monitor our improvement?
Improvement was measured using the results of the CQC inpatient survey over the period 2013-17 to assess patients’ awareness of discharge plans.

How was progress reported?
Progress has been reported to the Trust Quality and Safety Committee, a sub-committee of the Trust Board.

The Executive Lead for patient experience is the Director of Nursing and Quality.

Priority 2: To use responses to the Friends and Family survey, and other sources including complaints, to identify themes for action and to display progress on ward boards.

Why was this a priority?
The Friends and Family Test (FFT) is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

What was our aim?
To use our Friends and Family survey data as a timely source of information about patients’ experiences that can be fed back to wards and departments. This allows staff to make changes and improvements while an issue is still current.

Baseline
The information comes from a sample of forms returned by patients or service users who have added their comments in the box provided on the form.

![Negative feedback or concern FFT returns 2016/17](source: Trust information systems (Datix))
Did we achieve this priority?
This priority has been partially achieved and is difficult to assess because the data collection method has changed.

In 2016/17 all Friends and Family responses were paper based and comments written on the forms were recorded on the Datix system by the PALS team. During 2017 the data collection has changed to entries made via an electronic tablet and the number of comments received has decreased.

A similar graph of the comments received is shown below but it should be remembered that only a quarter of the number of comments were received as had been in 2016/17.

![Negative feedback or concern from sample of FFT returns 2017/18](image)

Source: Trust information systems (Datix)

How have we improved our performance?
Ward Managers have reported the following changes as a result of feedback from FFT

- **Surgical pre-assessment at Queen Mary’s Hospital (QMH):** ‘Our clinic letter previously stated that patients should expect to be in the department for up to 3 hours. At QMH patients have to pre pay for parking as at DVH they pay on exit. Patient feedback and audit showed that the average time patients were in the department was an hour. So we had the letter changed to reflect this. It saved the patients money and if we did foresee the appointment running over we would contact the parking to let them know the clinic is running late and to give the patients grace’ **Pre-assessment Sister**

- **Chestnut Ward:** ‘from positive feedback I have laminated and put the word cloud and pie chart on my quality board’. **Ward Sister**

- **Endoscopy DVH:** ‘Patient underwent a colonoscopy procedure, which was hindered slightly as the patient had eaten seeded bread a few days prior to the procedure. (The seeds can remain in the colon for a few days despite the bowel prep and can hinder mucosal views, potentially block the scope, and so prolong the procedure). The patient explained that he didn’t know this otherwise he wouldn’t have eaten them. In response to this, I adapted our patient information leaflets to include this advice’. **Lead Nurse Endoscopy**
• Intensive Therapy Unit DVH: ‘the pictures show the survey question and the responses and changes board detailing improvements and changes we’ve made’. Senior Nurse

How did we measure and monitor our improvement?
Progress to achieve this priority was measured by monitoring which wards display the feedback in the Friends and Family survey each month/quarter on the ward quality board.

How was progress reported?
By reporting to the Trust Quality and Safety Committee, a sub-committee of the Trust Board.

The Executive Lead for patient experience is the Director of Nursing and Quality.

Priority 3: To assess the effectiveness of the Vanguard programme including seeking feedback from patients and service users about their experiences.

Why was this a priority?
The new care models Vanguard programme was a key element in the NHS England ‘Five Year Forward View’, looking to develop innovative system models. Through the Vanguard programme, Dartford and Gravesham NHS Trust (DGT) and Guy’s and St Thomas’ NHS Foundation Trust (GSTT) came together to form the collaborative Foundation Healthcare Group.

What was our aim?
The aim of the Foundation Healthcare Group aimed to deliver the benefits of collaboration between a large London teaching hospital and a district general hospital, without the need for a costly and distracting transaction involving merger or acquisition. During the programme, seven work streams were formed; three clinical (cardiology, paediatrics and vascular services) and four non-clinical (IT, location, Dartford Health Partnerships and designing a new governance approach to collaborative group working.

The clinical work streams allowed teams from GSTT and DGT to collaborate on innovations in care in order to drive patient, staff and organizational benefits. For example, work streams ensured more specialist care could be provided locally to Dartford and Gravesham, and created more joined-up pathways of care. The ongoing improved outcomes and access
achieved by these work streams will continue to contribute to meeting the challenger of increasing demand at DGT, especially from the new Ebbsfleet Garden City currently under construction.

In addition, the non-clinical work streams looked to both take advantage of immediate non-clinical opportunities for the two Trusts and to create a structure which would enable future collaboration.

Baseline:
The Vanguard programme mobilised as a new initiative in quarter one of 2016/17.

Did we achieve this priority?
The Trust has achieved this priority and the project will move on to the next stage which will be the creation of the Guy’s and St Thomas’s Healthcare Alliance of which Dartford and Gravesham NHS Trust will be a member.

How have we improved our performance?
• Introduction of proactive care of Older People undergoing Surgery (POPS) service at Dartford and Gravesham NHS Trust.
• Between November 2016 and December 2018 over 37,000 patient travel miles were saved.
• Over the same period 853 appointments were held locally at Dartford and Gravesham rather than Guy’s and St Thomas’, enabling care to be delivered closer to home.
• Focus groups and patient feedback have supported the paediatrics work stream to co-design the pathways and services.
• The Foundation Healthcare Group has been discussed at the Annual General Meeting where public, patients and carers discussed the ambitions for the programme.
• A coffee morning has been held for parents to talk about their experiences of paediatric neurology services and to talk through our plans for the future.
• Emergency Department (ED) staff (nurses and doctors) have contributed to the design of new pathways to reduce variation in the management of children attending the ED.
• Coffee mornings were held for cardiology and vascular patients and their families to discuss their experiences and highlight changes that they would like to see.
• Videos have been produced which summarise the work of the vanguard programme and include interviews with lead clinicians and patients and their families.
• On 4 July the Foundation Healthcare Group (FHG) hosted a Celebration and Showcase event in Robens Suite, Guy’s Tower. The event was attended by over 100 healthcare leaders who have contributed to the Vanguard programme.

How did we measure and monitor our improvement?
Progress to achieve this priority was measured by keeping a stakeholder engagement log for each of the work streams. In addition sources of patient experience information, including patient survey data and the Friends and Family feedback is monitored for good practice and identifying areas for improvement.
How was progress reported?
By reporting to the Trust Quality and Safety Committee, a sub-committee of the Trust Board.

The Executive Lead for patient experience is the Director of Nursing and Quality.

C) CLINICAL EFFECTIVENESS

Priority 1:
To improve the management of sepsis in the Emergency Department monitoring sepsis screening and initiation of antibiotic treatment and care.

Why was this priority?
Sepsis is a serious illness caused by the body’s response to an infection. The immune system protects us from many illnesses and infections, but it’s also possible for it to go into overdrive in response to an infection.

Sepsis develops when the chemicals the immune system releases into the bloodstream to fight an infection cause inflammation throughout the entire body instead. Severe cases of sepsis can lead to septic shock, which has a 50 percent mortality rate and is a medical emergency.

Although sepsis is potentially life-threatening, the illness ranges from mild to severe. There’s a higher rate of recovery in mild cases. Having a case of severe sepsis can also increase the person’s risk of a future infection.

What was our aim?
To demonstrate improvement in achievement against the metrics of the Royal College of Emergency Medicine (RCEM) severe sepsis audit.

Baseline
As recorded 2013/14 RCEM Emergency Medicine Sepsis Audit report.

Did we achieve this priority?
This priority has been achieved.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2013/14 Audit Report</th>
<th>2016/17 Audit Report</th>
<th>National aggregate (UK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Set of observations (respirations, heart rate, temperature, blood pressure etc) completed on arrival in the Emergency Department (ED).</td>
<td>n/a</td>
<td>56.6%</td>
</tr>
<tr>
<td>2</td>
<td>Seen by senior ED or Critical Care doctor before leaving the ED.</td>
<td>n/a</td>
<td>64.2%</td>
</tr>
<tr>
<td>3</td>
<td>Oxygen given within one hour of arrival unless contraindicated.</td>
<td>12.0%</td>
<td>30.2%</td>
</tr>
<tr>
<td>4</td>
<td>Lactic acid in blood measured within one hour of arrival in the ED.</td>
<td>20.0%</td>
<td>52.8%</td>
</tr>
<tr>
<td>5</td>
<td>Blood test for bacteria and microorganisms done within one hour of arrival in the ED.</td>
<td>58.0%</td>
<td>67.9%</td>
</tr>
</tbody>
</table>
6 Intravenous (IV) fluids given within one hour of arrival in ED. | 56.0% | 56.6% | 43.2%
7 Antibiotics given within one hour of arrival in ED | 50.0% | 56.6% | 44.4%
8 Urine output measured and fluid balance chart started within four hours of arrival. | n/a | 3.9% | 18.4%

Source: CQC Insight Report, April 2018 (n/a = value not applicable)

How have we improved our performance?
- Discharge advice sheets for adults and children following an ED attendance says ‘… you can go home now, however you may be at risk of developing sepsis. Please use this guide to monitor your condition and know how to seek help’.
- The Trust intermediate resuscitation course includes a 15 minute module on sepsis.
- Sepsis teaching is included in both the nursing and medical education days.

How did we measure and monitor our improvement?
RCEM Audit results published following submission of 50 records to data collection. Reproduced in the monthly CQC Insight Tool.

How was progress reported?
By reporting to the Trust Quality and Safety Committee, a sub-committee of the Trust Board.

The Executive Lead for clinical services is the Medical Director.

Priority 2: To audit the effectiveness of the National Early Warning System (NEWS) within the Trust Vital Signs Nursing Audit.

Why was this is a priority?
Identifying those patients at risk of clinical deterioration is a major issue in hospitals and some in-hospital deaths are predictable and preventable where the deterioration is recognised on the ward.

Early warning scoring systems are used in hospitals to identify deterioration in a patient’s condition and to trigger escalations to provide additional clinical care. The aim is to reducing the likelihood of the patient having a cardiac arrest or becoming an unplanned admission to intensive care. NHS England supports the use of a common national early warning system (NEWS) across the NHS and the use of NEWS is also supported by NICE guidance recommendations.

In NEWS patients are given a score for each of their vital signs e.g. breathing, heart rate, blood pressure; the aggregated score is called the NEWS score and at specified thresholds the healthcare worker must call for assistance as the patient’s condition may be deteriorating.

What was our aim?
To measure compliance with the Trust Vital Signs Policy. The expected standard is for all areas to be 100% compliant.

Baseline
Trust Vital Signs Audit results in 2016.
Did we achieve this priority?
This priority has been partially achieved and the 2017 audit results can be seen in the table below.

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recording of all 7 vital signs (temp, respiration rate, supplemental oxygen requirement, Oxygen saturations, heart rate, blood pressure, AVPU)</td>
<td>89%-100%</td>
<td>76%-98%</td>
</tr>
<tr>
<td>Frequency and appropriateness of vital signs</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Vital signs recorded between 5am &amp; 9am</td>
<td>97%</td>
<td>82%</td>
</tr>
<tr>
<td>Vital signs charts initialled</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>NEWS recorded within the last 12 hours</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>Of those patients with a NEWS score recorded, was this score accurate?</td>
<td>95%</td>
<td>94%</td>
</tr>
</tbody>
</table>

How have we improved our performance?
We have improved with the recording of all seven vital signs and achieved 100% in four of those seven areas. In addition the recording of the vital signs between 5am and 9am has improved by 15%.

How did we measure and monitor our improvement?
The Matron and Wards Managers now carry out monthly audits to monitor their own areas, so the 2017 results are taken from these ward audits as no formal trust wide audit was carried out. The Matrons and Ward Managers review compliance and set priorities for improvement where required.

How was progress reported?
Progress to achieve this priority was monitored by reports to the Trust Quality and Safety Committee as part of reporting on the Quality Account priorities, in addition the audit results are reported every six months to the Matrons and Ward Managers huddle.

The Executive Lead for Nursing services is the Director of Nursing and Quality.

Priority 3: To improve mandatory training rates across the Trust using the Trust metric of an 85% compliance rate in directorates and departments.

Why was this a priority?
The Trust Board has an obligation to ensure all staff are adequately trained in those areas that have been defined as mandatory training. The term ‘mandatory training’ refers to both statutory and local mandatory training requirements. All staff have a responsibility to participate in training and managers are obliged to release staff from the workplace to do so.
Baseline:
The compliance level achieved in quarter four of 2016/17.

Mandatory training includes:
- Fire
- Equality, Diversity and Human Rights
- Health, Safety & Welfare
- Infection Prevention & Control (levels 1 and 2)
- Information Governance
- Moving & Handling (levels 1 and 2)
- Preventing Radicalisation (levels 1 and 2)
- Resuscitation (appropriate to role)
- Safeguarding Adults (level1)
- Safeguarding Children (levels 1, 2 and 3)
- Conflict Resolution
- Emergency Resilience (appropriate to role)

Did we achieve this priority?
Overall the Trust achieved an aggregated compliance of 89.6% and the priority was achieved.

Three trainings: Infection Prevention and Control. Level 2; Moving and Handling, level 2; and Child Safeguarding, level 2 are all within one half of one percent of the 85% target.

(Note: Emergency Resilience and Preventing Radicalisation are more recent additions to the mandatory training and not included in aggregated totals until 2018/19).

Fig 15

Source: Trust information systems
How have we improved our performance?
- Introduction of e-learning for a range of topics in December 2016.
- Big push for Infection Prevention and control (level 2) in last quarter of 2015/2016. resulted in large number of staff all being out of date at the same time in 2016/2017.
- Introduction of Pay Progression Policy.
- Greater emphasis of Mandatory training compliance in Non-Medical Appraisal.
- Improved data information sent to managers by e-mail and on ADAGIO.
- Ability for staff to self-check on the Trust intranet to see when training is due.

How did we measure and monitor our improvement?
Monthly spreadsheets circulated to the Workforce Committee and, for some training, the Quality and Safety Committee. Also monitored at directorate performance meetings.

How was progress reported?
Progress was reported to the Trust Quality and Safety Committee as part of reporting on the Quality Account priorities.

The Executive Lead for clinical services is the Medical Director.
Introduction to the 2018/19 priorities for improvement

The next section describes our priorities for quality improvement in the coming year 2018/19 and provides the required statements of assurance from the Board with regard to services, clinical audit, research, clinical quality goals, CQC registration and data quality, the priority being to ensure that no patient suffers avoidable harm or complications whilst in our care.

Qualitative information from a number of sources including patient surveys, staff surveys and complaints has helped inform the Trust’s priorities for 2018/19.

The themes decided by the Board were:
- Patient safety
- Patient experience
- Clinical effectiveness

These priorities have been agreed by the Trust Board and each priority has an identified Executive Director lead. Progress towards achieving these priorities will be recorded in the Trust internal data management systems and submissions to the external reporting bodies e.g. Public Health England, the National Reporting and Learning System and NHS Digital as per the reporting schedule. Progress and interim results will be reported to the Trust Quality and Safety Committee, a sub-committee of the Trust Board. The papers and minutes of the Trust Board are published on the Trust website.

Some of the schemes presented here also form part of the Commissioning for Quality Improvement (CQUIN) programme, agreed with our local lead commissioners, Dartford Gravesham and Swanley Clinical Commissioning Group (CCG).

The following priorities under the headings of Patient Safety; Patient Experience; and Clinical Effectiveness were selected by the Trust Board having reviewed information from incidents reported by staff, letters and complaints from patients and/or their carers, comments placed by service users on the NHS Choices website and other social media and internal audit outcomes.

A) Patient Safety

| Priority 1: | Continued reduction of MRSA bacteraemias and progress on a reduction trajectory for gram negative bacteraemias. |
| Rationale: | Infection Prevention and Control was identified as an issue in the 2017 CQC inspection. The Trust has had an ongoing programme to reduce healthcare acquired infections and the Board has decided to maintain this as a priority for a third year. |
| Monitoring: | By monitoring the number of hospital acquired infections identified by the Laboratory and incident forms submitted by staff to the Datix incident management system. |
| Reporting: | The Infection Prevention and Control Committee, the Trust Quality and Safety Committee and reporting to Public Health England. |

Priority 2: Safeguarding vulnerable groups by increasing the levels of staff trained in awareness of the Mental Capacity Act (MCA) to support the care and safeguarding of vulnerable patients.
Rationale: Numbers of staff conversant with the MCA and their level of knowledge was identified in the 2017 CQC inspection. The Trust Board has decided to make this a safety priority.

Monitoring: By using monitoring training levels in safeguarding and the MCA in clinical staff groups.

Reporting: The Trust Patient Safety Committee and the Quality and Safety Committee.

### Priority 3:

**Rationale:** Reducing mortality from fractured neck of femur as shown in the Hospital Standardised Mortality Ratio (HSMR)

**Monitoring:** By monitoring the HSMR published by Dr Foster Health for improvement in the mortality rate compared to the published rate for 12 months (Mar 17 to Feb 18) when rate was 159.8.

**Reporting:** The Trust Patient Safety Committee and the Quality and Safety Committee.

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### B) Patient Experience

**Priority 1:** To improve patient experience by promoting better privacy and dignity – reducing the occurrence of avoidable mixed sex breaches.

**Rationale:** The incidence of mixed sex breaches has increased and the Trust is aware that, whilst this is sometimes unavoidable when patients need some types of monitoring, it is not acceptable as an ongoing solution. The Board has identified actions to address this and will be monitoring for improvement in 2018/19.

**Monitoring:** Daily reporting and validation of mixed sex breaches with monitoring of data by the Executive Board.

**Reporting:** The Trust Quality and Safety Committee.

**Priority 2:** To improve telephone responses to patient calls regarding appointments in the Outpatients Department.

**Rationale:** Patient and service user feedback to members of the Patient Experience Committee has indicated a level of dissatisfaction during contact with the telephone response service.

**Monitoring:** By monitoring feedback to the Patient Advice and Liaison Service (PALS) on adverse telephone user experience.

**Reporting:** The Trust Quality and Safety Committee.

**Priority 3:** Maternity services - To increase use of the Birth Centre, in line with women’s feedback through the experience and engagement strategy.

**Rationale:** The Birth Centre creates an ideal environment for women to have a home birth experience with the availability of enhanced services close by. Women using the Birth Centre are likely to experience normal birth, with reduced risk of intervention in labour.

**Monitoring:** Via Maternity Dashboard and Birth Centre monthly statistics/dataset.

**Reporting:** Maternity Risk Management and Governance Forums, Maternity 12 monthly focussed Report to Quality and Safety Committee.
### C) Clinical Effectiveness

<table>
<thead>
<tr>
<th>Priority 1:</th>
<th>Older peoples’ services. To evaluate the outcomes from the proactive care of older people having surgery (POPS) project.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale:</td>
<td>To improve the quality of care and outcomes for patients presenting for surgery in the Trust, and to reduce inappropriate variation in practice.</td>
</tr>
<tr>
<td>Monitoring:</td>
<td>Quarterly measurement of length of stay, readmissions, completion of comprehensive geriatric assessment, geriatric review of patients in National Emergency Laparotomy Audit (NELA).</td>
</tr>
<tr>
<td>Reporting:</td>
<td>The Trust Quality and Safety Committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority 2:</th>
<th>Mortality - To demonstrate as per Learning From Deaths priority that we have responded to findings from mortality reviews.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale:</td>
<td>The NHS Quality Board has mandated a process for review of all patient deaths in hospitals. The Trust has a review process and the Board seeks to monitor the effectiveness of this process.</td>
</tr>
<tr>
<td>Monitoring:</td>
<td>By monitoring the outcome of the review process of all patient deaths.</td>
</tr>
<tr>
<td>Reporting:</td>
<td>Reports to the Patient Safety Committee, the Quality and Safety Committee and quarterly reports to the Trust Board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Priority 3:</th>
<th>Workforce - To transfer the obstetric scrub role to main theatres via a collaborative partnership.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale:</td>
<td>In recent years, there has been an increase in the proportion of births by caesarean section and this puts additional pressure on hospital maternity services. Maternity Matters (DH, 2007) and Towards Better Births (Healthcare Commission, 2008) highlight the importance of adequate levels of appropriate staff to support women and provide choice throughout their maternity care. It is believed that members of the perioperative team can make an important contribution to the care of those women where the delivery of their baby is assisted by caesarean section.</td>
</tr>
<tr>
<td>Monitoring:</td>
<td>Via the CQC Action Plan- for Maternity Services and Main Theatres.</td>
</tr>
</tbody>
</table>
| Reporting: | Trust Quality and Safety Committee  
Trust Workforce Committee  
Obstetric and Gynaecology Clinical Governance Forums |
**Mandatory declarations and assurances**

The information on the following pages contains mandatory text that all NHS trusts must include in their Quality Account. We have added some explanations of key terms.

The requirement for all NHS trusts to produce Quality Accounts is included in Chapter 2 of the Health Act 2009. Subsequent to the Act guidance may be issued annually by the Secretary of State for Health and Social Care relating to the content and form of trust Quality Accounts. Dartford and Gravesham NHS Trust receives this guidance in notification by letter(s) issued by the NHS England and the implementation of the guidance is overseen by a designated Executive Director.

**Statements of assurance**

**Review of Services**

During 2017/18 the Dartford and Gravesham NHS Trust provided and/or sub-contracted twelve relevant health services.

The Dartford and Gravesham NHS Trust has reviewed all the data available to them on the quality of care in twelve of these relevant health services.

- Emergency Department (Accident and Emergency).
- Acute inpatient care: medicine and surgery, both elective (planned) and emergency (unplanned).
- Critical care (Intensive Care) and Theatres.
- Day-care.
- Outpatient care.
- Maternity services.
- Gynaecology services.
- Children’s services.
- Therapy services.
- Diagnostic services (i.e. Radiology and Pathology)
- Pharmacy services

The income generated by the relevant health services reviewed in 2017/18 represents 89 per cent of the total income generated from the provision of relevant health services by the Dartford and Gravesham NHS Trust for 2017/18.

The Trust receives the other 11 per cent of its income for other aspects of work for example; training and education, research and development, recharges of salaries and wages for staff working at other organisations and other direct credit and miscellaneous income.

Each clinical directorate is led by a senior doctor, who is responsible for monitoring quality in the directorate through the directorate’s governance processes.
Services are managed through a clinical directorate structure

The clinical directorates each have individual governance meetings which report into the Trust’s Quality and Safety Committee, which is a sub-committee of the Trust Board and is chaired by a Non-Executive Director. The Directorate Governance Committees review complaints and compliments, incidents, compliance with national requirements and standards and data from clinical audits. The agenda is centred on patient safety, patient experience and clinical effectiveness.

Board to Ward to Board

The Executive and Non-Executive Director members of the Board have ‘adopted’ a ward or clinical department. This is very helpful in allowing Board members to understand the successes and challenges of those areas. For example, the practical difficulties of maintaining the provision of single sex accommodation. This creates a meaningful ‘Board to Ward to Board’ relationship and dialogue. The relationship is equally valued by staff who have a direct pathway to an Executive Director.

The Trust Board receives regular clinical presentations from nursing and/or medical staff as part of the Board agenda each month to keep up with clinical initiatives.
Participation in National Clinical Audits and National Confidential Enquiries in 2017/18

The required wording has been used by the Trust in this section of the Quality Account.

Clinical audit aims to improve the quality of patient care by looking at current practice and modifying it where necessary.

During 2017/18 38 national clinical audits and 4 national confidential enquiries covered relevant health services that Dartford and Gravesham NHS Trust provides.

During 2017/18 Dartford and Gravesham NHS Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Dartford and Gravesham NHS Trust was eligible to participate in during 2017/18 are as follows: these are presented in the table on pages 29 and 30.

The national clinical audits and national confidential enquiries that Dartford and Gravesham NHS Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Participation Y or N</th>
<th>No. of cases submitted</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case mix Programme (CMP) ICNARC</td>
<td>Y</td>
<td>684</td>
<td>100%</td>
</tr>
<tr>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>Y</td>
<td>85</td>
<td>28-33%</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Y</td>
<td>119</td>
<td>94%</td>
</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>Y</td>
<td>Knee 333 Hip 240</td>
<td>100%</td>
</tr>
<tr>
<td>Fractured Neck of Femur - Care in Emergency Departments</td>
<td>Y</td>
<td>49</td>
<td>98%</td>
</tr>
<tr>
<td>Pain in Children - Care in Emergency Departments</td>
<td>Y</td>
<td>51</td>
<td>100%</td>
</tr>
<tr>
<td>Procedural Sedation in Adults - Care in Emergency Departments</td>
<td>Y</td>
<td>60</td>
<td>100%</td>
</tr>
<tr>
<td>Blood and Transplant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion - Re-Audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients</td>
<td>Y</td>
<td>38</td>
<td>95%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion - 2017 NCA of Transfusion Associated Circulatory Overload (TACO)</td>
<td>Y</td>
<td>40</td>
<td>100%</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme</td>
<td>Y</td>
<td>16</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Bowel Cancer (NBOCAP)</td>
<td>Y</td>
<td>145</td>
<td>100%</td>
</tr>
<tr>
<td>Lung Cancer (NLCA)</td>
<td>Y</td>
<td>207</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older Patients (NABCP)</td>
<td>Y</td>
<td>*</td>
<td>100%</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Y</td>
<td>200</td>
<td>100%</td>
</tr>
<tr>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Y</td>
<td>52</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Heart</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Y</td>
<td>289</td>
<td>100%</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>Y</td>
<td>280</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary Angioplasty / National Audit of PCI</td>
<td>Y</td>
<td>225</td>
<td>100%</td>
</tr>
<tr>
<td>National Cardiac Arrest Audit (NCAA)</td>
<td>Y</td>
<td>96</td>
<td>100%</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Y</td>
<td>370</td>
<td>95%</td>
</tr>
<tr>
<td><strong>Long term conditions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Diabetes Foot Care Audit</td>
<td>Y</td>
<td>128</td>
<td>100%</td>
</tr>
<tr>
<td>National Diabetes Inpatient Audit</td>
<td>Y</td>
<td>55</td>
<td>100%</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>Y</td>
<td>136</td>
<td>100%</td>
</tr>
<tr>
<td>National Pregnancy in Diabetes Audit</td>
<td>Y</td>
<td>36</td>
<td>100%</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>Y</td>
<td>84</td>
<td>100%</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit</td>
<td>Y</td>
<td>225</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Older People</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database</td>
<td>Y</td>
<td>352</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) – Inpatient Falls</td>
<td>Y</td>
<td>28</td>
<td>93%</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>Y</td>
<td>50</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP) (Data entry still in progress)</td>
<td>Y</td>
<td>366</td>
<td>91%</td>
</tr>
<tr>
<td>UK Parkinson's Audit</td>
<td>Y</td>
<td>70</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine and Thyroid National Audit (39 cases for 2017-18 not yet entered onto the registry)</td>
<td>Y</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR Programme)</td>
<td>Y</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Percutaneous Nephrolithotomy (PCNL)</td>
<td>Y</td>
<td>40</td>
<td>73%</td>
</tr>
<tr>
<td><strong>Women's and Children's Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit</td>
<td>Y</td>
<td>4994</td>
<td>100%</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRACE)</td>
<td>Y</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Y</td>
<td>839</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source – Trust locally validated data Apr 2017 – Mar 2018
These audits are reviewed and managed by the Trust Audit Leads Committee and reported to the Quality and Safety Committee.

In addition Dartford and Gravesham NHS Trust was eligible to, but did not, participate in these national clinical audits and national confidential enquiries.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source – Trust locally validated data Apr 2017 – Mar 2018

**Participation in National Confidential Enquiries into Patient Outcome and Death**

A National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an investigation into an area of healthcare. When the enquiry is complete a report is produced which details recommendations for improvement.

The NCEPOD documents have been discussed within the directorate and a report provided to the Trust Quality and Safety Committee. The Quality and Safety Committee monitors and advises the Trust Board on progress against the NCEPOD recommendations requesting action plans as appropriate.

In addition there are 4 current NCEPOD studies:

<table>
<thead>
<tr>
<th>National Confidential Enquiry into Patient Outcome and Death</th>
<th>Participated in 2017/18</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-operative Diabetes</td>
<td>On-going</td>
<td></td>
</tr>
<tr>
<td>Acute Heart Failure</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Young people’s mental health</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Cancer in children, teens and young adults</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

Source – Trust locally validated data

**Maternal and Perinatal Mortality Notification**

The National Patient Safety Agency took over the monitoring of maternal and perinatal mortality from the Centre for Maternal and Child Enquiries (CEMACE) from April 2011.

<table>
<thead>
<tr>
<th>Maternal and Perinatal Mortality Notification</th>
<th>Participated in 2017/18</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality surveillance i.e. mothers</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>Perinatal mortality surveillance i.e. babies</td>
<td>Yes</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source – Trust locally validated data
National Audits reviewed by the Trust in 2017/18

The reports of the three national clinical audits were reviewed by the provider in 2017/18 and Dartford and Gravesham NHS Trust intends to take the following actions to improve the quality of healthcare provided.

1. National Audit of Dementia, Round 3 - Royal College of Psychiatrists

The National Audit of Dementia examines care received by people with dementia in general hospitals in England and Wales. Darent Valley Hospital has participated in all three rounds of the audit, and shown a steady improvement in many areas of care following the implementation of recommendations from rounds one and two. Results from the audit gave significant assurance of the quality of care for people with dementia in the areas of assessment and discharge, and reasonable assurance for meeting the patients’ nutritional needs. The audit areas of (a) carer rating of patient care, and (b) staff and carer rating of information and communication gave limited assurance, and an action plan has been devised to address these.

The following actions were agreed:

- Ebony and Linden wards have enrolled in the Royal College of Psychiatrists national accredited Quality Mark for Elder-Friendly Hospital Wards quality improvement programme. Participation in this process will ensure a continuous focus on the care provided for people over the age of 65, and will demonstrate the commitment made by the hospital, the wards and the staff to identify and carry out improvements, and to achieve a consistent quality of care for older people. Progress to date: Registration and completion of all parameters for baseline measures. DVH have scored highly, gaining stage 1 accreditation in year one. Programme completion due March 2020.

- Communication: We will increase the use of a personal information document called ‘This is Me’ in order to uphold person-centered care.

- Nutrition: A specific dementia friendly menu is being trialled, including a new finger food menu with a pictorial guide, to ensure snacks are available between meals for people with dementia.


The National Pregnancy in Diabetes (NPID) audit measures the quality of antenatal care and pregnancy outcomes for women with pre-gestational diabetes.

Pre-gestational diabetes increases adverse pregnancy outcomes for women and babies, including congenital malformation, miscarriage, preterm delivery, pre-eclampsia, macrosomia, and perinatal mortality. These risks can be reduced with careful management before, during and after pregnancy.

The audit results showed that fewer women attended Darent Valley Hospital for pre-conception care than was the case nationally; the number of women seen by the diabetes
team prior to 10 weeks gestation was lower than nationally, but that glucose control of women in the third trimester was higher than nationally.

After review of the audit results, the following action plan was agreed:

- Pre-conception clinic to commence in May 2018. The aim of this is to implement national recommendations to lower the HbA1c levels prior to pregnancy in order to reduce congenital abnormalities and stillbirth rates. Social media will be used to publicise the new clinic.

- Access to the diabetic specialist services to be improved through changes to the referral pathways.

- Diabetes study days to be held for G.Ps and practice nurses to highlight the referral pathways.

- Reduce admission of neonates to the special care baby unit. New guidelines were implemented in November 2017 to offer treatment to the neonate on the ward, therefore reducing the incidence of separation and stress to the mother and baby.

3. Sentinel Stroke National Audit Programme (SSNAP) – Royal College of Physicians

SSNAP is the national stroke audit which measures the quality and organisation of stroke care in the NHS. It is the single source of stroke data in England, Wales, and Northern Ireland. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke. The overall aim of SSNAP is to provide timely information to clinicians, commissioners, patients, and the public on how well stroke care is being delivered so it can be used to improve the quality of care provided to patients. The clinical audit collects a minimum dataset for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of six month assessment.

Audit reports are published every three months and these are reviewed and actioned locally by the Stroke Team. The audit results give reasonable assurance and indicate compliance with best practice in the of areas of CT scanning, patients receiving Thrombolysis within one hour, time to review by a Stroke Nurse, setting rehabilitation goals, swallowing assessment, mood screening, length of stay and low mortality.

The areas identified where improvement is required, and the actions agreed, are as follows:

- Patients are not always admitted directly to the stroke unit. To address this, the stroke team will assess patients in the Emergency Department (ED) in a timely manner to identify those requiring direct admission to the stroke unit. The stroke unit will ring fence one bed per day to be made available at short notice should a stroke patient need to be admitted from the ED.

- All patients must be seen by a Stroke Nurse and at least one therapist within 24 hours, and be seen by all relevant therapists (Physiotherapy, Occupational Therapy and Speech and Language Therapy) within 72 hours of admission. These targets are not always met, particularly if the patient is not admitted directly to the stroke unit. The
Stroke Nurse will be notified of any stroke patient on another ward in order for all appropriate assessments to be carried out as soon as possible after admission.

- Continence plans were not always carried out in a timely manner. The action agreed is for nurses to initiate a continence assessment on admission, and for this to be completed within 48 hours of admission and reviewed weekly.

Local Initiatives in Clinical Audit

In order to define the outcomes of clinical audit and other improvement and assurance projects, the Trust has implemented the use of ‘assurance levels’ (as used by internal audit providers across the public sector). These give a rating of the confidence which may be had in the quality of care, with four reportable levels: ‘significant’, ‘reasonable’, ‘limited’ or ‘no assurance’. The Trust is also taking steps to refocus local clinical audit plans on strategic and risk-related topics.

The reports of the following local clinical audits were reviewed by the provider in 2017/18 and Dartford and Gravesham NHS Trust intends to take the following actions to improve the quality of healthcare provided.

1. National Early Warning System (NEWS) Audit

The National Early Warning Score (NEWS) system was developed by the Royal College of Physicians (RCP) to standardise the assessment and response to acute illness across the NHS. NEWS is based on a scoring system assigned to physiological measurements taken when patients present to, or are being monitored in hospital. The system uses a red, amber and green (RAG) classification to determine the appropriate clinical response to the patient’s condition and NEWS was implemented across Dartford & Gravesham NHS Trust in 2017.

To improve the quality of care for all acutely ill patients, it is essential they are adequately managed when their condition deteriorates, triggering an amber NEWS response, as this reduces the risk of further deterioration. Accordingly, in addition to meeting the monitoring requirements as outlined in the 2016/17 Quality Account, a Trust wide audit was designed to measure compliance with the clinical response guidelines, and to highlight any underlying barriers to compliance so that focused improvements could be identified.

The audit results gave limited assurance that the guidelines were being followed consistently. The key actions agreed were:

- To introduce an “amber call to the Outreach team” facility, to be used when the medical team of a patient triggering an amber NEWS score are unable to review them within one hour.
- As part of the launch of an updated NEWS2 later in 2018, the escalation requirements for NEWS scores are to be updated to clearly state who, what and when actions should be taken.
- As part of launch of NEWS2, multiple training and education sessions are to be implemented, including:
- Presenting at a Grand Round meeting for clinical staff
- Ward roadshows
- The Outreach team to educate staff in their own areas of clinical responsibility
- Introduce mandated training for all nursing staff
- Ward Matrons and senior staff to cascade

- Introduce the use of stickers in doctors’ notes to easily record and identify SBAR (Situation, Background, Assessment, and Recommendation) following an amber NEWS score.

2. **Urology 30 Day Return to Hospital Project**

The Getting It Right First Time (GIRFT) national audit programme aims to bring about high quality care in hospitals by reducing unwarranted variations in services and practices. GIRFT results showed that Dartford and Gravesham NHS Trust Urology patients had a higher than expected readmission rate. A further local project was carried out to identify the reasons for patients being readmitted or attending the Emergency Department within 30 days of discharge, in order to identify the main causes of avoidable returns to hospital within 30 days.

The two most common presentations were found to be infection and haematuria (blood in urine) and an action plan was agreed to address the possible causes of these:

- Provide an information leaflet to patients having urological procedures to increase awareness of the possibility of haematuria and other common post-procedure symptoms, highlighting when these do/do not require medical attention.

- To work with microbiology regarding the incidence of readmissions with urinary tract infections and urosepsis to review antibiotic preventative protocols.

3. **Maternity Suturing Proforma Audit – Maternity**

Following the delivery of a baby it may be necessary for the mother to require perineal suturing. Swabs used should be counted at the end of the procedure to ensure they are all accounted for. One of the measures taken by the Maternity Department following a Never Event was the introduction of a new non-theatre swab count proforma. An audit was undertaken in June 2017 with the aim of providing assurance that the new proforma was being used and fully completed in all cases. The results showed that overall 83% of cases had appropriate detail of swab counts documented in the patients notes, however only 60% included a fully completed swab count proforma. The audit findings provided the Trust with only Limited Assurance.

The following action plan was put in place to address the issues found:

- To combine the proforma within the existing care notes booklet.
• To ensure awareness of the new notes booklet by discussing at handover meetings and disseminating the audit results throughout the department.

A re-audit was undertaken in December 2017, and the results showed that in 96% of cases there was evidence that the swab count proforma was used. Overall the results now gave the Trust reasonable assurance that detailed swab counts are taking place for women requiring perineal suturing. To ensure that the improvements are sustained and good practice is embedded, there will be continuing education around the correct in-room swab count procedure through mentorship, Professional Midwifery Advocates, study days and huddles.

**Participation in clinical research**

Clinical research involves gathering information to help understand the best treatments, medication or procedures for patients. It also enables new treatments and medications to be developed. Research involving patients must be approved by an ethics committee within the National Research Ethics Service.

The number of patients receiving relevant health services provided or sub-contracted by Dartford and Gravesham NHS Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 605.

Participation in clinical research demonstrates the Trust’s commitment to improving the quality of the care we offer and to making our contribution to wider health improvement priorities. Our clinical staff stay abreast of the latest possible treatments and actively engage in participation in research.

Dartford and Gravesham NHS Trust was involved in conducting clinical research studies in cancer, cardiology, diabetes, epilepsy, gastroenterology, gynaecology, haematology, hepatology, infection control, ITU, mental health, musculoskeletal, nephrology, neurology, paediatrics, respiratory, stroke, surgery and urology during 2017/18. There were 50 clinical staff participating in research approved by a research ethics committee at Dartford and Gravesham NHS Trust 2017/18. These staff participated in research covering 16 medical specialties.
Goals agreed with Commissioners

Commissioning for Quality and Improvement (CQUIN) 2017/18, progress and achievement

The Clinical Commissioning Group (CCG) held the NHS budget for their area in 2017/18 and decided how money was spent on hospitals and other health services. This is known as ‘commissioning’. Dartford Gravesham and Swanley CCG was the main commissioner of services at Dartford and Gravesham NHS Trust. The CCG set performance targets based on quality and innovation.

A proportion of Dartford and Gravesham NHS Trust’s income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Dartford and Gravesham NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2017/18 and for the following 12 month period are available online at: [https://www.england.nhs.uk/nhs-standard-contract/cquin/](https://www.england.nhs.uk/nhs-standard-contract/cquin/)

CQUIN 2017/18 progress and achievement

For 2017/18, the Trust had 9 CQUIN indicators (7 national and 2 local) to achieve.

Six of the indicators were set at a level of 2.5% of total contract value for all healthcare services commissioned by Clinical Commissioning Groups (CCG), excluding high cost drugs, devices and listed procedures.

The remaining 3 indicators were set at a level of 2% of total contract value for all healthcare services commissioned by NHS England (NHSE), excluding high cost drugs, devices and listed procedures. CQUIN as a whole is now worth around £4.9 million a year for the Trust.

The trust estimates that it will achieve 84.5% delivery against the nine indicators in 2017/18.

The following information gives details of the CQUIN goals and achievements for the year 2017/18, see also appendix 1, page 61.

CQUIN 2017/18 financial assessment of achievement

<table>
<thead>
<tr>
<th>Indicator No.</th>
<th>Indicator Name</th>
<th>CQUIN Achievement %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Improvement of health and wellbeing of NHS staff.</td>
<td>0%</td>
</tr>
<tr>
<td>1b</td>
<td>Healthy food for NHS staff, visitors and patients.</td>
<td>100%</td>
</tr>
<tr>
<td>1c</td>
<td>Improving the uptake of flu vaccinations for front line staff within providers</td>
<td>100%</td>
</tr>
<tr>
<td>2a</td>
<td>Timely identification of sepsis in ED and Acute IP settings</td>
<td>100%</td>
</tr>
<tr>
<td>2b</td>
<td>Timely treatment of sepsis in ED and Acute IP settings</td>
<td>70%</td>
</tr>
<tr>
<td>2c</td>
<td>Antibiotic review</td>
<td>100%</td>
</tr>
<tr>
<td>2d</td>
<td>Reduction in antibiotic consumption per 1,000 admissions</td>
<td>33%</td>
</tr>
<tr>
<td>4</td>
<td>Improving services for people with Mental health needs who</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>present at A&amp;E</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7</td>
<td>NHS e-Referrals CQUIN</td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>Map existing discharge pathways</td>
<td></td>
</tr>
<tr>
<td>8b</td>
<td>ECDS</td>
<td></td>
</tr>
<tr>
<td>8c</td>
<td>Discharge to usual place of residence</td>
<td></td>
</tr>
<tr>
<td>DGS Local</td>
<td>To support engagement with STP</td>
<td></td>
</tr>
<tr>
<td>Bexley Local</td>
<td>Demand Management</td>
<td></td>
</tr>
<tr>
<td>NHSE GE5</td>
<td>Shared Decision Making</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What others say about the provider:**

**The Care Quality Commission**

The Care Quality Commission (CQC) regulates and inspects health organisations.

Dartford and Gravesham NHS Trust is required to register with the Care Quality Commission and its current registration status is ‘registered’. Dartford and Gravesham NHS Trust has the following conditions on registration.

- There are no conditions on the registration.

The Care Quality Commission has taken enforcement action against Dartford and Gravesham NHS Trust during 2017/18.

Dartford and Gravesham NHS Trust has participated in a special review or investigation by the Care Quality Commission relating to the following areas during 2017/18.

- Urgent and emergency services.
- Medical care (including older people’s care).
- Surgery.
- Maternity

Dartford and Gravesham NHS Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission.

**Immediate corrective actions**

- Reviewed and amended the internal safeguarding procedures in the Emergency Department.
- Updated identified safety assessments and training requirements in theatres.
- Made structural improvements to an internal fire door in theatres.

**Other actions**

- Following the inspection the Trust developed an action plan encompassing all recommendations made by the CQC. This was broken down into the core areas with each area made responsible for enacting corrective actions. Progress was reviewed weekly by the Executive team.
- The Trust has given the required assurances to the Care Quality Commission and will participate in the local engagement meetings with the CQC going forward.
The CQC ratings for the Trust are shown below.

**Fig 17**

Dartford and Gravesham NHS Trust has made the following progress by 31 March 2018 in taking such action.

- The Trust has commissioned an external report on staff engagement with Trust leadership and a second report on clinical governance structures and systems. Both reports have been delivered to the Executive team and form the basis of ongoing improvement activities.

- The Trust is participating in a national improvement programme called ‘Getting to Good’ with a number of staff members from across the Trust attending collaborative events with other providers.

- The remaining actions from the initial action plan have been assimilated into and outcome-based improvement plan which will be discussed with stakeholders and progress monitored by the Executive team.
The CQC National Inpatient Survey results 2017

The Trust also reports on the results of the annual National Inpatient Survey conducted by the Care Quality Commission.

People are asked what they thought about different aspects of the care and treatment they received. Each NHS trust receives scores out of 10, based on the responses given by their patients. A higher score is better. The results take into account the age, gender and method of admission (emergency or elective) of respondents for each trust. The survey information is collected anonymously, and all responses are confidential.

Table to show national inpatient survey results 2016 and 2017

<table>
<thead>
<tr>
<th>2016 question number</th>
<th>Question</th>
<th>2016 score (out of 10)</th>
<th>2017* question number</th>
<th>2017 score (out of 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q35</td>
<td>Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.2</td>
<td>Q34</td>
<td>7.1</td>
</tr>
<tr>
<td>Q38</td>
<td>Did you find someone on the hospital staff to talk to about your worries and fears?</td>
<td>5.5</td>
<td>Q37</td>
<td>5.1</td>
</tr>
<tr>
<td>Q40</td>
<td>Were you given enough privacy when discussing your condition or treatment?</td>
<td>8.5</td>
<td>Q39</td>
<td>8.4</td>
</tr>
<tr>
<td>Q63</td>
<td>Did a member of staff tell you about medication side effects to watch for when you went home?</td>
<td>4.6</td>
<td>Q58</td>
<td>4.4</td>
</tr>
<tr>
<td>Q69</td>
<td>Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?</td>
<td>7.7</td>
<td>Q64</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Source – Care Quality Commission Inpatient survey 2017 (published Jun 2018)

The questionnaire was sent to 1200 inpatients that had been treated at Dartford and Gravesham NHS Trust in quarter two of 2017 and responses were received from 434 patients (35%). The five questions shown above (the survey includes over 70 questions) were included in an overall ‘patient responsiveness’ score in 2017 and have been matched to the same questions in the 2016 survey.

Quality of Data

This measure of data quality refers to whether the Trust recorded patients’ NHS and GP numbers in their clinical notes.

Dartford and Gravesham NHS Trust submitted records during 2017/18 to the 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:
  99.7% for admitted patient care;
  99.8% for outpatient care; and
  98.9% for accident and emergency care.
which included the patient’s valid General Medical Practice Code was:
- 100% for admitted patient care;
- 100% for outpatient care; and
- 99.8% for accident and emergency care

**Information Governance Toolkit attainment levels**

Information governance means keeping information about patients and staff safe. The Information Governance Toolkit is an annual assessment that all NHS organisations are required to complete.

Dartford and Graveshams NHS Trust Information Governance Assessment Report overall score for 2017/18 was 72% and was graded ‘green’.

**Clinical Coding Error rate**

Clinical codes are a way of recording patient diagnosis and treatment. NHS hospitals are paid different amounts for different groups of codes. This system is called Payment by Results.

Dartford and Graveshams NHS Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

**Statement on relevance of data quality**

Dartford and Graveshams NHS Trust will be taking the following actions to improve data quality:
- Working with primary care clinicians to resolve differences in data collected.
- Continue the on-going collaboration between clinicians and clinical coders which supports the accuracy and consistency of coding.
- Embedding the use of real time bed management and order communications across the organisation; this increased use of information technology in direct patient care leads to an improvement in overall data quality.
- Developing enhanced data quality reporting to allow errors to be detected earlier in the data submission cycle.
The Department of Health requires the inclusion of a core set of indicators in the Quality Account in 2017/18. The guidance on wording and presentation is prescriptive and there is no latitude. For convenience and clarity we have labelled these core indicators (A) to (H).

Note re Mortality

The indicator used in the core indicator set is the Summary Hospital Level Mortality Indicator (SHMI) – shown below. There are other mortality indices in use, summary as follows:

1) Crude mortality as measured by the mortality rate as a percentage of in-patients. This rate includes elective, emergency and low risk surgery. This method of reviewing mortality does not take any contributory factors into account, e.g. palliative care coding, and is the mortality rate expressed as a percentage of all hospital spells.

2) Risk adjusted mortality is the rate that is adjusted for predicted risk of death. Risk adjusted mortality excludes palliative care coding so where there is a higher percentage of palliative care coding this raises the risk adjusted mortality rate.

3) Hospital Standardised Mortality Rate (HSMR). The HSMR data is calculated by Dr Foster limiting the data analysis to 56 clinical care groups which cover 80% of in-hospital deaths. It takes into consideration comorbidities, palliative care, place from which admission occurs, age, sex etc.

4) The Summary Hospital Level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It extends to include deaths occurring within 30 days of discharge.

A) Summary hospital mortality indicator (SHMI)

The data made available to the Trust by NHS Digital with regard to:

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 Dartford and Gravesham NHS Trust considers that this data is as described for the following reasons: the Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by Dr Foster, the Trust’s information partner.

The Dartford and Gravesham NHS Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by:

- Mortality indices will continue to be an agenda item at Directorate Governance meetings.
- Outliers identified will be subject to scrutiny and review.
- The Trust Quality and Safety Committee receives a monthly report on mortality to enable assurance to be given to the Trust Board.
Table to show SHMI, trust banding and percentage palliative care coding

<table>
<thead>
<tr>
<th>SHMI</th>
<th>The value and banding of the summary hospital-level mortality indicator (&quot;SHMI&quot;) for the Trust for the reporting period.</th>
<th>The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dartford and Gravesham Trust (DGT)</td>
<td>National average</td>
</tr>
<tr>
<td>Oct 15 – Sep 16</td>
<td>1.037 (Band 2)</td>
<td>1.003</td>
</tr>
<tr>
<td>Oct 16 – Sep 17</td>
<td>1.113 (Band 2)</td>
<td>1.003</td>
</tr>
</tbody>
</table>

Source: NHS Digital Indicator Portal

B) Patient reported outcome measures (PROMS)
The data made available to the trust by NHS Digital with regard to the Trust’s patient reported outcome measures scores for:
  I. Groin hernia surgery,
  II. Varicose vein surgery,
  III. Hip replacement surgery, and
  IV. Knee replacement surgery, during the reporting period
The Dartford and Gravesham NHS Trust considers that this data is as described for the following reason: the Trust has made regular and timely data submissions to NHS Digital

The Dartford and Gravesham NHS Trust intends to take the following actions to improve this score, and so the quality of its services, by:
- Continuing to make timely PROMS data submissions.

The health gain index used in PROMS
PROMS uses a standardised instrument for use as a measure of health outcome. It is applicable to a wide range of health conditions and treatments and provides a simple descriptive profile and a single index value for health status. A higher score indicates better health and/or greater improvement in function after the operation.

The health gain index is primarily designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics and face-to-face interviews. It is cognitively simple, taking only a few minutes to complete. Instructions to respondents are included in the questionnaire.

Table (a) PROMs for groin hernia

<table>
<thead>
<tr>
<th>Period</th>
<th>Adjusted Health Gain (Trust)</th>
<th>National Average</th>
<th>Highest Reported Trust</th>
<th>Lowest reported Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/2015-03/2016</td>
<td>0.076</td>
<td>0.088</td>
<td>0.157</td>
<td>0.021</td>
</tr>
<tr>
<td>04/2016-03/2017</td>
<td>0.067</td>
<td>0.086</td>
<td>0.135</td>
<td>0.006</td>
</tr>
</tbody>
</table>

Source: NHS Digital (EQ5-Index Measure)

The adjusted average health gain for groin hernia surgery, see table (a), does not indicate an
improvement in health status of those patients surveyed in 2016/17.

Table (b) PROMS for varicose veins

<table>
<thead>
<tr>
<th>Period</th>
<th>Adjusted Health Gain (Trust)</th>
<th>National Average</th>
<th>Highest Reported Trust</th>
<th>Lowest reported Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/2015-03/2016</td>
<td>0.053</td>
<td>0.095</td>
<td>0.149</td>
<td>0.018</td>
</tr>
<tr>
<td>04/2016-03/2017</td>
<td>0.084</td>
<td>0.092</td>
<td>0.155</td>
<td>0.010</td>
</tr>
</tbody>
</table>

Source: NHS Digital (EQ5-Index Measure)

The adjusted average health gain for varicose veins surgery, see table (b), indicates an increase in health status of those patients surveyed in 2016/17.

Table (c) PROMS for hip replacement

<table>
<thead>
<tr>
<th>Period</th>
<th>Adjusted Health Gain (Trust)</th>
<th>National Average</th>
<th>Highest Reported Trust</th>
<th>Lowest reported Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/2015-03/2016</td>
<td>0.458</td>
<td>0.438</td>
<td>0.520</td>
<td>0.320</td>
</tr>
<tr>
<td>04/2016-03/2017</td>
<td>0.488</td>
<td>0.437</td>
<td>0.533</td>
<td>0.335</td>
</tr>
</tbody>
</table>

Source: NHS Digital (EQ5-Index Measure, 2016/17 results provisional)

The adjusted average health gain for hip replacement surgery, see table (c), indicates an increase in health status for those patients surveyed in 2016/17.

Table (d) PROMS for knee replacement

<table>
<thead>
<tr>
<th>Period</th>
<th>Adjusted Health Gain (Trust)</th>
<th>National Average</th>
<th>Highest Reported Trust</th>
<th>Lowest reported Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/2015-03/2016</td>
<td>0.318</td>
<td>0.320</td>
<td>0.398</td>
<td>0.198</td>
</tr>
<tr>
<td>04/2016-03/2017</td>
<td>0.363</td>
<td>0.323</td>
<td>0.394</td>
<td>0.237</td>
</tr>
</tbody>
</table>

Source: NHS Digital (EQ5_Index Measure, 2016/17 results provisional)

The adjusted average health gain for knee replacement surgery, see table (d), indicates an increase in health status for those patients surveyed in 2016/17.

Note: NHS England undertook a consultation on the national PROMs programme in 2016. Subsequent to the results of the findings of that consultation, the mandatory varicose vein surgery and groin-hernia surgery national PROM collections ended on 1 October 2017.

C) 28 day readmissions

The data made available to the Trust by NHS Digital with regard to 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.

The Dartford and Gravesharn NHS Trust considers that this data is as described for the following reasons: the Trust has made regular and timely data submissions to NHS Digital
and the figures are consistent with those produced by Dr Foster, the Trust’s information partner.

The Dartford and Gravesham NHS Trust has taken the following actions to improve these percentages, and so the quality of its services, by:

- Increasing numbers of Elderly Care Consultants
- Progression and development of dementia services – this work has been recognised by the Care Quality Commission, and has resulted in better discharge arrangements for this vulnerable patient group.
- The development of ambulatory care pathways.

**Table to show 28 day readmissions under 16 years**

<table>
<thead>
<tr>
<th>28 day readmissions Age &lt;16</th>
<th>Trust</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-12/2015</td>
<td>9.7</td>
<td>8.2</td>
</tr>
<tr>
<td>01-12/2016</td>
<td>9.7</td>
<td>8.7</td>
</tr>
<tr>
<td>01-12/2017</td>
<td>8.1</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Source: Dr Foster (www.drfoster.co.uk)

**Table to show 28 day readmissions over 16 years**

<table>
<thead>
<tr>
<th>28 day readmissions Age 16+</th>
<th>Trust</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-12/2015</td>
<td>7.5</td>
<td>7.9</td>
</tr>
<tr>
<td>01-12/2016</td>
<td>7.2</td>
<td>8.2</td>
</tr>
<tr>
<td>01-12/2017</td>
<td>7.4</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Source: Dr Foster (www.drfoster.co.uk)

**D) Responsiveness to needs of patients**

The data made available to the Trust by NHS Digital with regard to the Trust’s responsiveness to the personal needs of its patients during the reporting period. The figures are an average score from a selection of questions from the National Inpatient Survey measuring patient experience. The score is out of 100 and data is available up to the 2017 survey.

The Dartford and Gravesham NHS Trust considers that this data is as described for the following reason: the Trust has participated in the national Care Quality Commission (CQC) inpatient survey which provides the data used by NHS Digital.

The Dartford and Gravesham NHS Trust has taken and intends to take the following actions to improve this percentage, and so the quality of its services, by:

- The Trust has implemented a Quality Improvement plan as a result of the findings of the inspection by the Care Quality Commission (CQC) in December 2017.
- The Endoscopy team have updated a patient leaflet after feedback from a patient who had not understood that eating seeded bread should be avoided as part of the preparation for colonoscopy. The seeds can cause the procedure to be prolonged. This has been added to the ward display board.
- The Trust has used the patient feedback to improve the experience of patients attending the Outpatient clinics by reducing the number of hospital cancellations of appointments.

### Responsiveness to needs of patients indicator score

<table>
<thead>
<tr>
<th>Year</th>
<th>Trust average score</th>
<th>National Average</th>
<th>Highest Reported Trust*</th>
<th>Lowest reported Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>66.5</td>
<td>68.7</td>
<td>84.2</td>
<td>54.4</td>
</tr>
<tr>
<td>2015</td>
<td>64.5</td>
<td>68.9</td>
<td>86.1</td>
<td>59.1</td>
</tr>
<tr>
<td>2016</td>
<td>64.9</td>
<td>69.6</td>
<td>86.2</td>
<td>58.9</td>
</tr>
<tr>
<td>2017</td>
<td>66.7</td>
<td>68.1</td>
<td>85.2</td>
<td>60.0</td>
</tr>
</tbody>
</table>

Source: NHS Digital (NHS Outcomes Framework - based on 5 aggregated question scores in the CQC National Inpatient Survey)

*a higher score indicates greater improvement

E) Staff recommendation to family or friends

The data made available to the Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

The data is produced in the Department of Health NHS Staff Survey. The highest and lowest scores are unavailable for this question however the average for acute trusts is included below.

The Dartford and Gravesham NHS Trust considers that this data is as described for the following reason: the figure is taken from the National NHS Staff Surveys and published by the Department of Health. This annual survey is a poll of NHS Trust staff each year.

The Dartford and Gravesham NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- The Trust has continued the use of 85% staff with current appraisal at Directorate level as a quality metric in 2017/18.

- All staff have direct access to the Trust Occupational Health Services as well as direct access to independent counselling services.
Staff recommendation of the Trust as in the National Staff Survey Results for the indicator: ‘Staff recommendation of the trust as a place to work or receive treatment’

<table>
<thead>
<tr>
<th>Year</th>
<th>Trust score</th>
<th>National Average</th>
<th>Highest Reported Trust*</th>
<th>Lowest reported Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>4.01</td>
<td>3.67</td>
<td>4.20</td>
<td>2.99</td>
</tr>
<tr>
<td>2015</td>
<td>4.05</td>
<td>3.72</td>
<td>4.10</td>
<td>3.30</td>
</tr>
<tr>
<td>2016</td>
<td>3.93</td>
<td>3.75</td>
<td>4.84</td>
<td>2.82</td>
</tr>
<tr>
<td>2017</td>
<td>3.95</td>
<td>3.74</td>
<td>4.54</td>
<td>2.97</td>
</tr>
</tbody>
</table>

Source: Department of Health annual staff survey (www.nhsstaffsurveyresults.com)

*Note: This is a scale summary score for which the maximum achievable is 5.0 and the lowest possible score is 1.0. A higher score is better.

F) Assessment for venous thromboembolism (VTE)

The data made available to the Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

Percentage of adult inpatients (over 18 years) assessed for risk of developing VTE

<table>
<thead>
<tr>
<th>Year</th>
<th>Quarter</th>
<th>Number of admissions to Trust assessed for VTE</th>
<th>Total Admissions to Trust</th>
<th>Percentage of admitted patients assessed for VTE</th>
<th>Percentage of admitted patients risk assessed for VTE</th>
<th>Highest Reported Trust</th>
<th>Lowest reported Trust</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16</td>
<td>Q1-Q4</td>
<td>63,993</td>
<td>66,717</td>
<td>96.0%</td>
<td>100%</td>
<td>75.16%</td>
<td>95.72%</td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>Q1</td>
<td>16,321</td>
<td>16,982</td>
<td>96.11%</td>
<td>100%</td>
<td>80.61%</td>
<td>95.73%</td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>Q2</td>
<td>16,472</td>
<td>17,027</td>
<td>96.74%</td>
<td>100%</td>
<td>72.14%</td>
<td>95.51%</td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>Q3</td>
<td>16,918</td>
<td>17,409</td>
<td>97.18%</td>
<td>100%</td>
<td>76.48%</td>
<td>95.64%</td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>Q4</td>
<td>16,572</td>
<td>17,118</td>
<td>96.81%</td>
<td>100%</td>
<td>63.02%</td>
<td>95.53%</td>
<td></td>
</tr>
<tr>
<td>2016-17</td>
<td>Q1-Q4</td>
<td>66,283</td>
<td>68,536</td>
<td>96.71%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>Q1</td>
<td>16,647</td>
<td>17,259</td>
<td>96.45%</td>
<td>100%</td>
<td>51.38%</td>
<td>95.20%</td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>Q2</td>
<td>16,686</td>
<td>17,153</td>
<td>97.28%</td>
<td>100%</td>
<td>71.88%</td>
<td>95.25%</td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>Q3</td>
<td>17,152</td>
<td>17,935</td>
<td>95.63%</td>
<td>100%</td>
<td>76.08%</td>
<td>95.36%</td>
<td></td>
</tr>
<tr>
<td>2017-18</td>
<td>Q4</td>
<td>17,152</td>
<td>17,873</td>
<td>95.97%</td>
<td>100%</td>
<td>67.04%</td>
<td>95.18%</td>
<td></td>
</tr>
</tbody>
</table>

Source: NHS Digital, NHS Improvement (only available by Quarter)

The Dartford and Gravesham NHS Trust considers that this data is as described for the following reasons: the Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by the Trust internal information systems.

The Dartford and Gravesham NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- VTE assessment and prescribed VTE prophylaxis are included as a mandatory section on the Trust patient drug chart.
- Hospital acquired VTE cases are reviewed by the Consultant led VTE monitoring group.
and reported to the Trust Patient Safety Committee. For each case of avoidable hospital acquired VTE in 2017/18 an RCA summary investigation will take place.

G) Hospital acquired C-difficile infections and post 72 hour C-difficile cases per 100,000 bed days

The data made available to the Trust by NHS Digital with regard to 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.

<table>
<thead>
<tr>
<th>Period</th>
<th>Trust C-difficile cases</th>
<th>Trust rate (per 100,000 bed days)</th>
<th>National average rate for acute trusts</th>
<th>Trust with highest rate</th>
<th>Trust with lowest rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/2012-03/2013</td>
<td>26</td>
<td>13.5</td>
<td>17.4</td>
<td>31.2</td>
<td>0</td>
</tr>
<tr>
<td>04/2013-03/2014</td>
<td>21</td>
<td>10.9</td>
<td>14.7</td>
<td>37.1</td>
<td>0</td>
</tr>
<tr>
<td>04/2014-03/2015</td>
<td>17</td>
<td>9.2</td>
<td>15.1</td>
<td>62.2</td>
<td>0</td>
</tr>
<tr>
<td>04/2015-03/2016</td>
<td>25</td>
<td>13.5</td>
<td>14.9</td>
<td>66.0</td>
<td>0</td>
</tr>
<tr>
<td>04/2016-03/2017</td>
<td>19</td>
<td>9.9</td>
<td>13.2</td>
<td>82.7</td>
<td>0</td>
</tr>
<tr>
<td>04/2017-03/2018</td>
<td>16</td>
<td>7.7</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: NHS Digital (GOV.UK - Clostridium difficile infection: annual data) (2017)

* DARTFORD AND GRAVESHAM NHS TRUST BOARD Minutes April 2018

In respect of indicator G, the information reported in the quality account is provided by NHS Digital on an annual basis following submissions made by the Trust. The information for 2017-18 was not available at the time of publishing our quality report and therefore the most recent information internally available has been included.

The Dartford and Gravesham NHS Trust considers that this data is as described for the following reasons: the Trust has made regular and timely data submissions to NHS Digital and the figures are consistent with those produced by the Trust internal data systems.

The Dartford and Gravesham NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:

- Training and education of ward and department staff on the risk assessment process/isolation and stool specimen collection.
- C-difficile /Bowel risk assessment training to be undertaken by key staff identified by Matrons.
- Enhanced measures undertaken following each case of post 72 hour C-difficile.
- Audits of C-difficile risk assessment compliance, of patient management for all C-difficile cases, of hand hygiene and of commode cleanliness.
- Review of cleaning processes following discharge of patients with an infection and on a daily basis.
H) Patient safety incidents resulting in severe harm or death

The data made available to the Trust by NHS Digital with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

The Dartford and Gravesham NHS Trust considers that this data is as described for the following reasons: the Trust has made regular and timely data submissions to the National Recording and Learning System (NRLS) which provides the data used for NHS Digital figures.

The Dartford and Gravesham NHS Trust has taken the following actions to improve this number and/or rate, and so the quality of its services, by:

- Timely monthly data submissions to the National Recording and Learning System for incidents report in the Trust.
- Training, individual and group, of staff unfamiliar in the use of the Datix web system.

### Patient Safety Incidents resulting in severe harm and death as reported to the National Recording and Learning System

<table>
<thead>
<tr>
<th>Patient Safety Incidents Reported (Severe or Death)</th>
<th>Trust</th>
<th>National Average</th>
<th>Trust with Highest Score</th>
<th>Trust with Lowest Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate</td>
<td>Number</td>
<td>Rate</td>
<td>Number</td>
</tr>
<tr>
<td>10/2014 - 03/2015</td>
<td>0.08</td>
<td>7</td>
<td>0.18</td>
<td>3,089</td>
</tr>
<tr>
<td>04/2015 – 09/2015</td>
<td>0.04</td>
<td>4</td>
<td>0.16</td>
<td>2,717</td>
</tr>
<tr>
<td>10/2015 – 03/2016</td>
<td>0.08</td>
<td>8</td>
<td>0.16</td>
<td>2,642</td>
</tr>
<tr>
<td>04/2016 – 09/2016</td>
<td>0.06</td>
<td>6</td>
<td>0.16</td>
<td>2,516</td>
</tr>
<tr>
<td>10/2016 – 03/2017</td>
<td>0.01</td>
<td>1</td>
<td>0.15</td>
<td>2,623</td>
</tr>
<tr>
<td>04/2017 – 09/2017</td>
<td>0.05</td>
<td>5</td>
<td>0.15</td>
<td>2,482</td>
</tr>
</tbody>
</table>

Source: NHS Digital (NHS Outcomes Framework Indicator 5.6 - Acute Trusts (non-Specialist))

Notes: Rates are Per 1,000 Bed days

* More than one Trust tied for lowest rate. Number of severe harm or death incidents in those trusts.

In respect of indicator H, the information reported in the quality account is provided by NHS Digital on an annual basis following submissions made by the Trust. The information for 2017-18 was not available at the time of publishing our quality report and therefore the most recent information available has been included.

### Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017 which added a new mandatory disclosure requirement relating to ‘Learning From Deaths’ for inclusion in the quality accounts in 2017/18.

Dartford and Gravesham has in place systems to report, investigate, manage and learn from incidents and errors, including those leading to death. Mortality review (MR) hinges on
analysis of standardised mortality ratios (SMR) for patient populations, together with case review of individual patient mortality.

SMR gauges the mortality profile of the whole organisation and, controlling for factors such as diagnosis, age, sex and co-morbidity, compares it with other Trusts, hence standardised. In detecting problems in care, SMR have limits to their sensitivity and specificity, the often raise false alarms and possibly fail to detect concerns in the noise of the general data collected.

It is suggested that adding in systematic review of individual patient records will identify problems in care in between 3-4% of cases not previously recognised by SMR or trust processes. The new mortality review process is proposed to increase the learning and openness about the care of patients who died at the Trust. Case note review looks back at the care received by the patient in the time leading up to death. When trust processes indicate an incident possibly linked to death, a detailed case note review and usually further investigation is carried out as part of the root cause analysis to determine the facts and seek to identify problems in care. An investigation of this sort leads to trust actions including family liaison.

According to the NHS mortality review process, case notes must be reviewed under certain headings-regardless of whether concerns have or haven’t been raised by trust processes or SMR. If problems in care are identified, actions include serious incident declaration and root cause analysis, or liaison with other healthcare partners. Patterns of mortality that do not reflect problems in care may still have important learning opportunities and are captured as ‘themes’

During 2017/18 2,380 of the Dartford and Gravesham NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 593 in the first quarter;
- 530 in the second quarter;
- 535 in the third quarter;
- 722 in the fourth quarter.

By 31/03/18, 98 case record reviews and 7 investigations have been carried out in relation to 2,380 of the deaths included above.

In 7 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 15 in the first quarter;
- 25 in the second quarter;
- 32 in the third quarter;
- 26 in the fourth quarter.

6 representing 0.25% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 0.17% for the first quarter;
- 2 representing 0.38% for the second quarter;
- 2 representing 0.37% for the third quarter;
- 1 representing 0.14% for the fourth quarter.
These numbers have been estimated using the structured judgement review process as per RCP.

**Progress at Dartford and Gravesham NHS Trust**

- The Trust has been developing its response to these requirements of the learning from death agenda over the last year. The process has been developing since October 2016 and became fully operational in March 2017.
- Executive leadership and accountability: Medical Director
- Policy: Learning from Death Policy published on the trust website
- Review process: Described within policy
- Mortality review group: Established and integral to the Patient Safety Committee
- Monthly mortality reports presented to the Quality and Safety Committee of the Board chaired by a Non-Executive Director.
- Board reports published quarterly from December 2017
- Trust communications: Mortality Review Group, Mortality leads, Grand Round, performance review and audit meetings.
- Review: Linked to the Academic Health Science Network (KSS) community of practice for learning from deaths, attendance at NHSI Learning from Death events, communications from NHSI, CQC etc.

**Seven day services**

The amended reporting regulations of July 2017 also include a requirement for providers of acute services are asked to include a statement regarding how they are implementing the priority clinical standards for seven day hospital services.

The trust is intended to be compliant with the four main standards by 2020. The last audit showed performance against standard 2 is improving when comparing 14 hour review between March and September 2017.

**Fourteen hour review (Standard 2) of non-elective admissions to Darent Valley Hospital**

<table>
<thead>
<tr>
<th>Review period</th>
<th>Total 14 hour</th>
<th>Weekday 14 hour</th>
<th>Weekend 14 hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>66%</td>
<td>71%</td>
<td>54%</td>
</tr>
<tr>
<td>September 2017</td>
<td>67%</td>
<td>68%</td>
<td>65%</td>
</tr>
</tbody>
</table>

The Trust is showing a gradual improvement in this domain across seven days, reviews completed across all days of the week within 14 hours has remained constant, but there is an increase in the reviews conducted at weekends, close to the national average as published in March 2017.

The plot below shows that weekend reviews are still slightly behind weekday but that the graph below shows the position is improving over time.
The graph below shows an improving position for DGT 14 hour weekend review (square) compared to national (triangle)

Further work to be done on 7 day services includes the following plans:
The planning priorities fall into 3 groups:
- Patient segmentation.
- Increasing paid consultant on site time 24 hours, seven days and compensatory rest.
- Team support and other services to make best use of consultant time.

The actions for each
- Developing trust IT systems (Medicus/PAS/EDN) with clinical information team.
- Weekend working model and medical ward cover projects in the Emergency Care and Adult Medicine Directorate beginning in January 2018. Challenge to each directorate on seven day service plans and monitoring in performance review.
- Non-medical input may follow planned alongside consultant-led service.
The Trust had a visit from NHS Improvement just prior to the April 2018 biannual national audit to enable them to view Trust plans and provide support if necessary to meet the 2020 trajectory. A working group with clinical lead will be required to scope the next series of changes for the whole Trust leading up to 2020. In addition the Trust has sought to engage the wider healthcare system in a response to the requirements of seven day services, the focus having shifted from weekend mortality to weekend/weekday discharges requires an equivalent response from community and primary care to optimise patient discharge.
Part Three
Other information

Trust achievements in 2017/18

This section describes some of the 2017/18 awards and achievements and other highlights of the last year.

IT Training Team Success
In April the Clinical Systems Development Training Team were awarded TSA Accreditation. The award issued by NHS Digital and followed a site visit to assess the Trust in March. The assessment included extensive scrutiny of all aspects of the training service. Demand for IT Training has doubled over the last 18 months. The Trust has been awarded Level 2 Accreditation.

Queen Mary’s Hospital, Sidcup

The Trust continued to focus on moving routine elective surgery to Queen Mary’s Hospital (QMH). To meet an increase in demand for elective procedures in the short and longer term the Trust has designated Queen Mary’s Hospital, Sidcup (QMH) as a Planned Care Centre. It is used for routine elective surgery to maximise use of additional operating theatres and ward space. As there are no emergency cases arriving, cancellations or long delays for surgery are extremely rare.

The hospital Outpatient waiting times are lower than two weeks in some specialties. Pre-surgical assessments of fitness for surgery and admission dates can be offered on the same day as the first appointment making the service ‘one-stop’ in some cases.

The Trust is proud to say that services at Queen Mary’s were rated as ‘Good’ by the CQC in the recent inspection. Being local, accessible, with easy parking and with faster appointments, treatment at Queen Mary’s is an excellent choice for treatment.

Promoting Clean Hands

In October, the Trust supported the WHO Global Handwashing ‘Clean Happy’ raises awareness about Infection Prevention and Control throughout the hospital. Staff have been proactive in highlighting the importance of hand washing to effective Infection Prevention and Control. This applies to MRSA, C-difficile and other bugs, and helps prevent them spreading.
LEARNING FROM THE VANGUARDS:

STAFF AT THE HEART OF NEW CARE MODELS

On Tuesday 4 July the Foundation Healthcare Group (FHG) Vanguard hosted a Celebration and Showcase event in Robens Suite, Guy’s Tower. The event was attended by over 100 healthcare leaders who have contributed to the Vanguard programme, including Chief Executives of both partner trusts, Susan Acott, Dartford and Gravesham NHS Trust and Amanda Pritchard, Guy’s and St Thomas NHS Foundation Trust, as well as representatives from NHS England and the clinical teams who are delivering the improvements for patients.

During the panel discussion both Sir Ron Kerr and Louise Watson spoke about the FHG Vanguard’s commitment to collaborative working and how this has accelerated the pace of change.

Roald Dahl Specialist Nurse

The Trust has a new Roald Dahl Paediatric Epilepsy/Neurology Specialist Nurse who started work this year. Emily is the first Roald Dahl nurse in Kent, and the first to work with one of NHS England’s 50 Vanguard sites – The Foundation Healthcare Group. She joined the paediatric team at Darent Valley Hospital in July and works with children and young people with epilepsy at all stages of their illness, and also with their families.

Support for Emily’s role is included as part of the Vanguard programme working with staff at the Evelina London Children’s hospital. Roald Dahl’s Marvellous Children’s Charity also provides ongoing training and support to all its nurses.

HSJ Top 50 Chief Executive

The Trust Chief Executive, Susan Acott, has been listed in the Health Service Journal’s Top 50 Chief Executives for 2017/18. This list celebrates exceptional chief executives leading NHS provider organisations.

To be named in the Top 50 list Chief Executives have to have demonstrated positive leadership to their people during some of the toughest times the NHS has faced.
New Emergency Department streaming

In October the Trust welcomed Primary Care Services to the Emergency Department (ED) by locating GPs in the department. The Service provides expert care for patients presenting to with minor illnesses that will be referred through to see a GP. The new system is designed to reduce waiting time and improve flow through the Emergency Department for patients with more acute/complex conditions leading to an improvement in the overall quality of care.

Other Quality Indicators

Responding to Complaints

There were 280 complaints received in the period 1st April 2017 to 31st March 2018, which includes complaints relating to services at Queen Mary’s Hospital (QMH) site, compared to 292 for the same period in 2016-17.

Within the time period 14 complaints were reopened, compared to 30 reopened in 2016/17. Reopening a complaint usually happens because the person who has complained is not satisfied with the response and asks for additional clarification.

The Trust supported and facilitated 31 local resolution meetings (LRMs). This is an opportunity for the person who has made the complaint to meet with senior staff – usually the Consultant and the Matron for the service, and to discuss any outstanding issues face to face. These LRMs are documented and an audio CD recording provided as part of the formal response.

No cases have been accepted for further investigation by the Parliamentary and Health Service Ombudsman (PHSO). This is the next stage of the NHS Complaints Process if the person who made the complaint is dissatisfied with the Trust’s response.

Performance for the initial acknowledgement of complaints within 3 days was 100% for the year.
Management of Complaints

Each new complaint is screened to determine the most appropriate means of responding – this could be by a phone call, a face to face meeting, or by letter. The complaint is then taken forward by the Complaints Officer working with the directorate. All complaints are tracked to monitor deadlines and achieve timely responses.

The majority of complaints result in action being taken to identify what went wrong and to put systems in place to avoid this happening in future.

The Complaints Department assesses complaints as these are received to identify those that are more complex; for these the person making the complaint is advised that it may take up to 60 days to complete the work involved and is kept informed if there are subsequent delays.

Prominent themes of Complaints 2014/15 to 2017/18

Source: Trust information management system (Datix).
Complaint themes and trends are monitored by the Director of Nursing and reviewed quarterly by the Trust Quality and Safety Committee. Any emerging themes or variation is scrutinised in detail with further breakdown on the numbers to directorate and ward level. Directorates are asked to provide action plans in response to complaints received about services.

**NICE Standards compliance**

The National Institute for Health and Care Excellence (NICE) guidance is designed to promote good health and prevent ill health, is based on the best evidence and intended to deliver good value for money, weighing up the cost and benefits of treatments.

New NICE guidance is received monthly and the Medical Director decides the appropriate clinician to review the guidance to see that the Trust is compliant.

**Chart to show number and type of NICE guidances received Apr 17 – Mar 18**

![Chart showing number and type of NICE guidances received Apr 17 – Mar 18](source: Trust information systems)

**NICE Guidances received in 2017/18 and status as at March 31st 2018**

* Includes NICE Quality Standards
NICE guidance is discussed at local meetings to ensure all clinicians are aware of the latest guidance and are practising in accordance with the guidance. In the very rare situation that a department or directorate decides not to adhere to the guidance there must be a formal record of this decision made.

**Incident Reporting**

The Trust uses the Datix incident reporting system which is available to all staff through the intranet portal on all Trust computers. Incidents reported include those which cause harm to patients or have potential to cause harm, environmental incidents, those affecting staff and incidents which have potential to impact the provision of Trust services. The majority of incidents reported are about potential or actual harm to patients.

**Graph to show incidents affecting patients reported by staff Apr 2016 to Mar 2018**

*Fig 22*

Staff willingness to report incidents is seen as a positive indicator of an open culture where staff are not afraid to report. This finding of openness and good communication between staff and managers is also seen in the 2017 NHS staff survey.

**Outcome from 2017 NHS staff survey for Dartford and Gravesham Trust**

<table>
<thead>
<tr>
<th>KF6. Percentage of staff reporting good communication between senior management and staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2017</td>
</tr>
<tr>
<td>National 2017 average for acute trusts</td>
</tr>
</tbody>
</table>

*Source: NHS Staff Survey 2017*
Incidents which cause harm to patients are identified at the weekly Serious Incident Declaration Group meeting. An investigator is assigned and the management of the investigation is the responsibility of the Trust Patient Safety Committee. It is difficult to identify a pattern in the occurrence of harm caused to patients except to say that the overall trend is downward. Two of the most frequent causes of harm to patients are pressure ulcers and falls resulting in fractures. These figures should be viewed against the background of an increasing patient population of frail and elderly people, more likely to be admitted in winter and general levels of activity and bed occupancy in the Trust at different times.

**Duty of Candour**

The duty of candour means that the Trust must be open and honest with patients if things go wrong. Medical treatment and care is not risk free. Errors will happen and nearly all of these will in part be due to failures in the organisational systems.

Where errors have taken place, organisations and individual staff must engage honestly with patients and their carers to tell them what has happened and this includes offering an apology.

The CQC inspection found that the Trust applied duty of candour, and this was evidenced in reports on adverse events and serious incident investigations. The CQC said that candour, openness, honesty and transparency were evident throughout the surgical services. Of medicine and maternity they found:

‘all staff we spoke to were aware of their responsibilities relating to Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014’.
The Trust has produced written information for patients to explain duty of candour and what the patient should expect. This includes details of any investigation process and providing the contact details of a senior member of staff who will keep the patient informed of progress and who can be contacted with any questions. This person will also meet with the patient to listen to information which the patient wishes to be included in the investigation process.

The completion of the duty of candour requirement is recorded in the Root Cause Analysis report completed for each serious incident and reviewed by the Patient Safety Committee.

Incidents resulting in harm to patients and the subsequent investigations are overseen by the monthly Trust Patient Safety Committee and progress is monitored in a weekly meeting chaired by the Director of Nursing and the Medical Director.

**Workforce – our quality resource**

The Trust’s workforce is critical to the provision of high quality services to our patients. This section of the Quality Account outlines the number of staff we employ, feedback on the staff survey, and our approach to staff engagement.

The table below shows the Trust’s headcount; vacancy, turnover and sickness rates at 31st March 2018

<table>
<thead>
<tr>
<th>Total staff headcount (full-time and part-time) as at 31 March 2018</th>
<th>Vacancy rate as at 31 March 2018</th>
<th>Turnover rate</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>3407</td>
<td>9.5%</td>
<td>12.9%</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

*Source: Trust information management systems*

**Staff Survey**

The NHS Staff Survey results were published in March 2018. The number of staff who completed the survey was 48% this gave us a good indication of how staff feel about working for the Trust. The overall feedback from staff was amongst the most positive for acute trusts in the NHS.

Staff responses to the survey show that on a number of key findings we remain amongst the very best acute trusts in the NHS. The most improved areas were the percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month; fairness and effectiveness of procedures for reporting errors, near misses and incidents; effective team working and the percentage of staff reporting good communication between senior management and staff.
Overall the Trust was rated in the top 20% of acute trusts on 20 of 32 measures, above average for six measures, average for three measures and below average for three measures.

**Five top ranking scores**

<table>
<thead>
<tr>
<th>Key factor</th>
<th>2017 Trust score</th>
<th>2017 national average score</th>
<th>2016 Trust score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>60%</td>
<td>51%</td>
<td>58%</td>
</tr>
<tr>
<td>Quality of appraisals</td>
<td>3.39</td>
<td>3.11</td>
<td>3.30</td>
</tr>
<tr>
<td>Quality of non-mandatory training, learning or development</td>
<td>4.14</td>
<td>4.05</td>
<td>4.11</td>
</tr>
<tr>
<td>Percentage of staff reporting good communication between senior management and staff</td>
<td>43%</td>
<td>33%</td>
<td>43%</td>
</tr>
<tr>
<td>Support from immediate manager</td>
<td>3.87</td>
<td>3.74</td>
<td>3.82</td>
</tr>
</tbody>
</table>

Source: Department of Health Annual Staff Survey. Scoring out of a possible 5

Staff responses to the national staff survey rated the Trust in the top 20% of acute trusts for the proportion of staff who would recommend the Trust as a place to work or receive treatment.

**Bottom five ranking scores**

<table>
<thead>
<tr>
<th>Key factor</th>
<th>2017 Trust score</th>
<th>2017 national average score</th>
<th>2016 Trust score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>14%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Percentage of staff experiencing physical violence from staff in last 12 months</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>29%</td>
<td>28%</td>
<td>28%</td>
</tr>
<tr>
<td>Percentage of staff working extra hours</td>
<td>72%</td>
<td>72%</td>
<td>72%</td>
</tr>
<tr>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>25%</td>
<td>25%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: Department of Health Annual Staff Survey

**Staff engagement and empowerment**

The Chief Executive has held open sessions throughout the year and across the hospital sites to speak directly to staff, and leads a monthly briefing session. The Trust has constructive discussions with staff representatives through Joint Consultative Committee and Local Negotiating Committee.

The Trust was also rated in the top 20% for staff engagement compared to other acute trusts

**Plans for improvement**

There are some areas for improvement and actions are planned as part of the Trust's quality improvement plan to address them.
### CQUIN 2017/18 financial assessment of achievement - National Indicators:

**RAG** - Red = Not Achieved, Amber = Partially Achieved, Green = Achieved in full.

<table>
<thead>
<tr>
<th>1a: Improvement of staff health and wellbeing</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress.</td>
<td>Achievement of the 5% point improvement in 2 of the 3 questions in the staff survey results</td>
<td>100% Red</td>
<td>(3.3%) Not Achieved</td>
</tr>
</tbody>
</table>

**Notes**
- Achievement of the CQUIN requires a 5% point improvement. It is very difficult to achieve even the 3 point gain; There is no mid-way measurement to track progress; Confirmed non-achievement

<table>
<thead>
<tr>
<th>1b. Healthy food for NHS staff, visitors and patients</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firstly, maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 &amp; 2018/19</td>
<td>Each provider must evidence to commissioners that they have maintained the changes in 2016/17 and introduced the 2017/18 changes by providing at least the following evidence:</td>
<td>100% Green</td>
<td>(3.3%) Achieved 100%</td>
</tr>
<tr>
<td>a.) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following are common definitions and examples of price promotions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal);</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Multi-buy discounting: for example buy one get one free;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS);</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Price pack or bonus pack deal (for example 50% for free); and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2017/18 onwards no HFSS products will be able to be sold through meal deals).

b.) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS);

Secondly, introducing three new changes to food and drink provision:

a.) 70% of drinks lines stocked must have less than 5 grams of added sugar per 100ml. In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).

b.) 60% of confectionery and sweets do not exceed 250 kcal.

c.) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

Notes
- Quarter 4 assessments are yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.

<table>
<thead>
<tr>
<th>1c. Improving the uptake of flu vaccinations for frontline clinical staff</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description: Achieving an uptake of flu vaccinations by frontline clinical staff of 70</td>
<td>Providers to submit cumulative data monthly on the ImmForm website.</td>
<td>100% Green</td>
<td>(3.3%) Achieved 100%</td>
</tr>
</tbody>
</table>

Notes
- Achievement level confirmed.
### 2a. Timely identification of sepsis
in emergency departments and
acute inpatient settings

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
</table>
| Quarter 1: Sliding scale achievement of eligible patients screened –  
< 50% no payment, 50% - 89.9% 50% payment  
>= 90% full payment. | [12.5% Green](#) | (2.5%)  
Achieved 100% |
| Quarter 1: ED 99% | [12.5% Green](#) |       |
| Quarter 1: IP 100% | [12.5% Green](#) |       |
| Quarter 2: Sliding scale achievement of eligible patients screened | [12.5% Green](#) |       |
| Quarter 2: ED 99% | [12.5% Green](#) |       |
| Quarter 2: IP 100% | [12.5% Green](#) |       |
| Quarter 3: Sliding scale achievement of eligible patients screened. | [12.5% Green](#) |       |
| Quarter 3: ED 99% | [12.5% Green](#) |       |
| Quarter 3: IP 97% | [12.5% Green](#) |       |
| Quarter 4: Sliding scale achievement of eligible patients. | [12.5% Green](#) |       |
| Quarter 4: ED | [12.5% Green](#) |       |
| Quarter 4: IP | [12.5% Green](#) |       |

#### Description:

The percentage of patients who met the criteria for sepsis screening and were screened for sepsis

The indicator applies to adult and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards.

#### Notes

- Final quarter 4 assessment is yet to be ratified, however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN
### 2b Timely treatment of sepsis in emergency departments and acute inpatient settings

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1: Sliding scale achievement of eligible patients screened – &lt; 50% no payment, 50% - 89.9% 50% payment &gt;= 90% full payment.</td>
<td>12.5% Green</td>
<td></td>
</tr>
<tr>
<td>Quarter 1: ED 72%</td>
<td></td>
<td>12.5% Green</td>
</tr>
<tr>
<td>Quarter 1: IP 69%</td>
<td></td>
<td>12.5% Green</td>
</tr>
<tr>
<td>Quarter 2: Sliding scale achievement of eligible patients screened</td>
<td>12.5% Green</td>
<td>(2.5%) Achieved 70%</td>
</tr>
<tr>
<td>Quarter 2: ED 85%</td>
<td></td>
<td>12.5% Green</td>
</tr>
<tr>
<td>Quarter 2: IP 80%</td>
<td></td>
<td>12.5% Green</td>
</tr>
<tr>
<td>Quarter 3: Sliding scale achievement of eligible patients screened.</td>
<td>12.5% Green</td>
<td></td>
</tr>
<tr>
<td>Quarter 3: ED 90%</td>
<td></td>
<td>12.5% Amber</td>
</tr>
<tr>
<td>Quarter 3: IP 85%</td>
<td></td>
<td>12.5% Amber</td>
</tr>
<tr>
<td>Quarter 4: Sliding scale achievement of eligible patients.</td>
<td>12.5% Amber</td>
<td></td>
</tr>
<tr>
<td>Quarter 4: ED</td>
<td></td>
<td>12.5% Amber</td>
</tr>
<tr>
<td>Quarter 4: IP.</td>
<td></td>
<td>12.5% Amber</td>
</tr>
</tbody>
</table>

### Notes

- In 2017-2018, the Trust aimed to deliver early recognition and early definitive treatment as specified within the CQUIN for sepsis 2017-18. Significant improvement has been made compared to 2016-17 however there is scope for further improvement. Our ability to identify unwell patients with sepsis is good and our ability to ensure antibiotics were given to the patient within a specific time from identification is improving.  
- We are in the process of providing more resources promoting and training in good antibiotic practice and backing this with data collection to ensure that once identified, patients can be shown to have been managed in accordance with recommended practice. 
- Final quarter 4 assessment is yet to be ratified, however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN
**2c. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.**

<table>
<thead>
<tr>
<th>Description: Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1: Perform an empiric review for at least 25% of cases in the sample</td>
<td>25% Green</td>
<td>(2.5%)</td>
<td></td>
</tr>
<tr>
<td>Quarter 2: Perform an empiric review for at least 50% of cases in the sample</td>
<td>25% Green</td>
<td>Achieved 100%</td>
<td></td>
</tr>
<tr>
<td>Quarter 3: Perform an empiric review for at least 75% of cases in the sample</td>
<td>25% Red</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4: Perform an empiric review for at least 90% of cases in the sample</td>
<td>25% Red</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**
- Final quarter 4 assessment is yet to be ratified; however, the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.
### 2d Reduction in antibiotic consumption per 1,000 admissions

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 Reduction required: Total antibiotics: 1% Piperacillin/tazobactam: 2% Carbapenems: 1% Predicted Total Abx: 11% Increase Piperacillin/tazobactam: 77% Decrease Carbapenems: 6% Increase</td>
<td>100% Amber</td>
<td>(2.5%) Achieved 33%</td>
</tr>
</tbody>
</table>

- There are three parts to this indicator with reductions of set amounts for each part; data is submitted to PHE, processed and returned to us; very long time lag between reporting and output; data was submitted in October 2017 and results were published in January 2018; updated results for Q2 published so far are that we have achieved 1 out of the 3 reductions required;
- An increase in total antibiotic consumption can be seen from Q2 results. This may be due to the shortage of multiple antibiotics which prompted a change in the Trust guidelines to manage this. In some instances where one single agent may have been used now a combination of antimicrobials are used. CQUIN is actively monitored at Bi-monthly Antimicrobial Stewardship Group.

### 4. Improving services for people with mental health needs who present to A&E.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Jointly identify cohort</td>
<td>10% Green</td>
<td></td>
</tr>
<tr>
<td>Q2 Jointly conduct internal coding Audit</td>
<td>40% Green</td>
<td></td>
</tr>
<tr>
<td>Q3 Establish Joint Governance arrangements</td>
<td>10% Green</td>
<td></td>
</tr>
<tr>
<td>Q4 20% reduction</td>
<td>40% Green</td>
<td></td>
</tr>
</tbody>
</table>

**Notes**
- Final quarter 3 and 4 assessments is yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.
### 6. Offering advice and Guidance (A&G)

<table>
<thead>
<tr>
<th>Description:</th>
<th>Constraint</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>To set up and operate A&amp;G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&amp;G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.</td>
<td>Q1 Agree Specialties, trajectory and timetable</td>
<td>25% Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q2 Mobilise services and agree quality standard</td>
<td>25% Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q3 A&amp;G services operational for first agreed tranche of specialties.</td>
<td>25% Green</td>
<td></td>
<td>(10.0%)</td>
</tr>
<tr>
<td></td>
<td>Q4 A&amp;G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter</td>
<td>25% Green</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**
- Final quarter 3 and 4 assessments is yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.

### 7. NHS e-Referrals CQUIN

<table>
<thead>
<tr>
<th>Description:</th>
<th>Constraint</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system.</td>
<td>For Q1: Submit a baseline plan to deliver Q2, Q3 and Q4 targets.</td>
<td>25% Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q2 80% of Referrals to 1st O/P Services able to be received through e-RS.</td>
<td>25% Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q3 90% of Referrals to 1st O/P Services able to be received through e-RS.</td>
<td>25% Green</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Q4 100% of Referrals to 1st O/P Services able to be received through e-RS. Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less</td>
<td>25% Green</td>
<td></td>
<td>(10.0%)</td>
</tr>
</tbody>
</table>

**Notes**
- Final quarter 3 and 4 assessments is yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.
### 8a. Supporting Proactive and Safe Discharge – Acute Providers

<table>
<thead>
<tr>
<th>Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Part a) 40% of weighting for this measure</td>
</tr>
</tbody>
</table>

**Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories.**

**i)** Map and streamline existing discharge pathways across acute, community and NHS-care home providers and roll-out protocols in partnership across local whole-systems.

**ii)** Develop and agree with the commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the part b indicator for year 1 and year 2. As part of this, agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers.

**Value**

<table>
<thead>
<tr>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4%)</td>
<td>Achieved 100%</td>
</tr>
</tbody>
</table>

**Notes**

• Only Q2 assessment applies for this part

### 8b. Supporting Proactive and Safe Discharge – Acute Providers - ECDS

<table>
<thead>
<tr>
<th>Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Part b) 20% of the weighting for this measure (applicable to acute only, with category 1 or 2 A&amp;E departments).</td>
</tr>
</tbody>
</table>

**Emergency Care Data Set (ECDS)**

Type 1 or 2 A&E providers to have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017.

See milestone section for detail of the requirements.

Further information on the ECDS can be found at:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Q1 Type 1 or 2 A&amp;E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017.</td>
<td>75% Green</td>
<td>(2%) Achieved 75%</td>
</tr>
<tr>
<td>For Q3 Type 1 or 2 A&amp;E provider is returning data at least weekly AND 95% of patients have both a valid Chief Complaint and a Diagnosis (unless that</td>
<td>25% Red</td>
<td></td>
</tr>
</tbody>
</table>

DGT 2017/18 Quality Account
patient is streamed to another service) so that 95% of patients have a diagnosis. Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). Diagnosis should be any value from the ECDS diagnosis code set (SNOMED CT).

Notes
- Supplier delays have meant that we are unable to meet this CQUIN due to period of testing required before full deployment; anecdotally we should not get penalised if the supplier was not able to meet deadline: we are not the only Trust in this position in Kent; being investigated further; Circumstances out of our control proposed to CCG; high risk of system wide PAS failure accepted especially in light of Winter pressures.
- Final quarter 3 and 4 assessments is yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.

<table>
<thead>
<tr>
<th>8c. Supporting Proactive and Safe Discharge – Acute Providers</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Part c) 40% of weighting for this measure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.</td>
<td>For Q4 Finished discharge episodes of patients aged 65+ admitted via non-elective route within Q3 and 4 with a LOS of &gt;2.</td>
<td>100% Green</td>
<td>(0.0625%) Achieved 100%</td>
</tr>
</tbody>
</table>

Notes
- Final quarter 3 and 4 assessments is yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.

<table>
<thead>
<tr>
<th>STP DGS</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description:</td>
<td>Attendance and engagement with the STP</td>
<td>100% Green</td>
<td>(20%) Achieved 100%</td>
</tr>
</tbody>
</table>

Notes
- Confirmation received
<table>
<thead>
<tr>
<th>STP Bexley</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong>&lt;br&gt;Create and increase the number of:&lt;br&gt;1. Virtual clinics (telephone, email, skype etc.) for prioritised specialties&lt;br&gt;2. One Stop shops where patients may receive tests, diagnostics and treatment within a single appointment in one location, reducing the total number of appointments required&lt;br&gt;3. Nurse and other AHP led clinics&lt;br&gt;By the end of Q4 17/18 there should be a 7% shift of activity, as set out below, from face to face consultant-led follow-up outpatient appointments to alternatives to outpatient appointments. (Excluding AQP activity)&lt;br&gt;The prioritised, but not limited to specialties are as follows:&lt;br&gt;1. Diabetes / Endocrinology&lt;br&gt;2. Urology&lt;br&gt;3. Gynaecology&lt;br&gt;4. Cardiology</td>
<td>For Q2&lt;br&gt;Develop ideas for virtual clinics to cover all relevant specialties/pathways where possible and agree TFC based local tariff.&lt;br&gt;Establish Q4 16/17 baseline against which reduction in attendances will be measured, taking into account growth, QIPP etc.&lt;br&gt;Present the above items to CQUIN sub-group of CMB</td>
<td>40% Green</td>
<td>(20%) &lt;br&gt;Achieved 86%</td>
</tr>
</tbody>
</table>

**Notes**<br>- Final quarter 3 and 4 assessments is yet to be ratified; however the Trust feels the estimate above accurately reflects the likely achievement due for this CQUIN.

<table>
<thead>
<tr>
<th>GE5 NHSE Shared Decision Making</th>
<th>Indicator</th>
<th>% weighting and RAG</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong>&lt;br&gt;To ensure ALL relevant treatment options are discussed with patients, to enable choices aligned to a patient’s overall needs and values and clinical ability to benefit. To achieve this clinical teams require skills to engage patients in shared decision making and need to be aware of the range of treatment or support options beyond their immediate area of expertise and the associated</td>
<td>For Q4&lt;br&gt;Meet in full 5 triggers as below:&lt;br&gt;Trigger 1: Planning &amp; Set-Up&lt;br&gt;Trigger 2: Team Building&lt;br&gt;Trigger 3: Pilot Application of SDM Tool&lt;br&gt;Trigger 4: Finalisation of SDM tool and supporting information&lt;br&gt;Trigger 5:</td>
<td>100% Red</td>
<td>(2%)&lt;br&gt;Not Achieved</td>
</tr>
</tbody>
</table>
outcomes. The ultimate aim is to ensure clinical teams understand the full range of treatment options available and emphasise to patients their ability to benefit from all of these options as part of the decision making process. It is anticipated that this should reduce the demand for successive treatments which is particularly relevant to specialised services. Providers will need to develop a Shared Decision Making resource that is specific to the particular condition, encompassing the range of options that should be offered, with reference to the local services available.

<table>
<thead>
<tr>
<th>Implementation:</th>
</tr>
</thead>
</table>

### Notes
- Agreement has been protracted; difficulty establishing baseline

Source: Trust data management and recording systems.
Annex 2
Statements from other organisations

1) Dartford Gravesham and Swanley Clinical Commissioning Group comments on the 2017/18 Quality Account for Dartford and Gravesham NHS Trust.

The Trust’s draft Quality Accounts document was sent to Clinical Commissioning Groups (CCGs) for consultation and comment. The CCGs have a responsibility to review the Quality Accounts of the Trust 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.

Of the 2017/18 priority updates included, it is confirmed that this is an accurate reflection of achievement and gives clear articulation to the outcomes and what did/didn’t work well. It is unfortunate that not all priorities were achieved, of the nine priorities set, three were fully achieved, five partially achieved and one not achieved relating to infection, prevention and control, of which this priority will continue into 2018/19.

The Trust recognises and acknowledges areas where improvement is required and the Quality Account is an open and honest report on the challenges the trust is facing and areas it is required to improve. It is positive to note that the trust have acknowledged the hard work of its staff and the importance of patient experience in delivery of a safe and quality service.

The Trust has clearly outlined nine priorities for 2018/19 of which the CCG agree are pertinent areas to drive forward improvements in patient care and largely based upon recommendations from the CQC inspections. In addition the CCG would have welcomed the inclusion of a priority related to improving incident reporting which incorporates learning from incidents and Duty of Candour but are engaged with the trust in supporting improvements in this area outside of the Quality Account. The CCG are committed to supporting the trust in achieving against the priorities set and acknowledge some cross over between Quality Account priorities and CQUINs in particular in relation to sepsis management which was achieved in 2017/18 under the priorities but not fully achieved within CQUINs. The CCG are aware that the trust is working towards further improvements within the Sepsis pathway. It is an expectation that the trust regularly report updates against the Quality Account priorities to provide ongoing assurance that they are on track to be achieved or where there is a deviation that this is reconsidered in the priority requirement.

In conclusion, the report identifies that providing a safe and effective service whilst maintaining patient’s quality of care and experience is a high priority for the Trust, and that this is only achieved and supported by a well led Executive Team that provides clear direction and vision to an effective and committed workforce.
The CCG thanks the Trust for the opportunity to comment on this document and looks forward to further strengthening the relationships with the Trust through closer joint working in the future.

Gail Locock, Chief Nurse
Dartford Gravesham and Swanley CCG & Swale CCG
2) Healthwatch Kent commentary on Dartford and Gravesham NHS Trust Quality Account

Dartford and Gravesham NHS Trust Quality Account Response

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

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

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

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

We have seen that Dartford and Gravesham NHS Trust value and understand our role as a “critical friend” which has translated into a good working relationship. Some of our involvement with the Trust this year has included:

- Being a proactive member of the Patient Experience Committee. We have worked with the Trust to help them recruit new members to the group and continue to support the group’s development.
- Meeting regularly with the Director and Deputy Director of Nursing to discuss involving and listening to patients and families.
- We have worked with the Trust on a collective project looking at how commissioners, Care Homes and Hospital staff can work together.
- The Trust hosts us each month when we come and listen to patients about their experiences.
- The Trust has been making a number of improvements following our report detailing the experiences of patients who have been discharged from hospital.

This year we will be visiting the Trust to test out how they are implementing the Accessible Information Standard.

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

Healthwatch Kent May 2018
3) Kent County Council Health Overview and Scrutiny Committee (HOSC)

Dartford and Gravesham NHS Trust response to the comments received from other organisations.

We would like to thank all the above organisations for their comments on this Quality Account. These will be helpful in further developing the document for the Quality Account 2018-19. Following receipt of these comments no amendments have been made to the Quality Account 2017-18.
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009 to prepare a Quality Account 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 and the National Health Service (Quality Accounts) Amendment Regulations 2012)).

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

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

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

By order of the Board

Date: 28 June 2018

Gerard Sammon, Acting Chief Executive

Date: 28 June 2018

Peter Coles, Chairman
INDEPENDENT AUDITORS’ LIMITED ASSURANCE REPORT TO THE DIRECTORS OF DARTFORD AND GRAVESHAM NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Dartford and Gravesham NHS Trust’s Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Patient safety incidents resulting in severe harm or death; and
- Hospital acquired C-Difficile infections per 100,000 bed days

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the Directors and the auditor
The Directors are required under the Health Act 2009 to prepare a Quality Account 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 Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

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

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners;
- feedback from Local Healthwatch dated May 2018.
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 21/06/2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 30/01/2018;
- the latest national staff survey dated 2017;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 18/05/2018;
- the annual governance statement dated 24/05/2018; and
- the latest Care Quality Commission’s Intelligent Monitoring Report.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Dartford and Gravesham NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Dartford and Gravesham NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
15 Canada Square, Canary Wharf, London, E14 5GL
29 June 2018
<table>
<thead>
<tr>
<th>Abbreviations and Acronyms</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AandE</td>
<td>Accident and Emergency Department</td>
</tr>
<tr>
<td>ACS</td>
<td>Acute Coronary Syndrome</td>
</tr>
<tr>
<td>ACU</td>
<td>Ambulatory Care Unit</td>
</tr>
<tr>
<td>AKI</td>
<td>Acute Kidney Injury</td>
</tr>
<tr>
<td>AKIN</td>
<td>Acute Kidney Injury Network</td>
</tr>
<tr>
<td>AMI</td>
<td>Acute Myocardial Infarction</td>
</tr>
<tr>
<td>AMU</td>
<td>Acute Medical Unit</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Catheter Associated Urinary Tract Infection</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CD</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>CEMACE</td>
<td>Centre for Maternal and Child Enquiries</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CHKS</td>
<td>Caspe Healthcare Knowledge Systems</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQS</td>
<td>Composite Quality Score</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Improvement</td>
</tr>
<tr>
<td>CT</td>
<td>Computerised Tomography</td>
</tr>
<tr>
<td>DandG</td>
<td>Dartford and Gravesham</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOLS</td>
<td>Deprivation of Liberty Safeguards</td>
</tr>
<tr>
<td>DVH</td>
<td>Darent Valley Hospital</td>
</tr>
<tr>
<td>EBUS</td>
<td>Endobronchial Ultrasound</td>
</tr>
<tr>
<td>ECIST</td>
<td>Emergency Care Intensive Support Team</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EDN</td>
<td>Electronic Discharge Notification</td>
</tr>
</tbody>
</table>
FFT  Friends and Family Test
FYTD  Full Year To Date
GP    General Practitioner
GI    Gastrointestinal
GMC  General Medical Council
HAPPI Hospital Antimicrobial Prudent Prescribing Indicators
HCAI  Healthcare Associated Infections
HES  Hospital Episode Statistics
HF    Heart Failure
HOSC Health Overview and Scrutiny Committee
HSJ  Health Service Journal
HSMR Hospital Standardised Mortality Ratio
ICE score Implementation of Clinical Effectiveness score
ICNARC Intensive Care National Audit and Research Centre
IT    Information Technology
ITU   Intensive Therapy Unit
IG    Information Governance
KPI   Key Performance Indicator
LOS   Length of Stay
LRM   Local Resolution Meeting
MDT  Multidisciplinary Team
MET   Medical Emergency Team
MINAP Myocardial Ischaemia National Audit Project
MMC  Mitomycin-C
MRSA  Meticillin Resistant Staphylococcus Aureus
MSSA Meticillin Sensitive Staphylococcus Aureus
MUST Malnutrition Universal Screening Tool
NatSSIPs National Safety Standards for Invasive Procedures
NBOCAP National Bowel Cancer Audit Programme
NCDAH National Care of the Dying Audit - Hospitals
NCEPOD National Confidential Enquiry Into Patient Outcome and Death
NCAG National Chemotherapy Advisory Group
NDA National Diabetes Audit
NEWS National Early Warning Score
NELA National Emergency Laparotomy Audit
NHFD National Hip Fracture Database
NHS National Health Service
NHSLA National Health Service Litigation Authority
NICE National Institute for Health and Clinical Excellence
NIV Non Invasive Ventilation
NJR National Joint Registry
NLCA National Lung Cancer Audit
NNAP National Neonatal Audit Programme
NPSA National Patient Safety Agency
NRLS National Reporting and Learning System
NSF National Service Framework
ODP Operating Department Practitioner
OSC Overview and Scrutiny Committee
PAS Patient Administration System
PCI Primary Coronary Intervention
PHSO Parliamentary Health Service Ombudsman
PROMS Patient Related Outcome Measures
PSC Patient Safety Committee
QIPP Quality Innovation Productivity and Prevention
RAG Red Amber Green
RCA Root Cause Analysis
RTT Referral To Treatment
SALT Speech and Language Therapist
SCBU Special Care Baby Unit
SHA Strategic Health Authority
SHMI Standardised Hospital Mortality Indicator
SIDG Serious Incident Declaration Group
How readers can comment on the Quality Account

By email –  glyn.oakley@nhs.net

By letter –  Gerard Sammon, Acting Chief Executive,
Darent Valley Hospital, Dartford,
Kent DA2 8DA
How readers can comment on the Quality Account

By email – glyn.oakley@nhs.net

By letter – Gerard Sammon, Acting Chief Executive, Darent Valley Hospital, Dartford, Kent DA2 8DA

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www.dvh.nhs.uk