



July 2010

**Kent Local Involvement Network (LINK)  
Summary Report on Dartford and Gravesham NHS Trust  
Quality Account 2009 / 2010**

**1. Overview**

This report will offer a more detailed review of Dartford and Gravesham NHS Trust's Quality Account 2009 / 2010 to accompany the 500 word statement (Appendix 1) which was submitted to the Trust for inclusion when the Quality Account was published on the NHS Choices website and Trust website on 30 June 2010. It will also provide further evidence of the work which was undertaken with Canterbury Christ Church University to produce the LINK's statement.

The document will be made available to the Trust, NHS West Kent (the Primary Care Trust), Care Quality Commission, Department of Health and LINK participants via the Kent LINK website and on request from the central administration office.

The LINK will be reviewing the work which took place this year and hopes to work closely with the Trust at an early stage to establish an effective process for informing and assuring next year's Quality Account.

**2. Background**

'*High Quality Care for All*' (2008) set the vision for quality to be the key organising principle of the NHS using a new quality framework. The new framework is expected to bring clarity to the definition and measurement of quality in healthcare, by ensuring that priorities are identified correctly, that appropriate standards are set, that correct tools for measuring quality are available and that information on quality performance is published.

Quality care has been defined as having three dimensions: safety, effectiveness of processes and outcomes and a positive patient experience. It is proposed that all healthcare providers working for or on behalf of the NHS should produce Quality Accounts which aim to provide the public with information on the quality of care from their local healthcare providers. Quality Accounts are expected to drive improvements in care and most healthcare providers will be required to publish Quality Accounts from April 2010 (to cover the financial year 2009 - 2010) and onwards.

The objectives of Quality Accounts are to allow the public to hold providers to account for the quality of NHS healthcare services, for Commissioners and providers to agree priorities for improvement and for NHS Trust Boards and their non-NHS equivalents to ensure that they place quality at the heart of their planning and delivery.

Part of the Quality Account has been specified by the Department of Health; however, there must be locally determined elements contained in the Quality Account. There will also be a core of nationally determined information which is likely to include information on quality that providers supply to the Care Quality Commission for performance, assessment and registration purposes; information on quality indicators that may be needed by PCTs (for CQUIN) and information from clinical audits etc. In preparation for Quality Accounts, all Foundation Trusts in England were asked to produce 'Quality Reports' (forerunner to Quality Accounts) during 2009.

To ensure that Quality Accounts can achieve these purposes, they need to cover the provision of NHS Healthcare services and contain information that is:

- A truthful and fair picture of the quality of services provided
- Meaningful and relevant to users of quality accounts
- Designed to allow for comparisons to be made
- Produced in a timely fashion
- Published in a way that promotes easy access for users.

### **3. Role of LINKs in the production of Quality Accounts**

LINK organisations should be given the opportunity to provide a comment of no more than 500 words on the Quality Accounts in advance of them being published. In order for their commentaries to be effective they need to possess a number of features. These include the need for the commentary to represent the consensus views of LINK participants, use of robust evidence / information to back up their statements, contain examples of users experience to illustrate the points being made. In addition the limitations of the commentary will need to be reported and the commentary will need to be clearly structured.

Kent LINK sought the support of the Canterbury Christ Church University Centre for Health and Social Care Research in accessing participants and seldom heard groups to inform the commentary for 2009 / 2010 in order to establish a pilot methodology which could be evaluated for future years.

### **4. Methods employed by Kent LINK to produce commentary for 2009 / 2010**

Kent LINK sought the support of the Canterbury Christ Church University Centre for Health and Social Care Research in producing the commentary for 2009 / 2010 in order to establish a pilot methodology which could be evaluated for future years.

- i. Each Trust's quality related plans for 2009 / 2010 were initially identified from their 2008 / 2009 Annual Report. Plans for 2009 / 2010 were specified under the three quality domains of patient safety, clinical quality and patient experience.
- ii. Qualitative and quantitative data (related to two key areas identified above) were collected from published research, policy documents etc and summarised to provide a context for understanding the quality targets.
- iii. Patients (six) were recruited from existing LINK participants, voluntary sector organisations and other relevant sources to provide balance in terms of specific characteristics such as gender, age, ethnicity etc. They were asked to comment on the three quality dimensions: safety, effectiveness / outcomes and patient experience for the Trust, whether these were important areas to focus on and what they would focus on if they were managing the Trust. Data was collected via telephone communication and face to face interviews.
- iv. The demography for the Trust's catchment area was examined and 'hard to reach' groups located within the catchment were identified. In order to elicit the views of people from these minority groups, contact was made with local voluntary or third sector providers who work with specific individuals and groups, as well as, with local faith based organisations. In order to engage sensitively and appropriately (for example taking account of gender sensitive issues) with 'hard to reach / seldom heard' groups data was collected via two focus groups. The focus group respondents were asked the same questions as those undertaking individual interviews but were also asked to specifically comment on the Trust's draft Quality Account document.
- v. The data from all sources was collated and analysed and key messages, including patients' stories, identified. This data was then used by a 'consensus panel' consisting of LINK staff, LINK Governors, volunteers and members of the Centre for Health and Social Care Research at Canterbury Christ Church. The 'consensus panel' discussed the draft Quality Account and compared the contents with the evidence from the literature, patients and focus groups. The content of the draft Quality Account in terms of its language, presentation, accuracy of data etc was examined by the 'consensus panel' which then drafted and agreed the final 500 word response.

## **5. Results**

### **The content and layout of the Quality Account**

Overall, the content appeared to focus on national targets with little emphasis on issues that were identified as being of local importance.

### **The review of performance – patient safety**

The section on the review of quality performance (patient safety) for 2009 - 2010 described national targets that had been set eg target of no more than 12 cases of MRSA, but used graphs that were difficult for non-scientists to understand and which at

first glance tended to indicate the opposite of what was being claimed. For example, the first graph in this section gives the impression of a rise rather than fall in cases.

Respondents' perspectives:

The focus group members did not understand what the graphs in the whole section were saying, nor did they understand the need to present mortality data in the manner it was presented (concepts of absolute mortality, risk adjusted mortality etc) were not within their sphere of understanding. There was a feeling that concentrating and reporting the number of people who died was 'dreadful' and did not equate with quality. Many had not heard of *Clostridium difficile* (C. diff).

None of the respondents had heard of Dr Foster so the section which criticises Dr Foster was of no relevance to them.

Most respondents felt it was 'logical' to try to reduce falls in hospital but again could not understand the graphs.

Patient safety was articulated in terms of:

- Having more security personnel in evidence
- Making sure that patients who were being discharged were fit to go eg not bundled into a taxi with their pyjamas on
- Making sure that junior doctors were supervised so that they did not make mistakes
- Ensuring that nursing staff do not wear their uniforms outside the hospital grounds and wash their hands when entering and leaving clinical areas
- Ensuring that patients are fed and given drinks and helped when unable to feed themselves
- Ensuring that clinicians speak English sufficiently well for patients to understand what they are saying.

Where local projects or improvement schemes were reported, insufficient information was provided for people to be able to judge the full scope of the projects or how they had improved quality. This was a missed opportunity to 'sell' local quality improvement.

### **The review of performance – patient experience**

The document describes areas for improvement but the information on how improvements in quality were made is variable. For example, the section on basic nursing care states that patients said an improvement in nursing care for the elderly was needed and that this was the focus of several objectives but it does not state what objectives were set or what measures were put in place to improve care etc. The information on the 'productive ward' does not tell the reader how it has impacted on the quality of patient experience.

Respondents' comments:

Respondents reported that the care for the elderly was not always what it should be, that there was a need to 'bring back' the matron (Hattie Jakes). Although single sex accommodation was universally preferred it was not top of their list of priorities.

The number one issue for respondents was poor communication. They discussed not being treated as a person but rather just as a number, of it being difficult to get their view heard by doctors and nurses, as patients they felt that they did not matter. They wanted to feel that they could discuss their problems and be confident that what they were being told was right, they would like to have the opportunity to discuss their case with the consultant without him / her looking at their watch.

Secondly, they felt that their experience was not as good as it could be due to 'un-professional' behaviour on behalf of some staff, eg porters collecting a body from the next bay laughing and joking, ambulance crew and nurses commenting on a patient's mental ability in a way that everyone else could hear, having to wait a long time for nurses to respond to the call bell and as a consequence not being given a bed pan in time, being left waiting to be moved to a ward because they have been 'forgotten'.

The other areas that they felt were important were improving the food and catering for different cultures / religions, reducing car parking fees and reducing waiting times in A&E.

### **The review of performance – clinical outcomes / effectiveness**

The document identifies the introduction of a 'Quality Laboratory' and 'Patient Reported Outcome Measures' but does not provide enough explanation of the value of these or demonstrate ways in which they have improved clinical outcomes.

Respondents' comments:

Respondents reported that they were not able to judge clinical outcomes. They discussed their treatment and how well it had gone. Most were happy with the hospital, giving it a score of eight to 10 out of ten for inpatient stays but they described having both good and bad experiences depending on which service they were accessing. They reported variation on their experiences with coronary care being positively received and A&E being criticised (A&E scores of three to four out of 10).

## **6. Setting of future objectives**

Priorities specified for improvement in 2010 - 2011 do not have objectives / plans / targets etc, so it will be difficult to make a judgement about whether there has been any improvement in quality in a year's time.

## **Dartford and Gravesham NHS Trust Quality Account 2009 – 2010 Kent LINK Response**

The Kent LINK would like to thank Dartford and Gravesham NHS Trust for the opportunity to comment on its Quality Account for 2009 / 2010. Our assessment is based on the extent to which the account achieves the following intentions:

1. Aiding the public's understanding of what the organisation is doing well
2. Where improvements in service quality have been made and what the priorities for improvement are for the coming year
3. How the organisation has involved service users, staff and others with an interest in the organisation in determining those priorities for improvement.

The LINK has assembled information from a range of sources to inform its commentary using qualitative and quantitative data and academic input from a local University.<sup>1</sup>

### **1. Aiding public understanding**

The report begins well and the tone set by the Chief Executive's statement is promising. However, other sections in the report appear to have been imported from other documents and do not make for cohesive reading.

The font size and paragraph lengths are readable but the graphs are considerably less so due to small print, confusing labels and a lack of context, making them difficult for the lay reader to understand. Several examples of jargon and acronyms in the text, such as Dr Foster, CHKS and CQUIN, are not universally understood.

Statements are made to illustrate what the Trust is doing well but there is little evidence to back these up. More information as to how improvements have been made is required. Where evidence has been provided there is a lack of context, making it difficult to interpret how an improved outcome for the patient has been achieved, for example the reduced length of stay on the stroke unit (page 13 of report).

### **2. Required improvements in service quality**

Objectives for improvement are not outlined clearly, such as in section 1.1 which states that "quality objectives have been met" yet these are not stated.

Generally speaking there are insufficient data to back up the claims made in the report; however the data presented for the stroke unit performance (page 14) begin to enable

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<sup>1</sup> Canterbury Christ Church University Centre for Health and Social Care Research

readers to make an informed judgement as to the improvements which have been made.

### **3. Priorities for service improvement**

No clear targets for improvement identified, which will make it difficult to measure future progress.

### **4. Involvement of service users, staff and others**

Overall, the majority of the content appears to have been determined by national as opposed to local priorities, with no evident link between patient feedback and how the Trust selected its priorities.

There are clear successes for the Trust, such as establishing the real-time patient feedback system, and these could have been presented better in order to make the most of such achievements and show good quality improvement.

The LINK recognises the limited time available to put the accounts together and looks forward to supporting the Trust with the process in the future.