Plymouth Hospitals NHS
NHS Trust

Quality Account 2011/2012

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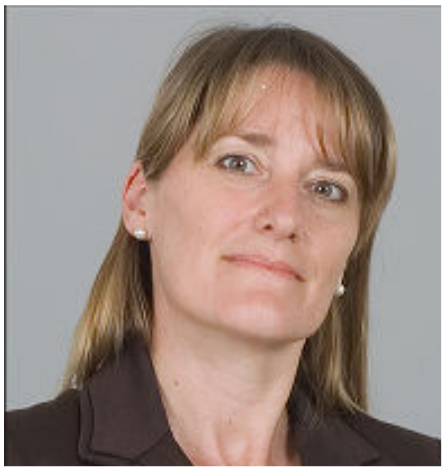


We are continuing to keep patient safety and a high quality patient experience at the centre of all we do to ensure we continue to meet our key objective of providing excellent patient outcomes.

We recognise that this depends on the actions of all our staff and on our commitment at Board level to provide the correct environment for this culture to flourish.

This Quality Account reflects our approach to doing this and outlines the progress we are making.

During 2011/12 we have made significant progress. Our hospital's mortality rates are some of the lowest in the country, and we have seen significant reduction in events that cause harm to our patients, such as serious pressure sores and falls. Our national patient surveys continue to highlight that our staff care for patients and carers with dignity and compassion.

We have also introduced a number of initiatives in our operating departments to embed a culture of safety and have been asked to share this good practice with other organisations. We have continued to

work with partner organisations to ensure that our patients are cared for in the most appropriate settings.

We have continued our strong focus on reducing hospital acquired infections in the Trust. Our infection control team were recognised nationally for their work in reducing surgical site wound infections and we were successful in delivering a very challenging C Difficile target. Whilst our performance in reducing MRSA was significant, unfortunately, the Trust had 6 cases against a target of 5.

During 2011/12 we have continued to work hard to find ways to involve our frontline clinical staff from all disciplines in improving the quality of the services we provide for our patients and carers. This Quality Account presents some of their successes.

I am therefore pleased to present this third Quality Account for 2011/12, which I believe to be a fair and accurate report of our quality and standards of care.

Signature to be added:

Helen O'Shea
Interim Chief Executive

Quality Account requirements

All providers of NHS services must produce an annual Quality Account as set out in the National Health Service (Quality Account) Regulations 2010 which took effect in April 2010

This is the third Quality Account that we have published.

The regulations specify what should be in the Quality Account. We have used the Department of Health Toolkit as the basic template for our Quality Account as well as the published guidance from Monitor, the Independent Regulator of NHS Foundation Trusts.

The Quality Account provides information about our progress over the last year and our ambitions for the year ahead. We believe it will be of interest and value to patients, carers and the public as well as those who buy our services.

Quality narrative

1.1 Our current view of the Trust's position and status on quality

This year we will embed our newly developed Quality Framework based on Safe Care, Personal Care and Effective Care. This will enable us to inform the users of our services what we do well, what we need to improve and how we will do this.

During 2011/2012 we have improved our approach to the delivery of safe, personal and effective care for our patients. We have continued to develop our quality framework to ensure timely delivery of important information to our clinical teams. This includes information on mortality rates, investigations, infection control rates, privacy and dignity and end of life care.

How did we do?

We have reduced our mortality (death) rate by 12%. Our current mortality rate shows that we are significantly better than most hospitals.

We introduced Root Cause Analysis training. This enables staff to analyse adverse events to reveal the root cause of the problem and learn how to prevent the same thing happening again.

Our incident reporting rate has doubled. During the year we encouraged more reporting of 'no harm' or 'near miss' incidents to improve our understanding. A high incident reporting rate is a positive thing and demonstrates a safe culture where potential problems are identified and action taken to prevent harm.

We have seen a 28% reduction in adverse events measured through the Global Trigger Tool (GTT). The Trust uses this tool for measuring the frequency and severity of adverse events. The GTT complements our incident reporting process to identify areas for improvement.

A number of patients were unintentionally harmed during surgery last year. These incidents were investigated and it was highlighted that the appropriate safety checks were not always completed. We have learnt from these incidents and have improved our compliance. 98% of surgical patients have the Surgical Safety Checklist completed appropriately.

We have improved reporting and monitoring of hospital acquired pressure sores. This information has allowed us to implement interventions that have reduced the number of serious pressure sores being reported.

We have worked with our patients, commissioners and our teams to ensure patients are treated in the most appropriate place, this could be in hospital or at home.

To provide more effective care we have introduced the 'Enhanced Recovery Programme' across four key specialities: Gastroenterology, Orthopaedics, Urology and Gynaecology. This is reported later in this document.

Our commitment to patients can be summed up in our patient promises which were implemented during 2011/2012:

- **I will…… care for you compassionately and respectfully**
- **I will …… give you clear information and involve you in your care**
- **I will ….. give you the best treatment I can when you need it**
- **I will ….. make sure you are treated in a clean and safe environment**

2 Priorities and Statement of Assurance

2.1 Report on Priorities for 2011/12

Last year we identified five priority areas for improvement. The following sections describe our achievements against these priorities.

These priorities were:

Priority 1

Reduce avoidable harm through improved levels of learning from incidents and complaints.

Priority 2

Ensure the early detection and appropriate escalation of unwell patients.

Priority 3

Ensure effective pathways of patient care across the health community (including appropriate follow up, continuity of clinical care, reducing length of stay and reducing delayed discharges)

Priority 4

Ensure optimal outcomes of care through delivery of evidence based best practice

Priority 5:

Improve overall patient satisfaction scores, based on the results of the National Inpatient Survey, and aim for the upper quartile for all NHS Hospitals.

Priority 1: To reduce avoidable harm through improved levels of learning from incidents and complaints

Our priority was to reduce levels of harm, continuously improve services and to ensure that when things go wrong lessons are learnt and changes made. It is acknowledged internationally that despite our best efforts some patients suffer harm in hospital and many others narrowly avoid a similar experience, this is known as a 'near miss'.

How did we do?

What we did well:

- We have reduced our mortality (death) rate by 12%. This is measured via the Dr Foster mortality database. Dr Foster can predict the expected number of deaths for each hospital in England based on local information and patient type. Our current mortality rate shows that we are significantly better than average in this area.
- Root Cause Analysis training was introduced. This enables staff to analyse adverse events to reveal the root cause of the problem and learn how to prevent the same thing happening again. Root Cause Analysis is nationally recognised as an important learning aide when things go wrong. This training is available every month for all members of staff.
- Our incident reporting rate has doubled. During the year we encouraged more reporting of 'no harm' or 'near miss' incidents to improve our understanding. A high incident reporting rate is a positive thing and demonstrates a safe culture where potential problems are identified and action taken to prevent harm.
- We have seen a 28% reduction in adverse events measured through the Global Trigger Tool (GTT). The Trust uses this tool for measuring the frequency and severity of adverse events. The GTT complements our incident reporting process to identify areas for improvement. The tool involves clinical teams regularly reviewing a number of randomly selected medical records to identify any adverse events that occurred during a patients stay in hospital.
- A small number of patients were unintentionally harmed during surgery last year, including the occurrence of one never event. These incidents were investigated and it was highlighted that the appropriate safety checks were not always completed. We have learnt from these incidents and have significantly improved our compliance. Currently, 98% of surgical patients have the Surgical Safety Checklist completed appropriately. We have been asked to share this good practice with other hospitals and have worked with several other hospitals in the region to disseminate this learning.
- We have improved reporting and monitoring of hospital acquired pressure sores. This information has allowed us to implement interventions that have reduced the number of serious pressure sores being reported.

What we need to work on:

- We have not yet achieved all of the targets we set for this priority. In particular, we have not achieved a 30% reduction in the percentage of patients with hospital acquired pressure sores. As mentioned above we have improved our processes for identifying patients with pressure sores and will continue to work with clinical teams. We will monitor our improvement through regular audit of our inpatient areas using the National Safety Thermometer and report to the Safe Care Group.

Next steps:

- Reducing avoidable harm to patients remains a key priority for 2012/13 see section 2.2.

Priority 2: Ensure the early detection and appropriate escalation of unwell patients

This priority was to reduce the number of unexpected cardiac arrests by ensuring patient observations are carried out in a timely way and that the deterioration in patient condition is dealt with quickly and by someone with the appropriate level of knowledge and skill.

Improving care for the acutely unwell patient is a key focus for the Trust. We know that earlier recognition of acutely unwell patients improves their chance of surviving. Recognising and managing deterioration of acutely unwell patients can prevent the majority of cardiac arrest calls. This also allows us to identify patients who are approaching end of life and make appropriate decisions for a dignified and peaceful death.

How did we do?

What we did well:

- The number of unexpected cardiac arrests has reduced by 11% compared to the previous year. This indicates that the actions summarised below are improving the care of the deteriorating patient.
- We introduced a colour banded 'early warning system' observation chart for the detection and appropriate escalation of unwell patients – patients that "trigger" on the observation chart are added to a special notice board and discussed at a daily briefing.
- Briefings were introduced to ensure a structured handover of key patient information.
- In addition all cardiac arrest calls are investigated to identify areas for improvement.
- The percentage of patients who "trigger" on the early warning system and receive an appropriate response is monitored monthly, alongside the number of rapid response calls made per month. We are seeing improvement in this area, resulting in better outcomes for our patients.

What we need to work on:

- Although we have seen significant improvements in the number of unexpected cardiac arrests, further work is required to ensure that every clinical observation that triggers on our colour coded chart is escalated and acted on appropriately.

Next steps:

- We will continue to work with clinical teams and provide education about the importance of early intervention when caring for acutely unwell patients. This is one of our key safety indicators and this work will be monitored monthly by our Safe Care Group.

Priority 3: Ensure effective pathways of patient care across the health community (including appropriate follow up, continuity of clinical care, reducing length of stay and reducing delayed discharges)

This priority aimed to improve both patient and carer experience and to reduce costs. We are aiming to reduce the average length of stay for both our emergency and planned patients. We are also working to reduce our follow-up waiting list backlog to ensure that patients receive timely appointments.

We have introduced an Outpatient Efficiency Work Programme to improve and streamline administration processes for outpatients and provide a better experience for patients and carers.

We have introduced the Enhanced Recovery Programme. This was identified as an essential element of the Quality, Innovation, Productivity and Prevention (QIPP) National Programme. Enhanced Recovery Programme benefits include:

- The patient will be in the best possible condition for surgery i.e. any pre-existing conditions will be managed in Primary Care.
- The patient will have the best possible management during and after the operation i.e. minimally invasive surgery, reduced starvation and fluid management.
- The patient has the best post-operative rehabilitation i.e. planned mobilisation and improved pain relief.

How did we do?

What we did well:

- We have achieved a 49% reduction in the follow-up waiting list backlog.
- Introduction of Outpatient Efficiency Work Programme.
- The 'Enhanced Recovery Programme' was implemented across four key specialities: Gastroenterology, Orthopaedics, Urology and Gynaecology.
- Orthopaedics: Enhanced Recovery (ERAS) for major joint surgery – length of stay has reduced by two days for both hip and knee replacement. The team are proactively measuring patient satisfaction on discharge and at six weeks post operatively. Patient feedback to date has been very positive.
- Gastroenterology – a patient diary outlining daily goals has been piloted. The diary aims to manage patient expectations and encourages a standardised approach from the clinical teams. This concept has been well received by patients and staff and is being considered for adoption by other specialities.

What we need to work on:

- Further work is required to ensure that the Enhanced Recovery Programme is rolled out to other surgical specialties including Urology and Gynaecology.

Next steps:

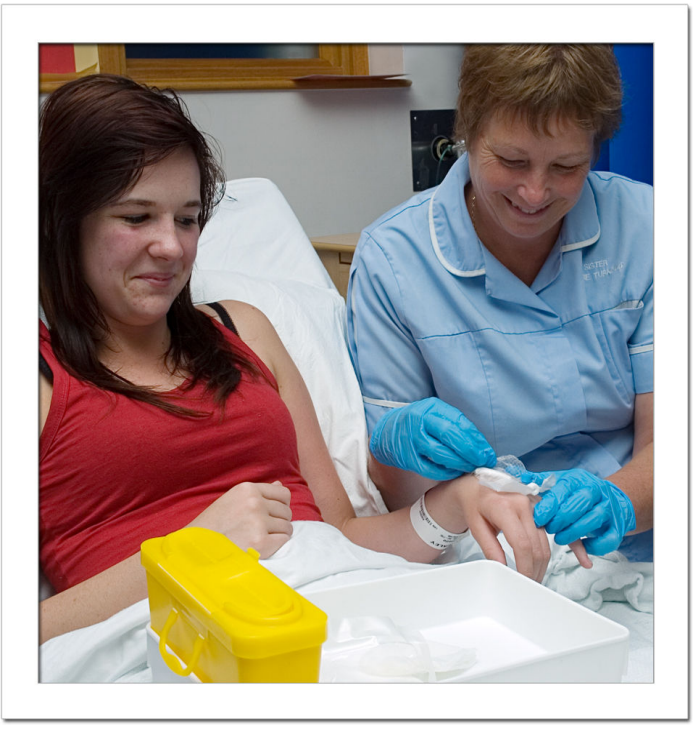
- Enhanced Recovery Programme to be rolled out to other surgical specialties.
- Continue work to reduce follow-up waiting list backlog. This is being monitored closely by our Safety & Quality Committee.

Priority 4: Ensure optimal outcomes of care through delivery of evidence based best practice

This priority was set as we recognise adopting best practice provides the maximum opportunity to ensure optimal outcomes for patients. There are a number of key healthcare organisations who are responsible for identifying best practice which is shared through published guidance, including:

- NICE Clinical Guidelines, Interventional Procedure Guidance, Technology Appraisal Guidance and Public Health Guidance.
- National Confidential Enquiries in Peri-Operative Deaths (NCEPOD) – 'Age Old Problem' and 'Mixed Bag'.
- National Patient Safety Agency (NPSA) Alerts and Reports.
- Royal College and Professional Society Guidance and Reports.

Implementation of guidance is closely monitored to ensure that we provide all our patients with best practice treatment as recommended nationally.



How did we do?

What we did well:

- Compliance with NICE guidance has increased to 70%.
- Targets to ensure appropriate VTE risk assessment and thromboprophylaxis were met.

What we need to work on:

- We will continue to work on improving our compliance with national best practice guidelines and this has been identified as a key priority for the coming year, see section 2.2.

Next steps:

- We have selected a number of important Quality Standards as our focus for the coming year, see section 2.2 for full details.

Priority 5: Improve overall patient satisfaction scores, based on the results of the National Inpatients survey, and aim for the upper quartile for all NHS Hospitals

This priority was set as we believe patients have the right to be treated in an environment that makes them feel safe and cared for. We listened to patients and acted on their concerns to make improvements, with the aim that patients will leave us having had a positive experience.

The National Inpatient Survey provides an annual view of patient experience and our goal was to improve the percentage of patients who rated the care received as 'excellent'.

What we did well:

- Every month patients are asked if they are happy with the care they received through a programme of continuous local inpatient surveys. Survey results are shared with the relevant teams with action plans developed to address key issues raised.
- We appointed a Matron for Safety & Quality to focus solely on improving the patient experience.
- 94% of our patients were cared for in a single sex setting.
- Introduction of our learning disabilities website, including information to ease the patient journey and provision of specialist trained liaison nurses. Our service has been commended by Mencap.
- In 2010 we developed four patient promises after consultation with patients and staff. During 2011, we focused on implementation of the promises listed below:
  - I will…… care for ***you*** compassionately and respectfully
  - I will …… give ***you*** clear information and involve you in your care
  - I will ….. give ***you*** the best treatment I can when you need it
  - I will ….. make sure ***you*** are treated in a clean and safe environment

What we need to work on:

- Further work is required to ensure we deliver an improvement in 'excellent' and 'very good' response rates for overall care received as described in our National Inpatient Survey. We aim to be in the top 20% of acute Trusts.
- Continued work is required to ensure we are in the top 20% performing Trusts for provision of single sex accommodation in the national inpatient survey.

Next steps:

- Expand our local survey activity to include outpatients, maternity and A&E. Provide instant feedback which will enable timely improvement to services for our patients and carers.
- Train our staff to focus on putting you as the patient first and to let you know what we are doing to help you.
- We will include all our feedback into one report to ensure rapid continuous improvement.
- We will roll out specific training for our staff to embed our patient promises to improve our patient and carer experience.

2.2 Priorities for 2012/13

When choosing the quality priorities for the coming year we reviewed achievement against last year's priorities. A selection of priorities for delivery in 2012/2013 have been developed in consultation with key Trust stakeholders including the Safety & Quality Committee, Trust Board and senior executives.

The Trust's three quality improvement priorities for 2012/2013 are:

Priority 1: Safe Care
To reduce avoidable harm to patients from:

- Pressure ulcers (hospital acquired)
- Falls
- Catheter associated urinary tract infections
- VTE
- MRSA
- C.Difficile

Priority 2: Personal Care
To improve the overall patient experience with particular focus on the following domains:

- Communication
- Responsiveness to call bells
- Food and nutrition
- Access and Waiting

Priority 3: Effective Care
To improve pathways of care in line with NICE Quality Standards for:

- Cancer standards
- Chronic Heart Failure
- Chronic Kidney Disease
- Glaucoma
- Specialist Neonatal Care
- Stroke
- VTE prevention

Priority 1: To reduce avoidable harm to patients from: Pressure ulcers, Falls, Catheter associated urinary tract infections, VTE, MRSA, C.Difficile

Rationale

Pressure ulcers, falls, catheter associated urinary tract infections and venous thromboembolism (VTE) are the most commonly reported avoidable harm events within acute trusts. The National Safety Thermometer is a local improvement tool for measuring, monitoring and analysing these harm events. We will use this information to drive improvements and reduce avoidable harm.

We have a zero tolerance approach to infection. This means we will do all we can to improve cleanliness and prevent infection. Our Infection Prevention and Control Team will continue to work with clinical teams to reduce the number of cases of MRSA and C.Difficile reported per year.

Current status

We have reviewed our current position based on information from the past 12 months. We have then used this information to set targets for the coming year. Our current status is as follows:

Improvement Area	Performance 2011-12	Target 2012-13
Reduce the percentage of patients with grade 3 and 4 hospital acquired pressure ulcers	3.7% Apr 11 – Feb 12	<3.0%
Reduce the number of inpatient falls resulting in serious harm	78 incidents	<50
Reduce harm from catheter associated urinary tract infection by reducing the number of days where a catheter is in situ	Data not previously collected	Monthly data collection
Reduce harm from venous thromboembolism by ensuring that patients receive a risk assessment and are given appropriate prophylaxis	92%	>95%
Reduce the number of MRSA bacteraemias	6	<3
Reduce the number of C.Difficile cases	41	<25

* Targets to be agreed with commissioners.

How will we do it?

We will improve our surveillance of the improvement areas listed above by implementing the National Safety Thermometer. Each of the improvement areas is supported by a workstream with a designated clinical lead.

Measuring progress

We will monitor progress and implement changes to practice via the Safe Care Group chaired by the Medical Director with a monthly Safety & Quality Dashboard produced and presented at these meetings.

We will introduce the 'Knowing How we are Doing' initiative into all of our ward areas; this is a dashboard that is made up of a number of key safety and quality indicators, which will enable ward staff to monitor their progress in these areas and take action.

Priority 2: To improve the overall patient experience with particular focus on the following domains: communication, responsiveness to call bells, food and nutrition, access and waiting

Rationale

We believe patients have the right to be treated in an environment that makes them feel safe and cared for. Our previous patient survey results indicate areas for continued improvement. This is in addition to the requirement to take appropriate action in response to trends and themes identified through PALS and Complaints. We will particularly focus on the experiences of patients with learning disabilities, dementia and elderly patients and their carers.

Current status

We have expanded local survey activity over the past 12 months using an electronic system (Meridian) whereby patients are asked if they are happy with the care they received. Results are shared with relevant teams and actions agreed to address key issues raised. The new electronic survey system provides instant feedback which enables timely improvements for our patients.

The National Inpatient Survey provides an annual view of patient experience and our goal was to improve the percentage of patients who rated the care they received as 'excellent'.

The National Outpatient Survey which is undertaken every 2 years, showed that patients rated the hospital in the top 20% of similar organisations.

Improvement Area	Performance 2011-12	Target 2012-13
Improve the percentage of patients who would recommend the Trust to family/friends	88%	>90%
Improve the percentage of patients rating the hospital as 'excellent' or 'very good' as an overall satisfaction score	80%	>85%
Increase the percentage of patients being given a choice of appropriate admission date	19%	>25%
Improve the percentage of patients who feel they were treated with dignity & respect by staff	79%	>85%
Improve the percentage of patients rating the quality of hospital food as 'very good' and 'good'	49%	>75%
Improve the percentage of call bells responded to within 5 minutes	80%	>90%
Reduce the percentage of patients reporting that they were given conflicting information by staff	66%	<50%

* Targets to be agreed

How will we do it?

We have an agreed Patient Experience Action Plan which we will continue to develop throughout the year. This includes actions to address issues highlighted through local and national survey activity, feedback from our stakeholders including

LINk/Healthwatch, and themes identified through complaints and PALS. We will measure progress in several areas, including those listed below.

Measuring progress

We will monitor progress and implement changes to practice via the Personal Care Group chaired by the Chief Nurse on a bi-monthly basis. We will provide quarterly updates to the Safety & Quality Committee and results will be included as part of the Safety & Quality Dashboard produced and presented at these meetings. They will include:

- Overall satisfaction scores
- If your admission was planned in advance were you given a choice of admission dates?
- If you required assistance at mealtimes was this offered to you?
- If you needed to use your call bell was this responded to within a reasonable timeframe?
- During your stay do you consider that the nurse staffing levels were adequate?
- Were you involved in discussions about your discharge?
- During your stay, were you treated with dignity and respect?

Priority 3: To improve pathways of care in line with NICE Quality Standards for: Cancer standards, Chronic Heart Failure, Chronic Kidney Disease, COPD, Diabetes, Glaucoma, Specialist Neonatal Care, Stroke, VTE prevention

Rationale

NICE Quality Standards are derived from the best available evidence and set out aspirational but achievable markers of high quality cost-effective patient care.

How will we do it?

Each of the Quality Standards will have a designated clinical lead responsible for leading on each improvement workstream. A baseline assessment will be completed to identify where work is required, action plans will then be produced and actions implemented.

Measuring progress

We will monitor progress and implement changes to practice via the Effective Care Group chaired by the Assistant Medical Director for Quality with a bi-monthly dashboard produced and presented at these meetings. This work will be supported by Clinical Audit.

2.3 Statements of assurance from the board

During 2011/12 Plymouth Hospitals NHS Trust continued to provide (or sub contract) 64 NHS services.

The Trust has reviewed all data available to us on quality of care in all these NHS services.

The income generated by the NHS services reviewed in 2011/2012 represents 100% of the total income generated from the provision of NHS services by Plymouth Hospitals NHS Trust for 2011/2012.

Clinical Audit

Clinical audit is an evaluation of the quality of care provided against agreed standards and is a key component of quality improvement. Its aim is to provide assurance and to identify improvement opportunities. The Trust has a yearly programme of clinical audits which includes three types of audit:

- National audit where specialties are asked to become involved.
- Corporate audit where we set a list of clinical audits which are carried out by the Clinical Audit Support Team on a Trustwide basis.
- Local audit which clinical teams and specialties determine and which reflect their local priorities and interests.

National Clinical Audit

During 2011/12, the Trust completed 17 National Clinical Audits (NCA) as listed below, those highlighted in grey are those on the HQIP approved list. The Trust is also in the process of actively participating in a further 35 NCAs shown in the second table.

Speciality	Audit Title	Organising Body	Completion Date	Audit Lead
Dietetics	Children's Nutrition Audit 2011	Ulster University	May-11	Susan Love (Vivienne Jones as directorate lead)
Emergency Department	Rolling 3 year programme - Vital signs in majors recording	College of Emergency Medicine	Jan-11	Dr Andrew Kelly
Emergency Department	Rolling 3 year programme - Fever in Children (Paediatric fever)	College of Emergency Medicine	Jan-11	Dr Andrew Kelly
Gastroenterology	IBD National Audit Ulcerative colitis & Crohn's disease	British Society of Gastroenterology	Jun-11	Mr Chris M Hayward
Gastroenterology	IBD Quality Improvement Project (QIP)	Royal College of Physicians	Aug-11	Mr Chris M Hayward
Gynaecology - Fetal Medicine	NHS FASP/RCOG amniocentesis & chorionic villus	FASP	14 March – 8 April 2011	CRW/IAM

Speciality	Audit Title	Organising Body	Completion Date	Audit Lead
Healthcare Science & Technologies – Small Cell Lung Cancer	CONVERT – Concurrent Once daily Versus twice daily Radiotherapy	Christie Hospital NHS Foundation Trust	Apr-10	Nikki Blackler
Healthcare Science & Technologies – Clinical & Radiation Physics	Third UK National CT Survey	HPA	28-Feb-11	Nick Rowles
Healthcare Science & Technologies – Clinical & Radiation Physics	National Patient Dose Database	HPA	14-Feb-11	Nick Rowles
Healthcare Science & Technologies – Radiotherapy Physics	Breast Dose Import Low	National Radiotherapy Trials Team	Mar-11	Nicola Blackler, Savva Rizkalla
Healthcare Science & Technologies – Radiotherapy Physics	IMRT Implementation Programme	NCAT	Dec 10 – March 2011	Jackson Zifodya
Medicine - Respiratory	COPD	Royal College Physicians	2010	Dr Phil D Hughes
Medicine - Respiratory	Adult Asthma (2011)	British Thoracic Society	Oct-11	Helen Harris
Medicine - Respiratory	Adult Community Acquired Pneumonia	British Thoracic Society	May-11	Dr Phil D Hughes
Medicine - Respiratory	Adult Non Invasive Ventilation NIV	British Thoracic Society	May-11	Dr Phil D Hughes
Plastic Surgery – Breast Surgery	National Mastectomy and Breast Reconstruction Audit	The NHS Information Centre for Health & Social Care	31-Mar-11	Mr Eric Drabble
Medicine - Respiratory	Emergency Oxygen Audit (15)	British Thoracic Society	01-Nov-11	Dan Higgs & Natalie Lewis

Speciality	Audit Title	Organising Body	Completion Date	Audit Lead
Breast Screening	NBSS Audit	Quality Assurance Reference Centre, National Breast Screening Service	Continuous, running April to March every year, finalised in September each year	Dr Jim Steel Mrs Frances Slater
Child Health - Cystic fibrosis	Port -CF	Cystic fibrosis trust	Ongoing	Dr Alan Cade
Child Health	Epilepsy (12)	RCPCH	Ongoing	Dr Rebecca Smith
Child Health - Diabetes	National diabetes audit (Paediatrics)	RCPCH	Ongoing	Dr Rebecca Smith
Endocrinology	Acromegaly Database	Society of Endocrinology		Dr Daniel Flanagan
Gynaecology	BSGE Endometriosis data base	Gynae endoscopy society		Mr Jonathon Frappell

Speciality	Audit Title	Organising Body	Completion Date	Audit Lead
Gynaecology	National Heavy Menstrual Bleeding audit (HMB)	RCOG		Mr Peter Scott
Haematology	Does follow up blood test predict relapse of diffuse large B cell lymphoma (1215)			Dr Simon Rule
Healthcare Science & Technologies – Radiotherapy Physics	SABRE	Cancer Research UK	31-May-13	Savva Rizkalla
Hepatology	Demographics and management of Hepatitis B (908)			Dr Matthew Cramp
Histopathology	National: Audit of NHSBCPS specimens for 2010 (1496)			Dr C McCormick
Medicine - Care of the Elderly	National Audit of Dementia (1230)	Royal College of Psychiatrists		Karen Grimshaw
Medicine - Care of the Elderly	National audit of falls and bone health in older people (1352/ 8)	Royal College of Physicians		Dr Jamie Fulton
Medicine - Respiratory	Port CF	Cystic Fibrosis Trust	On-going	Dr David Derry
Medicine - Respiratory	LUCADA	Royal College Physicians * NCASP	On-going	Dr Philip J Pearson
Medicines Management	National: Southwest SHA quality & patient safety improvement programme: Missed doses	Southwest SHA	Ongoing	Ann Cardell
Neonatology	Vermont – Oxford Network	Vermont – Oxford Network	Continuous	Dr Alex Allwood
Neonatology	Centre for Maternal and Child Enquiries	CMACE / MBBRACE	Continuous	Dr Alex Allwood
Neonatology	National Neonatal Audit Programme	National Neonatal Audit Programme	Continuous	Dr Alex Allwood
Neonatology	Neonatal Data Analysis Unit	Neonatal Data Analysis Unit	Continuous	Dr Alex Allwood
Neonatology	British Paediatric Surveillance Unit	British Paediatric Surveillance Unit	Continuous	All NICU Consultants
Neurology	The Sentinel Stroke Audit	Royal College of Physicians	Continuous	Ian Wren
Neurology	Acute Stroke – Stroke Improvement National Audit (SINAP)	Royal College of Physicians	Continuous	Ian Wren
Neurosurgery	Outcomes in cerebral Abscesses (1102)			Mr Kevin Tsang

Speciality	Audit Title	Organising Body	Completion Date	Audit Lead
Neurosurgery	Timing of Prothrombin Complex Concentrate Therapy in anticoagulated patients with intracranial haemorrhage (1218)			Mr Peter Whitfield, Mr Elfyn Thomas
Neurosurgery Emergency Critical Care	National: retrospective review of neurosurgery intervention in traumatic brain injury (1516)			Dr Peter MacNaughton
Neurosurgery	Shunt Registry	Addenbrookes Hospital	Ongoing	Prof John Pickard
Oncology - Cancer Support Centre	Skin cancer patient satisfaction survey(1478)			Ruth Devlin
Orthodontics	Advice on use of mouth-guards	British Orthodontic Society		Nominated SpR
Orthodontics	Use of functional appliances	British Orthodontic Society		Nominated SpR
Orthodontics	Cross-infection control of orthodontic impressions	British Orthodontic Society“		Nominated SpR
Orthopaedics	LMT Hemiarthroplasty for fractured neck of femur audit (814)			Mr Jonathon Keenan, Mr Christoph McAllen
Orthopaedics	National: Audit of VTE risk factors in patients who have had VTE and been treated in DVT clinic (1657)			Mr Christoph McAllen
Orthopaedics	National Joint Registry	National Joint Registry	Ongoing	
Urology	National Suprapubic Catheter insertion Audit (1214)			Mr Paul McInerney

The reports of national clinical audits are reviewed by the appropriate clinical lead together with the Medical Director.

Corporate Audit

A total of 6 corporate themed audits have been conducted during 2011/12, the results of which have been reported to the individual directorates as completed and Trust wide summary reports have been reported to the Clinical Governance Steering Group and later the Effective Care Group for monitoring of actions.

Local Audit

The results of local audits are reviewed by the relevant Directorate Governance Groups along with analysis of the proposed actions following audit findings.

Research

The Trust's Strategic Plan for Research and Development is an important step forward in the Trust's business both financially and in terms of reputation.

Clinical research is about improving the clinical treatments available to patients and discovering new ways of managing conditions. Our strategy aims to ensure that we are at the forefront of research and that patients can have confidence in the treatments we provide. This work supports the Trust's strategic care programmes by developing a research rich culture and an environment which is based on research strengths, targeted investment and collaborative research.

PHNT has a well-established research base, demonstrating significant and sustained growth over the last two years (296 active projects in 2009-10 and 415 active projects in 2011-12), especially in commercial clinical trials. Research income from commercial clinical trials has grown from £574,525 in 2009-10 to £854,822 in 2011-12. PHNT is a member of the new Quintiles Peninsula Prime Site. This collaboration is expected to attract a further £2m to the Peninsula in the next four years.

The Research & Development Department (R&D) have identified pathways and processes to deliver an income increase of £500k in 2012-13. With recognition by all departments that research is part of core business, together with continually improving pathways and processes, we expect to see further increases in recruitment figures. These increases will maintain and attract extra funding from the research networks hosted by PHNT, as well as attracting greater commercial research to the Trust over the next five years. PHNT is currently the highest recruiter of patients to interventional studies in the Peninsula; recruiting more patients to this type of study than the rest of the Peninsula put together. The 2011-12 patient recruitment data for the National Institute for Health Research (NIHR) portfolio studies is still being collected, but currently stands at 4287 patients receiving NHS services which were recruited to participate in research for the Trust. This represents a 235% increase on 2008-09. Areas of particular research expertise include neurology, haematology, diabetes, emergency services research and oncology. Recruitment to these and other specialties will be further enhanced by PHNT research nurses working collaboratively across the healthcare community. PHNT is committed to improving recruitment by 10% over the next 2 years.

There has been a strengthening of the research infrastructure by R&D partially through utilisation of funding from the National Institute for Health Research (NIHR) Clinical Research Networks. PHNT now employs 52 whole-time-equivalent research nurses across the Trust. Workforce changes planned within the Research Nurses structure will see the development of a team structure to support particular specialties. The implementation of the Research Nurse competency initiative will develop the research nurse workforce, offering a career structure which will both support and help to retain the Research Nurse skill base. With this infrastructure, and with other support arrangements, the Trust has been able to confidently operate in the 'delivery phase' of the Trust's Strategic Plan for Research and Development.

Dr Simon Rule the Associate Medical Director (AMD) for R&D, has been proactive in engaging with the Peninsula College of Medicine and Dentistry (PCMD) and Plymouth University leadership teams to identify opportunities for research synergies between the organisations. Dr Helen Neilens, the Trust Research Advisor, has also been instrumental in encouraging research links between the Trust and the University, with many active collaborations involving the Faculty of Health, the School of Biomedical and Biological Sciences and the School of

Psychology. From a nursing perspective there have been links with the University to look at developing a research framework which seeks to identify practical opportunities for collaboration in postgraduate education and research. The Trust also hosts a NIHR accredited Clinical Trials Unit (PenCTU) which, with the split of the Peninsula Medical School, on re-accreditation the plan will be for it to become the Plymouth Clinical Trials Unit; helping to further support academic research and act as a complementary resource for R&D here in Plymouth.

In view of the recently announced proposed split of the Peninsula Medical School, PHNT is currently engaging closely with Plymouth University to develop collaborative working across the research environment. Plymouth University has identified a budget of £25m in support of this collaboration. The planned Medical School split offers a unique opportunity to Plymouth to develop a robust collaborative research structure across the healthcare community.

The R&D Dept successfully hosted its inaugural *Plymouth Hospitals Research Conference 2011: Leading Research for Patient Benefit.* This event was a very well received and attended by researchers and clinicians from the Plymouth area. The Conference will take place again this September and bi-annually in future.

The Trust continues to play a full and active part in the organisation and promotion of clinical research in the Peninsula. Specialty groups were created by the NIHR Clinical Research Network to ensure *'access to clinicians with the topic based expertise and enthusiasm that is critical to the success of the NIHR CRN'*. Regional leads are appointed for speciality groups both to promote NIHR portfolio research in the speciality area and to provide a channel of communication between the regional and national levels. The Trust is represented amongst the Peninsula speciality group leads, by Professor Freeman (Reproductive Health), Dr Cramp (Hepatology) and Dr. Minto (Anaesthetics).

The Trust also plays a key role in the training of researchers throughout the Peninsula. Dr. Chris Rollinson (Trust's Research Governance Manager) is the Peninsula NIHR Link Facilitator for training.

The Trust will seek to maintain the momentum of growth in research activity. Our efforts will be focused on supporting our researchers to enable them to develop as research leaders able to win significant research grants and become Chief Investigators of major research studies with a national and international profile.

The R&D Department welcomes the priority the Trust Board attaches to R&D in its developing strategic thinking and the challenging target of top ten percent performance for R&D involvement nationally.

Care Quality Commission

The Care Quality Commission (CQC) is the organisation which regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with CQC in order to provide services and are required to maintain specified 'essential standards' in order to retain their registration. As part of its role the CQC is required to monitor the quality of services provided across the NHS and to take action where standards fall short of the essential standards. Their assessment of quality is based on a range of diverse sources of external information about each Trust which is regularly updated and reviewed. This is in addition to their own observations during periodic, planned and unannounced inspections. If an issue raises concern during the data review process or from other sources of information CQC may undertake an unplanned, responsive inspection.

No enforcement action has been taken against the Trust during 2011/12 and the Trust has not been the subject of a responsive inspection. The Trust was, however, the subject of a routine planned inspection in 2011/12. This involved a detailed review of relevant information, observations on how people were being cared for, discussions with staff and talking to people who use services. The CQC's report was published in August 2011 and concluded that the Trust was compliant with all of the essential standards of safety and quality but, in order to maintain this, suggested some improvements were made. These improvement areas and the Trust's response may be summarised as follows:

- **The CQC concluded that "In a small number of areas within the hospital there are not always sufficient numbers of suitably qualified, skilled staff available to provide adequate cover for short term temporary absences". Specifically, some wards were short of staff at the time of the Care Quality Commission inspection.**
  The Trust has reviewed staffing levels across all wards has actively recruited additional Healthcare Assistants and Registered Nurses to bring staffing up to established levels. This issue continues to be monitored on a weekly basis by the Chief Nurse and the Senior Management Team.

- **The Care Quality Commission concluded that "Improvements are needed to ensure women and their families know how to make a complaint". Specifically, it was noted that Maternity Services patients were not receiving information about the Trust's complaints process.**
  The Maternity Service has been provided with a supply of the complaints leaflets for inclusion in patient information packs. We have also improved the timeliness of responding to complaints. This is reviewed by our Safety & Quality Committee on a monthly basis and continues to improve.

- **The Care Quality Commission concluded that "There are new arrangements being made for training clinical staff on the management of medicines and assessing that they have the competency and skills needed, but these are not fully implemented yet."**
  The medicines management training programme has now been implemented.

In summary, the Trust continues to be fully registered with CQC across all if its locations without conditions and continues to monitor compliance across all of the essential standards.

Data quality

Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement.

At Plymouth Hospitals NHS Trust we monitor the accuracy of data in a number of ways including the monthly Data Quality Steering Group (DQSG). This group utilises the Trust's internal Data Quality Dashboards and external Dashboards to monitor key indicators. Within the Performance & Management Information Department is a Data Quality Team, whose priorities are led by the DQSG.

Each directorate area in the Trust has one or more Data Quality Champions. These operational Data Quality leads ensure their area is performing in accordance with the required standards. As well as the internal Data Quality Dashboard, there are a variety of Data Quality reports used by the Data Quality Team and operational leads to validate and correct issues.

National Data Quality Validity and Benchmarking

Plymouth Hospitals NHS Trust provides submissions to the Secondary Uses System (SUS). This is a single source of comprehensive data which enables a range of reporting and analysis in the UK and is run by the NHS Information Centre.

This SUS data feeds the SUS Data Quality Dashboards and the Dr Foster Data Quality reports used to validate and benchmark performance. Each month the DQSG reviews any failing indicator and ensures there is an action plan to resolve this. During 2011/2012 this has led to improvement in NHS Numbers, Registered GP Practices, Postcodes and Attendance Outcomes.

Information Governance Toolkit Attainment Levels

The Information Governance Toolkit provides an overall measure of the quality of data systems, standards and processes. The score a trust achieves is therefore indicative of how well they have followed guidance and good practice.

The Trust's Information Governance Toolkit score for 2011/12 was 75% which demonstrates satisfactory compliance against a scoring matrix of satisfactory/not satisfactory. An improvement plan has been produced in order to further progress the agenda in preparation for the 2012/13 submission.

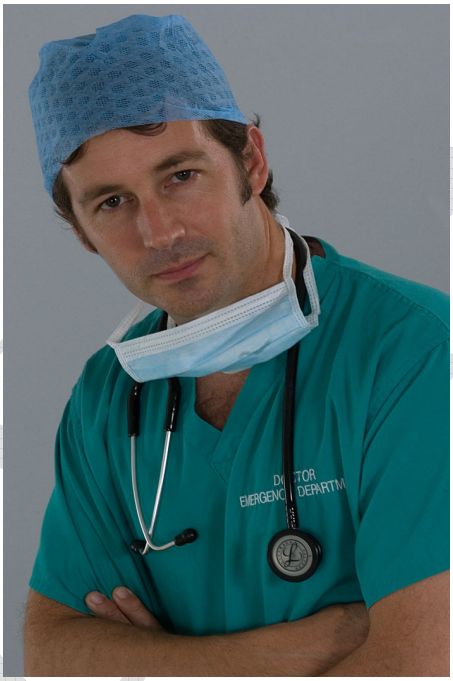
Clinical Coding

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes which reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records. PHNT was subject to a successful Payment by Results clinical coding audit by the Audit Commission during 2011/2012.

Revalidation

Revalidation is the process by which doctors are assessed as competent to continue to provide medical care to their patients. This is administered by the General Medical Council and is coming into force in 2012/2013. It will take approximately five years for all doctors to be accredited.

The Trust Board has nominated its Responsible Officer, who is leading on the implementation of revalidation for all medical staff. The timetable is being set by the GMC, and we expect that our first revalidation recommendations will be made during 2012/2013. The Trust participates in the Regional Responsible Officers network events, and submits quarterly Organisational Readiness Self Assessment returns.



3. Quality overview

In selecting our quality metrics for the quality overview we have chosen measures from the Trust Quality and Safety scorecard which forms part of our continuous Trust review and reporting.

These measures cover patient safety, experience and clinical outcomes. The metrics are nationally known to be important indicators in their respective areas, as well as reflecting our quality priorities. Historical performance has been included along with a column to specify what an individual measure means.

Target	Performance 2010-11	Target 2011-12	Performance 2011-12	What this means
Safety measures reported				
Incidence of C-diff	32	43	41	Lower score is better
Incidence of MRSA	4	5	6	Lower score is better
Hand hygiene completion rates	100%	100%	97.5%	Higher % is better
Hand hygiene compliance rates	99%	95%	97%	Higher % is better
Patient falls resulting in harm or death	103	97	78	Lower score is better
Incident reporting rate – per 100 admissions	3.86 (Sept 10)	5.25	6.37	Higher score is better
Number of Never events	6	0	1	Lower score is better
% of observation charts completed accurately	89%	95%	95%	Higher % is better
Number of cardiac arrest calls	239	215	212	Lower score is better
Ulcer prevalence (% of patients with pressure ulcers) Grades 2, 3, 4 ► Total patients: ► Hospital acquired:	7.8% 4.1%	30% reduction	8.3% Apr 11 – Feb 12 3.7% Apr 11 – Feb 12	Lower % is better
% patients receiving appropriate VTE risk assessment (started recording from July 2010 – month on month increase to Feb 2011)	Jun 10 - 59% Feb 11 – 90%	90%	92%	Higher % is better
% patients receiving appropriate thromboprophylaxis	96%	95%	95%	Higher % is better
Clinical outcome measures reported * National Average = 100				
Mortality (HMSR)	77.7 Relative Risk*	73.8 Relative Risk*	80.1 Apr 11-Jan 12	Lower score is better
% stroke patients spending 90% of their stay on ASU	68%	80%	77.3%	Higher % is better
Fractured NOF – delays to surgery < 36hrs	59%	70%	62%	Higher % is better
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	1.6% (942)	0.8%	1.37%	Lower % is better
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were not treated within 28 days	2.9% (27)	2%	1.8%	Lower % is better

Target	Performance 2010-11	Target 2011-12	Performance 2011-12	What this means
Patient experience measures reported				
PEAT Scores ► Food & hydration ► Environment ► Privacy & dignity	 Excellent Good Good	 Excellent Excellent Good	 Good Good Good	Higher is better
Recommender scores (would definitely recommend)	86%	88%	88%	Higher is better
Overall satisfaction scores (excellent and very good)	79%	84%	80%	Higher % is better
Overall Dignity and respect (always)	79%	84%	79%	Higher % is better
% patients receiving care in single sex setting	82%	85%	94%	Higher % is better
% patients given a choice of admission date	21%	25%	19%	Higher % is better
% patient rating cleanliness as very or fairly clean	97%	97%	98%	Higher % is better
% involved as much as wanted to be in decision about their care	54%	57%	55%	Higher % is better
% experiencing delayed discharge from hospital (stating no)	43%	35%	41%	Lower % is better
Complaints and concerns	702	600	733	Lower is better
Complaints and concerns responded to within target time	38%	80%	81% at the end of March	Higher % is better

3.2 National targets and regulatory requirements

Target	Performance 2010-11	Standard 2011-12	Performance 2011-12	What this means
Incidence of C-Diff	32	43 (max)	41	Lower score is better
Incidence of MRSA	4	5 (max)	6	Lower score is better
18 week maximum wait for admitted patients from point of referral to treatment	93.5%	90%	92.8%	Higher % is better
18 week maximum wait for non admitted patients from point of referral to treatment	98.3%	95%	96.8%	Higher % is better
Maximum time in ED of four hours from arrival to admission, transfer or discharge	96.7%	95%	94.78%	Higher % is better
All cancer two week wait	95.4%	93%	94.5%	Higher % is better
Two week wait for symptomatic breast patients (cancer not initially suspected)	97.8%	93%	97.5%	Higher % is better
31 day (diagnosis to treatment) wait for first treatment: all cancers	98.0%	96%	98.3%	Higher % is better
31 day wait for second or subsequent treatment: surgery	97.2%	94%	96.9%	Higher % is better
31 day wait for second or subsequent treatment: anti cancer drug treatments	100.0%	98%	99.8%	Higher % is better
31 day wait for second or subsequent treatment: radiotherapy treatments	95.4%	94%	96.6%	Higher % is better
62 day (urgent GP referral to treatment) wait for first treatment: all cancers	86.2%	85%	84.7%	Higher % is better
62 day consultant upgrade wait for first treatment: all cancers	90.5%	85%	90.3%	Higher % is better
62 day wait for first treatment from consultant screening service referral: all cancers	91.9%	90%	89.2%	Higher % is better
Access to genitor-urinary medicine clinics (48 hours)	100.00%	100%	100%	Higher % is better
Access to rapid access chest pain clinics within two weeks from referral from GP	100.00%	>=98%	100%	Higher % is better
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	1.6%	<=0.8%	1.37%	Lower % is better
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were not treated within 28 days	2.9% (27)	<5%	1.8%	Lower % is better
Delayed transfers of care	3.4% (1352)	3.5%	2.3%	Lower % is better

Shadow Governors Feedback & Contribution

The Shadow Governors have contributed to this Quality Account during the consultation and review process.

The Governors have expressed support for a culture of continuous improvement in all areas and have suggested a number of specific areas for improvement based on their own experiences.

The Governors commented on some of the key achievements over the past year and expressed their encouragement with regards to these improvements. The Governors have also helpfully provided feedback on the style and language used and this will be incorporated during the development our future Quality Accounts.

Statement from our Local Involvement Network (LINk) Plymouth LINk

Statement to be inserted following consultation.

Statement from our Local Involvement Network (LINk) Cornwall LINk

Statement to be inserted following consultation.

Statement from commissioning PCT

Plymouth Hospitals NHS Trust has worked extremely hard to ensure that its focus on the continuous improvement of quality of care is at the centre of the services it provides, and as lead commissioner, the Western Locality of NHS Devon, Plymouth & Torbay is pleased to work in partnership with the Trust to support this approach. The Quality Account for 2011/12 describes the achievements, priorities and planned actions to drive forward quality improvement focusing on national, local and regional priorities as well as those areas which we know are important to patients. The Quality Account also recognises the importance of issues of consistency and productivity that underpin quality improvement. NHS Devon, Plymouth & Torbay is happy to support the development of the Trust's quality and safety improvement programme through the use of CQUIN, which has provided incentives to clinicians to continuously respond and improve care based on patient experience and best evidence.

The Trust has demonstrated improvement on the priorities identified with last year's account with some areas of outstanding performance and areas which can be further improved during this year. The Trust performance in reducing MRSA has been significant despite failing to achieve its challenging target – having 6 cases against a target of 5. The work of the infection control team has been exemplary in reducing surgical site infections and good progress has been made in terms of embedding a culture of safety in operating departments.

Good progress has been made in the strengthening, monitoring and reporting of the quality of care provided. The Trust has demonstrated its commitment to capturing and acting upon patient experience with the introduction of systems to perform real time surveys of the quality of care received. This will ensure that quality improvement is built upon feedback from patients. Overall in the year 2011/12 we would agree with the progress on quality improvement described within the Quality Account, and we have been witness to the efforts of the Trust to put quality of care at the heart of everything it does.

The 2011/12 priorities described by the Trust are consistent with the priorities agreed with NHS Devon, Plymouth & Torbay in improving the experience of patients within the care they receive, working to increase reliability and productivity, ensuring patient safety and progressing clinical excellence. NHS Devon, Plymouth & Torbay has also worked with the Trust to support these improvements through CQUIN where possible. In particular, the focus on the avoidance of hospital acquired pressure sores and efficiencies in outpatient processes are supported by NHS Devon, Plymouth & Torbay, as we know that these are issues which can make a significant difference to the outcome for patients both clinically and in terms of their experience.
The alignment of the Trust's philosophy for quality of care with NHS Devon's is critical as it is only an open and respectful partnership between commissioner and provider and its managers and clinicians that will drive improved outcomes for patients. The description of the achievements made in 2011/12 and the focus on quality during 2012/13 demonstrate in absolute terms the commitment of the Trust from ward to Board to improving quality of care and we continue to support the approach the Trust has taken, the principles for quality improvement it has adopted and its priorities for the future.

Cornwall Health & Adults Overview & Scrutiny Committee

Cornwall Council's Health and Adults Overview and Scrutiny Committee (HAOSC) agreed to comment on the Quality Account 2011-2012 of Plymouth Hospitals NHS Trust (PHT). All references in this commentary relate to the period 1 April 2011 to the date of this statement.

The Committee is extremely concerned regarding the lack of permanent leadership and the financial challenges faced by the Trust at a time of possible significant change in their status and within the national health frameworks. There is also anxiety about the impact of this on the recruitment and retention of staff, and the impact on essential nursing care.

The work undertaken by PHT in relation to Cornish patients is welcomed but we wish to see an ongoing commitment to service provision and increasing use of Cornish health facilities for outpatient's appointments for these patients where appropriate.

The Committee is disappointed with the Trust performance in relation to stroke and fractured neck of femur.

The improvements in theatres, pressure sores and cleanliness is commended by the Committee and is felt to demonstrate the continued hard work of the staff within the Trust.

The HAOSC believes that the Quality Account is a good reflection of the services provided by the Trust, and provides a comprehensive coverage of the provider's services.

Plymouth Health & Adults Overview & Scrutiny Committee

Statement to be inserted following consultation.

Devon Health & Adults Overview & Scrutiny Committee

Devon County Council's Health and Wellbeing Scrutiny Committee has been invited to comment on the Plymouth Hospitals NHS Trust Quality Account 2011/12 which includes the priorities for 2012/13. All references in this commentary relate to the reporting period 1st April 2011 to 31st March 2012 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee believes that the Quality Account 2011-12 is a fair reflection and gives a comprehensive coverage of the services provided by the Trust, based on the Scrutiny Committee's knowledge.

The Scrutiny Committee particularly welcomes the 12% reduction in mortality rates as well as the 28% reduction in adverse events achieved in the reporting period. The Scrutiny Committee would like to see the Trust achieve the desired target of 30% reduction in pressure sores and welcomes the inclusion as a priority for the coming year. The committee is concerned about the patients who were unintentionally harmed during surgery but accepts the 98% compliance with the surgical safety check list. The Committee hopes that the Trust will achieve 100% compliance. The Scrutiny Committee also notes the progress against action taken in response to the Care Quality Commission's identified areas for improvement.

The Trust has attended Devon County Council's Health and Wellbeing Scrutiny as part of the consultation arising from the application for NHS Foundation Trust status by April 2013. The Trust's Medical Director confirmed that NHS Trust status would be granted and that the consultation related to process, strategy and future plans including proposed governance arrangements. The Committee had an informative discussion leading from the Trust's presentation.

The Scrutiny Committee is content with the level of patient involvement detailed in the Quality Account and welcomes the quality priorities for improvements 2012/13. The Committee fully supports the core values of the Trust relating to respect and positive attitudes and the vision to deliver excellent clinical outcomes and looks forward to continued partnership working.

Statement of Directors' Responsibilities

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.

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

Chairman
Date:

Interim Chief Executive
Date: