Clerk: Kate Spencer
Telephone: 01803 207014
E-mail address: scrutiny@torbay.gov.uk
Date: Thursday, 02 May 2013

Overview and Scrutiny
Town Hall
Castle Circus
Torquay
TQ1 3DR

Dear Member

HEALTH SCRUTINY BOARD - WEDNESDAY, 8 MAY 2013

I am now able to enclose, for consideration at the Wednesday, 8 May 2013 meeting of the Health Scrutiny Board, the following reports that were unavailable when the agenda was printed.

Agenda No	Item	Page
5.	**Quality Accounts 2012/13 - Torbay and Southern Devon Health and Care NHS Trust**	(Pages 71 - 113)
6.	**Quality Accounts 2012/13 - South Devon Healthcare NHS Foundation Trust**	(Pages 114 - 172)

Yours sincerely

Kate Spencer
Clerk

Torbay and Southern Devon Health and Care NHS Trust

TORBAY AND SOUTHERN DEVON HEALTH AND CARE NHS TRUST

QUALITY ACCOUNT 2012-13

Chief Executive's Statement

Welcome to our Quality Account for 2012-13. You will read within this publication the significant progress we have made to improve the quality and safety of our services during 2012-13 and the priorities that we as a health and adult social care organisation have set for the next year.

In the last year the NHS landscape has continued to change. Clinical Commissioning Groups (CCGs) became authorised on 1st April 2013 to buy healthcare services for the local population and as a Trust we have been going through our own process to seek an NHS acquisition partner in a bid to become a Foundation Trust. Whilst these changes are important to the internal workings of the NHS we have never been wavered from our overall goal of ensuing that every patient receives the right care, in the right place, at the right time.

The integrated model of care that we provide in Torbay and Southern Devon is not unique but nor is it common place across the country and the way we work together with our two local authorities to deliver integrated health and adult social care is something that has continued to seek national interest and recognition.

In November 2012 Andy Burnham MP, Shadow Secretary of State for Health visited the Trust to find out more about our integrated model of care and how the model works in action. The Trust also opened its doors once again to around 50 delegates from NHS organisations and local authorities. Visitors came from widespread locations in England, Scotland and as far as Denmark to find out more about the development of integrated care and hear some examples of how integrated care works in practice. The event also took some time to look to the future and how we can continue to build upon our model of care by ensuring a joined up approach through partnership working across the health and social care community.

A good example of where this is already happen is a recent project led by the South Devon and Torbay Clinical Commissioning Group to develop a Virtual Ward Service. The service which received the *working together: Best Example of Integrated Care award* at this year's Alliance Acorn Awards involves community teams, social care, mental health, palliative care and GPs working together to provide fully joined-up care so that patients' conditions are better targeted, managed and controlled. Through this way of working more and more local people can be cared for within their own homes and the number of hospital admissions is reduced.

Projects such as this, which involve organisations working closely together to achieve better outcomes for patients and clients, not only enhances the quality of the services but provides opportunities for organisations to share learning and increase the standard and safety of services at every level; ensuring that every single person within our care has the best possible experience.

Quality and improvements are brought about by challenging ourselves through regular review and continually asking ourselves the question 'what can we do better?' It is of course no secret that the NHS is working within a challenging financial environment and whilst it is vital we are able to deliver services in a cost effective and efficient way, developments and changes to service are and must be driven by quality and safety.

For a number of years now we have been undertaking a piece of work called Productive Community Teams where we review our systems and processes to ensure they are lean, practical and can support effective practice. In April 2012 the Department of Health extended the scope of non-medical prescribing of controlled drugs. Such legislation has enable improved efficiency and quality of care in our community drug and alcohol team and in community nursing to better support the care of patients in their own homes who require controlled drugs as pain relief at the end of life.

In addition to regularly reviewing the quality and safety of our services in their current format we also have to review their ability to meet the standards of safety and quality in the future, by taking into account the ever changing health and social care needs of the local population and future requirements of care. This is something that we don't do alone and the views of the people that we care for and who use our facilities are extremely important in helping to shape our services.

That is why in November 2012 the Trust consulted with local communities in Ashburton, Bovey Tracey and Buckfastleigh on proposals to reshaping community services for the future. The consultation proposed the relocation of inpatient services from two of our community hospitals to our state of the art and purpose built facility at Newton Abbot Community Hospital, with the hope of bringing new services to the local communities which would improve access to a wider range of services, the quality of services available and overall patient experience.

The consultation had a good and varied response from the local community and whilst we still need to look to the future of the service we decided to take more time to consider the responses and not to progress the proposals at this stage. The feedback and information gained throughout the consultation has been made available to our commissioners who will now be looking to undertaking fresh discussions with local communities about the future development of wider community hospitals and services.

Looking ahead to this year the Trust's Experts by Experience group will continue to focus on different ways to capture the voice of those who use our services and its members will be starting a 'Mystery Shopper' observation of care with residential and nursing homes in April 2013. This work will incorporate the monitoring of defined standards included within the Winterbourne View Serious Case Review such as family inclusion and activities for residents.

Regularly reviewing, observing, and evaluating are what creates change and helps the NHS to evolve and develop. Quality can never stand still and it is something that we will always need to focus on but it is something that we could not achieve and maintain without the dedication and commitment of our staff. The Quality Account gives you an overview of where we have focused our resources to improve quality and safety outcomes for patients and clients but I know from conversations with patients and staff that quality is driven from the very smallest of actions to improve a person's experience. In our 2012 staff survey we scored an extremely positive 3.88 from a maximum score of 5 in the question of staff recommending the Trust as a provider of care for their family. This rated as one of the highest scores across the country, and I think you will all agree a great testimony to the services we provide.

I hope this year's Quality Account will give you a more in depth insight into our performance and the priorities in which we will focus our energies to further enhance quality, safety and patient experience as we go forward into 2013-14.

To the best of my knowledge I believe the information within this document to be both reliable and accurate and provides a balanced picture of Torbay and Southern Devon Health and Care NHS Trust performance between 2012- 13.

Mandy Seymour

Chief Executive

Torbay and Southern Devon Health and Care NHS Trust

Statement of Directors

Statement of Directors' responsibilities 2012-13

The Quality Account 2012-13 has been produced in accordance with the requirements of the Health Act 2009, the NHS Quality Account Regulations 2010 and the NHS Quality Account Amendment Regulation 2011.

To the best of our knowledge we believe the information within this document to be both reliable and accurate and provides a balanced picture of Torbay and Southern Devon Health and Care NHS Trust performance between 2012- 13.

Mandy Seymour

Chief Executive

Torbay and Southern Devon Health and Care NHS Trust

Jon Andrews

Chairman

Torbay and Southern Devon Health and Care NHS Trust

PART 2

In this part of the Quality Account we will explain the priorities the Trust has agreed for 2013-14. The Strategic Aims of the Trust listed below will provide a strong foundation on which we will build our quality and safety improvement work:

STRATEGIC AIMS

- **Offer a value for money, sustainable service**
- **Provide high quality safe care with no delays**
- **Provide a flexible and motivated workforce**
- **Deliver care as part of a community wide system**
- **Involve our community in developing our services**
- **Promote public health in all contacts with our community**
- **Deliver the best model of care to achieve the best possible outcomes**

In 2012-13 we achieved a great deal of success in the priorities we set; Part 3 of this account will provide information on some of these achievements with a full report in Appendix 1. We do recognise that these projects do not stop but that were we have seen real benefits we will continue to drive forward and develop quality initiatives.

We have also consulted widely with the public and clinical and social care staff to identify priorities that we would wish to focus our improvement work on in 2013-14. These priorities are in addition to National Commissioning for Quality and Innovation (CQUIN) objectives defined by the NHS Commissioning Board. Details below include the National CQUINs.

National Priorities

- **<u>Improving the Patient Experience</u>**

  We will listen to people who use our services using this feedback to improve quality and share good practice

  To improve the experience of service users the Trust has introduced the 'Friends and Family Test' which the Department of Health has made compulsory to all acute hospital settings. However in the South West it has been extended to include community hospital wards and minor injury units (MIUs). This will provide timely, granular feedback from patients about their experience in our hospital services. The 'Friends and Family Test' question is:

  'How likely are you to recommend our services to your friends and family if they need similar care or treatment?'

  The Trust has also included additional questions within the questionnaires to obtain valuable feedback for example the persons involvement in their hospital discharge plan, their understanding of medication and their assessment of the level of dignity afforded to them during their stay. The Trust will publish the initial results on our Trust website in July, with more detailed ward by ward figures from October 2013. During 2013-14 it is our intention to extend the questionnaire to other Trust services.

Please refer to page 27 for results of the questionnaire for Community Hospitals and MIU's.

- **The Development of the National Safety Thermometer**

We will build upon the data collected as part of the National Safety Thermometer project undertaken in 2012-13. We will continue to focus on the following four elements of the NHS Safety Thermometer: pressure ulcers, falls, VTE and urinary tract infection in patients with a catheter.

In 2012-13 we introduced this safety monitoring tool as part of a national programme. We will implement this process for measuring harm caused within our community health services during 2013-14 allowing us to gather sufficient data during the first year to provide a baseline from which we will be able to measure the effect of quality and safety improvements in the future. (See graph on pages 20-21).

In our community hospitals we have collected this data for a year and will therefore be able to begin to measure safety improvement. In March 2013 our harm free care rate was 82% with 15% of harms being old harms transferred into our hospitals and 3% harms acquired whilst in our hospital.

This year we will work to achieve a 90% harm free care rate with specific focus upon reduction in the harm from Pressure Ulcers.

In the community we plan to start to collect safety thermometer data in 2013-14 developing a greater insight into harms caused and the effect improvement work can have on improving safety for patients in their own home. This will build upon the processes we have in place in our community hospitals to begin to begin to monitor and measure any impact of quality and safety initiatives introduced.

- **Reduction in the Harm Caused by Avoidable Pressure Ulcers**

We will undertake a pressure ulcer prevention programme that will include information leaflets, training and general awareness of the simple measures patients, carers and care providers can take to avoid pressure damage.

Reducing the prevalence of avoidable pressure ulcers acquired in our care is both a national and local priority. The occurrence of a pressure ulcer can cause increased risk of infection, emergency hospital admission, a longer stay in hospital, pain, psychological distress and often loss in independence. The occurrence of a pressure ulcer is considered to be a key indicator of the quality of patient care. Our investigations into the development of pressure ulcers using the Root Cause Analysis methodology has identified a small number of key root causes which if addressed will reduce the risk of pressure damage developing, these include:

- A need for more education and training of carers employed within the Trust and those employed by independent care providers
- Raised awareness for patients and their families so that they can take preventative action
- Ensuring people at risk are aware of how they can prevent pressure damage with simple steps such as well-fitting footwear and frequent changes to position when sitting or lying in one position for long periods of time.

- Ensure that patients, families and carers are aware of the early signs of damage and who to contact for help before significant damage occurs.
- Nurses must share care plans and actions with patients and with their consent others who may be involved in their care.

In 2013-14 we intend to implement a comprehensive prevention programme that will focus on our hospitals, care for patients in their own homes and within nursing and residential homes. The aim will be to reduce the numbers of patients who develop Grade 3 and 4 pressure ulcers across the health community.

The project will:

- Establish an effective Pressure Ulcer education strategy for staff in the community hospitals and community including care homes, domiciliary care agencies, informal carers and patients. This will include interactive education films and information leaflets such as "PROMPT" awareness cards (early intervention that will care for the skin and help to avoid pressure damage).
- Increase the number of "link nurses" with more specialist knowledge in the community teams and community hospitals to support improvements in pressure ulcer prevention.
- Work with independent care homes and care agencies to provide training and awareness for staff as well as undertaking routine visits to meet with carers and patients/clients to identify risks and develop care plans to promote well-being. This will build upon the experience in pressure damage prevention education currently undertaken by community nursing teams in Teignmouth and Kingsbridge where they are working in collaboration with care homes.
- Review the use and supply of pressure relieving equipment to ensure the right equipment is supplied at the right time to meet the needs of the patient.

- **<u>Support for Carers of People with a Dementia</u>**

  We will ensure carers feel supported and able to access services with a specific focus on hospital discharge.

  This national CQUIN will allow us to build upon the work undertaken in 2012-13 to identify how we can provide greater support for carers; by supporting carers we can improve the lives of both carers and those cared for, helping to avoid crises occurring. We plan to develop this with our local priority 10 (see page 11). This work will be undertaken with our partners across Torbay and Southern Devon. In Section 3 details have been included of work undertaken in our community hospitals during 2012-13 including an education programme for staff and improvements to the ward environment.

- **<u>Reducing the Incidence of Healthcare Associated Infections</u>**

  We will treat and care for people in a safe environment and protect them from avoidable harm in accordance with the NHS Outcomes Framework 2013-14; Domain 5

  This includes work to maximise the potential to reduce the rate of MRSA bloodstream and Clostridium difficile infections.

In 2012-13 the Trust reported two MRSA bloodstream infections against a regionally agreed target of two. Work continues to reduce the level of Clostridium difficile infection rates of 115 against a regional target of 108.

The Torbay and Southern Devon health community has developed a joint strategy that will support our continued focus on reducing the incidence of these very serious infections that include:

- Continued in-depth analysis, including Root Cause Analysis investigation of the casual factors for Clostridium difficile sharing any learning and making recommendations for best practice in the avoidance of Clostridium difficile, including advice in antibiotic prescribing and medication that may interact with this disease process.
- We will continue to analyse the type of Clostridium difficile strain that occurs within the community to identify any trends.

The targets set for 2013-14 are MRSA two cases and 77 cases of Clostridium difficile.

Local Priorities

During December 2012 we developed a list of potential Quality improvement projects with managers and professional leads. In January and February 2013 we consulted with a number of internal and external forums to identify what we should focus our quality and safety priorities on in 2013-14 including:

- Devon and Torbay HealthWatch (previously LINks)
- The Trust Engagement and Experience Committee Members (who have circulated it within their networks).
- Devon and Torbay Overview and Scrutiny Committees
- The Trust's Experts by Experience Group
- The Trust also sought the views of clinical leaders and staff in defining the final list of local priorities

The link to the online questionnaire via the Trust website was made available and advertised widely in:

- The all staff via the bulletin
- The Carers Forum website
- The VCS via the CVA bulletin
- The Torbay Council staff via their bulletin
- On Facebook and Twitter

A copy of the consultation questionnaire and the full results can be found in Appendix 2. The Local Priorities listed below were agreed by clinical leads and the Trust's Engagement and Experience Committee in March 2013. The priorities agreed reflect the feedback received during the consultation process.

Safety

- **Medicines Optimisation**

  We will maximise the beneficial clinical outcomes for patients from medicines with an emphasis on safety, governance, professional collaboration and patient engagement.

  There are a variety of ways in which this priority will be achieved including support at hospital discharge.

  We will help patients and carers to understand their medication at discharge. It can be confusing for people when they have medications changed whilst in hospital. Our intention is to provide information and explain medications prior to someone being discharged from hospital providing them with a greater understanding of the type of medication and the purpose for taking it.

  Additionally we will seek to provide a clear and systematic approach to the selection of prescription products. Working with and liaising with local healthcare providers we will further promote the Joint Formulary to improve prescribing and supply adherence e.g. wound dressings. This will help to promote a consistent approach to treatment option selection and improved patient care.

- **We Will Support Our Independent Partners in Quality and Safety Improvement**

  It is our intention to work in a supportive manner to support quality and safety across the health and social care services that we commission.

  'We will continue our work with care home providers to develop a Quality, Effectiveness and Safety Trigger Tool (QuESTT)'. This web based self-assessment tool provides a quality and safety monitoring function for care home managers and matrons and can also be used by the care homes to support their compliance assessment for the Care Quality Commission (CQC) as it includes many of the key quality and safety outcomes.

  A number of care homes have expressed an interest in working with us to develop the QuESTT and we are now defining the indicators for monitoring the quality, effectiveness and safety of care in many areas including pressure area prevention, palliative and end of life care, medicines management, staff training and development and infection control.

Effectiveness

- **We will work to reduce childhood obesity through a family intervention and weight management programme in Torbay**

  We will design, manage and deliver a community based programme for overweight children and young people aged 5-15 years and their families to enable progress towards and maintenance of a healthy weight.

This programme will take into account and respond to the diverse needs and home circumstances of its users. The multi-component model will be aimed at supporting long-term lifestyle changes, providing skills and information for healthy eating, physical activity and positive communication skills. Included within this programme will be motivational components focussing on behaviour change that will involve the family as well as the child.

The programme will provide an average of 10-14 sessions of 1-2 hours duration, with up to 15 families being accommodated per programme.

Once the final programme format is agreed it will be piloted during April – October 2013, activity levels and numbers of children/families engaged and completing the courses will be monitored alongside evaluation and service user feedback.

The service will provide an annual audit and report on activity and recommendations to inform future commissioning specifications

The Trust in not commissioned to provide public health services to Southern Devon this will therefore only apply to Torbay.

- **We will ensure that the care we commission on behalf of people with a learning disability is outcome focused**

  We intend to continue to protect those most vulnerable in society, taking the learning for the Winterbourne View Serious Case Review.

Some of this work will ensure effective care for people with a learning disability undertaking reviews that focus on personal outcomes for clients that support them in achieving their personal goals. It is essential that we listen to people and gain feedback on their experience at these reviews, using this information in partnership with the care providers to achieve high quality services that meet individual needs.

Our staff will undertake regular care reviews with people who receive these commissioned services in Torbay to achieve this, although this has always been undertaken by our staff, there is an emphasis to be able to provide a more outcome focussed approach to these reviews. We will audit the number of reviews undertaken to ensure that outcomes are achieved

Patient Engagement

- **We will Improve communication and information for patients on how to access care after they are discharged from hospital**

  We will work with partners to develop a discharge pathway as part of a joint project to improve communication for patients, carers and others who provide their care

  We recognise that the initial 48 hours at home once discharged from Hospital is a critical time for both patients their families and carers, by providing improved communication to people at discharge, including information about future follow-up appointments and medication, we should improve the safety and quality of discharges from our hospitals.

  We will measure how effective this improvement work is by obtaining feedback as part of the routine patient experience questionnaire, given to all patients discharged from our hospitals.

  Our aim in 2013-14 will be to develop a discharge information pack in one community hospital to test this and gain feedback for improvement from patients and carers and then implement it in all community hospitals.

- **We will improve access to carers support networks**

  Recognising the valuable contribution carers have in the wellbeing and quality of life for those they care for we will develop a programme to identify carers, including those who care for someone with dementia, allowing good support networks to be established, and improving their access to this support.

  In partnership with carers and other agencies we will develop a 'Carers Pathway' through the whole system to establish the key points for carers to be identified and to access support. An action plan will be agreed to prioritise areas for improvement, and this will be published. Following on from our learning in 2012-13, there will be a particular emphasis on the Carers involvement in hospital discharge and identifying 'hard to reach' Carers.

  Staff awareness of the needs of carers is critical, and a programme of staff training will be rolled out to hospital and community based staff. We will measure the impact of this on identification of carers and improvements in their experience of support.

  Recognising the valuable contribution carers have in the wellbeing and quality of life for those they care for we will develop a programme to identify carers, including those who care for someone with dementia, allowing good support networks to be established.

  The minimum number of staff trained in Carer Awareness will be:

  - Minimum of 50% of District Nurses across Torbay and Southern Devon
  - 50% of Nursing staff at Brixham and Paignton Community Hospitals
  - Intermediate Care Teams in Torbay

To demonstrate the number of carers identified and support available we will:

- Quarterly audit of District Nurse Assessments to show number of carers identified and actions taken, for example the numbers of “carer contact cards” distributed and number of referrals made to services for advice and information
- The number of referrals from Community nurses and identified hospitals for Carers Assessment (from June 2013)
- Analysis of monthly enquiries to the Signposts Carers Information service – source of referral and whether prompted by Carers Contact card (from May 2013)
- An increase of Carers on Torbay GP Practice Registers (measured from baseline at April 2013)
- An increase in the number of Carers joining Torbay Carers Register during 2013-14.

PART 3

Within this section of the Quality Account we will provide information of the achievement of priorities set for last year.

The Trust has had a successful year with many achievements in improving safety, quality and effectiveness this report will provide examples of some of these achievements.

In November the Trust was 'highly commended' in the Provider Trust of the Year category at the recent Health Service Journal Awards 2012 (HSJ).

The prestigious HSJ awards aim to celebrate healthcare organisations across the country and have helped raise the standards of healthcare in the UK by providing high quality care and services, in an innovative and effective way.

The Trust was one of six Trusts to be shortlisted within this highly contested category and was the only Trust awarded 'highly commended'. Receiving 'highly commended' in the category followed a stringent judging process where Judges visited the area to understand how the Trust operates, what the Trust's priorities are and hear about patient experiences. The judging process also required senior leaders from the Trust to present their case for why they think the Trust is worthy of the award.

The HSJ also acknowledged the Trust for our work with carers; our very small but dedicated team actively support carers across Torbay, recognising the valuable contribution these people make in society. A role that often goes unnoticed we are committed to involving carers in decisions about those they care for and later in this report the results of a study which examined ways that discharge from hospital can be improved. As in many of the priorities set each year they are not time limited but develop a momentum that will continue to develop as we strive to improve the services we offer.

Our community hospitals provide a valuable resource in caring for people however we recognise that for most people their preference is to return home gaining independence as soon as possible. In 2012 we developed a reablement service that would support this with time limited rehabilitation undertaken in the patient's own home with successful outcomes.

Statements of Assurance from the Board
(This is a mandatory reporting section)

Review of services (Regulation 4)

During 2012-13 the Torbay and Southern Devon Health and Care NHS Trust provided and/or sub-contracted seven relevant health services.
The Torbay and Southern Devon Health and Care NHS Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2012-13 represents 100% of the total income generated from the provision of relevant health services by the Torbay and Southern Devon Health and Care NHS Trust for 2012-13.

Clinical Audit

During 2012-13 two national clinical audits and no national confidential enquiries covered relevant health services that Torbay and Southern Devon Health and Care NHS Trust provides.

During that period Torbay and Southern Devon Health and Care NHS Trust participated in 100% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Torbay and Southern Devon Health and Care NHS Trust participated in during 2012-13 are as follows:

- National Audit of Falls and Bone Health in Older People
- Stroke National Audit Programme (combined Sentinal and SINAP)

The national clinical audits and national confidential enquires that Torbay and Southern Devon Health and Care NHS Trust participated in, and for which data collection was completed during 2012-13 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.

- Falls and Bone Health *Torbay and Southern Devon Health and Care NHS Trust* undertook this audit with South Devon Healthcare Foundation Trust, 100% (40) of the total number of cases were submitted.
- Stroke National Audit Programme (combined Sentinal and SINAP). The combined acute and rehabilitation unit agreed to submit data on 5 cases as part of the SSNAP pilot. The rehabilitation unit participated in the Organisational Audit and collected data on 15 cases for the process of care audit. The unit is in the process of recruiting some additional A&C support to enable continuous data entry.

The reports of two national clinical audits were reviewed by the provider in 2012-13 and Torbay and Southern Devon Health and Care NHS Trust intends to take the following actions to improve the quality of healthcare provided.

Acute stroke (SINAP)

This audit report was received in May 2012 reflecting the findings from an audit of records collected in 2011

Acute Stroke Audit

	RECOMENDATION	ACTION COMPLETED
1	To develop an Early Supported Discharge Service(EDS) in all areas of the Trust	This is now in place across all areas of the Trust
2	To provide a minimum of 45 minutes five days each week of all types of physiotherapy, occupational therapy and speech and language therapy to patients who require therapy interventions.	We are monitoring achievement of the 45 minute NICE quality marker on the stroke unit at Newton Abbot. Achievement for each profession to date is: Physiotherapy : 70% of patients identified as tolerating 45 minutes Occupational Therapy (OT) : 77% of patients identified as tolerating 45 minutes Speech and Language Therapy (SLT) : 30% of patients who were identified as tolerating 45 minutes Achievement of the Physiotherapy and OT target fell this year due to vacancies in Rehabilitation Support Worker Posts and delays in approval to recruit to these. Vacant posts are currently being recruited to. For SLT the service has reviewed skill mix and is in the process of adding an additional Rehabilitation Support Worker to enable a 7 day approach to SLT.
3	To review the number of patient being discharged into care homes from hospital following Stroke.	To date in 2012/13 23% of those leaving our specialist stroke ward went to care homes with 74% going home (3% to hospitals out of area or intermediate care) further work will be undertaken to relate these results to the total number of placements in care homes

Future work on stroke is being discussed at the Stroke Clinical Pathway Group. It is likely to include expanding the seven-day rehabilitation service to all parts of the stroke pathway, launching a pathway for psychological support and providing continuous service user feedback.

National Falls and Bone Health Audit

	RECOMENDATION	ACTION COMPLETED
1	Appointment of a consultant(s) orthogeriatrician to improve peri-operative medical care and co-ordinate comprehensive falls and bone health assessments	*3 consultants now in post*
2	Evaluation of Infoflex (an electronic recording system) falls pilot and Trust wide roll out to facilitate a more comprehensive assessment of falls and onward referral to community evidence based exercise programmes	*Infoflex pilot still on going, changes to original work made and pilot continues. The statistics will be collected on the CPG dashboard. Being rolled out in a sustainable manner with further work now being undertaken to look at alternative IT solutions*
3	Home hazard assessment by occupational therapists to be increased, particularly in non hip fracture patients	*This piece of work is outstanding and will be a challenge within our current capacity as a Trust and within SDHCT home hazard assessments have significantly reduced over the last 3 years. By increasing awareness in all health professionals allowing them all to undertake a falls risk assessment when visiting patients at home we aim to increase the detection and reduction of hazards within the home.*
4	Development of a cponsistent Fracture liason servcie	*In November 2012 this was rolled out to include South Devon CCG area*

A summary of all local clinical audits are included in Appendix 3.

Research

The number of patients receiving relevant health services provided or sub-contracted by Torbay and Southern Devon Health and Care NHS Trust in 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 58.

Quality improvement and innovation goals agreed with commissioners

A proportion of Torbay and Southern Devon Health and Care NHS Trust income in 2012-13 was conditional on achieving quality improvement and innovation goals agreed between Torbay and Southern Devon Health and Care NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012-13 and for the following 12 month period are available on request from Torbay and Southern Devon Health and Care NHS Trust.

Care Quality Commission Registration

Torbay and Southern Devon Health and Care NHS Trust is required to register with the Care Quality Commission and its current registration status is registered with the CQC with conditions attached to registration. Torbay and Southern Devon Health and Care NHS Trust has the following conditions on registration:

Torbay Care Trust for Accommodation for persons who require nursing or personal care

1. The registered provider must ensure that the regulated activity accommodation for persons who require nursing or personal care is managed by an individual who is registered as a manager in respect of the activity, as carried on at or from the location of Occombe House.

2. The registered provider must ensure that the regulated activity 'accommodation for persons who require nursing or personal care' is managed by an individual who is registered as a manager in respect of the activity, as carried on, at or from the location of Baytree House.

3. This Regulated Activity may only be carried on, at or from the following locations: Baytree House and Occombe House.

Conditions of registration that apply to: **Torbay and Southern Devon Health and Care NHS Trust** for **Personal care**

1. The registered provider must ensure that the regulated activity accommodation for persons who require nursing or personal care is managed by an individual who is registered as a manager in respect of that activity at or from all locations.

2. This Regulated Activity may only be carried on at or from the following locations:

   Baytree House

Additional conditions that apply at this location

1. The registered provider must not provide nursing care under accommodation for persons who require nursing or personal care at Baytree House.

2. The registered provider must only accommodate a maximum of 10 service users at Baytree House and Occombe House

Additional conditions that apply at this location

1. The registered provider must not provide nursing care under accommodation for persons who require nursing or personal care at Occombe House.

2. The registered provider must only accommodate a maximum of 12 service users at Occombe House.

The Care Quality Commission has not taken enforcement action against Torbay and Southern Devon Health and Care NHS Trust during 2012-13.

Torbay and Southern Devon Health and Care NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in February 2013 at Occombe House. The CQC's assessment of the Torbay and Southern Devon Health and Care NHS Trust following that review was Occombe House was meeting all the essential standards of quality and safety Inspected.

Torbay and Southern Devon Health and Care NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period

Information Governance

Torbay and Southern Devon Health and Care NHS Trusts declared Level 2 (satisfactory) across the Information Governance Toolkit at 31 March 2013.

Torbay and Southern Devon Health and Care NHS Trust submitted 43,587 records during 1st April 2012 – 28th February 2013 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. N.B. Data for the full year 2011-12 will be available in May 2013

The percentage of records in the published data which included the patient's valid NHS number was:

- *100 % for admitted patient care*
- *99.7 % for outpatient care and*
- *96.0 % for accident and emergency care*

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- *100 % for admitted patient care*
- *100% for outpatient care and*
- *99.4% for accident and emergency care*

The data made available to the Torbay and Southern Devon Health and Care NHS Trust by the Health and Social Care Information Centre with regard to the percentage of patients 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

N.B Further information will be made available in April 2013

Year	RE-admission rate	National Average	Highest Rate	Lowest Rate
2011/12	1.2%	Data available Dec 2013	Data available Dec 2013	Data available Dec 2013
2012/13	1.5%	Data unavailable	Data unavailable	Data unavailable

The Torbay and Southern Devon Health and Care NHS Trust considers this data is as described for the following reasons:

- *Our figures are likely to be lower than comparative Trusts because they only relate solely to admissions /re-admissions at our Community Hospitals, in many areas this rate is a combined reported for Community and Acute Hospitals*

- *The majority of emergency admissions will be to the Acute Trust, therefore even if patients discharged from our Hospitals did require re-admission, it is more likely that they will have been sent to South Devon Healthcare Foundation Trust or Royal Devon and Exeter Foundation Trust.*

The Torbay and Southern Devon Health and Care NHS Trust intend to take the following actions to improve this percentage and so the quality of its services, by working with its partner organisations to ensure effective discharge planning by:

- *Improving the timeliness of discharge information to General Practitioners*
- *Provide Support for Carers*
- *Improve patients understanding of their medication on discharge*

The data made available to the Torbay and Southern Devon Health and Care NHS Trust by the Health and Social Care Information Centre 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.

Year	Percentage of Staff who would recommend the trust as a provider of care to their family or friends	National Average	Highest	Lowest
Dec 11	3.68 (73.6%)	3.44	3.68	3.04
Dec 12	**3.88 (77.6%)**	**3.58**	**3.88**	**3.24**

Action plan for 2012-13 included:

- *The appointment of a equality and diversity manager to progress the agenda*
- *Reinvigorating the health and wellbeing group.*
- *The establishment of a planned programme of Organisational Development*
- *Review of the appraisal process – This action plan will be taken forward during 2013/14*

The number and, where available, rate of patient safety incidents reported within the Torbay and Southern Devon Health and Care NHS Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. With actions taken and comparisons to similar organisations.

Year	total	Similar Trust [a]	severe	Similar Trust [a]	death	Similar Trust [a]
2011/12	383[b]	2634	0	63	3[b]	3(0.113%)
2012/13 *NB to 1.3.13*	3386	*Information not available*	1 (0.031%)	*1.1%* [c]	3 (0.089%)	*0.3%* [c]

[a] ***Similar Trust Cornwall and Isles of Scilly PCT (a community Trust with 11 community hospitals)***

[b] ***We are unable to capture the specific number of incidents that occurred in the southern area of Devon during 2011/12. These incidents continued to be reported to the former Devon PCT Datix system until a new system was introduced for the whole of the Trust in August 2012. The 2011/12 number illustrated in the chart above was for the previous Torbay Care Trust area that only included 2 community hospitals.***

[c] ***Comparisons based on information provided by the NHS Commissioning Board incident report for the National Reporting and Learning System 1.4.12 – 31.9.12 Full year results are not available at the time of this publication***

- *Root Cause Analysis Investigations are undertaken for all serious incidents with commissioners being informed using the Strategic Executive Information System (STEIS)*

- *The Care Quality and Safety Group receive these reports and recommendations made for shared learning or practice changes. Further discussion and sharing of learning occurs in professional and managerial forums.*

Part 3

Quality Account Priorities 2012-13

An update of performance against the 2012-13 priorities is included at Appendix 1. Below are some examples of quality improvement work completed during the year. These are presented under the headings Safety, Effectiveness and Patient Experience.

Safety

- **We said we would implement the Quality, Safety and Effectiveness Trigger Tool (QuESTT) in Independent health care providers in 2012**

"Research shows that the leaders of clinical teams have a major contribution to make in creating a climate in which patients receive the best possible care. This is achieved by engaging, motivating and supporting staff to perform at their best. Staff also need to be able to blow the whistle when things go wrong, without fear of repercussions and in the knowledge that their concerns will be heard and acted on." **Professor Chris Ham, Chief Executive of The King's Fund, Jan 2012.**

Community QuESTT
New or no line manager in post (within last 6 months)
Monthly review of key quality indicators
Planned annual appraisals performed
Able to attend planned team meetings, training and/or special interest groups this month
Formal feedback obtained from patients in last 3 months
2 or more formal complaints in a month
Learning from incidents/complaints has been shared, actioned and implemented this month
Evidence of resolution to recurring themes from incidents/complaints this month
Unusual demands on service exceeding capacity to deliver this month
Office base/department appears untidy
Currently more than 1 on-going RCA investigation
Date of oldest referral
5 day target for intermediate care achieved
All staff have received professional/clinical supervision

Taking the learning from the first Francis Report (2010) and building on the successful implementation of the Quality and Effectiveness Tool in our community hospitals, reported last year, we have now developed a similar tool that will provide information for managers on key quality indicators including safety incidents, complaints, staffing levels, sickness rates and other quality markers. The indicators are based upon the recommendation of the Francis report into the failings identified at the Mid Staffordshire Foundation Trust. Having all of this information available in one report allows General Managers and Heads of Professions to ensure communication and appropriate supportive interventions are available for any teams who are experiencing unusual demands and safety concerns.

The first community QuESTT was completed across community Occupational Therapy, Physiotherapy, Social Work (Torbay) and Nursing Teams in October 2012 and also the learning disability service and older people's mental health services. Further work is continuing to ensure that this reporting is used to ensure most effective use of resources and that where necessary support is provided to improve the care we provide.

The Community QuESTT is very similar to the hospital QuESTT introduced in 2011 but measures vary slightly to measure the quality and effectiveness of community team work. The table opposite provides an indication of some of the additional areas that we monitor in addition to the general measures of vacancy and absence rates, staff appraisal and client feedback.

The monitoring tool is supported by a protocol that defines the level of support to be provided to teams who are experiencing abnormal pressures on quality and effectiveness. This tool is seen as an early indicator of the need for support and is not used as a performance measure encouraging open and honest reporting.

Scores of 16 and over trigger a response from the professional practice team and manager, the supportive actions taken depend upon the score and factors that have been highlighted as a concern. The community nursing, occupational therapy, physiotherapy, adult social care and public health teams are now providing regular reports using this tool. An example of scores reported in December 2012 below provides an insight into the dashboard used. These scores are not taken in isolation but used as part of a more sophisticated monitoring of quality and effectiveness. Monthly scores in isolation are helpful but greatest benefit can be achieved by looking at trends in monthly scores over a minimum of three months. This work will continue in 2013-14 to ensure that reporting is consistent and sustainable.

QuESTT scores for December 2012 Occupational Therapy and Physiotherapy

	Torbay Locality - Physio Teams					Torbay Locality - O.T. Teams					Southern Devon Locality - Physio Teams								Southern Devon Locality - O.T. Teams							
Community QuESTT	Brixham	Paignton	Torquay North	Torquay South	Community Stroke/ABI/Neuro Torbay	Brixham	Paignton	Torquay North	Torquay South	Community Stroke/ABI/Neuro Torbay	Coastal	Dartmouth	Ivybridge	Kingsbridge	Moorland	Newton Abbot	Tavistock	Totnes	Community Neuro Teignbridge	Coastal	Dartmouth	Ivybridge	Kingsbridge	Moorland	Newton Abbot	Tavistock	Totnes	Community Neuro Teignbridge
Rating and Total Score	6	10	8	6	4	4	4	14		6	4	5	4	7	8	7	5	8		10	1	6	9	2	8	3	0	

We are currently working with independent care providers to develop a version of the QuESTT for use in local care homes. There are currently 13 care homes using this tool across Torbay with others very interested in adopting it next year. We intend to continue this work with the implementation of the tool in August 2013 in more areas of the Bay. The Trust has a project group that monitors the results and roll out of the care home QuESTT.

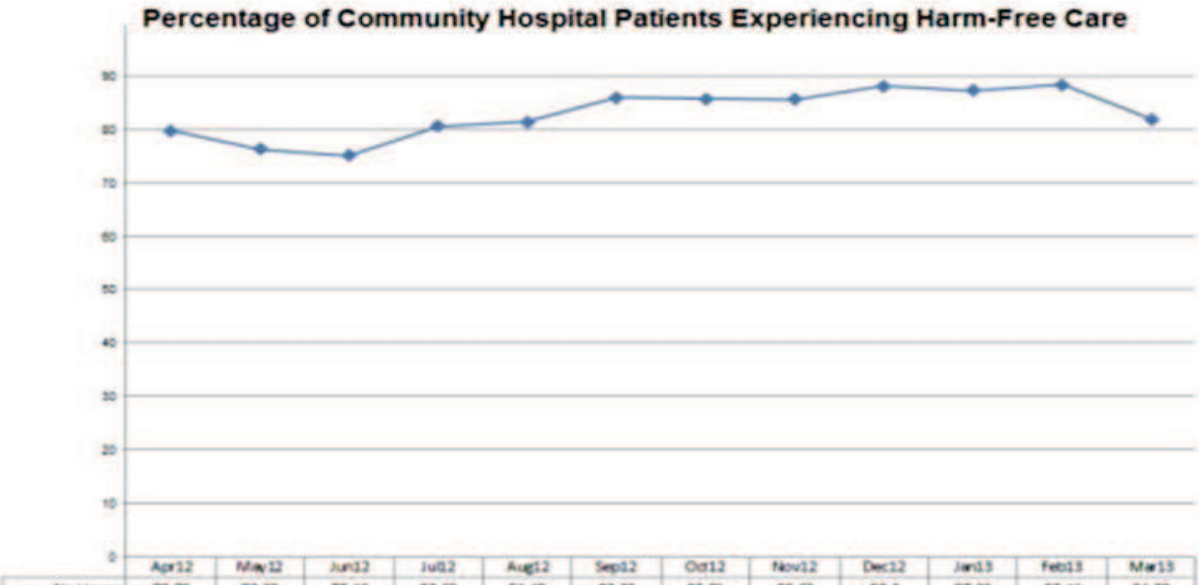
National Safety Thermometer

- ***We said we would implement the National Safety Thermometer in 2012.***

This has been successfully completed with our community hospitals with developmental work underway to spread this across all services in the community. This tool allows us to measure the level of harm free care provided to our patients, looking particularly at the incidence of four harms:

- Pressure Ulcers
- Urinary tract infection in patients using a urinary catheter
- Falls resulting in harm
- Venous thromboembolism (VTE)

The National Safety Thermometer will feature in our quality improvement intentions this year as we now use the baseline data collected during 2012 to measure the effect of quality and safety improvement work undertaken in 2013. Figures below illustrate the Trust results for 2012-13.



	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12	Jan13	Feb13	Mar13
No Harms	79.76	76.33	75.16	80.62	81.48	85.99	85.81	85.63	88.2	87.36	88.44	81.98
Patients	168	169	153	160	162	157	155	167	178	174	173	172

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for Venous Thromboembolism. The first year of this scheme has enabled us to establish and refine our data collection systems, train our staff in collecting the data and identify priorities for improvement.

The tool is called the NHS Safety Thermometer because it takes only minimum set of data that helps to signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement. Now that the Trust has collected 12 months of data we are in a position to begin to use the data to measure safety improvements. In 2013/14 we intend to use the same system to collect data for patients in their own homes, this data will allow us to measure community wide safety improvements in the future.

It should be noted that the tool was designed to measure local improvement over time and should not be used to compare organisations. There are differences in data collection methods and patient mix, which can invalidate comparison across organisations. For example, trusts that have a high percentage of older patients or specialist services may present with more harms on this measure.

Reducing Harm from Falls

- ***We said we would continue to reduce the level of harm sustained from falls in our community hospitals***

Awareness continues to improve with over 400 staff from the Trust, care homes and care agencies attending our foundation falls awareness course. All the care homes in Torbay receive bespoke training on falls prevention and bone health by the fracture liaison nurses to

improve compliance with bone health medication and reduce the risk of residents sustaining hip fractures. There is now a network of falls and bone health champions across the care homes to promote and support this work.

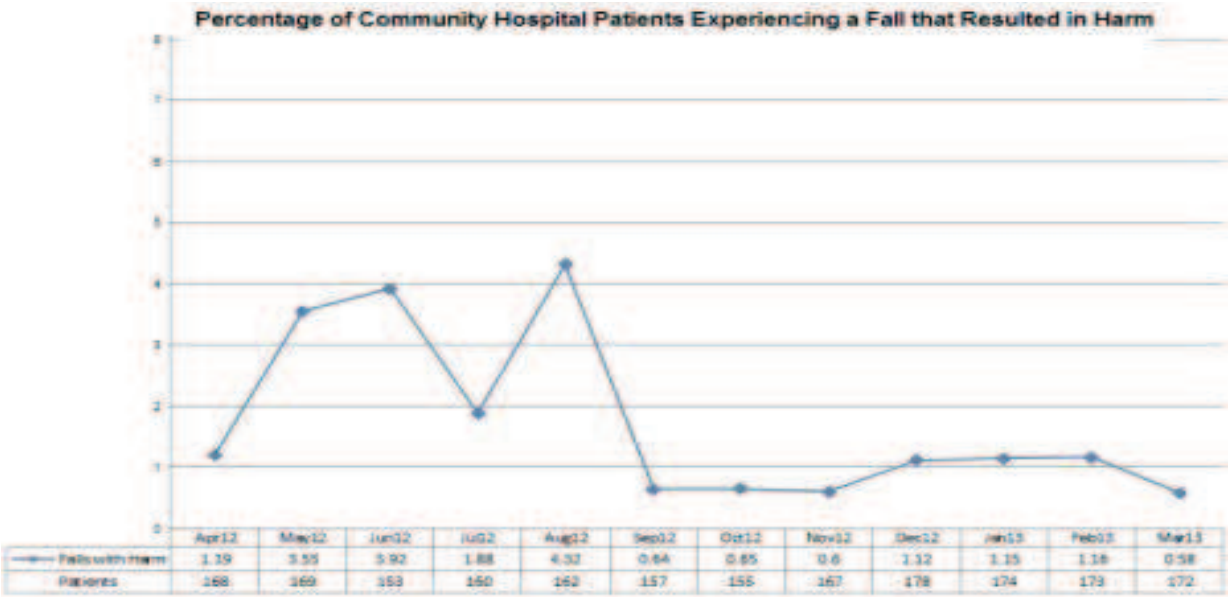
Over 300 members of the public attended a successful Active for Life day at Oldway Mansions in Paignton our evaluation demonstrated the benefits of this kind of event. With 87% being reminded about their activity levels, 67% about their bone health, 69% about falls prevention and 62% about their diet.

The postural stability strength and balance groups remain in high demand and we hope to increase and replicate this service in Southern Devon in the next year. Analysis of the outcomes demonstrated that people attending the whole course are less likely to have a hospital admission.

Multifactorial falls assessments are now carried out by health teams across Torbay and Southern Devon and we are working to ensure that they are carried out at the right time for the right group of patients. Six surgeries in Torbay and Southern Devon are involved in a national trial called PreFIT regarding the most effective treatment for people who fall.

Falls in Community Hospitals

We are experiencing an increase of near miss and no harm incidents associated with falls in our community hospitals due to successful awareness raising and training, leading to more appropriate reporting, along with a new simpler reporting system. As a consequence we are seeing early intervention being put in place for vulnerable people and a decrease in our harm from fall incidents.



One example of the preventative work undertaken includes the introduction of falls champions; staff with particular responsibility regarding falls prevention in each of the community hospitals who provide a regular short training programme, '15 minutes to stop a fall'. The recent launch of the Royal College of Physicians Fall Safe project is keeping falls prevention at the top of the hospital's agendas.

Infection control

- ***We said we would continue to reduce MRSA bloodstream and Clostridium Difficile infections in 2012-13 using our performance last year to measure this improvement.***

Whilst we did not reduce our incidence of MRSA bacteraemia we did sustain the level of the previous year with 2 cases. We narrowly missed our target to reduce the incidence of Clostridium Difficile with 115 against a target of 108. The Trust infection control team are working collaboratively with consultant microbiologists and others specialists in their efforts to reduce the incidence of this infection. We wish to reassure the public that our Director with special responsibility for infection prevention and control is involved in the work being undertaken and reports to the Board regularly on progress of the work and incidence of infections. We will continue to report and investigate Clostridium Difficile infections sharing any learning with colleagues across the health community during 2013/14.

We did achieve our target for the incidence of MRSA bacteraemia Target 2 cases 2.

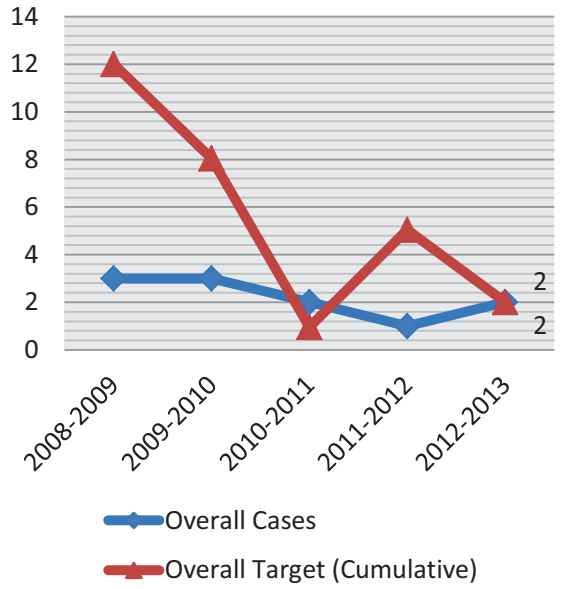


Figure 1: Mandatory Surveillance of MRSA Bacteraemia by Financial Year (Plotting cases against local Target)

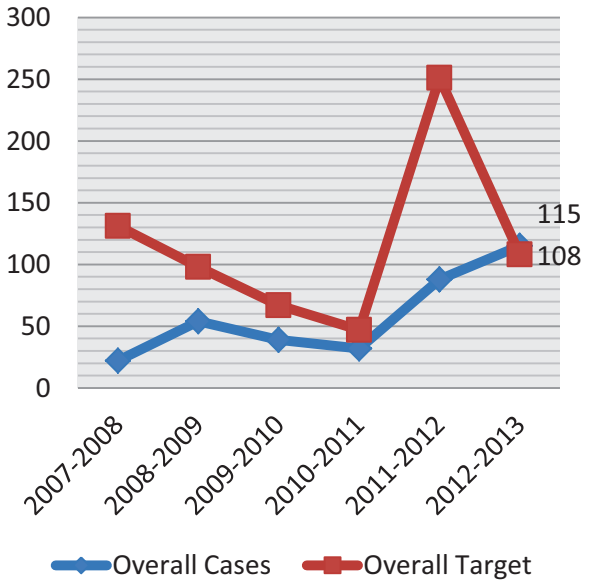


Figure 2: Mandatory Surveillance of CDT by Financial Year (Plotting cases against local target)

We will continue to prioritise this work and do all that we can to reduce the incidence against targets set for 2013-14.

Effectiveness

Celebrating our NHSLA Assessment Success

The NHS Litigation Authority (NSHLA) manages the negligence and other claims against the NHS in England on behalf of member organisations. A key role of the NHSLA is to contribute to improvements in the safety of NHS patients and staff. An important aspect of this work is to enable and encourage learning by sharing information and knowledge on the clinical and non-clinical claims that they manage with the NHS.

The Trust was successful in achieving Level 1 of the NHSLA Risk Management Standards in December 2012. The full report will be published on the NHSLA website shortly and can be accessed using the following link:

http://www.nhsla.com/Pages/Publications.aspx?library=safety%7cassessments
As part of the findings the NHSLA stated that "The assessment had been prepared for thoroughly and the evidence presented clearly".

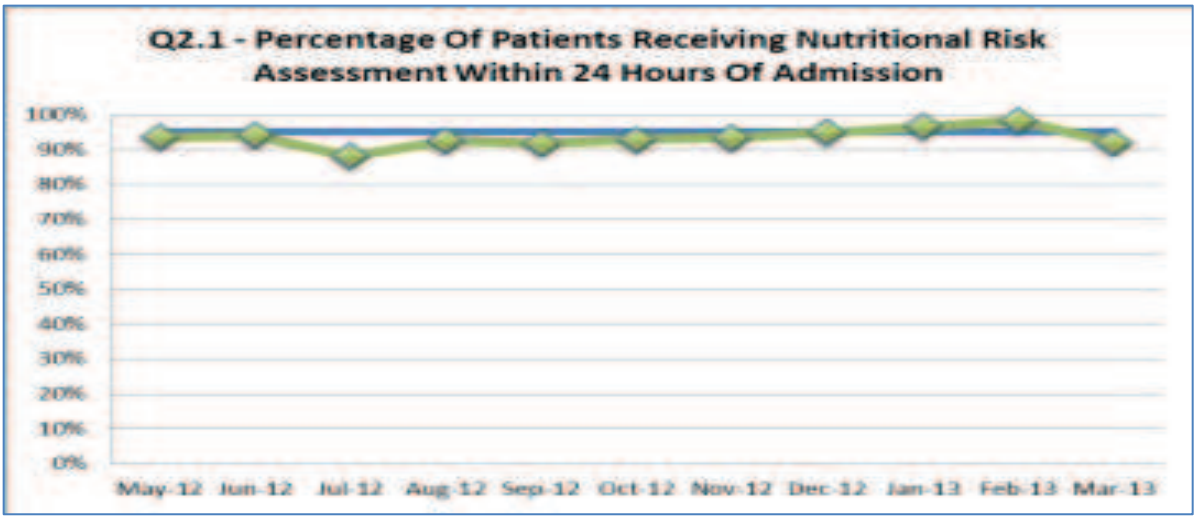
Nutritional care

- ***We said that we would improve services for older people in our community hospitals.***

The Care Quality Commission Report "dignity and nutrition for older people" focused upon two outcomes in their review of services in 2011 with further reviews undertaken in 2012.

- Outcome 1, 'respecting and involving people who use services,' and
- Outcome 5, 'meeting nutritional needs'. We have monitored our performance during the year with the results demonstrating that:
  100% of nutritional care plans were reviewed after one week (Feb 13)
  96.6% of patients had a full nutritional assessment within 24 hours of admission

The Trust recognises the importance nutritional wellbeing plays in a person's recovery from illness with Ward able to offer snacks and drinks at any time.



With the publication of the 2nd Francis Report in February 2013 we are aware of the many patient and public concerns regarding the quality of food served to patients and how ward staff support those who due to illness find it difficult to eat. We are very aware that nutrition if a key element in a patients recovery and continued well-being including the healing of wounds and pressure ulcers. The data illustrated above confirms that we do take this seriously with care plans developed that reflect any risks identified, this data is reported to the Trust Board monthly. The Trust PEAT results (see page 29) are another method used to assess the quality of food provided in our hospitals.

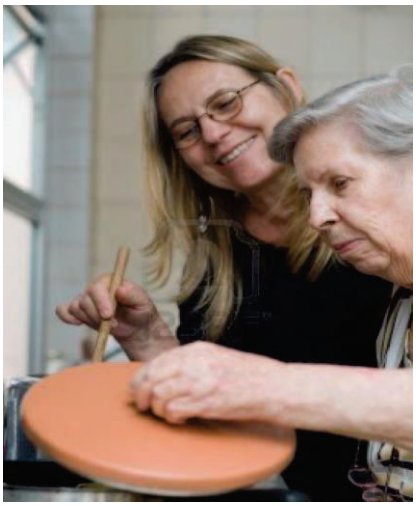
As part of the Trust Non-executive Directors quality assurance role regular visits are undertaken to care teams, at a recent visit to Brixham Hospital the visiting Director commented that:

"*Patients were well supported at the meal time with personal service from the nurses and health care assistants. This was impressive with each person clear about the needs and appetite of the patient being served".*

- ***We said we would develop services to increase peoples independence after discharge from hospital***

The Trust priority to help people to regain their independence after a period of illness is important to the individual and their family. In providing enhanced reablement services we have been able to support people's confidence and their self-care. The project introduced in August 2012 has demonstrated that by setting individual goals for people and working with them to achieve them we have made a difference their quality of life. The Trust Intensive home Support Service (IHSS) received training in setting patient goals and other aspects of reablement as part of this project.

Of the clients that completed the programme 80% experienced improvement in their independence. Of those 61% were fully independent/fully reabled and 20% were partly, in 15% there was no difference and 4% were less reabled due to deterioration in their long term health conditions. The case studies below offer examples of the impact these services have had on two individuals and their families and/or carers.



Case Study 1

Mrs Smith was admitted to Torbay Hospital following a stroke affecting her right side. She had previously been independent and lived alone. Although she remained independently mobile with help of a walking aid following her stroke, she had difficulty managing her personal care tasks such as washing and dressing and preparing meals and snacks. She also needed further practice in managing her own medications.

She was referred to the IHSS Reablement team for ongoing support to continue to practice these activities. With guidance with the Early Supported Discharge team therapists, the IHSS support workers encouraged Mrs Smith to practice these tasks every day.

After six weeks, Mrs Smith was completely independent again and managing her personal care, meals and medication. She was discharged requiring no on-going package of care.

Case study 2

Mr Smith had planned hip surgery for pain. During his stay in hospital he became unwell with a urinary tract infection. This also affected his mood and motivation and on discharge from hospital he had ongoing confusion. He had difficulty managing his medication independently and managing his meals.

He was referred to the IHSS Reablement team to encourage him to be more independent in his personal care and to encourage him to return to his previous level of function. Due to the confusion and issues around motivation initially, Mr Smith's reablement programme was devised by the team lead to be graded. Initially his focus was on learning to manage his medication more effectively, and the later stage of the programme included outdoors mobility practice and meal preparation.

After five weeks, Mr Smith was completely independent

- ***We said we would improve services for people with a dementia implementing the National Dementia Standards***

The National Dementia Strategy has provided a set of standards for caring for patient in hospitals who have a dementia. We have dementia champions n all or our community hospitals who are committed to improving understanding or dementia and simple things we can do to improve the patient's experience. Improvements we are making include:

- Changing the colour of the skirting boards and door frames so that the boundaries of the room are much clearer.
- Altering the colour of the grab rails in toilets to ensure that they are much more visible.

- Extending the signage project already implemented within hospital wards to the whole hospital
- Purchasing dementia friendly bold coloured crockery for all units
- Purchasing dementia friendly clocks in all hospital units
- Improving the information about patients on admission that allows staff to get to know them and understand the people or memories that are important to them.

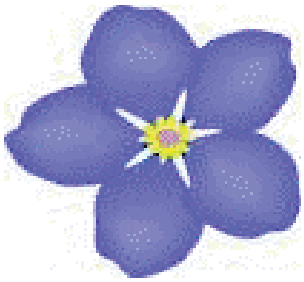
All community hospital champions deliver education for all staff allowing them to gain a greater understanding of dementia and how best to support patients whilst in hospital.

'Dementia Friendly' signage is currently being produced for all our Community Hospitals Signs including all bathrooms, lounges and dining rooms.

Dementia friendly crockery

New signage for all hospital wards

Dementia Friendly Clock



These are the 'Forget me not' symbols used in our hospitals as an 'alert' system for medical and other clinical notes.

Patent Experience

- ***We said that we would listen to people who used our services allowing us to constantly review and strive to improve the patient's experience. We have introduced the "Friends and Family Test" across our community hospitals.***

In October the Department of Health published the latest guidance for the implementation of the 'Friends and Family Test' for the NHS. Since February 2013 we have asked all community hospital inpatients and minor injury attendees over 16 years old the question, 'How likely are you to recommend our services to your friends and family if they need similar care or treatment?' There are further questions included in the questionnaire which relate to dignity and their involvement in care planning. Questionnaires are given out at discharge to either the service user or their representative.

The monthly results and comments from minor injury unit attendees and community hospitals inpatients will be published in line with the guidance from the Department of Health

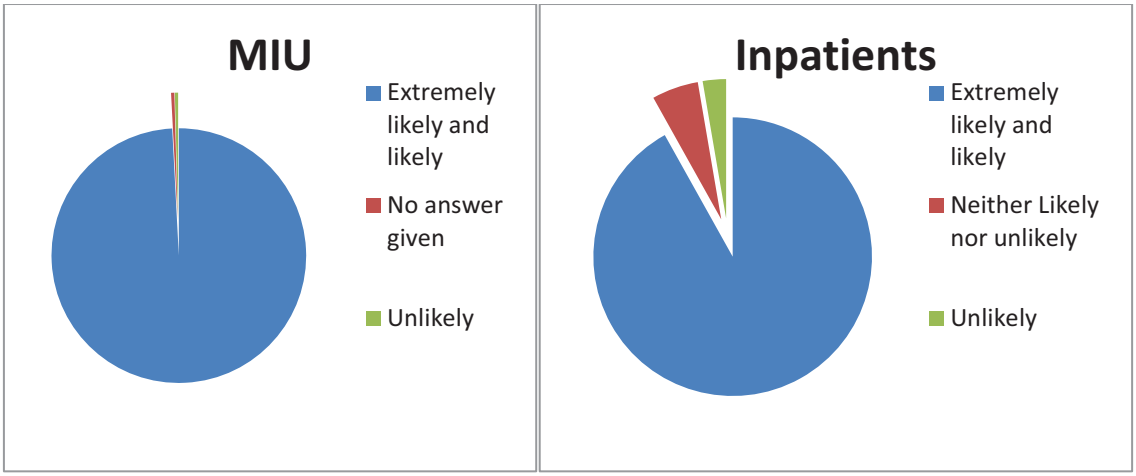
in July 2013. This national reporting will enable bench marking for service users and organisations at a national and local level. It will also allow us to measure the effect of any improvement work undertaken.

We intend to develop other methods of capturing this information through web based services, text messaging and smart phone application. We will also roll-out this questionnaire to other services including adult social care clients in order to collate their experiences and action upon locally (see part 2 of this account). The Trust will also seek to gain more qualitative data with comprehensive service user stories and learning such as the mystery shopper project conducted in North Devon Healthcare NHS Trust.

In March 2013 the majority of Minor Injury Unit attendees and inpatients stated they were extremely likely or likely to recommend our services, with 99% for MIU and 92% for inpatients.

The results for March are shown below:

Question 1: How likely are you to recommend our service to friends and family if they need similar care or treatment?



Comments received from Minor injury unit can be seen below, those that were repeated regularly are in larger print.

Each ward will receive results monthly to allow clinical leaders to address any areas requiring improvement and then assess the effectiveness of any changes made. The intention being that timely feedback is available to keep teams.

We will raise public awareness during 2013-14 to increase the response rate and to explain to service users the importance of the feedback.

- ***We said we would gain feedback from vulnerable adults who have been supported by our safeguarding adult services***.

We have now completed this study listening to peoples experience of the safeguarding process as a result we have developed a list of recommendations that will be implemented to ensure that our services are designed to meet the needs of those we aim to protect from harm.

Feedback received includes:

1. Consider the environment and location of the safeguarding meeting and for the safeguarding person to be involved in this decision. Evidence from our research seemed to indicate that when the location was familiar to the individual their engagement was more relaxed and involvement in the process easier for them.
2. For consideration where a meeting is held in two parts it is more appropriate for the person to be the first in the room rather than enter a room of professionals.
3. Consideration for the same people from all agencies and professionals to remain consistent in meetings and throughout the process, including the chair.
4. Consider person –centred safeguarding meetings as best practice with the right people being present for their contribution they can make rather than a reflection of professional roles e.g.; ensuring the safeguarding person is asked who they would like to attend, not duplicating roles and reducing the possibility of participants feeling overwhelmed. Thus making best use of resources available.
5. Design a range of information leaflets alongside service users to reflect the different parts of the process and the agencies that will be involved.

Community Nursing Services

- ***We said we would implement an on-going patient experience feedback process.***

All patients discharged from our service are provided with a short questionnaire, with pre-paid envelope. The tool used has been adapted from the NHS Institutes Productive series 'patient perspective' module. All responses are reported quarterly.

Results from the 61 completed surveys returned between April and December 2012:

- 96% of respondents stated that they had confidence in the person who visited them
- 85% of respondents stated that they were involved in the decisions about their care
- 97% stated that they felt they had been treated with dignity and respect
- 97% were satisfied with their care overall
- 84% were given information about how to contact their community nursing team

We have developed some actions to help us address areas for improvement and these include trialling the use of appointment slips to give patients and carers an approximate time of our next visit and also improving the provision of information to patients about how we may use and share their information.

Community nursing services in Southern Devon are carried out a similar survey in January 2013 as part of their productive series modules.

Recognised, Valued, Supported

- ***We achieved a greater understanding of the causes of Carer breakdown***

This priority was aimed at recognising early those carers at risk of crisis, in order to facilitate early intervention. The paper 'Carers as Partners in Hospital Discharge' (ADASS 2010) highlighted the period immediately after a 'cared for' person is discharged from hospital as very stressful for the carer.

A literature review was undertaken and a local carer survey developed to identify those factors that most help carers and reduce the likelihood of crisis or breakdown.

A key outcome of the vision set out in government's Carers Strategy - 'Recognised, Valued and Supported' (2010) is that "carers will be supported to stay mentally and physically well and be treated with dignity".

It is well recognised that some carers do not receive the support they need until they reach crisis. The aim of this work is to develop a mechanism whereby those at risk of breakdown are recognised early and receive the support they need and deserve.
The three areas highlighted most frequently requiring improvement are:

1 Raising Carer awareness amongst key staff
2 Follow up phone calls for carers of patients discharged from Community Hospitals
3 Providing Carers with contact details for support post discharge

Carer Awareness for staff

- to maintain the existing awareness raising activity in Torbay Hospital by Steve Black Carers Support Worker
- to reinstate weekly visits to Brixham and Paignton Community hospital wards by the Signposts Information Officer from January 2013
- to undertake a programme of Carer Awareness training for community teams, and Community Hospital staff (Jan – March 2013)

Follow Up calls

- Carers / patients to be contacted by phone 48 hrs after discharge of patients from Paignton and Brixham Community Hospitals to identify if further support is needed and appropriate action taken.

Contact Card for Carer

- Produce a Carers Contact card with key information of where to get support if needed. Card to be given to Carers (or patients) at point of discharge from Torbay Hospital and Community Hospitals

This initial work will be reviewed and then spread across all our services during 2013

Improving care by “Building Bridges”

Additional work that is being undertaken to improve the patients experience in our community hospitals and other care settings includes the “Building Bridges” project led by Norms McNamara with the Torbay Dementia Action Alliance promoting *joined up care* between nurses and carers. The projects aim is to support and provide information to Nurses from the patient’s carer themselves, involving them in the patients care and learning from their experiences, to provide the best care for the patient using the information from the people that know them best.
This project supports the fact that carers know the patient, their likes and dislikes and anything that can cause them distress. In working together we will provide a much improved quality of experience for the patient with dementia who is often unable to communicate their thoughts and wishes. This can include bathing, assistance at mealtimes as well as involvement in some aspects of rehabilitation, and generally empowering carers to become more involved in aspects of patient care if they wish to do so.

- **We said we would maintain peoples dignity in hospital**

Staff are delighted to be able to provide services within the enhanced environment at Teignmouth Community Hospital

.

The Trust is continuous reviewing and improving the facilities available to patients and staff with specific focus on infection control, privacy and dignity and safety. In 2012 the Trust in partnership with the Hospital League of Friends improved the facilities at Teignmouth Hospital including a new reception and waiting area for patients, single sex recovery areas and new changing facilities, improving the privacy and dignity for patients using their surgical theatre. The work also included improvements to the clinical areas to improve efficiency and safety.

In 2012 the Trust undertook its routine Patient Environmental Action Team Assessments, assessing the cleanliness, infection control, food and environmental series in all our hospitals. The table below illustrates this year's results.

Hospital	Environment Score	Food Score	Privacy & Dignity Score
PAIGNTON	4 Good	5 Excellent	4 Good
BRIXHAM	5 Excellent	5 Excellent	5 Excellent
ASHBURTON AND BUCKFASTLEIGH	5 Excellent	5 Excellent	5 Excellent
DARTMOUTH	5 Excellent	5 Excellent	5 Excellent
DAWLISH	5 Excellent	5 Excellent	5 Excellent
NEWTON ABBOT	5 Excellent	5 Excellent	5 Excellent
TEIGNMOUTH	5 Excellent	5 Excellent	5 Excellent
TOTNES	5 Excellent	5 Excellent	5 Excellent
BOVEY TRACEY	5 Excellent	5 Excellent	4 Good
SOUTH HAMS (KINGSBRIDGE)	5 Excellent	5 Excellent	5 Excellent
TAVISTOCK	5 Excellent	5 Excellent	4 Good

Overall the Trust achieved 29 **Excellent** scores from a possible 33, over the 3 categories. The Trust also achieved four Good scores in the remaining categories - three for Privacy and Dignity at Paignton, Bovey Tracey and Tavistock hospitals and one for the Environment at Paignton hospital.

The concerted effort from the Facilities, Infection Control and Estates Teams together with the hospital staff, has resulted in on-going improving in all the Trust's hospital environments. With an increased staff awareness overall there is an increasing pride in local services and better communication and working relationships both in and between the various sites and services.

On 6th January 2012, the Prime Minister announced the replacement of the Patient Environment Assessment Team programme of assessments with a new patient-led inspection programme (Patient-Led Assessments of the Care Environment) from April 2013.

The revised process and assessment will continue in collaboration between hospital staff and patient assessors; however, there will be greater involvement of patients in the assessment - both in terms of their numbers and their role. The term 'patient assessor' in this context applies to anyone whose experience of healthcare is as a user of services. Therefore patients, their family, carers, patient advocates and volunteers would all qualify to act as patient assessors.

Anyone wishing to be involved in this programme should contact their local hospital in the first instance.

Review Section

This will include responses form the Overview and Scrutiny Committee, Clinical Commissioning Group and HealthWatch as a part of the consultation process during May 2013

Report of Quality Account Priorities 2012/13

Appendix 1

N.B. RAG rating Red (R) = no progress | Amber/Red (A/R) some progress but risk of not achieving outcome

Amber Green (A/G)= on target for full compliance | Green(G)= outcome achieved

National Priorities				
	Detail	Lead	**Achievement**	**R;R A;A/ G;G**
1	We will implement the good examples in the Care Quality Commission's report "Dignity and Nutrition for Older People". treating patients with dignity and respect and training for staff to ensure that patients have care plans that will be outcome focused that will improve services for older people. implementation of the National Institute for Health and Clinical Excellence Quality Standards for Dementia Care,	J Phare	**Dignity questionnaire** The eleven community hospitals all undertake a monthly dignity questionnaire for all in-patients. See section 3 for more information. The Trust had no beaches of the National Standards for Eliminating Mixed Sex Accommodation and PEAT results for 2012 demonstrate a scores of good or excellent in all hospitals **Nutrition for Older People** We have set a standard that all hospital patients will receive a nutritional risk assessment within 24 hours of admission. This is audited monthly through the safety thermometer and has demonstrated an average of 93.5% of patients received this assessment within 24 hours. Over the year 1820 patient's data were audited of which 1702 were risk assessed within 24 hours of admission. A review of the patients nutritional care plan after one week took place on average throughout the year 90% of the time with many months achieving 100% including March 2013. Community Dieticians are able to provide specialist care to patients and train staff/carers in their care. **Quality Standards for Dementia Care** The national standards for dementia care continue to be implemented across the 11 community hospitals by local dementia champions. The champions are responsible for developing practice at a local level and contributing to the dementia steering group whose achievements include the production of an information leaflet for carers/ relatives is being piloted at present and information resources for all staff and relatives and carers. On- site training for all community hospital staff has commenced led by the community hospital matrons. Dementia friendly signage has been installed in all community hospitals, dementia friendly clocks and crockery.	G
2	Implementation of the NHS Safety Thermometer	J Mitchell	100% of our community hospitals have completed and submitted data monthly since April for the National Safety Thermometer. All submissions have taken place within the required timescales. Headline reports are distributed to clinical areas assist in reviews, promote improvement work and prompt discussion where necessary. With a full years data it is anticipated that safety improvement work will now be able to be monitored using this tool as a high level trend indicator.	G
3	We will develop a feedback survey for those people receiving care in the community.	L Webber	Community Nursing Services have implemented an on-going patient experience feedback process. All patients discharged from our service are provided with a short questionnaire and reply paid envelope. The tool used has been adapted from the NHS Institutes Productive series 'patient perspective' module. Responses are reported quarterly. One of the actions being implemented from feedback in Torbay includes the introduction of an 'appointment card' for patients providing the day/date and approx. time of next nurse visit.	G

National Priorities				
	Detail	Lead	**Achievement**	**R;RA;A/G;G**
4	To reduce MRSA bloodstream and Clostridium Difficile infections in 2012/13 using our performance last year to measure this improvement.	N Illingworth	We continue to report and investigate C Difficile infections sharing any learning with colleagues across the health community. Despite following best practice in prescribing and care we narrowly missed our aspiration to reduce the number of cases at the end of this target year. The target of 108 was exceeded by 7 to a total of 115 cases. We have been relentless in our efforts to investigate cases and interrogate data to identify any possible causes of C Difficile infection with special focus upon patients where there have been recurrent infections. MRSA bacteraemia Target achieved with 2 cases against a target of 2.	R A
5	To achieve level 2 compliance in medicines reconciliation as directed by the National Patient Safety Agency (NPSA) and the National Institute of Clinical Excellence (NICE).	P Humphriss	Medicines reconciliation Stage 2 continues to be reported as part of the Quality dashboard. Monthly sampling of drug charts are undertaken to monitor Stage 2 compliance as in excess of 60%. The Medical Director is working with doctors responsible for Medicines Reconciliation Stage 2 within the community hospitals; this will be to be included in the Medical contract from April 2013. A new drug chart has been developed for use across the whole organisation which will standardise paperwork and support the reconciliation process, after a slight delay it is anticipated to be implemented by May 2013. The monthly sampling data collection tool is to be reconfigured in line with policy so that Medicines Reconciliation stage 2 target will be set at 72 hours post admission. This will provide sufficient time for GPs to complete the process if patients are admitted over a weekend when regular medical checks are not available. It is anticipated that this QA priority will remain appropriate for 2013/14 as there is further improvement work to be undertaken in this area	G
6a	We will enhance existing adult and children safeguarding training to ensure that 90% of staff caring for vulnerable adults and children have received the training appropriate to their role.	S Matthews	Current training figures indicate that **89%** of the workforce have received child protection training against a target of 90%. We anticipate that we will achieve 90% within the first quarter of 2013/14; however we are pleased to be able to report that this achievement does support improved knowledge and the ability of staff to raise safeguarding concerns and take appropriate action.	G
		J Anthony	Training figures indicate **86%** of staff have received Safeguarding Adults training against the target of 90%. We are delighted to report this level of training despite a number of workload pressure during the winter we have seen a substantial progress toward our aspiration to train 90% of the total workforce. Work will continue to focus on this training during 2013/14 reaching our target of 90% by 31.5.13	A/G

National Priorities				
	Detail	Lead	**Achievement**	**R;RA;A/G;G**
6b	We will develop a method to measure service user satisfaction with our adult safeguarding processes.	J Anthony /Jo Jackson	This has been completed by the Experts by Experience Group who have undertaken feedback interviews with people who have used the safeguarding service the learning from these interviews is contained within the full account. Phase two is now underway as a result of the success of the work undertaken; gathering the views from older people who have been through the safeguarding process. People who wish to participate in the evaluation have been identified with the Older Peoples Mental Health Team and zone teams.	G
7	We will develop, introduce and evaluate a quality and safety monitoring tool for independent health care providers from whom we commission services to ensure service users are treated safely, with consideration for their dignity and respect, and that this care is person centred.	N Barker	Since the project commenced in November 2012 there are now 13 homes both residential and nursing, using the quality monitoring tool as part of the pilot across the bay. The QuESTT data is being collated and analysed for full roll out in 2013/14. Care homes have received information on both the QuESTT tool and the Observational Checklist (OC) that our staff will complete when they visit clients. Both were well received by the homes that agreed that the tool would aide their quality assessment with CQC. The Observation of Care Tool is now fully developed and will be used by the Paignton Community Team and the Older Peoples Mental Health Team and rolled out in early August 2013.	G

National Priorities				
	Detail	Lead	**Achievement**	**R;RA;A/G;G**
8	To further expand our adoption of the productive community service principles by implementing two further productive modules.	L Webber	**Community Nursing (Torbay):** Standardised documentation and monthly care records quality audit continue. A stakeholder 'Vision Day' event identified 4 key improvement areas: • systems, processes & communication , • IT • Skills and competences • Shared care arrangements This work has commenced with: Competency frameworks for all registered nursing staff implemented and a similar framework for support staff in progress. Activity recording, scheduling and allocation processes undergoing review Assessors of practice being developed in all zones to assess the standards of nurses' clinical practice as part of the continual professional development. **Community Nursing feedback** Patient experience feedback has been analysed and shared with key stakeholders and teams. Over 90 % of respondents gave 'strongly agreed' answer to questions in relation to standards of care, involvement in decisions about their care and being treated with dignity & respect. **Multi –disciplinary Zone Teams:** Current work streams on-going within the Productive Care modules include: • OT and Physiotherapy services have a 'live working week' workload data collection and analysis planned for May 2013. • Organisation of satellite equipment stores under review • Telephone 'Hunt system' under review in Brixham (learning to be shared across other zones) • Monthly QuESTT completion in all zones. • Use of white boards for patient status at a glance – further development work within intermediate care. • Intermediate care development of service across Southern Devon areas. Community Nursing teams and Zones MDT will continue to progress workforce and service development and work towards completion of Productive Care modules. The underpinning methodology used will continue to support our future changes.	G

National Priorities				
	Detail	Lead	**Achievement**	**R;RA;A/G;G**
9	To improve access to local level 2 and level 3 obesity services.	L Ware	Obesity services are now available in 10 different venues at different days and times. Patients are now able to attend as many of the various exercise sessions that they wish per week. Level 2 Obesity service- referral Target for year one – 340 referrals. We exceeded this target with a total of 473 referrals received by the service to date. A furhter 136 are starting a programme and 155 still on the waiting list. We set a goal to attract 25% of referrals from deprived wards we have achieved 41.6%. Out of the 57 clients who had both initial and end measurements taken 49 lost weight and 42 reduced waist measurement. The average weight loss is 3.3kg and average reduction in BMI is 1.2units. In order to reduce waiting times the Level 2 programme has 2 programmes commencing every 8 weeks. Level 3 Obesity services- A total of 8 programmes have commenced over the 12 month period. 156 service users have attended the pre-group sessions. The first 2 programmes have been completed. The programmes have used service user feedback to adapt the delivery model in order to insure that we are meeting the needs of the service users and maximising our ability to achieve the desired outcome measures. In order to reduce waiting times the Level 3 service has 2 programmes starting every month.	G
10	To introduce a tool to enable early recognition of carers at risk of crisis	J Drummond	A Carers Discharge 'contact' card has been produced and distributed to Hospitals (acute and community), GP surgeries and other staff. Plan for rollout of cards to Community Nursing agreed. Arrangement to monitor distribution of cards is now in place. (See full report for more information).	G
11	To improve the participation of children and young people who use our Child and Adolescent Mental Health Services – we will implement the 'Hear by Rights' assessment tool.	C Foy	Young Devon appointed to support the implementation of 'hear by Rights' and the IAPT pledges. With young volunteers involved in recruitment of staff in the Child and Adolescent Mental Health Service. Offering improvement ideas for waiting areas for patient's and a "Have your Say Board" for all users to add comments and feedback. Attending staff meetings to support recruitment of service user representatives Contribute to staff training on "participation in practice"	G

Questions contained within the quality account survey for staff, patients and public

1. Please tick one box

Are you a member of staff ☐ Are you a member of the public ☐

Below are 3 areas where new developments in the quality of services we provide, might be made. For each question there are four options. Please indicate which one is the most important one to you.

2. **Thinking about the safety of our patients and service users which of the 4 options below do you believe should be our main priority. Please tick one box**
   - **a.** ☐ To develop quality and safety with our independent sector partners who provide care on our behalf.
   - **b.** ☐ To promote safe, nutritional mealtimes in community hospitals, care homes.
   - **c.** ☐ To reduce the number of falls occurring within community hospitals and residential homes.
   - **d.** ☐ To make sure patients and their carers are fully aware of the medication they are prescribed and how it should be taken.

3. **Thinking about the effectiveness of our services which of the following 4 options do you believe should be our main priority? Please tick one box.**
   - **a.** ☐ To support clients with learning disabilities in achieving personal outcomes.
   - **b.** ☐ To improve care for patients with leg ulcers.
   - **c.** ☐ To develop methods of capturing patient experience in all areas, using nationally recognised measures.
   - **d.** ☐ To work on the prevention of childhood obesity through a family intervention and weight management programme in Torbay.

4. **Thinking about patient experience which of the following 4 options do you believe should be our main priority? Please tick one box.**
   - **a.** ☐ To improve communication and information for patients on how to access care after they are discharged from hospital.
   - **b.** ☐ To develop methods of capturing patient experience in all areas, using nationally recognised measures.
   - **c.** ☐ To develop a programme to identify carers, including those who care for someone with dementia, allowing good support networks to be established.
   - **d.** ☐ To embed Mental Capacity Act and Deprivation of Liberty Safeguards to ensure that people who use services are safeguarded and improve their quality of life with choice and control.

Question	Staff	Public	Total
Thinking about the safety of our patients and service users which of the 4 options below do you believe should be our main priority			
To develop quality and safety with our independent sector partners who provide care on our behalf	57	48	105
To promote safe, nutritional mealtimes in community hospitals, care homes.	8/9	15	23
To reduce the number of falls occurring within community hospitals and residential homes.	16	9	25
To make sure patients and their carers are fully aware of the medication they are prescribed and how it should be taken	32	39	71
Thinking about the effectiveness of our services which of the following 4 options do you believe should be our main priority?			
To support clients with learning disabilities in achieving personal outcomes	29/27	26	55
To improve care for patients with leg ulcers	21	10	31
To develop a preventative educational programme to reduce the uptake of smoking in young people	17	23	40
To work on the prevention of childhood obesity through a family intervention and weight management programme in Torbay	46	52	98
Thinking about patient experience which of the following 4 options do you believe should be our main priority?			
To improve communication and information for patients on how to access care after they are discharged from hospital	45	42	87
To develop methods of capturing patient experience in all areas, using nationally recognised measures	14	13	27
To develop a programme to identify carers, including those who care for someone with dementia, allowing good support networks to be established.	27	41	68
To embed Mental Capacity Act and Deprivation of Liberty Safeguards to ensure that people who use services are safeguarded and improve their quality of life with choice and control.	27	15	42

Clinical Audits undertaken in 2012/13 — Appendix 3

PATIENT SAFETY	
Title	**Key Actions**
Record Keeping (paper and electronic) These audits are completed for each clinical area with local action plans that reflect the standards for record keeping set in Trust policy	This annual audit is completed across all clinical teams with individual action plans in place; reported to the Audit & Effectiveness Committee, results also fed into Information governance Team for monitoring of standards. Trends indicate that further work is required to raise staff awareness of record storage; Improved information at discharge; making alterations to clinical records
Community Nursing Records Audit, undertaken within the Community Nursing Service with action plans that reflect the standards for record keeping set in the Trust policy.	Audit undertaken monthly with results presented quarterly to the Audit & Effectiveness Committee. Audit areas include: Care plan audits, risk assessments, communications, and medication administration records.
VTE prevention These audits measure compliance with NICE standards • % receiving risk assessment (by GP) within 24 hours of admission • % reassessed within 24 hours of admission for risk of VTE and bleeding • % patients/carers offered verbal/written VTE info on admission & discharge	Undertaken monthly, improvements have been made with an average of 95.4% of patients in our community hospitals assessed with 24 hours of admission, 93.4% reassessed within 24hrs of initial assessment and 97% patient/carers offered verbal/written VTE on admission & discharge. ***NB figures above represent mean average for full year results***
Prevention of Pressure Ulcers – • assessment on admission/Care planning/Grade 2+ ulcers • % receiving risk assessment (by nurse) within 12 hours of admission	2012/13 has focused on improvement work in the avoidance of pressure ulcers in hospital wards data shows 96.4% patients received assessments and 94.1% received pressure ulcer care plans. Improvement project is in place to improve this ***NB figures above represent mean average for full year results***
Prevention of Malnutrition – **In-patient Settings** • % receiving risk assessment (by nurse) within 24 hours of admission, % of those at risk receiving care plans ,MUST nutritional assessment care plan for high risk patients and weekly review	Work continues to ensure that this assessment is completed within 24 hours of hospital admission. Data demonstrates some improvements in this area with current target >95% for both categories with the data for each totalling 91.9% & 95.8% respectively.
Nutritional Supplement Audit – To assess if standards are being met regarding waiting time and follow up of domiciliary visits for malnourished patients.	Audit undertaken during the period Feb to April 2012. Results demonstrated a significant increase to the number of referrals for the same period during the last year. • 225 referrals made between Jan to Dec 2010 (average 19 referrals per month • 337 referrals made between June 2011 and May 2012 (average of 28 referrals a month Following presenting the results to the Clinical Audit & Effectiveness Committee a business case was put to Commissioners for additional funding to expand this service in the future.
Prevention of Falls - Assessment on Admission/Care Management Plan for high risk patients, and risk assessment within 24 hours of admission, % of high risk patients with a care plan, & of high risk patients receiving intentional rounding	Monthly audit data demonstrates standards are on target to be met. March 2013 results highlight that 97.7% of patients in our community hospitals receiving assessment within 24 hours of admission.
Medicines Reconciliation - assessment on admission, a minimum of stage 1 to be completed within 24 hours of admission	Work continues to improve results. Monthly audit data demonstrates an improvement in standards. January 2013 results highlight that 80.2% of patients in our community hospitals assessed with 24 hours of admission.
Controlled Drug Audit to monitor safe storage of Drugs	Controlled Drug audit continues to be undertaken by Medicines Management Lead in all community hospitals with recommendations for each ward based on findings and action plans implemented if improvements required. Findings are reported to the Medicines Governance Group.
Missed Drug Dosage; compliance with best practice standards in administration of medicines	Audit in place, undertaken monthly by Dashboard reporting. Improvement evidenced as in Jan 2013, 95 out of a total of 22,427 doses omitted that equates to 0.42%. Work continues to improve this.
Antimicrobial Prescribing to audit the effective prescribing of antibiotics	Audit undertaken annually results not available for this report.
Patient Medication and Administration Record Audit (PMAR) – standard of prescribing for inpatients in Community Hospitals	Twice yearly audit undertaken, Audit undertaken annually to establish a baseline observation of the quality of prescribing standards within community hospitals and highlight areas for improvement. Thorough audit with 'Productive Ward' methodology or 'Safety Crosses' to be utilised to ensure compliance with required standards.
Safeguarding Children adherence to policies and procedures	Annual audit, progress reports presented to Clinical Audit & Effectiveness Comm. Results presented to Torbay Safeguarding Children's Board. Action plan and re-audit scheduled in place.

PATIENT EXPERIENCE	
Title	**Key Actions**
Infection Control - Sharps/IPS/MRSA/Mattresses & equipment	Audits undertaken by the infection control team and reported to the Infection Control Committee. January 2013 HCAI results ranges between 80% to 100% compliance with Hand Washing, averaging 90% for the Trust. Robust action planning is in place to address issues from audit led by Hospital Matrons.
Safety Thermometer – harm free care for Community Hospital patients and future plans to capture Community Nursing data.	Monthly audit undertaken for local Community Hospitals, to with 100% compliance. Plans underway to incorporate Community Nursing from April 2013. (See main Quality Account document)
Patient Experience - patient survey results, measures of improvement against national inpatient survey and 5 national inpatient survey questions. (This will be replaced by Friends & Family)	Positive results received to date, on track with action planning. Questionnaires undertaken during Feb 2013, results: **For MIUs** • Out of 200 responses, 99% stated they would be extremely likely to recommend the MIU Unit to their friends and family, with the remaining 85 stating likely to recommend. **Community Hospitals Inpatients** • 92% stated extremely like to recommend, Matrons undertake local actions when feedback is required, both good and sub optimal feedback.
Privacy & Dignity in Community Hospitals Eliminating same sex accommodation	Monthly audit captured via Dashboard, no breaches of ESMA standards to date, Positive feedback from patients with very few exceptions. (See full Quality Account Report.)
Personalised Care plans, care records are audited to identify engagement with patient family and carers in their development	Action plans are in place and care plans reviewed to ensure that they reflect a personalised approach to recording care planning. Monthly audits undertaken.
PEAT - Privacy & Dignity, Environment & Food, now re-named PLACE = Patient Led Assessment of Clinical Environment	All Community Hospitals have either scored good or excellent in this audit, 29 excellent and 4 good. (See full Quality Account)
Community Nursing Patient Satisfaction Survey	Audit results positive to date, work continues to improve service. (See full Quality Account.)
Audit Assessments – patient feedback	Audit commenced in January 2013, data will be available after April 2013..
Community Records Audit (AHPs) – personalisation/CQC requirement	Audit commenced January 2013, results/data will be available post April 2013.
CLINICAL EFFECTIVENESS	
Title	**Key Actions**
Diabetic Foot Problems - in-patient management CG119 assessing the effectiveness of care in compliance with NICE standards	Audit completed and presented to Clinical Audit & Effectiveness Committee, overall good compliance. Key actions from this audit: 1. Development of a new guideline for the management of diabetic foot ulcers specifically in Community Hospitals, focusing on foot inspection and documentation, management and pressure relief of any wounds during the in-patient stay with follow up and referral pathways. 2. To ensure staff attend toe nail cutting training sessions.
Stroke (SINAP Stroke Improvement National Audit) & SSNA (Sentinel Stroke National Audit)	Part of the National Audit Programme undertaken with the Acute Trust, awaiting results.
Dementia Standards: • Dementia Screening - % of patients aged 75 and over admitted by a GP that have been screened using the dementia screening question • Dementia Risk Assessment - % of patients aged 75 and over identified from above as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission to hospital using the hospital dementia risk assessment tool. • Dementia Specialist Diagnosis and Referral - % of patients aged 75 and over identified as at risk of having dementia that are referred for specialist diagnosis.	Audit data collected quarterly for all patients admitted directly to Community Hospitals, to monitor compliance with Dementia Assessment Standards. The current total for each area within Dementia Standard is 90%.
End of Life Care – Planning & Management – CQUIN/National – End of life care strategy	Data collected monthly that reflects the percentage of patients with completed Treatment Escalation Plan in Community Hospitals. Action plan on track with an average of 94.5% of patients having a TEP completed.

Mental Capacity Assessment Project (re-audit) – Safeguarding/CQC Outcomes/MCA	A monthly audit where the Trust has the target of >75% to have a Mental Capacity Act Form completed plus the appropriate care planning. Data for the year reflects an on-going improvement, on average 81.6% of patients in our Community Hospitals that do not have mental capacity have an MCA form completed and appropriate care planning. Actions include training and further work to improve this.

*Where audits are undertaken monthly, the results contained with this report represent the mean average across the year 2012/2013.

South Devon Healthcare NHS
NHS Foundation Trust

Quality Accounts for 2012/13

N.B This is a draft document and a more user friendly version will be designed incorporating graphics and photographs prior to final publication

About this document

What are Quality Accounts and why are they important to you?

South Devon Healthcare NHS Foundation Trust are committed to improving the quality of our services we provide to our patients, their families and carers.

Our 2012/13 Quality Accounts are an annual report of:

- How we have performed over the last year against the quality improvement priorities which we laid out in our 2011/12 Quality Accounts.
- Statements about quality of the NHS services provided.
- How well we are doing compared to other similar hospitals.
- How we have engaged staff, patients, commissioners, Governors, Local Involvement Networks (LINKs) and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year.
- Statements about quality provided by our Commissioners, Governors, OSCs, LINKs and Trust Directors.
- Our quality improvement priorities for the coming year (2013/14).

If you would like to know more information about the quality of services that are delivered at Torbay Hospital, further information is available on our website www.sdhct.nhs.uk

Do you need the document in a different format?

This document is also available in large print, audio, braille and other languages on request. Please contact the Communications team on 01803 656720.

Getting involved

We would like to hear your views on our Quality Accounts. If you are interested in commenting or seeing how you can get involved in providing input into the Trust's future quality improvement priorities, please contact susan.martin@nhs.net or telephone 01803 655701.

Contents

Part 1: Introduction & statement of quality from the Chief Executive

I am delighted to present the South Devon Healthcare NHS Foundation Trust Quality Account for 2012/13. The purpose of this report is to promote the quality of service provision provided at Torbay Hospital in a way that's open and transparent.

We believe that quality is at the heart of everything we do, whether its nurses and doctors caring for patients on wards or IT services ensuring we have the tools to help us do our jobs on a daily basis.

This Quality Account is a reflection of the work we have undertaken during the year and clearly demonstrates how we have achieved continued success at the hospital.

As a qualified nurse with a focus on care and compassion notable highlights include the ward-based projects such as the 'productive ward' and the end-of-life care work. Both have a direct impact on the way people experience our services and the quality of care we offer.

We will continue to focus on improving the quality of services at the front line and this is reflected in the 2013/14 priorities agreed with local stakeholders including Governors, Local Involvement Networks (now HealthWatch Devon), Commissioners and Councils.

We know that 2013/14 will be a challenging year but with the development of our joined-up vision of health and care with our health and social care partners, we believe that through working together we can deliver a continued programme of improvement across services bringing a wide range of benefits to our local community in South Devon and Torbay.

I hope you will find this year's Quality Account informative and stimulating. I confirm that, to the best of my knowledge, the information in this document is accurate

Paula Vasco-Knight,
Chief Executive

Part 2: Priorities for improvement

Looking back: 2012/13

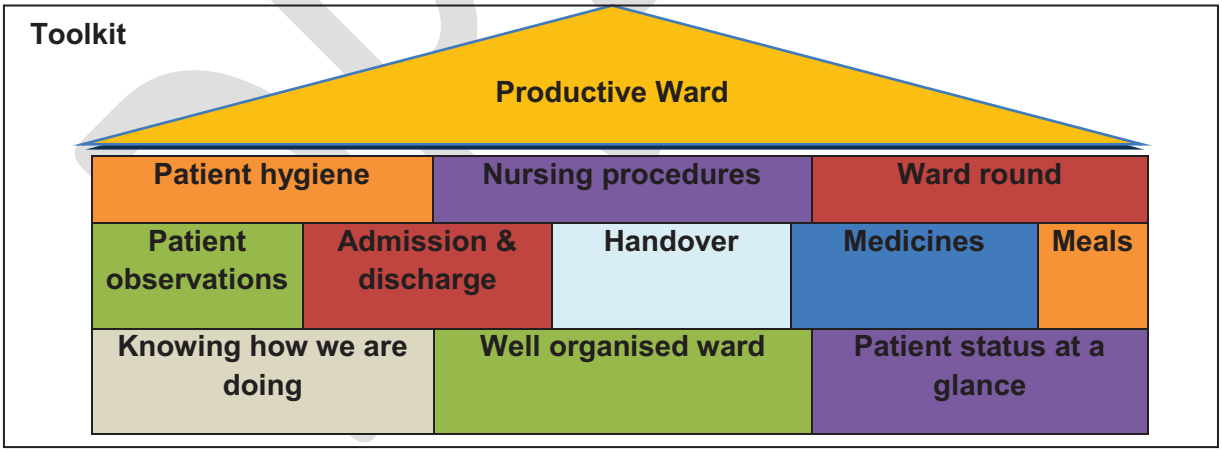
In our 2011/12 Quality Accounts we reported that we would focus on five priority areas for quality improvement in the period 2012/13. These were all locally agreed priorities based on national best practice and best clinical evidence.

Patient safety

Priority 1: To improve the wards using the Productive Ward methodology

The Productive Ward programme is a proven national approach to improving quality by helping ward teams to redesign and streamline the way nursing staff work to release time back to direct patient care. The time released back to patient care is then invested in patient safety work, therefore ultimately improving patient outcomes and experience.

The ward team work through a number of modules from a national toolkit and this has been the second and final year of the Productive Ward programme as a standalone project.



Over the last two years there have been significant improvements evidenced through:

- **Increased awareness and understanding of 'Knowing How We're Doing'**
  The ward teams have set up a Productive Ward board to communicate with staff about planned improvements such as handovers, share successes and learn from tests of change which did not result in the expected benefits. Weekly 'huddles' have been established on some wards to allow staff to come together and make changes quickly.

- **Increased staff empowerment and ward engagement**
  Ward teams run PDSA (plan, do, study, act) cycles to improve their services, supported by their ward manager, matron and the Trust's Ward Improvement Group. All the ward improvements have been identified, tested and implemented by front line staff.

"The Productive Ward has allowed nurses to feel empowered to make changes to care.

The nursing team feel involved in changes that happen in the ward area.

In addition, the Productive Ward is a good benchmarking tool".

Ward Manager

- **Development of Visual Management Boards**
  Operational Status at a Glance boards have been established on the wards to give all staff and visitors information about the clinical team allocated across the area, therefore reducing interruptions to the ward team and releasing time back to care.

  Swiftplus boards have also been set up across the Trust, as part of another ward improvement project. The ward teams are now using the boards to support the regular running of the ward and at the daily multidisciplinary board round to support on-going care planning and future discharge.

- **Improved medicines management**
  Medication rounds have been improved by developing a pre-medicine round checklist to ensure that the correct equipment and medication is available at the point of need. Medicines stock levels are also regularly reviewed on each ward to ensure there is no unnecessary waste.

- **More efficient handovers**
  The time taken for a morning handover has been reduced from approximately 40 minutes per nurse per shift to 15 minutes per nurse per shift as a result of the development of standardised procedures.

  Ward teams have also implemented bedside/meet and greet handover processes that involve patients and their carers in the handover process.

As a result of completing the productive ward toolkit over the last two years, time has been released on all in-patient wards back to front line care, resulting in improved efficiency, patient safety and better patient experiences.

In 2013/14 the ward teams will continue to revisit the productive ward modules, continuously improving systems and processes to increase the quality of ward based

services. The productive ward way of working will also support the roll out of the enhanced recovery in medicine project across the medical wards. (see page x)

Priority 2: To improve the quality of medicines information provided to patients, families and carers

Most medication supplied to patients, either at discharge or following an outpatient consultation, is accompanied with a patient information leaflet produced by the manufacturer of the medicine.

Sometimes this information is hard to interpret and the size of the print makes it difficult for some patients to read. For patients it is important that these leaflets are kept and read again when circumstances change e.g. when starting or stopping medication.

Over the last 12 months, Pharmacy has focused on improving medication information of 'High Risk Medicines'. These medicines are the ones that are associated with serious adverse effects or are medicines that need to be closely monitored whilst being prescribed.

Using national and local data, a list of medicines has been drawn up and designated as 'High Risk Medicines'. From this the current patient information leaflets have been reviewed. Further work needs to be undertaken for a few high risk medicines to ensure that the information provided is clear, understandable and available at the appropriate time.

High risk medicines	Patient Leaflet	Action required 2013/14
Anticoagulants	Booklet given to all patients	None - Booklet appropriate
Insulin	Passport given to all patients	None - Insulin passport appropriate
Potent analgesics	Manufacturers information provided	Information sheet to be developed
Methotrexate	Handbook provided	None - Handbook appropriate
Amiodarone	Manufacturers information provided	Information sheet to be developed
Oral chemotherapy	Information provided at Clinic	No action required

Specific information sheets are currently being developed for acute pain management and for Amiodarone. The leaflets will be available in summer 2013 and issued to all patients being prescribed one of these medicines.

A 'Medicines Advisory Note' is also planned for 2013/14 for those patients who are not taking a high risk medicine but where it has been identified that there are specific

safety or compliance concerns. These notes will be provided to patients by a member of the pharmacy team.

A proof of concept project working with community pharmacies in Paignton has also started. The aim of the project is to improve the provision of medicines information to patients post discharge, utilising the resources available in high street pharmacies. Part of these new services will be inviting patients and their carers to come into their community pharmacy with all their medication so they are able to have a full medication review.

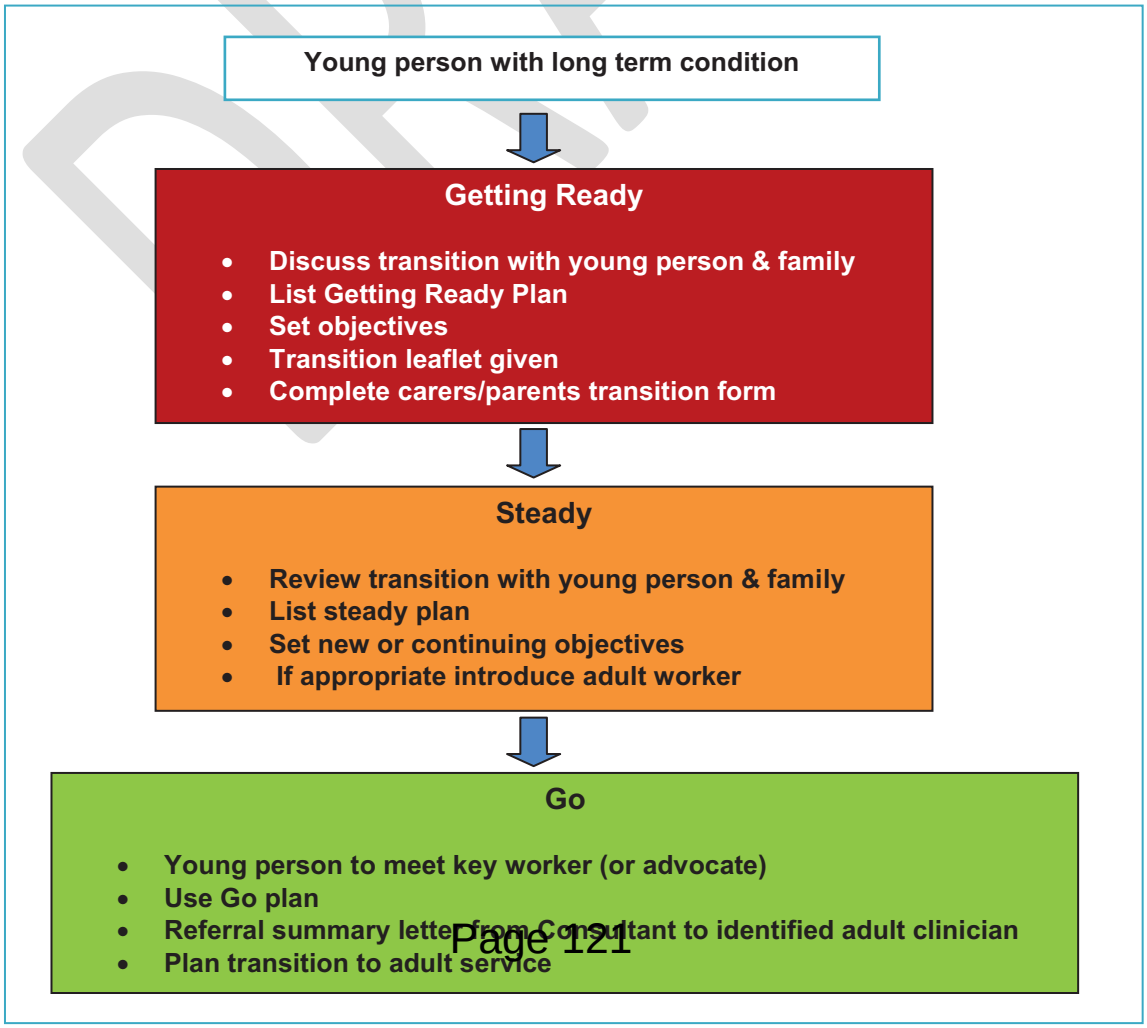
If successful, this concept will be rolled out to other communities across South Devon and Torbay in 2013/14.

Clinical effectiveness

Priority 3: To improve the transition of care of young people with epilepsy, cystic fibrosis and neuromuscular disorders

For some time research studies have shown that the effective transition of children between paediatric health services and adult health and social care has a major impact on the long term outcomes of young people with chronic medical conditions.

Over the last 12 months the Trust's paediatric team have focused on setting up effective transition arrangements starting with cystic fibrosis, epilepsy and neuromuscular disorders. Using the work developed by Southampton University Hospital the Trust has adopted the 'Ready, Steady, Go' approach.



Using this approach, the project team has now designed a new transition pathway of care and policy. This is applicable to all young people with chronic long term conditions.

The team has also developed a pre-transition and post-transition questionnaire as well as systems to identify young people for transition earlier (typically 12 yrs old). Starting the transition process earlier enables better target setting by the young person and allows them to take more control over the condition as they become older.

The feedback from the project has been positive.

The project has built strong relationships between young patients, specialist nurses and adult care consultants and the ready, steady, go approach provides a simple understandable framework for all to use.

"I think the plan really works well when children and young people are capable of answering the questions.

We plan to tailor the pack for special needs in the future and include a section for the parent/advocate."

Epilepsy Specialist Nurse

For 2013/14 the team will continue to spread their work into other long term conditions and use electronic services such as 'Patient Knows Best' to enable young people to have access to their own information as they transition between services.

Patient experience

Priority 4: To improve the quality of end of life care provision

The Department of Health's End of Life Care Strategy (2008) emphasises that improved end of life care provision in hospitals is important as currently more than half of all deaths take place in this setting.

Torbay Hospital has been involved in a national end of life care project called 'Routes to Success in End of Life Care in Acute Hospitals'. As one of 25 pilot sites, this project builds on the end of life care work already done by the Trust over the last few years including:

- Support for people to die in the place of their choice, which may or may not be hospital.
- Improved patient and family experience.
- An increase in the skills and confidence of hospital staff in providing end of life care.

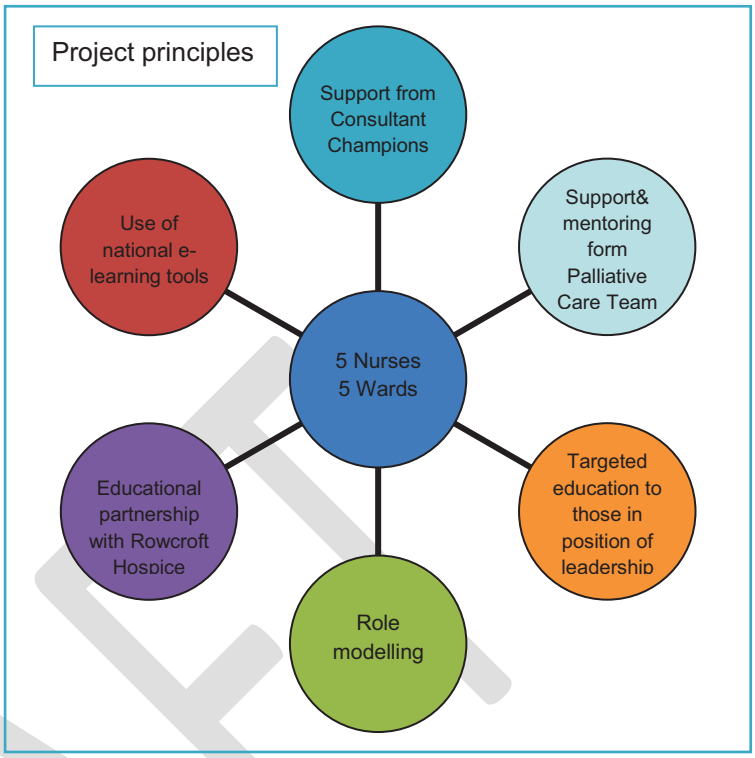
- Improved links and communication with community staff.

During 2012/13 nurses from five wards in the Hospital took part in the project.

They each attended end of life care teaching sessions and they also spent time on their own wards looking at ways to improve care for people who may be in the last year(s) of life.

The nurses were also supported in their work by a consultant led hospital palliative care team.

Three of the nurses also attended an 'Enhanced Palliative Care Skills Course at Rowcroft Hospice, with the other two having previously completed the course.



As a result of the project:-

- Staff on the five wards now have a better understanding of ways to improve care in the last year(s) of life for patients, their families and friends.
- There is an increased awareness of end of life issues across the Hospital as staff move between wards.
- Better information is now sent to GPs, out-of-hours doctors and ambulance service staff, when patients leave hospital.

"We are certainly more proactive in facilitating patients' choice of where they would like to die and discharging patients in a safe and supported manner"

Ward Sister on a project ward.

- There are now information folders on end of life care produced by the 5 project nurses for the other 12 adult wards in the hospital as a way to share learning from the project.

Over the next year we will continue to work hard on this important area of care and for this reason it will continue be a Trust Quality Account improvement priority for 2013/14.

Priority 5: To increase the number of letters written directly to the patient and copied to the GP

Part of the Government's current policy is to ensure that patients have better access to their own medical information such as medical records and laboratory results. There is considerable evidence to suggest that patients receiving good quality letters/information respond very positively, resulting in improved patient satisfaction and reduced anxiety.

In 2011/12 we reported that we would test the feasibility of Hospital doctors adapting their current practice and writing to patients direct and copying in GPs. We have piloted this change on an individual clinician by clinician basis. Specialities involved in this work include gastroenterology and respiratory services.

With the development of a new clinic letter replacement programme, this should enable clinicians to tailor letters more appropriately to the audience intended. Also there should be more scope to ensure all patients receive copies of letters as this will be auditable for the first time. A recent finding from the Governors' survey suggests that only 36% of people responding to the survey were offered a copy of the letter resulting from the outpatient appointment.

We also stated in the 2011/12 Quality Accounts that we would test the feasibility of providing patients with direct access to medical records and laboratory tests and provide an online forum for clinicians and patients to share information.

Over the last year we have been piloting an IT system to improve communication and information flows between doctors, nurses and patients. 'Patients Know Best' is a fully secure online tool which enables patients to view, organise, manage and control their own health care provision.

Specialities involved in the pilot work to date include:

- diabetes
- paediatrics - where young people are transitioning to adult health services
- inflammatory bowel disease & colorectal surgery
- Speech and language therapy

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www.**patientsknowbest**.com/

The feedback so far has been positive and more specialities will be involved in offering their information direct to patients via the Patient's Know Best secure website.

We are also currently exploring with Commissioners, local GPs and our health and social care partners across South Devon and Torbay whether this system could be used to provide all patients with direct access to their own information in a safe and secure environment longer term.

Continuous quality improvement in 2012/13

In our last year's Quality Accounts we reported on a number of areas where we had focused on improving patient safety, clinical effectiveness and patient experience.

Work has continued in these areas as we recognise that quality improvement is a continuous cycle. Below is a snapshot of our continued progress from a number of our continuous quality improvement programmes reported to the Board, including CQUINs, a payment framework which enables commissioners to reward excellence by linking a proportion of the Trust's income to local quality improvement goals.

2012/13 CQUINs

The Trust has been involved in 16 CQUIN (Commissioning for Quality Improvement and Innovation) projects covering safety, clinical effectiveness and patient experience. Some of these projects are nationally mandated such as:

- Improving the recognition, assessment and referral of people with dementia
- reducing the risk of patients who are admitted to hospital subsequently developing a blood clot (thrombus) in a vein

whilst others are locally agreed.

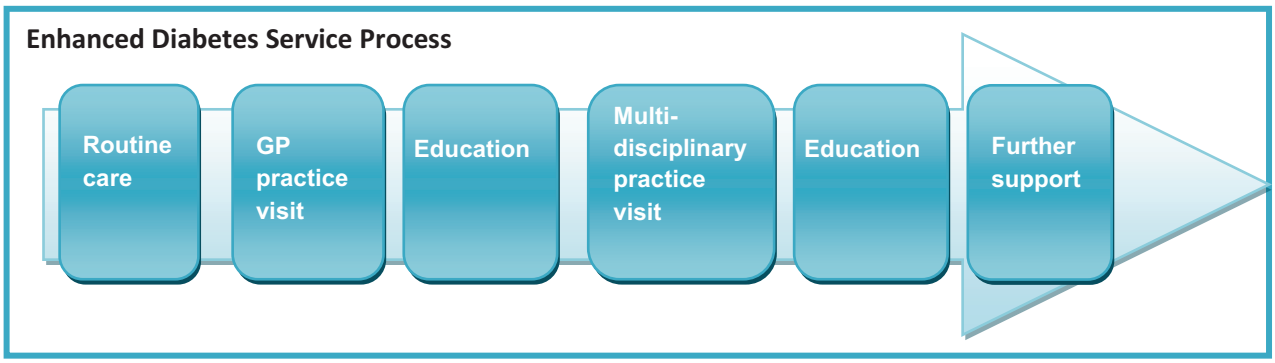
A breakdown of the 2012/13 CQUINs over the year can be found in appendix 2.

2012/13 CQUIN highlights include:

Diabetes

The successful set up and delivery of a new enhanced diabetes care service to primary care.

This is already reducing the number of unnecessary referrals into the hospital and enabling GPs and the primary care team to better support patients, their carers and families at home.



Timeliness of clinic letters to GPs

The timeliness of providing information within health care is critical, but due to workforce pressures and clinical priorities this can sometimes be difficult to achieve.

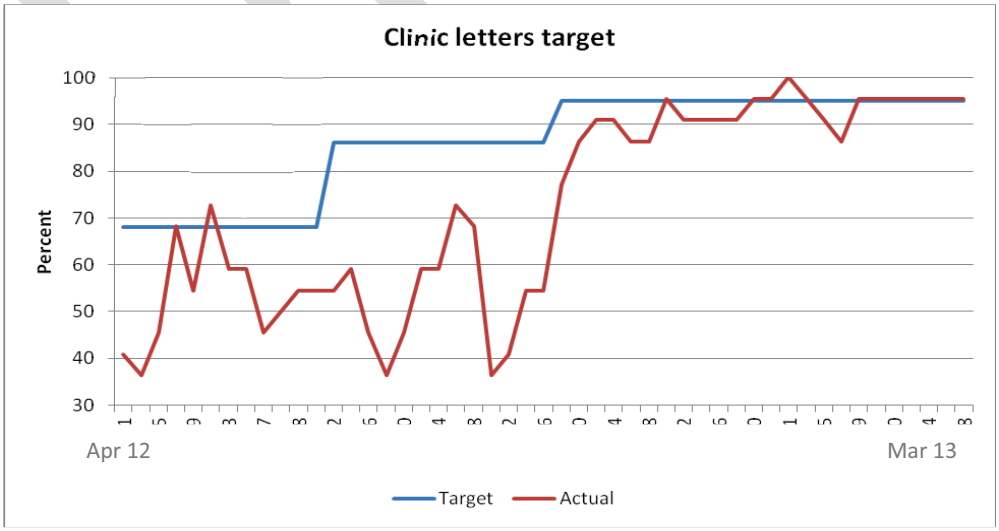
In 2012/13 the Trust agreed to improve the timeliness of outpatient letters, working towards a target of ensuring that 95% of letters produced are typed and sent out within 5 working days.

The project focussed on:

- Introducing a process to monitor the backlog of typing and the number of outstanding clinics requiring support.
- Identifying how a greater level of flexibility can be achieved across the permanent and part time/temporary secretarial workforce.

Over the year the number of secretarial staff has been increased and more flexible working practices means that any typing gaps can be filled more quickly.

By the end of the year 95% of specialities now type and send letters within 5 working days.



In 2013/14 the aim will be to maintain this performance.

Patient Experience

Improving patients' experience is a national CQUIN, with the Trust required to improve its performance against the NHS's national inpatient survey and recording and acting on patient feedback in real time.

The Trust is very proactive in collecting information and listening to patients, carers and families to build a picture of the quality of care offered by the Trust from each patient's perspective.

Currently patient complaints, patient stories, real time patient survey information and positive feedback from patients and their families are shared across the organisation throughout the year in a number of forums.

A snapshot of patient feedback for 2012/13 includes:

This year, in addition, the nursing leadership team have been working with ward nurses to embed 'Observations of Care' into ward routines. This is a technique where a small group of trained ward staff and lay volunteers quietly observe an area of practice and feedback their observations to share good practice and suggest improvements.

Feedback from ward staff has been positive with staff and lay volunteers now undertaking monthly observations of care.

"Worthwhile experience, seeing good quality care in real time and having the opportunity to discuss with the staff".

Bereavement officer

The Trust has also been involved in five national patient surveys in 2012/13:

- National Inpatient Survey
- National Cancer Survey
- National Emergency Survey
- Day Surgery Survey
- Radiology and Imaging Survey

The results are available on the Trust's website www.sdhl.nhs.uk and more details are available in the Trust's 2012/13 annual report.

In relation to **overall patient experience,** according to the National Inpatient Survey (Q68) the Trust scored 8.1 out of 10 with the lowest performing trust scoring 7.2 and the highest 9.0.

Also the staff when asked, as part of the annual national NHS staff survey, whether 'they would recommend the Trust as a place to work or receive treatment" scored better than the national average.

In 2013/14 a patient version of this question known as the 'friends and family test'is being introduced into the hospital and the Patient Services team has already started to roll this out.

Other continuous quality improvement work in 2012/13

The Trust is involved in other improvement and innovation work throughout the year. Some of this is championed through the Clinical Management Group, a forum of Senior Clinicians and Managers and through the CIP Board which is chaired by the Chief Executive.

Projects undertaken in the last year include:

- iTorch - an innovative project to introduce junior doctors to quality improvement work and which enables them to undertake small scale projects. In 2012/13 over 20 projects have been undertaken and shared with the health and care community. These range from developing improved referral forms in psychiatry to designing improved drug packaging for anaphylaxis.

- Telemedicine in paediatrics – this is a new project enabling clinicians to share information and undertake shared consultations via a portable telemedicine unit with specialist units from across the region.

- 24/7 care - this builds on the work already undertaken during the year to understand more clearly future health and social care capacity and patient demand. Tests of change include Sunday consultant ward rounds and increased junior doctor provision at weekends to support the timely completion of discharge information for GPs.

- Dementia – this is a key priority for the Trust. Work has been undertaken in the year through the CQUIN framework to improve the recognition, assessment and referral of patients suspected with dementia. Although the Trust did not achieve its end of year target, it continues to work hard to achieve this. There is a also a Devon wide dementia action plan which the Trust is actively working on alongside their partners.

- Joined-up health & care – the Trust alongside Commissioners, the Councils and community health and social care have come together to publish a vision of joined up health and care for the people of South Devon and Torbay. The document has been published and is available on the Trust website www.sdhl.nhs.uk

- Clinical negligence scheme for Trusts - Maternity Services achieved Clinical Negligence Scheme for Trusts (CNST) level three for the Maternity Clinical Risk Management Standards. This is the highest level of the NHS Litigation Authority's stringent standards to improve the safety of women and their babies.

More information about the Trust's quality improvement work can be found on our Trust website, the Trust Board reports and in also in our 2012/13 annual report.

Looking forward: 2013/14

The Trust has identified 5 quality improvement priorities for 2013/14. These have been developed through discussions with our clinical teams and through receiving feedback from the users of our services. We have taken into account new best practice and national guidance and have met with key stakeholders to discuss and agree the priority areas for 2013/14 (see Annex 1). These priorities have been signed off by the Trust Board.

In brief, the improvement projects are:

Patient safety

Priority 1: Reduce the prevalence of hospital acquired pressure ulcers

Pressure ulcers are a type of injury that affects the skin and underlying tissue due to excessive friction. This can occur when the force of the body is static for too long and a shearing effect occurs where the deep skin layers are forced over one another.

Across the NHS there is a drive to improve the recognition, management and care of people with pressure ulcers. This initiative is being driven through the Department of Health's Safety Thermometer work. It is also a nationally mandated quality improvement priority.

The Trust, through its Pressure Ulcer Steering Group, is working with the wards to reduce the number of pressure sores acquired whilst in hospital.

The outcomes will be reported through the 13/14 Quality Accounts and also to Commissioners as part of the Trust's CQUIN work.

Clinical effectiveness

Priority 2: Rollout 'enhanced recovery in medicine' onto three medical wards within the Hospital

The enhanced recovery model of care within surgery is clinically proven, enabling patients to recover more quickly with earlier discharge and reduced postoperative complications. What is less well known is whether the principles can be more widely applied outside the field of surgery.

In 2012/13 a project was undertaken on the Emergency Assessment Unit (EAU) to see if the principles of enhanced recovery applied to medical patients. This includes early mobilisation, improved nutrition and patients with their families or carers being more actively engaged in their care earlier.

The preliminary data suggests that people have shorter stays and a better patient and carer experience. In 2013/14 the aim will be to see whether the benefits made to date can be replicated more widely.

Priority 3: Implement the integrated heart failure service

In the UK, heart failure accounts for a total of 1 million in-patient bed days and 5% of all emergency medical admissions to hospital.

Hospital admissions due to heart failure are projected to rise by 50% over the next 25 years largely due to an ageing population, improved survival of people with heart

disease and more effective treatments for heart failure. The average age at first diagnosis is 76.

The Trust, with Community Services, have come together to develop one integrated service with the aim of providing seamless care, whether at home or in hospital. In 2013/14, the focus will be on identifying people with heart failure and setting up systems to allow people to be both supported with their condition and manage it more effectively themselves.

Patient Experience

Priority 4: Continue to improve end of life care provision in Torbay Hospital.

The provision of high quality end of life care within Torbay Hospital will continue to be an important function and one by which the hospital will be judged by its local community.

We only have one chance to get this right for patients, their families and friends. As a result, it is vital that work continues to build on the improvements undertaken over the past 2 years and to identify areas where the care we provide can be improved upon.

Priority 5: Test the cost benefit of employing ward clerks during the evening and weekends.

Ward clerks undertake administrative tasks for doctors and nurses including managing patient notes, recording appropriate information on clinical systems, answering the phone and providing basic administrative tasks for the ward team. With patients arriving and being discharged later in the day, the ward can often be at its busiest when ward clerks are just finishing their shift.

With a shift to 24/7 care, the demand for more front line support at weekends and evenings is increasing. This, however, is set against a backdrop of no additional income to employ staff.

The aim of this improvement work is to undertake a test of change on two wards to see whether ward clerks release more time to care with clear cost benefits including improved patient experience.

All 2013/14 quality improvement priorities will be reported and monitored via the Trust Board with quarterly updates and progress reported against action plans for each improvement priority.

Continuous quality improvement work in 2013/14

Quality improvement is at the heart of what the Trust does and the five quality improvement priorities already described in this section are key to underpinning our Trust objectives of safer care with no delay and improved patient experiences.

Alongside these five priorities the Trust has a number of additional quality improvement projects which are supported through CQUINs and via the Trust's CIP Board. Also, engagement with programmes such as the 'Safer Patient Initiative' supports the Trust's mission to drive up quality.

As with the previous year, the 2013/14 CQUIN schemes will continue to be published on the Trust website.

2013/14 CQUIN work will include dementia, carers, heart failure, enhanced recovery in medicine, timeliness of information to GPs, shared decision making and alcohol.

Other quality improvement work includes 24/7 care, patient flow, theatre efficiency and publishing more quality measures for clinical teams to benchmark their practice against.

Statements of assurance from the Board

Review of services

During 2012/13 South Devon Healthcare NHS Foundation Trust provided and/or sub-contracted 44 relevant health services.

South Devon Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in 44 of these relevant health services.

The income generated by the relevant health services reviewed in 2012/13 represents 84% of the total income generated from the provision of NHS services by South Devon Healthcare NHS Foundation Trust for 2012/13.

Participation in clinical audits

For the purpose of the Quality Accounts, the National Clinical Audit Advisory group (NCAAG) has published a list of national audits and confidential enquiries. Participation in these is seen as a measure of quality of any Trust's clinical audit programme. The detail which follows relates to this list.

During 2012/13, 44 national clinical audits and 3 national confidential enquiries covered relevant health services that South Devon Healthcare Foundation NHS Trust provides.

During 2012/13 South Devon Healthcare Foundation NHS Trust participated in 82%

of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that South Devon Healthcare NHS Foundation Trust was eligible to participate in during 2012/13 are as follows:

South Devon Healthcare NHS Foundation Trust	Eligibility	Participation
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Feverish Children (College of Emergency Medicine)	Yes	Yes
Pain in Children (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	No	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	N/A
Inpatient audit of children with Diabetes (HQIP)	Yes	Yes
Diabetes (RCPCH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes
Non-invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Neck of femur (College of Emergency Medicine)	Yes	Yes
Adult critical care (ICNARC Case Mix Programme)	Yes	Yes
Severe sepsis and septic shock (CEM)	Yes	Yes
Potential Donor Audit	Yes	N/P
Long term conditions		
Diabetes (National Diabetes Audit)	No	N/A

Diabetes Inpatient audit (HQIP)	Yes	Yes
Heavy Menstrual Bleeding (RCOG)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	N/P
COPD (British Thoracic Society/European Audit)	Yes	No
Adult asthma (British Thoracic Society)	Yes	Yes
Bronchiectasis (British Thoracic Society)	Yes	N/P
National audit of Dementia	Yes	Yes
Parkinson's disease	Yes	N/P
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No	N/A
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Acute stroke (SINAP)	Yes	Yes
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes
Renal disease		
Renal replacement therapy (Renal Registry)	No	N/A
Renal transplantation (NHSBT UK Transplant Registry)	No	N/A
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes

Head & neck cancer (DAHNO)	Yes	Yes
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	Yes
Psychological conditions		
Prescribing in mental health services (POMH)	No	N/A
Blood transfusion		
Audit of patient info & consent (National Comparative Audit of Blood Transfusion)	Yes	Yes
Blood sampling & labelling (National Comparative Audit of Blood Transfusion	Yes	Yes
Audit the use of Anti D (National Comparative Audit of Blood Transfusion)	Yes	Yes
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No
End of life care		
Care of dying in hospital (NCDAH)	Yes	No
National Confidential Enquires		
Patient Outcome and Death (NCEPOD)	Yes	Yes
Suicide and Homicide by People with Mental Illness	No	N/A
National Review of Asthma Deaths	Yes	Yes
Child Health programme	Yes	Yes

Of those national audits that the Trust did not participate in, the reasons are outlined below:

- Bronchiectasis (British Thoracic Society) – the decision not to take part in this audit was made because of the difficulty in capturing the data required.
- Cardiac arrest. – the specialty concerned decided not to take part in this audit as there was a cost implication.
- Non-invasive ventilation (COPD) – the speciality declined to take part.
- Parkinson's disease – the speciality declined due to workload.

- Potential donor – the speciality had taken part in a previous audit but due to small numbers felt that there was little benefit in taking part again this year.

- IBD (Biologics) – the decision not to take part was due to problems with the national data audit system and the lack of availability of site specific data in t e national report.

The national clinical audits and national confidential enquiries that South Devon Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, 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.

South Devon Healthcare NHS Foundation Trust	Cases submitted	% cases
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	359	100
Children		
Paediatric pneumonia (British Thoracic Society)	15	100
Paediatric asthma (British Thoracic Society)	9	45
Feverish Children	50	100
Pain management (College of Emergency Medicine)	50	100
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	25	100
Inpatient audit of children with Diabetes	Not Known	
Diabetes (RCPCH National Paediatric Diabetes Audit)	116/130	89
Acute care		
Emergency use of oxygen (British Thoracic Society)	10	90
Adult community acquired pneumonia (British Thoracic Society)	50/20	250
Severe sepsis & septic shock (College of Emergency Medicine)	30	100
Non-invasive ventilation (NIV) Adults (British Thoracic Society)	14/20	70
Neck of femur (College of Emergency Medicine)	50	100
Adult critical care (ICNARC Case Mix Programme)	679	100
Renal Colic (College of Emergency Medicine)	14/50	28

Long term conditions		
Diabetes Inpatient audit (HQIP)	40/50	80
Heavy menstrual bleeding (RCOG National Audit of HMB)	112	100
Chronic pain (National Pain Audit)	53	100
National audit of dementia	40	100
Parkinson's disease (National Parkinson's Audit)	21	70
Adult asthma (British Thoracic Society)	21/20	105
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	683	100
Coronary angioplasty (NICOR Adult cardiac interventions audit)	350	100
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Not Known	
Carotid interventions (Carotid Intervention Audit)	31	100
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	474	99.2
Heart failure (Heart Failure Audit)	359	150
Acute stroke (SINAP)	537	100
Stroke care (SNNAP) (Organisation only)	Completed	100
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	189	100
Cancer		
Lung cancer (National Lung Cancer Audit)	201	100
Bowel cancer (National Bowel Cancer Audit Programme)	223	100
Head & neck cancer (DAHNO)	70	100
Oesophago-gastric cancer (National O-G Cancer Audit)	52	100
Trauma		
Hip fracture (National Hip Fracture Database)	438	100
Severe trauma (Trauma Audit & Research Network)	265	100

Blood transfusion		
Blood sampling & labelling (National Comparative Audit of Blood Transfusion)	35	100
Platelet use (National Comparative Audit of Blood Transfusion)	26	100
National Confidential Enquires		
Are We There Yet? A review of organisational and clinical aspects of children's surgery	1	100
Knowing the risk - A review of the peri-operative care of surgical patients	86	100
Bariatric surgery for weight loss	Not Known	

The reports of 41 national clinical audits were reviewed by the provider in 2012/13 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions
ND0046	**Acute Myocardial Infarction & other ACS (MINAP) - (Quarterly reports)**
	• Data collection evaluation • Improvement in drugs documentation.
ND0055	**Acute Stroke (SINAP)**
	• Report received March 2013. Response pending.
ND0030	**Adult Asthma (BTS)**
	• Ensure blood gases are performed on all patients with low Sa02 • Oral steroids to be given promptly to all patients with acute asthma • Peak flow recordings to be recorded in all asthmatic patients at least 12 hourly. • Outpatient appointments to be offered to all patients admitted under medicine with acute severe asthma.
ND0071	**Adult Community Acquired Pneumonia (BTS)**
	• First dose of antibiotics to pneumonia patients - Junior Doctors to undertake • Re-emphasise local antibiotic guidelines for pneumonia
ND0053	**Bowel Cancer Audit (NBOCAP)**
	• Check data accuracy and ensure accurate coding. • APER rate incorrectly stated as 100%, correction requested.

ND0066 - Cardiac arrhythmia (Cardiac Rhythm Management Audit)
• No specific actions.
ND0074 - Carotid Intervention Audit
• Multi-factorial reasons for the delay between patient symptoms and surgery. • Areas to explore further include where services (e.g. TIA) fragmented across Trust , consultant job plans , staffing
ND0064 - Childhood Epilepsy Audit (Epilepsy 12)
• Design local guidelines for children seen in A & E, children's wards and referred by GP with a first febrile seizure.
ND0038 - Chronic pain - Organisational audit of pain services (2010/12)
• Report received Dec 2012, Response pending.
ND0049 - Coronary Angioplasty: (NICOR Adult Cardiac Interventions audit) – BCIS
• More detailed examination of outcomes after primary PCI for patients with cardiogenic shock or other adverse risk factors • On-going monitoring of trends in D2B times to be included in quarterly PCI audit meetings.
ND0049 - Coronary Angioplasty: (NICOR Adult Cardiac Interventions audit) – BCIS
• No action plan required.
ND0047 - Data for Head and Neck Oncology (DAHNO)
• Improve recording of staging, performance status and co-morbidities, • Timetable adjusted to enable Restorative Dentistry consultant to attend MDT which will improve identification of appropriate patients for assessment – • Pre-treatment clinic improving figures for patients receiving swallow and dietetic assessments pre treatment.
ND0028 - Dementia audit
• Include dementia assessment & referral on discharge summary • Design care pathway.
ND0065 - Diabetes (RCPH National Paediatric Diabetes audit)
• Development of multidisciplinary team • High HbA1c policy to be ratified and followed for all patients not currently achieving HbA1c levels within target range. • Review protocols and guidelines relating to the care of children with diabetes
ND0037 - Emergency use of Oxygen (BTS)
• Incorporate oxygen prescribing into VITALPACK observations.
ND0060 - Feverish children (CEM)
• Report received February 2013. Response pending

ND0092 - Fractured neck of femur (CEM)
• Report received February 2013. Response pending
ND0039 - Heart Failure Audit
• Appoint integrated Heart Failure Nurse (HFN) Team. • Identify all patients admitted with heart failure whilst on EAU (BNP and Echocardiogram). • Improve use of proven therapies (ACE/ARB, b-blockers, MRA) in patients identified with systolic heart failure (target >80%). • All patients with heart failure require management plan and HFN follow up.
ND0054 - Heavy Menstrual Bleeding (HMB) (RCOG)
• No Trust level data in report. No identifiable actions required.
ND0043 - Hip Fracture (NHFD)
• Improve the completeness of the data submitted to the NHFD particularly 30 day and 120 day data. • All patients admitted with a fall and fragility fracture to be referred to FLS and infoflex MFFRA completed. • All patients with a hip fracture to have AMTS recorded on admission and post operatively. • Improve the % of patients achieving the BPT of time to theatre within 36 hours • Set up clinical pathway group to review Hip Fracture Pathway to reduce community hospital length of stay
ND0042 - Hip, Knee and Ankle Replacements (NJR)
• No action plan required.
ND0051 - ICNARC: Adult Critical Care (Case Mix Programme)
• No action plan required.
ND0090 - Inpatient Diabetes Audit (Adults)
• Development of business case to provide more podiatry input to inpatients with diabetic foot ulcers. • Modification of drug chart to include dose validation for insulin prescription. • Educational initiative for foundation doctors wrt insulin prescribing including e-learning module. • Implementation of 'think glucose' programme.
ND0044 - Lung Cancer (National Lung Cancer audit)
• No action plan required.
ND0093 - National comparative audit of blood transfusion programme (Blood Sampling and Labelling
• Report received January 2013. Response pending
ND0093 - National comparative audit of blood transfusion programme (Platelet use)

• Threshold for prophylactic platelet transfusions agreed
ND0035 - National Neonatal Audit Programme (NNAP)
• NNAP results to shared to paediatric staff • Data entry into the Badger system to be reviewed to ensure its accuracy and robustness - weekly case notes audit to be undertaken • Separate form for communication to be included in Admission pack. • SCBU - new magnetic board has been installed with an aim to highlight relevant issues. • Data for follow-up at age two years to be included. Re-audit in 6 months.
ND0012 - Non Invasive Ventilation (BTS)
• Improve current NIV data collection sheet. • Provide oxygen alert cards for all patients who have received NIV in hospital.
ND0086 - Oesophago-gastric cancer (National O-G Cancer Audit)
• No action plan required.
ND0041 – Paediatric Asthma (BTS)
• Report received Feb 2013. Response pending
ND0040 - Paediatric Pneumonia (BTS)
• Create Paediatric Community Acquired Pneumonia Guideline.
ND0083 - Pain Management (CEM)
• PGD for analgesia prescriptions for nursing staff. • Posters in Emergency Department. • Pain assessment education for nurses
ND0011 - Parkinson's Disease (Parkinson's UK)
• Service Development – Parkinson's – Trust/Commissioner action • Improve provision of written information • Trial the non motor questionnaire • End of life care - develop paperwork to enable better communication between patients and GPs.
ND0062 - Renal Colic (CEM)
• Report received February 2013. Response pending
ND0082 - Severe Sepsis and Septic Shock (CEM)
• Sepsis lecture as part of mandatory junior doctors' teaching (for each rotation block) • Introduction of 'Red box' for high amber scored ED patients to ensure patients seen in priority order. • Alter Sepsis stickers to better reflect important audited parameters including urine output. • Use magnetic markers on emergency department patient board to identify priority patients with high amber scores.
ND0026 - Severe Trauma (TARN) ***Clinical Report III (Head and Spinal Injuries) Nov 12***

• Report received Dec 2012. Response pending
ND0026 - Severe Trauma (TARN) TARN - Torbay Hospital Trauma Report II, August 2012 (Orthopaedic Injuries)
• Review Trauma team activation criteria • Improve data completeness • Review trauma data 3 times a year
ND0026 - Severe Trauma (TARN) TARN – Torbay Hospital Trauma Report I (Abdominal Injuries, Shocked patients)
• Trauma calls – new protocol re leadership designed • Improve timeliness of CT scan
ND0027 - Stroke care (National Sentinel Stroke audit) SSNAP
• Report received Dec 2012. Response pending.
ND0027 - Stroke care (National Sentinel Stroke audit) SNAP - National Sentinel Stroke Clinical Audit 2010 - Supplementary report on Therapy intensity March 2012
• Improved accuracy of contact time data will be measured via the SNNAP audit tool • Audit appropriateness for 45 minutes therapy and code variance. • Audit patients who are appropriate for 45 minutes therapy and do not receive it Identify a lead therapist to co-ordinate the therapy team • Reliable 7 day therapy working. Business case to be developed.
ND0031 - Ulcerative colitis & Chrohn's disease (National IBD audit) (Biologics)
• Report received June 12. Report not applicable as data incorrect & no local report produced.

The reports of 103 local clinical audits were reviewed by the provider in 2012/13 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions
6149	**Initial Assessment of Self harm and Overdose in the Emergency Department (ED)**
	• Establish action group of Senior ED and Psychiatric Liaison staff • Preliminary Assessment: • Introduce a standardised template/ pro-forma for clerking cases of self-harm • Undertake further training for ED doctors (of all grades) • Mental health aspects of preliminary assessment in ED and Mental Capacity Act (MCA) and Mental Health Act (MHA) for those refusing consent and action required. This is to be provided interdepartmentally by Psychiatric Liaison • Agree streaming/ co-ordinator referrals. • Develop local policy for those refusing consent to referral that includes safety net/ follow up plan

• Continue Psychiatric Night Nurse Practitioner role
6183 Nutrition Risk Screening
• Introduce MUST scoring sheet into EAU clerking pro-forma • Re-education of EAU nursing staff on the risks of malnourishment and the importance of using MUST tool through staff training sessions • Improve access to scales within EAU
6203 Head Injury [CG-56]
• Continue to review assessment/ triage and monitor the impact of the new IT system • Education for head injury management/ documentation to junior doctors, paediatric staff and emergency nurse practitioners • Revision of adult head injury advice leaflet to include advice regarding post-concussion syndrome and services available
6222 Identification of 'At Risk' Children in A&E – 2012
• Consultant team to target the Middle Grade doctors for ad hoc teaching, (to include paediatric liaison referrals and MASH (Multi-Agency Strategic Hub) referrals).
6242 Nutrition and Dietetics Record Keeping for Domiciliary Visits
• No specific changes can be made to documentation to aid completion.
6188 Intra Hospital Patient Transfer
• Present audit and proposed changes to a Monday 'medical' meeting. • Modification of Kettering document on Clinical Governance approval. • Produce a quick checklist for transfer personnel to do and to call an anaesthetist if needed.
6139 False Negative Triple Assessment
• No plan is required but continue with on-going monitoring to ensure that we are working to national guidance and providing an effective triple assessment service.
6181 Diagnosis, treatment and management of urinary tract infection (UTI) in infants and children (CG- 54)
• No action required
6195 Paediatric Rapid Access Clinic: Referrals from the Emergency Department (ED)
• Re-evaluation of the process of Rapid Access clinic referrals involving Consultant triage • Creation of more specific criteria for referral to Rapid Access clinic • Training for Middle Grade doctors regarding the Rapid Access process • Training for ED staff regarding Rapid Access process
6105 Safeguarding Children (Torbay)
• Arrange dates to attend committees and team meetings to discuss audit results, recommendations and actions. • Prepare staff briefing for inclusion in Staff Bulletin. • Present staff briefing at team meetings. • Supervision Standard Operating Procedure (SOP) to be revised. • Training on supervision SOP to be developed. • Training on supervision SOP to be delivered. • Develop training for staff on how to write a comprehensive report covering all areas of Child Protection identified through audit.
6137 Community Diabetic In-patient foot care
• A flyer will be sent to all community hospitals giving details of the next toe nail cutting training courses and recommending that two members of staff from each attend • Produce a new guideline for the management of diabetic foot ulcers specifically in

	community hospitals, • Set up a 'training update' on diabetic foot checks and referral pathways
6148	**Care Trust Note Keeping 2011/12**
	• No action taken other than individual team plans against their own results
6185	**Prescribing in Community hospitals**
	• Discuss results with the Medical Director (MD) of T&SDHC Trust • Disseminate copies of report and the Trust Medicines policy to prescribers via MD • Present report at the Medicines Governance Group • Produce and issue a "Top tips for Community hospital prescribing" aide-memoire
6194	**Community Hospital Infection Control**
	• No plan required
5989	**Certolizumab pegol for the treatment of Rheumatoid Arthritis (RA) (NICE TA-186)**
	• No action plan required
6058	**Management of Acutely Unwell Patients with Anorexia Nervosa (AN) in Torbay Hospital**
	• Developing expertise in the Medical Service • Identify an Eating Disorders Nutrition Physician • Psychiatric input links with medicine • Improve dietetic input and liasion with Nutrition Support Teams • Pathway redesign • Nasogastric feeding – guidelines • Managing risks of re-feeding and Underfeeding Syndrome – risk stratification – use purpose designed admission pro-forma • Families - In admission pro-forma include section to show that plan has been discussed with family. • Criteria for transfer to SEDU
6129	**Acute management of hyperkalaemia**
	• Ttrial of charts through patient safety initiative.
6134	**Patients with negative Troponins at six hours who then had a Troponin at 12 hours**
	• Raise awareness through ED Clinical Effectiveness meeting (CEM) that negative Troponin should not re-assure patient is risk free • Two ECG's should be routinely performed
6150	**Insulin Prescribing**
	• Insulin education to junior doctors
6154	**Waiting times for Multiple Sclerosis (MS) from GP referral to time of diagnosis**
	• Increase the number of MS Clinic slots,
6180	**Monitoring of Paediatric IBD Patients who are taking Azathioprine or 6-Mercaptopurine**
	• Produce a drug information leaflet for patients
6182	**GP Referrals to Transient Ischemic Shock/ Attack (TIA) Clinic**
	• Re-structuring of TIA clinics to initially create a five day walk in clinic • Further re-structuring to create a seven day walk in clinic • Ensure GPs aware of any new structuring, through best mechanism of GP to hospital discussions and commissioning meetings
6192	**Management of Diabetes Ketoacidosis (DKA) in adults**

• Introduce revised DKA guideline
6246 Use of blood cultures prior to administration of antibiotics
• Disseminate results to all Clinical Directors • A reminder is needed in the antibiotic section on the drug chart
6247 NICE BCA - Rituximab for the treatment of relapsed or refractory chronic lymphocytic leukaemia (TA-193)
• No action required
6249 NICE BCA - Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell
• No plan required, compliance demonstrated
6258 Metastatic Spinal Cord Compression (MSCC)
• Compliance achieved in four of the five standards, Standard one will be re-audited in another registered audit project ref: 6244
6260 - NICE BCA - Dronedarone for the treatment of non-permanent atrial fibrillation (TA197)
• No action required
6273 NICE BCA - Rituximab for the first-line treatment of chronic lymphocytic leukaemia (TA-174)
• No action required
6151 Management of Acute Surgical Admissions
• Discuss the possibility of 5 pm post take ward round by consultants of all new admissions. • Senior review on EAU
6166 Inappropriate Abdominal Radiograph Requests in Surgical Emergency
• Produce new guidelines agreed between Radiology and General Surgery.
6186 Emergency Repair of Femoral Hernias
• Continue with on-going education programme • Involvement of Care of the Elderly (COTE) in early post-operative period
6103 Five year oral cancer survival following surgery
• No action required
6202 Consenting lower third molar surgical removal
• Produce a pre-written/ 'bespoke' Consent form for lower 3rd molar removal
6204 Referral guidelines for CT scanning in sinusitis
• Laminate guidelines for distribution to raise awareness of guidance
6085 Inter Agency Communication Forms
• Present findings and highlight areas of improvement at Obstetrics and Gynaecology audit meeting, Midwifery Team Leaders meeting
6093 Contacting Clients Post Administration of Emergency Hormonal Contraception (EHC)
• Review EHC template and EHC SOP. • Simplify the process – alterations to both SOP and Lillie (computer system) templates.
6107 Use of General Anaesthetic (GA) for Colposcopy Treatment
• After 3 months all cases performed under GA will be reviewed and each discussed with the appropriate surgeon.

• All surgeons performing this procedure to be contacted to advise of the requirement for tissue depth to >7mm for ectocervical lesions.
6138 Maternity CNST Fetal Blood Sampling (FBS)
• Change wording on policy from 'stapled' to 'attached'. • Ensure medical staff aware of requirement to document timing of repeated FBS'. • Findings to be disseminated to all midwives via Team Leaders • Email all midwives with Stork guidance and reinforce on Delivery Suite. • Publish findings in Clinical Governance newsletter. • Laminate notice on FBS trolley to remind doctors to document requirements for further tests.
6145 Outcome following Injection of Botulinum Toxin to Bladder for overactive bladder (CG-40)
• No action required
6146 Effectiveness of Antenatal Communication SCBU Form
• No action required
6171 Maternity CNST Intermittent Auscultation
• Highlight to midwives the importance of palpating and documenting the maternal pulse at the onset of labour, through Team Leaders meeting and Clinical Governance newsletter.
6172 Maternity CNST CTG
• Results to go to Delivery Suite sub-group to formulate an action plan. • Highlight via the newsletter the requirement of those giving an opinion and any intrapartum event to be documented. • Laminated signs to be produced and placed in clinic rooms as a prompt to sign antenatal obstetric notes. • Discuss achievement of hourly 'fresh eyes' at Delivery Suite sub-group meeting. • Findings to be disseminated to all midwives via Team Leaders. • Findings to be published in Clinical Governance newsletter.
6173 Maternity CNST Use of Oxytocin
• Policy 461 needs to be updated with minor amendments to reflect current practice in regards to documentation of a plan prior to Oxytocin in low risk women. • Highlight to staff the importance of documenting when oxytocin should be stopped by disseminating to midwives via Team Leaders meeting and minutes. • Findings to be published in the Clinical Governance newsletter.
6174 Maternity CNST Caesarean section
• Undertake a check of the clocks on the ward, theatre and Galaxy to assess any discrepancies. • Highlight to the Co-ordinators the need to check and correct the times on the CTG machines every day. • There needs to be clear documentation that the decision to do emergency caesarean section is joint with a Consultant (P16 yellow birth notes). • Audit forms to be completed at time of delivery notes. • Need to ensure that the correct classification is used. • Share findings with midwives through Team Leaders meeting and minutes • Publish results in the Clinical Governance newsletter. • Raise at Delivery Suite Clinical Governance sub-group
6175 Maternity CNST Induction of Labour
• Raise awareness of areas showing poor compliance with the Meridian staff working on John MacPherson ward and also highlight at the Team Leaders meeting. • Highlight to Midwives the importance of:

• Induction at Term +12 for post maturity - Documenting maternal pulse every 6 hours during induction (may be 8 hourly overnight) through Team Leaders meeting and minutes and the Clinical Governance newsletter.
6176 Maternity CNST Shoulder Dystocia
• Incident forms to be stapled to the pro-forma to encourage completion. • Shoulder Dystocia pro-forma to be ratified and added current Trust policy.
6177 Maternity CNST Operative vaginal delivery
• Highlight and raise the profile of the use of fluid balance. • Findings to be disseminated to all midwives via Team Leaders. • Findings to be taken to Delivery Suite Clinical Governance sub-group. • Findings to be published in the Clinical Governance newsletter.
6178 Maternity CNST Perineal Trauma
• Ensure old pro-formas previously being used have been removed from the unit and the master copy destroyed. • New prompt sticker produced. • Disseminate findings to all midwives via Team Leaders meeting and minutes. • Highlight audits at Delivery Suite Clinical Governance sub-group
6179 Maternity CNST Care of women in labour
• Results to be taken to Delivery Suite sub-group to formulate an action plan • Actions from Delivery Suite sub-group: • Posters to be placed around unit • Highlight on newsletter • Take results to Team Leaders meeting. • Cascade findings • Raise at Delivery Suite Clinical Governance sub-group meeting
6189 Management of Suspected Ectopic Pregnancy
• Review Trust policy (0468 - Early pregnancy management/ suspected ectopic pregnancy): • Update and amend flowchart to make it clearer • Change the urine test follow up from 2 to 3 weeks post miscarriage • Undertake a re-audit after the new NICE recommendations for Early Pregnancy Patients are released.
6197 Pre-operative pregnancy assessment prior to sterilisation
• Letter to be sent to DSU to inform that all women undergoing laparoscopic sterilisation will need to have a urine pregnancy test done prior to the procedure.
6207 Maternity CNST Eclampsia
• No action required.
6208 Maternity CNST Venous Thromboembolism
•Share findings
6209 Maternity CNST Severe Pre-Eclampsia
• To highlight the requirement to document: • The BP 15 minutely until BP <160/100 • Clear lines of communication with Consultant Anaesthetist and Paediatrician • Share the use of magnesium of sulphate and why not used • Disseminate findings to all midwives via Team Leaders meeting and minutes • Findings to be discussed at Delivery Suite Clinical Governance sub-group • Findings to be published in Clinical Governance newsletter
6210 Maternity CNST Referral When a Fetal Abnormality is detected

• Review and update existing Obstetric Paediatric Referral Communication form, which will include a formal process for ensuring paediatric communication, is received, returned or acted on. This will also be highlighted and initiated at the next perinatal meeting. • Present findings at Paediatric audit meeting.
6211 Maternity CNST Pre-Existing Diabetes
• Audit meeting minutes to be disseminated to all staff including diabetic multidisciplinary team • Add findings to newsletter and circulate to diabetes team. • Raise at Antenatal and Postnatal Clinical Governance sub-group. • Disseminate to maternity staff through team leaders meetings and minutes
6212 Maternity CNST Postpartum Haemorrhage (PPH)
• New pro-forma for the documentation of PPH to be introduced. To be available in delivery Action rooms and also on the PPH trolley. • Policy 1127 to be amended. • Draft pro-forma to be trialled for two months. • Pro-formas to be available for use in theatre (particularly theatres 1 and 4). • Remind staff of requirement to: • Complete pro forma if PPH in theatre • Complete Incident Form for all PPH of 1500ml • Findings to be disseminated to all midwives via Team Leaders. • To disseminate findings to Team Leaders and via the Newsletter and also Delivery suite Clinical Governance Sub-group. • Policy to be updated with guidance about documentation if the Consultant Anaesthetist and Obstetrician are not required, if the bleeding has been managed.
6213 Maternity CNST Postnatal Care
• Highlight via the newsletter the need to document on individual postnatal care plan including relevant factors from the antenatal, intrapartum and postnatal period. • Highlight via Team Leaders the importance of completing all relevant sections on the front and back pages of the notes. • Add findings to Clinical Governance newsletter and circulate to Obstetric, Midwifery and Paediatric teams and Paediatric teams • To present at SCBU Governance • Disseminate findings through Team leaders meeting and minutes • To discuss the pilot and introduction of NEWS chart at SCBU Clinical Governance
6214 Maternity CNST Patient Information
• Highlight at Team leaders meeting to ensure all staff are aware of the patient information policy • Findings included in Clinical Governance newsletter • Raise at Antenatal Clinical Governance sub-group
6215 Maternity CNST Obesity
• Disseminate to the Consultant Anaesthetists the requirement of them to document any discussions with women. • Disseminate findings to all midwives via Team Leaders meeting and minutes.
6216 Maternity CNST Non-Obstetric Emergency Care
• Findings disseminated to all midwives via Team Leaders.
6217 Maternity CNST Newborn Feeding
• Findings to be disseminated to all midwives via Team Leaders meeting. • Discuss at Antenatal Clinic / Postnatal Clinical Governance sub-group.

6218 Maternity CNST Newborn Life Support
• Daily date sheets to be implemented on delivery suite. • Findings to be fed back to Team Leaders.
6219 Maternity CNST Multiple Pregnancy & Birth
• A 'plan of care for twins' pro-forma has been developed which will include provision of information, discussion and documentation of the planned and agreed place and timing of birth and management of the second stage. • Findings to be disseminated to all midwives via Team Leaders meeting and minutes. • Findings to be discussed at Antenatal Clinic/ Postnatal Clinical Governance sub-group. • Findings to be discussed at the Delivery Suite Clinical Governance sub-group. • Findings to be published in the Clinical Governance newsletter
6220 Maternity CNST Missed Appointments
• Review policy and amend non-attendance flow-chart. • Disseminate to midwives via Team Leaders meeting and minutes • Highlight findings and above in Clinical Governance newsletter. • Raise at Antenatal Clinical Governance sub-group
6221 Maternity CNST Mental Health
• Revise awareness on the Health and Safety mandatory training day (2012) around documentation of risk assessments. • Present the audit at Team Leaders meeting. • Update Mental Health guideline to change the Whooley questions, now to be asked at booking and in 3rd trimester. • Disseminate findings through Team Leaders meeting and minutes. • Discuss at Perinatal Mental Health Clinical Action Governance meeting. • Discuss findings at mandatory obstetric update day. • Publish findings in Clinical Governance newsletter. • Discuss at Antenatal Clinical Governance sub-group
6223 Maternity CNST Maternal Antenatal Screening Tests
• Disseminate results to Team leaders meeting and minutes. • Review the process of checking results for clinics held with no intranet access. • Remind staff to document results by the 16 weeks appointment in the Clinical Governance newsletter • Raise at Antenatal Clinical Governance sub-group. • Women to be given written results whether positive or negative for all screening tests.
6224 Maternity CNST Immediate Care of the Newborn
• Disseminate to Obstetric, Midwifery and Paediatric teams via newsletter (Group B Strep) • Present at SCBU Governance & Audit meeting • Present meconium findings at Paediatric audit meeting • Findings of meconium audit to be disseminated to all midwives via Team Leaders • Discuss the pilot and introduction of NEWS chart at SCBU Clinical Governance
6226 Maternity CNST Examination of the Newborn
• Present at Paediatric audit meeting. • Ensure all trained midwife practitioners are aware of complete documentation, individual newsletter and minutes to be emailed.
6227 Maternity CNST Bladder Care
• Disseminate findings to staff via Team Leaders meeting and minutes • Publish findings in Clinical Governance newsletter • Results to be discussed at the Antenatal and Postnatal Clinical Governance sub-group
• **6228 Maternity CNST Clinical Risk Assessment (Labour)**
• Disseminate findings to all staff via Team Leaders meeting and minutes

- Publish findings in Clinical Governance newsletter
- Raise at Delivery Suite Clinical Governance sub-group

6229 Maternity CNST Admission to Neonatal Unit

- Add findings to newsletter and circulate to obstetric, midwifery and paediatric teams.
- Present at Paediatric audit meeting.
- Present at SCBU Clinical Governance meeting
- Disseminate findings at Team leader's meeting & minutes distributed to staff

6230 Maternity CNST Clinical Risk Assessment (AN)

- Proposal to merge two separate overlapping policies – Antenatal schedule of care and Risk assessment
- Antenatal Clinical Governance to discuss and if approved, to launch at July Team leaders meeting
- Remind staff of on-going risk assessment in newsletter and at Team Leaders meetings and minutes.
- Publish findings in Clinical Governance newsletter.
- Raise at Antenatal Clinical Governance sub-group.

6231 Maternity CNST Recovery

- Disseminate findings to all staff - Recovery and Obstetric via Team Leaders and Recover Ward Manager.
- Highlight to Midwives importance of:
- Monitoring respirations
- Completing transfer details on back of birth notes
- Fluid balance
- Highlight to Recovery staff importance of completing handover part of recovery care document
- Disseminate findings to all staff – Maternity via Team Leaders meeting.
- Discuss at Delivery Suite Clinical Governance sub-group
- Publish in Clinical Governance newsletter
- Highlight findings to Recovery ward manager to disseminate to theatre staff.
- Findings sent to Recovery Ward manager

6232 Maternity CNST Support for Parent(s)

- Present to SCBU governance meeting.
- Remind Consultant Paediatrician of importance of documenting all discussions within 24 hours of delivery
- To disseminate findings through Team Leaders meeting and minutes
- Present to Paediatric Audit meeting

6233 Maternity CNST Maternity Records

- Present audit at Team Leaders meeting and disseminate results via the Team Leaders minutes.
- Present audit at Supervisors of Midwives forum.
- Be critical about loose notes, in particular anaesthetic details ensuring they are completed and secured within the note. Highlight at Team Leaders meeting and via newsletter.
- Disseminate findings to all maternity staff via Team Leaders and monthly newsletter. Also include importance of:
- Labelling CTG envelopes and closing securely
- Cord gases to be written in notes as well as attached.
- A&C staff to be informed via Practice Manager - notes to be filed chronologically behind correct divider and no loose documentation.
- Anaesthetic dividers and CTG envelopes to be placed on wards.
- Raise at Delivery Suite Clinical Governance sub-group

6234 Maternity CNST Booking Appointments

• Ensure all staff are aware of policy, through Team Leader meeting and minutes. • Findings published in Clinical Governance newsletter • Raise and discuss at Antenatal Clinical Governance sub- group.
6235 Maternity CNST Severely Ill Women
• Highlight the requirement to document the following via the newsletter, Team Leaders and Delivery Suite sub-group:- • Respiratory rate • The totalling of red and yellow scores • The referral to Obstetrics Registrar when appropriate • MEOWS chart to be correctly filed chronologically behind Obstetrics and Gynaecology divider. • Findings to be disseminated to all midwives via Team Leaders. • Findings to be sent the Midwife Education Lead so they can be incorporated into the Obstetrics and Gynaecology mandatory day ' Early Recognition of the Severely Ill Pregnant Women' session for 2013. • To be taken to Delivery Suite Clinical Governance sub-group. • Publish findings in Clinical Governance newsletter.
6236 Maternity CNST Maternal Transfer by Ambulance
• To highlight at Team Leaders all the documentation requirements for transfers in Action from the community. • Disseminate findings to Team Leaders via the newsletter and also Clinical Governance sub-group.
6237 Maternity CNST Handover of Care (Onsite)
• Findings will be disseminated to all Midwives and Midwifery Care Assistants (MCAs) via Team Leaders. • Findings to be sent to the A&C manager for dissemination to all ward clerks. • To be discussed at Delivery Suite Clinical Governance sub-group. • - Publish findings in Clinical Governance newsletter.
6238 Maternity CNST Vaginal Birth after Caesarean Section
• Findings will be disseminated to all midwives via Team Leaders. • Findings will be discussed at the Antenatal Clinic and Post Natal Clinical Governance sub-group. • Findings will be discussed at the Delivery Suite sub-group. • Audit findings to be published in the Clinical Governance newsletter.
6239 Maternity CNST High Dependency Care
• Highlight to anaesthetists the need to complete an SBAR form. • Highlight to obstetric medical staff the requirement to complete an SBAR handover if women go directly to ICU form maternity services. To include this requirement in the April newsletter and the Clinical Governance sub-group meeting. • Reminder to midwifery and obstetrics staff to complete SBAR transfer form via Team Leaders meeting and minutes. • Findings to be discussed at the Delivery Suite Clinical Governance sub-group. • Findings to be published in Clinical Governance newsletter. • To include SBAR handover as a trigger on the WHO Maternity Safety checklist.
6022 Tissue Donation - Eye Retrieval
• No plan implemented
6030 Intravitreal Injection of Lucentis (Ranibizumab) for Neovascular Age Related Macular Degeneration (ARMD) by Ophthalmic Nurse Practitioners (NP)
• No plan required
6132 Diabetic Retinopathy Screening Service (DRSS)

• Funding for image management software is needed to implement 'virtual clinics' for service provision.
6152 Accuracy of Horizontal Squint surgery
• No action required
6190 Glaucoma (CG 85)
• Ensure full assessment of patients is carried out, to include; • IOP measurement using Goldmann applanation tonometry (slit lamp mounted) • CCT measurement • peripheral anterior chamber configuration and depth assessments using gonioscopy • visual field • Review and amend current patient information leaflet. • Highlight the importance of accurate documentation, through team meetings
6196 Surviving Sepsis
• Amend managing sepsis bundle pending issue of updated guidelines • Education/ Training of medical and nursing staff re the correct implementation of 'bundle' • Update of 'Surviving Sepsis' local guidelines when international update available
6191 Incidence and Subsequent Outcome of B1 Breast Biopsies
• No action required.
6198 Reporting Accuracy of Chest Radiographs in Patients Subsequently Shown to have Lung Cancer
• No action required.
6205 Uterine Artery Embolisaton for the Treatment of Fibroids (IP-367)
• No action required
6240 PET/ CT Correlation with Pathology in Lung Cancer Staging
• T-staging needs to be improved, this will be achieved by reviewing previous cases to look for learning points then feedback to and discuss with the 'team'.
6140 Femoral reamings and histology - Post operative follow up
• Add histology section to patient details section of trauma list • Remind all staff through Clinical Effectiveness meeting that histology should be chased and clearly documented in the notes • Histology/ Reamings documentation on consent form • Add Histology/ Reamings to operating list • Documentation of positive/ negative histology result should be added to Infloflex summary
6170 Follow-up of children who have failed to attend fracture clinic appointments
• Re-distribute guideline to all staff to ensure they are familiar with the policy • DNA sheets used at the end of clinic need to have age of patient printed on them to prompt clinician to review case notes • All DNAs to be dictated in future
6261 Prophylactic antibiotic guideline for fracture of hip repair to minimise clostridium difficile (C.diff) infections
• No action required
6029 Negative pressure wound therapy (NPWT) for the open abdomen (IP-322)
• No action required
6096 Infoflex Care Planning Summaries (CPS) - Safeguarding Children
• List of co-morbidities on Infoflex needs to be appropriate to children.

- Heading of 'Social Services/ AHP/ Nursing' is not appropriate for children.
- Discharge medication to be written on drug chart as well as TTA slip.
- Medication list and investigation list need completing fully for each patient.
- Surgical summary quality and timeliness needs to be improved.

6108 Managers Accountability for their Contribution to Safeguarding Children/ Information Sharing (inc CG89)

- Safeguarding needs to be in safety briefings in clinical areas
- Safeguarding/ Child Protection to be included in all departmental induction checklists, including how to access webpage
- Managers need to monitor training uptake.
- Safeguarding question in annual appraisals to be completed.
- Named Nurse will feedback in next Safeguarding newsletter.
- Named Nurse to remind of above and also remind of need for all clinical staff to access Level 2 training.
- Named Nurse will make departmental visits in next six months.

6135 Liverpool Care Pathway (LCP) ~ 2011/ 2012

- Develop clearer guidance for detail of death and where information should be held in the notes.
- The CNSs will continue with their on-going ward based education along with any other opportunities that are presented.
- Present audit to as many meetings as possible with a view to improving compliance with required standards. In addition to those meetings already covered it is recommended that the audit is also presented to the Matrons meeting.

6136 Note keeping 2011/ 2012

- A poster will be developed as a visual representation of good note keeping practice and highlight the importance of note keeping.
- Update note keeping Minimum Standards (Bleeps state Doctors & Specialist Nurses) and make more available.
- Laminate minimum standards (see above) and attach to ward note trollies
- Separate audit looking in more detail at ADs to be undertaken within three months of action plan agreement if deemed necessary
- Junior Doctors to arrange for a five minute training slot to be added to their teaching sessions for F1's and F2's
- Cascade information/ results to ADN's for dissemination to Modern Matrons
- Cascade results and actions to Clinical Directors, Health Records Stake Holders, Ward Managers, Consultants and Junior Doctors and MMA's of Health Professionals
- Improve membership of the Health Records Committee, with representatives from all divisions for both nursing and medical staff
- Rollout Ward audits currently used in Medicine to all divisions
- Documents signed off by the Health Records Committee to include above: JD Lesson Plan Logging Queries for Entries in Medical notes, Clinical Induction Handbook, E-Learning, Writing in Medical Notes, Minimum Standards for Note keeping, Health Records Management Policy

6169 Safeguarding Adults - Form 4 Consent

- Visit all wards to ensure that they are using the correct version of Mental Capacity Act (MCA) form and that an MCA form is attached to every Form 4.
- Results to go to Clinical Governance Leads
- Visit all wards to teach MCA use in practice
- Work with one area at a time to find a solution to the issues with consenting elective patients, rolling out across all areas.

Anaphylaxis Awareness (CG-134)

• Change anaphylaxis packs. Ideally pre-filled syringes in box reading "ANAPHYLAXIS, GIVE IM" • Ward Managers to encourage attendance at anaphylaxis training • Target staff to improve documentation (Particularly A&E) • Review and standardise Immunology referrals

The report of 3 national confidential enquiries was reviewed by the provider in 2012/13 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

ND0106 - Are We There Yet? A review of organisational and clinical aspects of children's surgery
• Guideline for the care of the critically ill and injured child being ratified compliant with PICS standards, Regional HDU and Regional Surgical Network Standards.
ND0098 - Bariatric surgery for weight loss
• Development of follow-up guidelines for patients discharged back to primary care after bariatric surgery and follow-up in the Level 3 service.
ND0103 - Knowing the risk - A review of the peri-operative care of surgical patients
• No action plan required.

Research

The number of patients receiving relevant health services provided or sub-contracted by South Devon Healthcare NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1798.

Participation in clinical research demonstrates South Devon Healthcare NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

South Devon Healthcare NHS Foundation Trust was involved in conducting 333 clinical research studies during 2012/13 in 30 medical specialities.

81 clinical staff participated in research approved by a research ethics committee at South Devon Healthcare NHS Foundation Trust during 2012/13. These staff participated in research covering 30 medical specialties.

As well, in the last three years, more than 28 publications have resulted from our involvement with the National Institute Health Research, which shows our

commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates South Devon Healthcare NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques. Here are just a few examples of how our participating in research improves patient care.

Ophthalmology.

The INTREPID study

Wet Age Related Macular Degeneration (AMD) is a debilitating disease affecting millions worldwide involving expensive and burdensome treatments such as near monthly injections.

Torbay took part in an international study which showed a onetime non invasive radiation therapy using a new device which is rapid and comfortable for the patient and easy to perform; significantly reduced the need for injections to successfully treat Wet Aged Related Macular Degeneration.

The company will now start commercialising this new device so this new treatment can be offered to patients more widely.

Diabetes

The EXPLORER study

Torbay is currently participating in Europe's first double blind randomised controlled trial to assess the efficacy and tolerability of a new dressing in the treatment of diabetes foot ulceration.

There is an urgent need to have more effective treatment and this study will help provide important evidence to support better wound care in such patients to improve patient's outcomes and reduce the expense and burden to both society and healthcare.

Cancer

The Stanford V study

This study showed that the efficacy of a new weekly chemotherapy regimen called Stanford V was comparable to the current standard twice weekly chemotherapy combination regimen (ABVD) when given in combination with appropriate radiotherapy in patients with advanced Hodgkin's Lymphoma.

CQUIN payment

A proportion of South Devon Healthcare NHS Foundation Trust income in 2012/13 was conditional on achieving quality and improvement and innovation goals agreed between South Devon Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Details of the 2012/13 CQUINs can be found is this report and the 2013/14 are available online through the Trust website.

In 2012/13 the potential value of the CQUIN payment was £4,519,547 and income subsequently received was £4,360,278 (tbc). In 2013/14 the value of the CQUIN payment is £4,500,000 (tbc).

Care Quality Commission

South Devon Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC). Its current registration status is for: -

- Diagnostic and screening procedures
- Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

South Devon Healthcare NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against South Devon Healthcare NHS Foundation Trust during 2012/13.

South Devon Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

The Trust received two unannounced visits from the Care Quality Commission during 2012/13 as part of their routine monitoring programme.

During their first visit in September 2012 they visited theatres, several ward areas and looked at the treatment records of patients. They also observed how people were being cared for and spoke with the people using the services and staff delivering the services.

Five of the seven CQC Outcomes were found to be fully compliant, whilst two (Outcome 4 (relating to theatre observations) and Outcome 8 (relating to cleanliness and infection control on just two wards)) were found to be non compliant. Action plans were submitted to the CQC.

A further unannounced visit took place in February 2013, to review compliance against Outcomes 4 and Outcome 8. Inspectors spent a morning in theatres and the afternoon on four wards. The outcomes were found to be fully compliant.

Data quality

Data quality is a key enabler in delivering high quality services. Data and information which is accurate, timely and relevant allows clinical teams to make informed decisions about patient care and service delivery. Within the Trust, the Board has access to a locally developed data quality dashboard and receives, on a monthly basis, an integrated performance report, a dashboard of key performance indicators and a more detailed data book. This allows the Trust Board to monitor performance and address any issues in the year.

NHS number and general practitioner registration code

South Devon Healthcare NHS Foundation Trust submitted records during 2012/13 to the Secondary Users' service for inclusion in the Hospital Episode statistics which are included in the latest published data. The percentage of records in the published data, as of February 2013 (Month 11), which included the patient's valid NHS number was:

- 99.5% for admitted care
- 99.7% for outpatient care
- 98.1% for accident and emergency care

which included the patient's valid General Practitioner Registration Code was:

- 99.9% for admitted care
- 100% for outpatient care
- 99.5% for accident and emergency care

Clinical coding

South Devon Healthcare NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Neonatal disorders

Clinical coding				
% clinical codes incorrect	% diagnoses incorrect		% procedures incorrect	
	Primary	Secondary	Primary	Secondary
24.0	30.0	21.1	0.0	0.0

Thoracic procedures and disorders:

Area	Clinical coding				
	% clinical codes incorrect	% diagnoses incorrect		% procedures incorrect	
		Primary	Secondary	Primary	Secondary
DZ11A-C *Lobar, Atypical or Viral Pneumonia with Major CC*	11.1	9.1	11.2	33.3	0.0
DZ15A-F *Asthma with Major CC with Intubation*	23.1	2.5	32.8	75.0	50.0
DZ17C *Asthma without CC without Intubation*	8.2	6.3	5.2	0.0	33.3

Information governance

South Devon Healthcare NHS Foundation Trust Information Governance Assessment report overall score for 2012/13 was 84% and was graded green.

Data quality improvements: looking back 2012/13

South Devon Healthcare NHS Foundation Trust committed to take the following actions to improve data quality in 2012/13:

- **Improve the quality of outpatient clinic outcome letters for patient attendances and email these within agreed timescales.**

  This has been a very difficult and complex project with clinicians involved in various cycles of development. The first Department, Breast Care, went live with a new electronic letter replacement system in March 2013 and a rolling 12 month programme is being deployed to cover the other specialities.

  In 2012/13 the Trust also undertook to improve the timeliness of outpatient letters received by general practitioners using the existing system. This has been achieved and more information can be found in the CQUIN section of the report.

- **Reduce the small number of clinical coding errors through providing additional training and reviewing ward based coding.**

Clinical coding staff have received coding refresher training. Processes are being reviewed to ensure timely information reaches the coders to ensure better accuracy. New methods are being trialled in cardiology wards and then rolled out across other areas.

Case note review audits are planned in 2013/14 with the results fed back to clinical teams to further improve clinical coding.

- **Act on any recommendations from the external audit of the 2011/12 Quality Accounts.**

  Price Waterhouse Coopers undertook three data quality audits as part of the 2011/12 Quality Account requirements.

  The following indicators were audited:

  - Clostridium difficile.
  - Maximum 62 days from urgent GP referral to first treatment for all cancers.
  - Emergency readmissions to hospital within 28 days of discharge – including readmissions following both elective and non-elective procedures.

  No errors were identified in the samples tested.

  Only one control issue was identified with the 62 day cancer indicator. This relates to the mismatch of dates to file performance returns on two mandated reporting systems. It has not been possible to align the dates as these are nationally and regionally set.

- **Improve our Information Governance rating to 90%**

  The Trust has improved its overall rating in the year by 1%, from 83% to 84%. However risks to information are being managed and controlled by applying a more robust assessment as part of the national Information Governance Toolkit return.

  A new action plan will be created to deliver improvements against the 2012/13 rating. Information Governance will be overseen by the Information Governance Steering Group which is chaired by the Senior Information Risk Owner who is also the Director of Finance, Performance and Information.

  Maintaining level three compliance for those requirements already at level three is a priority for 2013/14.

- **Set up a programme for undertaking data quality audits of the Trust Boards performance dashboard indicators with a minimum of 4 audits in 2012/13**

  Several additional Board level audits were undertaken including:

NHS Litigation Authority Audit

An audit was undertaken in preparation for the NHSLA Risk Management Standards assessment in October 2012, the national criteria for which had changed significantly since the last review in 2009.

The objectives of the audit were to:

- review the arrangements put in place to enable the Trust to assess its compliance with the standards
- review a sample of ten 'document processes' (two from each standard), as defined in Level one, to assess whether they included all necessary points as detailed in the criteria requirements
- undertake an assessment against Level two requirements for the same ten criteria as for the Level one review
- confirm that all actions from the last assessment carried out in November 2009 have been completed as appropriate.

The outcome of the audit included a Trust recommendation to apply for level one assessment and to continuing collecting evidence for level two.

Clostridium Difficile

One of the key dashboard indicators reported to the Board Monitor is Clostridium difficile. The Trust baseline target for 2012/13 hospital acquired cases of Clostridium difficile is 20.

The following were tested to confirm that:

- Clostridium difficile policy is being followed including identification of Clostridium difficile patients within four days of patient admission and management of patients with Clostridium difficile
- Every case of Clostridium difficile is appropriately followed up including completing a detailed root cause analysis.
- The action plan is being appropriately monitored and that actions are completed on a timely basis.

The outcome of the assessment was that that Trust were taking all appropriate actions and there were sufficient controls in place surrounding the management of Clostridium difficile across the Trust.

Accident and emergency 12 hour trolley wait
The Trust is required to report any incidences where a patient waited more than 12 hours in the Accident & Emergency (A&E) Department, from the time the decision was made to admit the patient or when treatment in A&E is completed. An audit was undertaken in Spring 2012 to review the number of patients admitted to A & E to establish whether there had been any incidents where a patient may have breached the 12 hour waiting time, which had not been reported as required. The results of the audit indicated that there were/were not x number of patients waiting for longer than 12 hours. It was also noted that the processes monitoring waits could be further improved and a new A & E system is being implemented in 2013/14 which will support improved monitoring.

- **Work with staff managing information assets (databases & IT systems) to review the data quality via regular data quality audits and spot checks**

  In 2012/13 a number of data quality audits and spot check were carried out including:

  - NHS Number compliance on letters sent via 3rd Party mailing company
  - Spot checks on the quality of scanned data into WinDIP (electronic document management system) completed by an external bureau
  - Patient administration system (PAS) spot checks on the data quality of PAS patient registrations

  We have also appointed a data quality specialist to develop a programme of work for data quality audits and spot checks for the period 2013/14.

- **License the trust to enable all staff to access the data quality dashboard which is hosted on the SharePoint collaboration.**

  Clinicians are being encouraged via clinical coding champions and the Clinical Audit Lead to utilise the Data Quality Group to focus on areas of concern with data quality and identify root causes.

Data quality improvements: looking forward 2013/14

South Devon Healthcare NHS Foundation Trust has committed to take the following actions to improve data quality in 2013/14:

- Giving clinicians access to information as part of Service Line Reporting to support their clinical duties and also help identify and resolve any data quality issues.

- Publish the ICT Strategy by summer 2013 with a heavy emphasis to implement systems which support data quality.

- Start to implement the new Emergency Department IT system which will involve paperless working by August 2014

- Implement fully patient held records system (Patients Know Best) for the Diabetic service providing patient's visibility of data, errors or omissions which can be feed back to the areas concerned. Sharing laboratory results, Care Plan Summaries, Outpatient Outcome letters.

- Implement UltraGenda, enterprise wide laboratory scheduling for clinicians by producing events, clinical pathway required for Oncology by December 2013. The system automation minimises manual errors.

- Create a test environment for a clinical portal by summer 2013 and when fully tested start to roll out to 80% of the clinical teams by March 2014. This will enable the clinical teams to analyse data and improve practices e.g. reviewing laboratory results alongside other data from four other clinical systems in a central view per patient.

- Electronic Document Management: continue to develop the use of this product and support areas with paperless/paperlight working. Pilot using the iPad for outpatient data capture will be undertaken by Speech & Language Therapy.

- Deployment of clinical mobile devices based on the apple iPads and iphone will support clinicians to record and review information on wards at the patient's bedside using systems such as VitalPAC to record vital signs observations

- Roll out additional software modules of VitalPAC around infection prevention and automatic doctor escalation and feedback.

- Continue the roll out of the Surgical Operation Note to enhance patient care and make information available to all clinicians via the clinical portal. Eleven specialties are live with the Surgical Operation Note, with three still to go live, although one of the three is Trauma and Orthopaedics one of the largest surgical areas.

Part 3: Our performance in 2012/13

Overview

Torbay Hospital is a Foundation Trust and as such is accountable to a number of different organisations for the delivery of high quality care as well as to the patients, families and carers who access our services at the Hospital.

Currently, we are accountable to

- Monitor, our regulator
- The Care Quality Commission
- The local commissioners via the various health contracts
- Our local communities through our members and governors

To ensure that we deliver high quality care we have robust governance arrangements in place to monitor our organisational performance and to make sure that annual national and local agreed standards and targets are met. This includes five governance work streams which report to the Trust Board.

Work stream1	Work stream 2	Work stream 3	Work stream 4	Work stream 5
Patient safety	Patient experience & community partnerships	Finance Committee	Workforce & educational governance	Infrastructure & environment

The work streams are made up of senior clinicians, nurse leads, Trust executives and are chaired by Non-Executive Directors. Governors attend as observers and the local commissioners attend both the Safety and Experience Committees.

The Trust Board also receives monthly Board reports and data dashboards indicating our latest performance and actions to address issues.

We meet with commissioners to share information, provide updates and to review our performance against a range of quality measures and we provide information to Monitor on a quarterly basis.

Good governance, sound financial management and high clinical standards are at the heart of ensuring we are performing well. In 2012/13 we continued to be rated amber-green by Monitor

Monitor Risk ratings at a glance

Finance

High risk *Low risk*

Governance

Source: Monitor website: April 09 2013

The Trust moved from green to amber-green in the year due to reporting 21 clostridium difficile cases against the required plan of 20. Monitor has acknowledged the work undertaken by the Trust in meeting this challenging target.

Our performance against mandated quality indicators

This year the Trust is required to publish a core set of quality indicators and statements as mandated in the Quality Account Regulations.

Previous quality indicators from last year's report have been included where they usefully supplement the mandated indicators.

For each indicator South Devon Healthcare NHS Foundation Trust considers that this data is as described, for the following reasons.

- Data is collected, collated and reported by the Trust following agreed local, regional or national criteria.
- Information is shared internally and published externally where appropriate.
- Data is audited periodically to ensure high quality data is reported.

The quality indicators are broken into the three areas: safety, clinical effectiveness and patient experience to allow for easier comparison.

Safety

Quality indicator	Source	Target (National or Local)	2012/13	2011/12	2010/11	End of year performance against Target
VTE risk assessed	UNIFY	90% (National)	92%	n/a	n/a	
• South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by capturing information electronically rather than through case note audits. This has allowed accurate reporting and timely feedback to clinical teams about their performance.						
Number of clostridium difficile cases (C diff)	Health Protection Agency *(6a)*	20 cases (Local)	21	24	26	
• South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number, and so improve the quality of its services, by the management of C diff using electronic white boards and EDDs to identify patients with CDT / GDH positive and PCR positive that are being discharged. This allows the deep cleaning team time to arrange for the rooms to be bioquelled .This has given added assurances to the standard of cleaning as well as ensuring areas are returned back to operational use in the shortest time . • The bioquell system has also been used for norovirus outbreaks reducing further risks of acquisition of C diff. The trust continues to have effective infection control processes which are always under review to meet the challenges of a complex and changing operational system.						
Number of patient safety incidents	Safeguard	Not applicable	4782	4826	4446	Not applicable
• South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by encouraging all staff to record and report incidents on the Trusts internal Safeguard Risk management and therefore we set no reduction target as this may have a negative effect on reporting. • The NRLS actively encourage organisations to report more incidents to ensure organisations have a clear picture of what incidents are taking place.						
Number & % of such patient safety incidents that resulted in sever harm or death.	Safeguard	10% reduction yr on yr	42	69	82	
• South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number and so improve the quality of its services by undertaking a root cause analysis investigation on all major and catastrophic incidents. • The Trust, through its safety work uses this data to help improve the quality and safety of its systems and services and is seeing a year on year reduction. The ultimate aim of the trust is to remove all avoidable harm from the system.						

Clinical effectiveness

Quality indicator	Source	Benchmark (National	2012/13	2011/12	2010/11	End of year performance against Benchmark
% of patients aged readmitted to hospital within 28 days	Dr Foster					
• 0-14		5.8%	4.0%	4..2%	4.4%	
• =>15		7.4%	.4%	7.4%	7.6%	
• South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by working with consultant teams and community services to audit and undertake root cause analysis of patients who have been readmitted to hospital. Where this identifies potential areas for improvement these will be used to form the basis of an ongoing action plan and future service developments.						
Summary hospital mortality indicator (SHMI)	Dr Foster	100	95.58	94.08	94.9	
Hospital Standardised Mortality rate (HSMR)	Dr Foster	100*	87.5	89.7	96	
• South Devon Healthcare NHS Foundation has taken the following actions to improve this rate, and so the quality of its services by maintaining a proactive approach to patient safety. This will be managed through the Patients Safety Committee and its subcommittees so that regular reviews of all clinical incidences are completed as well as taking action if any alerts are received from Dr Foster.						
% of patient deaths with palliative care coded at either diagnosis or speciality level	TBC					
• South Devon Healthcare NHS Foundation Trust ... tbc						

Patient experience

Quality indicator	Source	Benchmark (National)	2012/13	2011/12	2010/11	End of year performance against Benchmark
Patient Reported Outcome measures	PROMS online		Not yet available		Not applicable	Not applicable
Groin hernia surgery		49.8%		44.4%		
Varicose vein surgery		53.2%		56.5%		
Hip replacement surgery		87.4%		81.7%		
Knee replacement surgery		78.4%		78.7%		

- South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by ensuring that patients are fully engaged in the PROMS process and data is returned to inform these rates. The results of completed survey will be used and disseminated to relevant doctors.

Staff recommendation of the trust as a place to work or receive treatment	NHS Staff Survey *(KF24)*	3.57	3.85	3.79	3.57	

- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by engaging with staff to understand issues and to work proactively to improve the quality of care.

Number of patient complaints	Safeguard	n/a	tbc	173	170	n/a

- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve the percentage of timely responses and so the quality of its services, by clarifying the response times in the acknowledgement letters.
- The Trust welcomes all feedback and aims to ensure this learning is shared across the organisation and we continue to be patient focused.

Overall patient experience	NHS Inpatient survey	7.1 Lowest performer	8.1	n/a	n/a	

- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by capturing real time patient feedback promptly and ensuring there are robust mechanisms to respond to complaints, improvements required and positive feedback

Our performance against key national priorities

Monitor

We are required to report to Monitor quarterly on a range of targets/indicators. Our performance based on the Trust's data over the last 12 months is shown below.

Indicator/Target	Target 12/13	12/13	2011/12
C.difficile year on year reduction	20	21	24
MRSA - Meeting the MRSA objective	1	1	0
Cancer 31 day wait from diagnosis to first treatment	>96%	98%	98%
Cancer 31 day wait for second or subsequent treatment: surgery	>94%	97%	97%
Cancer 31 day wait for second or subsequent treatment: drug treatments	>98%	100%	100%
Cancer 31 day wait for second or subsequent treatment: radiotherapy	>94%	98%	97%
Cancer 62 day wait for first treatment (from urgent GP referral)	>85%	88%	90%
Cancer 62 day wait for first treatment (From consultant led screening service referral)	>90%	96%	93%
Cancer two week wait from referral to first seen date	>93%	97%	97%
Cancer breast symptoms two week wait from referral to first seen date	>93%	98%	100%
A & E – total time in A & E	95% <4hrs	96%	98%
Referral time to treatment time, admitted patients	90% <18 weeks	92%	93%
Referral time to treatment time, non admitted patients	95% <18 weeks	96%	97%

NHS Operating Framework and local priorities

We also collect from our local IT systems a range of data and report them against national and local measures to inform the Trust on quality and performance. These include:-

Other National and local priorities	Target 12/13	12/13	2011/12
Smoking during pregnancy	19.4%	15.0%	15.8%
Breastfeeding initiation rates (% initiated breast feeding)	76.3%	76%	74.6%
Mixed sex accommodation breaches of standard	0	1	9
Cancelled operations on the day of surgery	0.8%	1.2%	0.7%
DNA rate	6%	5.5%	5.7%
Diagnostic tests longer than the 6 week standard	1%	1%	1.5%
Rapid access chest pain clinic waiting times: seen in 2 weeks	98%	100%	100%

Primary PCI within 150 minutes of calling	68%	85%	88%
Other National and local priorities	**Target 12/13**	**12/13**	**2011/12**
Patients waiting longer than three months (13 weeks) for revascularisation	0.1%	0%	0%
Stroke care: 90% of time spent on stroke ward	80%	79%	89%
Diabetic retinopathy screening	95%	92%	97%
Ethnic coding data quality	80%	94%	95%

In 2013/14 we will continue to use a range of metrics to measure the quality and performance of the organisation and continue to make this more accessible to the Public through our website and various publications.

Annex 1

Engagement in developing the Quality Accounts

Prior to the publication of the 2012/13 Quality Accounts we have shared this document with:

- Our Trust governors and commissioners
- Torbay & Devon Local Involvement Networks(LINks)
- Torbay Council Health Scrutiny Board
- Devon County Council's Health and Wellbeing Scrutiny Committee

This year's Quality Accounts has benefitted again from a wider consultation process and greater engagement with our community in choosing the 2013/14 priority areas. In 2012/13 we worked with our Governors in developing the annual Foundation Trust Member's Survey and we have also continued to engage with a wide range of stakeholders including clinicians, charities, commissioners and lay representatives.

The development of CQUINs has been clinically led and the 2013/14 continuous improvement projects form part of our annual business planning cycle.

In March 2013, the Trust held its annual Quality Accounts Engagement event inviting key stakeholders to come together and recommend the priority areas to be included in this year's Quality Accounts. These have all been subsequently signed off at Board level.

We will share our progress against the quality improvement priorities throughout the year and continue to work closely with the users of our services to improve the overall quality of care offered.

Statements from Commissioners, Governors, OSCs and LINk

To be added

Annex 2

CQUIN 2012/13 performance - full details & outcome available at www.sdhl.nhsuk

GOAL	INDICATOR	Q1	Q2	Q3	Q4
VTE prevention	Compliance of 90% assessment at admission on UNIFY				
	Compliance with VTE Nice guidance for patient information and planning for discharge.				
Patient experience	Composite indicator on responsiveness to personal needs - Inpatient survey	**Not applicable**			4 out of 5 met
	Composite indicator on responsiveness to personal needs - Real-time feedback & observations of care				
Dementia	Improve Case finding				<90% achieved
	Improve risk assessment				
	Improve referral to specialist				
Safety thermometer	Improve collection of data - pressure ulcers, falls, UTIs in those with a catheter and VTE through implementing safety thermometer				
Productive ward	Productive ward – completion of 63 modules across the wards				
Patient flow	Understand the impact & variation of demand & service process time on patient flow & productivity along the emergency pathway				
Frequent users	Improve the identification and management of frequent users				
ER in medicine	Develop, test and apply the enhanced recovery model of care to medicine....				
Clinic letters	Improve the timeliness of clinic letters (<=4 days typed)				
Diabetes	Set up and deliver enhanced diabetes care service within primary care				
Meds management	Pass through drugs				
Clinical referral triage	To design and test CRT in minimum of two specialities				
End of Life	Implementation of Routes to Success in Acute Hospitals				
Care planning summaries	Maintain Timeliness – weekdays (77%)				
	Improve Timeliness – weekends (60%)				
Transition of care	Improve the transition of care for young people (epilepsy, neuromuscular disorders and cystic fibrosis)				
DOS	To set up and populate minimum requirements the new national Directory of Services				
SCG Breastfeeding	Breastfeeding				
SCG Haemophilia	Haemtrack				
SCG Dashboard	Quality dashboard				