Tuesday, 1 May 2012

HEALTH SCRUTINY BOARD

A meeting of **Health Scrutiny Board** will be held on

Monday, 14 May 2012

commencing at **2.30 pm**

The meeting will be held in the Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Committee

Councillor Barnby (Chairman)

Councillor Bent
Councillor Davies (Vice-Chair)
Councillor Doggett
Councillor James
Councillor McPhail
Councillor Parrott
Councillor Thomas (J)

Working for a healthy, prosperous and happy Bay

For information relating to this meeting or to request a copy in another format or language please contact:
Kate Spencer, Town Hall, Castle Circus, Torquay, TQ1 3DR
01803 207014
Email: scrutiny@torbay.gov.uk

HEALTH SCRUTINY BOARD
AGENDA

1. Apologies

To receive apologies for absence, including notifications of any changes to the committee membership.

2. Minutes (Page 1)

To confirm as correct records the Minutes of the meeting of this Board held on 26 March 2012.

3. Declarations of interests

(a) To receive declarations of personal interests in respect of items on this agenda.

For reference: Having declared their personal interest members and officers may remain in the meeting and speak (and, in the case of Members, vote on the matter in question). If the Member's interest only arises because they have been appointed to an outside body by the Council (or if the interest is as a member of another public body) then the interest need only be declared if the Member wishes to speak and/or vote on the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(b) To receive declarations of personal prejudicial interests in respect of items on this agenda.

For reference: A Member with a personal interest also has a prejudicial interest in that matter if a member of the public (with knowledge of the relevant facts) would reasonably regard the interest as so significant that it is likely to influence their judgement of the public interest. Where a Member has a personal prejudicial interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Democratic Services or Legal Services prior to the meeting.)

4. Urgent items

To consider any other items that the Chairman decides are urgent.

5. Quality Account 2011/2012 - Torbay and Southern Devon Health and Care NHS Trust (Pages 2 - 45)

To consider the draft Quality Account of Torbay and Southern Devon Health and Care NHS Trust for 2011/2012 and the Board's proposed response.

6.	**Quality Account 2011/2012 - South Devon Healthcare NHS Foundation Trust** To consider the draft Quality Account of South Devon Healthcare NHS Foundation Trust for 2011/2012 and the Board's proposed response.	(Pages 46 - 97)
7.	**Quality Account 2011/2012 - South Western Ambulance Service NHS Foundation Trust** To consider the draft Quality Account of South Western Ambulance Service NHS Foundation Trust for 2011/2012 and the Board's proposed response.	(Pages 98 - 120)
8.	**Quality Account 2011/2012 - Devon Partnership NHS Trust** To consider the draft Quality Account of Devon Partnership NHS Trust for 2011/2012 and the Board's proposed response.	(Pages 121 - 141)

Minutes of the Health Scrutiny Board

26 March 2012

-: Present :-

Councillor Barnby (Chairwoman)

Councillors Bent, Davies (Vice-Chair), Doggett, James, McPhail, Thomas (J) and Parrott

(Also in attendance: Councillors Hernandez and Lewis)

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618. Minutes

The minutes of the meeting of the Board held on 15 December 2011 were confirmed as a correct record and signed by the Chairman.

619. Public Health Transition Plan

The Director of Public Health answered a number of questions from the Board on the Public Health Transition Plan including Service Delivery, Form and Function, Communication, Budgets, Key Milestones, Risks and Member Involvement.

It was noted that NHS Torbay and Torbay Council have a good working relationship and the Director of Public Health would like to thank the Chief Executive of Torbay Council for the continued support that is received.

It was noted that although final budget allocation for Public Health has yet to be announced it was recognised that the team would have to operate within the budget allocation and there would be no additional costs to the council.

The Director of Public Health explained that she had seconded Sue Matthews to work with the Director of Children's Services to improve service delivery.

The Board heard that information about the Health Premium Reward Scheme will be available in May.

It was agreed that the Director of Public Health will provide a link to councillors to the NHS Torbay newsletter.

Resolved:

(i) that a detailed risk plan (with three key themes of finance, relationships with NHS agencies and clarity of expectations) be presented to a future meeting of this Board;

(ii) that the Executive Lead for Involved and Healthy Communities be included as a member of the Torbay Transition Team;

(iii) that the Public Health Transition Plan be presented as an update to each Health Scrutiny Board; and

(iv) that during the transition period there is regular communication with the Executive Lead and the Director of Public Health to ensure there is no duplication of work between the Health Scrutiny Board and the Health and Wellbeing Board.

620. Summary of Quality Accounts

The Board heard that although the public consultation was late NHS Torbay have done as much as possible to ensure a good response to the surveys.

The Board heard that 90% of staff who work for safeguarding vulnerable people will receive training at the appropriate level for the role they are in. Concerns were raised about the proportion of staff requiring training and the Board requested clarity that the current staffs are competent in their roles.

The Board heard that obesity was chosen by public and staff as the most important issue in the Bay.

The Board heard that carers will receive better help to avoid vulnerable people going into care/hospital.

The Board were informed that Quality Accounts will be published in April and presented to this Board in May.

Resolved: that public consultation should start earlier than December in the future.

Chairman

Torbay and Southern Devon Health and Care NHS Trust

Quality Account 2011/12

PART 1

Torbay Care Trust is pleased to provide this, their second quality account. We are delighted to share with you some of the successful quality and safety improvement work undertaken in 2011/12 in part 3 and in part 2 to explain the priorities we have agreed for 2012/13.

Quality Account
Chief Executives Statement

In April 2011 Torbay Care Trust began providing community health services within Southern Devon. The integration of community health services across the southern part of Devon, including nine community hospitals and the integration of 800 members of staff, has made 2011 a significant year for local health services.

The changes however haven't stopped there; on the 1st April 2012 Torbay Care Trust became known as Torbay and Southern Devon Health and Care NHS Trust. The name change reflects the new organisational responsibilities in Southern Devon but also reflects the necessary separation of commissioning and provider responsibilities, as part of the NHS reforms. From 1st of April the new Trust handed over commissioning responsibilities for local health services to an organisation known as NHS Torbay, who work to the PCT (Primary Care Trust) cluster of Devon, Plymouth and Torbay.

Our new organisation has retained responsibility for commissioning and providing adult social care in Torbay, meaning the new Trust remains the only organisation in the South West to provide an integrated model of health and adult social care. Something we are very proud of.

The changes, have of course required careful management but this has also proved to be an exciting time as it enables the Trust to deliver the highest possible standards of patient safety and quality across a much wider health community. It has given us the opportunity to provide a more joined up service across a larger area and to collaborate more closely with colleagues in Southern Devon.

The Trust's ambition of ensuring local people receive the right care, in the right place and at the right time remains at the heart of what we do and is fundamentally under pinned by our aspiration to provide everyone who comes in contact with our services with high quality, safe and effective standards of care. The aim of the Quality Account is to ensure that our service users, patients, public and our commissioners are able to see exactly how we do this and it is an opportunity for the Trust to demonstrate where and how improvements have been made.

Our second annual Quality Account shows the successes, achievements and progress that we have made in 2011 to improve the safety and quality of our services. In 2011 we met and surpassed our target for reducing the number of infections acquired in healthcare settings, our compliance with medicines reconciliation has improved from 42 per cent to 87 per cent and of the patients asked, 100% reported that they felt they had been treated with dignity and respect.

Over the last year we have worked closely with the Strategic Health Authority to develop safety initiatives in a number of key areas. One of which is to reduce the harm sustained from falls, the improvement work undertaken has seen a sustained reduction in number of patients falling in our hospitals. All 11 of our community hospitals have continued to perform well in the annual Patient Environment Action Team assessments, which look at privacy and dignity, food and the environment and at the end of last year we were highly commended at the national Health Service Journal (HSJ) awards for improving the efficiency and effectiveness of the care process.

The feedback from our patients, service users, local carers and staff is central to what we do and it is in my view that learning from the experiences of those in our care is the most important way of knowing what works well and what could be improved. That is why the development of the Quality Account has also included a range of stakeholder engagement through questionnaires, direct feedback and service evaluation. It also takes the opportunity in part two, to look to the future and outline the priorities for safety, clinical effectiveness and patient experience that the public and our staff want us to focus on in the next year.

The next year will no doubt prove to be just as challenging as the last; providing cost effective and efficient care has never been more important, not only to the Board of Torbay and Southern Devon Health and Care NHS Trust but to our staff and most importantly all of the people who use or may need to access our services in the future.

I hope that this year's Quality Account will give you an insight into how we are performing in the clinical effectiveness, safety and quality of care we provide and demonstrate our continued commitment to improve and develop over the next 12 months.

To the best of my knowledge the information contained within this document is accurate and provides a balanced picture of quality and performance in the organisation between 2011-2012.

Kind Regards

Anthony Farnsworth

Chief Executive
Torbay and Southern Devon Health and Care NHS Trust

Statement of Directors responsibilities 2011-2012

The Quality Account 2011-2012 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 Care Trust performance between 2011- 2012.

Anthony Farnsworth

Chief Executive

Torbay and Southern Devon Health and Care NHS Trust

Julie Dent

Chairman

Torbay and Southern Devon Health and Care NHS Trust

PART 2

In this part of the quality account we will look forward as Torbay and Southern Devon Health and Care NHS Trust, explaining our priorities for 2012/13. The guiding principles and intentions that underpin quality improvement and effectiveness in health and adult social care for the Trust are written below these provide a framework within which we will focus upon delivering safe, effective care shaped by those who use our services.

Our Intentions

People	To provide people with the support they need to maintain good health, recover from illness, remain in control of their lives, and live as independently as possible.
Quality	To ensure that all our services are of the highest quality because they are designed to keep people safe, prevent ill health, treat illness and promote independence.
Impact	To deliver services that are innovative, personalised and focussed on promoting healthy communities, restoring people who have been ill to good health, reducing delays and keeping people safe at home.
Partners	To work in a ways which generate success for all our partners, in the provision of health and social services, and achieves best value for tax payers and those who fund us.
Affordability	To make good use of public money by ensuring that our services are efficient, effective, sustainable and regarded as being the best at what we do.

Our principles

Our Staff	Our Staff are the foundation of all we do, we want to make sure they are involved in setting our priorities, know what is expected of them and receive the respect, trust and support they need to do their jobs.
Our Community	We will ask people about our services, listen to what they say and then design our services so that the care we provide matches the needs of the individuals and communities which we are here to serve.

In 2011/12 the Trust completed a number of excellent quality improvement projects addressing safety, clinical effectiveness and patient experience; we plan to build upon this work during 2012/13.

National priorities:

In 2012/13 there are a number of nationally mandated quality improvement projects that we will be undertaking in addition to the local priorities identified within this account. The national priorities are defined within the NHS Outcomes Framework 2012/13 (DH 2011). These require us to further develop the work we started last year relating to:

Implementation of the NICE Dementia Care Standards:

Within our community hospitals we recognise that whilst people with a dementia are receiving care for a physical illness it is essential that other needs including their dementia care are managed effectively, reducing the stress of a hospital stay on both the patient and their family and carers. As highlighted within the NHS Operating Framework 2012/13 we will continue to improve the patients experience and quality of care in nutrition and hydration, respecting their dignity and eliminating mixed sex accommodation within our hospitals.

We will implement the good examples in the Care Quality Commission's report "Dignity and Nutrition for Older People". This will include 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. This will include implementation of the National Institute for Health and Clinical Excellence Quality Standards for Dementia Care, meeting both the physical and mental health needs of people with a dementia.

Implementation of the National Patient Safety Thermometer:

Whilst the majority of patients experience no adverse events as a result of being in hospital, there is evidence that an unacceptable number do sustain an injury as a direct result of being in hospital. This could be a fall, an infection or a pressure ulcer for example. For this reason, a tool to measure patient harm called 'The Safety Thermometer' has been developed. We will implement the patient safety thermometer, a process that will enable us to monitor the incidence of adverse events such as falls, pressure ulcers, venous thromboembolism (VTE) and catheter acquired urinary tract infections.

It is our intention to reduce the incidence of these events with safety improvement projects. The Safety Thermometer will allow us to monitor progress and demonstrate the effectiveness of specific interventions.

Improving the service user experience:

Listening and learning from the experiences of those who use our services is essential to ensure we deliver the services our local community value and to a standard they expect. Last year we established a patient questionnaire that was completed by all of the patients discharged from our community hospitals. The results have provided valuable feedback about the patient experience. We will adopt a similar approach to engage with people who receive care from our community based teams. This will include peoples' experience of safeguarding adults as well as the more mainstream services such as community nursing and social work.

We will develop a feedback survey for those people receiving care in the community.

Reducing the incidence of Healthcare Associated Infections

The Trust supports the Department of Health ambition to reduce the number of MRSA bloodstream and Clostridium difficile infections, an objective set within the NHS Operating Framework for 2012/13. In 2011/12 the Trust reported 2 cases of MRSA bloodstream infections against a regionally agreed target of 4, and managing Clostridium difficile infection rates to 83 set against a regional target of 207. We will continue to work with our partners to further reduce the incidence of HCAIs by providing advice and training in infection control standards and continuing our focus on providing a clean environment within our hospitals.

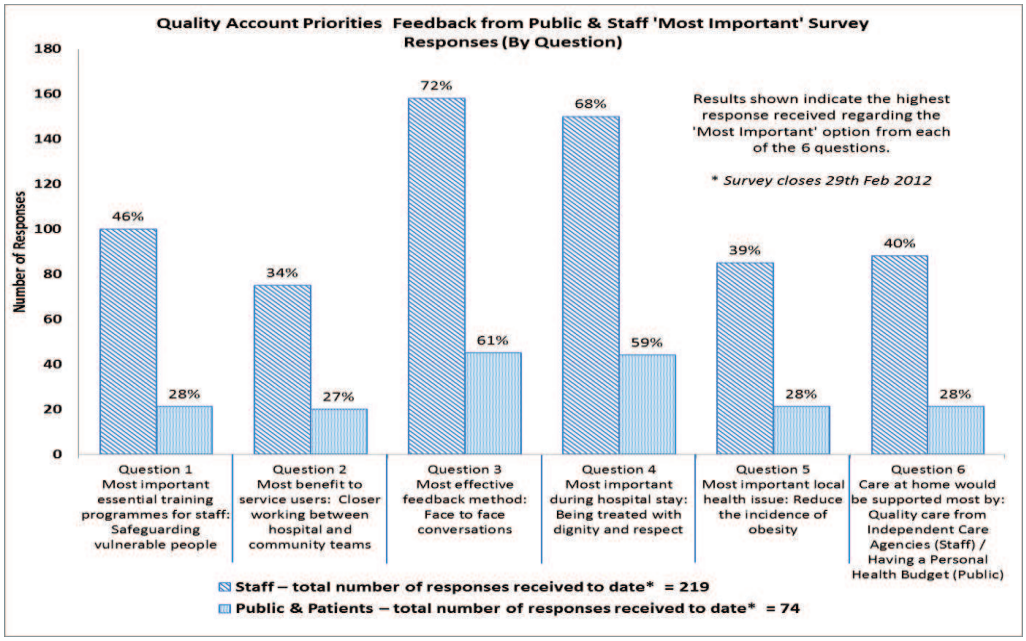
It is our intention to reduce MRSA bloodstream and Clostridium difficile infections in 2012/13 using our performance last year to measure this improvement.

An update on our performance against the improvement targets set last year for these national priorities can be found in section three. We will be enhancing and progressing improvements relating to the above priorities this year.

Local Priorities:

Stakeholder engagement:

As part of its duty to involve and consult service users, the public, carers, staff, members of our Local Authorities and commissioners to develop meaningful priorities for the coming year, the Trust developed a Quality Account survey. Respondents were asked to rank answers in order of importance. This survey was made available electronically via Torbay Care Trust website with paper versions provided where required accompanied by a pre-paid envelope. Posters were widely distributed inviting people to participate explaining the Quality Account, purpose of the survey and how to access the survey. Distribution included the Carers Support Workers in GP surgeries, carer support groups and the Torbay Carers Forum. Invites were also sent to the Overview & Scrutiny Committees, LINks in Devon and in Torbay, community hospital patients and staff within the Trust. The graph below shows the areas that have scored the highest and are felt most important to the participants. The results indicate that both staff and patients/public agree on most priorities. The results gathered from the survey have influenced a number of the Trust Priorities for 2012 – 2013.



In addition to the consultations undertaken, we have reviewed national and local best practice recommendations to inform our final list of priorities for 2012/13.

This scope of this review included but was not limited to:

- The NHS Operating Framework
- National Standards for Dementia Care
- Locally agreed Commissioning for Quality and Innovation (CQuIN) priorities
- National Institute for Clinical Excellence (NICE) guidance
- National Quality Standards
- Care Quality Commission (CQC) essential standards
- The Trust intentions that support its purpose and mission statement
- Priorities identified by the Trust as important to people who receive our care from feedback and other consultation events
- Discussions with clinical leads and managers within the Trust and partner organisations
- Patient and user publications such as the Department of Health NHS Future Forum (1) Report June 2011 and Phase 2 Report Jan 2012

The above process resulted in the production of a long list of 15 local priories. These were considered by the Trust Clinical Advisory Group, the Board and other internal and external groups to establish the priorities that we will focus on in 2012/13. These were again considered by stakeholders to determine the final list of 8 local priorities set out below and 4 national priorities explained on page 5 of this document.

These local priorities will relate to 3 specific areas of quality improvement:

1. Safety
2. Effectiveness
3. Patient Experience

1. Safety

1.1 **We will develop our work 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).**

To improve medicines reconciliation at hospital admission we will review our polices to make sure that staff have the information to support their work to check regular medications on admission to hospital. Whenever possible we will make sure that pharmacists are available to check medications as soon as possible after someone is admitted to a community hospital.

We understand that communication difficulties can make the checking of those medicines taken prior to admission difficult. We will therefore develop a mechanism to improve the collection of this vital information in 2012/13. We will develop strategies to obtain information about medications for people with communication difficulties.

Progress toward full compliance with this priority will be monitored quarterly by the Trust Clinical and Audit and Effectiveness Committee.

We will continue to work with prescribers in community hospitals to increase Medicines Reconciliation Level 2 compliance and quality. This will include:

- An audit of prescribing quality in our community hospitals to inform development of improvement action plans.
- Monitoring of the pharmacists involvement in medicines reconciliation as soon as possible after admission to enable early intervention.
- Review our current medicines polices and improve awareness of medicines management issues in community hospitals and across community services to ensure that the responsibilities of pharmacists and other staff in the medicines reconciliation process are clearly defined.

1.2 **(a) 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.**

(b) We will develop a method to measure service user satisfaction with our adult safeguarding processes.

The Trust is committed to continually improving safeguarding services for vulnerable people. Public and staff consultation supported this as a key priority for inclusion in this account. The training will reflect the national competency framework for safeguarding adults and the Mental Capacity Act code of practice. We will monitor performance against this priority at the Trust Integrated Safeguarding Committee Monthly.

In safeguarding children's services we will continue to promote effective training programmes for all staff to ensure that they have the necessary skills to enable them to undertake their responsibilities. For example how to recognise abuse, where to go for advice and support, and how to report suspected abuse including where allegations are against staff. The training will include staff working in adult services that may have contact with carers and parents, as well as occasionally with children. Training numbers will be reviewed monthly as part of the Safeguarding Children Dashboard and reported to the Safeguarding Children Executive, the Integrated Safeguarding Committee and the Torbay Safeguarding Children's Board.

As part of our plan to engage more widely with people who use our service to achieve the best outcome for them, we will develop an effective feedback system that will identify if the outcome of their safeguarding process provided the desired outcomes for them. We will report this to the Local Safeguarding Adults Board and the Trust Integrated Safeguarding Committee quarterly.

2. Effectiveness

2.1 **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.**

This will include working with:

- Intermediate Care
- Continuing Healthcare
- Nursing Homes in Torbay
- Learning Disability placements
- Out of area placements of all types

The standards that we will work towards will be:

Level 1 - assurance that all individuals placed with service providers are receiving appropriate care and are appropriately safeguarded

Level 2 – assurance that all service providers meet statutory regulations and related requirements with specific reference to safeguarding

Level 3 – assurance that all service providers have appropriate quality assurance and governance arrangements in place with specific reference to safeguarding.

By 31st March 2013, we will have a process in place to assure the quality, safety and client experience of care provided by non-NHS residential, nursing and domiciliary organisations.

We will work in partnership with a small group of homes to measure the effectiveness of early assessment and monitoring of care within an individual's support plan. Through agreed targets in areas such as skin care, nutrition, continence, medicines and falls prevention we believe this will demonstrate the good quality of the care provided.

We will develop a reporting framework that will enable providers to demonstrate through internal governance processes full compliance with the principles above, and report breaches and identified risks of non-compliance to the commissioner through Quality Review Monitoring Forums and the Quality, Safety and Clinical Risk Committee quarterly.

2.2 **Community Services – We will further expand our adoption of the productive community service principles by implementing two further productive modules.**

The productive community services principles enable the redesign of teams, their systems and processes to increase efficiency and safety. By using the methodology used in some manufacturing industries we can increase the amount of time we spend with patients and improve safety. Although the primary objective is to increase the face to face time with service users efficiencies often result in cost reduction.

From April 2012 a project plan will be established to support the launch of the Productive Community Services programme in Southern Devon and within our multidisciplinary teams in addition to further modules being completed in Torbay. As the teams are at different stages in the programme we will aim to complete a minimum of 3 modules in each area during 2012/13. Information on the productive community services can be found at *http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html*

We will monitor our achievement in this priority at the Productive Service Steering Group providing quarterly reports to the Quality, Safety and Clinical Risk Committee.

2.3 **Managing Obesity** – **We will improve access to local level 2 and level 3 obesity services.**

By managing some of the causes of long term conditions we can improve the quality of life for people as well as reduce the burden on health services in the future. In our local quality account priority survey this was rated the most important by the public and our staff. We will build upon the work of our public health teams in 2011/12 to develop services to support weight management services. We will improve access to local level 2 and level 3 Obesity (weight management) services and plan and deliver a newly commissioned Level 2 adult obesity programme, across Torbay. Performance data will be reported using the Clinical Pathway Group (CPG) dashboard which will be reported quarterly to the Quality, Safety and Clinical Risk Committee.

As part of the recently commissioned level 3 obesity service the public health life styles team will implement and deliver the community based group part of the new service across Torbay & Southern Devon, meeting the standards for best practice set within the NICE Obesity Clinical Guidance. This priority is supported by Torbay Care Trusts Strategic Improvement Framework, the Torbay Community Plan and Obesity CPG outcome framework. The planned launch of this new service in June 2012 will assist us in managing the Increasing numbers of adults who are clinically obese and the demands for level 4 bariatric surgery interventions as well as co-morbidity complications. Progress will be monitored by the Quality, Safety and Clinical Risk Committee quarterly.

3 Patient Experience

3.1 **Recognised, Valued, Supported**. **We will introduce a tool to enable early recognition of carers at risk of crisis**

To identify the causes of carer breakdown. This priority is aimed at recognising those carers at risk of not coping and providing support that will enable them to continue their caring role. The Association of Directors of Adult Social Services publication 'Carers as Partners in Hospital Discharge' (2010) highlights that the period immediately after a 'cared for' person is discharged from hospital can be very stressful for the carer. This priority will involve development of a carer survey to identify those factors that most help carers and reduce likelihood of crisis or breakdown. The results of this survey will be used to develop a project that will offer support based on the findings and then with feedback from the carer evaluate their success. A report outlining findings and recommendations will be developed to inform future carer support practice this will be reported to the Trust Engagement and Experience Committee quarterly.

Existing local data is not available but the Audit Commission report 'Support for Carers of Older People' (2004) highlights that 43% of carers received no additional help when the 'cared for' was discharged from hospital. The Government recognises and values the contribution of carers. By caring for people in their own time and supporting other people's independence, carers embody the spirit of the Big Society. Supporting carers' well-being is therefore in all our interests. And is supported by nationally recognised best practice described within 'Recognised, Valued and Supported: next steps for the carers strategy" (Dept. of Health 2010). Two key outcomes set out in this document are:

- Carers will be supported to stay mentally and physically well and be treated with dignity

- To support those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages.

This priority aims to develop a mechanism whereby those at risk of breakdown are recognised early and are offered the support they need and deserve. We will undertake a literature review to identify best practice supported by discovery interviews with carers who have had a good experience and those who have not to identify what needs to happen to reduce the risk of a crisis occurring. We will then pilot interventions that our audit has identified as key to avoiding a crisis occurring, producing an evaluation report that will enable the organisation to review current services and recommend changes that are demonstrated to make a real difference to carers and those that are cared for. Progress of this work will be

monitored by the Trust Engagement and Experience Committee Quarterly and to our commissioners as part of the CQUIN monitoring meeting.

3.2 **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.**

We will implement the 'Hear by Rights' assessment tool and develop an action plan to improve the participation of children and young people.

Over a number of years national legislation has increasingly emphasised the need to engage and involve service users, in the decision making process. Within the context of children and young people services, some of the relevant legislation and policy developments include:

i. UN Convention on the Rights of the Child (1989; ratified in UK law 1991)

ii. Children Act 2004

iii. National Framework for Children, Young People and Maternity Services

iv. Equality Duties for Local Government

To enable us implement this priority, we will develop an action plan from the Hear by Rights self-assessment tool and develop Simple, Measurable, Achievable, Realistic and Timely (SMART) objectives. This priority will also be supported by the successful entry for measuring children and young people's experience of healthcare, proposed by The Picker Institute Europe, using the Children's Outpatient Experience Indicator. The indicator measures the recent hospital outpatient experience of children aged 8 to 17 years and derives a single indicator score from responses to questions about aspects of the experience that matter most to children and young people (outcomes Framework 2012/13).

These priorities will be monitored quarterly by the Trust Engagement and Experience Committee, with progress reported to the Trusts Board; we will also link with our partners to ensure that they have information available to them on our progress.

Statements of assurance from the Board

Review of services (Regulation 4)

During 2011/12 the Torbay Care Trust provided and/or sub-contracted 7 NHS services.

The Torbay Care Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Torbay Care Trust for 2011/12.

Clinical Audit

During 2011/12 2 national clinical audits and 0 national confidential enquiries covered NHS services that Torbay Care Trust provides.
During that period Torbay Care Trust participated in 50% (1 of 2) 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 Parkinson's Nurse undertakes a local audit to measure service delivery against national standards.

The national clinical audits and national confidential enquiries that Torbay Care Trust was eligible to participate in during 2011/12 are as follows:

- National audit of falls and bone health in older people
- Parkinson's disease annual audit

The national clinical audits and national confidential enquiries that Torbay Care Trust participated in during 2011/12 are as follows:

- National audit of falls and bone health in older people

The Parkinson's Disease national clinical audit is led by secondary care Physicians with a small community component. This audit was not completed by our main secondary care provider who would have led this audit with our participation.

The national clinical audits and national confidential enquires that Torbay Care Trust participated in, and for which data collection was completed during 2011/12 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 Care Trust undertook this audit with South Devon Healthcare Foundation Trust, 100% of the total number of cases (40) were submitted

The reports of 2 national clinical audits were reviewed by the provider in 2011/12 and Torbay Care Trust intends to take the following actions to improve the quality of healthcare provided.

Acute stroke (SINAP) This audit report was received in May 2011 reflecting the findings from an audit of records collected in 2010.The recommendations for Torbay Care Trust were:

	RECOMENDATION	ACTION COMPLETED
1	To develop an Early Supported Discharge Service(EDS) in all areas of the Trust	*There is now ESD service in all areas of the Trust (see Priority 10 in appendix 1 of this account)*
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 : 100% of 55 patients identified as tolerating 45 minutes Occupational Therapy : 94% of 52 patients identified as tolerating 45 minutes Speech and Language Therapy : 53% of 19 patients who were identified as tolerating 45 minutes We will look at this data in more detail as part of the pilot of the dataset nationally scheduled for 2012/13.*
3	To review the number of patient being discharged into care homes from hospital following Stroke.	*We will be collecting this as part of the dataset pilot later in 2012/13 this will allow us to triangulate existing data to check accuracy. Once accurate data is available we will review and make any necessary recommendations for future hospital discharge planning.*

National Falls and Bone Health Audit

This is an annual audit undertaken in partnership with South Devon Healthcare Foundation Trust:

	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	*2 Consultants are in post with another appointment planned for Summer 2012*
2	Continued support to redesign patient pathways with integration of new NICE guidance in hip fracture care	*Hip fracture pathways have been redesigned to reduce pre-operative stay and it has been agreed to look at the redesign of the patients pathway. Clinical pathway group (CPG).*
3	Reaudit of the provision of anti resorptive therapy to hip and non hip fracture patients	*For Torbay Patients who are covered by the fracture liaison service (FLS) yes. South Devon funding bid is to extend the FLS across this area as well.*
4	Update of Joint Formulary Osteoporosis Guidelines	*Update is underway and initial draft presented at CPG 13/3/12.*
5	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.*
6	Ensure monitoring of local hip fracture rates	*Being monitored in the CPG dashboard.*
7	Establish a reliable mechanism of coding for falls in the Emergency Department to allow annual audit to ensure fallers presenting are assessed and referred to local falls clinics	*Outstanding issue for the CPG despite attempts to achieve this.*
8	Establish reliable pathways to ensure written information is provided about falls prevention to patients attending hopsital with falls	*Age UK's 'Staying Steady' leaflet is regularly given to those attending hospital following a fall but there was no evidence of this in patient's notes for the RCP audit.*
9	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.*

Local Audit Programme 2011/12

The reports of 23 local clinical audits were reviewed by the provider in 2011/12 Appendix 3 provides a summary of the actions Torbay Care Trust intends to take to improve the quality of healthcare provided as a result of these audits.

Research

The number of patients receiving NHS services provided or sub-contracted by Torbay Care Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was1156.

Quality improvement and innovation goals agreed with commissioners

A proportion of Torbay Care Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between Torbay Care 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 for2011/12 and for the following 12 month period are available on request from Torbay Care Trust.

Care Quality Commission Registration

Torbay Care 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 Care 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 Care Trust** for **Personal care**

1. The registered provider must ensure that the regulated activity 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 St Edmunds.

2. This Regulated Activity may only be carried on at or from the following locations: Bay House Headquarters and St Edmunds.

The Care Quality Commission has not taken enforcement action against Torbay Care Trust during2011/12.

Torbay Care Trust is subject to periodic reviews by the Care Quality Commission and the last review was on 14th November 2011 at Dartmouth Hospital. The CQC's assessment of the Torbay Care Trust following that review was that improvement was required in Outcomes 02, 04, 07, with one compliance action for outcome 14. (See Appendix 2 for details).

Torbay Care Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Information Governance

Torbay Care Trusts score for 2010/11for Information Quality and Records Management, assessed using the Information Governance Toolkit was 65% we do not yet have the results for 2011/12 but this will be updated once received.

Torbay Care Trust (TAL00) submitted 41,779 records during 1st April 2011 - 31st December 2011 (2011/12 Month 09 inclusive) 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 2012

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

- *99.9% for admitted patient care;*
- *100.0% for outpatient care; and*
- *98.1% for accident and emergency care.*

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

- *99.9% for admitted patient care;*
- *100.00% for outpatient care; and*
- *99.4% for accident and emergency care.*

Torbay Care Trust was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

Part 3

Quality Account Priorities 2011/12

An update of performance against the 2011/12 priorities is provided at Appendix 1. Below are some examples of quality improvement work completed in 2011/12. These are presented under the headings Safety, Effectiveness and Patient Experience.

1. Safety

Participation in the South of England Quality and Patient Safety Improvement Programme

The Trust has played an active part in this programme, now in its second year, we are working on the 5 key work streams:

1. Reducing Catheter Associated Urinary Tract Infections
2. Pressure ulcers.
3. Falls.
4. Medicines Reconciliation.
5. Recognising the Deteriorating Patient in our Community hospitals.

Regular events are held to share learning across the region with the leads for each work stream achieving excellent results using The Institute of Healthcare Improvement methodology in safety improvement as explained below.

Service improvement trials have been tested in small areas involving only 1 or 2 patients before expanding to larger numbers of patients across the whole ward. These 'tests of change' are monitored to measure reduction in the number of patients who, for example, fall or develop a pressure ulcer and where a positive outcome of the change is identified i.e. there has been a reduction then the good practice is expanded to whole ward. Once we have successfully implemented these changes in one community hospital we spread it to other hospitals and the wider health community.

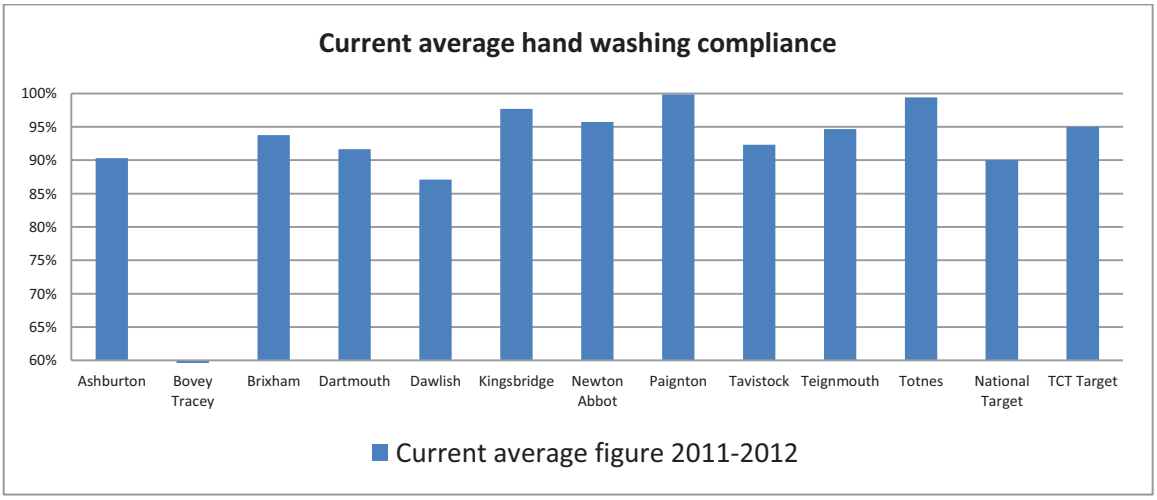
We said that we would - Continue to improve hand washing compliance across the Trust:

It is recognised that hand washing is a critical element for reducing all hospital infections including catheter associated urinary tract infections. For this reason we have focussed on improving compliance with hand washing standards.

The importance of effective hand washing cannot be underestimated in the prevention and spread of hospital acquired infections, such as MRSA. Taking steps to prevent infection control enhances the patient experience, safety and our ability run effective services. Infections such as influenza also place a great strain on our health resources and frequent and correct hand washing can reduce the risk and spread of this virus.

We set a target of 85% compliance in all of our community hospitals. Hand washing compliance remains above 90% in 10 community hospitals.

As a Trust we continue to train our staff in effective infection control practices, such as hand washing and reducing unnecessary cross-infection that could cause prolonged stays in hospital. We have also continued to raise the profile of infection control with the public. In November 2011 the Trust used the local media to convey messages about the importance of hand washing and where possible encouraging patients, visitors and staff not to enter a hospital or healthcare setting if you they have had signs or symptoms or flu or the winter vomiting bug, Noro-virus.



(Bovey Tracy Hospital was closed when this data was collated)

An internal campaign to encourage staff to have the seasonal flu vaccination took place. Having the vaccination helps reduce the risk of infection to those most vulnerable and ensures that our services can be safe, effective and maintained throughout the winter months, when there is often increased demand. As a result of the campaign 45.5% of frontline health and social care workers choose to protect themselves against seasonal flu.

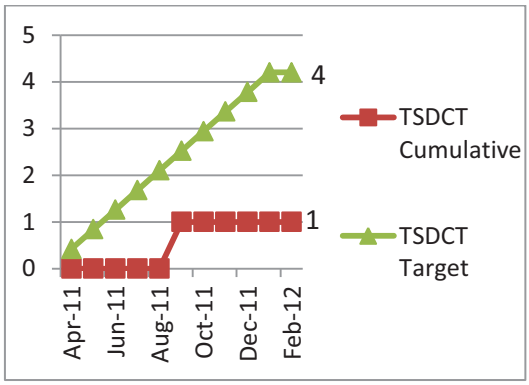
Dr Viv Thorn, Medical Director at Torbay Care Trust said: "Many infections are preventable and good hand hygiene is one of the best ways of helping tackle the spread of germs."

We said that we would ensure compliance with Healthcare Acquired Infection targets. Treating people in a safe environment and protecting them from avoidable harm.

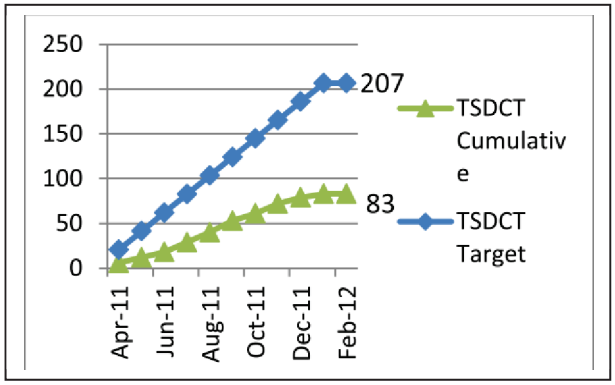
To date we are within the target set for Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteraemia, and have reduced our numbers year on year. Time and resources have been invested in keeping our staff up to date with their training with specific attention to inserting and managing devices such as intravenous cannulas and urinary catheters which are known to increase the risk of infections. We have investigated a number of the cases where infections have occurred to identify any learning that could help avoid people acquiring similar infections. This learning is shared at our Infection Control Committee meetings and in our training sessions to staff.

The graphs on page 8 illustrate the good progress we made during 2011/12; reducing Methicillin-resistant Staphylococcus Aureus (MRSA) to one case, 3 cases below the regionally agreed target of 4, and managing Clostridium Difficile infection rates to 83 set against a regional target of 207.

MRSA Bacteraemia rate 2011/12



Clostridium Difficile Infection rate 2011/12



Data for March 2012 will be available in May 2012

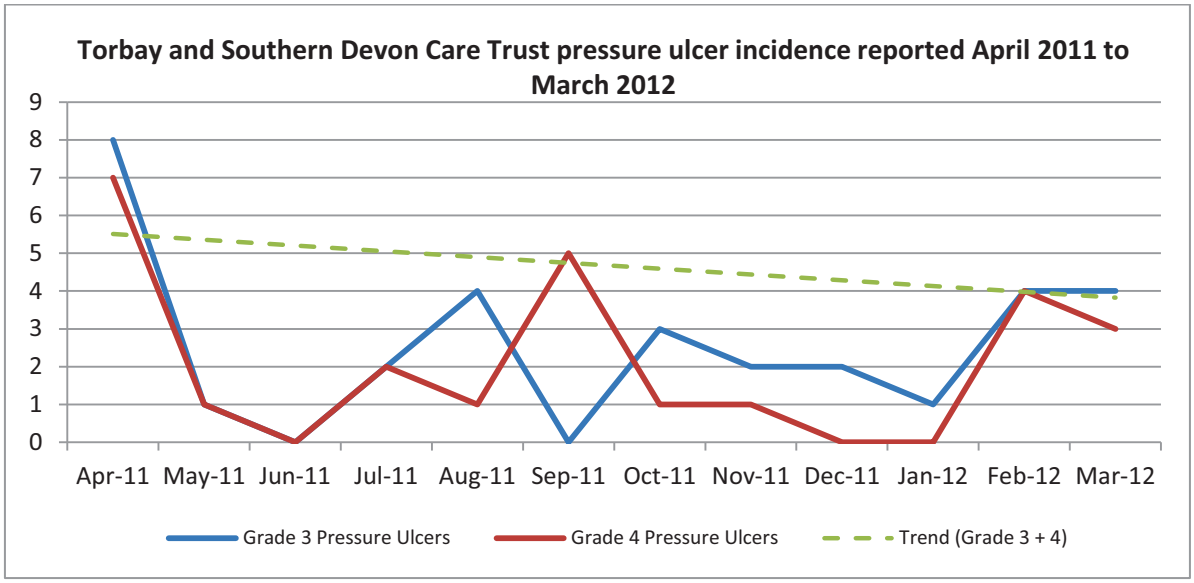
We will continue our work to reduce the incidence of Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (CD) infections in line with national objectives set within the Operating Framework 2012/13. This will be monitored by the Infection Control Committee and reported to the Clinical and Audit Effectiveness Committee as part of our quality and safety dashboard.

We said we would reduce the incidence of avoidable Pressure Ulcers:

As an organisation we have encouraged all pressure ulcers to be reported by staff – this has allowed us to really understand where they are occurring and to begin to measure improvement in reducing the severity as well as the frequency.

During 2011 reporting of pressure ulcers has been encouraged to enable us to gain a greater understanding of where they occur allowing us to focus our improvement work in these areas. As we work with our teams to encourage reporting and investigation to identify the causes of pressure ulcers we identify common themes that enable further improvement work across the Trust.

The diagram below illustrates the number of pressure ulcers at grade 3 and 4 that have been reported during the year. We have reduced the incidence of pressure ulcers in our hospitals, with the majority of incidents occurring to patients being cared for in their own homes.



Improvement work that the Trust has introduced includes:

- "Intentional Rounding", a routine undertaken within our wards when patients receive a regular visits from the nurse at a prescribed time interval to check they are comfortable and that their skin is not being damaged due to pressure, poor circulation, lack of drinks or movement. This is explained in the term 'skin bundle' shown in Fig 1 below.

- Regular assessment and comprehensive care planning when patients are admitted to hospital and at regular intervals throughout their stay.

- Staff Training provided by the specialist Tissue Viability Nursing Team has enabled nurses to identify risks and provide the most effective care to the patients.

Fig 1 - SKIN bundle

Surface selection *making sure the correct mattress is used to help relieve pressure on the skin*

Keep turning changing *position to improve circulation and reduce pressure*

Incontinence management *making sure people's skin is kept clean and dry*

Nutrition *Make sure people eat a healthy diet and drink sufficient fluids to keep the skin hydrated*

Although we have seen a small reduction in the incidence of grade 3 and 4 pressure ulcers in 2011, we anticipate that the changes we have implemented will see this reduction continue. We were unable to illustrate improvement in this priority compared to previous years as we did not have sufficient data to allow effective measurement, however, increased focus on reporting in 2011 will allow us to measure improvement in the future. We will continue to learn from investigations and implement best practice across all of our services.

We will continue to work to reduce the incidence of avoidable pressure ulcers in 2012/13 as we recognise that with more people being cared for in their own homes, and the majority of pressure ulcers reported in 2011 occurred whilst a patient was at home, we need to ensure

that family and carers are aware of the risks of developing pressure ulcers. In 2012 we hope to develop a greater awareness of the need to report within the local community encouraging early detection of risks to allow preventative measure to be implemented. We will continue to roll out and ensure that all carers and patients have prompt cards in pressure ulcer prevention.
It is recognised that as we raise awareness within the general population the reported incidence of pressure ulcers could increase making it difficult to measure improvement through statistics alone.

Jane Viner, Director of Professional Practice at Torbay and Southern Devon Health and Social Care NHS Trust said: "The focus on the early identification and management of pressure ulcers is showing positive results and moves us closer to our ambition to establish a zero incidence of grade 3 and 4 pressure ulcers in our community hospitals.

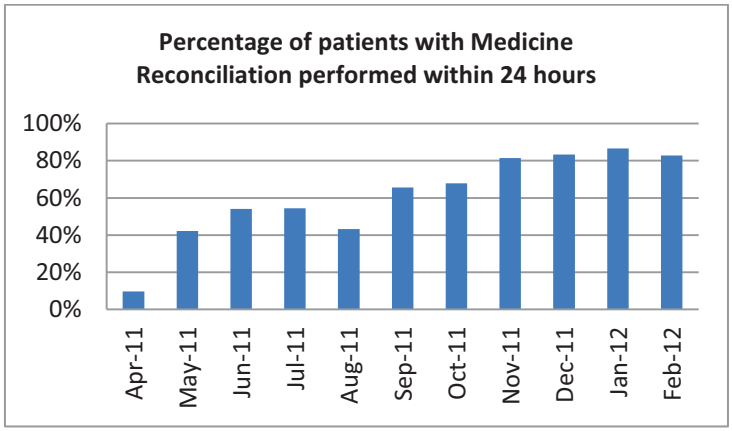
We said we would improve medicines safety

In 2011/12 we appointed a second Clinical Pharmacist to support our hospital teams and other the community based services. The Pharmacist is able to educate and raise awareness of potential risks in medicines management.

Omitted doses have been highlighted by the National Patient Safety Agency as a key risk area to patient care in hospitals.

The Medicines Management team undertook a community hospital wide 'omitted dose' audit in October 2011. A thorough report was generated and the results and recommendations were widely presented to the Medical Director, Director of Professional Practice, Community Hospital Managers and Hospital Matrons. This served to significantly raise the awareness of this issue across the Trust. As a result, hospital action plans were developed to heighten awareness with all staff and a new Trust standing operating procedure has been ratified. Significant improvement in the quality of recording of medicine administration has been realised.

The on-going review of ward drug charts to monitor omitted doses will be rolled out to all community hospitals by April 2012. This will be supplemented by a 6 monthly re-audit by the Medicines Management team.



We have achieved significant progress in the implementation of phase 1 of medicines reconciliation across all of our community hospitals. This work supports the best practice standards to ensure that information about the medicines patients were taking prior to admission are recorded with consideration of continuing the drugs during their hospital stay and on discharge.

We said we would reduce the number of patients falling whilst in community hospitals

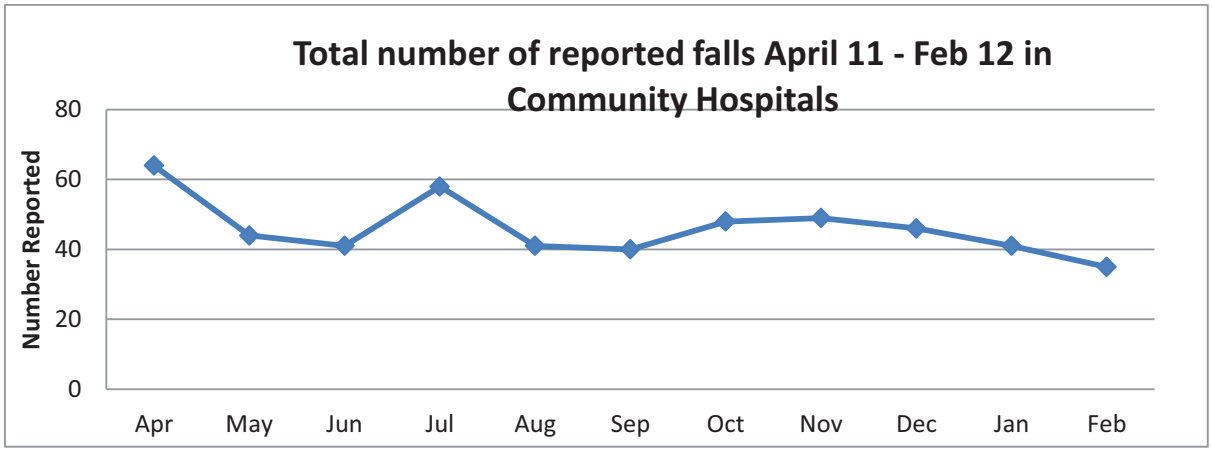
This priority is linked to the South of England Quality and Patient Safety Improvement Programme that aims to reduce the harm from patient falls in hospital. As part of the methods used to introduce this improvement work we have undertaken small tests of change i.e. small changes are made and then the effects are monitored and evaluated to measure any improvement or make recommendations of how the intervention could be more effective.

Tests of change that we have introduced include:

- The introduction of "Intentional Rounding", a regular review of patient needs at prescribed intervals e.g. 30 mins., one hour we have identified that some patients who are confused will attempt to walk without assistance resulting in a fall by checking on the patient and offering to help them move regularly we have reduce the incidence of falls.
- The introduction of a simplified risk assessment saves staff time and provides an effective assessment of a patient falls risk allowing specific care plans to be implemented.
- Inpatient falls prevention leaflets are given to patients and carers to raise awareness of simple precautions that can reduce the risk of falling such as safe foot ware
- The use of bed and chair exit sensors to alert staff when confused patients attempt to walk without assistance.

We have provided briefing sessions for staff in these simple precautions that can be implemented to reduce the risk of a patient falling and will continue to trial new and innovative tests of change to keep patients safe.

Although we commenced this improvement work in Paignton Community Hospital we are now spreading the proven interventions for improvement across all of our community hospitals. Recent reports demonstrate a steady decrease in the number of falls with a high of 65 in April 2011 to 35 reported falls in February 2012 across all of the community hospitals



We recognise the devastating effect that falls can have on an older person's confidence as well as the long term disabilities that can result for injury sustained as a result of a fall. We will therefore continue to roll out more tests of change spreading proven interventions across all of our community hospitals. We have also been working with care homes in Torbay to share the improvement work and reduce falls for their residents.

Improving bone health and reducing the risk of falls

Torbay Care Trust in collaboration with Torbay Council and South Devon Healthcare NHS Foundation Trust held an Active for Life event in June 2011. The event which is organised, as part of a national falls awareness campaign, was a huge success with over 100 local residents in attendance.

The annual event aims to raise awareness about the importance of keeping healthy into older age, maintaining good bone health and knowing the steps that can be taken to prevent falling.

Jane Reddaway, Falls Prevention Lead at Torbay Care Trust said: "With all the research that is now available we are becoming increasingly aware of the need to remain active into older age and how to go about it. We all hope to keep our independence and health but many older people become too sedentary, which leads to loss of balance and muscle strength; these are vital to keep us mobile and upright which will help us to keep well and avoid falling."

A volunteer exercise instructor at the falls awareness day (above)

(left) One of the many exercise classes held on the Falls Awareness Day

Those who attended were able to have a health MOT and try out exercise taster sessions, including barn dancing and Tai Chi. The event was supported by a number of local agencies, including Devon Fire and Rescue services, LINks, local dieticians, and pharmacy, amongst others.

We said we would improve safety the of patients

With the increasing ability to care for more acutely ill patients within our community hospitals we have recognised the need to introduce a more effective clinical observation tool traditionally used in acute hospitals wards known as the Early Warning Score. This monitoring record enables nurses and doctors to improve the assessment of acute illness through the use of specific physiological measures such as blood oxygen concentration in addition to the more traditional observations e.g. blood pressure, pulse rate and

temperature. The Early Warning Score (EWS) tool supports the continuous monitoring of a patients physical wellbeing throughout their stay in hospital tracking the trends in their clinical response to treatment, early detection of clinical deterioration and acts as the trigger for an escalation in clinical care and treatment.

Small tests of change have been carried out in our community hospitals resulting in the formatting of a new early warning score chart incorporating recent national best practice guidance on scoring clinical parameters. Following successful tests of change in both the new early warning score chart and audit tool, all 11 community hospitals will now participate in monthly audits of records to monitor the effectiveness of the early warning score. The Early Warning Score is also supported through an on-going training programme available to all staff in the "Recognition of the Deteriorating Patient".

Pilot audits in the use of the Early Warning Score in 2 community hospitals have consistently achieved over 95% compliance in recording early warning scores and over 95% in the appropriate escalation taken following early recognition in deterioration. We recognise that the early identification of deterioration in a patient's condition is essential if we are to provide safe and effective care – this will therefore remain a priority next year with continued focus on education.

Effectiveness

We said we would continue to manage the risk of Blood Borne Viruses

Above Torbay Care Trust Blood Borne Viruses Nurse

The Blood borne virus service, which is part of the Torbay primary care substance misuse team has offered 100 percent of clients the opportunity to have a test for Hepatitis C compared to 90 percent nationally and regionally; with 89 percent accepting the test, compared to 66 percent regionally and 62 percent nationally.
In the testing for Hepatitis B similar results have been achieved with 100 percent offered vaccination and 79 percent acceptance, compared to 40 percent regionally and 36 percent nationally. This is very positive news for high risk clients in Torbay, allowing them to access appropriate healthcare as a result.

How do we achieve this?

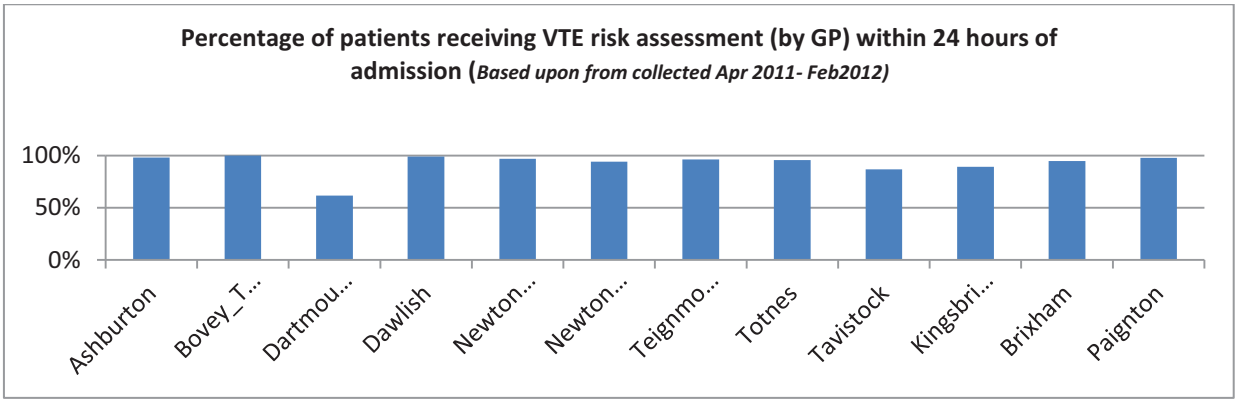
- A flexible and supportive outreach service.
- Putting patients at ease through the use of dried blood spot testing. The blood borne virus service has found this method encourages better uptake with patients, as it is a less invasive procedure.
- The use of health promotion with targeted groups.
- A greater understanding of blood borne viruses within the community and amongst professional.

We will continue to build on this success to ensure that clients have this service readily available to them.

We said we would - Keep our patients safe from the risk of Blood Clots
(Venous Thrombo Embolism (VTE) prevention)

Over the past 12 months across our all community hospitals doctors and nursing staff have worked to ensure patients are risk assessed against national standards of care, published by the National Institute of Clinical Excellence (NICE), within 24 hours of admission to a community hospital.

This clinical practice has been adopted and embedded across all our hospitals, monthly audits enable us to monitor performance and target support where required. (National target 90%)



We said we would improve the service users experience

Below are 2 examples of behind the scenes projects that are improving care for patients.

1. <u>Enhancing the effectiveness of care through a Single Community Care Record (SCCR)</u>

In 2011 Torbay Care Trust started work to create a Single Community Care Record for health and social care.

Once it has been developed, the IT system will provide staff with office and remote offline access to comprehensive and secure records of patient and client care details. The new system will improve efficiency by streamlining a number of forms and systems currently used and will make it possible for staff to view, update, and monitor records whilst they are out in the community. Once the new system is in place it will have enormous benefits. Staff will be able to full maximise their time with patients and clients, have access to the most up-to-date information about a person's care and needs and reinvest time on the frontline, that would have been previously spent travelling.

The Trust always values the feedback and views of patients, and to ensure that the new record system is meeting the needs of our patients, staff we are working with our Experts by Experience Group. The group is supporting the development of the record by providing feedback on the language and questions within the record and ensuring the system is customer friendly as well as user friendly.

"This innovative and more integrated technology will support our frontline staff, and enable them to deliver the safest and most effective care to their clients and patients The new system will also improve the patient experience with patients only ever having to tell their story once." said Mandy Seymour, Chief Operating Officer for Torbay Care Trust.

2. Improving the patient experience behind the scenes

Torbay Care Trust has been working with Mede Analytics following a patient through every aspect of the health and social care process to identify areas for improvement, efficiency and effectiveness in the care we provide. This work was recognised in December 2011 at the prestigious Health Service Journal awards. The Trust was highly commended in the Data and Information Management Category for the work that has taken place.

Anthony Farnsworth Chief Executive at Torbay Care Trust said: "Work such as this, taking place behind the scenes, does not normally get the recognition it deserves but has a vital impact upon our ability to provide local people with the best care."

We said we would improve efficiency by Releasing Time to Care:

Throughout 2011/12 we have worked to improve the effectiveness and efficiency of our community nursing teams within Torbay. Led by the community nursing team leaders the first two modules completed have been:

"well organised working environment" – This has resulted in standardisation of consumables held in each team, removing items no longer required and cease ordering. We established a central area to share short shelf life stock and consumables used intermittently by teams to reduced waste. This has led to reduced cost of consumables by £1,000 approximately per team for the year.

"Knowing how we are doing"- To understand how the community service is perceived by patients we undertook a pilot survey of 100 patients on the community nursing caseload 20 patients per zone which resulted in a 60 % response rate. This demonstrated overall high levels of satisfaction with the service, but one area where we could improve the service to patients included the time and date of a proposed visit. Teams are currently reviewing how this can be improved in each zone.
As part of our intention to improve efficiency we also looked at ways we could increase the amount of time spent with patients by reducing office work and avoiding unnecessary visits.

The work achieved to date has demonstrated how through adopting the productive community services model we can systematically identify where productivity is lost and develop systems to improve effectiveness.

NHS Institute for Innovation and Improvement 2006-2012

Productive Community Services will:

- Increase patient-facing contact time
- Reduce inefficient work practices
- Improve the quality and safety of care
- Re-vitalise the workforce
- Put staff at the forefront of redesigning their services.

We said we would improve safety

In 2011 the Quality, Effectiveness and Safety Trigger Tool was introduced in all our community hospitals. The Quality Safety and Effectiveness Trigger Tool was developed by the NHS Southwest by senior nurses from across the region. The tool provides a set of measures that when combined alert senior managers to the potential for a hospital ward to be at risk of not delivering safe, effective and quality care. It brings together a number of concerns that on their own would not appear significant but when collated into a report they provide an objective assessment of the factors affecting the ward at a specific time.

Quality Safety and Effectiveness Trigger Tool (QuESTT)

An example of some of the measures used in the tool.

- Vacancy rate higher than 3%
- Unfilled shifts is higher than 6%
- Sickness absence rate higher than 3.5%
- No monthly review of key quality indicators by peers (e.g. peer review or governance team meetings)
- Planned annual appraisals not performed
- No involvement in Trust-wide multi-disciplinary meetings
- No formal feedback obtained from patients during the month (e.g. questionnaires or surveys)
- 2 or more formal complaints in a month
- Unusual demands on service exceeding capacity to deliver (e.g. national targets, outbreak)
- Hand hygiene audits not performed
- Cleanliness audits not performed
- Ward/department appears untidy

It has been proven that when a number of these factors are present in a ward there is a potential risk to quality and safety

With a large number of community hospitals it is essential that the Trust has a consistent and measurable audit of safety and effectiveness to ensure we have oversight of all safety in all of our hospitals; this tool is one method that we use to do this.

The measures used have been developed using the lessons learnt from CQC reports such as the Mid Staffordshire NHS Foundation Trust inspection report. The tool demonstrates a proactive approach to managing for quality and safety alerting senior managers to potential problems, allowing restorative action and support to hospitals.

The tool is completed by the hospital matron monthly; any wards that score highly or show a significant change from their previous submission are followed up by the Director of Professional Practice and her team. The tool can highlight factors that require executive support to improve or resolve, more importantly it provides an overall picture of how wards are managing quality and safety by using a variety of other measures and observation; it has proved to be a very useful mechanism to trigger additional support.

QuESTT results and actions taken are reported to the Integrated Governance Committee.

Due to the success of this tool we intend to develop a similar method of monitoring quality and safety in our community based teams in 2012/13.

2. Patient Experience

Community Hospitals score highly with patients

In 2011 community hospitals across Torbay and Southern Devon received top ratings in a report published by the NHS Information Centre.

Seven out of the 11 community hospitals, run by Torbay Care Trust scored excellent in all three of the assessment categories with the other four achieving a 'good' or 'excellent' rating for environment, food, and privacy and dignity.

The self-assessments which are part of the Patient Environment Action Teams (PEAT) programme are carried out by a team of nurses, matrons, doctors, catering staff domestic service managers, and most importantly groups of patients. It aims to review key areas from a patient perspective and awards a score of excellent, good, acceptable, poor or unacceptable across a range of patient services within the three main categories.

***Pat Mcdonagh, Assistant Director of community hospitals at Torbay Care Trust said**: "Admission to hospital can be a worrying time for patients and their families we recognise that the environment, food and maintaining privacy and dignity are all an important part of a patient's overall experience".*

"The strong results across all of our hospitals in Torbay and Southern Devon demonstrate our commitment in making the whole patient experience as comfortable as possible by ensuring we deliver the highest standard of excellence and quality of care to all those who stay in our community hospitals."

Results of 2011 PEAT scores for our community hospitals are illustrated below

Site / Hospital Name	Environment Score	Food Score	Privacy & Dignity Score
Totnes	Good	EXCELLENT	EXCELLENT
Dartmouth	EXCELLENT	EXCELLENT	EXCELLENT
Tavistock Hospital	EXCELLENT	EXCELLENT	Good
South Hams (Kingsbridge)	EXCELLENT	EXCELLENT	EXCELLENT
Newton Abbot	EXCELLENT	EXCELLENT	EXCELLENT
Teignmouth	EXCELLENT	EXCELLENT	EXCELLENT
Dawlish	EXCELLENT	EXCELLENT	EXCELLENT
Bovey Tracey	Good	EXCELLENT	EXCELLENT
Ashburton and Buckfastleigh	Good	EXCELLENT	EXCELLENT
Paignton	EXCELLENT	EXCELLENT	EXCELLENT
Brixham	EXCELLENT	EXCELLENT	EXCELLENT

Refurbishment of Bovey Tracey Hospital

Bovey Tracey Community Hospital was reopened in January 2012 following a programme of improvement to inpatient care services. Inpatient care was temporarily relocated to nearby Newton Abbot Hospital in April last year, to facilitate refurbishment of the hospital. This provided the opportunity to undertake a comprehensive programme of recruitment, staff training and education. The Care Trust has also used the opportunity to improve the physical environment of the Hospital to make it safer, more comfortable and more functional for patients, visitors and staff.

In addition to general decoration, other improvements to the ward include a new physiotherapy unit and more flexible use of office space to enable visitors and patients more privacy when meeting with doctors or nurses.

Work has also been taking place on the hospital site, to improve the gardens and make them more accessible to those staying in or visiting the Hospital.

Pat McDonagh, Torbay Care Trust's Assistant Director for Community Hospitals, said: "The action taken at Bovey Tracey Community Hospital demonstrates our overriding commitment to providing our patients with safe and good quality care.

"Patients can now benefit from the new surroundings and facilities and as a Trust we are confident that our patients are receiving safe and effective care in a suitable environment."

We said - we will continue to listen and gain feedback from our patients:

We are mindful of the negative findings in the Ombudsman's Report "Care and Compassion" although the findings in this report related to care received elsewhere in the country , we will strive to ensure we learn from it to further improve the patient's experience here.
All community hospitals invite patients to complete a feedback questionnaire; this monthly survey enables Matrons to monitor compliance against a set of quality standards
The areas that we ask for feedback on include:

- their experience of staff treating them with dignity and respect
- their level of involvement in planning their plan of care and treatment
- how easy it was for them to recognise staff with different roles on the ward
- how accessible the staff were to discuss their care and answer questions
- that staff explained how to take their medicines and their discharge plans.

The results of these surveys are discussed with staff as part of a process of review and improvement.
Some key results include:

- Of 317 patients who responded between September 2011 and January 2012 only 1 patient stated that they were "occasionally but not always" treated with dignity and respect–with 316 patients reporting a more positive experience. Where such concerns are raised the hospital matron follows it up with the staff to reinforce the Trust standards of care and its expectation of its staff, reinforcing the NHS constitution
- Over the same 3 month period 90 per cent of patients felt that they had been involved in decisions about their care and treatment – we recognise that we need to improve this – the introduction of new care planning documentation will help us achieve the on-going monitoring and local improvements with ward teams will support improvement in our joint care planning with patients and their families and carers.
- The survey results have demonstrated that there is accessibility to doctors and nurses for patients and their families to ask questions and discuss their care rising from 86 per cent to 94 per cent during 2011/12 although we aim to improve this further in 2012, we are pleased to note that the responses show an improvement.

We have successfully implemented the national standards reporting of no mixed sex sleeping areas in our community hospitals. This has involved significant of investment. We will continue to review these standards aiming go above and beyond the minimum standards, as described in our PEAT overview above, with dignity champions in each hospital to reinforce the standards that we set.
We were fully compliant with National Standards to avoid mixed sex accommodation in 2011/12 with no breeches reported.

We said that we would broaden volunteering opportunities:

The Lifestyles Team have recruited 5 Health Trainer Champions to cascade Public Health Messages across Torbay and inform targeted groups of the health services available. Over the past 12 months Health Trainer Champions have attended community events including the Carers conference in Brixham, Watcombe Community Centre Christmas Party, Family Healthy Fun Day and a Workout @ Work Day event.

The Health Trainer Champions also promote healthy lifestyles to Young Adult Carers, the Homeless, Family's living in supported accommodation and unpaid carers of service users of ROC Active. As part of their training the Health Trainer Champions have attended the Royal Society for Public Health's Understanding Health Improvement Level 2 certificate.

Health champions discussing the aspects of health

This course covers:

1. The role of Health Champions in the community and the workplace.
2. An understanding of the factors that affect health.
3. The public health messages related to Lifestyle behaviours.
4. Communication skills and approaches used to facilitate behaviour change.
5. Practical skills on how to support individuals to make lifestyle behaviour changes.
6. Information about local support services available in Torbay.

Over the past 12 months a total of 52 people have attended this training course, delegates have included employees of Torquay Children's Centre, pharmacy assistants, councillors, groundwork, Jatis, Leonard Stocks and Folks @ Home, social workers, care workers, fire men and members of the public with an interest in healthy living have also completed this certificate.

We said we would support carers, caring for someone with a life limiting illness

During 2011 six courses were delivered on one day a week over 4 weeks, the aim of the course is to provide emotional support, empower, signpost and encourage carers to look after themselves. 42 carers enrolled and 32 attended the courses. Those who attended the courses felt that it provided them with support and advice to care for their loved one.

A Carers feedback following the course

"It helped me to learn what to expect on the journey. It gave me the nurse and social worker to ask specific questions which allayed added anxiety."

Feedback from a carer support worker who refers to the course regularly

"From their experience of the course these carers feel less isolated in their role and have a greater insight into the process they are going through. As a result they have come away much more confident about their ability to cope"

The diagnosis of the "cared for" is split nearly 50/50 between cancer and non-cancer diagnosis. The course is run in partnership with Torbay Care Trust and Rowcroft Hospice meeting National Institute of Clinical Excellence (NICE) End of Life Care for Adults Quality Standard Number 2.

In early 2011 a drop in group was started to offer support for those who could not access the four week course and for carers who requested ongoing support following the course. During 2011 a number of carers attended the drop-in, six drop-ins were held. 100% of carers completing the course would recommend it to a friend.

Review Section

This “review section” of the Quality Account will include statements from our commissioners, Overview and Scrutiny Committees and LINks in the final publication.

Appendix 1

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
1.	*Keeping our patients safe from Healthcare Associated Infections (HCAIs)*	Infection Control Team	Continue to improve hand washing compliance across Torbay and Southern Devon Health and Care NHS Trust. Target 85%	There are no national targets for hand washing compliance. Monthly hand washing compliance audits in community hospitals are completed, results continue to be well above the national average. The current average across all community hospitals 89%.	G
			Continue education and audit of our compliance with MRSA screening.	Education and audit of MRSA screening occurs in all 11 community hospitals. All patients admitted to our community hospitals have received screening for MRSA on admission or prior to hospital admission.	G
			Continue to deliver infection control training for staff, as part of their mandatory training requirement.	The training programme continues to be delivered to all staff as part of the mandatory training programme. The infection control team are collaborating with the training team on an E-learning approach for staff. Clinical staff undertake mandatory hand washing assessment annually. Infection control training is incorporated into all clinical skills training to reinforce best practice.	G
			Continue monitoring and reduce incidence of hospital acquired infection outbreaks in line with Department of Health requirements.	Hospital acquired infection outbreaks are reported and monitored across all 11 community hospitals when they occur. 2011/12 - 10 outbreaks (11 Community Hospitals) 2010/11 - 1 outbreak in Torbay Care Trust (In that year Torbay Care Trust had 2 Community Hospitals). We do not have 2010/11 data available for Southern Devon.	G
			Continue to deliver education & support for the efficient management of viral gastroenteritis (Norovirus).	An investigation is completed after every outbreak to look for the root cause. This is shared with the area affected and other Hospitals. All staff attending infection control training receive guidance in the avoidance and containment of outbreaks.	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
2	*Priority: Privacy and Dignity- Eliminating Mixed Sex Accommodation (EMSA)*	Head of Safety and Quality	We will continue to listen and gain feedback from our patients. We are mindful of the negative findings in the Ombudsman's Report Care and Compassion although the findings in this report related to care received elsewhere in the country, we will strive to ensure we learn from it to further improve the patient's experience here	The Trust has had no Breaches of ESMA standards during 2011-12 Questionnaires are completed by patients within community hospitals monthly. Results are analysed and any actions required are taken forward by Matrons. Leaflets are available to patients and visitors that explain the standards that we have regarding eliminating mixed sex accommodation.	G
3.	*Priority: Keeping our patients safe from the risk of blood clots*	Head of Nursing	We will continue to audit the prescription and medication record for appropriate VTE risk assessment and prophylaxis that monitors practice against the NICE recommendations to further improve quality.	Monthly audits of compliance with NICE standards in venous thromboembolism (VTE) prophylaxis are completed in all community hospitals as part of our CQUIN quality monitoring process. For initial assessment within 24 hours, a mean of 92% has been achieved for the year to date against a target of 95%. For reassessment within 24 hours, a mean of 80% has been achieved for the year to date against a target of 90%.	G
4.	*Reducing the incidence of pressure ulcers*	Head of Safety and Quality	We intend to spread the good practice from the pilot sites and introduce the 'SKIN bundle' to all community hospitals and community nursing teams in Torbay and Southern Devon Care Trust	Clinicians are now well informed of the importance of undertaking comprehensive assessments and care planning to avoid the incidence of pressure ulcers. Working within the SHA patient safety improvement network we have shared best practice in prevention and applied it to our services to begin to reduce the incidence of Pressure Ulcers this includes: • 'Intentional rounds' and the use of the 'SKIN bundle' in all community hospitals • Regular assessment and comprehensive care planning • Training provided by the specialist Tissue Viability Nursing Team. • The learning from incidents also informs policy and local procedures. When a pressure ulcer develops a comprehensive investigation is undertaken and the learning from this is shared with all clinical teams. • The introduction of *Prompt Cards* providing advice to patients and staff The information collated in 2011 will provide a baseline to measure improvement in the future, this will remain a priority. The data collected in 2011/12 will enable us to measure improvement in this priority	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
4.	*Reducing the incidence of pressure ulcers*	Head of Safety and Quality	We will develop education packages and written advice sheets on prevention of pressure ulcers and the use of the skin bundle to all agencies and carers of patients in the community.	We have developed prompt cards for patients and their carers' with very simple instructions on preventative measures they can take and when to alert a member of the community nursing team. These are being piloted in two community areas with an anticipated roll out in April 2012 across community services.	G
5.	*Keeping patients safe from the risk and harm associated with falls*	Falls Lead	The SHA improvement programme continues and we look to maintain the improvement in falls reduction we have made across Torbay and Southern Devon Care Trust.	The work undertaken to reduce the incidence of falls within our community hospitals includes: • The use of bed and chair exit sensors to alert staff when patients attempt to walk but need assistance. • Falls assessments and care plan now and integral part of new hospital documentation pack. • Education leaflets for patients and their carers on safety precautions such as sensible foot wear • "Intentional rounds" allowing clinicians to offer patients assistance to move/walk regularly. Initial reports have identified a small but steady decrease in the number of falls occurring in our community hospitals (see section 3)	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
5.	*Keeping patients safe from the risk and harm associated with falls*	Falls Lead	More postural stability classes will be available allowing greater numbers of less active older people to improve their mobility, strength and balance.	2 new classes (16 older people every 12 weeks) started in Torbay and a bid to sustain these is underway. A further person has been trained to deliver postural stability training	G
			Work will continue in the development of a revised multi-factorial falls assessment form to improve information for GPs about the assessments and interventions being carried out with patients and staff in the community.	Work is on-going to develop this area; 3 surgeries across Torbay and Southern Devon are involved in the national "PreFIT" research trial to establish the most effective interventions in falls prevention. Greater numbers of Multi-factorial Falls Assessments being carried out	G
			Improved communication to reduce duplication of falls assessments and interventions between hospital, general practice and community services. This will ensure care reflects NICE guidance	Electronic communication system now being piloted in Torbay Hospital with a plan to roll out across hospital in 2012/13. This provides comprehensive information for GPs to assist community services to continue existing treatment plans when patients discharged from hospital avoiding duplication. Results of the pilot area have been favourable. This tool is now being 'rolled out' across the whole organisation in a phased approach, starting in the Emergency Assessment Unit (EAU) at Torbay.	G
			There will be another public event aimed to promote healthy ageing in the older population and falls prevention.	Brixham event held in June 2011. 150 older people given lifestyle and fitness advice with a particular emphasis on vision.	G
			The final two elements of the advanced falls training will be delivered with the complete programme available to staff during 2011-12	All 6 modules of advanced falls training complete, 182 staff in Torbay trained across all the modules to date.	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
6.	*Safe management of medicines (MM)*	Head of Provider Medicines Management	We will build a firm infrastructure with the merger of Southern Devon and Torbay Care Trust to deliver an effective medicines management service.	The medicines management team, newly formed in April 2011, continues to evolve in order to support safe and high quality medicines governance within the community and community hospitals. To enable us to deliver effective medicines management services we are reviewing current service agreements with our providers to further improve efficiently and safety.	G
			Provide strong governance support to implement best practice identified by national guidelines (e.g. National Patient Safety Alerts).	The Medicines Governance Group monitors safety and quality including compliance with NPSA reports and other best practice standards which reports directly to the Care Quality & Safety Group. Compliance with medicines related NPSA reports listed below have been achieved with the implementation of appropriate policy and guidance. NPSA/2010/RRR009 Reducing Harm from Omitted and Delayed Medicines in Hospital NPSA/2010/RRR018 Preventing Fatalities from Medication Loading Doses Additional work by the medicines management team within the community hospitals has developed systems and processes in medicines reconciliation as well as education and guidance to staff in stage 1 medicines reconciliation".	G
			Continue to deliver training and education to staff to ensure best practice in medicines management, controlled drugs	During 2011-12 training targeted key areas of practice with a more formal programme of training in 2012-13 to support the implementation a newly published medicines policy. Training delivered to date • 6 calculation training sessions in 3 community hospitals with follow-up supervision sessions • Training delivered to support medicines reconciliation • Medicines management priorities (for Learning disability services and social care assistant practitioners and care homes) • Medicines management for health support workers • Medicines calculation in community hospitals • Provision of training in use of Patient Group Directions	G
			Continue to raise awareness of the safe use of medicines within the organisation and to the wider population.	CD stock checks are undertaken daily by matrons in community hospitals with medicines management team oversight. More in depth CD audits are carried out three monthly by the medicines management team. There is also clinical audit programme that supports the monitoring of nationally agreed best practice standards including omitted doses, record keeping and antimicrobial audits	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
7.	*Safeguarding Children*	Safeguarding Children lead	We will further the collaborative approach to safeguarding children with partner agencies within the Multi Agency Safeguarding Hub (MASH).	Due to delays in the launch of the MASH within Torbay and pending discussions to develop 2 Peninsula wide hubs this is currently on hold. This is due to the need for external partners to redesign their own services. Torbay Children's Services have developed a local safeguarding hub launched in February 2012 as part of a phased implementation. Health services are included in the Hub and with plans to discuss developing further multi-agency links and information sharing.	A
8	*Safeguarding Adults*	Safeguarding Adult lead	Continuation of the safeguarding adults improvement action plan objectives, • clearance of the backlog of case conferences • continued training and development of staff • a review of policies standard operation procedures • improved reporting functions	Backlog cleared within timescale. Procedures developed to minimise risk of backlog developing in cases and improved reporting systems to support management of safeguarding cases. Training in place with new programme reflecting national competencies and lessons from case file audits. Safeguarding scorecard has been developed to more accurately report performance to Safeguarding Adult Board and commissioners. Department of Health returns also completed. Safeguarding Adult Board (SAB) Annual Report for 2011 was published during March 2012. The Safeguarding Adult Policy was revised during March 2012.	G
9.	*Support the health of carers to enable them to care for their loved one when they die*	Head of Nursing	It is planned for carer support sessions to continue	Four weekly courses held every 2 months 8 courses were delivered in 2011 (42 carers enrolled and 32 attended) Courses are planned for January and March 2012. Six additional support sessions have been provided bi- monthly during 2011 (39 carers attended)	G

10.	*Early Supported Discharge for stroke patients*	Head of Physiotherapy	Finalise staffing for new Early Supported Discharge service in Torbay.	Team now in post providing early supported discharge services to patients who have had a stroke; allowing them to continue treatment at home after discharge from hospital	G
			Determine level of service which can be provided within the initial funding levels and aspire to 7 days per week service	Metrics in place; patient reported outcome measures and patient feedback plus clinical outcome measures. This will allow audit of effectiveness and identify efficiencies that could provide long term financial resources and consideration of a 7 day a week service	G
			The implementation of the Torbay Early Supported Discharge service.	Due to recruitment delays the original start date was deferred to 01.11.11 40 referrals received between 01.11.11 and 03.02.12.	G
			Enable systems to support staff so that referrals and discharge summaries can be provided from the acute ward to the community teams electronically to reduce any treatment delays.	Process being trialled using existing paper based system with the aim of reducing duplication and improving the quality of information a new electronic system will be developed as part of the single community care record project scheduled for release in 2012.	G
			Rationalise supervision arrangements for staff so they are employed and managed within local teams (zones or clusters).	Management arrangements agreed and supervision now in place within local teams providing an integrated approach to multidisciplinary working.	G
			To expand the specialist stroke and Early Supported Discharge service to other parts of the Trust	6 month pilot commenced 01.12.11 in South Hams and Tavistock	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
11.	*Helping people towards a healthier lifestyle*	Lifestyles team	Delivering the 4 week quit target (vital signs) for year. This will be supporting at least 1031 individuals to stop smoking sustained for at least 4 weeks.	Final submitted figures for quarter 3 (not including refreshed data) 612 (target of 690) 11.3% down against target. Actual figures including refreshed /and late returns for quarters 1 & 2 (32 quitters) is 645 (down 6.6% against target). Latest update on 31.3.2012 for all quitters is 835. The service has been, and continues to remain busy this will continue to be a priority for the Trust in 2012/13.	A
			To continue to reduce numbers of women smoking during pregnancy.	Current performance year to date 18.8%, this is an improving position compared to previous years. With only March 2012 data to be received this is an excellent result. This Improving performance has been supported by the new developments of a voucher scheme for women and successful implementation of the "Rotherham model" in December.	G
			To routinely monitor all pregnant women for elevated Carbon Monoxide levels at their 12 week scan.	Since August 2011 routine CO monitoring has been in place for all pregnant women as part of their routine 11 week scan appointment. This allows all women with a "smokers reading" of CO to be referred in to stop smoking service.	G
			Develop a referral pathway and stop smoking service in hospital	On-going work, with progress being made with more staff referring patients that smoke. Including automated text messaging system for all newly admitted patients that will inform of Hospital Smoke Free status and availability of Nicotine Replacement Therapy.	G
			To provide support for obesity management programmes.	The lifestyles service continues to provide services to the community group programme. With a plan to change the contractor to South Devon Healthcare Foundation Trust in 2012.	G
			To continue the integrated delivery of the public health services from a high street shop	Stop smoking and young peoples' health 'drop in' integrated into the service which is also used for open access drop in (drug/alcohol), and been used by the Chronic Obstructive Pulmonary Disease Nurse and Dental Service in local campaigns the lease for this shop has been extended for a further year.	G
			To broaden volunteering opportunities to support the work of the lifestyle services	We now have 5 health trainer champions (volunteers) working for the team. In addition a further 17 volunteers support Bay walks and cooking in the community projects.	G
			To develop obesity services for children / young people (& families)	A service specification has been written for children and young people with support from the lifestyles team. Not yet commissioned. This is planned for 2012/13.	A

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
12.	*Supporting recovery from drug and alcohol dependence*	Torbay Primary Care Substance Misuse Services	We will continue with the roll out of the training programme to front line staff	This programme continues to be delivered; it is being monitored via the Prevention of Harm Torbay Children's Safeguarding Board Sub-group. During the course of the calendar year 2011, a total of 157 individuals have been trained in screening and brief advice for drug and alcohol misuse.	G
			We will implement an alcohol service redesign plan with other local service providers	The alcohol treatment service is currently provided by staff in Torbay and Southern Devon Health and Care Trust and Devon Partnership Trust (DPT); to improve quality and efficiency it is planned to second DPT staff into the "Torbay team". This will provide a fully integrated service for Torbay. This will occur in April 2012. In preparation, work is being undertaken to redesign the service to ensure that is meets the needs of the client group and provides the most effective treatment.	A
			We will develop recovery services led by service users themselves to support recovery	Self-Management and Recovery Training (SMART) programme and Torbay Open Recovery Community (TORC) groups are both now fully established in Torbay. Together with the Primary Care Service staff, ex-service users from TORC ran 'Recovery Month' in March 2012, where promotional activities took place at a number of venues throughout Torbay. Events were received well and there were many opportunities to promote all services in relation to recovery.	G
			Support the implementation of screening and brief advice programmes within Acute Hospital.	A referral pathway has now been completed and agreed by South Devon Healthcare Foundation Trust. On-going work with the A&E department is continuing to build upon this, both for adults and young people with staff training and additional awareness raising on-going.	G
			Developing a new group work programme to support the recovery agenda focusing on 'Recovery Capital'.	This has been fully embedded in service provision for the past 9 months. This model helps an individual look at all of the resources available to them in assisting with their recovery from addiction (i.e. medical interventions, psycho-social interventions family, friends, employment, activity, life skills, volunteering, education) and increasing individual responsibility for developing personal recovery plans.	G
			Implement intervention programme for non-prescribed drug users.	The new development has been fully implemented; delivering a highly effective 63% successful completion, drug-free percentage.	G
			Maintaining progress achieved in relation to Blood Borne Virus testing and immunisation.	• Hepatitis C test received = 89 %(Regional = 66%, national = 62%) • Hepatitis B test received = 79% (Regional = 40%, national = 36%) The Hepatitis B vaccination received figure is still outperforming the regional and national figures, but below the 90% target set by the NTA, although this target is currently being challenged.	G

No	DETAIL	LEAD	PRIORITIES SET FOR 2011/12	UPDATE	RAG = Red, Amber, Green
13.	*Enabling independence re-ablement pilot*	Assistant Director of Performance	To work with care home and domiciliary care providers to: Change the ethos of contracted care provision to secure a re-ablement focussed service: To better meet the needs of patients , Provide care in an appropriate setting and secure closer working arrangements between the different carers	Re-ablement training has been provided to care homes and domiciliary care staff with very positive feedback. The Trust and Somerset Care staff also attended a National Skills for Health conference outlining the pilot and its remit. The Trust remains committed to establishing stronger partnership working arrangements and in order to increase the number of clients participating as a result of the pilot a further 3 joint initiatives have been agreed. They aim to secure more seamless services and handovers between Care Trust and domiciliary care agency staff.	G
14.	*Quality Payments for Care Homes*	Asst Dir Performance	We will be working with the Care Homes forum to review the scheme. We will investigate different options for the use of CQUIN payments.	A 2011/12 CQUIN has been constructed focussed on Falls prevention • To increase Falls Awareness in care homes and reduce the number of falls • This will enhance well-being for residents and reduce expenditure on non-elective care. • Dedicated falls champions in the homes and engagement of all staff will improve the quality of care for all in the home. The indicator is a three year reduction in the number of Fractured Neck of Femur (NOF) procedures. The results of this CQUIN was not available at the time of this account	G
15.	*Productive Community Services*	Head of Nursing	Further work continues to improve efficiencies in how we manage the supply of some specialist equipment to nursing teams.	The community services have undertaken 2 modules in the productive programme with a focus on Clinical stores, equipment, communication and patient experience.	G

Appendix 2

Recommendations and Actions from CQC review of Dartmouth Community Hospital

Torbay Care Trust intends to take the following action to address the points made in the CQC's assessment and lists below a brief summary of the progress so far as well as what is planned:

Desired Outcome, Governance / Evidence Required	Issue / Recommendation	Action There may be a number of actions for each Issue / Recommendation	Desired Outcomes	Target date due to be completed	Update / Evidence Available on Completion
Outcome: 2 Before people are given any examination, care, treatment or support, they should be asked if they agree to it.	People are not constantly involved in decisions about how they choose to be cared for especially in the event of life threatening situations	To communicate the need for a Treatment Escalation plan (TEP) that supports patient's wishes and that this is clearly documented and agreed by the patient. Agreement and discussion with treatment escalation plans between GP's and ward team to provide consistent approach Audit undertaken and reported monthly	All patients will have a TEP completed to indicate patient wishes.	March 2012 Complete	Revised TEP implemented across all services GPs are completing TEPs Monthly audit of compliance show positive results
Outcome: 4 People should get safe and appropriate care that meets their needs and supports their rights.	Inconsistent and non-individualised care plans and risk assessments.	A full review to be undertaken to review the current records used in the Nursing across the Trust – currently a lead has been employed Training programme to be implemented on Care Planning. Use of clinical supervision to reflect on how the plans of care are progressing. Interim plan of working with individual staff to start change process	Staff aware of need to personalise care plans. Monthly audit of standards of records Consistent planned care that is individualised to patient need is evident.	June 2012 Established Complete	New documentation in place. Stage 1 Individualised Care Plan held at patients bedsides. Stage 2 To reduce the risk of error all medical and nursing records being stored in one place.
Outcome: 7 People should be protected from abuse and staff should respect their human rights.	Safeguarding process not always used to ensure that appropriate investigations of issues take place.	Ensure that all staff are aware of the incident policy and flowchart for referrals to safeguarding and the importance of linking this to any reported incidents. Training session at Dartmouth as part of the implementation plan for this policy to be set up in January for staff. Review the need for a standard operating procedure to record staff training. Work on-going corporately to set up a link between incident reporting and the safeguarding lead Key pad in use without a standard operating procedure	All staff are aware of the correct process to alert via safeguarding Links for the organisation are robust between incident reporting and safeguarding Write a standard operating procedure.	March 2012 complete Feb 2012 complete Feb 2012 complete March 2012 complete	New Incident policy now in place communicated with staff Not required – to use ESR SOP written now being shared across other areas
Outcome: 14 Staff should be properly trained and supervised and have the chance to develop and improve their skills.	Suitable arrangements are not in place to provide staff with appropriate supervision in order for them to deliver care and treatment to service user's to an appropriate standard.	• Ensure monthly supervision for all staff. • Review of one to one and clinical supervision records. • Ensure all staff aware of supervision policy and expectations • Training lead to carry out two local training sessions on clinical supervision.	All staff will receive clinical supervision.	April 2012 complete	Training for supervision completed Jan 2012 Group Supervision commenced Jan 2012.

Clinical Audits undertaken in 2011/12 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 is completed across all clinical teams with individual action plans in place; reported to the Record Management Committee and Audit & Effectiveness Committee
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	Undertaken monthly within community hospitals, improvements have been made with over 96.8% of patients in our community hospitals assessed with 24 hours of admission and 91.4% reassessed within 24hrs of initial assessment
Prevention of pressure ulcers – • assessment on admission/Care planning/Grade 2+ ulcers traced or photographed • % receiving risk assessment (by nurse) within 12 hours of admission	2011/12 has focused on improvement work in the avoidance of pressure ulcers in hospital wards data shows improvement of compliance with 99.6% and 99% respectively.
Prevention of malnutrition – • % 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 admission (100%). This is a monthly audit Monthly audit data demonstrates standards are being met or on target to be met
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 being met or on target to be met. December results highlight that 98% 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 standards are on target. December results highlight that 82.5% of patients in our community hospitals assessed with 24 hours of admission
Controlled Drug Audit to monitor safe storage of Drugs	Controlled Drug audit undertaken in all community hospitals with recommendations for each ward based on findings and action plans implemented if improvements required.
Missed drug dosage; compliance with best practice standards in administration of medicines	Audits in place - see part 3 of full report for more detail
Antimicrobial Prescribing to audit the effective prescribing of antibiotics	Audit undertaken in February 2012 results not available for this report
Safeguarding Children adherence to policies and procedures	In progress
Infection Control - Sharps/IPS/MRSA/Mattresses & equipment	Audits undertaken by the infection control team and reported to the Infection Control Committee
PATIENT EXPERIENCE	
Title	**Key Actions**
Patient Experience - patient survey results	Positive results recorded details in part 3 of full report
Privacy & Dignity in Community Hospitals Eliminating same sex accommodation	No breeches of ESMA standards Positive feedback from patients with very few exceptions
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 being reviewed to ensure that they reflect a personalised approach to recording care planning. Monthly audits undertaken.
PEAT - Privacy & Dignity, Environment & Food	All Hospitals have scored good or excellent in this audit
Community Nursing Patient Satisfaction Survey	Positive results received in pilot area for Torbay and plan to repeat audit across whole service in 2012
CLINICAL EFFECTIVENESS	
Title	**Key Actions**
Diabetic Foot problems - in-patient management CG119 assessing the effectiveness of care in compliance with NICE standards	Audit completed Dec 2012
Community MDT Stroke Audit	Part of the Nation Audit Programme, awaiting results
Dementia Standards	Baseline audit undertaken by all community hospitals with action plan in place, Dementia champions in each hospital and training for staff in progress
Community Nursing - Staff engagement questionnaire	As part of the productive community services and on-line audit was undertaken with action plans in place for teams
Parkinson's Disease – to audit service against local and nations standards	Audit undertaken in Feb 2012 no results available to date – this is an annual local audit

Draft Statement from Torbay Council's Health Scrutiny Board on Torbay and Southern Devon Health and Care NHS Trust's Quality Account 2011/2012

Torbay and Southern Devon Health and Care NHS Trust's Quality Account for 2011/2012 has been considered by Torbay Council's Health Scrutiny Board. The Board has had the benefit of seeing early drafts of the Quality Account. It believes that the Trust has clearly stated what its priorities are for the coming year and has provided an easy to understand summary of how it has met its priorities for 2011/2012.

The Board is reassured that the Trust's priorities will continue to meet its ambition of local people receiving the right care, in the right place at the right time. The Board is particularly pleased to see the inclusion of a priority to enable the early recognition of carers at risk of crisis and about improving the participation of children and young people who use Child and Adolescent Mental Health Services. It has been a long standing position of the Board that carers play a vital, but often unsung, role within the health and social care community. Equally the involvement of children and young people in the development of the services they use ensures that services are as effective as they can be.

Over the course of the coming year, the Board would like to receive further information about how the Trust is developing and implementing its proposed quality and safety monitoring tool for independent health care providers from whom it commissions services as this is likely to form part of the Board's Work Programme for 2012/13.

Over the past year, the Board has benefited from regular formal and informal updates from the Trust on a range of issues such as the re-provision of services at Occombe House, the personalisation of health and social care and the redevelopment of Brixham Hospital. Representatives of the Trust have attended meetings of the Board and this has always been appreciated.

The Health Scrutiny Board was able to consider the Quality Accounts from all of the Trusts that it works with at the same time. This has enabled councillors to see how the priorities and work of each Trust as very much inter-dependent and, given the reducing availability of resources in the public sector, the Board will be aiming to review how well organisations are continuing to work together on the preventative agenda to reduce the pressure for acute services.

The Board commends the former Torbay NHS Care Trust for its openness in its dealings with the Board, recognises the implications of the change to Torbay and Southern Devon Health and Care NHS Trust and hopes that it can continue to build a positive relationship and work closely with the Health Scrutiny Board of Torbay Council.

May 2012

South Devon Healthcare NHS
NHS Foundation Trust

Quality Accounts for 2011/12

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 2011/12 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 2010/11 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 Oversee 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 (2012/13).

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

If 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.

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

At South Devon Healthcare NHS Foundation Trust we are committed to ensuring that we provide excellent care. To achieve this, quality must be central to everything that we do, underpinned by our core objectives of safest care, no delays, and ensuring the best patient experience.

These are our third year of Quality Accounts and the information in the report allows us to share the work we have undertaken on improving quality over the last twelve months and how we compare to other organisations.

Torbay Hospital has a proven track record of providing high quality services and I was delighted that in November last year the organisation was recognised for this and named Acute Healthcare Organisation of the Year at the Health Service Journal (HSJ) awards. Our focus on patients' experience and teamwork to deliver seamless care were just two of the areas commended by the judging panel. We continue to focus on both and the implementation of 'Observations of Care', which is described in these accounts, is just one example of people working together to capture patient experience in new ways.

Our quality improvement priorities over the last 12 months have been extremely challenging at a time of unprecedented change within the NHS. It is testament to the commitment and dedication of the staff that they have risen to the challenge and delivered against those priorities in our key areas.

In the forthcoming year it will be even more important to focus on quality to ensure we continue to have a vibrant, sustainable and innovative care system for our patients, their families and carers. I have every confidence the staff will rise to this challenge and the Quality Accounts will be one of the tools we will continue to use to report our progress.

I would like to thank our stakeholders for contributing to the development of the Quality Accounts, in particular our staff, Foundation Trust Governors, the Local Involvement Networks (LINKs), Overview and Scrutiny Committee (OSCs) and commissioners to ensure that we reflect and address the concerns of our care community. I hope you will take time to read this year's Quality Accounts.

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: 2011/12

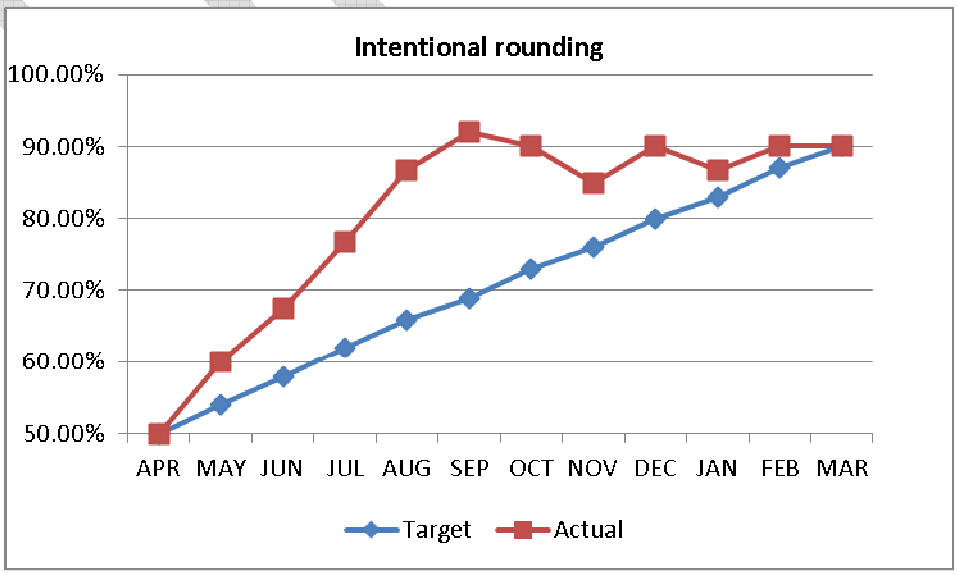
In our 2010/11 Quality Accounts we reported that we would focus on five priority areas for quality improvement in the period 2011/12. These were all locally agreed priorities based on national best practice or best clinical evidence.

Patient safety

Priority 1: To undertake 'intentional rounding' on 90% of patients identified as being at high risk of falls, malnutrition or pressure sores, within the first 24 hour period.

Intentional rounding is a proven practical process to improve the quality of patient care at the bedside. Instead of waiting for a patient to buzz for help, with intentional rounding the nurse takes the initiative and visits the patient's bedside at set intervals to assess and manage the patient's needs. Key to this is letting the patient know that the nurse has time to support the patient with any request; "Is there anything else I can do for you - I have the time".

Over the last twelve months we have been designing and testing systems and undertaking intentional rounding on an orthopaedic and on a stroke ward. Based on a monthly random audit of patient notes for each ward, the wards are now 90% compliant.



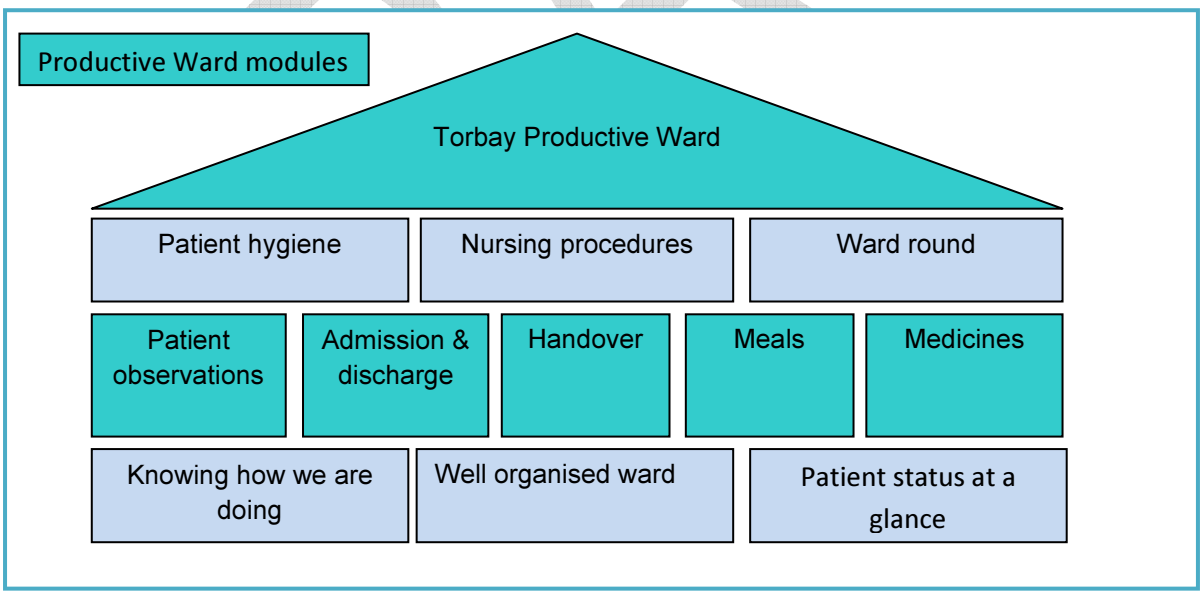
Alongside the intentional rounding work, we have also been measuring the number of reported falls on both wards as a way of measuring the impact of this process on patient safety. On both wards the number of reported falls has reduced. One ward has seen a reduction of 60% with only one fall per month now reported. The second ward has reduced the number of reported falls by 50%.

Work is already underway with other clinical teams to embed intentional rounding into their daily ward routines with the aim of achieving similar levels of compliance and associated improved benefits across the hospital by the end of 2012/13.

Priority 2: 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 they work to release nursing time back to support care at the bedside. The programme is made up a number of modules which are shown in the diagram below.

At the beginning of the project, we set ourselves the challenging target of completing 58 out of a total of 120 modules across 12 wards by the end of the year. By Spring 2012 the ward teams have completed 63 modules in total including modules on *shift handovers, medicines, the well organised ward, knowing how we are doing* and *nursing procedures.*



Through the work the ward teams have undertaken, a simple change such as holding the nursing-shift handover-meeting in a different format has released twenty minutes per nurse per shift. This has all been reinvested in the delivery of safer high quality care.

The ward teams have improved ward environments by sorting, organising and clearing store rooms and colour coding equipment in a standardised way across the

Trust. These improvements have made it easier and quicker for staff to locate equipment, releasing time back to direct patient care, reducing stock spend and helping staff who work across different wards e.g. junior doctors.

As a result of the Productive Ward work, the wards now include interactive patient boards which give up to date information about the beds in use, the professionals involved in each person's care and each patient's predicted length of stay. The boards allow any member of the clinical team to see a patient's status 'at a glance' and to support patient care without the need to interrupt other busy professionals.

Modules such as *medicines* have allowed teams to review the way they manage current drug rounds. Areas the teams have focused on improving include reducing the number of interruptions and ensuring patients take their medication in the presence of a nurse.

For 2012/13 the clinical teams will continue to complete the remaining 54 Productive Ward modules and this will continue to be a Trustwide quality improvement priority.

Clinical effectiveness

Priority 3: To embed 'enhanced recovery' across Torbay Hospital

Enhanced recovery is a nationally proven method to improve patient outcomes through a range of measures that include careful preparation before and during surgery to minimise the disruption of the body's normal functions. This results in more rapid recovery after surgery with earlier discharge and reduced postoperative complications.

Torbay Hospital has led the field in adopting enhanced recovery across a number of surgical specialities including orthopaedics. For 2011/12, our aim has been to embed enhanced recovery across all the surgical teams within the Hospital.

Over the last twelve months we have been setting up our enhanced recovery processes including redesigning patient information, developing data collection systems and reviewing our surgical pathways.

We have used two measures to assess our progress. The measures and performance are shown below.

The first measure aims to ensure over 90% of patients are admitted on the day of their surgery and not the day before, which would result in unnecessary waiting.

Minimum of 90% patients admitted for their procedure on the day of surgery											
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
97%	97%	97%	97%	93%	93%	95%	95%	95%	94%	98%	97%

The second measure aims to ensure that over half of these patients are discharged earlier or on the same day of their planned date of discharge. This is earlier than traditional methods of care.

Minimum of 50% of patients discharged on or before the intended median post operative day length of stay.											
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
67%	63%	62%	67%	69%	66%	61%	60%	68%	66%	61%	66%

Over the last year, we have made steady progress and by the end of the year have exceeded both our internal targets. In areas such as colorectal surgery, where there has been a requirement to develop detailed action plans to ensure patients are admitted on the day of surgery, by the end of the year over 90% of patients are now being admitted on the day of their planned surgery.

For 2012/13 we will continue to monitor our performance and aim to benchmark ourselves against other organisations to ensure we are in the best performer's range of enhanced recovery performance measures.

Patient experience

Priority 4: To measure care and compassion with which older people in Torbay Hospital are treated in response to the 2011 Health Ombudsman report highlighting the following areas of dignity, healthcare associated infections, nutrition, personal care and discharge from hospital.

Within the Hospital we believe that it is important to capture a patient's experience using a range of methods from monitoring, acting on and learning from complaints to participating in national inpatient and outpatient surveys and conducting daily surveys with patients due for discharge. In this way, by triangulating our information we can learn what works well and where we need to improve.

Over the last twelve months we have focused on measuring care and compassion in our largest group of patients, the elderly. We now capture care and compassion information on our Trust complaints and incident system and have modified our in-house patient survey to get better quality patient feedback. A simple but effective question that has now been added asks the question "Have staff looking after you been kind?"

On the wards we have successfully trialed and are now running monthly 'observations of care'. A member of the clinical team, with a trained lay person, observes and records care and gives instant feedback to the ward team. This ensures that any issues are acted on immediately and also good quality care can be recognised.

Extract from an observations of care action plan

Description of issue/area for action	Actions to be taken	Deadline	Person responsible
Quiet environment	Praise staff	December	Unit manager
Call bells easily accessible for all patients	Praise staff for the safe caring of patients within the ward	December	Unit manager
Red trays indicated	Staff to be reminded of the ability for patients to have a 'red tray for patients who do not appear to be eating	December	Ward sisters
Patient did not like the food she had ordered. This was replaced by another meal.	Dementia specialist nurse to discuss with the Dementia Forum the need to order food later in the morning. Patient with short term memory loss do not remember what they have requested.	January	Dementia nurse specialist
Conversations can be heard outside bay areas.	Remind all staff re voices	December	Ward sisters
ECG electrodes left on patient's legs.	All staff to be reminded that electrodes left on frail skin may cause friction and wounds, all electrodes should be removed on admission if not needed.	December	Unit manager.
Hand washing was undertaken by staff when attending to patients.	Congratulate all staff on their hand washing.	December	Unit manger.

Over the next year we will continue to undertake observations of care and to capture, measure and triangulate patient feedback and complaints. This information will be reported through the Trust's Patient Experience Workstream meeting chaired by a Non Executive Director and clinical staff and lay representatives.

Priority 5: To monitor compliance and outcomes against the community wide End of Life Care Rapid Discharge Pathway.

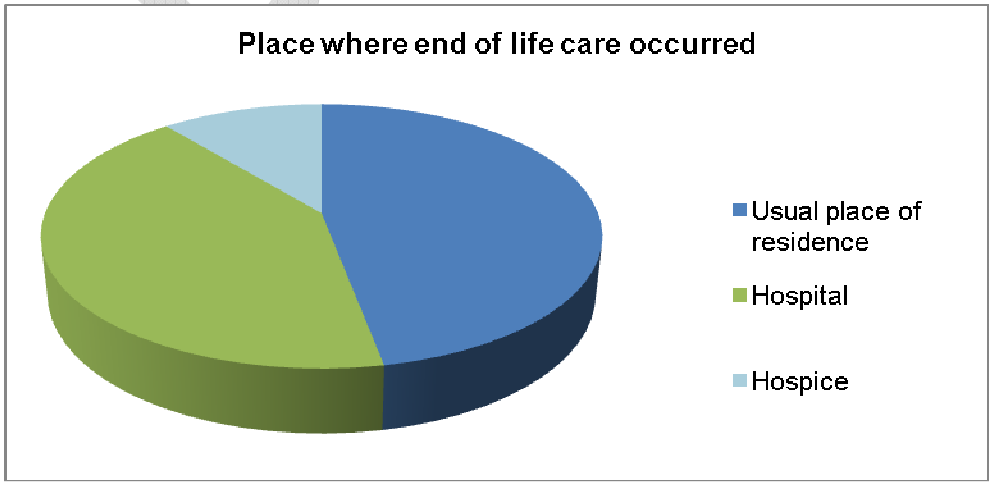
The 2008 National End of Life strategy puts an emphasis on giving patients a choice about where they are cared for at the end of their life. Sometimes people are admitted to hospital for a good reason, but subsequently feel that if time may be short, they would prefer to be cared for elsewhere. Some patients may opt to stay in hospital or be transferred to a hospice or community hospital.

Torbay Hospital has a Rapid Discharge Pathway to guide staff through the sometimes complex process of supporting patients to leave hospital and return to their home or care home with the right care, drugs and equipment. Staff are supported in this process by the Hospital Palliative Care Team.

Over the past year we have looked in some detail at the care that 36 patients nearing the end of their lives, and their families, received both in Hospital and if they left Hospital. Looking at this information has allowed us to identify themes relating to what is working well, but also where we can improve upon or build services for the future. In addition to reviewing these themes within the hospital, we have shared throughout the year the findings with our commissioners, the Patient Experience and Community Partnerships Governance Group, and the Torbay and South Devon End of Life Clinical Pathway Group.

What did we find and learn?

More than half of the 36 people who wanted to leave hospital were helped to do so by Hospital and Community staff working together. Sometimes a patient's condition changed too quickly to allow a safe transfer out of hospital. On occasions the equipment or care that they required in the community was difficult to organise or unavailable at short notice.



As a result of undertaking a detailed analysis of care towards the end of a person's life we have already made several changes. These include:-

- The discharge form has been updated to make it as useful as possible for hospital staff.

- A review of timely availability of equipment in the community is under way, to ensure equity across our health community.

- Many patients and carers have expressed a need to know that nursing support at home could be available 24 hours a day for the last few days of life should they need it. The importance of this request has been emphasised to our commissioners.

- Hospital ward managers have received direct feedback on areas of good practice and areas where end of life care could be even better.

"It is good to get feedback on what we are doing right for patients approaching the end of their lives, and how we can improve care further for them and their families". ***Ward manager, Torbay Hospital***

For 2012/13 we will continue to work with the community service teams and our commissioners to ensure we work together to deliver the best possible care as patients near the end of their life.

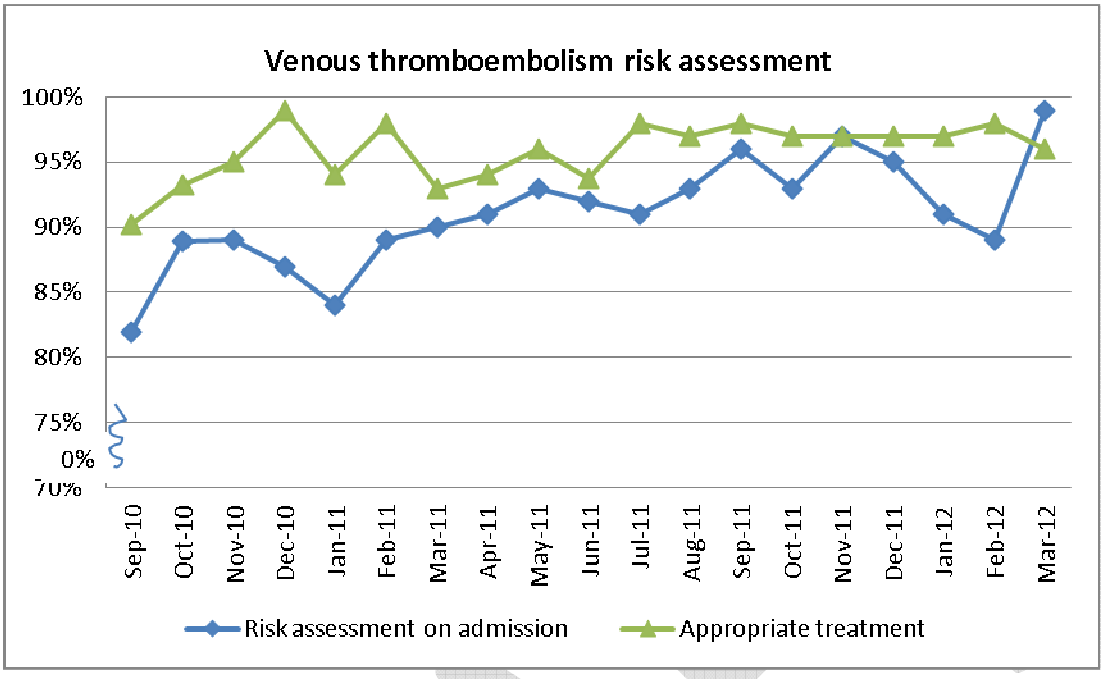
Continuous quality improvement

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 quality improvement is a continuous cycle. Below is a snapshot of our continued progress from a number of our 2010/11 quality improvement priorities and other continuous improvement programmes.

Reducing the risk of patients who are admitted to hospital subsequently developing a blood clot (thrombus) in a vein

In April 2010 we set ourselves a local standard that at least 95% of adult patients are assessed on admission and given appropriate preventative treatment, when required. This is 5% above the national standard. Since Spring 2011 we have been consistently achieving the national standard on assessing risk and exceeding the

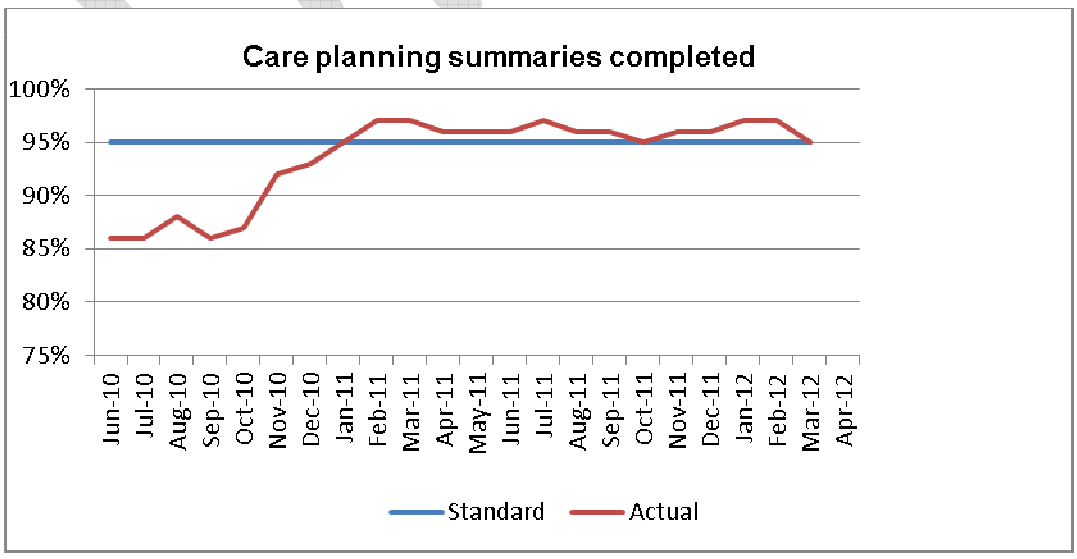
national standard for appropriate preventative treatment. We will continue to monitor venous thromboembolism and report our performance to the Trust Board.



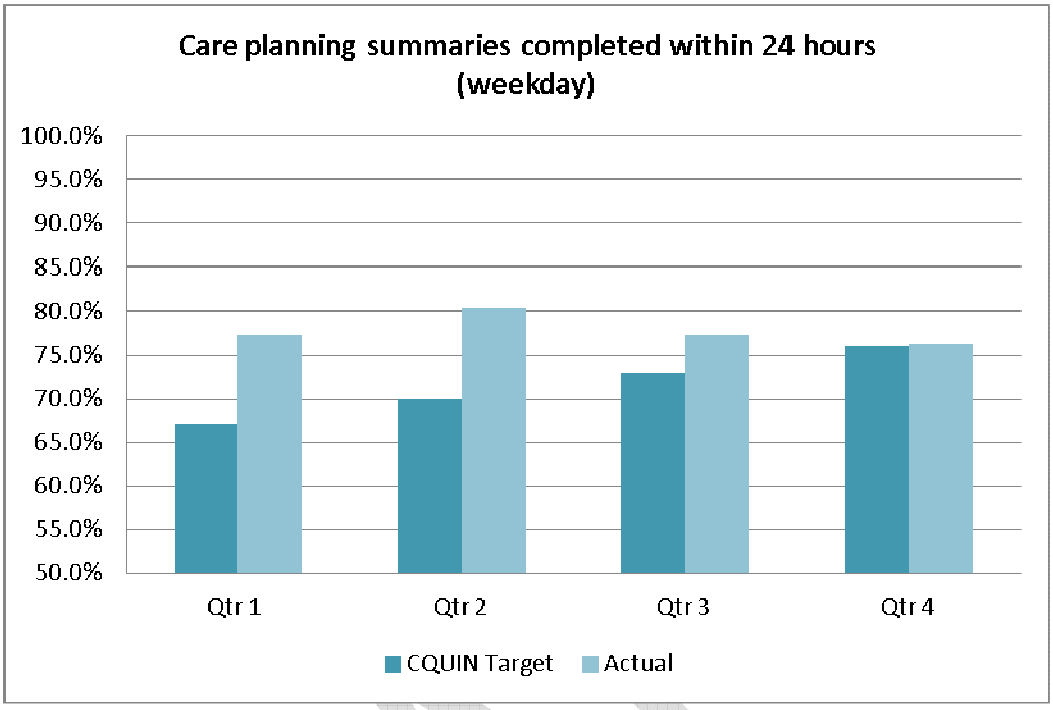
Improving the timeliness and quality of care planning summaries

Care planning summaries are clinical reports written by a doctor summarising their patient's care during their hospital stay. This information is provided to GPs and other health care professionals to ensure they can follow up care effectively.

Over the last year we have been continuing to focus on ensuring that a minimum of 95% of patients discharged have a care planning summary and that the timeliness of summaries being completed and sent to GPs continues to improve.



We have over the last year maintained the 95% standard and have continued to improve our timeliness overall.



For the period 2011/12 we have met our quarterly CQUIN *(National quality improvement framework)* milestones. However, we missed our end of year target of 77% in March by 3% due to unprecedented admissions and service pressures.

We will continue to focus on ensuring that our weekday timeliness performance does not deteriorate and have set ourselves a timeliness improvement target for the next year for weekend care planning summaries. Our performance will continue to be monitored internally and by our commissioners.

Theatre improvement

Alongside our Productive Ward work, we have also been involved in adapting the nationally recognised Productive Operating Theatre programme to help us to improve our theatre environment and processes for both patients and staff.

Some of the highlights include:-

- Embedding the World Health Organisation's safety checklists across theatres. Staff recognise that spending a few minutes doing checks can save vital time and lives throughout the operating lists.

"There has been lots of effective change for the better, although people are anxious about change, communication has certainly been improved."
Specials Theatre Nurse

- Operational status boards in each theatre area help co-ordinators, theatre staff, and surgeons etc to easily see what is happening within the theatre suite. Co-ordinators can recognise arising issues more quickly and mitigate operational risks.

Preparatory work has started on improving theatre scheduling and communication has improved across the clinical teams by holding weekly Productive Theatre 'huddles'. For 2012/13 work will continue on the Productive Theatre work with a focus on scheduling and theatre efficiencies.

Improving the experience of patients with dementia

Within the Trust, we have been working to improve the quality of care experienced by patients with dementia. In Autumn 2011 the South West Dementia Partnership undertook a peer review of our work against the eight national dementia standards.

Their subsequent report identified many areas of good practice including an individualised approach and adjustments made for patients with dementia in pre-operative assessment and outpatient areas.

Suggested areas for improvement included making wider use of memory boxes. In 2012/13 the Trust will continue to focus on dementia care and in particular dementia assessment and referral. This will be monitored by the Trust Board and we will work with partner organisations to improve services for patients with dementia.

"Up to a quarter of people on a general ward at any one time have dementia and Alzheimer's Society welcomes the improvements to dementia care at Torbay Hospital" *Support Services Manager for Alzheimer's Society*

Looking forward: 2012/13

The Trust has identified five quality improvement priorities for 2012/13. 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 agree the priority areas for 2012/13. More information on our engagement process is detailed in Annex 1.

Patient safety

Priority 1: To improve the wards using the 'productive ward' methodology

This is the second and final year devoted to putting into operation processes from the national Productive Ward programme into Torbay Hospital. This year, the aim will be to complete the remaining Productive Ward modules. The modules will include reviewing and improving current ward-based nursing procedures and ward round practices with the aim of releasing more time back to support direct patient care.

The Productive Ward programme will continue to be overseen by the Ward Improvement Project Board chaired by the Director of Nursing and Governance and Deputy Chief Executive.

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

Providing patients with appropriate information about their medicines on discharge is critical to ensuring they are used safely and appropriately.

Over the next twelve months we will focus on ensuring that patients or carers of patients discharged on a 'high risk drug' or patients that belong to particular vulnerable groups e.g. dementia are provided with an appropriate level of medicines information.

We will work with our community colleagues and patient representatives to develop and test this information before making the literature accessible more widely.

Clinical effectiveness

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

Medical advances over the last 30 years mean that increasing numbers of children with long term conditions require adult health services because they are surviving to adulthood. This means the way children make the transition from paediatric health services to adult health services is important. Successful transitional care arrangements may improve a young person's adult health quality of life outcome.

Within the hospital, the focus for 2012/13 will be to ensure that there are effective transitional care arrangements for children with epilepsy, cystic fibrosis or those with neuromuscular disorders. The Trust will review current arrangements and, working with patients and their families, set up improved transitional pathways of care.

Patient Experience

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

Over the last twelve months, end of life care has been a key quality improvement priority. We noted in the 'looking back' section that we would continue to build on the excellent work already undertaken.

In 2012/13 our priority will be to implement new procedures and learning as part of being a national pilot site for 'Routes to Success in End of Life Care in Acute Hospitals'. We will work with community service teams to mirror elements of this work in community hospitals and patients' homes and care homes to ensure that patients receive improved and timely care at the end of their life at their place of choice.

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

Part of the Government's policy is to increase patients' involvement in their own care and treatment and also for them to have more ready access to their information. There is considerable evidence and experience to suggest that patients receiving good quality letters/information respond very positively and with the outcome of improved satisfaction and reduction of anxiety.

Currently most letters are addressed to health professionals e.g. GPs and only get copied to patients. The aim is to move away from this being the norm to patients receiving information direct which is then copied to other health care professionals. Over the next 12 months, a small pilot will be undertaken with doctors changing their practice and writing to patients direct to see whether it improves communication and increases engagement. We will also be using internet services such as '*Patients knows Best*' to improve communication and information flows between doctors, nurses and patients.

Statements of assurance from the Board

Review of services

During 2011/12 South Devon Healthcare NHS Foundation Trust provided and/or sub-contracted 49 NHS services (as per schedule two of its Terms of Authorisation).

South Devon Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in 49 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 87% of the total income generated from the provision of NHS services by South Devon Healthcare NHS Foundation Trust for 2011/12.

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 which is seen as a measure of quality of any Trust's clinical audit programme. The detail which follows relates to this list.

During 2011/12, 40 national clinical audits and 2 national confidential enquiries covered NHS services that South Devon Healthcare Foundation NHS Trust provides.

During that period South Devon Healthcare Foundation NHS Trust participated in 83% 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 2011/12 are as follows:

South Devon Healthcare NHS Foundation Trust	Eligibility	Participation
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	Yes	Yes
Perinatal mortality (MBRRACE-UK)	No	N/A
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes

Pain management (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
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	No
Pleural procedures (British Thoracic Society)	Yes	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	Yes
Adult critical care (ICNARC Case Mix Programme)	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes
Seizure management (National Audit of Seizure Management)	Yes	No
Long term conditions		
Diabetes (National Diabetes Audit)	No	N/A
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	Yes
Parkinson's disease (National Parkinson's Audit)	Yes	Yes
COPD (British Thoracic Society/European Audit)	Yes	Yes
Adult asthma (British Thoracic Society)	Yes	Yes
Bronchiectasis (British Thoracic Society)	Yes	No
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Elective surgery (National PROMs Programme)	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
National Audit of Schizophrenia (NAS)	No	N/A
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	No
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		
Perinatal mortality (CEMACH)	Yes	Yes
Patient Outcome and Death – Cardiac arrest (NCEPOD)	Yes	Yes
Suicide and Homicide by People with Mental Illness	No	N/A

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

- Non-invasive ventilation (NIV) – Adults (British Thoracic Society). The Trust took part in this audit last year and decided not to take part this year. However we intend to take part next year.

- Care of dying in hospital (NCDAH). The Trust took part in previous audits and the Clinical Effectiveness Group in consultation with the Lead Consultant decided to undertake a local audit.

- Medical use of blood (National Comparative Audit of Blood Transfusion – Insufficient data available to participate.

- Cardiac Arrest. – The specialty concerned decided not to take part in this audit as there was a cost implication of £1,000.

- Seizure management (National Audit of Seizure Management). We did not take part in the 2010 audit, but consideration will be given to the next round which is due in 2013.

- Bronchiectasis (British Thoracic Society). The decision not to take part in this audit was made because of the difficulty in capturing the data required.

- Risk Factors (National Health Promotion in Hospitals Audit). The Trust took part in a previous audit organised by Stockport which proved to be of poor quality and therefore little benefit was achieved, so it was decided not to take part in this one.

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 2011/12, 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)	346/346	100%
Children		
Paediatric pneumonia (British Thoracic Society)	10/10	100%
Paediatric asthma (British Thoracic Society)	22/20	110%
Pain management (College of Emergency Medicine)	50/50	100%
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	25/25	100%
Diabetes (RCPCH National Paediatric Diabetes Audit)	Not Known	Not Known
Acute care		
Emergency use of oxygen (British Thoracic Society)	11/10	110%
Adult community acquired pneumonia (British Thoracic Society)	78/20	390%
Pleural procedures (British Thoracic Society)	23/20	115%
Severe sepsis & septic shock (College of Emergency Medicine)	30/30	100%
Adult critical care (ICNARC Case Mix Programme)	684/684	100%
Potential donor audit (NHS Blood & Transplant)	42/42	100%
Long term conditions		
Heavy menstrual bleeding (RCOG National Audit of HMB)	111/111	100%
Chronic pain (National Pain Audit)	52/100	52%
Ulcerative colitis & crohn's disease (National IBD Audit)	38/40	95%
Parkinson's disease (National Parkinson's Audit)	21/30	70%
Adult asthma (British Thoracic Society)	19/20	95%

Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	683/683	100%
Elective surgery (National PROMs Programme)	Not Known	Not Known
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Not Known	Not Known
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	92/92	100%
Carotid interventions (Carotid Intervention Audit)	31/31	100%
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	522/522	100%
Heart failure (Heart Failure Audit)	414/240	173%
Acute stroke (SINAP)	874/781	112%
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	240/240	100%
Cancer		
Lung cancer (National Lung Cancer Audit)	193/193	100%
Bowel cancer (National Bowel Cancer Audit Programme)	158/158	100%
Head & neck cancer (DAHNO)	37/37	100%
Oesophago-gastric cancer (National O-G Cancer Audit)	52/52	100%
Trauma		
Hip fracture (National Hip Fracture Database)	395/495	80%
Severe trauma (Trauma Audit & Research Network)	263/275	96%
Blood transfusion		
Bedside transfusion (National Comparative Audit of Blood Transfusion)	56/40	140%
National Confidential Enquires		
Perinatal mortality (CEMACH)	All cases	100%
Patient Outcome and Death (NCEPOD) – Cardiac Arrest	1	100%

The reports of 40 national clinical audits were reviewed by the provider in 2011/12 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions
N0035	**National Neonatal Audit Programme**
	• To develop an operational policy for medical attendance on SCBU to clearly state, that all admissions need to be seen by a Consultant Paediatrician within 24 hours of admission (NNAP standard)
N0040	**Paediatric Pneumonia (BTS)**
	• No action plan required

N0041	Paediatric asthma (BTS)
	• Introduce a care bundle to standardise early management – reduce use of nebulisers and chest x-ray use • Update the asthma guideline • Update the paediatric emergency assessment document to improve documentation of discharge planning and education about inhaler/device use
N0083	**Pain management (CEM)**
	• Awaiting publication of report
N0064	**Childhood epilepsy**
	• Awaiting publication of report
N0065	**Diabetes – paediatrics**
	• Monitor current good clinical practice and payment by results tariffs in this area and update our processes if necessary • Continue to target poorly controlled young people • Work with commissioners to identify funding for increased Diabetes Nurse, Dietetic and Psychology time
N0037	**Emergency use of oxygen (BTS)**
	• Embed oxygen prescribing more clearly within induction • Use opportunities at F1 and F2 training to promote oxygen prescription
N0071	**Adult community acquired pneumonia (BTS)**
	• Improve compliance with trust antibiotic policy for pneumonia • Maintain education of junior doctors regarding the use of CURB65 score • Emphasise the importance of early diagnosis and initiation of treatment
N0056	**Pleural procedures (BTS)**
	• No action plan required
N0082	**Severe sepsis & septic shock (CEM)**
	• Awaiting publication of report
N0051	**Adult critical care**
	• Review all unit deaths. • All deaths with APACHE II or ICNARC predicted mortality <20% to be presented for peer review by senior nurses and consultants. • Review and discuss difficult cases each month to support consistent decision making across the consultant body • Use data in activity planning, i.e. workforce plan, budget setting, capacity increase to 9 beds based on acuity and volume trends and proposal for new unit built underpinned with data from this database. • Audit unit readmissions

N0036 Potential donor audit
• Increase SN-OD presence on the unit in order to: Increase referrals Improve timeliness of referral to reduce the occurrence of families changing their minds through clinical education. Increase the percentage approached for consent.
N0054 Heavy menstrual bleeding
• Action Plan being complied (tbc)
N0038 Chronic pain
• No action plan required
N0031 Ulcerative colitis & Crohn's
• Action Plan being complied
N0011 Parkinson's disease
• Awaiting publication of report
N0030 Adult asthma (BTS)
• Arrange for Asthma Nurse Specialist to return to normal activity.
N0042 Hip, knee and ankle replacements (National Joint Registry)
• No action plan required
Elective survery (National PROMs Programme)
• Action Plan being complied (tbc)
N0049 Coronary angioplasty (NICOR Adult cardiac intervention audit
• No actions required .
N0033 Peripheral vascular surgery (VSGBI Vascular Surgery Database)
• Multidisciplinary peer review meetings taking place regularly to address regarding the treatment of aortic aneurysms. • Refurbishment of room to accommodate endovascular aneurysm repair
N0074 Carotid interventions (Carotid Intervention Audit)
• Stroke physicians, vascular surgeons, radiologists and anaesthetists working with local stroke care pathway group to address issues identified in the management of carotid surgery at Torbay Hospital.

N0046	**Acute Myocardial Infarction & other ACS (MINAP)**
	• Investigate reasons behind low rates of beta blocker and ace inhibitor usage post MI
N0039	**Heart failure Audit**
	• Action Plan being complied
N0055	**Acute stroke (SINAP)**
	• Improve documentation • Improve eligible patients thrombolysed – Aim 10%
N0066	**Cardiac Arrhythmia**
	• No action plan required
N0044	**Lung cancer**
	• No action plan required
N0053	**Bowel cancer**
	• Ensure all patients are seen by the CNS • Investigate ways of reducing permanent stoma rate
N0047	**Head & Neck Cancer**
	• Ensure 100% completion of data collection in all data fields
N0086	**Oesophago-gastric cancer**
	• Awaiting publication of report
N0043	**Hip fracture**
	• Improve the completeness and accuracy of the data submitted to the National Hip fracture Database including 30 day mortality • Improve access to medical assessment for all hip fracture patients • Ensure all patients admitted with a fall and fragility fracture to be referred to Fracture Liaison Service and Infoflex MFFRA completed • Ensure that all patients have AMTS recorded on admission
N0026	**Severe trauma (TARN)**
	• Reduce the time to CT for head injuries associated with other injuries. • Review all trauma laparotomies to ensure compliance with Trauma Network Key Performance Indicators.
N0081	**Bedside transfusion**
	• No action plan required

The report of two national confidential enquiries was reviewed by the provider in 2011/12 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

NCEPOD Knowing the risk: a review of peri-operative care of surgical patients (2011)
Report presented to Patient Safety Committee Spring 2012 and assurance sought on a number of issues including: • assessment of mortality risk being clearly recorded on the consent form • consistency and reliability regarding pre-assessment of high risk patients
NCEPOD Surgery in children : are we there yet? (2011)
Report presented to Patient Safety Committee Spring 2012 with detailed review of recommendations & action plan. Actions include: • Guideline of the critically ill and injured child being finalised. This will be compliant with the PICS standards & Regional Surgical Network.

The reports of 38 local clinical audits were reviewed by the Trust in 2011/12 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

	Recommendations and actions
6167	**Orthopaedic surgical operation notes**
• Introduce new operation note proforma based on Royal College of Surgeon guidelines • Operation note posters to be put up on walls in Theatres	
6124	**Surgical safety in nail surgery**
• Redesign the nail surgery treatment record to be more user friendly and easier to check for completeness • Pilot, train-in and implement the new forms through peer reviews, spot checks and team meetings	
6125	**Adherence to ENT UK indications for tonsillectomy**
• Sticker to be added to patient notes at the time of listing for theatre listing the indications for surgery	
5973	**Death documentation**
• Review guideline 0238	

6068	Tongue tie release

- Highlight the importance of using and completing the breastfeeding assessment form prior to referral

5841	Safeguarding quality in children's notes

- Proforma to be produced that can provide a constant audit trail of all children with safeguarding issues and act as a prompt in documentation of all issues in relation to the Laming Report recommendations

5866	Collagen injection for vocal cord augmentation

- Surgeon undertaking this procedure to add a note regarding efficacy to the consent form
- Voice Handicap Index to be introduced as an outcome measure

6012	Identification of 'at risk' children in A&E

- Introduction of new forms in A&E:-
  - new paediatric assessment document for In-patients
  - new A&E card
- Annual update for permanent members of staff on child protection and database of training updated.

6013	Personal protective equipment (PPE)

- Infection Control to discuss with ward managers education package for staff:
  - - chain of infection
  - - role of PPE
  - - when to use/ or not
  - - how to remove and dispose of PPE
  - - wash with soap and water after removal
- Establishment of training plan

6016	Histology of transurethral resections of prostate (TURPs)

- Reminder to include histology in discharge plan.
- Set up a database to monitor TURP patients to ensure histology checked one week post-operatively
- Urology nurses to book patients, who fail catheter trials, onto urology outpatient clinic within two weeks

6017	Correct and appropriate prescribing of pabrinex in Emergency Department

- Increase junior doctor awareness of the importance of prescribing pabrinex for appropriate patients
- Either include pre-printed section on the drug chart for pabrinex or a pre-printed sticker onto the infusions section
- Ensure all juniors are aware to prescribe two pairs, IV TDS for total of nine doses

6019	Waterlow score assessments in Trauma and Orthopaedics
• Inform and remind staff of best practice with regards to Waterlow scoring and assessment • Regular review of case notes to ensure Waterlow scores documented and assessed • Continue to complete safety crosses for risk assessments (Productive Ward)	
5781	**Effect of epidural anaesthesia on foetal cardiotocograph (CTG) and documentation**
• CTG Trust policy to be reviewed to include NICE guidelines on intrapartum care and to state that 'Fresh Eye' stickers, once used, are stuck in the delivery notes • Ensure easier access and increase the use of the 'Fresh Eyes' stickers	
5923	**Opioid prescribing**
• Review and increase education on opioid prescribing	
5015	**Pressure Ulcer prevention and management**
• Trust policy and assessment/ monitoring tools to be reviewed to include intentional rounding' and 'skin bundle • Feed audit results into the pressure ulcer prevention safety project	
5901	**Antimicrobial prescribing on surgical wards**
• Staff education programme for prescribing and reviewing antimicrobials	
5870	**Informed consent for blood transfusion**
• Hospital Transfusion Committee to respond to the findings of the audit	
5923	**Safer use of intravenous gentamicin for neonates**
• Orange aprons ordered for staff to wear when preparing the drugs • Posters to be produced highlighting to patients that when they see staff wearing orange aprons they are to refrain from interrupting staff • Staff training sessions to be conducted to ensure that all staff are aware of the gentamicin care bundle requirements	
6072	**Safeguarding children that did not attend outpatient appointments**

• Policy to be updated:-
  ○ To include Looked After Children
  ○ The need for an outcome slip to be completed for non-attendances and for the consultant to make an entry in the notes by the clinic stamp
  ○ When referral made to Children's Services, written follow-up to be made within 48 hours
  ○ If a parent phones to cancel an appointment the notes must be passed to the consultant for review
• Education around the policy
• Ensure that the laminated flowchart is in all outpatient clinic rooms, including community clinics
• Policy to be incorporated into the Trust child protection induction for doctors.
• Title of policy to be changed to 'Was Not Brought'.	

6028	Domiciliary patient referrals
• Increase the number of referrals that include MUST scores to ensure that appropriate referrals are made and first line advice has been initiated. This will be done by; ○ Dieticians to routinely ask for MUST score for all verbal referrals ○ Ensure MUST score requested on primary care referral forms ○ Request for MUST score, where applicable, to be added to the primary care desktop guide to dietetic referrals ○ Continue MUST training programme for care homes, as funding allows and depending on available maternity cover	
6065	**Radiofrequency ablation for varicose veins**
• Procedures are now done under local not general anaesthetic and simultaneous avulsions are not performed.	
5977	**Otitis media with effusion (OME) in children**
• Implement a checklist form for OME to improve documentation	
6071	**Note keeping 2009 – 2010 (General Medicine)**
• Re-training of doctors and nurses in note-keeping • Medical pages to have patient details on both sides • Discuss/ highlight requirement that discharge summaries should be filed at front of notes	
5648	**Management of suspected sub-arachnoid haemorrhage (SAH)**
• Produce a protocol for the management of SAH	
6000	**Management of Syphilis**
• Raise awareness that the rates of syphilis are increasing nationally and locally through GP and hospital newsletter • Raise awareness and promote regular screening among high risk groups • Improve documentation & use Lilie template to manage treatment and follow up. • Improve health education and offer written information to every patient diagnosed with syphilis	
5927	**Note keeping 2009 – 2010 (Ophthalmology)**
• Raise awareness of note keeping standards • E-mail all Ophthalmology staff regarding the Trust standards for note keeping	
6002	**Pre-operative X-rays using discs**
• Develop a protocol • Raise awareness of the need to document on the x-ray requests diagnosis of arthritis and possible surgery	
5969	**"Risky" sexualised behaviour in people with learning disabilities**

- Review/ investigate the possibility of a "chronology" sheet of incidents being made available
- Investigate how to indicate/ confirm that a risk assessment has taken place without the need to fully complete the whole of the documentation
- Clients without psychology/ SHEALD assessment to have a short chronology produced
- Liaise with referrals co-ordinator to ensure that referrals from out of the area/ Children's services have a risk assessment completed as part of the information provided at referral
- Investigate how to improve MDT contributions to risk assessments

5986	**Malnutrition and screening in emergency surgical patients**

- Deliver MUST training to all new starting employees at their induction.
- Develop new MUST pro-forma to aid accurate scoring of patients nutritional risk and to advise on nutritional interventions to be trialled to decrease malnutrition risk.
- Use of safety crosses (indicating if risk scores are being completed

5987	**Nurse led management of the surgical voice restoration patient**

- As well as the paper record held in clinic, a letter will be dictated to confirm the valve change and placed on the hospital records.

5940	**Shoulder dystocia - brachial plexus injury**

- Trust policy to be reviewed to clarify risk factors and if any of the three main risk factors are identified then a documented discussion should take place.
- Staff to receive teaching/ education in the correct completion of the proforma

6023	**Acute Stroke Care and Transient Ischaemic Attack (TIA) management**

- Re-emphasise importance of using FAST score. (Teaching and action plan)
- ROSIER score to be included in stroke clerking proforma, education
- GCS needs to be documented. (Ongoing education)
- CT request form needs to include box for entering time

6046	**Note keeping 2009 – 2010 (General Surgery)**

- Raise awareness of note keeping standards at the ENT audit meeting
- Produce a laminated sheet highlighting the Trust note keeping standards for Forrest Ward

6056	**Surgery of the parotid gland**

- Increase data collection items regarding complications, particularly around the permanent facial nerve palsy
- Review published paper (M McGurk) to offer more comparative data
- Approach Pathology to try to identify patients more easily

6039	**Dementia in older adults and the DVLA**

- E-mail presentation and request Team Managers to discuss/ present to Team Business meeting
- Each of the three teams to ensure that clients are advised to contact DVLA and this advice/ action evidenced/ recorded in notes
- Each team to select a leaflet of their choice for use with clients
-

6079	Fluid balance in General Surgical Patients
• Review fluid balance charts and develop a standardised form for all surgical wards to use, ensuring that this has space to enter ward name • Ensure new documentation is approved by the Clinical Records Committee prior to introduction	
6081	**Venous thromboembolism (VTE) prophylaxis in vitreoretinal (VR) surgical patients**
• Dissemination of results to raise awareness of requirements amongst doctors plus additional training for nursing staff	
6116	**Dietetic In-patient record cards**
• The in-patient record card to be amended to take account of the results. The colour of the card will be changed to lilac to ensure staff are aware that there is a new record card.	

Research

The number of patients receiving NHS services provided or sub-contracted by South Devon Healthcare NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1953.

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 348 clinical research studies during 2011/12 in 29 medical specialities.

There were 86 clinical staff participating in research approved by a research ethics committee at South Devon Healthcare NHS Foundation Trust during 2011/12. These staff participated in research covering 29 medical specialties.

As well, in the last three years, over 32 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.

Rossini study - Reduction of surgical site infection using a novel intervention

The aim of this study is to find out whether using a sterile plastic wound-edge protection device during an operation can reduce the chances of a patient developing an infection.

The study is funded by the Research for Patient Benefit Programme (of the National Institute for Health Research and the Trust is one of several organisations participating.

The study has just closed and the data is being analysed.

R-CHOP 14 vs R-CHOP 21

This is a study looking at rituximab and CHOP* given over 14 days versus 21 days in patients with newly diagnosed diffused large B cell non Hodgekin's lymphoma.

The study showed no evidence that R-CHOP 14 is better than R-CHOP 21, they were equally effective.

**CHOP is an acronym for a chemotherapy regimen*

Gastroenterology

Blood samples and data collected as part of a Trust led Inflammatory bowel disease (IBD) serological and genetic study has now been linked up with data from other studies and colleagues as part of the UK IBD Group. This has added vital knowledge about the genetics of Crohn's disease and Ulcerative Colitis.

Significantly this information has also played a part in the discovery of a new gene and the role it plays in the gut function, helping unravel the complex causes of both these conditions.

CQUIN payment

A proportion of South Devon Healthcare NHS Foundation Trust income in 2011/12 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.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically at

http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

In 2011/12 the value of the CQUIN payment and income subsequently received was £2,487,054. In 2012/13 the value of the CQUIN payment is xxx (tbc).

Care Quality Commission

South Devon Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and 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 2011/12. South Devon Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC in the reporting period.

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 medical practice validity

South Devon Healthcare NHS Foundation Trust submitted records during 2011/12 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 which included the patient's valid NHS number was:

- 99.3% for admitted care
- 99.7% for outpatient care
- 97.8% for accident and emergency care

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

- 99.8% for admitted care
- 100% for outpatient care
- 99.2% for accident and emergency care

Information governance

South Devon Healthcare NHS Foundation Trust Information Governance Assessment report overall score for 2011/12 was 83% and was graded green.

Data quality improvements: looking back 2011/12

South Devon Healthcare NHS Foundation Trust committed to take the following actions to improve data quality in 2011/12:

To improve the timeliness of data entry on all wards, including ensuring that as patients are transferred to wards all information relating to their clinical management is updated at the same time and then routinely updated up to the point of discharge.

The Trust has implemented an electronic whiteboard system on wards called SWIFT Plus. This allows clinical staff to record patient information in real time and for the clinical teams to see a patient's status 'at a glance'. The Trust are now using them for multi-disciplinary 'board rounds' on a daily basis ensuring a patient's care is proactively managed throughout the day.

To improve the data quality for Referral to Treatment (RTT) pathways.

Over the last 12 months intensive support has been provided to different clinical teams to improve the data quality of information recorded following an outpatient appointment. Selected specialities have undertaken a week or two week data audit, looking at what was recorded on the outpatient appointment outcome slip compared to what was recorded on the Patient Administration System.

As a result of the audits, data errors have been identified and a programme of advice and guidance and retraining has been provided. Also crib sheets have been produced for the clinical teams and ongoing monthly validation of RTT data provides the teams with information regarding their improvement and where further action is required.

To improve the quality of the Trust workforce data held on the Electronic Staff Record (ESR) system.

Work has been ongoing to improve the accuracy of workforce data. The Trust's national data accuracy rating position has improved from 319th out of 423 NHS organisations using ESR in August 2011 to 15th out of 423 in January 2012. Workforce forms including 'Change of Circumstances' forms have been revised to improve data collection and data integrity and these are available on the Trust intranet website for staff to download.

A request has been made to align the staff rostering system with ESR on a daily basis. This is planned to go live in May 2012 and will ensure hierarchies and staff details are aligned, improving data quality.

To review and update the Information Asset Register to ensure that all known and any previously unknown information assets are identified and that data is maintained and shared in a managed way outside the organisation.

A review has been undertaken over the last 12 months with a survey sent to staff managing the Trust's information assets. As a result of the responses a number of additional IT systems have been identified as well as a number that have been decommissioned. This information has been uploaded on the Trust's Information Asset Register. All the staff responsible for managing the Trust's information assets have access to the register and can amend their information on an ongoing basis.

Written guidance has also been created to assist staff in updating and adding information assets to the register and this has been shared at a range of stakeholder meetings. Staff job descriptions for IAO roles and IAA now include reference to data quality and information sharing. This is particular important when there are staff sharing information with third parties as part of their clinical team's work. In addition, a small team from the Health Informatics Service, has been educating the staff around understanding and assessing the information requested and ensuring data quality checks are undertaken periodically.

Over the next year, work will continue to disseminate guidance to new staff managing information assets and all these staff will continue to undertake information governance training to improve their understanding of data quality.

To improve our information governance score from 71% to 85%.

The Trust was just short of its local target for the year at 83% rather than 85% because several pieces of evidence require further development before they can be

approved; this evidence will now be submitted as part of the information governance submission for 2012/13.

Plans for 2012/13 include the increase in the number of compliance spot checks.

To improve the management of Trust policies and procedures to ensure they are recorded consistently, in a standard format and are kept up to date.

In 2011/12 a project was initiated to agree a standard template incorporating new data fields to allow better searching and retrieval of information as well as indicating when documents are out of date and due for renewal. This has been undertaken in preparation for departments moving to the Trust's new Intranet platform which will store Trustwide policies in this new format from 2012.

The new Trust Intranet system went live in February 2012 and a plan is being developed to transfer all existing policies into the new format. By the end of 2013, the aim will be that all Trust policies will have been updated according to the new format and placed on the new Trust Intranet with key words and meta data to aid searching.

To act on any recommendations from the Quality Accounts' external data quality audit of two nationally mandated performance indicators and one local indicator agreed by the Trust Governors.

PWC undertook the external data quality audit for the Trust. The audit for the three indicators included sampling the data and evaluating the key process and controls for managing and reporting the indicators. The indicators and findings are described in the table below.

Indicator	Type	Findings
MRSA	National	No errors identified in sample tested No control issues identified
Maximum 62 days from urgent GP referral to first treatment for all cancers	National	No errors identified in sample tested No control issues identified
% of ST elevation myocardial infarction (STEMI) patients who received primary angioplasty within 150 minutes of call (call to balloon time)	Local	Eight errors identified in sample tested, which do not affect the performance reported One control issue identified

The Trust has reviewed the Auditor's recommendations for Heart Attack (call to balloon time) and the following actions have been undertaken:

- A training session has been run for all the Chest Pain Unit staff with regard to recording the 'stop time' using the Carddas system and patient notes.

- The Trust has implemented the process of printing a copy of the procedure log from the Mac Lab system showing the correct 'balloon time' and filing this in the patient notes.

- The MINAP database has now been moved to a 'Web Based' system.

Data quality improvements: looking forward 2012/13

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

- Improve the quality of the outpatient clinic outcome letter for patient attendances and email these within agreed timescales to GPs
- Work with staff managing information assets (databases, IT systems etc.) to review the data quality via regular data quality audits and spot checks;
- Set up a programme for undertaking data quality audits of the Trust Board's performance dashboard indicators with a minimum of 4 audits in 2012/13.
- License the Trust to enable all staff to access the data quality dashboard which is hosted on the SharePoint collaboration site.
- Improve our Information Governance rating to 90%
- Reduce the number of clinical coding errors through providing additional training and reviewing ward based coding practices.
- Act on any recommendations from the forthcoming external audit of these Quality Accounts. This includes the auditors reviewing the data quality of two nationally mandated indicators and one locally governor agreed indicator. The indicators are namely:-
    - Clostridium difficile –national indicator
    - Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers – national indicator
    - Emergency readmissions to hospital within 28 days of discharge – local indicator

Clinical coding error rate

South Devon Healthcare NHS Foundation Trust was subject to 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 (average procedure error rate = 16.3%, average diagnosis error rate =18.5%)

- Primary diagnoses incorrect 17.5%
- Secondary diagnoses incorrect 18.7%
- Primary procedures incorrect 14.0%
- Secondary procedures incorrect 17.5%

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Part 3: Our performance in 2011/12 and other quality initiatives

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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 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 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 and the CQC on a quarterly basis.

Good governance, sound financial management and high clinical standards are at the heart of ensuring we are performing well. In 2011/12 we continued to be rated a low financial risk by Monitor with the same financial rating as in the previous year.

Monitor Risk ratings at a glance

Finance

High risk *Low risk*

Governance

Source: Monitor website: 24/4/2012

With regards to governance, the regulator has amended the governance risk rating to amber-red for 2011/12 to reflect the Trust missing one of its eight healthcare targets.

The Trust was set a clostridium difficile healthcare target of 21 reported cases. This is one of the lowest targets in the country. By the end of the year the total number of reported cases was 24, however it is still an improvement from 20101/11.

In relation to standards of care, as part of the Care Quality Commission (CQC) normal review programme, the Trust was subject to two unannounced visits during the year. In Spring 2011, the Trust was subject to its first visit where the CQC reviewed two CQC outcomes relating to dignity and nutrition. The Trust was judged to be compliant, with no compliant actions.

In November, the CQC visited the Trust to review a further 12 CQC outcomes out of a total of 28. All of these outcomes were judged to be compliant, with no compliant actions. Only one improvement action relating to documentation was identified and an action plan was put in place to address the issues.

Our performance against our key quality objectives

Patient safety

The Trust collects a range of data and information on patient safety both Trustwide and from clinical teams. These are reported at a range of meetings including at Trust Board and Workstream1 where patient safety issues and improvements are discussed and assurance is sought from different clinical specialities.

Information currently collected and reported includes number and types of incidents, infection control rates, VTE assessment, Hospital Standardised Mortality Ratio (HSMR) and medicines reconciliation. The Trust is part of the NHS South West Quality and Patient Safety Improvement Programme.

Indicator	Data source	Nationally set Trust Target	2011/12	2010/11	2009/10
Number of methicillin-resistant Staphylococcus aureus bacteraemia reports[1]	Health Protection Agency *(2b)*	3	0	1	2
Number of clostridium difficile cases[1]	Health Protection Agency *(6a)*	21	24	26	28
Level of hand hygiene compliance	Trust Audit	n/a	90%	90%	94%

Percentage of staff saying hand washing materials are always available	NHS Staff survey *(KF19)*	n/a	65%	63%	61%
Number of never events	Trust Safeguard database	0	0	0	n/a

Patient experience

The Trust uses a combination of methods to collect information relating to patient experience. These included patient stories, patient complaints, observations of care and patient representation on a range of clinical pathway groups. Information is disseminated through Workstream 2, the Trust's Patient Experience Group and the Trust participates in a range of national and local patient and staff surveys with findings shared with everyone through team briefings and the Trust's website .

Each year we participate in the national inpatient survey and the full details of the survey can be found in the 2011/12 Trust Annual Report. Highlights from the 2011 survey include increased access to single sex accommodation. Areas requiring improvement include visibility of information about how to complain and hospital choice when being referred to see a specialist.

"I was always made to feel I was important. I was never dismissed and always made to feel like I was a priority..."
Inpatient survey comment

Every two years the national outpatient survey is conducted and in Spring 2011/12 the Trust participated in the survey. The overall scores (out of 100) are detailed below benchmarked against the national average and other acute hospitals in the South West.

Outpatient survey – overall scores	England average	South West average (SHA)	Trust
Access & waiting	75	77	79
Safe, high quality, coordinated care	84	85	86
Better information, more choice	79	80	85
Building relationships	88	89	90
Clean, comfortable, friendly place to be	71	72	71

These national surveys triangulated with real time feedback information, plus a range of staff and patient measures paint a positive picture throughout the year of patient experience at Torbay Hospital.

Indicator	Data source	National standard or average 11/12	2011/12	2010/11	2009/10
Overall rating of care received	NHS inpatient survey*(Q74)*	n/a	Tbc	80	82
Number of patient complaints	Trust Safeguard	n/a	173	170	229
Staff job satisfaction	NHS Staff Survey *(KF32)*	3.67	3.64	3.50	3.55
Staff recommendation of the trust as a place to work or receive treatment	NHS Staff Survey *(KF34)*	3.50	3.79	3.57	3.75
Annual staff sickness absence rate	Electronic Staff Record	4.14%	3.91%	3.76%	3.96%

Clinical effectiveness

Clinical effectiveness is informed through using a broad range of indicators including the hospitalised standardised mortality rate (HSMR) and compliance with national and local standards such as clinical audits and National Institute of Clinical Excellence guidance. Timeliness is important and waiting time information is collected on a daily basis as well as the time spent in the most appropriate setting for a person's care.

Clinical quality is also measured in part through metrics such as re-admission rates and length of stay and we are starting to collect outcomes data as it becomes nationally available for different surgical procedures. In next year's Quality Accounts we will aim to report on a range of patient related outcome measures.

Indicator	Data source	National benchmark= or national average	2011/12	2010/11	2009/10
HSMR	Dr Foster*	100	86.7	96.1	95.1
Length of stay (days)	Dr Foster	5.5	3.3	3.3	3.6
Day case rate	Dr Foster*	100 Actual%	53.3 91.5%	63.1 89.8%	63.6 89.2%
Re-admission rate	Dr Foster*	100 Actual%	98 7.3%	99.3 7.2%	98.6 6.9%

** Dr Foster benchmarking data uses a calculated relative risk score based the actual observed value against the expected value based on national case mix data. Values below 100 are better than expected.*

Our performance against key national priorities

Monitor

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

Indicator/Target	Target	Q1	Q2	Q3	Q4
C.difficile year on year reduction	21				
MRSA - Meeting the MRSA objective	1				
Cancer 31 day wait from diagnosis to first treatment	>96%				
Cancer 31 day wait for second or subsequent treatment: surgery	>94%				
Cancer 31 day wait for second or subsequent treatment: drug treatments	>98%				
Cancer 31 day wait for second or subsequent treatment: radiotherapy	>94%				
Cancer 62 day wait for first treatment (from urgent GP referral)	>85%				
Cancer 62 day wait for first treatment (From consultant led screening service referral)	>90%				
Cancer two week wait from referral to first seen date	>93%				
Cancer breast symptoms two week wait from referral to first seen date	>93%				
A & E – total time in A & E	<4hrs				
Referral time to treatment time, admitted patients	<18 weeks				
Referral time to treatment time, non admitted patients	<18 weeks				
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	n/a				

NHS Operating Framework and local priorities

We also report against a range of national and local measures to inform the Trust on quality and performance. These include:-

Other National and local priorities	Target	2011/12
Smoking during pregnancy	19.4%	15.8%
Breastfeeding initiation rates (% initiated breast feeding)	76.3%	74.6%
Mixed sex accommodation breaches of standard	0	9
Delayed transfers of care	2%	0.6
Cancelled operations on the day of surgery	0.8%	0.7%
DNA rate	5%	4.9%
Diagnostic tests longer than the 6 week standard	1%	1.5%
Rapid access chest pain clinic waiting times: seen in 2 weeks	98%	100%

Primary PCI within 150 minutes of calling	68%	88%
Patients waiting longer than three months (13 weeks) for revascularisation	0.1%	0%
Stroke care: 90% of time spent on stroke ward	80%	89%
Stroke care: TIA seen within 24 hours	60%	70%
Diabetic retinopathy screening	95%	97%
Ethnic coding data quality	80%	95%
Access to GUM clinics – offered	100%	100%

Other Trustwide initiatives in 2011/12

Looking back over the last year, the Trust has continued to build and develop the quality of its services. More information can be found in the Trust's 2011/12 annual report and annual review.

Below are just a few of the highlights from 2011/12:

- The opening of the new Women's Health Unit which co-locates inpatient services for women receiving healthcare and includes enhanced facilities for maternity and neo-natal services

- A new outpatients area designed specifically for children and young people attending outpatient appointments

- Development of acute physician role to improve the timeliness to see a senior decision maker (consultant)

- Introduction of a new early warning trigger tool, designed by the Directors of Nursing in the South West. The tool uses a set of measures designed to determine the potential for deteriorating standards on a ward and highlights to the ward manager the need to put actions in place to ensure that any deterioration does not occur.

- The Trust has replaced all patient beds for new electric beds allowing patients greater movement and comfort.

- As part of the Trust's sustainability strategy, a new waste recycling scheme has been introduced across the Trust. Staff are able to recycle paper, cans, bottles plastic and batteries.

Annex 1

Engagement in developing the Quality Accounts

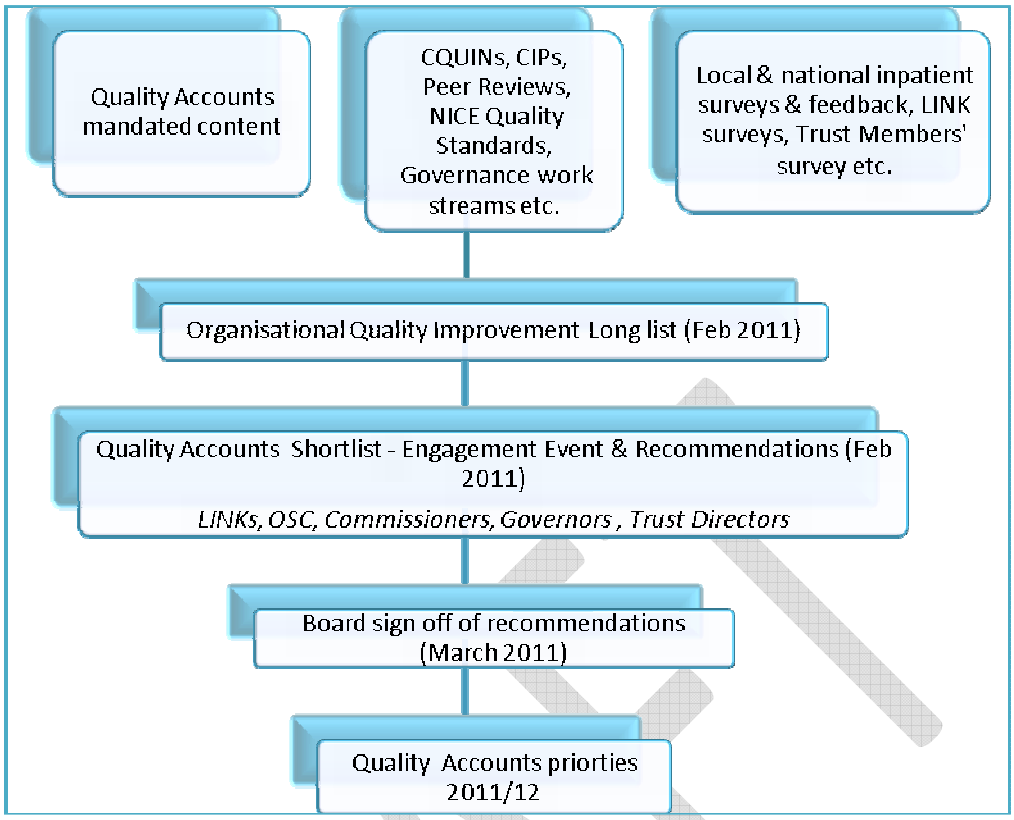
Prior to the publication of the 2010/11 Quality Accounts we have shared this document with:

- Our Trust governors and commissioners
- Torbay & Devon LINKs
- Torbay and Devon County Council's Health Overview and Scrutiny Committee.

This year's Quality Accounts has benefitted again from a wider consultation process and greater engagement with our community in choosing the 2011/12 priority areas. This year we reviewed feedback from the Foundation Trust Member's Survey as well as other national and local surveys and data. We have also continued to engage with a wide range stakeholders including clinicians, governors, commissioners and lay representatives.

The development of CQUIN's has been clinically led and the 2012/13 continuous improvement projects have been driven as part of our annual business planning.

In February 202, the Trust held its annual Quality Accounts Engagement event inviting key stakeholders including the OSCs, LINKs, commissioners and Trust governors to come together and recommend the priority areas to be included in this Quality Accounts. (See diagram below). These have all been subsequently signed off at Board level.



Statements from Commissioners, Governors, OSCs and LINKs

Commissioners
To be written

South Devon Healthcare NHS Foundation Trust Governors
To be written

OSC – Devon & Torbay
To be written

Torbay & Devon LINKs

To be written

Statement of Directors' responsibilities in respect of the Accounts (susan)

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Accounts.

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

- the content of the Quality Accounts meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2011 to June 2012
    - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
    - Feedback from the commissioners dated xx/xx/2012
    - Feedback from governors dated xx/xx/2012
    - Feedback from OSCs dated xx/xx/2012
    - Feedback from LINKs dated xx/xx/2012
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated November 2011
    - The 2010 national inpatient survey dated 24/04/2012
    - The 2011 national staff survey dated 09/03/2012
    - The Head of Internal Audit annual opinion over the trust's control environment dated xx/xx/2012
    - Care Quality Commission quality and risk profiles dated March 2012.
- the Quality Accounts presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the Quality Accounts is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Accounts has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Accounts (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board

Signatures xxx

Annex 2

Glossary of terms

TBC

Draft Statement from Torbay Council's Health Scrutiny Board on South Devon Healthcare NHS Foundation Trust's Quality Account 2011/2012

South Devon Healthcare NHS Foundation Trust's Quality Accounts for 2011/2012 has been considered by Torbay Council's Health Scrutiny Board. The Board welcomes the clarity with which the Trust has explained how it has met its priorities for 2011/2012 and what its priorities are for the forthcoming year.

The Board is reassured that the Trust has embraced national initiatives such as "intentional rounding", "productive ward" and "enhanced recovery" with the aim of ensuring the best patient experience. The Board has confidence that, through committing to continuous quality improvement, the performance of the Trust will continue to improve.

The Board particularly supports the inclusion of Priority 3 (To improve the transition of care of young people with epilepsy, cystic fibrosis and neuromuscular disorders) and Priority 4 (To improve the quality of end of life care provision). The transition of young people between services for children and services for adults has been a long-standing issue of concern for the Board and it is pleasing to see that further work will be carried out in this specific area. Likewise, given the ageing population in Torbay, ensuring that services and agencies work effectively together to ensure patients receive timely and improved care at the end of their life is to be welcomed.

The Board would request that the actions identified to address the following local clinical audits be undertaken as a matter of urgency:

- Safeguarding quality in children's notes
- Identification of "at risk" children in A&E
- Safeguarding children that did not attend outpatients appointments

The Health Scrutiny Board considered the establishment of regional networks of trauma care at its meeting in September 2011 when councillors were able to hear from representatives of the Trust as well of those from NHS Devon and South Western Ambulance Service NHS Foundation Trust. The Board were also invited to attend the Trust's Quality Accounts Engagement Meeting which provided an opportunity to discuss the development of the Trust's priorities for the coming year.

The Board commends South Devon Healthcare NHS Foundation Trust for its openness and transparency of its operations and hopes that the Trust will continue to work closely with the Board and Torbay Council as a whole.

May 2012

South Western Ambulance Service NHS
NHS Foundation Trust

responsive
committed
effective

foundation trust

quality review 2011/12
quality account 2012/13

An introduction to Quality

Professor Sir Bruce Keogh
NHS Medical Director Department of Health

Mr David Bennett
Chief Executive of Monitor

Quality Accounts now represent a critical part of the overall quality improvement infrastructure of the NHS. Their introduction in 2010 marks an important step forward in putting quality reporting on an equal footing with financial reporting.

The Government's White Paper, Equity and Excellence: Liberating the NHS, set out how the improvement in quality and healthcare outcomes would be established.

Quality Accounts demonstrate a relentless focus on improving service quality. This compliments the duties set out in Monitor, independent regulator of NHS Foundation Trusts, current quality governance guidance.

Boards are ultimately responsible for quality of care provided across all service lines and they must ensure that Quality Accounts:

- demonstrate commitment to continuous, evidence-based quality improvement;
- set out to patients where improvements are required;
- receive challenge and support from local scrutineers;
- enable Trusts to be held to account by the public and local stakeholders for delivering quality improvements.

To improve accountability the Quality Account must provide progress against previously identified improvement priorities, or explain why such priorities are no longer being pursued. Demonstrate how the review of services and patient, public and, where appropriate, governor engagement has led to these priorities being set.

This will realise the vision of an open and transparent NHS, enabling the success of the NHS Foundation Trust governor model to become autonomous and locally accountable.

The published evidence shows that public disclosure in itself does not generally drive improvement, but rather it is the organisational response that Trusts put in place to improve their record on quality that drives improvement.

Quality Accounts are beginning to demonstrate quality improvements for the things that matter most to patients.

This joint statement to the NHS sets the context nationally and underpins the South Western Ambulance Service NHS Foundation Trust approach to continuous quality improvement.

A statement on quality from the Chief Executive

This is the second Quality Report for the South Western Ambulance Service NHS Foundation Trust and I am pleased to confirm that the Trust has again exceeded all of the national targets for the year 2011/12.

The Trust provides 999 Emergency Ambulance Services (A&E), GP out of hours Urgent Care Services and Patient Transport Services across the four counties Cornwall and the Isles of Scilly, Devon, Dorset and Somerset. The Urgent Care Service operate in Dorset and Somerset only. The Trust is a key conduit to the effective delivery of the health and social care network for the residents and visitors of the south west.

The Trust is committed to making the safety of patients a high priority for all of the services we provide. In 2012/13 the Trust will continue to focus on the implementation of quality improvement initiatives. The commitment to improve the experience and clinical outcomes for patients and to enhance patient safety is key to every decision made by the Trust.

The Trust Strategic Goals have been updated for 2012/13 and continue to be focus on modernisation to deliver all standards and quality requirements:

- High Quality, High Performing;
- Improving Patient Pathways;
- Right Care, Right Place, Right Time;
- To be a credible competitor for Urgent Care Services;
- To be the obvious choice for Patient Transport Services.

In addition to these, the Trust has four annual corporate objectives which reflect relevant ambulance priorities:

- Deliver and improve upon the national clinical quality indicators;
- Deliver and improve upon the national and local commitments;
- Work towards sustainable services;
- Demonstrate the Trust commitment to social and organisational responsibilities.

The Trust has a good track record of improving quality aims to continuously expand, refine and develop its services. It will continue to work closely with all staff, volunteers and the people it serves to make improving services a priority for the coming year. This report celebrates the collective hard work and outstanding achievements of all staff and volunteers.

I confirm that, to the best of my knowledge, the information in this Quality Report is accurate.

Ken Wenman
Chief Executive

Priorities for improvement and statements of assurance from the Board

A review of quality improvement priorities for 2011/12

The modern ambulance service plays a much more crucial role in delivering care to those with urgent needs in relation to both acute and chronic medical presentations and also social care and mental health care.

In 2011/12 the Trust introduced the Right Care, Right Place, Right Time initiative, which continues to focus on providing patients who contact the 999 service with the most appropriate care. Care that meets the clinical need, is delivered by the most appropriate clinician and is provided at a location that is most suitable to the needs of the patient and the wider health care community.

NHS Pathways was launched in the Clinical Hubs just before the start of 2011/12. The system is designed to improve the patient experience through 999 call takers have using enhanced processes to enable better identification of the clinical skills and time frame required to meet the individuals needs.

The Trust has continued to develop its engagement with stakeholders, with the new Communications and Membership Sub Group of the Council of Governors meeting throughout 2011/12.

In 2011/12 the Trust published a quality account which built on the continuous quality improvement journey. An overview of the Trust's performance against its 2011/12 Quality Account priorities and improvements are set out below:

Priority 1 – Patient Safety

Falls - Why a priority?

Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged above 75 years in the UK. Each year, over 700,000 older people in the UK attend Emergency Departments following a fall. In people aged 65 years and over, the fall, together with the resulting fractures, accounts for over four million bed days each year in England alone.

The consequences of a fall can be significant, life changing, and in many cases life-threatening. Increased rates of falling, and the severity of the consequences, are associated with advancing age. Falls are not however an inevitable consequence of old age; they are normally due to the presence of one or more underlying risk factors. Falls have a diverse multi-factorial aetiology, with more than 400 separate risk factors being identified. Recognising and modifying these risk factors is crucial to preventing falls and injuries.

Aim

To explore the impact of patients who fall in the community and who are not transported to hospital, in order to devise, implement and monitor an enhanced falls referral system.

Initiatives

- Establish a coherent system in the 999 control rooms (Clinical Hubs) to identify fallers and agree reporting

mechanisms and data formats with Commissioners;
- Undertake a Falls Audit in Cornwall and the Isles of Scilly, Devon and Somerset (Dorset complete 2010/11);
- Produce a Falls Review with recommendations;
- Agree with Commissioners standard patient falls pathways across all four counties.

Did we achieve this priority?

Yes, the Trust has worked closely with Primary Care Trusts (PCTs) to develop falls referral pathways across the South West, with every area now covered by a falls scheme. The focus has been to further develop the current systems to enable referrals to be made to a single point of access within each County. Such a system already exists within Cornwall, and is set to be launched across Dorset and Somerset during 2012. In order to support the continued development of falls services, the Trust implemented systems to enhance the analysis of calls where patients have experienced a fall. This enabled the provision of data to PCTs on the number of patients who had experienced a fall in nursing and residential homes, in order to focus on this vulnerable group. A leaflet was introduced to provide patients with information and support following a fall, and a staff awareness campaign was conducted to highlight the importance of falls referrals. The Trust is committed to continuing the focus on establishing a single point of access for falls referrals across the South West during 2012/13.

Priority 2 – Clinical Effectiveness

Analysis of Healthcare Professional Calls - Why a priority?

The majority of Healthcare Professional Calls are received from General Practitioners (GPs). We aim to explore the number and demand profile of Healthcare Professional Calls received from each practice across Cornwall and the Isles of Scilly, Devon, Dorset and Somerset. Understanding the impact of the Healthcare Professional Calls workload will help us inform future service developments.

Aim

Analyse the ratio of Healthcare Professional Calls to the number of patients registered at each GP practice during the Urgent Care Services in and out of hours GP and healthcare professional operational periods. This will enable joint working between the Trust and PCTs to establish local variations and further analyse outlying practices eg those with very high or low rates of referral.

Initiatives

- Understand the impact of call re-categorisation on the A8 response time target and Healthcare Professionals Call workload;
- Undertake an analysis of Healthcare Professional Calls activity, identifying trends, patterns and differential use of the service by localities;
- Work with Commissioners to explore local variations in utillisation by practices;
- With the support of Torbay Care Trust, link with GP Consortia leads to explore unscheduled admissions and focus on the impact of the long term conditions agenda;
- Explore the potential role of the Trust in undertaking GP home visits;
- Publish guidance to Healthcare Professionals booking an appropriate ambulance service response, highlighting the current response times to each category, to promote the use of longer three to four hour responses when clinically safe and appropriate;
- Agree on-going monitoring and review of the Healthcare Professional Calls workload to identify changes in access.

Did we achieve this priority?

Yes, working with all commissioning PCTs, the Trust ensured that the details of all GPs working across the South West were available within the Clinical Hub call management system (C3). This has enabled more accurate recording of the Healthcare Professional booking each call, with a summary report presented to PCTs on a monthly basis.
In order to support the utilisation of ambulance services by GPs and other Healthcare Professionals, a publication detailing how to book the most appropriate services was disseminated widely across the South West. The Executive Medical Director will be leading further GP engagement during 2012/13.

Emergency Care Practitioner (ECP) - Why a priority?

ECPs are the Trust's highest skilled Paramedics. Their contribution to patient care is invaluable. However, across the Trust operational counties there are known disparities in clinical skills and productivity levels.

Aim

Scope current clinical performance and productivity levels of ECPs. Identify best practice and areas for improvement. Determine new models of clinical service provision and scope opportunities from GP Commissioning Consortia; especially within the primary care setting.

Initiatives

- Develop a tool to measure ECP clinical performance;
- Roll out measurement tool, understanding the impact of the different service models across the four operational counties;
- Following the introduction of the ECP skills passport, evaluate the current skill set of ECPs;
- Understand the variation in ECP clinical practice and performance across the Trust;
- Implement the ECP strategy, pilot different models of service provision and establish the optimum clinically effective and productive use of ECPs;
- Produce a generic skill-set based on the most productive models of care, whilst appreciating that 'one size does not fit all';
- Scope the benefit of utilising ECPs in the primary care setting and identify new opportunities that arise from development of GP Consortia;
- Build relationships with GP Consortia to scope the financial investment required and clinical effectiveness of utilising ECPs within the primary care setting.

Did we achieve these priorities?

Yes, the Trust worked closely with NHS Pathways and the senior ECP team to embed the standard ECP skill set within the Clinical Hub (Control Centre) systems. The development enables each call to be assessed for suitability for an ECP response, as part of the Trust's strategy for increasing their utilisation.

A clinical performance tool was developed and utilised within a comprehensive audit which for the first time measured the clinical performance of ECPs. A survey of the current clinical skill level practiced by each ECP was also completed, which will influence further developments during 2012/13. A range of trials have been successfully conducted to evaluate different models of service provision. The publication of the ECP Strategy and Policy during March 2012 places the Trust in a strong position to develop the role and its contribution to patient care over the forthcoming year and beyond.

Clinical Research - why a priority?

High quality clinical research evidence is vital to assess the effectiveness of clinical services. It underpins the development of robust clinical policies to support service developments that optimise clinical outcomes for patients. High quality research ensures patients can benefit from new and better healthcare treatments, based upon sound and relevant evidence.

Aim

Increase participation in clinical research contributing to the knowledge base for pre-hospital care. Increase engagement with studies on the UK Clinical Research Network portfolio. Continue to raise awareness of the importance of clinical research. Embed clinical research within the Trust culture by ensuring all relevant staff have completed the Good Clinical Practice training.

Initiative

- Align the Trust Clinical Research strategy with the objectives of the Peninsula Comprehensive Local Research Network. The Trust will strengthen contacts with partners in health, academia and industry to fully exploit opportunities to participate in clinical research, and increase public engagement with clinical research engagement and development;
- The Trust continues to work with the NHS National Institute for Innovation and Improvement and other partner organisations in developing an Intelligent Mattress. Development work is progressing well with GX Design who have completed a mattress prototype that enables patients to be weighed, supporting clinicians in managing paediatric emergencies. Hoana Medical are also working closely with the Trust to embed patient monitoring technology within the Intelligent Mattress.

Did we achieve this priority?

Yes, much has been achieved during 2011/12 in terms of promoting the research agenda, raising awareness and embedding a research culture within the organisation. The Trust participated in all applicable National Institute for Health Research portfolio studies (n=5), as well as four non-portfolio projects. The well established Research and Development Group continues to provide an oversight of the research process, and has enabled the Trust to deliver a robust and efficient approval process for new projects. Research focused key performance indicators have been introduced to enable monitoring of related performance by the Trust Board. All relevant staff have completed Good Clinical Practice training. Looking ahead to 2012/13, the Trust has expressed an interest in supporting a further four projects, many of which will hopefully progress to become active research studies within the organisation. The robust research management and governance mechanisms which have been established will ensure that the research agenda continues apace over the coming years.

Priority 3 – Patient Experience

Increase Patient Satisfaction - Why a priority?

The Trust has consistently put the patient at the heart of every decision it makes by making patients the focus of everything we do. However, the Trust can go further and do more. By creating better and more transparent opportunities for patient feedback, the Trust will better understand the patient experience to make improvements across its three service lines.

Aim

The Trust will establish a systematic approach to gather patient satisfaction and experience feedback for improvement action planning.

Initiative

- Analyse the 999 Emergency Ambulance Service (A&E) and Patient Transport Services (PTS) patient surveys completed in 2010/11;
- Analyse the new Urgent Care Services (UCS) patient surveys distributed each month from 1 April 2011;
- Establish a Patient Experience and Quality sub group with the Trust Council of Governors to consider action plans for implementation in 2011/12. Develop a Trust policy for the systematic collection of patient experience to influence the Trust future priorities;
- Carry out regular audits on the new NHS Pathways triage system in Clinical Hubs (999 control rooms), which is a new call handling software.

Did achieve this priority?

Yes, the surveys were analysed and the outcome reported to the Trust Quality and Governance Committee and Commissioners. The reports were extremely positive and only three actions were identified for the A&E survey, all of which have been completed. Due to the overwhelmingly positive response from patients to the PTS survey, the Trust issued a further new survey to those who book the service; the results will be reported in 2012/13.

The UCS team analysed the surveys received throughout 2011/12 and produced reports back to staff published in the Chief Executive's Bulletin newsletter.

A Patient Experience Sub Group of the Council of Governors was established in June 2011, meeting four times in 2011/12. The Sub Group reviewed and commented on the new Patient Experience Policy which was approved in September and monitored by the Quality and Governance Committee, and was also involved in the development of a new patient experience feedback leaflet.

Two in depth reviews of the impact of NHS Pathways were undertaken by the Trust Learning from Experience Group in 2011/12 and reported to Commissioners. These considered feedback through complaints and incident reports; call handling audits; and measured improvements made to the system throughout the year to improve the patient experience.

Quality priorities for improvement 2012/13

The Trust aspires to involve patients, members, the public and all stakeholders in developing its ongoing priorities. As a newly authorised NHS Foundation Trust the organisation has a Council of Governors and a membership of over 10,000, which have enabled greater patient and public involvement during 2011/12. The Council of Governors established a Patient Experience sub group to support this key agenda.

In 2011/12 the Trust Board of Directors monitored the Quality Account and Commissioning for Quality and Innovation priorities within the Corporate Performance Report which is presented each month. The Quality and Governance Committee also received detailed reports at its bi-monthly meetings. These effective monitoring systems will be continued and maintained throughout 2012/13.

Patient Safety

Priority 1 patient re-contact with the ambulance service - why a priority?

Following the publication of Taking Healthcare to the Patient (2005), the Trust has worked to align its workforce and the clinical skill set they provide with the needs of patients. An increasing emphasis has been placed upon the development of systems which enable patients who call for an ambulance to be assessed over the telephone, and their issue resolved without the attendance of an ambulance resource. The introduction of the NHS Pathways triage system has better equipped Clinical Hub (Control Centre) staff with the ability to undertake this role, supported by experienced Nurses and Paramedics in the role of Clinical Supervisors.

Where an ambulance resource does attend an incident, transportation to hospital is not always the most appropriate outcome; a key part of the transformation has been the need to support our clinicians to access alternative care pathways that enable patients to remain on-scene. The attending clinician may decide that the patient's condition does not require admission to hospital, or that referral to an alternative care pathway is preferable. Alternatively, the patient may decide that they do not wish to attend hospital. It is vital that all such decisions follow clinical guidelines, the patient is safe to remain on-scene, and decisions are made in conjunction with them, are appropriate, clinically sound and made in their best interests.

The introduction of the Ambulance Clinical Quality Indicators during 2011 highlighted the importance of measuring the clinical safety of episodes of care which either do not result in an ambulance attending (hear and treat) or where an ambulance attends but the patent is not conveyed to hospital (see and treat). Although in some cases re-contact with the ambulance service after closure of the original call is inevitable, the measure may prove beneficial in evaluating the effectiveness and safety of the advice and care delivered.

Aim

Establish the clinical rationale behind re-contacts with the 999 service, in order to ensure patient safety. The project would identify trends, manage associated risks and develop potential means to reduce re-contact rates, leading to the agreement of a re-contact rate improvement target or trajectory.

Initiatives

- Complete an audit of patients who were initially attended to by an ambulance during the agreed sample period and re-contacted the service. The audit will include in-depth clinical review of the initial and subsequent Patient Clinical Records (PCRs);
- Complete an audit of patients who were initially dealt with using hear and treat pathways during the agreed sample period and re-contacted the the service. The audit will include review of the initial and subsequent NHS Pathways call triage and an in-depth clinical review of the PCR for the subsequent attendance;
- Hold meetings with Lead Commissioner to review evidence for the actions above, and to establish whether areas of potential improvement have been identified during the initial audits;
- Subject to area/s of improvement being identified, agree an improvement target or trajectory for the reduction of the re-contact rate with the Lead Commissioner.

How will we know if we achieve this priority?

Audits completed and actions for areas of potential improvement agreed with the Lead Commissioners.

Priority 2 Infection Prevention and Control Monitoring- Why a priority?

Healthcare acquired infections cause serious problems for the NHS. Infections can complicate illnesses, cause distress to patients and their family, and in some cases may even lead to patient death. It is estimated that healthcare acquired infections kill around 5,000 people a year and contribute to 15,000 more deaths. Around 100,000 people acquire a healthcare associated infection each year, with 30% of these being preventable. The Trust is committed to creating robust systems of infection prevention and control. Three of our key priorities as part of the Cleaner Care Initiative are:

- Thoroughly cleaning the vehicles during each shift;
- Cleaning the trolley bed and any equipment used after each patient;
- Ensuring that patients receive care in an environment that we would be proud for our relatives to experience.

In addition to daily cleaning by ambulance staff, all ambulance interiors receive a comprehensive clean every eight weeks, by dedicated Make Ready Operatives. The Trust has consistently achieved the internal 90% compliance target for the delivery of this cleaning regime. In order to ensure that regular cleaning has occurred and the deep clean has achieved the standards expected by the Trust, it is important to measure the outcome of the clean, not just the fact that it has taken place. During 2011 the use of Adenosine Triphosphate (ATP) monitoring technology was piloted on emergency ambulances and will be expanded to include the assessment of Patient Transport Service (PTS) ambulances during 2012/13.

ATP monitoring is an emerging technology which enables organisations to monitor the effectiveness of their environmental surface cleaning. ATP is the energy molecule within all living cells. After cleaning, the amount of ATP that remains on a surface is a direct indication of cleaning effectiveness. Using a chemical reaction involving an enzyme isolated from the firefly, ATP monitors convert the amount of organic matter containing ATP on a surface to an objective numerical measurement.

The monitor enables the reading to be assigned to an individual vehicle, allowing remote monitoring and analysis of the results. In addition to providing a new and novel method to evaluate the Trust's cleaning programmes, the initiative will also reaffirm the importance of vehicle cleaning amongst staff.

Aim

During 2012/13 PTS Team Leaders will utilise ATP monitors to obtain random swabs of vehicle interior surfaces, according to a sampling protocol. The results will be evaluated to assess the effectiveness of routine daily and eight weekly deep cleaning on PTS vehicles.

Initiatives

- Conduct ATP monitoring across the PTS ambulance fleet.

How will we know if we achieve this priority?

Monitoring of ATP conducted across the PTS ambulance fleet and reported to the Infection Prevention and Control Group.

Priority 3 pressure ulcers - Why a priority?

Pressure ulcers, also sometimes known as bedsores or pressure sores, are a type of injury that affects areas of the skin and underlying tissue. Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle. Pressure ulcers develop when pressure and/or friction is applied to an area of skin over a period of time. The extra pressure disrupts the flow of blood through the skin, starving the surrounding tissues of oxygen and nutrients, causing it break down and form an ulcer.

Healthy people do not get pressure ulcers, because they are continuously adjusting their posture and position so that no part of their body is subjected to excessive pressure. However, people with health conditions that make it difficult for them to move or those with type two diabetes are more vulnerable to pressure ulcers. It is estimated that just under 500,000 people in the UK will develop at least one pressure ulcer each year. For some people, pressure ulcers are a minor inconvenience, but for others they develop into life-threatening complications such as blood poisoning.

The presence of significant pressure ulcers which are not being actively managed by the patient's GP or any other Healthcare Professional may indicate that the patient is suffering from neglect.

Aim

Increase staff awareness of the identification and reporting of pressure sores, according to the National Institute of Clinical Excellence (NICE) Guidance.

Initiatives

- Develop educational materials for ambulance clinicians to increase their awareness of and ability to recognise pressure sores;
- Launch a Pressure Sore Learning Zone within the Trust's Intranet to link Trust resources with those available externally;
- Deliver additional education to 75% of eligible frontline clinicians across the Trust to increase staff awareness and ability to recognise pressure sores.

How will we know if we achieve this priority?

Development of educational materials, availability of the Pressure Sore Learning Zone, delivery of additional education to frontline clinicians.

Clinical Effectiveness

Priority 4 Major Trauma (MTC) - Why a priority?

Major trauma is the leading cause of death in all groups under 45 years of age, and a significant cause of short and long term morbidity. The National Audit Office estimates that there are at least 20,000 cases of major trauma each year in England resulting in 5,400 deaths, and many others resulting in permanent disabilities requiring long-term care. Trauma costs the NHS between £0.3 and £0.4 billion a year in immediate treatment alone, as well as resulting in an annual lost economic output of between £3.3 - £3.7 billion.

Historically, all trauma patients have been transported to the nearest hospital Emergency Department, with those with the most significant injuries subsequently being transferred to a specialist centre. International evidence demonstrates that over 600 additional lives could be saved across the UK each year, if patients with the most severe injuries were transported directly to specialist Major Trauma Centres.

During 2011/12 the Trust has worked closely with organisations across the South West to develop the major trauma system, which was launched on 2nd April 2012. Ambulance clinicians use a triage tool to identify those patients who would benefit the most from direct admission to one of the MTCs at Plymouth, Southampton and Frenchay Hospitals. Patients who are unable to reach a MTC within a safe time, or have less severe injuries, will continue to be transported to more local Trauma Units (normally the Emergency Department at their local hospital).

The introduction of the major trauma system significantly increases the length of time that ambulance clinicians are required to deliver care to critically injured patients during long journeys to hospital. Further education and assessment is required to ensure that all ambulance clinicians are confident and competent in the care of this group of patients; a group to which individual clinician exposure has been low. The Trust has committed to the delivery of a two day educational programme, focusing on the assessment and management of trauma to support the introduction of new interventions such as the EZ-IO intraosseous device (the insertion of a needle into a patient's arm or leg bone in order to give medicines or fluid therapy). The training will also focus on the accurate identification of patients who are suitable for direct admission to a MTC, as this is one of the most significant pre-hospital challenges.

Over-triage creates inefficiencies for the ambulance service, with ambulances tied up in longer unnecessary round trips to major centres. There is also an impact on other patients in MTCs, whose quality of care may suffer due to an excessive number of patients with less severe trauma. In contrast, under triage may result in patients who may benefit from direct care at a MTC receiving less timely care at their local hospital, or being unnecessarily delayed by a later secondary transfer to a MTC.

Aim

Increase the availability of major trauma specialist care across the South West, by ensuring that patients are transported to the most clinically appropriate centre for their needs.

Initiatives

- Deliver a second day of trauma training to frontline clinicians across the Trust;
- Introduce the EZ-IO intraosseous access device to all frontline emergency ambulances and RRVs;
- Audit the percentage of patients transported to a MTC who did not fulfil the major trauma criteria (excluding those within the standard MTC catchment area.).

How will we know if we achieve this priority?

Delivery of the second day of trauma training to 95% of frontline clinicians across the Trust by 31st March 2013.
Evaluation and reporting of the over triage rate for patients within the Trauma system.

Patient Experience

Develop a targeted approach to patient feedback - why a priority?

The Trust is proud of its patient-centred approach and constructive investigation of and response to the feedback it receives through concerns raised by patients and their families. However, these form only a very small proportion of the Trust contact with its service users and there may be useful comments and feedback of which the Trust is not aware. Further work is planned for 2012/13 to encourage patients and their families to provide as much as information about their experience of the Trust services as possible, and how it meet their expectations.

Aim

The Trust will develop a targeted approach to gather feedback on patient experience, including seeking input from support groups for specific conditions, and with an awareness of any potential for inequity of access.

Initiatives

- Undertaking dignity, privacy and respect discovery interviews;
- Establishing feedback clinics at summer events;
- Dissemination of patient experience leaflets by Trust governors;
- Analysis of feedback to develop an improvement plan.

How will we know if we achieve this priority?

Discovery interviews completed and reported. Approval of an improvement plan by Trust Commissioners.

Statement of assurance from the Board

Statutory statement

This content is common to all providers which make Quality Accounts comparable between organisations and provides assurance that the Board has reviewed and engaged in cross-cutting initiatives which link strongly to quality improvement.

1 During 2011/12 the South Western Ambulance Service NHS Foundation Trust provided and/or sub-contracted three NHS services:

- Emergency (999) Ambulance Service;
- Urgent Care Service;
- Non Emergency Patient Transport Service.

1.1 The South Western Ambulance Service NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

1.2 The income generated by the NHS services reviewed in 2011/12 represents 93.48% of the total income generated from the provision of NHS services by the South Western Ambulance Service NHS Foundation Trust for 2011/12.

2 During 2011/12, nil national clinical audits and nil national confidential enquiry covered NHS services that South Western Ambulance Service NHS Foundation Trust provides.

2.1 During that period South Western Ambulance Service NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquiries that South Western Ambulance Service NHS Foundation Trust participated in during 2011/12 are as follows: not applicable.

2.3 The national clinical audits and national confidential enquires that South Western Ambulance Service NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a % of the number of registered cases required by the terms of that audit or enquiry. not applicable

2.4 The reports of one national clinical audit were reviewed by the provider in 2011/12 and South Western Ambulance Service NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Call to needle target verification.

This action will improve the quality of health care from this one national clinical audit:

- Myocardial Ischemia National Audit Project (MINAP) – national database gathering information on all patients who have had a heart attack and who have acute coronary syndromes.

The reports of three local clinical audits were reviewed by the provider in 2011/12 and South Western Ambulance Service NHS Foundation Trust intends to take actions to improve the quality of healthcare provided which are listed on the Trust website www.swast.nhs.uk.

3 The number of patients receiving NHS services provided or sub-contracted by South Western Ambulance Service NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 249.

4 A proportion of South Western Ambulance Service NHS Foundation Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between South Western Ambulance Service 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. Further details of the agreed goals for 2011/12 and for the following 12 month period are available on request from www.swast.nhs.uk.

The monetary total for the Commissioning for Quality and Innovation payments, for all service lines, for 2011/12 was 1,559,801 and 2010/11 was 1,672,343.

5 South Western Ambulance Service NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'compliant without conditions'.

The Care Quality Commission has not taken enforcement action against South Western Ambulance Service NHS Foundation Trust during 2011/12.

6 South Western Ambulance Service NHS Foundation Trust has not participated in special reviews or investigations by the Care Quality Commission during the reporting period.

7 South Western Ambulance Service NHS Foundation Trust did not submit records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

8 South Western Ambulance Service NHS Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 82% and was graded green, satisfactory.

9 South Western Ambulance Service NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

Part 3 – Quality overview

The Trust long term Strategic Goals and annual Corporate Objectives reflect quality priorities which include national priorities and local commitments. These are reported within the Trust Corporate Performance Report which is presented to the Trust open Board at each meeting.

The indicators and information below have been selected to describe the continuous quality journey the Trust is making. Where possible either historical or benchmarking against national information has been provided to help contextualise the Trust's performance.

Emergency Ambulance 999 Services

Key Performance

Key Performance Indicator	Target %	Performance 2011/12	Performance 2010/11	Performance 2009/10
Category A8	75	76.05 (provisional)	78.86	78.3

* Category A8 – Life threatening emergency calls, presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

Urgent Care Service (UCS)

The Trust has 13 quality targets for this service and regularly meets and exceeds 12 of these. This has shown considerable improvement from 2010/11 when 10 quality targets were met or exceeded. An improvement plan is in place to ensure the Trust continues to improve and meets all 13 in the future.

Patient Transport Service (PTS)

Key Performance Indicator	Target %	Performance 2011/12	Performance 2010/11
Calls received and answered within 25 seconds	80	Tbc	87
Calls into the PTS Control abandoned	Less than 4	Tbc	3
Contracted activity levels to be completed	100	Tbc	100

Additional Quality Achievements

✓ Successfully developed and introduced the Right Care, Right Place, Right Time Initiative;
✓ Hosted two Award Ceremonies for hundreds of clinical and support staff to acknowledge their outstanding and excellent long service and achievements;
✓ Continued to meet Level 1 for NHSLA Risk Management Standards with top scores;
✓ Nil Ombudsmen complaints upheld;
✓ Implementation of a new triage system - NHS Pathways;
✓ Implementation of a new Capacity Management System;
✓ Implementation of access to patients Summary Care Record integrated within the Adastra system in all treatment

centres and the east clinical hub;
- ✓ Launch of Senior Clinician on Call;
- ✓ Appointed a dedicated Patient Safety Improvement Manager to focus on learning arising from patient feedback and incidents;
- ✓ Appointed a Stakeholder Engagement Manager to improve service user involvement
- ✓ First Ambulance Trust to launch Transexamic Acid;
- ✓ Launch of Hazardous Area Response Team (HART);
- ✓ Continued registration with the Care Quality Commission without compliance conditions;
- ✓ Successfully completed a series of health promotion campaigns;
- ✓ Patient Advice Leaflets reviewed and placed on every ambulance;
- ✓ Completed preparations for the launch of the Major Trauma System across the Southwest from Monday 2 April 2012, including training all clinicians;
- ✓ Monthly patient surveys for Urgent Care Service always report high satisfaction 90% plus;
- ✓ Completed an independent staff survey.

Performance of Trust against selected metrics

Safety Measures and Patient Experience Reported	2011/12	2010/11	2009/10
Adverse Incidents	2,498 of which: 0% – significant 6.9% – moderate 93.1% – low	2,384 of which: 2% – significant; 6% – moderate; 92% – low	2,345 of which: 08.29% - significant 29.00% - moderate 64.71% - low
Serious Incidents	28	45	29
Making Experiences Count – Complaints, Concerns and Comments	496	489	504
Patient, Advice and Liaison Service (PALS) – Lost Property, signposting to other services etc	454	428	370
Health Service Ombudsman complaints upheld	0	0	0
Compliments	719	788	945
Central Alert System (CAS) received	170	191	193

During 2011/12 the Trust, as last year, continued to be one of the highest reporters of incidents to the National Patient Safety Agency (NPSA) National Reporting and Learning Scheme (NRLS) database. This level of reporting reflects a strong practice of incident recognition and supports a good a continuous patient safety culture.
In addition to providing reports on adverse incidents for the Learning From Experience Group, the Quality and Governance Committee and a number of internal Trust meetings, comprehensive reports on adverse incidents are also produced for the Trust's Lead Commissioners at quality monitoring meetings. Sharing such information is good practice and enables shared learning of incidents.

A fundamental part of the Trust's risk management system is to ensure that serious incidents are appropriately managed to ensure lessons are learnt. During 2011/12 28 incidents were identified as falling under the Trust Serious Incident Policy and 29 Serious Incident investigations were heard by Serious Incident Review Meetings, chaired by

a clinical director or deputy director. Following a Serious Incident Review Meeting the Outcome report and draft Action Plan is presented to the Directors Group for final approval of the actions before they are included within the Trust's Serious Incident Action Plan. Progress against actions contained within the Serious Incident Action Plan is monitored by the Trust Board of Directors and lessons disseminated via Trust publications.
The Central Alert System (CAS) is an electronic web-based system developed by the Department of Health, the National Patient Safety Agency (NPSA), NHS Estates and the Medicines and Healthcare products Regulatory Agency (MHRA). This aims to improve the systems in NHS Trusts, Strategic Health Authorities, and the Department of Health for assuring that safety alerts have been received and implemented. During 2011/12 the Trust acknowledged 100% of CAS' within 24 hours, which exceeds the requirement to acknowledge these within 48 hours. In 2011/12 1 alert (0.6%) has exceeded the time specified for implementation.

Ambulance Clinical Quality Indicators:

2011/12 has been a pilot year for Ambulance Clinical Quality Indicators (ACQI) data collection from all ambulance trusts in England, no national targets have been introduced this year.

These new indicators are not targets in themselves but are designed to stimulate continuous improvement in care. It is recognised that 2011/12 is a transitional year to enable definitions to be confirmed and to improve the consistency of reporting across Ambulance Trusts.

The Department of Health have developed a national dashboard enabling the comparison of the trust performance to its fellow ambulance services. The Trust has also established a sub-group of the Corporate Performance Review Group to work specifically on the ACQI.

With effect from 2012/13 the Department of Health intends to require organisations to include the following indicators from the ACQI in the Quality Account.

Ambulance Clinical Quality Indicators (collected for reference during 2011/12)

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	National Average (Oct)
Outcome from Acute ST-Elevation Myocardial Infraction (STEMI) - % of patients suffering a STEMI and who receive an appropriate care bundle	73.79%	76.70%	76.04%	81.67%	83.42%	79.68%	79.43%	**74.00%**
Outcome from Stroke for Ambulance Patients - % of suspected stroke patients (assessed face to face) who receive an appropriate care bundle	53.92%	64.93%	57.44%	56.33%	55.70%	55.66%	65.55%	**68.40%**

Data for these indicators is not currently available for information after October 2012. The longer timeframe for the production of this clinical data is due to the manual nature of the collection process and the delays experienced in collecting some of the data from third party sources (eg acute trusts, MINAP system).

Clinical Performance Indicators (CPIs)

Clinical Effectiveness - Outcome Measures Reported	Cycle 4 Oct 2009 to Apr 2010	Cycle 5 May 2010 to Sept 2010	Cycle 6 Oct 2010 to Apr 2011	Cycle 7 May 2011 to Sep 2011	Cycle 7 National Average
Care of Patients with Acute MI (STEMI) - Heart Attack					
Aspirin Administered	88.62%	91.60%	85.71%	93.50%	96.50%
GTN Adminstered	85.83%	86.40%	77.14%	86.50%	92.17%
2 Pain Scores Recorded	90.15%	89.70%	89.60%	91.60%	80.80%
Morphine Administered	68.20%	70.40%	80.41%	89.80%	81.30%
Analgesia Administered	67.27%	68.00%	79.80%	88.80%	86.20%
Care of Patients with Hypoglycaemic Attacks					
Blood Glucose 1 Recorded	99.00%	98.20%	97.59%	100.00%	98.80%
Blood Glucose 2 Recorded	97.20%	96.70%	98.78%	98.63%	97.90%
Treatment Recorded	98.40%	99.30%	100.00%	98.97%	97.90%
Care of Patients with Asthma					
Respiratory Rate Recorded	99.30%	91.00%	94.36%	98.54%	99.10%
PEFR Recorded	33.20%	37.00%	42.72%	73.66%	78.70%
SpO2 Recorded	88.20%	85.00%	92.45%	89.76%	92.70%
B2 Agonist Administered	98.20%	95.00%	95.45%	98.54%	96.60%
Oxygen Administered	98.40%	97.00%	97.65%	99.02%	95.80%
Care of Patient with Stroke and Transient Ischaemic Attack					
FAST 1	93.77%	98.92%	91.50%	97.67%	95.60%
Blood Glucose Recorded	94.63%	92.98%	93.00%	98.33%	95.60%
Blood Pressure Recorded	99.32%	98.66%	96.30%	99.33%	99.50%

The method of calculating the results for these CPIs has been updated to reflect the way in which the recently

introduced national Ambulance Clinical Quality Indicators are calculated. Cycles 1 to 6 were calculated under the old method and Cycle 7 under the new method and therefore direct comparison to previous cycles is not valid.

Assurance statements - verbatim

to follow

Statement of directors' responsibilities in respect of the quality report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    a. Board minutes and papers for the period April 2011 to June 2012;
    b. Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
    c. Feedback from the commissioners dated tbc;
    d. Feedback from governors dated tbc;
    e. Feedback from LINks dated tbc;
    f. The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated tbc;
    g. The latest national patient survey and the latest national staff survey 2011;
    h. The Head of Internal Audit's annual opinion over the trust's control environment dated tbc;
    i. CQC quality and risk profiles dated from April 2011 to March 2012.
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and

review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual).

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

By order of the Board

3 June 2011 Date  **Heather Strawbridge,** Chairman

3 June 2011 Date  **Ken Wenman,** Chief Executive

Independent Assurance Report to the Council of Governors of South Western Ambulance Service NHS Foundation Trust on the Annual Quality Report

to follow

Would you like to have a say in the future of South Western Ambulance Service by becoming a Foundation Trust member?

Help us to help you by calling 01392 261526 or visit www.swast.nhs.uk/ft

If you would like a copy of this report in another format such as braille, audio tape, total communications (suits the needs of learning disabled) large print, another language or any other format, please contact:

Telephone: 01392 261586 **Email:** publicrelations@swast.nhs.uk **Fax:** 01392 261560

Draft Statement from Torbay Council's Health Scrutiny Board on South Western Ambulance Service NHS Foundation Trust's Quality Account 2011/2012

South Western Ambulance Service NHS Foundation Trust's Quality Accounts for 2011/2012 has been considered by Torbay Council's Health Scrutiny Board. The Board welcomes the clarity with which the Trust has explained how it has met its priorities for 2011/2012 and what its priorities are for the forthcoming year.

The Board is pleased to note the range work which is ongoing to reduce the impact on acute services; not only those offered by the Ambulance Service but by other agencies as well. The Board would encourage both health and non-health partner agencies to continue to work together given the reducing resources available within the public sector.

The Health Scrutiny Board considered the establishment of regional networks of trauma care at its meeting in September 2011 when councillors were able to hear from representatives of the Trust as well of those from NHS Devon and South Devon Healthcare NHS Foundation Trust. Councillors questioned the rationale for the threshold of forty-five minute travel time to a Major Trauma Centre, especially given the rurality of the region. The Board welcomes Trust's the aim of increasing the availability of major trauma specialist care in the South West by ensuring that patients are transported to the most clinically appropriate centre for their needs.

During the course of the year, members of the Health Scrutiny Board raised concerns about the level of ambulance cover within Torbay. A representative of the Trust accepted the Board's invitation to brief them on the issue and, as a result of a very insightful presentation, the members of the Board were reassured that appropriate levels of ambulance cover are in place in Torbay and South Devon. At the same time, the Board gained an appreciation of the rationale behind the changes to ambulance provision in the area and a greater understanding of the operation of the Trust in South Devon. The Board were assured of the Trust's continuing commitment to delivering high quality, patient-centred, innovative and timely care in South Devon.

The Board commends South Western Ambulance Service NHS Foundation Trust for its openness and transparency of its operations and hopes that the Trust will continue to work closely with the Board and Torbay Council as a whole.

May 2012

Devon Partnership NHS
NHS Trust

Quality Account

2011 / 2012

Contents

Chief Executive's Statement

Welcome to our third Quality Account, which provides an accurate summary of our continuing work to improve safety, clinical effectiveness and the experience of people using our services.

At Devon Partnership NHS Trust, our benchmark for quality remains very simple. To provide services that are 'good enough for my family', by which we mean services that are Safe, Timely, Personalised, Recovery-focused and Sustainable.

In March 2011, following an extensive planned review of our services, the Care Quality Commission (CQC) confirmed that we had emerged from the review with 'a clean bill of health'. This provided an excellent start to 2011/12 and one which we built upon steadily during the course of the year.

We have had two further reviews by the CQC since then. In November 2011, the Trust became one of the first mental health providers in the country to undergo a review of its community mental health services. The review included a month of visits and interviews with staff and people who use services, as well as the close examination of a selection of clinical records. We received the results at the start of 2012 and were delighted to hear that the CQC found all of the services it inspected to be compliant.

The CQC also visited some of our services for people with a learning disability during 2011. While there were some positive findings, the reports into two of our services did identify some concerns. The Trust took immediate action to address these and a follow-up visit by the CQC later in 2012 confirmed that these services are now compliant with all relevant standards.

During the year, we opened four completely refurbished wards for older people with mental health needs, at a total cost of almost £5m. These developments were an important part of our drive to improve services for older people. The new wards, which are in Barnstaple, Exeter and Torbay, are now providing safe, high quality care in a modern environment for some of the most vulnerable people in our care. They represent a huge leap forward in terms of the quality of service that people will experience.

In 2012/13, we have identified a number of priority areas on which we will place a particular emphasis. These include reducing waiting times for people referred to our services from primary care; providing better information for people about their medication and ensuring regular medication reviews; and minimising the number of delayed transfers of care.

"...an excellent start to 2011/12 and one which we built upon steadily during the course of the year."

Iain Tulley
Chief Executive

Priorities for Quality Improvement

The Trust has expressed its aim to provide services that are 'good enough for my family' and the organisation's long-term strategic objectives are designed to support the attainment of this goal. In order for services to be good enough for our own families the Trust believes that they have to be:

"...services good enough for my family"

SAFE	Minimum risk of harm to people and best possible quality of care
TIMELY	Based on early intervention, available when people need them, without unnecessary waiting
PERSONALISED	Tailored to meet the needs of individuals, and planned with them
RECOVERY-FOCUSED	Emphasising hope, opportunity and the ability to exercise control over treatment and life choices
SUSTAINABLE	Making best use of our human and financial resources, building our reputation, establishing consistency and reducing our carbon footprint

Priorities for 2012/13

The Trust has identified its key quality improvement priorities for 2012/13 in the fields of Safety, Clinical Effectiveness and Improving the Experience of People Using Services.

The Trust sought the views of staff and other stakeholders in identifying these priorities In addition, the indicators that have been selected reflect the priorities expressed by the Trust's commissioners and are aligned to the Trust's Commissioning for Quality and Innovation (CQUIN) priorities.

Performance against the priorities will be reviewed at monthly Quality and Safety meetings and considered by the Trust's Board of Directors. The Trust's capacity and capability to deliver enhanced quality improvement will also be regularly considered by these groups.

1. Safety

To collect data on the level of harm caused by pressure ulcers, falls, catheter-acquired urinary tract infections and venous-thromboembolism (VTE).

2. Clinical Effectiveness

To reduce the waiting times for people to be assessed when they have been referred to our Trust from primary care services.

3. Improving the Experience of People Using Services

To increase the number of people who report that they have been given information about the purpose and possible side effects of their medication and to increase the number of people who have their medication reviewed at least once every six months.

National Priorities

- To minimise the number of delayed transfers of care.
- To minimise the number of hospital admissions by ensuring access to crisis resolution and home treatment services.
- To record the percentage of patient safety incidents resulting in severe harm or death.

Local Priority

- To ensure that people are followed-up within 48 hours of their discharge from hospital.

The Trust has identified its key quality improvement priorities for 2012/13 in the fields of Safety, Clinical Effectiveness and Improving the Experience of People Using Services

Statements of Assurance from the Board of Directors

During 2011/12 the Trust provided or sub-contracted four NHS services. The Trust has reviewed all the data available to it on the quality of care in all of these services.

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the Trust for 2011/12.

During 2011/12, six national clinical audits and one national confidential enquiry covered NHS services that Devon Partnership NHS Trust provides.

During that period the Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which the Trust participated, and for which data collection was completed during 2011/12, 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.

The reports of two national clinical audits and 47 local clinical audits were reviewed in 2011/12 and the Trust will take action to improve the quality of healthcare where appropriate. Action plans will be created and implemented within the relevant Directorate and progress will be monitored by the Trust's Clinical Effectiveness Group.

The number of patients receiving NHS services provided or sub-contracted by the Trust during 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 298.

A proportion of the Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services. This was done through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available on the Trust's website at www.devonpartnership.nhs.uk

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Registered with no conditions'. The CQC has not taken enforcement action against Devon Partnership NHS Trust during 2011/12.

Case Study	No of cases
POMH - Topic 6: *Assessment of side effects of depot antipsychotics*	*28 cases: no set number of returns expected*
POMH Topic 7: *Monitoring of patients prescribed lithium,*	*45 cases: no set number of returns expected*
POMH Topic 10: *Use of antipsychotic medication in CAMHS*	*62 cases: no set number of returns expected*
POMH - Topics 1f and 3f combine: *Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards*	*107 cases: no set number of returns expected*
POMH Topic 12a: *Prescribing for people with a personality disorder*	*10 cases and data still being collected: no set number of returns expected*
Schizophrenia (NAS)	17 cases, (17%)
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	returns completed directly by clinicians upon request from the University of Manchester so number of cases not recorded centrally.

The Trust has participated in reviews and investigations by the CQC during 2011/12 and further information about these is available on page x of this document.

The Trust has taken a number of important steps to improve data quality. These are set out in detail on page x of this document.

The Trust submitted records during 2011/12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data that included the patient's valid NHS number was 92% for admitted patient care.

The percentage of records in the published data that included the patient's valid General Medical Practice Code was 95% for admitted patient care.

The Trust's Information Governance Assessment Report overall score for 2011/12 was 74% and it was graded 'green'.

The Trust was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.

Review of Quality Performance in 2011/12

Last year, the Trust set out three priority areas as indicators of quality improvement. These were:

Safety

The Trust has invested significantly in medicines management over the last couple of years and is committed to doing everything possible to improve quality and reduce errors and mistakes in the administration of medicines.

The goal for 2011/12 was for 95% of people to have their medicines checked within 72 hours of admission to hospital. This was monitored through audits of people's medicines charts.

How did we do?

To follow

Maintaining good communication when people are transferred from one place or service to another is a key factor in delivering safe care.

The goal for 2011/12 was to follow-up 95% of adults within 48 hours of their discharge from hospital. This was recorded on the RiO electronic care records system.

How did we do?

To follow

Clinical Effectiveness

The Trust has set-out a clear set of standards that relate to the care and recovery of people using its services.

The goal for 2011/12 was to increase the percentage of recovery standards that are being met across the Trust. This was measured through the refreshed Clinical Record Self- Monitoring tool

How did we do?

To follow

Improving the Experience of People Using Services

What people say about the service they receive is one of the most important indicators of quality and whether or not the Trust is getting the basics right.

The goal for 2011/12 was to increase the percentage of people who rate the service as good or excellent and would recommend it to a family member. This was measured through the monthly survey which now goes out to 1,000 people who use the Trust's services.

How did we do?

To follow

Compliance with National Priorities

The Trust complied with the national performance indicators specified for all mental health trusts during 2011/12:

Detail to follow

Developments and Improvements

Focusing on Recovery

Recovery is about people building a meaningful life, as defined by themselves, whether or not there are ongoing problems related to their mental health. The recovery movement represents a shift away from focusing on illness and symptoms towards a focus on health, strengths and wellness. Focusing on personal recovery has been proven to have a profound impact on the quality of care and support that people experience.

The Trust remains active at both a local and national level to embed the notion of personal recovery and recovery practice at the heart of mental healthcare. Much of the material produced by the Trust, and people associated with it, is endorsed by the Royal College of Psychiatrists and, at the Refocus on Recovery conference in London in March 2012, a number of delegates from Devon spoke and actively participated.

The Trust has been selected as one of just six pilot sites across the country to participate in an initiative to put recovery at the heart of mental health services. The Supporting Recovery project sets out ten key indicators for organisations to support the recovery of people using mental health services. It is the result of a partnership between the Centre for Mental Health, the NHS Confederation and the National Mental Health Development Unit and is a national initiative.

During 2011/12, the Trust participated in a pilot to promote the health and personal wellbeing of staff through the Five ways to wellbeing initiative. The health promotion messages within this campaign are particularly attractive because they guide people to value doing things that are simple, available and free. The Devon project was an immediate success and a range of resources has now been created for individuals and teams to help them consider the potential benefits.

The Trust has continued to work with Recovery Devon on a range of initiatives and, working with mental health charity Rethink, is supporting Recovery Devon to become an independent organisation. The Trust is also continuing to work alongside the Devon Recovery Research and Innovations Group (D-RRIG), which has been meeting since June 2010 and already generated a range of successful projects. It was established as a broad, inclusive group of professionals, managers and people with personal experience who share an interest in promoting recovery through research and innovation.

For more information about the Supporting Recovery project, visit www.nhsconfed.org/Networks/MentalHealth/OurWork/Pages/NMHDUImplementingRecovery.aspx

Safety

Patient safety programme

Over the last 12 months, improving the safety and quality of our services has remained a priority. Devon Partnership NHS Trust has worked not only with teams internally, but also with local partners organisations. As part of this, we have introduced the Suicide Prevention Toolkit on our hospital wards and worked with both hospital and community teams on risk management, decision making, productivity and delivery.

A monthly Safety Briefing is produced highlighting learning from local investigations into serious incidents and promoting best practice based on nationally-recognised evidence.

The Trust has also played a leading role in the NHS South Quality and Safety Programme, with the Medical Director acting as the clinical lead for the programme and several staff involved in its delivery. The key workstreams for this programme include:

- Safe and reliable care (including falls prevention) – adopting local, national and international evidence-based best practice
- Prevention of suicide – improving communication after discharge from hospital
- Provision of service user and family-centred care
- Medicines management – improving safety around the prescription and administration of medicines.

Medicines management

The Trust has continued to strengthen its focus in this area. It has set out a five year vision and strategy and has achieved compliance with CQC Outcome 9, which relates to the management of medicines.

During 2011/12, the Trust reviewed its needs in respect of Medicines Management services and agreed to increase the team's capacity so that it can broaden access to, and ensure the provision of, a high quality, consistent level of support across the whole organisation.

The Medicines Management team works very closely with its Link Practitioners, ward teams and community teams across the Trust, as well as with pharmacy partners, based in the county's acute hospitals and primary care settings. It actively participates in the Quality and Safety Improvement Programme (QSIP) and has made encouraging headway in the field of medicines reconciliation (making sure that people's medication is reviewed promptly when they are in hospital). This is particularly important as it is one of the Trust's CQUIN targets (see page?).

The team has made good progress in working with healthcare colleagues within the county's three prisons to improve the quality of medicines management and is also striving to embed recovery-oriented practice and principles in the prescribing of medicines right across the Trust. As part of this work, in December 2011, it commenced a project with the Patients' Association to conduct a survey of people who use the Trust's services to gain a better understanding of their information needs in relation to medication and their use of medication. When completed, the survey's findings will help shape the future of medicines management within the Trust.

Among the priorities for the next year is a further increase in the team's capacity and developments and improvements with electronic prescribing and other automated pharmacy services.

Electronic patient records

The Trust has gradually been introducing a new electronic record system, called RiO, over the last couple of years and the system is now operational across the majority of the Trust's services. This has been a major project and has involved the training of over 2000 staff, as well as a significant investment in new technology in front line services throughout Devon.

The RiO system, which is widely used by mental health Trusts across the South of England and London, replaces paper records and the existing electronic recording system. It means that the Trust now has an integrated patient record that can follow a person seamlessly from hospital to community, with different healthcare professionals able to share a single, secure care plan that they can all update in real time. People who use services benefit from improved quality of care and safer services as healthcare professionals involved in delivering care can share information immediately and on a 24 hours basis. This means better coordinated, safer and more informed care for people using the service.

Executive walkaround programme

Members of the executive visit services right across the organisation to discuss quality and safety on a regular basis. The aims of the programme are:

- To help resolve difficult issues
- To provide senior leaders with a better understanding of safety concerns
- To provide a forum for discussion about quality and safety issues
- To develop face-to-face communication with frontline teams
- To promote a safer environment.

The walkaround visits are about supporting and listening to teams and understanding their needs and concerns.

The Trust increased the Medicine Management team's capacity so that it can broaden access to, and ensure the provision of, a high quality, consistent level of support across the whole organisation.

Clinical Effectiveness

Care Quality Commission (CQC) compliance

In March 2011, following an extensive planned review of the Trust's services, Ian Biggs, Regional Director of the CQC in the South West, said: "This has been a very thorough review of the services provided for people with mental illness in Devon. Devon Partnership NHS Trust provides a vital service to a large population – and overall the trust has emerged with a clean bill of health."

Since then, the Trust has participated in two further reviews by the CQC. In November 2011, the Trust became one of the first mental health providers in the country to undergo a review of its community mental health services. The review included a month of visits and interviews with staff and people who use services, as well as the close examination of a selection of clinical records. The Trust received the results of this review at the start of 2012 and was delighted to hear that the CQC found all of the services it inspected to be compliant.

As part of the national review of services for people with a learning disability, prompted by issues raised at the Winterbourne View home near Bristol, the CQC also visited some of the Trust's services for people with a learning disability during 2011. While there were some positive findings, the reports into Owen House at Langdon Hospital in Dawlish and Knightshayes and the Additional Support Unit on the Whipton Hospital site in Exeter did identify a number of concerns. The Trust took immediate action to address these concerns and is confident that these sites are now compliant with CQC standards.

Improving standards of practice

The Trust has worked with clinicians, managers and people who use services to set standards of practice for the assessment, planning, delivery, coordination, and review of care.

Compliance with these practice standards is now monitored through the review of a monthly sample of clinical records which is taken by each clinical team leader or ward manager. The Clinical Record Self-Monitoring (CRSM) tool has been developed for this purpose and has three key functions:

- To provide assurance through the team dashboard that the standards of practice are being met
- For clinical team leaders to use in their supervision and appraisals with staff
- To measure the impact of the Care Quality Development Programme, a Trust-wide initiative to underpin the work that is being done to drive-up quality.

Performance in relation to the CRSM tool is regularly monitored by the Coordination Group. The Trust's Quality Improvement Plan sets targets for improved CRSM performance and compliance with standards. Effective monitoring is dependent on a high rate of return of the monthly samples sent to clinical team leaders.

It is encouraging that completion rates for the CSRM tool continue to show improvement, up to around 76% towards the end of 2011/12. The returns also show the following:

- Increased compliance with the 12 elements of care planning and clinical record keeping which make up the CSRM
- Particular improvement in the proportion of clinical records in which the person's desired outcomes are identified
- The Trust's target of 80% of the right clinical information being in the right place at the right time has been met

It is encouraging that completion rates for the CSRM tool continue to show improvement, up to around 76% towards the end of 2011/12.

...Infection prevention and control team available 24 hours a day, seven days a week.

- Improvement in the content and degree to which clinical records meet all of the Trust's practice standards – although the 80% target has not yet been met.

Quality improvement framework

The Trust has developed a quality improvement framework based on the measurement of compliance with standards and the evaluation of services by people who use them. These measures are combined with other quality and performance information to allow monitoring at the individual team level through the quality performance 'dashboard'. The dashboard enables teams to see performance data quickly and easily to assess how they are doing against the key indicators and standards. It also enables the Trust to identify those teams that require additional support to maintain standards, allows comparisons between teams and directorates and informs the Trust's Quality Improvement Plan, which is monitored fortnightly at the Quality Improvement Coordinating Group.

Infection prevention and control

The Trust has developed a proactive approach to infection prevention and control. Each year it develops an annual work programme which is approved by the Board of Directors. The Trust has a dedicated infection prevention and control team available 24 hours a day, seven days a week. The Infection Control Committee has representation from all directorates and professions, meets quarterly and reports to the Quality and Safety Committee via the Safety and Risk Committee.

The Board of Directors receives monthly statistics against MRSA bacteraemia and also Clostridium difficile, which provides an additional alert to the Board of any developing patterns or concerns. There were no cases of MRSA bacteraemia or Clostridium difficile during 2011/12.

The Trust has identified a Non-executive Director as a champion for infection control and also has a number of Link Practitioners within frontline teams who help promote best practice in infection prevention and control.

The Trust continues to perform well in terms of meeting the national specifications for cleanliness and the Care Quality Commission has confirmed that the Trust is compliant with its standards (outcome 8) and that appropriate arrangements are in place for the prevention and control of healthcare associated infections, with the exception of Exeter Prison – where some concerns still remain.

The Trust has continued to do a great deal of work at the prison, in partnership with Her Majesty's Prison Service, NHS South West and the Health Protection Agency, to make improvements and a huge amount of progress has already been made. Many of the challenges relate to the physical environment at the prison and the fabric of the building. The major refurbishment programme will be completed in the first half of 2012 and this will mean that the primary care area will be compliant with all environmental

standards under outcome 8. Action plans are also in place at Channing's Wood and Dartmoor prisons to address issues in relation to cleaning and cleanliness audits take place regularly at all three prisons.

The latest data shows that xx% of staff are up-to-date with their online compulsory training in infection prevention and control. Face-to-face essential training is also provided for relevant staff groups. The Trust is keen to assess infection prevention and control standards, and raise overall awareness about the issue, in relation to home visits and community services and this work will commence in the spring of 2012.

Clinical audit

The Clinical Audit Programme for 2012/13 was developed in conjunction with NHS Devon and staff from the Trust's four Clinical Directorates. It is led by a Co-Medical Director. The programme integrates quality improvement and mainstream clinical audit work.

This reflects the wider organisational shift towards an increased emphasis on service improvement, safety and the quality of people's experience of services. The work programme is based on the Trust's priorities for quality improvement and clinical audit activity and reflects both national and local priorities in the field of mental health.

The Trust's current priority areas for clinical audit cover both national and local priorities and include:

- Medicines management
- Implementation of NICE guidance.

Research and Innovation

Devon Partnership NHS Trust is committed to increasing its participation in research and contributing to better health outcomes for the people using its services. In 2011/12, the number of people recruited to research projects approved by a research ethics committee was 298. The Trust is currently recruiting to 28 projects of which 17 are supported within the National Institute of Health Research portfolio.

The Trust collaborates with the Peninsula Medical School, has recently become part of the Quintiles Peninsula Prime site, and co-hosts its Mental Health Research Group. It has close links with the West Hub of the UK Mental Health Research Network and the South West Dementia and Neurodegenerative Diseases Network.

Devon Partnership NHS Trust is committed to increasing its participation in research and contributing to better health outcomes for the people using its services

Improving data quality

In 2011, the Trust established an Enabling Quality Improvement (EQI) group which comprises senior staff and is led by the Director of Operations. The group advises on the Trust's approach to improving the quality of information. It is especially effective as it brings together all relevant departments and staff who contribute to, or manage, key data flows.

The Trust has also set-up a data infrastructure quality assurance project. This is being led by the Performance Information Team and has been established to review the data transformation and reporting associated with the Trust's new electronic records system (RiO) and identify and resolve errors.

Work is also being undertaken to ensure compliance with the national Information Governance Toolkit and assure the quality of the data being submitted by the Trust. Systems and processes have been established to check for data completeness and the consistency of activity levels, across time and similar types of service, on a monthly basis.

The Trust has also conducted a good deal of work in preparing for the introduction of Payment by Results (PBR). There has been a strong focus on ensuring the completeness and accuracy of data in relation to assigning people who use services to various different 'care clusters'. Each of these clusters describes a type of need or condition and the type of support that is required to meet it.

Improving the experience of people using services

Listening and talking

A strategy and workplan are in place to ensure that the Trust talks and listens to people who use its services, their families and the wider community.

In recent years, feedback from all sources has revealed that the attitude of staff and the need for good communication are amongst the top priorities for people. The main reasons for raising concerns or making a complaint continue to be insufficient information about the services available and how to access them, or the quality of service which falls short of people's expectations.

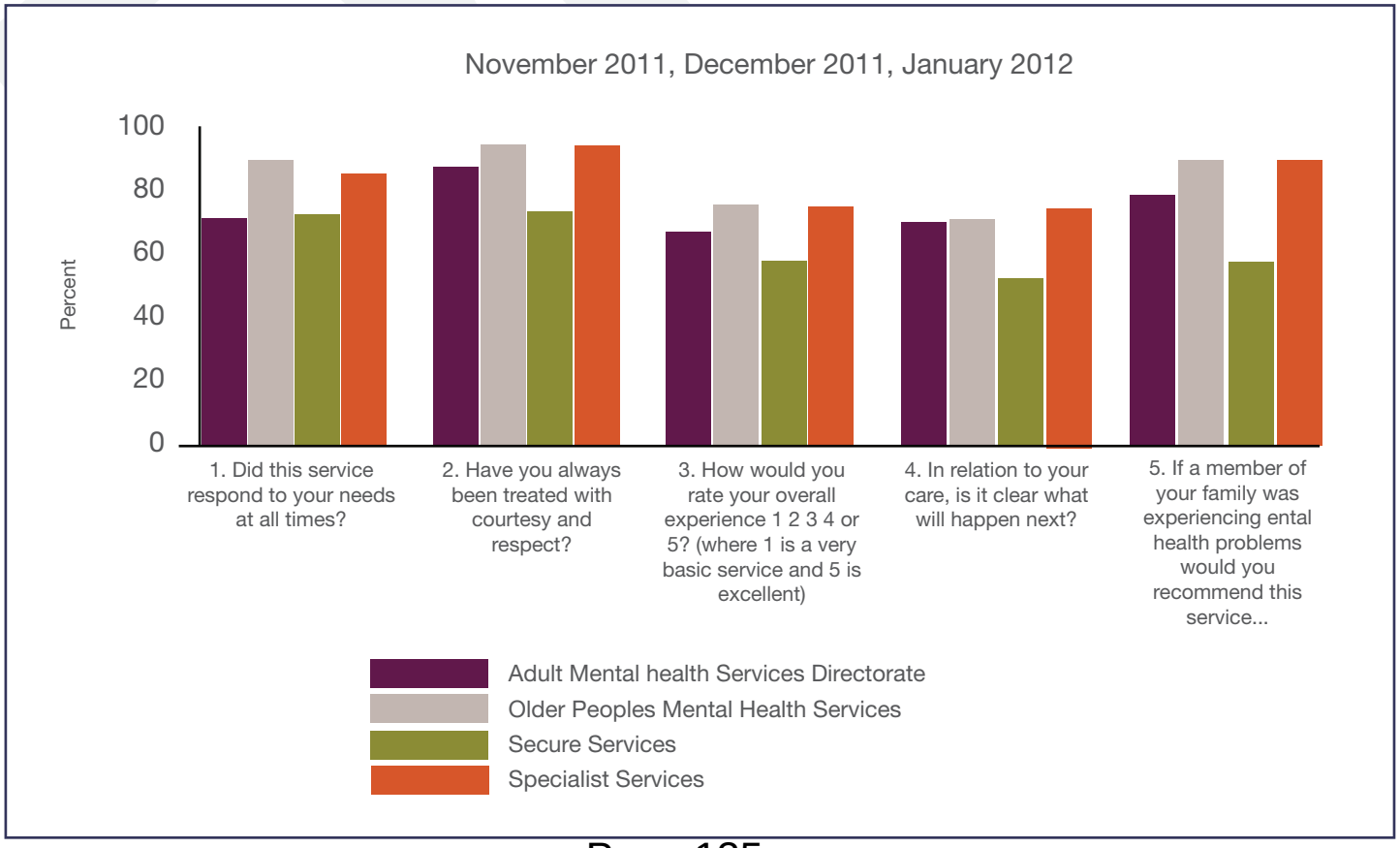
As a result, programmes have been introduced where people who have personal experience of services are involved in staff learning and development activities. This includes revised and improved monthly corporate staff induction sessions and specific team-based workshops to improve staff understanding of how people, or their families, feel about using the Trust's services.

These activities provide an important source of feedback to the Trust. Much of this activity is captured through the Patient Experience Team, based within the PALS office, which provides advice and support, handles enquiries, complaints and supports involvement. Reports of feedback captured by the Patient Experience Team are provided on a quarterly basis to the Quality and Safety Committee and annually to the Trust Board. These reports provide examples of feedback received, arising themes and action taken.

Monthly survey

The Trust has worked with people who use services to identify the key qualities of services which underpin a good experience and positive outcomes. This has informed the development of a questionnaire now used routinely to measure the extent to which people consider they have experienced these qualities and their level of satisfaction with the service provided. This questionnaire is sent to a sample of 1,000 people each month and the results are analysed and reported in team dashboards.

The response rate to the survey for November 2011 to January 2012 was 23.3% - around 700 responses. The graph below shows some key data about



...the principle forum for engagement with people is the Network Action Groups held regularly across the county.

overall satisfaction levels with each of the Trust's directorates:

Overall, the results from the monthly survey are extremely encouraging:

- More than 90% of people report that they are treated with dignity and respect
- Almost 90% of people confirm that they would recommend the service to a relative
- Around 70% of people rate the service as good or excellent.

Areas where the survey has identified the need for further improvement are:

- Having support available to meet personal goals
- Knowing who is responsible for care and who to contact if concerned
- Having the possible side-effects of medication explained (the Trust has begun a joint project with the Patients' Association to gain a better understanding of the barriers to effective communication about medication)
- Knowing what is happening next with someone's care
- Support with physical health conditions and the provision of practical support.

Acting on feedback

In its recent review, the CQC found evidence that improvements had been made in response to feedback at a team and service-wide level. Examples of recent service improvements resulting from feedback include:

- Depression and anxiety service - staff instructed to routinely give written information to people about how they can raise concerns
- Addiction services - better management of the 'smoking garden', improved medicines management and additional essential training for staff
- Recovery and independent living - change of policy in relation to supporting people with their funding applications (direct payments) and improved arrangements for sharing information with people who use services
- Crisis resolution and home treatment - people are now routinely given a copy of their assessments
- Haldon eating disorder service - review of nutrition options and changes to the way food is provided
- The introduction of a 'customer care' training package, called Mixed Messages, for all staff.

Engaging with people to develop services

NHS organisations have a statutory duty to involve people (directly or through representatives) in the planning of healthcare services, in the development and consideration of proposals for changes in the way those services are provided and in decisions affecting the operation of those services.

Outcome 16 of the CQC's performance assessment framework requires evidence that people who use services, and their relatives, are involved in the review and monitoring of service provision.

At Devon Partnership NHS Trust, the principle forum for engagement with people is the Network Action Groups (NAGs) that are held regularly across the county. The objectives of NAGs are to:

- Provide information about national, local and Trust developments
- Encourage Foundation Trust membership
- Seek feedback about the quality of services and proposed service developments or changes
- Offer partner organisations an opportunity to promote their services and engage in discussions about a range of issues

- Provide the opportunity for people to meet with senior staff and other representatives from the Trust.

As part of becoming an NHS Foundation Trust, the organisation will review its arrangements for involving and engaging people, including the Trust's 7,000 members, to provide reassurance that systems and processes for listening to people and capturing feedback are robust and appropriate.

Services for older people

The Trust has worked very hard over the last couple of years to develop and improve its services for older people. Towards the end of 2011, following an investment of almost £5 million, the Trust re-opened four of its inpatient wards for older people In Torbay, Exeter and Barnstaple. These fully refurbished wards bear little resemblance to their predecessors and provide far safer, more therapeutic environments in which to deliver high quality care. They also meet the national guidelines around privacy, dignity and single-sex accommodation.

As well as investing in inpatient care, the Trust is continuing with its plans to shift the emphasis of care and support towards more and better community services for older people. The development of Early Diagnosis and Intervention services is well under way and staffing levels have been increased in some areas to ensure that community teams can work with the expected increase in demand for services. This will enable greater access to services by the ever-increasing number of older people with mental health needs, while ensuring that hospital beds are available for the very small number of people with the most severe and challenging needs.

Single-sex accommodation

In line with best practice and national guidance, mixed-sex accommodation has been eliminated in all of the Trust's inpatient services. Every person using these services has the right to receive high quality care that is safe, effective and respectful of their privacy and dignity. Devon Partnership NHS Trust is committed to providing everyone with same-sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Case Study

Belvedere Ward at Franklyn Hospital

At the start of 2012, the King's Fund visited Belvedere Ward at Franklyn Hospital in Exeter and heaped praise on the work that has been completed there with the help of a £50,000 grant from the Enhancing the Healing Environment programme.

Belvedere ward supports people with dementia type illnesses and representatives from the King's Fund were particularly impressed by the way in which people using the service, carers, staff, schools, community groups and the Devon Wildlife Trust were involved in producing artwork and other pieces around the ward that prompt sensory stimulation.

The refurbished ward engages people through all the senses, through the creation of 'sensory trails' both inside and outside. Colour, lighting and artwork are all designed to both stimulate and calm, encouraging personal and social interaction and enabling people who use the service to explore ways of supporting their own wellbeing.

The Board of Directors closely monitors the delivery of same-sex accommodation and the Trust will seek feedback from people who use services through its questionnaires, programme of independent ward visiting and comments made through the Patient Experience Team.

From April 2011, all NHS Trusts are required to display a declaration of compliance on their website. The declaration for our Trust is set out below and can also be found at www.devonpartnership.nhs.uk

Declaration of compliance

Devon Partnership NHS Trust is pleased to confirm that it is compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary such as where people need the highest level of one to one nursing support and observation for short periods of time (for example in a high dependency or 'extra care' area in an acute inpatient ward).

If our care should fall short of the required standard, we will report it. We will also set up an audit mechanism to make sure that we do not misclassify any of our reports.

We will publish the results of that audit as part of our 'quality of care and patient experience' report in September 2012.

Mental Health Act

The Trust sets out its arrangements and authorisations in relation to the Mental Health Act in a Scheme of Delegation, which is approved by the Board of Directors. The Mental Health Act Administration team works to ensure that the Trust meets its legal requirements and a crucial part of this is the Trust's appointment of independent Hospital Managers who act on behalf of people detained under the Act.

The Trust has 15 Hospital Managers, who ensure that the Act is applied appropriately and fairly, and that hearings, appeals, reviews and other activities are conducted in accordance with the relevant legislation.

To ensure that Hospital Managers understand their role and remain up-to-date, regular development sessions are facilitated. Additional training is provided for those who Chair Mental Health Act hearings, appeals and reviews. The Mental Health Act Administration team works with a wide range of clinicians from across the Trust, providing advice, training and policy review. It also works closely with teams in response to Mental Health Act related visits, reviews and recommendations made by the Care Quality Commission to improve the Trust's compliance with the legislation.

Commissioning for Quality and Innovation (CQUIN)

The CQUIN payment framework is a national initiative that makes a proportion of income (1.5%) available to those Trusts providing services if they meet certain quality and innovation targets agreed with their local commissioning organisations. For its 2011/12 CQUIN scheme, our Trust has agreed a list of indicators which includes targets related to reducing the waiting time for people referred by GPs and other primary care services; increasing the number of people who are informed about the purpose and possible side effects of their medication and improving the quality of end-of-life care for people with dementia. The priority areas for quality improvement selected by the Trust for 2012/13 reflect some of these indicators.

Statement of Directors' Responsibilities
In respect of the 2011/12 Quality Accounts

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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

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

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account for 2011/12.

By order of the Board

Date **Mark Taylor**, *Chairman*

Date **Iain Tulley**, *Chief Executive*

Supporting Statements

Prior to publication, the Trust complied with the requirement to share its Quality Account for 2011/12 with:

- NHS Devon (the main commissioning Primary Care Trust)
- Devon County Council's Health and Adults' Services Scrutiny Committee
- Devon and Torbay LINks.

The Trust ensured that NHS Devon met its legal obligation to review and comment on the publication, and that the Devon County Council's Scrutiny Committee and Devon and Torbay LINks were offered the opportunity to comment on it. A range of other stakeholders were also given the opportunity to contribute to the report.

Commentary by NHS Devon

To follow

Commentary by Devon County Council's Health and Adults' Services Scrutiny Committee

To follow

Commentary by Devon LINk

To follow

Commentary by Torbay LINk

To follow

Engagement in Producing the Quality Account

The Trust sought ideas and suggestions for inclusion in the Quality Account from its key stakeholder groups, including staff, members and the people using services.

Devon County Council Health Overview and Scrutiny Committee

NHS Devon

Devon LINk

Torbay LINk

If you need a copy of this leaflet in a different language or format, please contact our PALS team on

0800 0730 741

or

dpn-tr.pals@nhs.net

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Reference number: 287/02/12

Draft Statement from Torbay Council's Health Scrutiny Board on Devon Partnership NHS Trust's Quality Account 2011/2012

Devon Partnership NHS Trust's Quality Account for 2011/2012 has been considered by Torbay Council's Health Scrutiny Board. The Account provides a rounded commentary on the work of the Trust and shows how its work integrates with that of the other Trusts whose Quality Accounts the Board has considered.

Whilst Torbay's Health Scrutiny Board has not carried out any formal work in conjunction with the Trust over the course of this year, the informal sharing of information continues to be appreciated.

The Board commends Devon Partnership NHS Trust for its openness and transparency of its operations and hopes that the Trust will continue to work closely with the Board and Torbay Council as a whole.

May 2012