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

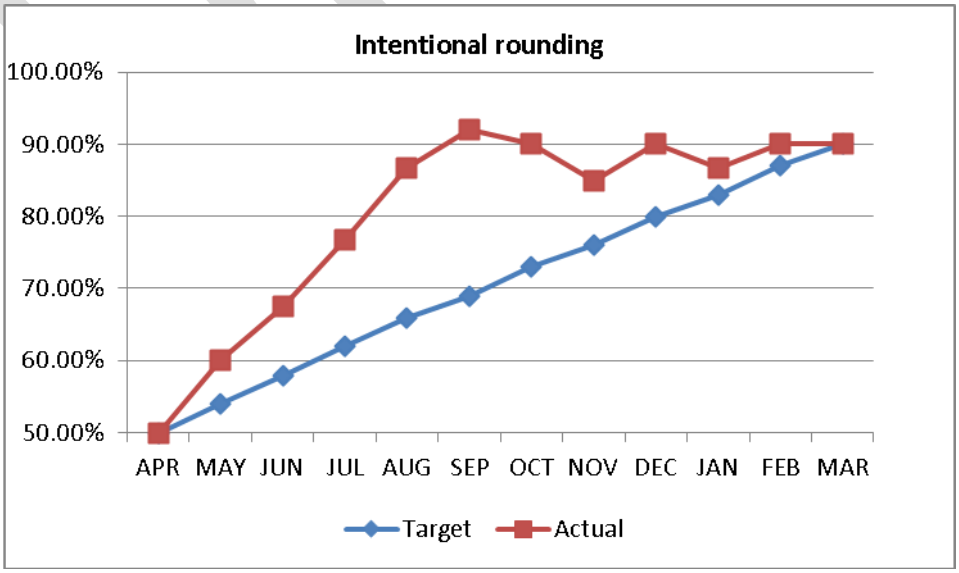
In our 2010/11 Quality Accounts we reported that we would focus on five priority areas for quality improvement in the period 2011/12. These were all locally agreed priorities based on national best practice or best clinical evidence.

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.



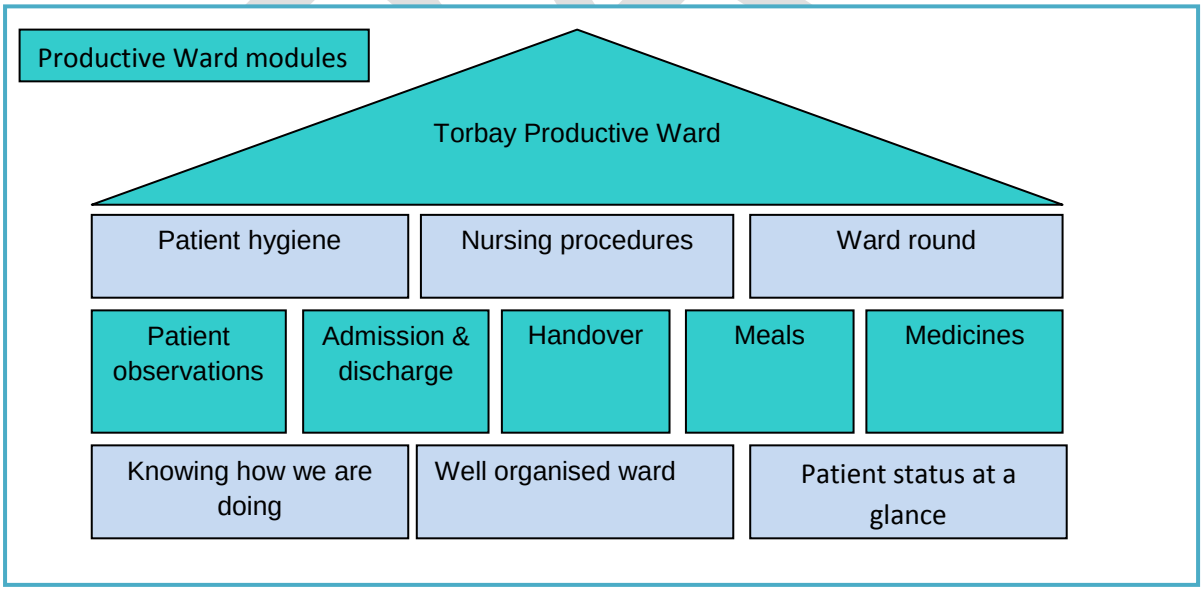
Alongside the intentional rounding work, we have also been measuring the number of reported falls on both wards as a way of measuring the impact of this process on patient safety. On both wards the number of reported falls has reduced. One ward has seen a reduction of 60% with only one fall per month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

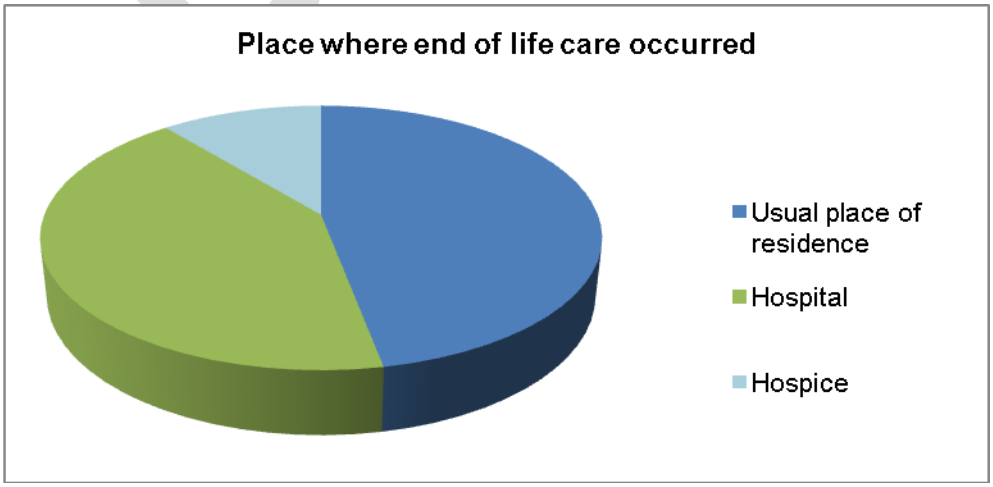
The 2008 National End of Life strategy puts an emphasis on giving patients a choice about where they are cared for at the end of their life. Sometimes people are admitted to hospital for a good reason, but subsequently feel that if time may be short, they would prefer to be cared for elsewhere. Some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

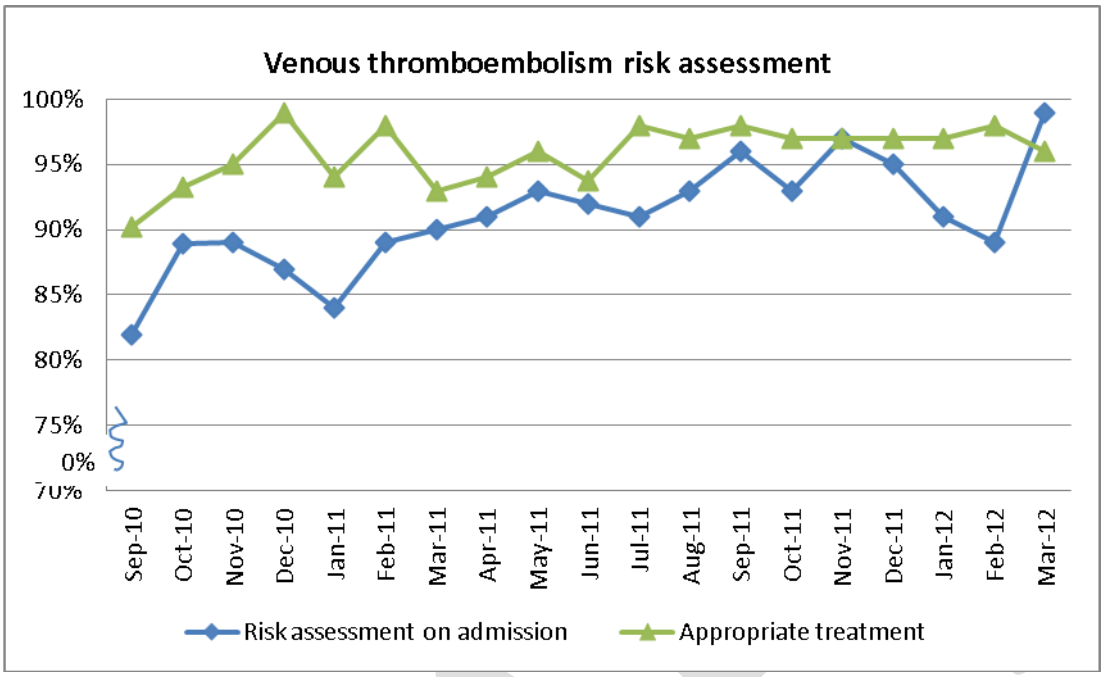
Continuous quality improvement

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

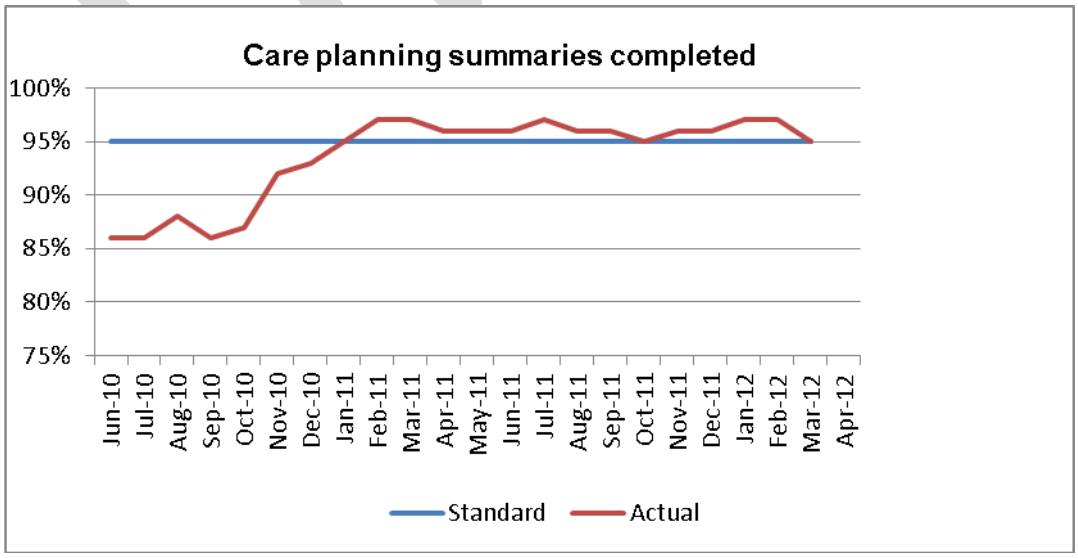
national standard for appropriate preventative treatment. We will continue to monitor venous thromboembolism and report our performance to the Trust Board.



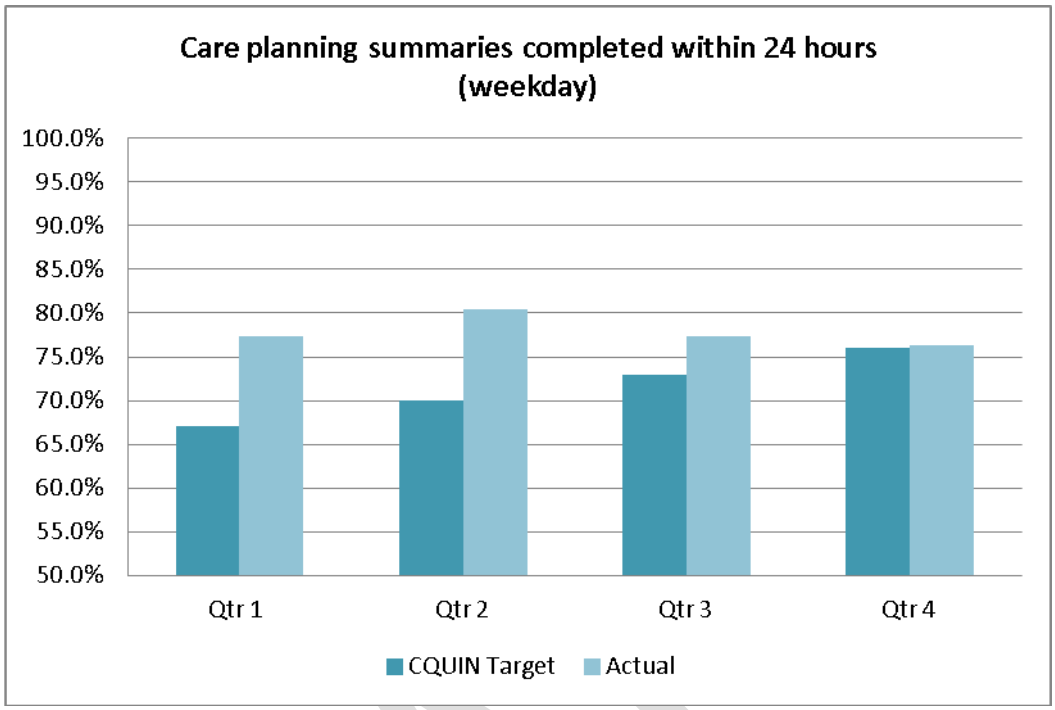
Improving the timeliness and quality of care planning summaries

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

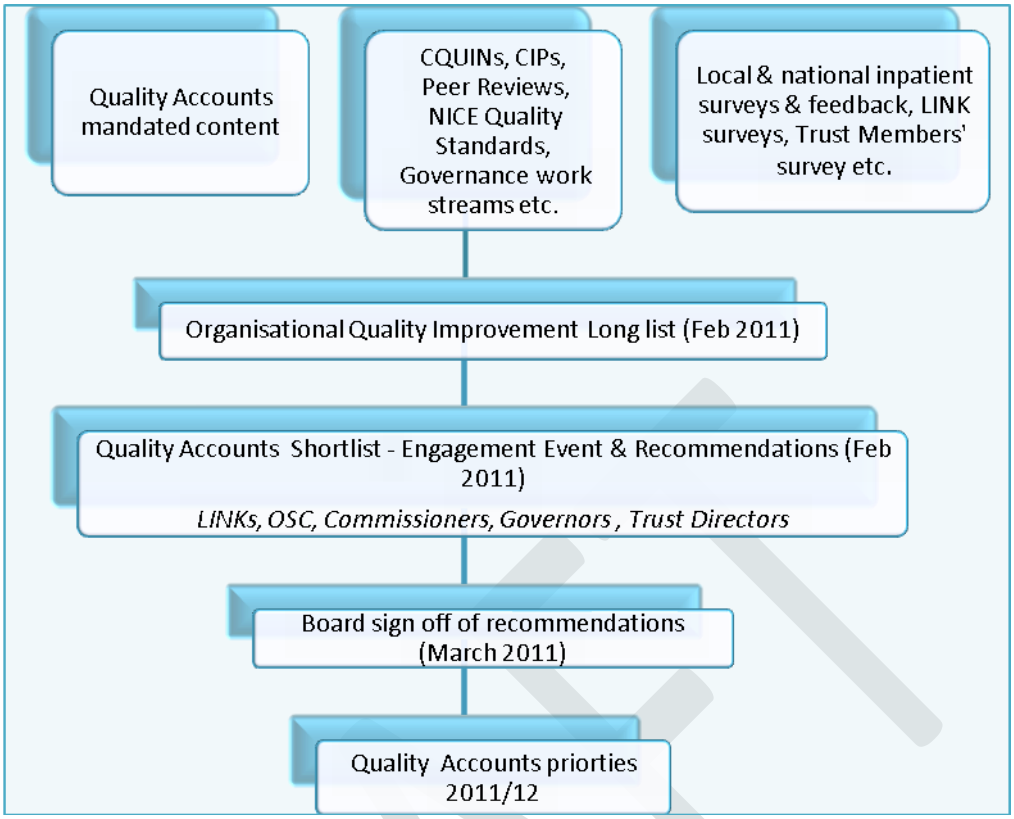
Prior to the publication of the 2010/11 Quality Accounts we have shared this document with:

- 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