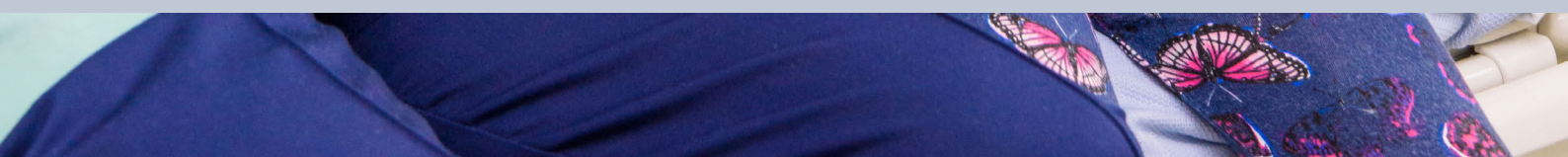
South Devon Healthcare NHS
NHS Foundation Trust

PATIENT SAFETY
CLINICAL EFFECTIVENESS
PATIENT EXPERIENCE

Quality Account 2014/2015



ABOUT THIS DOCUMENT

What is the quality account and why is it important to you?

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

Our 2014/15 quality account is an annual report of:

- How we have performed over the last year against the quality improvement priorities which we laid out in our 2014/15 quality account.
- 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, Healthwatch and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year.
- Statements about quality provided by our commissioners, governors, OSCs, Healthwatch and Trust directors.
- Our quality improvement priorities for the coming year (2015/16).

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

Do you need the document in a different format?

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

Getting involved

We would like to hear your views on our quality account. 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 655690.

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Introduction and statement of quality from the Chief Executive

I am delighted to introduce this year's annual quality account. As the new chief executive at South Devon Healthcare NHS Foundation Trust, I have been impressed with the Trust's commitment to quality and its ethos of placing the patient at the centre of all that it does.

We all know what great care looks like and what we expect, as we have all needed to use NHS services at one time or another. It's about 'what really matters to me' and not just 'what is the matter with me'. The Trust embraces what really matters to the patient, carer or family. A really good example of this is the Trust's work with carers which is described in this report. Small practical things such as free car parking can make a real difference.

It is also good to see the progress made over the last year with our work on managing severe sepsis; a potentially life-threating infection complication, and our commitment to make further improvements this year. It is important that we continually improve the quality of our care and services, as well as measuring any changes. This way we know whether they are leading to an improvement.

Ensuring that at least 95% of patients spend less than four hours in the emergency department has been a significant challenge for Torbay Hospital over the past year. I am pleased to see alongside our current plans to improve performance that one of our improvement priorities for the coming year is the development of a seven day ambulatory emergency care service.

This year we are looking forward to formally joining up with Torbay and Southern Devon Health and Care NHS Trust (TSDHCT) to become an integrated care organisation, which will improve the quality of services for the people of Torbay and South Devon, and our quality account priorities reflect this integrated approach to our work. All five of our key priorities will be delivered in collaboration with our community colleagues.

Our quality improvement initiatives reflect local, regional and national priorities and the feedback we receive from our patients and their representatives, staff and commissioners. Our annual quality account stakeholder event to agree the key areas continues to be well supported and all the recommendations have been agreed by our Board and the TSDHCT Board.

Embarking on a period of significant change whilst working within a limited financial budget will make 2015/16 a challenging year but I have no doubt that the staff working at Torbay Hospital and the community will rise to this challenge.

I commend this quality account to you and confirm that, to the best of my knowledge, the information it contains is accurate.

Mairead McAlinden, Chief Executive

Priorities for improvement

Looking back: 2014/15

In our 2013/14 quality account we reported that we would focus on five priority areas for quality improvement in the period 2014/15. These were all locally agreed priorities based on national best practice and best clinical evidence.

Patient safety

Priority 1: Severe sepsis

Sepsis is a time-critical condition which is potentially life-threatening. A person's immune system goes into overdrive in response to an infection (SIRS response), which can lead to organ damage, multi-organ failure, septic shock and eventually death. Within the NHS around 35,000 deaths are attributed to sepsis annually and sepsis affects all age groups.

Our aim over the last year has been to design, test and implement severe sepsis bundles to manage severe sepsis in adults and children. We have focused first on the Emergency Department and in the paediatric service.

Since spring 2014, we have tested and have now fully implemented bundles based on 'Sepsis Six' in the Emergency Department. These are bundles of diagnostic and therapeutic steps which need to be delivered rapidly and within the first hour of the initial diagnosis of sepsis. We have designed and introduced sepsis boxes in the Emergency Department, which hold everything required to deliver the severe sepsis bundle.

A video to increase staff awareness of severe sepsis has also been produced. This ninety second video 'Managing adult sepsis: your first hour response' is available within the Emergency Department and to all the wards. It can be viewed anytime by members of the clinical team and can form part of a ward team safety briefing or part of an educational session. To date eighty eight staff have watched this video and our plan is to increase this by at least 20% in 2015/16.

Within paediatrics the Trust has been involved in a peninsula wide sepsis working group. Together a new whole system pathway for paediatric sepsis has been developed, which we believe is the first of its kind in the UK.

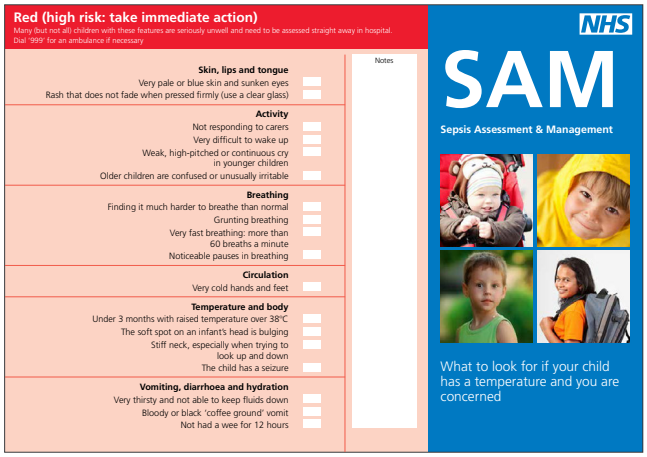
We have revised the paediatric sepsis bundle to include the national (NICE) guidance on the management of feverish illness in children and have worked with GP colleagues who have piloted the inclusion of the feverish child traffic light algorithm into GP IT systems. This will provide additional decision support for GPs when seeing sick children. The algorithm for sepsis and feverish illness has also been included into our new Emergency Department IT system which is due to be fully implemented in 2015/16.

The sepsis work is being championed by the Director of Patient Safety and the Consultant Paediatrician (Acute Care Lead). They have been involved in setting up systems to capture data with the aim of measuring and demonstrating that the sepsis bundles are being delivered reliably in a timely fashion. Further work is required in this area.

The Trust have also been involved in increasing the public's awareness of paediatric sepsis and provision and support for self-management of febrile illness through supporting the design and production of the 'SAM' leaflet which is now available in GP surgeries and health centres across the South West.

It is now also being used in the Emergency Department, in our minor injury units and the paediatric units at Torbay Hospital.

In 2015/16 we will continue to focus on severe sepsis with an emphasis on demonstrating delivery of reliable care. Sepsis is also now a national quality improvement initiative with agreed national measures and reporting for all acute hospitals. This year we have been developing tools to measure severe sepsis and will build on these to ensure timely reporting in 2015/16.



Red (high risk: take immediate action)

Many (but not all) children with these features are seriously unwell and need to be assessed straight away in hospital. Dial '999' for an ambulance if necessary

Skin, lips and tongue
- Very pale or blue skin and sunken eyes
- Rash that does not fade when pressed firmly (use a clear glass)

Activity
- Not responding to carers
- Very difficult to wake up
- Weak, high-pitched or continuous cry in younger children
- Older children are confused or unusually irritable

Breathing
- Finding it much harder to breathe than normal
- Grunting breathing
- Very fast breathing: more than 60 breaths a minute
- Noticeable pauses in breathing

Circulation
- Very cold hands and feet

Temperature and body
- Under 3 months with raised temperature over 38°C
- The soft spot on an infant's head is bulging
- Stiff neck, especially when trying to look up and down
- The child has a seizure

Vomiting, diarrhoea and hydration
- Very thirsty and not able to keep fluids down
- Bloody or black 'coffee ground' vomit
- Not had a wee for 12 hours

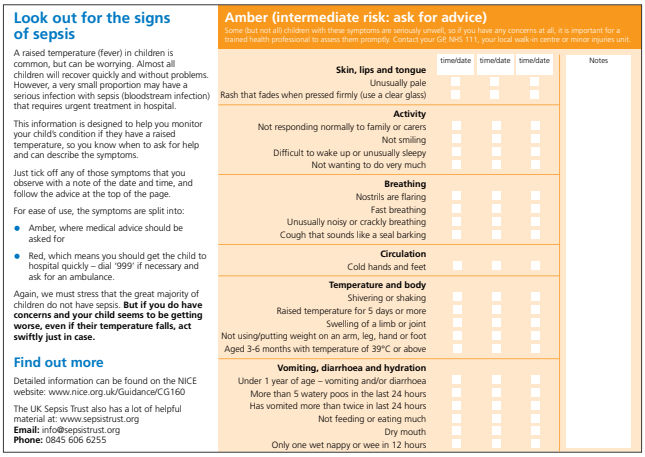
Notes

NHS

SAM

Sepsis Assessment & Management

What to look for if your child has a temperature and you are concerned



Look out for the signs of sepsis

A raised temperature (fever) in children is common, but can be worrying. Almost all children will recover quickly and without problems. However, a very small proportion may have a serious infection with sepsis (bloodstream infection) that requires urgent treatment in hospital.

This information is designed to help you monitor your child's condition if they have a raised temperature, so you know when to ask for help and can describe the symptoms.

Just tick off any of those symptoms that you observe with a note of the date and time, and follow the advice at the top of the page.

For ease of use, the symptoms are split into:

- Amber, where medical advice should be asked for
- Red, which means you should get the child to hospital quickly – dial '999' if necessary and ask for an ambulance.

Again, we must stress that the great majority of children do not have sepsis. **But if you do have concerns and your child seems to be getting worse, even if their temperature falls, act swiftly just in case.**

Find out more

Detailed information can be found on the NICE website: www.nice.org.uk/Guidance/CG160

The UK Sepsis Trust also has a lot of helpful material at: www.sepsistrust.org
Email: info@sepsistrust.org
Phone: 0845 606 6255

Amber (intermediate risk: ask for advice)

Some (but not all) children with these symptoms are seriously unwell, so if you have any concerns at all, it is important for a trained health professional to assess them promptly. Contact your GP, NHS 111, your local walk-in centre or minor injuries unit.

time/date | time/date | time/date | Notes

Skin, lips and tongue
- Unusually pale
- Rash that fades when pressed firmly (use a clear glass)

Activity
- Not responding normally to family or carers
- Not smiling
- Difficult to wake up or unusually sleepy
- Not wanting to do very much

Breathing
- Nostrils are flaring
- Fast breathing
- Unusually noisy or crackly breathing
- Cough that sounds like a seal barking

Circulation
- Cold hands and feet

Temperature and body
- Shivering or shaking
- Raised temperature for 5 days or more
- Swelling of a limb or joint
- Not using/putting weight on an arm, leg, hand or foot
- Aged 3-6 months with temperature of 39°C or above

Vomiting, diarrhoea and hydration
- Under 1 year of age – vomiting and/or diarrhoea
- More than 5 watery poos in the last 24 hours
- Has vomited more than twice in last 24 hours
- Not feeding or eating much
- Dry mouth
- Only one wet nappy or wee in 12 hours

Patient safety continued

Priority 2: Pressure ulcers and falls

The Trust records a high level of harm-free care 98% (Safety Thermometer, February 2015). Two areas of further improvement work that were identified for 2014/15 were to:

- Reduce grade 3 and 4 pressure ulcers by 25%.
- Reduce the number of hip fractures acquired in hospital by 25%.

Although the numbers are small, serious falls and severe pressure ulcers have the potential to be life-changing, moving people in some instances from independence to dependence.

Pressure ulcers

Over the last year the Trust has taken part in a Pressure Ulcer Collaborative in conjunction with Torbay and Southern Devon Health and Care NHS Trust. Five ward teams were given the opportunity to join the collaborative and learn about how to make improvements using an internationally recognised IHI (Institute for Healthcare Improvement) improvement method and were able to meet other healthcare professionals from the community and other hospitals in the peninsula to share ideas and learning.

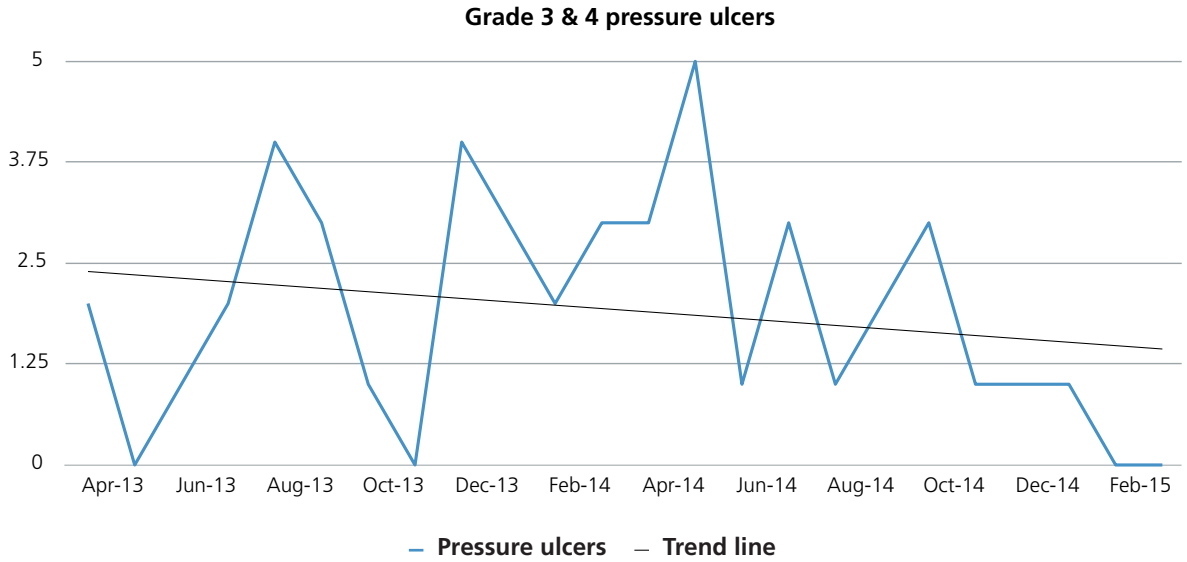
The teams were encouraged to make small changes which they thought could improve pressure ulcer prevention in their area. The results of their improvements were shared in the autumn with the collaborative in the form of pictures, presentations, video, song and even dance.

Across the hospital, we have also continued to raise awareness of pressure ulcer prevention. Over 60% of Emergency Department clinical staff have now attended pressure ulcer prevention training resulting in a significant improvement in the use of the pressure ulcer trigger tool, skin checks, use of the repose mattresses and re-positioning techniques.

The Trust has introduced an Emergency Department trolley replacement programme to ensure the trolleys are giving optimum pressure relief for the very vulnerable patients. The condition of theatre tables has also been reviewed and theatre and recovery staff have now introduced regular skin checks into their daily clinical routine.

Clinical staff continue to conscientiously report and robustly investigate each patient's management when a pressure ulcer has developed in our care and lessons learnt at all levels have resulted in small but significant improvements for future patients.

Over the last twelve months we have reduced the number of grade 3 and 4 pressure ulcers acquired in hospital by 19% (total of 21). The number of grade 1 and grade 2 pressure ulcers reported have slightly increased due to increased reporting. In 2015/16 we will continue training other ward teams into IHI improvement methods to enable them to implement small changes in pressure ulcer prevention. This will be supported by the Tissue Viability team and representatives from the five original wards.



Patient safety continued

Priority 2: continued

Further training events, posters, resource folders and trials of specific pressure relieving equipment suitable for Emergency Department trolleys are planned for the forthcoming year. We are also planning to implement a new training package which aims to reduce the occurrence and improve the management of 'moisture lesions' which are often mistaken for superficial pressure ulcers.

The overall aim for 2015/16 will be to reduce the number of grade 3 and 4 pressure ulcers further with a target of seventeen or fewer.

Patient safety continued

Priority 2: continued

Falls and hip fractures

In our last year's quality account we said we would reduce the number of hip fractures acquired in hospital by 25%. The Falls Steering group have supported several hospital initiatives. These include looking at the feasibility of introducing a new floor surface which absorbs energy when people fall. A trial of this new 'hip hop' flooring has been undertaken at Portsmouth Hospital.

To reduce the risk of falls as a result of people feeling faint or dizzy, due to low blood pressure on sitting or standing up (postural hypotension), we have developed an e-learning package. This is the first package on lying and standing blood pressure in the UK and complements our hands on training. We can also provide patients and staff with a postural hypotension leaflet and have commenced a fallsafe audit. This data will provide a baseline from which we can improve the number of patients having their lying and standing blood pressure taken and recorded.

For patients at high risk of falling in hospital, we provide equipment such as frames and we check patients' footwear. Bed/chair sensor alarm pads are available and physiotherapists will also assess and support high risk patients.

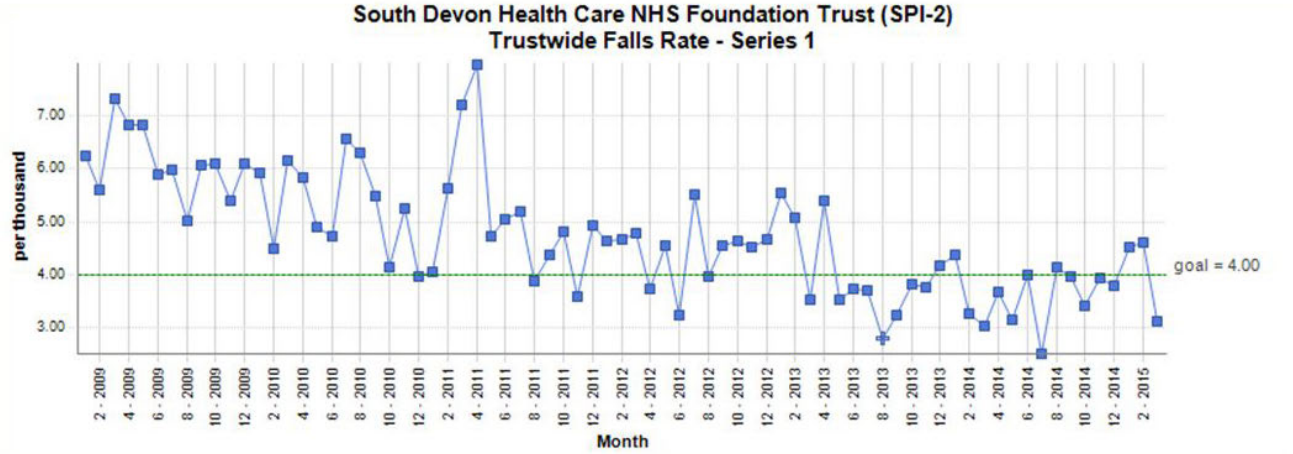
For clinical staff there are seven ninety second teaching videos which include techniques on 'how to get up off the floor' as well as a comprehensive ward based teaching programme led by a falls nurse specialist.

Every patient on admission is assessed for patient handling, falls and bedrail risk and on discharge strength and balance classes are available in the community for suitable patients.

In the last twelve months as a result of the work described we have reduced the number of hip fractures acquired in hospital by 20% (total of 8.) Over the long term our falls rate continues to decline.

In 2015/16 we will continue with our falls prevention work. We are planning to purchase some beds which can be lowered closer to the floor which will reduce the risk of harm to patients. We are also working with our community colleagues to develop joint falls prevention policies and processes to ensure that patients anywhere in Torbay and Southern Devon receive consistent and reliable falls prevention support.

Number of falls at Torbay Hospital February 2009 – February 2015



Clinical effectiveness

Priority 3: Frailty

Torbay and South Devon has a rapidly ageing population. Currently 35% of our local population is over sixty five and 4% over eighty five. This is higher than most areas in England.

Elderly frail people are significant users of our services and it is important that we continue to develop services to support people to live well for longer.

Our objectives for 2014/15 were to:

- Research, pilot and evaluate a frailty scoring tool to help us understand what levels of frailty we have in our local population so we can tailor our services more effectively.
- Complete the roll out of enhanced recovery in medicine onto our medical wards.
- Deliver specialist training to improve the care of those with dementia and develop a companionship service for patients in hospital with dementia.

Frailty scoring tool

During 2014/15 the Trust researched into a number of nationally and internationally recognised frailty scoring tools and chose to undertake a small scale trial of the Edmonton Frail Scale.

The Edmonton Frail Scale has been designed to assist clinicians who aren't specialists in geriatric medicine to assess the frailty of an older patient. The tool looks at a patient's cognitive function, their balance and mobility and enables a doctor to classify a patient from 'not frail' through to severe frailty with several indicators in between.

We tested this tool in the Torbay Assessment Investigation & Rehabilitation Unit (TAIRU), where many of our older outpatient clinics are held. From a total of thirty eight patients over the age of seventy five, we found that eighteen were categorised as not frail whilst three were severely frail.

Edmonton Frail Scale results for patients over seventy five

Category	Score	Results
Not frail	0-5	47%
Apparently vulnerable	6-7	21%
Mild frailty	8-9	14%
Moderate frailty	10-11	10%
Severe frailty	2-17	8%

The information and learning from the trial has been shared with our health and care partners to inform the future service provision for the elderly in Torbay and Southern Devon. We have also used the trial to inform the de-escalation prescribing guidelines for older patients which will be published for clinical staff in early 2015.

We have now stopped the trial of the Edmonton Frail Scale in TAIRU and are investigating whether the scale can be usefully incorporated into advance care planning and treatment escalation plans. The Edmonton Frail Scale is being used in some clinical services to guide treatment, e.g. consideration of surgical versus conservative management in hyperparathyroidism and follow-up in thyroid cancer.

We are also currently trialling an alternative frailty scale in our Emergency Department and Early Assessment Units called the Rockwood Frailty score. This score is more tailored to inpatient assessments and is being used by our frailty nurse to support the development of patients' individualised care plans. This is part of good progress made in the acute frailty service integrated care organisation project.

The information and learning from the trial has been shared with our health and care partners to inform the future service provision for the elderly in Torbay and Southern Devon. We have also used the trial to inform the de-escalation prescribing guidelines for older patients which will be published for clinical staff in early 2015.

Clinical effectiveness continued

Priority 3: continued

Enhanced recovery in medicine

The enhanced recovery in medicine programme seeks to address the acknowledged lack of involvement in shared decision-making experienced by patients when admitted as a medical emergency to hospital. This, together with lack of involvement of carers and families, and processes of care which restrict mobility, freedom and autonomy, can lead to a poor patient outcome and satisfaction.

Over the last two years we have been developing a set of principles based on the internationally recognised enhanced recovery after surgery principles, adapting, testing and creating new principles which can be used for medical patients.

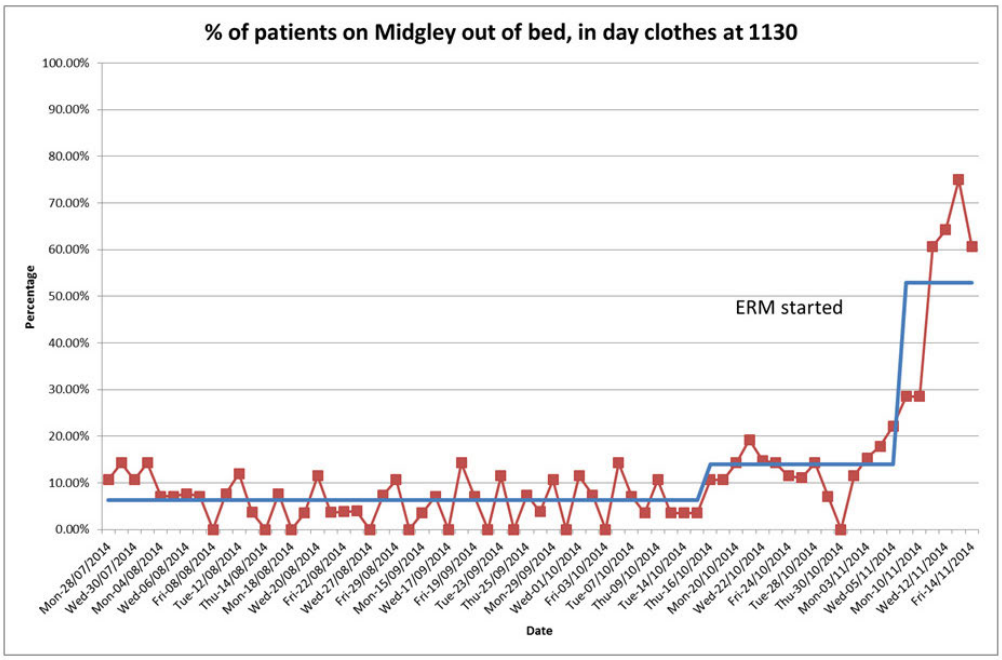
These include:

- Providing open access to the wards for principal family members or unpaid carers.
- Improving nutrition by offering patients an energy drink, as part of their treatment, every day.
- Early mobilisation through encouraging patients to get out of bed dressed in comfortable day clothes.
- 'No decision about me, without me' - with the patient's agreement, offering principal carers the opportunity to attend ward rounds to support the patient and discuss the care plan with the patient and the consultant.

We have now tested and rolled out the programme onto all our medical wards with a mixture of success of embedding it into daily ward routines.

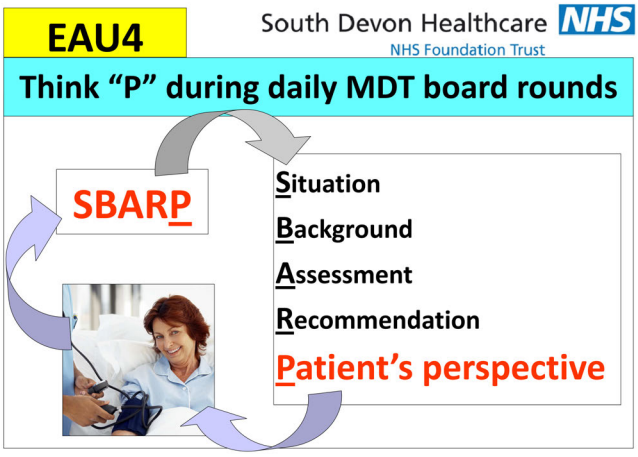
On Midgley ward, where we introduced enhanced recovery in medicine last year, we saw a significant shift in the number of patients out of bed and dressed

Snapshot of test of change: Respiratory ward (Midgley)



Clinical effectiveness continued

Priority 3: continued



before late morning.

On EAU4 a daily enhanced recovery in medicine round is undertaken to check whether the enhanced recovery in medicine principles have been applied such as whether a carer has been given the opportunity to attend a ward round. Daily multi-disciplinary board rounds include the patient's perspective and junior doctors include this as standard when they are making inpatient referrals or documenting requirements for weekend handover.

There has also been national interest in the programme and we have produced a short video to explain what enhanced recovery in medicine is and its value to patients, carers and staff.

http://vimeo.com/hiblio/review/105631245/4191078be1

In 2015/16 we will undertake a more detailed analysis of enhanced recovery in medicine on two wards. We are working with Plymouth University and PenCLAHRC, a local research organisation, to develop a set of measurement tools to more fully understand the benefits of enhanced recovery in medicine. We also aim to produce a 'how to' toolkit for use locally and nationally.

We have recently put in a bid to the Health Foundation for £75,000 to fund this analysis and development of enhanced recovery.

Dementia

Torbay and Southern Devon has a rapidly ageing population which means that there will be an increasing number of people with dementia. One of our main goals is to increase dementia awareness, support and access to care. Initiatives range from the introduction of memory cafes in local communities to the use of dementia screening, assessment and referral tools within the hospital.

In 2014/15 we said we would:

- Deliver specialist training to improve the care for people with dementia.
- Develop a companionship service for patients in hospital with dementia.

Through our CQUIN (Commissioning for Quality Improvement and Innovation) work we also stated that we would continue to focus on increasing dementia awareness as well as improve the use of the dementia screening, assessment and referrals tools.

To date, over two thousand staff have undertaken dementia training awareness. All the clinical areas have now been awarded 'Purple Angel' status. The 'Purple Angel' is a national dementia initiative that symbolises when 95% of staff in an area has undergone specific training to become more dementia aware.

In addition, over three hundred staff have attended the 'Specialising, dementia and safe approaches course', developed in 2014. Three trainers from the educational service have been trained to deliver the course to health and care community staff. The main group trained have been health care assistants as these are often the staff that are called into the wards to work alongside dementia patients and therefore need the most support.

In the last twelve months there has been an overall reduction in the number of security officers attending the care of the elderly wards (Simpson & Cheetham Hill), with a reduction of thirty seven incidents in 2013/14 to seventeen in 2014/15. This may be as a result of staff de-escalating our dementia patients with

Clinical effectiveness continued

Priority 3: continued

skills learnt from our course.

We are also in the process of launching our companionship service and have recently recruited 5 volunteers to work on Simpson ward. The service is primarily aimed at people with dementia and/or people who need befriending.

The volunteers, known as ward buddies use activities to stimulate conversation and engagement. They undertake dementia training, mandatory training, ward orientation as well as having links whilst on the ward with the occupational therapy service.

The development of the companionship service is part of a larger volunteer project called VICTor (Volunteering in care Torbay project) which aims to mobilise more volunteers to support patients in the hospital. Currently there are over four hundred registered volunteers of which one hundred and sixty are currently active. A new website has been developed to provide a 'shop window' for volunteer opportunities and a new forum through which volunteers can learn more about what is going on the hospital. The web address is:

http://torbay.volunteercommunity.uk.

Finally, through our CQUIN work we continue to focus on dementia. Our main challenge continues to be increasing the use of the dementia screening, assessment and referral tool. As a Trust we have failed to meet the national 90% target by the end of the year. This is because despite undertaking screening, we were unable to capture and record the information in one place.

In 2015/16 the national 90% dementia target will remain a Trust priority. The recent purchase of a clinical task management system will streamline processes; ensuring information is reliably captured once.

Patient experience

Priority 4: Bereavement

Torbay Hospital has a bereavement officer whose role is to liaise with clinical and ward staff, the mortuary and the Coroners Office to provide bereaved families with the correct advice and paperwork following the death of their loved one. They can provide signposting to services that can support grieving family or friends.

Our aims for 2014/15 were to improve the timeliness of information to GPs about a patient death and improve bereavement support and signposting.

Building on the work in 2013/14 to develop and publish a bereavement booklet 'Help for you following your bereavement', which is available on all wards, a new feedback card has been incorporated. This enables family and friends to comment on their experience in the hospital of end of life care for their loved one as well as offering a courtesy follow-up call four to six weeks later. The latter is generally taken up by spouses of elderly deceased patients who are pleased to be able to comment after a period of time has elapsed.

Overwhelmingly the feedback about the care delivered on the wards to the deceased patients and their families has been positive. This feedback is shared at the Trust`s end of life care group and at our patient experience work stream in a patient services report. As a result of the introduction of the feedback card we have noticed comments about the difficulty in parking for families when collecting death certificates and we are currently exploring options to make this easier for families.

Comments from families about the quality of care they have noticed include:

"Paramedics- excellent. All staff in critical unit- compassionate, professional, excellent. Bereavement Office- excellent. Parking- nightmare"

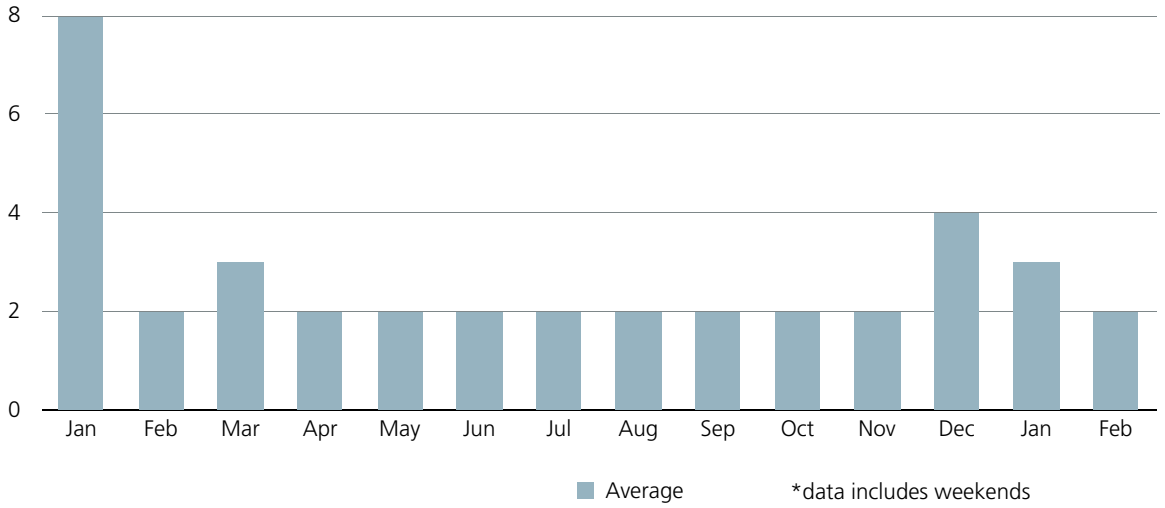
In addition during 2014/15, the bereavement officer has worked with the wards to improve the timeliness of information to GPs about a death. Ward teams should always inform GP practices as soon as practicable of a patient's death. This however was not always consistently happening.

In early 2014 the bereavement team set up an email service to GPs as a failsafe process to inform them of a patient's death. This has resulted in an overall improvement in timeliness over the year.

At the same time they started to work with a small group including the palliative care consultant to redesign the ward current death verification form. This redesigned form and process is being tested on Turner ward. This has received mixed reviews from the clinicians so far and is planned to be tested on other wards and further changes made before rolling out throughout the organisation.

In 2015//16 we will continue to test and change the verification form and participate in a Trust wide task and finish group to improve timeliness of completion of death certificates.

No of days from hospital death to inform GPs by email



Patient experience continued

Priority 5: Support for carers in the discharge planning process

Unpaid carers, such as family and friends involved in a person's care and support, are an essential part of the discharge planning process. Evidence shows that involving and supporting them from the beginning encourages a safe and effective discharge, fewer readmissions and an improved experience for both the patient and their carer.

To improve the involvement and support of carers in the discharge planning process we asked carers what their top three issues were and then agreed to start to fix them. As there is no national annual carers survey as a benchmark from which to improve, we used previous Trust evaluations and carer consultations. The top three areas to improve were:

- Communication with carers.
- Involvement in discussions about medication.
- Addressing practicalities for carers.
- Communication with carers

We worked on developing ways that carers could be treated as experts in a patient's care and amended paperwork to make it more user-friendly. We developed and tested a communication mat for the bed table, with helpful information for both patients and carers.

From testing the mat it soon became clear that the biggest difference to carers was having a person who can sit and talk to them about the situation and give support to them as carers. We therefore have trained some ward based volunteers to encourage carers to become involved and to let them know about the available support.

Involvement with medication

Carers are often responsible for administration or supervision of medication after a patient's discharge and it is an area they generally worry about. Carers have not routinely been included in conversations about medication when a patient is on the ward, which has the potential for problems or anxieties post-discharge. Additional funding for a ward-based pharmacist enabled a pilot to be run to improve this.

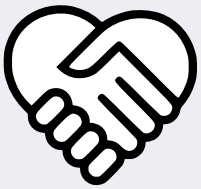
Carers were contacted at the point of admission to assist with checking what medications people were on and then were informed if there were any medication changes at discharge, plus any side-effects to look out for. Now we have done one test of change, we will continue to do more over the next year.

Practicalities for carers

This covers a wide range of issues, from knowing when carers can visit, to supporting carers with parking, caring for in-patients, and spending time at the hospital.

General agreements have been reached with regards to visiting times for carers, and arrangements for their remaining time involved in someone's care while they are in hospital.

Carers who are actively involved in someone's care can get staff reductions at Bayview restaurant, and may be able to stay overnight (in a reclining chair) if agreed with ward staff. A symbol has also been agreed to let staff know that a carer is actively involved, to encourage active communication with the ward team.



One of the biggest improvements is the introduction of free parking for registered carers when supporting someone either attending or staying in the hospital. This has been a resounding success with carers, and will hopefully encourage friends and family who may not realise that we consider them to be carers, to ask about it and then get the appropriate support.

"Life as a carer is tough. Anything that helps make our lives easier, and makes us feel valued for what we do is really welcomed"

"Made attendance at the clinic easier, and my husband did not feel so guilty at the "trouble" his required attendance had put on me and our financial situation. It was a bonus to see him smiling instead of the worried frown he usually has when attending for necessary treatment"

A leaflet has been developed which will be launched in spring 2015, to let carers know all about the support that is available at Torbay Hospital.

In 2015/16 we will focus on carers and medicines as a quality account priority and more information about this improvement project can be found in the next section.

Patient experience continued

Continuous quality improvement in 2014/15

As a Trust the organisation is continually focusing on improving the quality of its care, whether this is through large strategic programmes such as developing an integrated care organisation or through small front line projects such as improving the timeliness of consultant to consultant referrals for inpatients.

The Trust also continues to participate in delivering a range of national and local CQUINs (Commissioning for Quality Improvement and Innovation) as well as delivering a number of cost improvement programmes (CIP). It has started to bring together existing staff with quality improvement and innovation skills to form the new Horizon Institute. Its aim is to support all staff to improve care whether this is through improving patient safety, experience and improving health and care outcomes.

A snapshot of our work is described in the next section and more information about the Trust's work can be found on the website www.sdhft.nhs.uk and through our annual report and Trust newsletter.

CQUINs 2014/15

The Trust has been involved in delivering eight CQUINs made up of fifteen projects covering safety, patient experience and clinical effectiveness. As in previous years these are a mixture of national and local priorities.

A breakdown of the 2014/15 CQUINs can be found in annex 3 alongside the performance. Two CQUIN examples are described in more detail below.

Alcohol

Alcohol related conditions place a significant financial burden upon healthcare services, both within the community and the hospital setting. We know that Torbay has statistically significantly higher rates of alcohol related and alcohol specific admissions than our South West counterparts, and indeed national averages.

Torbay also has significantly higher rates of alcohol liver disease, early mortality and alcohol related admissions for people under eighteen than regional and national figures. Alcohol misuse within South Devon is also an issue that we need to address, but this is seen to a much lesser extent than in Torbay.

In order to address these issues, the role of early intervention is paramount, and the need for a universal screening programme for alcohol is key to this. Only by asking all patients presenting to the hospital about their alcohol use can we identify people drinking at risky levels and provide an intervention to help them reduce their intake, improve their health and reduce the likelihood that they may present again to the hospital in the future.

As well as identifying dependent drinkers, any such programme also needs to identify people drinking at increasing risk levels (we call these groups hazardous and harmful drinkers) who may not consider themselves to have an alcohol problem, but are regularly drinking in excess of the recommended limits for alcohol consumption (fourteen units per week for a woman and twenty one units per week for a man). Estimates show that this figure may be as high as twenty three thousand individuals within Torbay alone.

In response, our approach has been to embed a universal screening programme for alcohol across some of the 'high risk' areas within the hospital setting where we may expect alcohol to be more of an issue (emergency department - including EAU's 3 and 4, gastroenterology and endoscopy). We have also

Patient experience continued

CQUINs 2014/15 continued

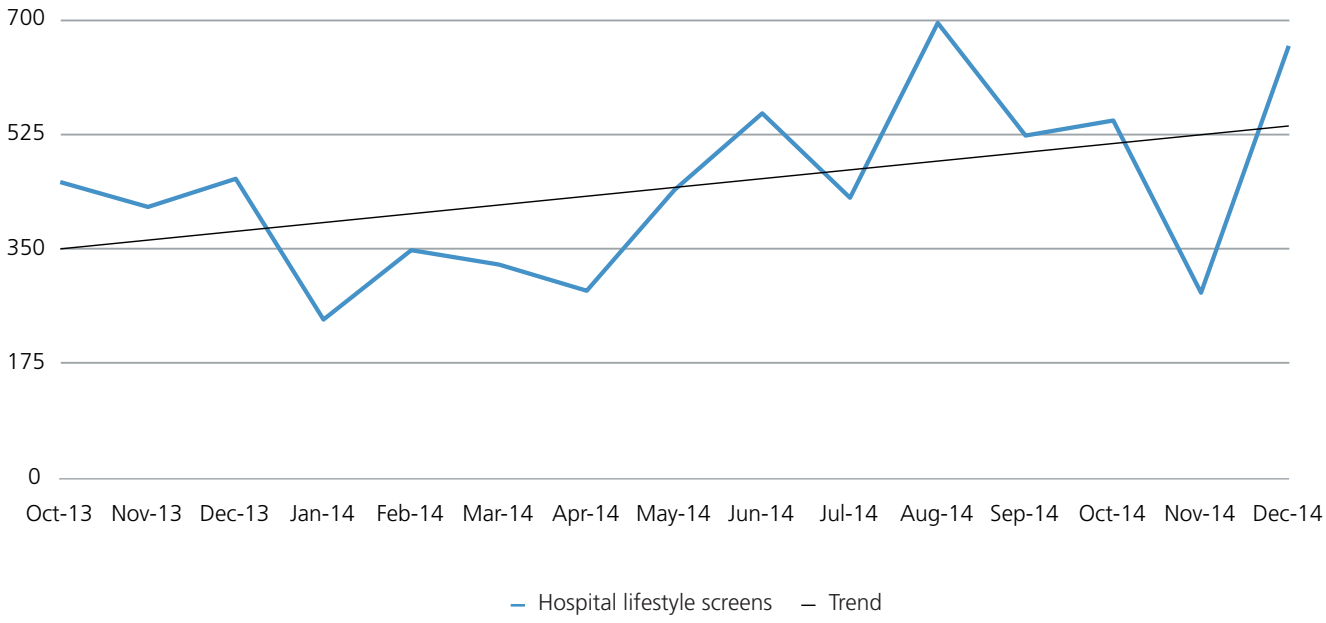
extended our screening programme to other areas such as the pre-assessment clinic where early detection of alcohol problems can be met with an early intervention in the form of information and brief advice.

The screening programme results are shown in the table below.

The ultimate vision is that all assessment processes would include the recognised screening tool for alcohol, the Alcohol Use Disorders Identification Test (AUDIT) as part of routine practice. Anyone identified as drinking at increasing risk levels would then be followed up by a trained individual delivering a brief advice and information session. Evidence shows that 1 in 8 people receiving brief advice (a 10-15 minute intervention) will reduce their drinking to safe limits as a consequence.

In 2015/16 we plan to increase the screening programme across more areas and departments within the hospital, and train more staff in the information and brief advice model. We are also testing the use of volunteers with 'lived experience' of alcohol themselves to help support more dependent drinkers into specialist alcohol services in the community and access treatment.

Lifestyle screens Nov 13 - Dec 15



Patient experience continued

CQUINs 2014/15 continued

Staff Friends and Family Test

The Staff Friends and Family Test was introduced nationally in 2014 by the Department of Health following the launch of the Patients' Friends and Family Test the previous year. Research shows that the higher level of staff engagement in an organisation, the better the outcomes including patient satisfaction and improved safety as well as reduced absenteeism.

The new national survey provides an opportunity for all staff to feedback their views on the Trust, and it complements the national annual staff survey which is sent to a random sample of staff.

With the Staff Friends & Family Test, staff are asked to rate:

- How likely are you to recommend Torbay Hospital to friends and family if they needed care or treatment?
- How likely are you to recommend Torbay Hospital to friends and family as a place to work?

They are also offered an opportunity to provide additional comments in response to both questions.

Over the last twelve months, the Trust has undertaken targeted sampling, whereby each quarter staff within a specific work division are invited to respond to the survey, primarily online. The survey remains live for a month following which the data is collated and a report is produced and shared with the area for local action.

The results are also published nationally and are shown below.

A large number of positive comments have been received over the year including

"There has always seemed to be a real family feel with the staff at Torbay Hospital".

"A great place to work with a clear vision to deliver high quality care. The Trust really appears to care about its employees".

"Staff are valued and are able to make a real contribution to patient management".

"Friendly supportive working environment".

Common themes identified as needing improvement include communication and staff recognition. The findings from the 2014 NHS Staff Survey have also identified communication as an area for further development, together with ensuring staff are aware that their roles make a real difference to patient care. The findings from the annual staff survey have been shared with staff and an action plan is being developed to address those areas identified for improvement.

In 2015/16 our work will focus on:

- Improving staff recognition and helping staff to understand how their roles make a real difference to patient care.
- Improving the quantity and quality of staff appraisals completed.
- Ensuring staff feel they are treated fairly and that there are equal opportunities for career progression.
- Helping staff to feel secure in raising concerns about clinical practice and improving communication
- Continuing to review and develop initiatives focused on addressing violence from patients.

	Quarter 1 (Apr-Jun 14)	National Average	Peninsula Ranking	Quarter 2 (Jul-Sept 14)	National Average	Peninsula Ranking
Recommend work	**76%**	**62%**	**2nd best of 9 trusts**		**75%**	**3rd best of 9 trusts**
Not recommend work	**8%**	**19%**			**10%**	
Recommend care	**89%**	**76%**	**2nd best of 9 trusts**		**87%**	**3rd best of 9 trusts**
Not recommend care	**4%**	**8%**			**4%**	

**Quarter 3 not applicable as national staff survey. Quarter 4 published May 2015.*

Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15

Special education needs

For children and young people up to age twenty five the SEN (Special Education Needs) reforms that went through Parliament in 2013 saw the biggest changes to the SEN system in thirty years. These were incorporated in the Children and Families Act 2014 and specified two new duties which directly impact on health professionals. There is a new duty on health commissioners to deliver the health care provision specified in an education, health and care plan and a new duty which requires local authorities and clinical commissioning groups to commission services jointly for children and young people with special educational needs.

Children and young people with special education needs require integrated support to achieve their full potential and too often, parents' experience of getting their children the support they need is a battle – dominated by arguments about who should pay for what service. The reforms are designed to address those issues head-on. They require local authorities and health partners to work together as a team, around a joint set of outcomes. The special education needs reforms went live in September 2014.

Recognising that professionals in the health sector have a significant role to play, Child Health registered this as a project supported through the Trust's quality improvement programme. Having consulted with families and the education services the first priority has been to streamline the process for seeking medical (paediatric) information about children and the timeliness for completing and reporting on medical assessments once children/ young people were on the pathway to an education, health and care plan.

The work undertaken by Child Health, working with a wide range of stakeholders, has enabled the service to:

- Increase awareness among staff involved in the pathway of the (statutory) timescales and importance of the work.
- Make minor changes to our information sharing agreement across organisations and access (faster) electronic communications safely.
- Increase the support to families who found it hard to access systems and appointments.
- Ensure that health commissioners were aware of the issues for health organisations and that the person new in post to the Designated Health Officer role had a clear contact point in the team.
- Set up a monitoring system and team meetings to take forward the next steps.

Child Health is continuing to seek on-going feedback from families and young people about their experience to improve the services offered.

Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15 continued

Electronic replacement of inpatient speciality (white slip) referrals

All trainee doctors are encouraged to learn quality improvement methods and to apply their learning to a quality improvement project either in their speciality or across the hospital.

In early 2014, two trainee doctors chose to focus on creating a reliable communication method for inpatient speciality referrals (white slips) in order to reduce the delays in referrals, treatment and discharge. Until this period, inpatient speciality referrals were paper based, mostly written by trainees and delivered by internal mail or fax, resulting in unnecessary delays. The doctors observed that they hadn't enough space to record information and the information was not trackable or receiptable. The trainees could not see whether the referral had safely reached its destination

The aim of the quality improvement project was to create a central referral hub using digital time stamped referral forms linked to patient records.

Supported by a quality improvement coach, the trainee doctors worked with a small team to develop a new electronic referral form, using an IT system familiar to all trainees. The layout was changed so it was more structured and in a format familiar to all doctors. A new electronic system was agreed as a result of co-designing a new administrative process with specialty administrators.

Data was collected prior to the test of change and twice after go live to measure the initial impact of the implementation and then subsequent further small changes.

The changes have resulted in a significant reduction in time from making the inpatient referral to a patient being reviewed. Most patients are now seen within twenty four hours.

The trainees have presented their work at a number of regional and national conferences, encouraging other trainees to get involved in quality improvement work. To date over two thousand inpatient referrals have been made using this new system.

Data collection period	Mean time to review (hours)
Nov 2013 (Pre-improvement)	60.32
Apr 2014 (Cycle 1)	17.30
Aug 2014 (Cycle 2)	15.65

Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15 continued

Menumate

The Trust has introduced Menumate over the last year on all its hospital wards with the aim of both improving patient food choice and reducing the time spent by staff sending information to the kitchen.

Menumate is an electronic way to order patient meals and food via an iPad which, once saved, is automatically linked to the kitchen. This means that ward staff no longer have to phone through at the same time of the day for lunch and evening meals, resulting in delays and mistakes. Also the system is capable of linking into kitchen stores automatically ordering supplies as they are used. This enables the Trust to keep better track of its stock levels.

Comments from staff include:

"The system is quicker, there is more choice and there is less chance of losing the information. It's a much better system once you get used to it"

For patients, pictures of the meals and dietary advice provide more information to make better choices. Dieticians can also helpfully keep track of what patients are eating. For long stay patients there is also the opportunity to review both the ward and staff menu.

In the next few months portion size control will also be brought in so patients can choose to have a small, medium or large meal. We are also currently investigating whether to use Menumate in the community hospitals.

Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15 continued

Patient feedback

Patient feedback is important to us as it helps us to know how we have performed from the perspective of the patient and what has mattered to them whilst being cared for by the Trust. We are increasingly using patient experience data to measure service improvements, capturing information from patients, families and carers before and after a service change.

As a Trust we have several ways of capturing feedback. These include participating in annual NHS surveys, conducting real time feedback surveys on the wards every day and recording complaints information. We also capture information from social media including Patient Opinion and NHS choices as well as participating in the national Friends and Family Test.

All this information is shared, alongside a patient story, at our monthly Patient Experience Community and Partnership meeting which is also attended by Healthwatch and the commissioners. The Committee provides assurance to the organisation about patient experience and the actions we are taking to improve care.

Over the last year new developments include systematically capturing compliments from patients, families and carers. This positive feedback is shared with the clinical teams and through the Trust wide weekly staff bulletin. Examples include:

"I was diagnosed with an arthritic ankle in September and referred to Torbay. The whole experience has been excellent and now the operation has been completed, the aftercare is well on track. Thanks to the Consultants, anaesthetists, all the staff in Ella Rowcroft as well as the physios and outpatient staff at the Fracture Dept. I could not have wished for better care and attention". February 2015

"The treatment I received whilst at Torbay Hospital was first class all of the staff from consultant to cleaner were outstanding because the whole package was so good I was able to leave after only 5 days! After major abdominal surgery. Well done all of you. You should be justly proud of what you do. You are worth twice what you are paid". October 2014

"I write to express my deep gratitude to the Audiology Department of Torbay Hospital for the care and support given to me over the months. Without exception your audiologists were most helpful, kind and supportive; at all times attentive, polite and professional". August 2014

We have also started to receive additional feedback from Healthwatch (Torbay) via their newly launched website (http://healthwatchtorbay.org.uk/).

As well as sharing all feedback with the clinical teams, we also share a compliment or a complaint at our monthly 'All managers meeting'. We continue to present a patient story at the Trust board meetings and share feedback with the public through 'You said we did'.

We have started to develop an engagement and experience strategy with our colleagues in Torbay and Southern Devon Health and Care NHS Trust and with our service users. This will be published in 2015/16 and will set out the key responsibilities for health and care teams and the organisation in ensuring full engagement of our local population in all that we do.

In 2015/16 we also continue to participate in the national Friends and Family Test as well as work together on one shared patient experience CQUIN, agreed by all our local care system.

Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15 continued

Medicines administration

When patients are discharged from hospital they often take home with them a number of medications for their on-going treatment. The time taken to prescribe, dispense and deliver these to take away (TTAs) drugs can result in patients waiting unnecessarily.

"Why am I waiting - the doctor has told me I can go home?"

As a result of direct feedback from a member of the Working With Us group, a small group came together led by Pharmacy and supported by an improvement coach. Their first task was to understand more fully the problem before agreeing what changes to make.

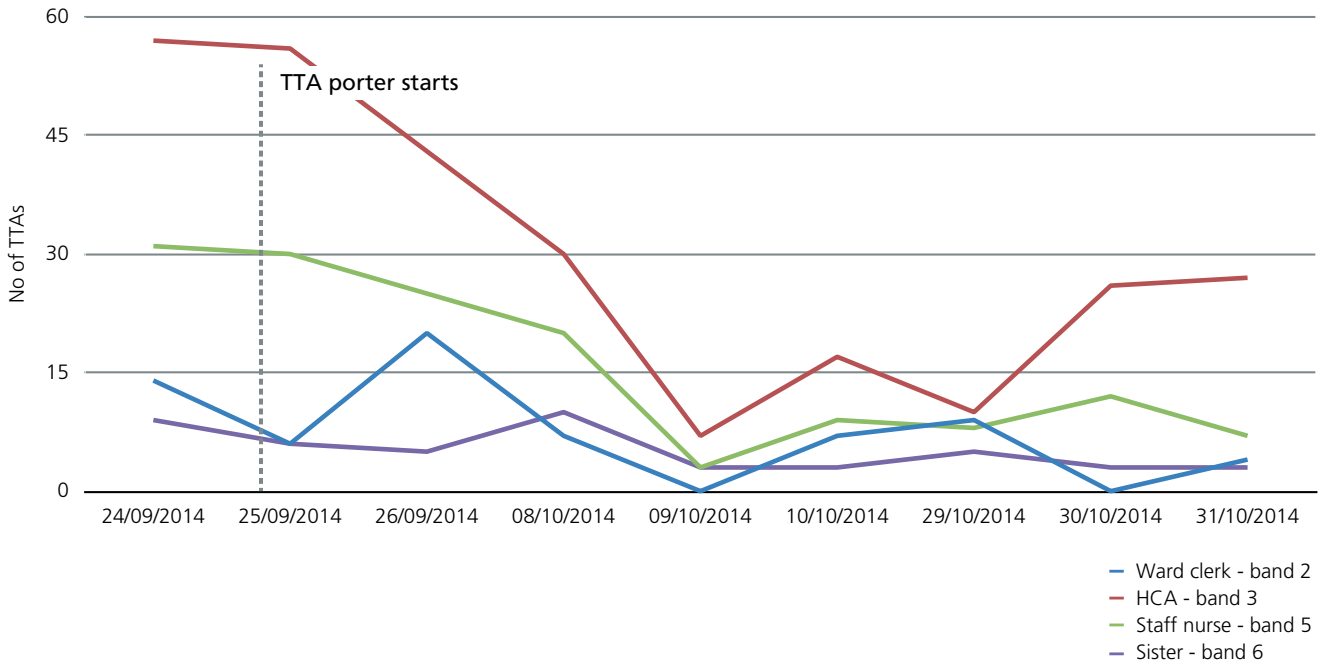
The group agreed to improve the timeliness of TTA delivery from pharmacy to the wards and to reduce the number of clinical staff required to collect from the wards through the introduction of a TTA porter.

Prior to the introduction of the TTA porter about one hundred and twenty five trips were being made daily by clinical staff to and from pharmacy. An average trip would take staff about eight minutes equating to about sixteen hours of staff time away from the wards per day.

With the introduction of the porter there was a significant drop off in clinical time away from the ward and also improved timeliness with the porter delivering on demand.

As a result of this test of change the Trust agreed to employ a TTA porter over the winter period with a view to writing a business case to employ a TTA porter permanently. This business case is now under consideration.

Reduction in time away from wards - top 4 roles



Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15 continued

Bed pans

Torbay Hospital is interested in product innovation. For the public, new or improved products can improve and change the way people use services. For health and care professionals product innovation can help them to do their job better or differently.

As part of the Horizon Institute, we have a small group of innovation experts and an innovation support group who work with any potential innovator. After ideas have been sufficiently worked up these are presented to the innovation panel whose role is to decide whether the idea is suitable for investment.

One recent idea from a junior doctor came in the form of a new design of bed pan. The idea came about when the doctor observed a nurse carrying faeces out of a side room with only paper towels covering the waste. He then realised this was a common practice and came up with a simple solution to improve the existing design – a lid. After approaching the innovation support group and subsequently presenting to the innovation panel, a company was found to work with the Trust to design an improved bed pan. The bed pan is now on sale.

Part of the revenue from these products is split between the Inventor and Trust. We have also started to work with patients who come forward with ideas for new products.

Patient experience continued

Snapshot of a selection of our improvement projects in 2014/15 continued

Horizon Institute

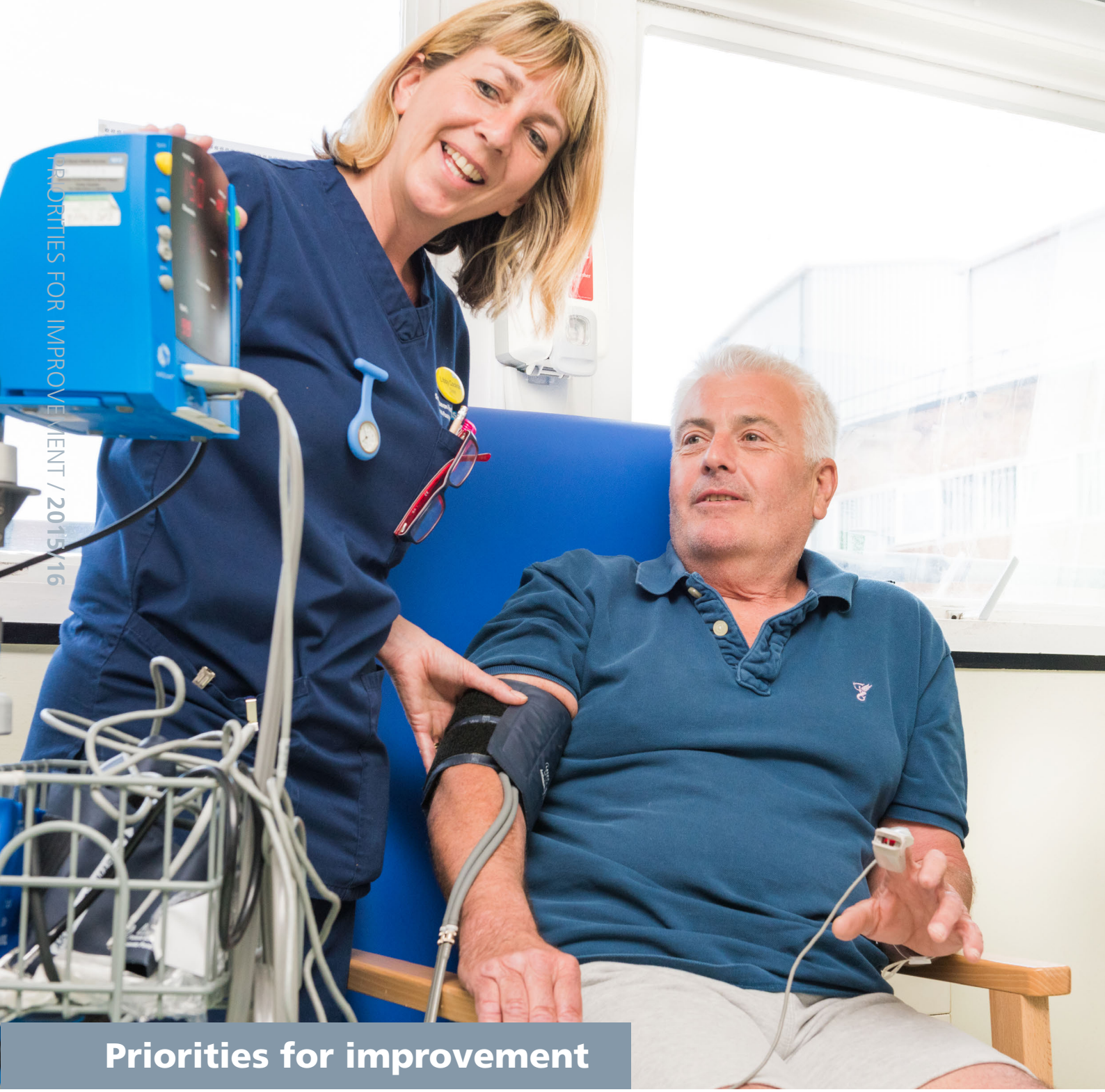
A major initiative to stimulate and encourage innovation and improvement was the establishment of the Horizon Centre in 2009. It is a multidisciplinary centre that brings innovation, education & research together and enables staff to conduct research, test new ideas and embed changes through education.

The Horizon Institute has recently been established to drive improvement. Setup in late 2014, it brings existing quality improvement and innovation experts from Torbay and South Devon together into one team. Many of the projects described in this annual quality account have been supported by these people.

The purpose of the Institute is to support front line health and care teams with improving the outcomes and experiences of people who use our services through innovation and quality improvement.

Its work includes training staff in improvement methodology and working with front line teams supported by improvement coaches. The Institute will also be an academic base for improvement science, encouraging service evaluation and measurement for improvement.

Most importantly the Horizon Centre and the Institute exist to promote a positive culture; a culture where staff come to work to do a good job today but think about how to make it better tomorrow.



Priorities for improvement

Looking forward: 2015/16

The Trust has identified five quality improvement priorities for the year. These have been developed through discussions with clinical teams, care colleagues, our commissioners and the senior clinical and business leaders in our organisation.

In recognition of the development of a joined-up care system we have worked closely with Torbay and Southern Devon Health and Care NHS Trust to develop a shared set of improvement priorities. We have also taken into account the views of key stakeholders when discussing and agreeing the priorities for 2015/16. (See annex 1) These priorities have been signed off by both Trust boards.

In brief the improvement projects are:

Patient safety

Priority 1: redesigning the reliability, accuracy and timeliness of information at the point of handover to enable an effective and safe transfer at each and every juncture

During a patient's stay it is often necessary to transfer the care of that patient to another hospital, care agency and/or another department/ward within the hospital.

These handovers are described as a transfer of care and, as such, need to be planned and properly performed to ensure the patients' wishes and safety remains paramount. Evidence has shown that poor communication at these handovers can have detrimental effects on the patients' health and harm can occur e.g. medications not being sent home with patients and next of kin details not available.

The aim of this safety initiative is to design a reliable and capable process, for these transfers that involves the patients and carers, health professionals and relevant agencies in passing on and receiving the relevant information, medication and equipment at each and every juncture.

The initiative is being designed in collaboration with acute and community hospitals, community care providers, patients and family members and the relevant multidisciplinary teams across a number of health sectors in producing a transfer care bundle that is fit for purpose, understandable and completed in a timely and reliable way.

Objective 2015/16: create and test a 'transfer of care bundle' across a number of pathways with direct patient/carer involvement

Individual objectives:

- Understand the size, number and scope of transfers within the health and care community and the issues that affect the transfer.
- Include patient, relative and carer involvement in the design.
- Design a 'transfer of care bundle' and test extensively making changes and re testing based on in situ learning.

Our plan will be to focus on transfers occurring between wards and departments, transfers occurring between community services and Torbay Hospital as well as our hospitals and nursing homes.

The Deputy Directors of Nursing at both Trusts will lead this work, supported by their Patient Safety Leads. Progress will be monitored quarterly through the Joint Leadership Group, an Executive group of staff from both the acute hospital Trust and the community Trust.

Patient experience

Priority 2: establish a single point of contact for people to access community based health and social care services in Torbay

The aim of setting up this new service is to make it as easy as possible for people to access the advice, assessment and support which they need over the telephone. This will include providing information about local services as well as undertaking assessments with people while they are on the phone and agreeing to arrange and provide support and assistance at home on the basis of the telephone call.

The service will also provide people already receiving services with a direct line of communication if they want to discuss any aspects of those services or have concerns about the care they are receiving.

The new single point of contact service (SPoC) will also support health and social care staff working out in the community by coordinating and arranging services to provide urgent care and support at home to avoid the need for someone to be admitted to hospital or a care home.

Care Direct Plus, which already serves Southern Devon, and the SPoC will provide support for people who are likely to need one-off or short term interventions and would not normally need to be visited at home as part of the assessment process.

Objective 2015/16: set up a single point of contact service (SPoC) in Torbay

Individual objectives:

- Set up the single point of contact for Torbay.
- Set up a directory of services that contains up to date information about the services and support which are available to people in Torbay. This directory will be created and run by voluntary sector organisations and will be available to the public on the internet. Measure and monitor the changes and evaluate the first year of its operation. People who use this service will be involved in the evaluation process.
- Develop linkages between the single point of contact service and specialist long term condition services based at Torbay Hospital.
- Improve the understanding of the aims of the single point of contact service and Care Direct Plus service with the Torbay Hospital ward teams and the long term condition specialist teams.

The Chief Operating Officer of Torbay and Southern Devon Health and Care NHS Trust will lead this work, supported by the relevant Assistant Director of Operations and the South Devon Healthcare NHS Foundation Trust Associate Medical Director (Long Term Conditions and Transformation). Progress will be monitored quarterly via the Joint Leadership Group.

Patient experience

Priority 3: improve the involvement of carers in the management of medications on admission and at discharge at Torbay Hospital and at our community hospitals

At Torbay and Southern Devon, we believe that carers are key members of the health and care team and we are committed to improve the involvement of all carers in all aspects of a patient's journey.

Carers are often the people who know their family members best and are an invaluable source of support and information. Information sharing is a two way process. Clinical staff need to understand a patient's background and health, and if admitted to a hospital, any medications being taken. Prior to their loved ones discharge, carers need information about changes to medication regimes, possible side effects and methods of administering the drugs.

Feedback from the national NHS inpatient survey tells us that most hospitals perform poorly in ensuring people are given appropriate information about medications at discharge. We have chosen to focus on working with carers and to build on the good work carried out in 2014/15.

Objective 2015/16: to test the process for identifying and involving carers in medicines reconciliation and planning medication regimes for discharge

Individual objectives:

- Design a reliable process to identify carers when patients are admitted to a ward in a community hospital or at Torbay Hospital.
- Design and test with carers, pharmacy and the ward teams a reliable process to involve carers in medicines reconciliation on admission.
- Design, test and develop a process to include carers' involvement in discharge medication regimes including medication changes, side effects and modes of administration.

The initial focus will be to design and test a process on two care of the elderly wards. We will then test the process in a community hospital and in a further two wards at Torbay Hospital. Carers will be co-designers in the change and support the evaluation of the project through post discharge surveys.

The work will be led by the Carers Lead supported by the Deputy Directors of Nursing from the two Trusts, as well as ward and pharmacy teams. Quarterly updates will be provided through the acute and community Joint Leadership Group.

Clinical effectiveness

Priority 4: improve multi-agency working across Torbay and South Devon through developing and extending the existing multi-disciplinary teams working across the community

Multi-disciplinary teams typically include community nurses, physiotherapists, occupational therapists and social workers.

Their joint aim is to provide people at risk of admission to hospital or care homes with the intensive support they need to remain living safely at home.

These multi-disciplinary teams will complement the work of the Single Point of Contact service in Torbay and Care Direct Plus in South Devon. The multi-disciplinary team will provide support for people whose circumstances are uncertain or require face to face contact to assess their needs and coordinate the care they need.

Objective 2015/16: Develop and extend the multi-disciplinary teams in Torbay and the complex care teams in South Devon, through integrated working with clinicians in Torbay Hospital and developing closer working relationships with other local services. This includes GPs and local voluntary organisations.

Individual objectives:

- Set up two multidisciplinary teams, one for Torquay and one for Paignton and Brixham.
- Pilot in at least two localities (one in Torbay and one in South Devon) to see how these multidisciplinary teams can be supported by specialist teams. This may involve moving out-patient clinics and other clinical support activities from Torbay Hospital out into the community.
- Pilot in at least two localities how these enlarged multi-disciplinary teams can work in partnership with other local services, including general practice and voluntary organisations.
- Measure, monitor and evaluate the changes including the impact of the enlarged multi-disciplinary teams on patient/client experience. People who use this service will be involved in the evaluation process.

The work will be led by the Chief Operating Officer of Torbay and Southern Devon Health and Care NHS Trust, supported by the relevant Assistant Director of Operations and the South Devon Healthcare NHS Foundation Trust Associate Medical Director (Long Term Conditions and Transformation). Quarterly updates will be provided through the acute and community Joint Leadership Group.

Clinical effectiveness continued

Priority 5: create a reliable and consistent ambulatory emergency care service available 7 days a week for patients coming to Torbay Hospital

The underlying principle of ambulatory emergency care is that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day either without admission to a hospital bed or through admission for only a few hours.

Nationally many organisations have implemented ambulatory emergency care as part of an action plan to address the non-achievement of the 4-hour standard in A&E. Ensuring 95% of patients spend less than 4 hours in the emergency department has been a significant challenge for the Torbay Hospital, particularly over this last year.

As part of a larger piece of work to try and address this problem and to improve the patient experience of emergency care, small tests of change have been in operation on the two Emergency Assessment Units since July 2014.

Our plan is now to expand the ambulatory emergency care service to ensure only those people who require bed based care are admitted and ensuring medical patients receive assessment by a physician as soon as possible after attending. In addition it is anticipated that this will significantly improve patient flow through the emergency department and healthcare system.

Objective 2015/16: create a reliable and consistent ambulatory emergency care service available 7 days a week

- Provide an Ambulatory Emergency Care Unit comprising eight chairs and four trollies within two bays on an Emergency Assessment Unit that will be open seven days a week.
- Reduce the proportion of medical patients requiring an overnight stay when safe and appropriate to do so.
- Improve the experience of emergency care for medical patients seen within the Ambulatory Emergency Care Unit.
- Reduce the number of bed days utilised by patients with ambulatory case sensitive conditions.
- Contribute to an improvement in patient flow through the emergency department as measured by achievement against the four hour standard.

Within the Care Trust work will focus on improvements in community based intermediate care services through developing a standardised crisis assessment process.

The ambulatory emergency care work will be led by a Consultant in Acute Medicine, supported by the Systems Manager (Acute & Community Care) and the Chief Operating Officer at Torbay Hospital.

The Care Trust will be led by the Pathway Manager (Integrated care) supported by the Torbay and Southern Devon Health and Care NHS Trust Medical Director.

Quarterly updates will be provided through the acute and community Joint Leadership Group.

Statements of assurance from the Board

Review of services

During 2014/15 South Devon Healthcare NHS Foundation Trust provided and/or sub-contracted 44 relevant health services.

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

The income generated by the relevant health services reviewed in 2014/15 represents 84% of the total income generated from the provision of relevant health services by South Devon Healthcare NHS Foundation Trust for 2014/15.

The data and information reviewed and presented covers the three dimensions of quality, namely patient safety, clinical effectiveness and patient experience.

Statements of assurance from the Board continued

Participation in clinical audits

For the purpose of the quality account, the National Advisory Group on Clinical Audit and Enquiries has published a list of national audits and confidential enquiries. Participation in these is seen as a measure of quality of any trust's clinical audit programme. The detail which follows relates to this list.

During 2014/15, thirty six national clinical audits and one national confidential enquiry covered relevant health services that South Devon Healthcare NHS Foundation Trust provides.

During 2014/15 South Devon Healthcare NHS Foundation Trust participated in 94% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that South Devon Healthcare NHS Foundation Trust was eligible to participate in during 2014/15 are as follows:

National Audits	Eligibility
Acute coronary syndrome or acute myocardial infarction	Yes
Adult cardiac surgery audit	Yes
Adult critical care (case mix programme) (ICNARC)	Yes
Bowel cancer	Yes
Cardiac rhythm management	Yes
Chronic kidney disease in primary care	No
Chronic Obstructive Pulmonary Disease	Yes
Congenital heart disease (Paediatric cardiac surgery)	No
Coronary angioplasty	Yes
Diabetes (Adult) ND(A)	Yes
National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric)	Yes
Elective surgery (National PROMs Programme)	Yes
Epilepsy 12 audit (Childhood epilepsy)	Yes
Falls and fragility fractures audit programme, includes national hip fracture database	Yes
Fitting child (care in emergency departments) (CEM)	Yes
Head and neck oncology (DAHNO)	Yes
Heart failure	Yes
Inflammatory bowel disease (IBD)	Yes
Lung Cancer (NLCA)	Yes
Maternal, newborn and infant clinical outcome review programme	Yes
National confidential enquiry into patient outcome and death	Yes
Mental health (care in the emergency departments) (CEM)	Yes
Mental health clinical outcome review programme: National confidential inquiry into suicide and homicide for people with mental illness (NCISH)	No
National audit of intermediate care	Yes
National cardiac arrest audit	Yes
National comparative audit of blood transfusion	Yes
National emergency laparotomy audit	Yes
National joint registry	Yes

Statements of assurance from the Board continued

National Audits continued	Eligibility
National vascular registry, including CIA and elements of NVD	Yes
National neonatal audit programme (NNAP)	Yes
Non–invasive ventilation (BTS)	Yes
Oesophago-gastric cancer	Yes
Older people (care in emergency departments) (CEM)	Yes
Paediatric intensive care	No
Pleural procedures	Yes
Prescribing observatory for mental health (POMH-UK) (Prescribing in mental health services)	No
Prostate cancer	Yes
Pulmonary hypertension	No
Renal replacement therapy (Renal Registry)	No
Rheumatoid and early inflammatory arthritis	Yes
Sentinel Stroke National Audit Programme (SSNAP), includes SINAP	Yes
Severe trauma (Trauma Audit & Research Network)	Yes

Statements of assurance from the Board continued

Participation in clinical audits

The national clinical audits and national confidential enquiries that South Devon Healthcare NHS Foundation Trust participated in during 2014/15 are as follows:

National Audits	Participation
Acute coronary syndrome or acute myocardial infarction	Yes
Adult cardiac surgery audit	N/A
Adult critical care (case mix programme) (ICNARC)	Yes
Bowel cancer	Yes
Cardiac rhythm management	Yes
Chronic kidney disease in primary care	N/A
Chronic Obstructive Pulmonary Disease	Yes
Congenital heart disease (Paediatric cardiac surgery)	N/A
Coronary angioplasty	Yes
Diabetes (Adult) ND(A)	N/A
National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric)	Yes
Elective surgery (National PROMs Programme)	Yes
Epilepsy 12 audit (Childhood epilepsy)	Yes
Falls and fragility fractures audit programme, includes national hip fracture database	Yes
Fitting child (care in emergency departments) (CEM)	Yes
Head and neck oncology (DAHNO)	Yes
Heart failure	Yes
Inflammatory bowel disease (IBD)	Yes
Lung Cancer (NLCA)	Yes
Maternal, newborn and infant clinical outcome review programme	Yes
National confidential enquiry into patient outcome and death	Yes
Mental health (care in the emergency departments) (CEM)	Yes
Mental health clinical outcome review programme: National confidential inquiry into suicide and homicide for people with mental illness (NCISH)	N/A
National audit of intermediate care	N/A
National cardiac arrest audit	Not participated
National comparative audit of blood transfusion	Yes
National emergency laparotomy audit	Yes
National joint registry	Yes
National vascular registry, including CIA and elements of NVD	Yes
National neonatal audit programme (NNAP)	Yes
Non–invasive ventilation (BTS)	Not participated
Oesophago-gastric cancer	Yes
Older people (care in emergency departments) (CEM)	Yes
Paediatric intensive care	N/A

Statements of assurance from the Board continued

National Audits continued	Participation
Pleural procedures	Yes
Prescribing observatory for mental health (POMH-UK) (Prescribing in mental health services)	N/A
Prostate cancer	Yes
Pulmonary hypertension	N/A
Renal replacement therapy (Renal Registry)	N/A
Rheumatoid and early inflammatory arthritis	Yes
Sentinel Stroke National Audit Programme (SSNAP), includes SINAP	Yes
Severe trauma (Trauma Audit & Research Network)	Yes

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

- Cardiac arrest
  Due to a £1000 subscription fee the Trust decided not to participate.

- BTS – Non Invasive Ventilation
  BTS advised that there would be no data collection in 2014/15 despite being on the national list.

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 2014/15, 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.

Statements of assurance from the Board continued

South Devon Healthcare NHS Foundation Trust	Cases submitted	% cases
Acute coronary syndrome or Acute myocardial infarction (MINAP)	tbc	
Adult critical care (Case Mix Programme) (ICNARC)	699	100
Bowel cancer	204	100
Cardiac Rhythm Management	547	100
Chronic Obstructive Pulmonary Disease		
Organisational Report	48	100
Excaerbations Report	47	100
Coronary angioplasty	394	100
National Diabetes Inpatient Audit (NADIA)	49	100
Diabetes (Paediatric)	120/105	88
Epilepsy 12 audit (Childhood Epilepsy)	8	100
National Hip Fracture Database (FFFAP)	430	100
Fitting child (care in emergency departments) (CEM)	50/10	20
Head and neck oncology (DAHNO)	56	100
Heart Failure	Not Known	Report not yet published
Inflammatory Bowel Disease (IBD) -		
Inpatient Care	50/15	30
Organisational	1	100
Lung Cancer (NLCA)	49	100
Mental health (care in the emergency departments) (CEM)	50	100
National comparative audit of blood transfusion –		
2013 Audit of Anti-D Immunoglobulin Prophylaxis	25/20	80
National emergency laparotomy audit – organisational report	1	100
National Joint Registry	790	100

Statements of assurance from the Board continued

South Devon Healthcare NHS Foundation Trust	Cases submitted	% cases
National Vascular Registry, including CIA and elements of NVD – Outcomes after elective repair of infra-renal abdominal aortic aneurysm	87	100
National Neonatal Audit Programme (NNAP)	320	100
Oesophago-gastric cancer	122	100
Older people (care in emergency departments) (CEM)	100	100
Pleural procedures	8/14	175
Prostate cancer	1	100
Rheumatoid and early inflammatory arthritis	Not known	Report not yet published
Sentinel Stroke National Audit Programme (SSNAP), includes SINAP	tbc	
Severe trauma (Trauma Audit & Research Network)	305	100

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Cases submitted	% cases
Remedial Factors in the care of patients undergoing tracheostomy insertion	8	100

Statements of assurance from the Board continued

The reports of twenty one national clinical audits were reviewed by the provider in 2014/15 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions

0082-02 Severe sepsis & septic shock

- Introduction of sepsis box
- Improve triage processes which runs from 0800 to 2000 every day and is staffed by a trained nurse and HCA, using a triage tool which is nationally validated but has been adapted for use here (ROSE tool). It is noteworthy that we have also submitted a business plan to extend this triage process across 24 hours.
- Educate staff - Induction sepsis talk/handover/sepsis posters.
- Regular review of sepsis performance.
- IT support through new IT system allowing bundle to be highlighted at point of clerking.

0027-07 SSNAP

- Review nursing establishment across the pathway.
- Consider specialist doctor ward rounds as part of Trust wide consultant weekend working.
- Direct admission to stroke unit. Meet with Emergency Department. Reinforce ring fencing policy with Executive.
- Check agreement with Podiatry regarding review within five working days and access to diabetic/non-diabetic patients.
- Consider 6-7 day therapy working as part of cross-organisational therapy review.
- TIA clinic. Dependent on recruitment of additional Stroke Consultants and being considered as part of 7- day service.
- Forthcoming Integrated Care Organisation offers opportunity for joint education across the acute and community Trusts. Consider in-house/training/hosting.
- Ensure patient version of local standards is available across pathway.

0030-06 Adult Asthma (Local report)

- As per British Thoracic Society (BTS) guideline, patients should be advised to attend their GP surgery within 48 hours of discharge. Highlight to junior doctors particularly on Midgley Ward to ensure timely and appropriate follow up.
- Registered nurse to highlight role and referral system within the Emergency Department to increase number of follow ups which should reduce the rate of re-admission.
- Repeat audit during next BTS National Asthma Audit period.

0031-04 National Clinical Audit of inpatient care for adults with ulcerative colitis (UK Inflammatory bowel disease IBD) audit

- Remind all staff of the following actions via email reminder from IBD Clinical Lead to the whole IBD team and cascaded to ward and teams by consultant staff
  o Stool samples for patients with diarrhoea and Ucon admission.
  o Nutritional screen during admission.
  o Bone protection with steroids.
  o Clear follow up plan in notes.

0031-07 National Audit of Inflammatory Disease (IBD) Service Provision/Organisational audit (round 4) Sept 2014

- IBD Standard A12, a named co-ordinator should be responsible for the preparation and oversight of transition from paediatric to adult service. Policy and protocol should be written. Non-compliance with standard to be raised with Divisional Managers Medicine and Paediatrics.
- IBD Standard A2 'The IBD service should have access to a defined psychologist and or counsellor with an interest in IBD'. Whilst patients with IBD can access the above by referral to the service there is not a defined psychologist or counsellor with an interest with IBD. Explore with therapies lead to see if this can be implemented.

Statements of assurance from the Board continued

0056-03 Pleural procedures 2014

Reminder to staff-
- Ensure that all patients have documented consent for chest drain insertion.
- Ensure that all people inserting chest drains know what needs to be documented in the notes post insertion.
- Make sure that all patients have chest drain charts.
- Documentation of saline flushes to the chest drain needs to be improved.
- The volume of fluid drained in the first hour needs to be accurately documented.

0120-01 National chronic obstructive pulmonary disease (COPD) programme site level organisational audit report October 2014

- Develop a respiratory High Dependency Unit.

0121-01 Inpatients falls pilot results 2014

- Fear of falling - OT's have been trialing FESI/fear of falling stickers in medical notes in three areas. Plan to roll out Trust wide to ensure we comply with NICE guidelines.
- Provide falls training for medical staff through corporate induction and F1 training.
- Lying and standing blood pressure - increase ward based training, 3rd measurement requested to be added to vitalpac and monthly falls audit to demonstrate patients have this taken in clinical practice.
- Assessing for vision - both doctors and nurses to ask if patients have had eye test in the last 12 months. Add onto falls assessment and include in training.
- Bedrail assessment- new shorter assessment form, training on wards and 'stop and think' signs to stop inappropriate use/confused patients falling from a height. Possible short teaching video.
- Audit/review new bedrail assessment in place since June 2014 as part of fallsafe audit. Identify any falls from bedrails. Trial new assessment in several community hospitals.
- Hi-lo beds - decide on hire or purchase options, identify any funding and put procedures in place to help reduce harm from falls.
- Identify executive and non-executive director leads for leadership and support on falls initiatives.
- Renewal of inpatients falls policy to include new NICE guidelines and links to other relevant policies and community.
- Implement fallsafe monthly audit to ward areas with electronic data collection to help keep falls on agenda, improve patient care/compliance with falls initiatives and reduce falls rate.

0107-01 NELA organisational report of the national emergency laparotomy audit May 2014

- Audit of emergency theatre provision within previous two years: "We need to clarify what we are auditing."
  Action plan:
  - Pathway for the management of patients with sepsis.
  - Pathway for enhanced recovery of EGS patients.
  - At least bi-monthly reviews of all EGS deaths.
  - Policy that Consultant Surgeons formally hand over in person.
  - Formal handover time in shifts for other surgeons.
  - Policy that Consultant Anaesthetists formally hand over in person.
  - Formal handover time in shifts for other anaesthetists.
  - Critical Care Outreach availability 24/7.
  - Formal calculation of risk of peri-operative mortality.
  - Policy for anaesthetic seniority according to risk.
  - Policy for surgical seniority according to risk.
  - Policy for location of post-op care according to risk.
  - Explicit arrangements for review by Elderly Medicine.
  - Policy for deferment of elective activity to prioritise emergencies.
  - Policy for transfer of EGS patients to sub-speciality consultant.

Statements of assurance from the Board continued

0043-07 National hip fracture database (NHFD extended report 2014) (FFFAP)

- Improve % of patients admitted to Ainslie trauma ward within four hours - via fast track admissions and ring fencing 'hip fracture' beds on Ainslie.
- Use new web-based run charts to inform the monthly clinical governance meeting.
- Develop hip fracture programme using quality improvement methodology initially using Paignton cohort of fractured neck of femurs
- Audit of operative management of displaced intracapsular fractured neck of femurs and the use of SHS versus IM nail in intertrochanteric fractured neck of femurs
- Audit completion of the falls section of the electronic care planning summary and subsequent referral onto community teams.
- Audit the patients who are not being discharged back to their own home to identify common themes to direct potential.
- Develop quality improvement projects that can influence this standard.

0044-06 National lung cancer audit report 2014

- Ongoing participation in the national lung cancer audit with high quality data collection.
- Ongoing recording of clinical (or pathological where appropriate) staging and performance status to high levels.
- Improve the collection of data to include lung function and co-morbidity by collection of information at multidisciplinary team meeting.
- Continue to ensure pathological confirmation of diagnosis, aiming for >75% of histological confirmation with non-small cell lung not otherwise specified rates maintained <20%.
- Review of bronchoscopy indication if done pre CT (aiming for <5% patients to undergo bronchoscopy pre CT).
- Continue to consider surgery for appropriate patients with early stage disease. Consider additional assessments e.g. CPET for borderline patients.
- Continue to offer chemotherapy to appropriate patients with small cell lung cancer.
- Continue to offer chemotherapy to appropriate patients of good performance status with advanced non-small cell lung carcinoma.

0044-07 National lung cancer audit - mesothelioma

- Ongoing participation in the national lung cancer audit with high quality data collection.
- Improve the recording of clinical (or pathological where appropriate) staging of mesothelioma using the IMIG staging system, aiming for staging in >85% of patients.
- Improve the collection of data to include performance status and co-morbidity.
- Continue to ensure pathological confirmation of diagnosis, aiming for >85% of histological confirmation with subtype assessment in >70% of cases.
- Adequate access to a lung cancer nurse specialist throughout their illness and for >85% of patients to have the clinical nurse specialist present at the time of diagnosis.
- Continue to offer chemotherapy to patients with a good probability of survival.
- Improve access to clinical trials.

0042-05 National joint registry 11th Annual Report 2014

- Discuss the compliance and consent rates with surgical care practitioners who enter data into the registry and theatres to see if we can improve compliance rates and consent.
- Follow up results of local audit and feedback with further information.

0026-17 TARN clinical report II (orthopaedic injuries)

- Repeat BOAST 4 trauma audit once sufficient numbers of patients seen.

0026-18 TARN clinical report III (head & neck Injuries)

- Re-audit the time to CT report now that a standardised report form is in use.
- Continue to work to reduce time from arrival to CT to below 45 minutes by keeping team leaders aware of targets.
- Keep under review unexpected survivors or deaths at regular trauma multidisciplinary team meetings.

Statements of assurance from the Board continued

0035-05 National neonatal audit programme. Annual

- Induction for junior doctors. Dedicated session for Badger training to improve data input and quality. This is on-going and every four months.
- Electronic board in Special care baby Unit. The important audit points are highlighted and discussed by medical and nursing staff.
- Safety briefing - important screening issues are discussed in the morning safety briefing.
- Rapid cycle audit - this was conducted for six months in 2013/14 with the result that data input significantly improved. Further such audit is planned with a different audit question each month.
- Development of SCBU record form. A new record form has been developed which will be used for daily ward round. This has been developed in line with national audit standards to record all relevant information regularly.
- Repatriation Form - This helps in identifying all necessary data before accepting the infants back to our care from other hospitals. The form has been modified and improved over the last two years.

3. National paediatric diabetes audit report local 2011-12

- Implement a care pathway for the first two years of newly diagnosed patient's care.
- Achieve a structured program of patient selection and initiation on insulin pump start.
- Achieve a rolling plan of service improvement and education through our weekly meetings.
- Work towards a comprehensive self-management education programme.

0024-01 Why asthma still kills - The national review of asthma deaths - NRAD

- Improve liaison with the Emergency Department in order to pick up all presentations with acute asthma and arrange follow up with asthma nurse specialist in order to comply with recommendations.

0075-01 Society of Acute Medicine benchmarking audit (SAMBA) 2012 - A day in the life of the AMU

- Improve documentation; particularly of time that patient is assessed by the first doctor, senior doctor and Consultant. Attempt to achieve this via changing the clerking booklet with Consultant sign off on the post-take ward round documentation sheet. Action arose from 2012 Day in the Life Audit and was incorporated on target and before the 2013 audit.
- 2013 audit showed a lower than average number of patients seen in an ambulatory system. Although this audit did not include our ambulatory deep vein thrombosis patients, who do not come through the on-call/acute medicine route, ambulatory care is still an area requiring development and consultant acute physician is currently looking at the space, systems and processes needed to treat non-elective patients in ambulatory area, without admission to a bed or trolley. Scoping exercise due July 2014.
- 2013 audit also showed less than 100% documentation of consultant review time (i.e. time still not being documented on post take ward round page). Emergency Department/ Emergency Assessment Units are implementing an electronic records system in 2014 which will automatically record what time these entries are made. The system is expected to be in place by the end of the year.

0095-01 Accidental awareness during general anaesthesia in the UK & Ireland. Report & findings Sept 14 NAP5

- Develop practice guideline for use of depth if anaesthesia monitors - this is currently agreed but informal.
- Develop practice guideline for use of Propfol infusions outside of theatre for General Anaesthesia.
- Implement pathway for management of awareness under general anaesthesia.
- Establish department database for cases of awareness, review and learn from future cases through case analysis.
- Establish clear route of referral to clinical psychology for support in event of potential posttraumatic stress disorder, following awareness.
- Present report findings to Anaesthetic Department for further discussion and agreed actions.

0054-04 National heavy menstrual bleeding. Final report

- Produce written information around the options for women presenting with heavy menstrual bleeding.
- Review heavy menstrual bleeding protocols.

Statements of assurance from the Board continued

The reports of sixty nine local clinical audits were reviewed by the provider in 2014/15 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions

6296 Baseline Respiratory Assessments for Patients with a Motor Neurone Disease (MND) Diagnosis.

- No action required

6356 GP Blood Transfusions Appropriateness & Best Practice

- Develop a universal admission/ booking pro-forma for community transfusions to improve documentation
- 'Lab' to send blood out in the morning so transfusions can be completed in daylight hours
- Produce clear guidelines (addendum to 0219) to aid prescribing e.g. speed of transfusion, recommended number of units for body weight, pre + post Hb etc.
- Increase awareness of iron infusions as a lower risk alternative to blood transfusion for Iron deficiency anaemia, we will look into the possibility of providing this in the community
- Explore setting up a pre-op optimisation clinic to reduce to the need for post-op transfusions
- Nursing education to help support safe community transfusion practice to include possibility of nurse prescribing course for transfusion

6314 Young people attending Emergency Department (ED) where alcohol, violence or drugs are a factor

- Take results to Paediatrics team
- Display posters in ED
- Disseminate findings to all ED staff by e-mail
- Include a section on this pathway in the next junior doctors training session

6317 Safeguarding children in A&E

- Staff education regarding completion of consideration of safeguarding to be highlighted to all staff and incorporated into new rotational staff induction
- Undertake safeguarding as 'Topic of the Week' so that it will be highlighted in every handover for a week

6318 Electrocardiogram (ECG) timing in A&E

- Door to ECG time <10 minutes to be extended to <20 minutes through local consensus
- Introduction of a rapid access pilot will help speed up response times

6344.Management of hypoglycaemia in the Emergency Department (ED)

- Education of medical and nursing staff working in ED with regards to management of hypoglycaemia and documentation - ED Consultants to provide this education at the daily board rounds
- Simplified flow-chart guideline to be displayed in the department with the aim of standardising management
- Liaise with diabetes team to amend guideline so that it states that either 40ml 20% glucose or 100ml 10% glucose can be given - department tends to stock 10% glucose rather than 20%
- Include a prompt on paperwork so that hypoglycaemia management is initiated at triage if blood glucose reading is low - likely to be incorporated once the paperwork becomes computerised

6311 NICE BCA - Golimumab for the treatment of rheumatoid arthritis after the failure of previous disease-modifying anti-rheumatic drugs (DMARDs) (TA-225)

- No plan required

6328 NICE BCA -Topotecan for the treatment of relapsed small-cell lung cancer (TA 184)

- No plan required

Statements of assurance from the Board continued

6329 NICE BCA - Pemetrexed for the maintenance treatment of non-small-cell lung cancer (TA-190)

- No plan required

6368 Initial antibiotic prescribing and review at 48 hours in the acute setting

- Launch 'Start Smart then Focus' campaign
- Distribute campaign materials; posters, screen savers - plan to put message out via intranet, e-mail and via board rounds etc.
- Drug chart has already been redesigned to facilitate 'Start Smart then Focus' and the 'App' has been updated with newer versions coming through
- Update antimicrobial intranet website with 'Start Smart then Focus' strategy
- Launch mini campaign through teaching, induction, posters, laminated algorithms, website and 'App'

6387 Hyperosmolar hyperglycaemic state management and adherence to recent Joint British Diabetes Society guidelines

- Design HHS pro-forma to maximise medical therapy

6365 Risk Assessment of young people (YP) <16 years by Torbay sexual medicine service

- No plan required

6133 Safeguarding quality in children's notes

- Feedback results of audit to paediatric nursing team.
- Review of two - three case notes each month to be undertaken and disseminate learning from these e.g. take learning points to paediatrician supervision
- Once there are two consultant paediatricians on for admissions and ward from 9am-9pm ensure:
  - o Transparent process where previous information is reviewed and documented that this has been done
  - o Paediatric consultant overview of cases held by other specialties e.g. CAMHS.
  - o Review notes in ward round to clarify who consultant paediatrician for that admission is and have transparent documentation

6300 Tranexamic acid (TXA) in total knee replacement

- New guideline to be produced along with haematology and orthopaedics for the use of TXA in all elective hip or knee replacement surgery (currently being ratified)

6334 Removal of tracheal tubes by PACU staff (Day Surgery Unit)

- No plan required

6335 Critical care nasogastric tube

- No plan required

6348 Airway skills in new anaesthetic trainees

- Good performance maintaining airway and ventilating using a face mask during induction for a list should be counted in lieu of one facemask anaesthetic
- Opportunities for trainees giving face mask anaesthesia to be maximised whenever feasible

6349 Quality of prescribing 'pre-meds' in the surgical admission setting

- Amend current drug charts.
- The amended chart will decrease the opportunity for multiple prescribing.
- Remove the prescription box on the in-patient Galaxy paperwork

Statements of assurance from the Board continued

6399 Antibiotic prophylaxis and tourniquet inflation for total knee replacements

- No plan required

6325 Management of otitis externa in primary and secondary care

- A newsletter will be issued to all GPs after reference to CCG to remind them of treatment available and recommended for otitis externa

6330 Objective hearing aid verification using real ear measurement (REM)

- Reminder issued to all staff of the need to clearly record why REM did not happen and/ or tolerances were not met in patient notes:
  o E-mail to all staff
  o Presentation to meeting

6336 Cricothyroidotomy

- Local guidance needs to be developed approved by ENT, Paediatric, A&E and Anaesthetic departments

6353 Vestibular schwannoma

- No plan required

6360 Implementation of an acute tonsillitis/ quinsy protocol

- Introduce adapted algorithmic protocol

6370 Pre-populated functional endoscopic sinus surgery (FESS) consent form sticker

- Introduce pre-populated FESS sticker to cover all risks

6290 Urology re-admissions

- Create clear and easily accessible guidelines regarding the management of the common causes for urological re-admissions

6324 Initial investigation for renal calculi on acute surgical take

- Discussion required with Emergency Department clinical lead with a view to considering and possible introduction of a 'Stone pathway'
- Consideration must be given to production of a poster and/ or a guideline that can be added to the general surgery intranet

6337 Holmium laser in urology at Torbay ~ 1st year results

- No plan required

6339 Eye casualty service in Torbay Hospital

- A review must take place to ensure short term follow up space is available within general clinics
- Casualty doctors must take ownership of patients with multiple short-term follow ups. This can be achieved by allowing juniors to book patients to see themselves as part of their normal clinic. The outcome can be monitored by prospective self-collected data from the juniors on the number of patients they follow-up themselves with the outcome of either discharge, escalation to consultant involvement or booked back into general clinics.
- Re-audit should include looking at how many clinic spaces are free the next day to book patients in and record how much time is spent dealing with telephone enquiries

Statements of assurance from the Board continued

6354 Lucentis in diabetic macular oedema

- Awareness of the guidance and the care pathway needs to be improved amongst all staff. This has been completed through presentation of this audit at a teaching session.
- Facilitate collection and recording of LogMar consider review in cacular clinic
- Make it a standard element of the process to question patients about any side-effects or adverse events that may have occurred during the course of treatment and record this clearly in the notes
- Closer supervision of non-consultant and locum consultant staff working in the medical retina clinics

6371 Retinopathy of prematurity screening 2012-2013

- No action required - consideration will be given to having a named nurse responsible for identifying ROP patients, this may enable special attention for transfers in

6275 Referrals for paediatric general anaesthesia extraction and the need for repeat general anaesthesia

- Review the referral form and how it arrives with oral and max fax surgery and the paediatric clinic
- Agree a protocol for the use of x-rays pre-general anaesthetic extractions

6319 'WHO Checklist' compliance for general and local anaesthetic in O&MFS

- Remind all operating staff of need to complete checklist. This (re)education completed by way of audit meeting presentation and issue of meeting notes including the PowerPoint to all staff
- Legibility of surgeon signature on checklist. Noted that some F1 & F2 staff have stamps, can they be made generally available? (Confirmed that stamps are not being made available) Amend checklist for O&MFS LA operations

6320 Accuracy of theatre listing and information for O&MFS

- Audit meeting agreed and re-affirmed that consent form should be signed before day of surgery for elective cases. This will be considered again as part of the re-audit for project ref 6202
- Educate administrative staff regarding completion of Galaxy list to enter teeth to be extracted in the comments field so that the data is not lost if patients are cancelled/ cancel.
- Clinicians listing patients must record teeth to be extracted whenever possible, if total clearance is expected this can be recorded

6375 Grave's disease - Indications, management and complications

- No plan required

6326 Seating of the ceramic liner for trident acetabulum

- No action needed

5997.Referral quality on discharge when requesting adult care

- Working with Care Direct Plus, a trial of processes and referral form will be undertaken. Five wards are participating in the initial trial; Acute - Cheetham Hill, Ainslie and Ella Rowcroft, Community - Totnes and both Newton Abbot wards. Trial will be evaluated and then next tranche of wards will be 'brought on board'
- A multidisciplinary team health needs assessment completion process is to be trialled at Brixham. If benefits discovered by way of timely and safe discharge, consider introduction at Paignton. This cannot be rolled into the other community sites due to their different use of referral forms and process (My Devon). The results from Brixham will inform whether there is any potential/ possibility of a similar system being brought into/ considered within acute wards

6277 Note Keeping (2013/ 14)

- Adjust audit tool and criteria to reflect Trust minimum note keeping standards
- E-Learning. Confirm with Education department that the e-learning continues to be included as part of the Mandatory training

Statements of assurance from the Board continued

- Send out a general reminder to all staff via the staff bulletin/ key stakeholders to ensure they are aware of the minimum standards and where to access them and also the elearning which is mandatory
- Keep Junior Doctor knowledge up to date regarding note keeping training, minimum standards and audit via e-mail
- Consider the introduction of 'use of stamps' as part of monthly NHS-LA ward checks
- Posters/ notices produced as part of the audit completed last time around should be 'reenergised' and then used at teaching sessions and audit/ effectiveness meetings to highlight results and minimum standards. The poster/ notice should also be available to all wards as introduced as a result of the last audit when this was attached to note trolleys
- Cascade results to all Clinical Directors, Associate Directors of Nursing and Ward Managers
- Junior doctors to ask if a review of one set of notes can be included in their teaching sessions

6299 Appropriate management of hypomagnesaemia with concurrent proton pump inhibitor (PPI) use

- Message to be added to Cyberlab for all magnesium results <0.5 to prompt clinicians to review PPI therapy. "Use of PPIs can cause hypomagnesaemia. If on a PPI please review"

6313 Ward compliance with protected mealtimes policy

- Present findings of the audit to the Nutrition Steering Group and matrons meeting
- Consider and convene a small working group to lead on improvement issues identified
- In the absence of a re-audit of this project, smaller, focussed audits and/ or quality improvement projects should be considered/ recorded

6342 TEP (treatment escalation plan) compliance

- Feed results into TEP working group.
- Feed results back to all specialties via clinical audit meetings

6355 Proton pump inhibitor prescribing in adults

- No plan required

6340 Paediatric spasticity management (CG-145)

- Through regular workshops at Bidwell Brook, Mayfield and John Parkes Unit (JPU), offer postural management training for carers
- PRE and strengthening strategies must be trained-in
- Work on a business plan to allow for intensive blocks of treatment, ensuring staff location taken account of
- Provide Administration staff time/ hours to support NICE Spasticity management pathway and database
- Publish local physio NICE Spasticity management pathway with checklist indicating compliance

6333 Breast sepsis prescribing

- Better education needs to be provided for junior doctors and GP's with regards to antibiotic management of breast abscesses
- Raise awareness of Trust guideline ref: 0040 at F1 teaching

6373 Wound Infection following breast surgery

- No plan required

6304 Serum bilirubin level and bilirubin results

- No plan required

6309 Bacterial meningitis and meningococcal septicaemia (CG-102)

- No plan initiated

Statements of assurance from the Board continued

6346 Attention deficit hyperactivity disorder in children and young people (CG072)

- No plan required

6347 Newly diagnosed diabetes in paediatrics

- Develop and initiate a care pathway for the first two years after diagnosis for paediatric patients with type 1 diabetes

6382 Neonatal heart murmurs

- Amend paediatric cardiology referral form to incorporate new-born murmur guideline

6274.Obesity in pregnancy

- Disseminate to all midwives via team leaders meeting and minutes
- Discuss at antenatal/ postnatal clinical governance sub-group
- Publish findings in clinical governance newsletter
- Trust policy to be updated
- Pro-forma to be amended to add:
  - o Tissue viability issues
  - o Bed
  - o Mattress
  - o Advice re mobility, hydration
- Complete spot checks every month to ensure we are improving

6298 Ovarian cancer survival

- No action required

6301 Use of Novasure for heavy menstrual bleeding

- No action required

6302 NICE Ovarian cancer: the recognition and initial management of ovarian cancer (CG-122)

- No plan required

6312 Methotrexate treatment for an ectopic pregnancy

- No plan required

6323 Severe pre-eclampsia

- No action required

6343 Pre-Term labour guideline

- Summary of magnesium sulphate usage, following regional meeting, to be given at Perinatal meeting
- Pre-Term labour policy to be updated

6350 Teenage pregnancy pathway

- Discuss results at team leaders meeting
- Public Health midwife to continue follow-up re multi-agency meetings on a monthly basis
- Ensure new staff aware of pathway at induction

6351 Pre-operative pregnancy assessment prior to gynaecological surgery

- No plan required

Statements of assurance from the Board continued

6352 Trial of assisted delivery and full dilatation caesarean section

- No plan required

6366 VTE Prophylaxis in post-natal obese women who deliver by caesarean section

- Highlight findings in clinical governance newsletter
- Raise at "AN/ PN clinical governance sub-group"

6379 Use of oxytocin

- Highlight to staff the importance of documenting assessment prior to syntocinon administration and use of sticker by disseminating results to team leaders meeting and clinical governance newsletter

6380 Fetal blood sampling

- Remind midwives to document fetal blood sampling results on CTG trace
- Remind doctors to document the requirements and when the next fetal blood sampling will be taken
- Disseminate to team leaders
- Include findings in clinical governance newsletter

6385 Postnatal care (QS-037)

- Remind the Team Midwifery Care Associates who make up post natal notes to add the contact sticker to all. Give a supply of the five teams contact stickers to Delivery Suite to add to any record with no sticker.
- Delivery midwife to add three stickers to notes on discharge.
- Team midwives to carry a stock of stickers
- Add to clinical governance newsletter as a reminder to staff to complete the management plan. Also midwives are being reminded as part of the growth assessment protocol training.

6390 Clinical risk assessment (labour)

- Remind all staff the importance of completing the risk assessment in the labour notes.
- Provide findings to all midwives via team leaders
- Discuss at Delivery Suite Clinical Governance sub-group
- Publish findings in clinical governance newsletter

6391 Antenatal clinical risk assessment

- Remind all staff the importance of:
  - o Documenting 2nd risk assessment
  - o Documenting smoking, alcohol and drug history at booking and mid trimester
  - o Asking Whooley questions/ assessing mental health status mid trimester and documentation of assessment
  - o Documenting accept/ decline use of blood products in an emergency for woman and baby
  - o Documenting discussion of information sharing
  - o Provide findings to all midwives via team leaders
  - o Discuss at antenatal Clinical Governance sub-group
  - o Publish findings in Clinical Governance newsletter

6332 Accuracy of pre-operative axillary ultrasound

- Agreed not to do repeat fine needle aspirations, patient should have core biopsy instead
- Recommend more patients are offered core biopsy from the outset

6357 Transient ischaemic attack protocol in Torbay Hospital

- Protocol maybe being used inappropriately so clinician can get scans same day - education needed
- Many referrals for MRI scan don't seem to have been discussed with correct people - radiologists need to refer back

Statements of assurance from the Board continued

The reports of two national confidential enquiries were reviewed by the provider in 2014/15 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

0100-1 On the Right Trach? A review of the care received by patients who underwent a tracheomstomy (NCEPOD)

- Actions taken include designing a modified WHO checklist sticker to be placed in the notes upon tracheostomy insertion as a simple but effective method of ensuring that important patient, team and environmental factors are considered.
- A tracheostomy safety study module has been set up to improve staff competence and confidence in managing tracheostomies and their complications.
- Issue of surgical coding being addressed with a form to be completed at the time of tracheostomy for input into the surgical database.

1 Lower limb amputation (NCEPOD)

- Under recommendations by specialist commissioners, all major vascular amputation should be performed at an arterial centre. This will be RD&E. The movement of arterial surgery to RD&E is subject to the need to assure equity of access to vascular wards, theatre and ICU by all patients in the network. Furthermore, it is important to ensure that patients from Torbay will receive at least as good quality of care in Exeter as they currently receive at Torbay.
- Diabetic consultants do not currently have inpatient beds at Torbay. Currently diabetic foot problems are admitted under vascular and orthopaedic consultants. As specialist vascular commissioning will recommend that no inpatient vascular beds will remain at Torbay once reconfiguration has occurred, the Trust will need to urgently discuss with Orthopaedic, Vascular and Diabetic consultants how these patients will be cared for.
- Prior to reconfiguration, diabetic patients admitted under Vascular and Orthopaedic consultants with limb threatening ischaemia or infection must be seen promptly by the diabetic team. Surgeons to refer all diabetic inpatients team by electronic referral with review within 24 hours.
- Discussion with Anaesthetic and ICU teams have already occurred regarding pre-operative pain relief, use of intra-operative nerve blocks and need for escalation of care. This should be on-going.
- As relatively few amputations are performed at Torbay, it may be unrealistic to expect physiotherapists to attend a weekly multidisciplinary team meeting. There should however, be a greater readiness to involve physiotherapists early in the care of patients admitted for elective major amputation.
- In view of the potential changes with vascular reconfiguration, the role of a co-ordinator for amputees total care should be considered. It may be that Vascular Specialist Nurses could fulfil this role in the future.

Statements of assurance from the Board continued

Research

The number of patients receiving relevant health services provided or sub-contracted by South Devon Healthcare NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was one thousand five hundred and ten.

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 three hundred and eighteen clinical research studies during 2014/15 in thirty three medical specialities.

Sixty five clinical staff participated in research approved by a research ethics committee at South Devon Healthcare NHS Foundation Trust during 2014/15. These staff participated in research covering thirty three medical specialties.

In the past year more than eight 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.

2014-15

Stroke – National TWIST Study
Torbay took part in the first UK randomised controlled trial assessing the feasibility, cost effectiveness and acceptability of the Nintendo Wii SportsTM in stroke rehabilitation. Patients who were suffering from arm weakness following a stroke were randomised to receive six weeks arm exercises / physiotherapy versus using the Wii for six weeks. Results showed patients in both group demonstrated improvement in their arm function at six weeks and six months in comparison to baseline. However there was no significant difference or change in arm function scores between the two groups. Similarly there was no difference seen in occupational outcomes, motor activity or quality of life scores between the two groups. The economic analysis overall showed that the Wii was a more expensive option compared to the arm exercises.

Prostate Cancer: National MRC PR07 study
Torbay Hospital participated in this study between 1997 and 2005. Long-term results recently published have confirmed that adding radiotherapy to the treatment of men who have high-risk prostate cancer improves survival. Adding radiotherapy to long-term hormone therapy halved the risk of men dying from prostate cancer within eight years. The combination of radiotherapy and hormone therapy is now an increasingly common approach to treating men with locally-advanced prostate cancer who are fit enough for radiotherapy. It's very encouraging to see that the benefits of adding radiotherapy to prostate cancer treatment are maintained over the long-term and helping to save thousands of lives.

Statements of assurance from the Board continued

Research continued

INTREPID study

Locally patients participated in the international INTREPID study looking at radiotherapy to the back of the eye in patients with age related macular degeneration. Initial results showed that patients who received radiation treatment needed 30% fewer injections of the standard Lucentis therapy and those with smaller lesions required only half the number of injections over a two year period compared to patients who received no radiation therapy.

Patients who received radiation therapy had similar levels of vision compared to standard care and those with smaller lesions often had better eyesight throughout the two years period after receiving radiotherapy compared to those that did not, despite having fewer Lucentis treatments. Minor abnormalities of the retinal blood vessels were found which arose as a result of the radiation treatment itself but did not usually affect eyesight.

Statements of assurance from the Board continued

CQUIN payment

A proportion of South Devon Healthcare NHS Foundation Trust income in 2014/15 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 relevant health services, through the Commissioning for Quality and Innovation payment framework.

Details of the 2014/15 CQUINs can be found in this report.

In 2014/15 the potential value of the CQUIN payment was £4,079 000 and income subsequently received was £4,041 000. In 2013/14 the potential value of the CQUIN payment was £3,793,615 and the income subsequently received was £3,300,073.

In 2015/16 the value of the CQUIN payment is £4,551,000 (tbc).

Care Quality Commission

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

- Diagnostic and screening procedures.
- Family planning services.
- Management and 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.
- Termination of pregnancy.

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 2014/15.

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

The Trust received no unannounced visits from the Care Quality Commission during 2014/15 as part of its routine monitoring programme.

Data quality

Data quality is a key enabler in delivering high quality services. Data and information which is accurate, timely and relevant allows teams to make informed decisions about care and the use of resources.

The Trust has a Data Quality Group led by the Head of Health Records. Areas the group focus on include monitoring the Trust data quality dashboard, reviewing data quality policies and procedures and tasking the Information Reporting Management Group to review key data quality issues. This group has been set up over the last twelve months to ensure all parties (finance, performance and information, informatics and operational leads) talk through issues and agree joined up and standardised approaches to data management and quality.

The Performance and Information team collate and analyse a range of safety, performance and experience data providing reports to the Trust Board and to service areas. Recent developments include bringing data sources together to ensure that all reports run off the same standard dataset.

Statements of assurance from the Board continued

NHS number and general practitioner registration code

South Devon Healthcare NHS Foundation Trust submitted records during 2014/15 to the Secondary Users' service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data, as of January 2015 (Month 10), which included the patient's valid NHS number was:

- 99.5% for admitted care
- 99.8% for outpatient care
- 97.9% for accident and emergency care

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

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

Information governance

South Devon Healthcare NHS Foundation Trust information governance assessment report overall score for 2014/15 was 90% and was graded green.

Statements of assurance from the Board continued

Clinical coding

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

HB – Orthopaedic Non-Trauma Procedures

Clinical Coding – Provisional				
Area	**% diagnoses incorrect**		**% procedures incorrect**	
	Primary	**Secondary**	**Primary**	**Secondary**
Orthopaedic non-trauma procedures	2.0	3.96	0.0	11.9

LB – Urological and male reproductive system procedures and disorders

Clinical coding				
Area	**% diagnoses incorrect**		**% procedures incorrect**	
	Primary	**Secondary**	**Primary**	**Secondary**
Urological and male reproductive system procedures and disorders	7.0	5.6	11.3	21.7

The results of the coding audit should not be extrapolated further than the actual sample audited.

Statements of assurance from the Board continued

Data quality improvements: looking back

South Devon Healthcare NHS Foundation Trust committed to take the following actions to improve data quality in 2014/15:

- **Implement the new emergency department IT system by December 2014.**

  Over the last 12 months work has been undertaken to implement the new IT system within the emergency department and although the planned 'go live' has been delayed it remains a priority for 2015/16. The system will introduce paperless ways of working within the department to ensure the right information is captured at the right time in close proximity to where the patient is being treated.

- **Implement the clinical portal across the hospital to support clinical teams accessing patient information by March 2015**

  A small pilot with the cross community heart failure service has been undertaken to ensure the clinical portal is able to be used widely across the organisation following which it is aimed to share more widely with the various clinical teams this year and remains a priority for 2015/16 with deployment commencing in March 2015 as planned.

- **Procure clinical coding audit software to facilitate the increasing number of coding audits undertaken in a year and define a further detailed coding audit programme by September 2014**

  Over the last year audit software has been purchased and an ongoing clinical coding audit programme within the organisation has been introduced.

- **Act on the recommendations of the three data quality audits undertaken from the Trust Board's performance dashboard indicators.**

  Internal Audit have undertaken three data quality audits reporting their provisional findings in February 2015.

Internal Audit data quality audits 14/15

Cancer – two week wait from referral to date first seen

Extract from report
A total of forty electronic patient records were reviewed from two different months to confirm that each had been correctly recorded and reported as a cancer patient on the waiting list, and that the waiting time from referral had been correctly calculated from the date of receipt of the referral to the date of their first appointment for all cancer types, suspected or actual.

Positive assurance can be provided for the data quality for this indicator, based on the sample findings.

Risks identified: controls in place are appropriate/effective to control risks associated with this area.

Audit recommendation: none – control operating/compliant

Pressure ulcers (categories 2,3 & 4)

Extract from report
A sample of three months of Safety Thermometer survey returns were reviewed on which new pressure ulcer details are recorded and submitted by the wards each month.

From the sample, pressure ulcer data is being accurately recorded, categorised and accurately reflected in the monthly dashboard figures.

As part of testing three different ward managers were also approached who were involved in the recording of the monthly Safety Thermometer Survey sheets. All those managers displayed in depth knowledge of pressure ulcer control and displayed very good patient awareness and confidence in being able to accurately record the necessary data in line with Trust policy and supporting guidance.

Internal Audit were also able to directly verify the data submitted for the December Survey by visiting one of the wards in the afternoon to check back to patient notes and bed numbers.

Statements of assurance from the Board continued

Data quality improvements: looking back continued

Risks identified: Low harm

Audit recommendation: Individual completed monthly ward sheets for Safety Thermometer Survey returns should be reviewed for accuracy prior to external submission and ultimately reflected in the Performance Dashboard presented to the Trust Board

It is also recommended that ward sheets are submitted electronically in excel rather than pdf copies to enable more efficient and accurate merging within the master return via the in-house developed program.

Diagnostics tests – longer than the 6 week standard

A total of 54 electronic patient records were reviewed from the 3 main clinical areas (Imaging / Physiology / Endoscopy) from which the sample was aimed at the 14 different reported diagnostic procedures covered by the Census Central Returns to NHS England across those areas. By this Audit ensured coverage of 6 of those procedures as per the below:

Imaging area – MRI procedures / CT Scans / Ultrasound
Physiological Measurement area – Audiology Assessments / Peripheral Neurophysiology
Endoscopy area - Colonoscopy procedures

The sample was taken from all valid patients who had been on the waiting list at the end of the Census reporting month of September 2014, to confirm that each had been correctly recorded and reported as a patient on that waiting list, and that the waiting time had been correctly calculated from their taken referral date to the date of their diagnostic procedure appointment. Positive assurance can be provided for the data quality for this indicator, based on the sample findings.

Risks identified: Controls in place are appropriate/effective to control risks associated with this area.

Audit recommendation: None – control operating/compliant

- **Act on the recommendations of the three data quality audits undertaken by the external auditor in May 2015 as part of the Trust's annual quality account.**

  The indicators are:

  - Compliance with WHO surgical checklist. This is an indicator chosen by the Trust governors.
  - The WHO surgical checklist is an internationally recognised tool to improve the safety of surgery by reducing deaths and complications. The checklist identifies three phases of an operation - before the induction of anaesthesia ("sign in"), before the incision of the skin ("time out") and before the patient leaves the operating room ("sign out"). In each phase, a checklist coordinator must confirm that the surgery team has completed the listed tasks before it proceeds with the operation.
  - Non-compliance of the checklist is through exception reporting at the Theatre Programme Board. The checklist data (time-out) is collected via the Galaxy Theatre system. Over the last 12 months our recorded compliance was 99.7% from the Galaxy Theatre system.
  - Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.
  - This indicator relates to consultant led referral to treatment times and specifically the number of patients still waiting to start their treatment within 18 weeks.
  - All urgent two-week wait GP referrals, which receive first definitive treatment for cancer within 62 days of the date at which the referral was received.
  - The national NHS cancer plan (2002) and national cancer reform strategy (2007) introduced specific national cancer waiting standards. One of these is ensuring that patients are treated within 62 days of receipt of GP urgent suspected cancer referral.

Statements of assurance from the Board continued

Data quality improvements: looking forward 2014/15

South Devon Healthcare NHS Foundation Trust will be taking the following actions to improve data quality in 2015/16:

- Implement the new emergency department IT system by August 2015.
- Implement the clinical portal across the hospital to support clinical teams accessing patient information by October 2015.
- Review health record documentation used on the wards and introduce standardised forms for admission and discharge by October 2015. The creation of a central corporate clinical documents forms library will also be undertaken as part of this activity.
- Integrate the performance reports combining both acute and community information by March 2016.
- Publish a business intelligence strategy for the newly developed integrated care organisation by October 2015. This will include a review of data quality.
- Reduce the number of clinical coding errors by acting on the audit recommendations from the clinical coding audit and re-auditing in autumn 2015.

Mandated quality indicators

Patient safety

Quality indicator	Source	National target	2014/15	2013/14	2012/13	2011/12	End of year performance against target
VTE risk assessed	UNIFY	95%	91%*	94%	92%	n/a	

**Quarter 4 figures are not yet published as of the 13/5/2015*

In 2014/15 the lowest performing trust was 81% and the highest was 100%. The national average was 96%

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information reported nationally and reported at Trust Board.

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services through:

- Making VTE mandatory on the electronic discharge information system as this is the data source for national returns.
- Piloting e-prescribing which will incorporate VTE, removing the need to record information twice.

Number of clostridium difficile cases *(rate per 100,000 bed days)*	HSCIC	n/a	Not published*	12.6	16.9	19.9	

**HSCIC has not published the 2014/15 data as of the 8/5/2015. The latest published data is 2013/14.*

In 2013/14 the lowest performing trust was 0 and the highest was 37.1. The national average was 13.9.

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information reported nationally via the Trust Performance and Information Team.

South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this rate, and so improve the quality of its services through:

- Improvements to the physical estate to improve cleanliness and deep cleaning.
- Programme of deep cleaning using decant ward.
- Hand washing and infection control escalation management.

Number of never events	Safeguard	0	2	2	2	0	

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported nationally and at Trust Board.

South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number to zero and so improve the quality of its services through:

- Full and transparent reporting including full root cause analysis and investigation.
- Providing assurance to Board that any recommendations have been implemented.
- Undertaking external audit of the WHO surgical checklist.

Mandated quality indicators continued

Patient safety continued

Quality indicator	Source	National target	2014/15	2013/14	2012/13	2011/12	End of year performance against target
Number of patient safety incidents	Safeguard	n/a	5546	5188	4506	4854	n/a

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is recorded on Trust incident reporting system.

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services through:

- Continue to positively promote incident reporting within the Trust to all staff.
- Appointment of governance pharmacist.

Quality indicator	Source	National target	Apr 14-Sept 14*	Oct 13-March 14	Apr 13-Sept 13	End of year performance against target
Number & % of such patient safety incidents that resulted in severe harm or death.	HSCIC	n/a				
Number			1	3	4	n/a
%			0%	0.14%	0.18%	n/a

**Latest published HSCIC data*

For the period April – Sept 14 the highest performing Acute (non-specialist) Trust for incidents resulting in severe harm or death was 0 and the lowest was 97. The average was 20.

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is recorded on Trust incident reporting system and reported nationally.

South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services through:

- The Trust continuing to promote and open and honest culture where incidents, of any nature, can be reported and understood.
- Through the use of Human factors training, particularly through the Theatre Terma work, a positive safety culture continues to be built.

Mandated quality indicators continued

Clinical effectiveness

Quality indicator	Source	Benchmark (National)	2014/15	2013/14	2012/13	2011/12	End of year performance against benchmark
% of patients aged readmitted to hospital within 28 days	Dr Foster		Nov 13-Oct 14	April 13 - Mar 14	April 12-Mar 13	April 11 - Mar 12	
• 0-15			6.39%	5.84%	5.23%	5.04%	
Relative risk for patient 0-15		100*	89.77	83.57	76.7	77.01	
• =>16			7.71%	7.68%	7.81%	7.53%	
Relative risk for patients => 16		100*	97.36	96.89	98.35	99.65	

**Figures for 0-14 did not include babies 1 – 365 days – all previous data has been adjusted*

The data used to benchmark readmission rates is taken from Dr Foster. The relative risk score represents how the Trust performs against the national benchmark of 100. Overall the Trust performs better than the expected rate based on the national benchmarking and has seen an overall improvement in the last year.

The national average benchmark is 100

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported via the Trust Performance and Information Team.

South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services through:

- Continuing to monitor readmission rates as a system indicator of performance.
- Readmissions rates are included in specialty clinical benchmarking reviews carried out with specialty teams.
- Incorporated in evidence for clinical revalidation and appraisal where relevant.

Our performance against mandated quality indicators

Clinical effectiveness

Quality indicator	Source	National target	2014/15	2013/14	2012/13	2011/12	End of year performance against target
Summary hospital mortality indicator (SHMI)	Dr Foster	100*	98.38	92.91	95.58	96.97	
Hospital Standardised Mortality rate (HSMR)	Dr Foster	100*	100.3	94.5	92.6	95.0	

The Summary Hospital-Level mortality Indicator, or SHMI, is a measure that takes account of a number of factors including a patient's condition. It includes patients that have died in hospital or within 30 days of being discharged from hospital. The SHMI score is measured against the NHS average which is 100.

The Hospital Standardised Mortality Ratio or HSMR is a measure of death recorded in hospital benchmarked against other hospitals.

For SHMI and HSMR a score below 100 denotes a lower than average mortality rate and indicates good, safe care.

SHMI data is published in arrears so the latest data is for the period July 2013 to June 2014

The highest SHMI score = 119. The Lowest Trust score = 54. National average = 100

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported at Trust Board.

South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services through:

- Continuing to monitor outcome benchmarks led by the Director of Patient Safety.
- Maintaining strong clinical governance systems with peer mortality review programme.

Mandated quality indicators continued

Patient experience

Quality indicator	Source	National target	2014/15	2013/14	2012/13	2011/12	End of year performance against target
% of patient deaths with palliative care coded at either diagnosis or speciality speciality level	HSCIC		July 13-June 14	April 13-Mar 14	April12-Mar 13		
SDHFT coding %			18.8%	19.5%	15.5%		

The Palliative care coding rate for recorded deaths at SDHFT has been consistent and is within expected levels. This rate is used as a data quality marker against the SHMI and HSMR benchmarking. Having palliative coding rates at expected levels gives greater assurance against the validity of the SHMI and HSMR values. A high rate of palliative care coding would indicate lower confidence in the SHMI.

Between July 13 – June 14 the highest trust rate was 49% and the lowest was 7.40%. The national average palliative care coding rate was 24.6%.

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

I• nformation is reported via the Trust Performance and Information Team.South Devon Healthcare NHS Foundation

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services through:

- Ensuring review of palliative care coding rates data collection and continuous improvements within clinical coding teams.

Mandated quality indicators continued

Patient experience

Quality indicator	Source	Benchmark (National)	2014/15	2013/14	2012/13	2011/12	End of year performance against benchmark
Patient Reported Outcome measures	HSCIC			April 13-Mar 14	April 12-Mar 13	April11-Mar 12	
Groin hernia surgery National average=0.085 Highest rate= 0.139 Lowest rate= 0.008			Not published*	0.073 adjusted average health gain	0.083 adjusted average health gain	0.089 adjusted average health gain	n/a
Varicose vein surgery			n/a due to low number	n/a due to low number	n/a due to low number	n/a due to low number	
Hip replacement surgery National average=0.435 Highest rate= 0.545 Lowest rate= 0.342			Not published*	0.417 adjusted average health gain	0.437 adjusted average health gain	0.392 adjusted average health gain	n/a
Knee replacement surgery National average=0.330 Highest rate= 0.416 Lowest rate= 0.215			Not published*	0.338 adjusted average health gain	0.329 adjusted average health gain	0.309 adjusted average health gain	n/a

**The latest national l PROMs data release covers the period April – Sept 14 (published Feb 2015). No adjusted health gain data has been published for our Trust. The 2013/14 data is the latest published national data for our organisation.*

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported via the Trust Performance and Information team.

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, through addressing areas requiring improvement:

- Implementation of clinical criteria agreed with commissioners for the treatment of patients where there is likely to be a low value clinical outcome.

Mandated quality indicators continued

Patient experience

Quality indicator	Source	Benchmark (National)	2014/15	2013/14	2012/13	2011/12	End of year performance against benchmark
Staff recommendation of the Trust as a place to work or receive treatment	Friends and Family Q12D	n/a	75	82	3.85	3.79	

In 2014 the national average for acute trusts was 3.67. the best score for acute trusts was 4.20. There was no lowest performing trust score.

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported nationally and to the Trust Board.

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, through addressing areas requiring improvement:

- Detailed action plan developed for areas of improvement, which also forms part of the 2015/16 CQUIN work.

Overall patient experience	NHS Inpatient survey	n/a	8.2	8.4	8.1	n/a	

In 2014/15 the lowest performing Trust was 7.2 and the highest was 9.2%. There is no national average.

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported nationally and to the Trust Board.

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services through:

- Learn from feedback received and action changes.
- Share compliments and patient stories at a range of meetings and through staff bulletins.
- Use real time feedback to augment the national inpatient survey.

In 2014/15 the Trust also received the results of the national A&E which is available from the Care Quality Commission website - http://www.cqc.org.uk/provider/RA9/survey/4#undefined

'The overall view of A&E experience for feeling their experience of being treated and cared for in the A&E had been good'. (7.5/10)

Mandated quality indicators continued

Patient experience

Quality indicator	Source	Benchmark (National)	2014/15	2013/14	2012/13	2011/12	End of year performance against benchmark
F and F: Inpatients	Friends and Family test		97% patients recommended	n/a	n/a	n/a	
F and F: A & E	Friends and Family test		81% patients recommended	n/a	n/a	n/a	

Source: NHS England – March 2015

For inpatients in March 2015 the lowest performing trust was 78% and the highest was 100%. The national average was 95%.

For A&E in March 2015 the lowest performing trust was 58% and the highest was 99%. The national average was 87%.

NHS England is now calculating and presenting the FFT results as a percentage of respondents who would/would not recommend the service to their friends and family. This change was introduced in the first publication of Staff FFT results on 25 September 2014 and across all existing patient FFT setting on 2 October 2014

South Devon Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported nationally and to the Trust Board.

South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services through:

- Promoting the Friends and Family test throughout the hospital.
- Conducting small tests of change to improve completion.
- Monitoring Friends and Family through the Trust contract.

Our performance in 2014/15

Performance

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 (CQC)
- 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 arrangements in place to monitor our organisational performance. This includes five governance work streams which report to the Trust Board.

The work streams are made up of senior clinicians, nurse leads, non-executive directors and executive directors. Governors attend as observers and the local commissioners attend both the safety and experience committees.

The Trust Board receives monthly board reports, a data dashboard and a detailed data book indicating our latest performance and actions to address issues. We meet with commissioners to share information, provide updates and to review our performance monthly. Our regulator 'Monitor' requires a quarterly performance assessment against the performance standards set out in their risk assessment framework. This is published on the internet for the public to view.

Ratings at a glance

Continuity of services rating

Source: Monitor website 21/3/15

3

Governance rating

Under review

Our performance against key national priorities

Monitor

Overview of the quality of care based on Trust performance

The Trust collects a large range of data to inform the quality of care provided by the organisation. Board level indicators are chosen to meet Monitor's requirements as well as the NHS operations framework. The quality measures are subdivided into safety, effectiveness and experience to ensure a balanced range of quality measures.

Indicator/Target	Quality Indicator	Target 14/15	14/15	13/14	12/13
C.difficile year on year reduction (Monitor)	Safety	11	4*	17	21
C.difficile year on year incidences (Public Health England)	Safety	11	24	17	21
MRSA - Meeting the MRSA objective	Safety	0	0	1	1
Cancer 31 day wait from diagnosis to first treatment	Effectiveness	96%	98%	98%	98%
Cancer 31 day wait for second or subsequent treatment: surgery	Effectiveness	94%	97%	98%	97%
Cancer 31 day wait for second or subsequent treatment: drug treatments	Effectiveness	98%	100%	99%	100%
Cancer 31 day wait for second or subsequent treatment: radiotherapy	Effectiveness	94%	98%	97%	98%
Cancer 62 day wait for first treatment (from urgent GP referral)[A]	Effectiveness	95%	90%	90%	88%*
Cancer 62 day wait for first treatment (From consultant led screening service referral)	Effectiveness	90%	94%	97%	96%
Cancer two week wait from referral to first seen date	Effectiveness	93%	96%	95%	97%
Cancer breast symptoms two week wait from referral to first seen date	Effectiveness	93%	95%	96%	98%
A&E – total time in A&E	Experience	95%	87%	96%	96%
Referral time to treatment time, admitted patients	Experience	90%	80%	90%	92%
Referral time to treatment time, non admitted patients	Experience	95%	95%	96%	96%
Referral to treatment incomplete pathways[A]	Experience	92%	93%	96%	96%

**c-diff - Only cases confirmed as lapse in care count towards target (New measure 2014/15)*

[A] Externally audited

Our performance against key national priorities

Performance exceptions in 2014/15

In 2014/15 the Trust has reported underperformance against two of the Monitor risk assessment indicators.

Total time in A+E as measured against the four hour standard

The Trust has declared ongoing risks against these standards whilst action plans to redesign services are completed. The Trust has engaged with external support from the national support teams to give the Trust Board and our regulators confidence that these plans address the issues affecting performance and provide robust plans for improving performance.

The challenges against the emergency pathways of care and managing the four hour maximum waiting time in A+E have been national phenomena in the last twelve months. The Trust along with other health communities is responding to an increasing demand for acute care and assessment particularly from our ageing population.

This requires a redesign of how the hospital capacity is used to most effectively meet the needs of these patients, as well as wider health and social care with the introduction of new pathways of care such as emergency ambulatory care and direct admissions to paediatric assessment beds.

Referral to treatment times for admitted patients against the 90% < 18 week standard

The Trust has had to respond to increases in waiting times in several specialties in 2014/15 and has not met the 90% standard for patients being admitted for treatment within eighteen weeks of referral or decision to treat.

Ophthalmology, treatment for cataracts, along with general surgery are the areas where the target has not been met. The plans to introduce the additional capacity needed to return these waiting times to less than eighteen weeks will be implemented in 2015/16. The Trust has used other local providers such as Mount Stuart Hospital and Derriford Hospital to support capacity in the interim whilst arrangements to increase capacity in these areas are implemented.

Mandated quality indicators

These are reported in part 2 of the quality account.

Our performance against key national priorities

NHS Operating Framework and local priorities

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

Smoking during pregnancy	Effectiveness	19%	16.%	17%	15%
Breastfeeding initiation rates (% initiated breast feeding)	Effectiveness	76%	74%	75%	76%
Mixed sex accommodation breaches of standard	Experience	0	3	12	1
Cancelled operations on the day of surgery	Effectiveness	0.8%	1.2%	1.1%	1.2%
DNA rate	Effectiveness	6.0%	5.6%	5.9%	5.9%
Diagnostic tests longer than the 6 week standard	Effectiveness	1.0%	1.3%	0.6%	1.0%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	64%	79%	79%
Summary hospital mortality indicator (SHMI)	Safety		98.38	92.91	95.58
Ethnic coding data quality	Experience	80%	94%	95%	94%

In 2015/16 we will meet the challenges of improving our performance against the A+E target through the action plans in place and further pathway redesign. The Trust will support the capacity needed to bring waiting times back to within eighteen weeks for admitted patients whilst working closely with GP's to ensure that demand for services are managed to the locally agreed pathways.

Stroke care will continue to be an area of focus for us. In order to reach the 80% target we will need to improve patient flow and discharge across the whole hospital. This will reduce the number of non stroke patients admitted to the stroke wards at times of increased pressure. This work will be overseen by the Trust's Patient Flow Board.

Patient safety and delivering quality outcomes will remain the highest priority to ensure that patients have access to, and receive, the best possible care. The Trust Board will ensure that governance arrangements will continue to provide the oversight and scrutiny against the quality and patient safety outcomes.

As we move towards an integrated care organisation in 2015/16, performance, quality and safety will remain our highest priority.

Annex 1

Engagement in developing the Quality Account

Prior to the publication of the 2014/15 quality account we have shared this document with:

- Our Trust governors and commissioners
- Healthwatch
- Torbay Council Health Scrutiny Board
- Devon County Council's Health and Wellbeing Scrutiny Committee
- Trust staff
- Carers Group
- Torbay and Southern Devon Health and Care Trust

As in previous years, we continue to hold an annual quality account engagement event inviting key stakeholders to come together and recommend the priority areas to be included in this year's quality account.

This year, for the first time, we presented the long list of priorities to the stakeholders alongside our care Trust colleagues with the aim of presenting one set of agreed care system priorities. This reflects our move in 2015/16 towards becoming a single integrated care organisation and our ambition to work in a more joined up way.

The feedback from the event continues to be positive with stakeholders feeling engaged in the development of the quality account and receiving feedback from the work undertaken in the previous year.

In 2015/16 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Devon County Council's Health and Wellbeing Scrutiny Committee on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15

Devon County Council's Health and Wellbeing Scrutiny Committee has been invited to comment on the South Devon Healthcare Foundation Trust Quality Account 2015/16. All references in this commentary relate to the reporting period 1st April 2014 to 31st March 2015 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account 2014-15 and believes that it is provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge. The Trust has not been invited to present to committee in the past year.

The Scrutiny Committee welcomes the progress made against the five priorities for improvement over the last year and particularly congratulates the Trust in progress against the 19% reduction in grade 3 and 4 pressure ulcers, achieving the 'Purple Angel' status for dementia training for staff and continued good performance in the friends and family test.

The enduring challenge from the Francis Review provoked to scrutiny has been to look for improvement in health care through critical friend challenge. In the climate of austerity this rigor becomes even more vital. The committee welcomes a continued positive working relationship with the Trust in 2015/16 and beyond to continue to ensure the best possible outcomes for the people of Devon.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Torbay Council's Health Scrutiny Board on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15

Due to Council elections and the timing of its submission for comment, Torbay's Health Scrutiny Board has not been able to consider South Devon Healthcare NHS Foundation Trust's Quality Account for 2014/15.

Overview and Scrutiny Committees are well placed to ensure the local priorities and concerns of residents are reflected in a provider's Quality Account. In line with this, Torbay's Overview and Scrutiny Board will welcome a continuation of the positive engagement process from the Trust in the coming year.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from South Devon and Torbay Clinical Commissioning Group on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15

South Devon and Torbay Clinical Commissioning Group (SDT CCG) is lead commissioner for South Devon Healthcare NHS Foundation Trust (SDHFT) and is pleased to provide our commentary on the Trust's Quality Accounts for 2014-15.

SDT CCG has taken reasonable steps to corroborate the accuracy of data provided within this account. We have reviewed and can confirm that the information presented in the Quality Account appears to be accurate and fairly interpreted, from the data collected regarding the services provided. The Quality Account demonstrates a high level of commitment to quality in the broadest sense and we commend it.

We are very pleased to see the extent of the Trusts participation in clinical audit and confidential enquires. We also note with interest the various improvement actions required as a result of the audits, and look forward to seeing next year's Quality Account report on the progress made and the improved outcomes.

Four local incentive schemes under Commissioning for Quality and Innovations (CQUINs) this year have been agreed with commissioners. These CQUINs will differ from previous years. They are multi agency, co designed CQUINs. They are patient, and staff focused, intended to improve experience, improve collaborative working across all of our providers, share expertise and knowledge and underpin the essence of joined up care. We are delighted that SDHFT have agreed to take part in this innovative way of working, and that they have been instrumental in developing and agreeing these quality improvements.

Looking Back

We were pleased to support the priorities selected by the Trust last year and in particular the initiative to reduce the numbers of patients who developed pressure ulcers whilst staying in the hospital and to reduce the number of people falling whilst in hospital care. Pressure ulcers cause pain and discomfort, and can cause infection. Preventing them from starting, and healing them quickly when they begin, is an important patient safety priority. We note that the Trust has seen a 19% reduction in the number of grade 3 and 4 pressure ulcers and this is to be commended. It is encouraging to see that the Trust is collaborating with other organisations to share learning across the local care system under the Pressure Ulcer Collaborative, and we will continue to monitor the incidence of pressure ulcers very closely.

The Trust has worked hard to reduce the number of hip fracture acquired in hospital, and whilst not hitting their target of 25% reduction, they did meet a 20% reduction which is a significant achievement.

The report highlights the work the Trust has done to improve the early identification of sepsis, which is a major cause of unexpected death in the UK. The implementation of the 'sepsis six' bundle within the first hour of initial diagnosis of sepsis is particularly welcomed, as is the work that the Trust have done working across care pathways, and in particular involvement with the system-wide pathway design for paediatric sepsis.

The work that supports bereaved relatives and families following the death of a loved one is excellent, and to be applauded as it supports a greatly improved experience for people during a very difficult time.

The initiative to roll out the 'enhanced recovery in medicine' onto all medical wards is noted. The CCG is very supportive of the principles of enhanced recovery. We would be very interested in hearing the results of the more detailed analysis that is being undertaken with Plymouth University and Pen CLAHRC about how the programme is improving the patient and carer experience.

The Trust reports that last year it sought to improve and support carers in the discharge planning process through better communication, involvement in discussions about medication, and addressing practicalities for

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from South Devon and Torbay Clinical Commissioning Group on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15 continued

carers. The Trust has undertaken a significant amount of work around these key areas and we are very pleased to see the improvements that have been made that are outlined in this quality account.

With respect to the CQUINS for 2014-15, we note that the Trust has reported in some detail on two of the eight schemes. One of these, the staff friends and family test (FFT) is of particular interest both nationally and locally as the NHS seeks to embed the FFT throughout the system. We are encouraged to see the positive comments from staff, and the high ranking of the organisation nationally and locally. However, it is disappointing to note that the Trust has not been able to achieve the level of patient feedback needed to meet the national targets for the Patient Friends and Family Test (PFFT) in A&E and inpatients during the year.

We support the Trusts renewed focus on achieving the target for FFT across the hospital, for patients and for staff, and we will continue to monitor the achievements against target in all departments.

Looking Forward

The CCG is happy to support the five quality improvement priorities chosen for next year as set out in the Quality Account. We approve and support the development of a shared set of improvement priorities with Torbay and Southern Devon health and Care NHS Trust (TSD) as we move towards a more integrated system.

The patient safety focus on redesigning the reliability, accuracy and timeliness of information at the point of handover to enable an effective and safe transfer each and every juncture is particularly welcomed. We look forward to working with both SDHFT and TSD to develop through a multi-agency CQUIN for 15_16 a series of 'Always Events', things that should always happen for patients, and for staff. This priority supports and enhances this.

General Comments

Quality Accounts are intended to help the general public understand how their local health services are performing and with that in mind they should be written in plain English. SDHCT have produced a comprehensive, attractive and well written Quality Account which is easy to read and clearly set out.

We feel that the Trust's attention to quality and safety is highly commendable and we are pleased to note the continued focus on patient safety. We have been informed of all the Serious Incidents and noted the two Never Events reported by SDHFT this year. We are keen to ensure that the learning taken from the thorough investigation of these events means that quality of care continues to improve across the Trust.

We were particularly pleased to see the Trust's response to the Francis recommendations. During our regular quality reviews we are continually given evidence of the Trust's determination to ensure safe, high quality care. There are routine processes in place within SDHCT to agree, monitor and review the quality of services throughout the year covering the key quality domains of safety, effectiveness and experience of care.

Overall we are happy to commend this Quality Account and SDHCT for its continuous focus on quality of care.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Governors on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15

In the coming year the Council of Governors will ultimately be responsible for taking any decision to form an integrated care organisation (ICO) in our area. An extensive programme of training has been received and ample opportunity for asking questions provided. Governors are now better placed to make a more informed, and therefore a better quality, decision in the interest of the Trust members and the wider community.

During 2014/15 the Council of Governors has continued to work closely with the board and has been kept informed about any incidents under the national heading of 'never events' as well as the high standards of treatment and patient care that were publicly recognised in previous governors' statements and which we reiterate now.

Reviews were undertaken to establish best practice for holding the non-executive directors (NEDs) to account. Among mechanisms in place to support governors' responsibility is the buddying system whereby each member of the governors' Nominations Committee is partnered with one of the NEDs. The lead governor remains the principal functional link between governors and the NEDs. Governors in general, and members of the Quality and Compliance Committee in particular, can communicate any matters related to NED performance to the chairman and the lead governor for inclusion in the annual appraisal of NEDs which they conduct jointly.

There is a governor observer on each of the five workstreams (and also on the Audit and Assurance Committee), which provide assurance on the quality of services offered at Torbay. The governor observer's role is to provide evidence that the workstream has considered the appropriate Care Quality Commission (CQC) outcomes as part of each meeting. The evidence is presented to every meeting of the Quality and Compliance Committee to gain a better overview of patient safety and quality of care. It also forms part of the documentation to be shown to the CQC inspectorate during any future visits. The governor observer role continues to be central to the governors' engagement with the quality and safety agenda and with the organisation's other areas of work including workforce, estates and facilities management. The practice of having governor observers in such active roles has been commended in the past by CQC inspectors. Governor observer seats are also available on five other committees/groups including Equalities Cooperative Group, Disability Awareness Action Group and Infection Prevention and Control Committee.

With regard to the annual quality account, representatives of the Council of Governors have again taken part as stakeholders in the annual process for agreeing Trust priorities for both boards. The governors are pleased to support the objectives framed for 2015/16 (see pages 30-35) as we move towards a more integrated health and social care system. As part of the Independent Auditor's Limited Assurance Report on the Annual Quality Report to the Council of Governors, the Trust's external auditors have reviewed several performance indicators. The two mandatory indicators under review are the 18 week referral to treatment and 62 day cancer treatment targets. Governors have also agreed that the external auditors should review compliance against the World Health Organisation (WHO) Safety Checklist.

The governors are again able to confirm that they continue to receive full assurance of the Trust's commitment to, and delivery of, improvement in the quality of care provided. We look forward to continuing to be part of the process and working together to improve the quality of care.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Healthwatch Torbay on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15

Healthwatch Torbay's role is to ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care (The Health and Social Care Act 2012). Our various ways of encouraging the public to provide feedback is building up a body of knowledge reflecting those views. This is the basis of our comment on this Quality Account.

There is always a challenge in creating a document which is aimed at both public and professional. We have been reassured that the final version will not be entirely text and thought given to explain medical terminology. 43% of English adult working-age population cannot fully understand and use health information using only text (Royal College of General Practitioners. Health literacy, 2014). Although not explicitly stated in this account as an aim, the Trust has shown its skill in producing attractive and creative information to support the public. We would specifically commend the caring behind the initiative to create the range of materials to support bereaved families.

Shared decision making is at the heart of NHS modernisation and probably one of the most difficult aspects of cultural change. The Account suggests that the Trust has taken this on board by putting in place the basic building blocks of patient dignity (being dressed in comfortable day clothes early in the day; including carers in ward rounds, discussion of care plans and discharge plans; ward awareness of dementia). This sits alongside the national drive "Hello, my name is ..." by the clinician and should support the growth of openness and transparency recommended by the Francis enquiry (Francis, R. Report of the Mid-Staffordshire NHS Foundation Trust public enquiry, 2013). Of all the Trust initiatives, this is probably one of the most important for Healthwatch Torbay to monitor through public reaction in the coming months.

The 2015/16 objectives set the scene for the joined-up care system. There are some significant strategic initiatives in this section. These will not happen overnight and the public will require clear information about modified pathways of care, in this the single point of contact as a priority for community based services is good news. Hopefully, there will be opportunity for shining examples of good practice. From Healthwatch Torbay viewpoint, the continued initiatives around involving carers (discharge, transfer and medication) is essential. This has an immediacy for individuals who can become lost and forgotten in the current fragmentation of care networks.

The real game-changers for 2015/16 are objectives around ambulatory emergency care services. The objectives indicate the level of system redesign required together with the involvement of all partners in health and social care. The 4hr waiting time, urgent care delivered in alternative ways, especially for children, are all high impact improvement initiatives in the public perception.

Overall, this Quality Account reflects the issues which are important to the public in Torbay. It is a good balance between small improvements, making a big difference to individual patients and carers, and the strategic vision with long-term implications. Healthwatch Torbay looks forward to being kept informed of progress and will play its part in keeping the public informed.

May 2015

Annex 1

Statements from Commissioners, Governors, OSCs and Healthwatch

Statement from Healthwatch Devon on South Devon Healthcare NHS Foundation Trust's Quality Account 2014/15

Healthwatch Devon welcomes the opportunity to provide a statement in response to the Quality Account produce by the SDHCFT this year. Our response is based on the feedback we receive about the quality of the services they provide and our involvement with the Trust.

Healthwatch Devon commends The Trust's achievements in relation to the priorities that were set for last year, in particular the patient experience priorities around bereavement and support for carers in the discharge planning process. Healthwatch Devon hears from carers and relatives across Devon who express concern about being listened to and involved when it comes to the person they care for leaving hospital or receiving end of life care.

Looking forward Healthwatch Devon is encouraged by The Trust's set of priorities for improvement which address the handover of information during transfer of care; the development of a single point of contact for information, advice, assessment and support and carer involvement in medication management. These are all topics that we hear about that can present difficulties for patients and carers, not only in South Devon, but across the County.

Hospital discharge has recently been the focus of community engagement for Healthwatch, both locally and nationally and our findings have been shared with Commissioners and local NHS Provider Trusts for their consideration and response. We found from people's experiences shared with us that concerns centred mainly around: timeliness of care assessments and care packages being in situ on return home; provision and quality of information provided to patients, carers and relatives; and coordination of care and communication between different organisations. SDHCFT has recently welcomed the findings of this latest consumer experience report and although only a small number of experiences relate directly to Torbay Hospital, the report and its findings are due to be considered by the engagement and experience group (Workstream 2) and we hope that the evidence presented in the report will help to inform service improvement going forward.

In respect of targets for A&E waiting times, we acknowledge that this situation mirrors what is happening nationally as well as in other parts of the South West. Healthwatch Devon recently reported its findings in relation to where people go if they are seeking non-urgent medical treatment and this report revealed that many people are unsure of their options and therefore go to A&E as a first choice. Others reported difficulties in getting GP appointments in Devon and others reported being signposted to A&E, when this was not necessary. These are all contributing factors that can have an impact on the capacity to treat people within targeted waiting times and therefore Healthwatch Devon recognises the need for multi agency commitment to improving access to the most appropriate care in a timely manner.

With regard to consumer feedback, the amount we receive that relates to SDHCFT is on the increase. With the imminent launch of our own online patient feedback centre, which Torbay, Plymouth and Cornwall also use, we will be able to directly share comments and experiences with the Trust as they are received.

A key function for Healthwatch Devon is to collect the views and experiences of patients, carers and the public about local health and care services and for these to be shared with those who commission and provide services on a regular basis. As such, Healthwatch Devon is committed to developing a dialogue with SDHCFT, through the emerging engagement and experience strategy, to ensure that all experiences and views that we capture, that relate to services that the Trust manages and delivers, are systematically shared with SDHCT and TSDHCT going forward and can be used to inform any work that is being undertaken to improve services for people now and in the future.

Annex 2

Statement of Directors' responsibilities in respect of the Accounts

The directors are required under the Health Act 2009 and the National Health Service (Quality accounts) Regulations 2010 as amended 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.

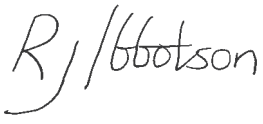
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014-15; and supporting guidance
- 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 2014 to June 2015
  - Papers relating to quality reported to the Board over the period April 2014 to June 2015
  - Feedback from the Commissioners (South Devon and Torbay CCG) dated 11th May 2015
  - Feedback from Governors dated 15th May 2015
  - Feedback from local Healthwatch organisations dated 11th May 2015 and 13th May 2015
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated January 2015
  - The 2014 national inpatient survey dated 21st May 2015
  - The 2014 national staff survey dated 24th February 2015
  - The Head of Internal Audit annual opinion over the Trust's control environment dated 27th May 2015
  - Care Quality Commission intelligence monitoring reports dated December 2014
- 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.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the quality report (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 report.

By order of the Board

Date: 27/5/2015



Sir Richard Ibbotson, Chairman

Date: 27/5/2015

Maired McAlinden, Chief Executive

Annex 3

CQUIN 2014/15 performance - full details & outcome available at www.sdhl.nhsuk

Goal	Objective	Q1	Q2	Q3	Q4
Severe sepsis	Improve the recognition, and timeliness and reliability of management of severe sepsis				
Safety thermometer	Reduce the prevalence of pressure ulcers				
Friends and Family -	Implement the Staff Friends and Family Test and act on feedback				
	Early implementation of the Patients Friends & Family Test Outpatients & Day Cases				
	Improve response rate of the Patients Friends & Family Test in A&E to - end of yr trajectory	n/a	n/a	n/a	
	Improve response rate of the Patients Friends & Family Test in inpatient areas to - end of year trajectory	n/a	n/a	n/a	
Bereavement	Improve the timeliness of information to GPs of patients who have died in hospital				
	Improve signposting of bereavement support for carers, families & children				
Patient flow	Set up and test a functioning assessment area where patients who may not need to be admitted can be assessed resulting in an agreed management plan initiated within 4 hours of registration				
Frailty	Identified clinical dementia lead with appropriate training for all staff including achieving purple angel status				
	Improve the % of patients over 75 admitted as an emergency screened for dementia, assessed and referred. *Target 90% - By end of yr 85%*				
	Identify and improve the top three areas of concern for carers involved in the discharge process				
	Complete the rollout of enhanced recovery on medicine				
	Pilot and evaluate a frailty / multi-morbidity measure (e.g. Edmonton score) or other identified way of capturing patient dependence across a pathway.				
Alcohol	Increase the % identified and screened by a minimum of 5%				
Yellow card scheme	Undertake a deep dive analysis of a current prevalent theme indicated through the Yellow Card system each quarter				

Available in large print on request

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NHS Foundation Trust

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