Quality Accounts for 2012/2013

PATIENT SAFETY
CLINICAL EFFECTIVENESS
PATIENT EXPERIENCE

South Devon Healthcare NHS
NHS Foundation Trust

ABOUT THIS DOCUMENT

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

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

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

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

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

If you need the document in a different format?

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

Getting involved

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

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CONTENTS

INTRODUCTION & STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

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

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

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

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

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

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

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

Paula Vasco-Knight
Chief Executive

PRIORITIES FOR IMPROVEMENT

Looking back: 2012/13

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

Patient safety

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

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

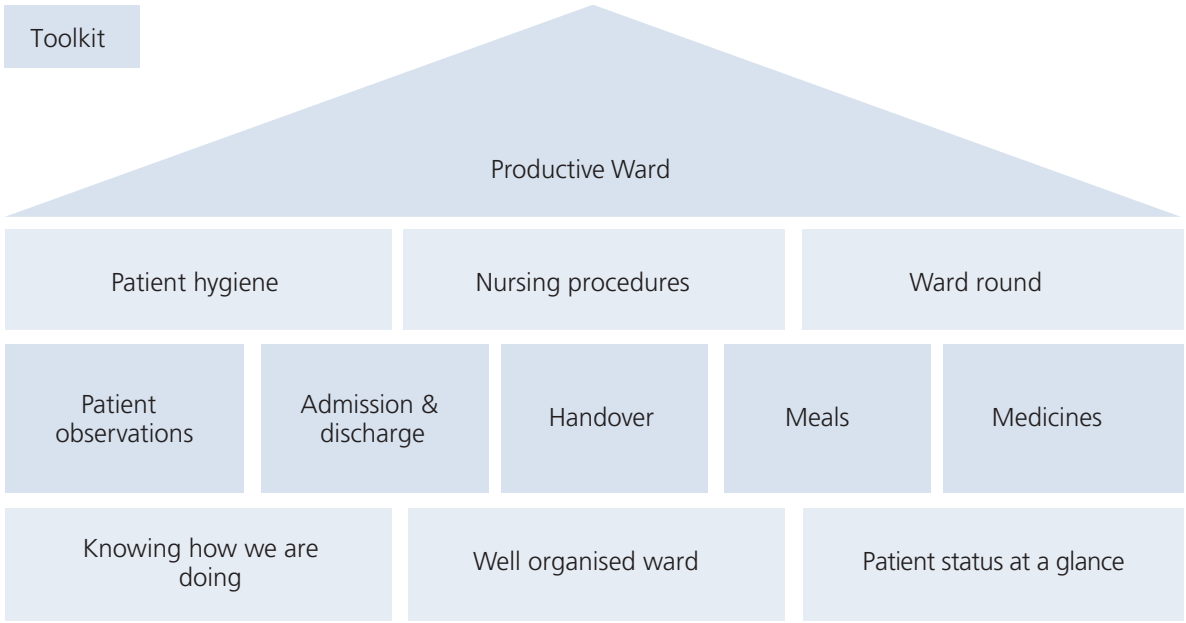
The ward team work through a number of modules from a national toolkit and this has been the second and final year of the Productive Ward programme as a standalone project.

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

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

> "THE PRODUCTIVE WARD HAS ALLOWED NURSES TO FEEL EMPOWERED TO MAKE CHANGES TO CARE.
> THE NURSING TEAM FEEL INVOLVED IN CHANGES THAT HAPPEN IN THE WARD AREA.
> IN ADDITION, THE PRODUCTIVE WARD IS A GOOD BENCHMARKING TOOL".
>
> Ward manager

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



Patient safety continued

Priority 1: continued

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

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

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

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

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

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

In 2013/14 the ward teams will continue to revisit the productive ward modules, continuously improving systems and processes to increase the quality of ward based services. The productive ward way of working will also support the roll out of the enhanced recovery in medicine project across the medical wards. (see page x)

Patient safety continued

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

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

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

Also our annual results from the national patient experience surveys suggest that medicines information on discharge is an area that we can improve.

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

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

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

A 'Medicines Advisory Note' is also planned for 2013/14 for those patients who are not taking a high risk medicine but where it has been identified that there are specific safety or compliance concerns. These notes will be provided to patients by a member of the pharmacy team.

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

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

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

Clinical effectiveness

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

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

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

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

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

> I THINK THE PLAN REALLY WORKS WELL WHEN CHILDREN AND YOUNG PEOPLE ARE CAPABLE OF ANSWERING THE QUESTIONS.
>
> WE PLAN TO TAILOR THE PACK FOR SPECIAL NEEDS IN THE FUTURE AND INCLUDE A SECTION FOR THE PARENT/ADVOCATE.
>
> Epilepsy Specialist Nurse

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

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

Young person with long term condition

↓

Getting Ready

- Discuss transition with young person & family
- List Getting Ready Plan
- Set objectives
- Transition leaflet given
- Complete carers/parents transition form

↓

Steady

- Review transition with young person & family
- List steady plan
- Set new or continuing objectives
- If appropriate introduce adult worker

↓

Go

- Young person to meet key worker (or advocate)
- Use Go plan
- Referral summary letter from Consultant to identified adult clinician
- Plan transition to adult service

Patient experience

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

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

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

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

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

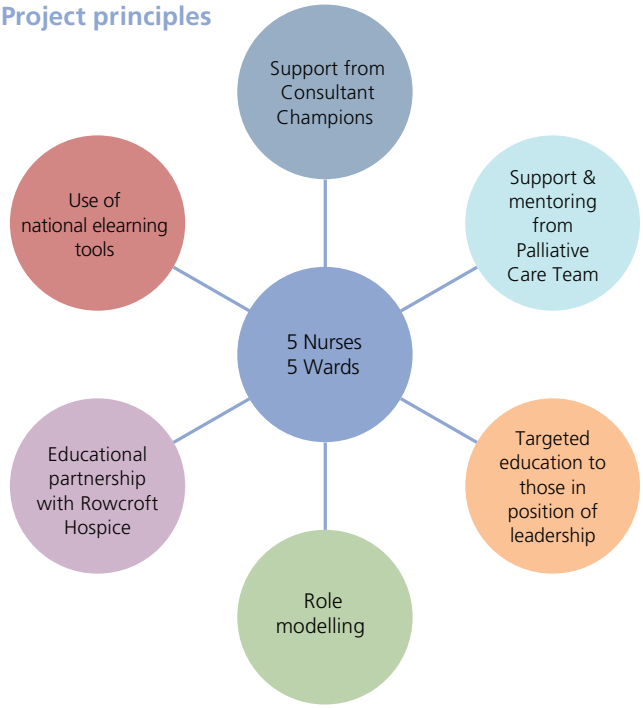
They each attended end of life care teaching sessions and they also spent time on their own wards looking at ways to improve care for people who may be in the last year(s) of life.

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

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

> "WE ARE CERTAINLY MORE PROACTIVE IN FACILITATING PATIENTS' CHOICE OF WHERE THEY WOULD LIKE TO DIE AND DISCHARGING PATIENTS IN A SAFE AND SUPPORTED MANNER"
>
> Ward Sister on a project ward.

Project principles



As a result of the project:

- Staff on the five wards now have a better understanding of ways to improve care in the last year(s) of life for patients, their families and friends.
- There is an increased awareness of end of life issues across the Hospital as staff move between wards.
- Better information is now sent to GPs, out-of-hours doctors and ambulance service staff, when patients leave hospital.
- There are now information folders on end of life care produced by the 5 project nurses for the other 12 adult wards in the hospital as a way to share learning from the project.

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

Patient experience continued

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

Part of the Government's current policy is to ensure that patients have better access to their own medical information such as medical records and laboratory results.

There is considerable evidence to suggest that patients receiving good quality letters/information respond very positively, resulting in improved patient satisfaction and reduced anxiety.

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

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

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

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

PATIENTS KNOW BEST®
MANAGE YOUR HEALTH

www.patientsknowbest.com/

Specialities involved in the pilot work to date include:

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

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

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

Patient experience continued

Continuous quality improvement in 2012/13

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

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

2012/13 CQUINs

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

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

whilst others are locally agreed.

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

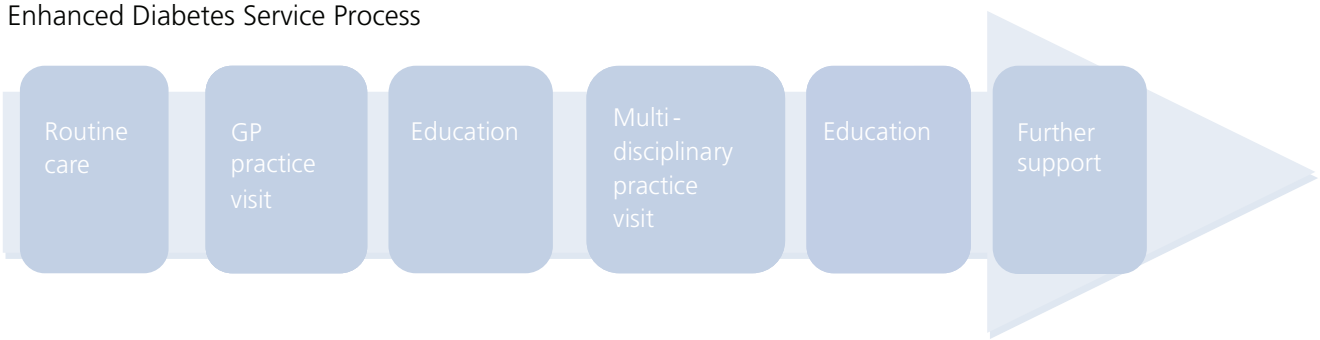
2012/13 CQUIN highlights include:

Diabetes

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

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

Enhanced Diabetes Service Process



Patient experience continued

2012/13 CQUINs continued

Timeliness of clinic letters to GPs

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

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

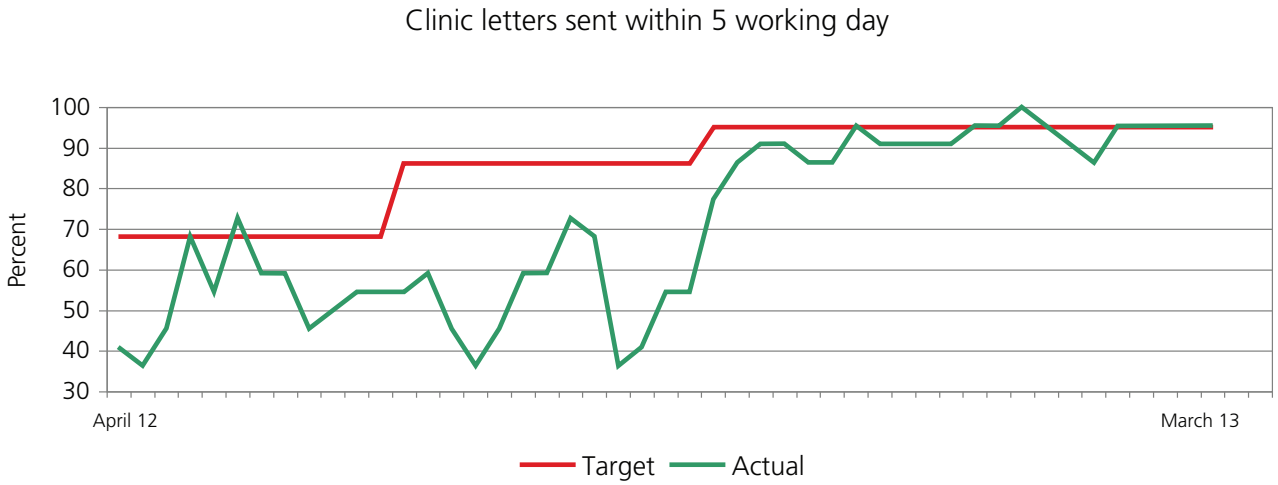
The project focused on:

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

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

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

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



Patient experience continued

2012/13 CQUINs continued

Patient Experience

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

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

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

A snapshot of patient feedback for 2012/13 includes:

"THE NURSES AND HEALTH CARE ASSISTANTS ON TURNER WARD IN TORBAY GENERAL HOSPITAL HAVE BEEN ABSOLUTELY SUPERB. THE CARE AND ATTENTION THAT THEY HAVE GIVEN MY VERY POORLY MUM HAS BEEN INCREDIBLE AND AT ALL TIMES THEY HAVE BEEN SUPPORTIVE AND ATTENTIVE TO MY SISTER AND I....."

Patient Opinion

"HUMOUR AND FRIENDLINESS OF STAFF - NO GLOOMY FACES. I ENJOYED MY STAY."

National Inpatient Survey

"DELIGHTED WITH ALL THE CARE AND ATTENTION I RECEIVED. I WAS ALSO WELL SATISFIED WITH THE FOOD, I CANNOT HAVE DAIRY PRODUCTS BUT THE CATERING DEPARTMENT LOOKED AFTER MY NEEDS WELL."

Real Time Patient Survey

"I WAS RATHER CONFUSED WITH ALL MY INFORMATION CONCERNING MY DISCHARGE."

Real Time Patient Survey

Patient experience continued

2012/13 CQUINs continued

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

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

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

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

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

> "WORTHWHILE EXPERIENCE, SEEING GOOD QUALITY CARE IN REAL TIME AND HAVING THE OPPORTUNITY TO DISCUSS WITH THE STAFF".
>
> Bereavement officer

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

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

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

Patient experience continued

Other continuous quality improvement work in 2012/13

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

Projects undertaken in the last year include:

- iTorch - an innovative project to introduce junior doctors to quality improvement work and which enables them to undertake small scale projects. In 2012/13 over 20 projects have been undertaken and shared with the health and care community. These range from developing improved referral forms in psychiatry to designing improved drug packaging for anaphylaxis.
- Telemedicine in paediatrics – this is a new project enabling clinicians to share information and undertake shared consultations via a portable telemedicine unit with specialist units from across the region.
- 7 day care - this builds on the work already undertaken during the year to understand more clearly future health and social care capacity and patient demand. Tests of change include Sunday consultant ward rounds and increased junior doctor provision at weekends to support the timely completion of discharge information for GPs.
- Dementia – this is a key priority for the Trust. Work has been undertaken in the year through the CQUIN framework to improve the recognition, assessment and referral of patients suspected with dementia. Although the Trust did not achieve its end of year target, it continues to work hard to achieve this. There is a also a Devon wide dementia action plan which the Trust is actively working on alongside their partners.
- Joined-up health & care – the Trust alongside Commissioners, the Councils and community health and social care have come together to publish a vision of joined up health and care for the people of South Devon and Torbay. The document has been published and is available on the Trust website www.sdhl.nhs.uk
- Clinical negligence scheme for Trusts - Maternity Services achieved Clinical Negligence Scheme for Trusts (CNST) level three for the Maternity Clinical Risk Management Standards. This is the highest level of the NHS Litigation Authority's stringent standards to improve the safety of women and their babies.

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

PRIORITIES FOR IMPROVEMENT

Looking forward: 2013/14

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

Patient safety

Priority 1: Reduce the prevalence of hospital acquired pressure ulcers

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

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

The Trust, through its Pressure Ulcer Steering Group, is working with the wards to reduce the number of pressure sores acquired whilst in hospital. In the first quarter of 2013/14 we will count the number of hospital acquired pressure ulcers and then use this baseline to reduce the number of grade 4 pressure ulcers in the first instance.

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

Clinical effectiveness

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

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

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

The preliminary data suggests that people have shorter stays and a better patient and carer experience. As a result of the initial outcomes of this pilot, the stakeholders in deciding the Trust's quality improvement priorities felt that prioritisation should be given to this innovative approach to patient care.

In 2013/14 the aim will be to see whether the benefits made to date can be replicated more widely by rolling out the programme into four medical wards and measuring the benefits including length of stay and patient experience.

Priority 3: Implement the integrated heart failure service

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

Hospital admissions due to heart failure are projected to rise by 50% over the next 25 years largely due to an ageing population, improved survival of people with heart disease and more effective treatments for heart failure. The average age at first diagnosis is 76.

Nationally and locally this is now becoming a significant issue and as a result, the Trust, with Community Services, have come together to develop one integrated service with the aim of providing seamless care, whether at home or in hospital.

In 2013/14, the focus will be on identifying people with heart failure and setting up systems to allow people to be both supported with their condition and manage it more effectively themselves. An action plan has been developed to ensure the effective roll out of the service during the year and this will be monitored through the Cardiology Care Pathway Group.

Patient Experience

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

The provision of high quality end of life care within Torbay Hospital will continue to be an important function and one by which the hospital will be judged by its local community. We only have one chance to get this right for patients, their families and friends.

As a result of the excellent work done by the End of Life Team in 2012/13, the stakeholders at the Quality Account Engagement meeting recommended that end of life care remain .a quality improvement priority.

The aim in 2013/14 is to build on the improvements undertaken and to identify areas where the care we provide can be improved upon. The improvement work will be measured and monitored through the End of Life Care Pathway Group, a cross organisational group of doctors and health and social care professionals.

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

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

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

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

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

Patient experience continued

Continuous quality improvement work in 2013/14

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

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

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

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

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

Statements of assurance from the Board

Review of services

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

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

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

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

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

During 2012/13 South Devon Healthcare Foundation NHS Trust participated in 82% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

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

South Devon Healthcare NHS Foundation Trust	Eligibility	Participation
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	Yes	Yes
Children		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Feverish Children (College of Emergency Medicine)	Yes	Yes
Pain in Children (College of Emergency Medicine)	Yes	Yes
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	Yes	Yes
Paediatric intensive care (PICANet)	No	Not applicable
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	Not applicable
Inpatient audit of children with Diabetes (HQIP)	Yes	Yes
Diabetes (RCPCH National Paediatric Diabetes Audit)	Yes	Yes
Acute care		
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes
Non-invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No
Neck of femur (College of Emergency Medicine)	Yes	Yes
Adult critical care (ICNARC Case Mix Programme)	Yes	Yes
Severe sepsis and septic shock (CEM)	Yes	Yes
Potential Donor Audit	Yes	No

Statements of assurance from the Board continued

South Devon Healthcare NHS Foundation Trust continued	Eligibility	Participation
Long term conditions		
Diabetes (National Diabetes Audit)	No	Not applicable
Diabetes Inpatient audit (HQIP)	Yes	Yes
Heavy Menstrual Bleeding (RCOG)	Yes	Yes
Chronic pain (National Pain Audit)	Yes	Yes
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	No
COPD (British Thoracic Society/European Audit)	Yes	No
Adult asthma (British Thoracic Society)	Yes	Yes
Bronchiectasis (British Thoracic Society)	Yes	No
National audit of Dementia	Yes	Yes
Parkinson's disease	Yes	No
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	Not applicable
Liver transplantation (NHSBT UK Transplant Registry)	No	Not applicable
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes
Carotid interventions (Carotid Intervention Audit)	Yes	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No	Not applicable
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes
Heart failure (Heart Failure Audit)	Yes	Yes
Acute stroke (SINAP)	Yes	Yes
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes
Renal disease		
Renal replacement therapy (Renal Registry)	No	Not applicable
Renal transplantation (NHSBT UK Transplant Registry)	No	Not applicable
Cancer		
Lung cancer (National Lung Cancer Audit)	Yes	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes
Head & neck cancer (DAHNO)	Yes	Yes
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes
Trauma		
Hip fracture (National Hip Fracture Database)	Yes	Yes
Severe trauma (Trauma Audit & Research Network)	Yes	Yes
Psychological conditions		
Prescribing in mental health services (POMH)	No	Not applicable
Blood transfusion		
Audit of patient info & consent (National Comparative Audit of Blood Transfusion)	Yes	Yes
Blood sampling & labelling (National Comparative Audit of Blood Transfusion	Yes	Yes
Audit the use of Anti D (National Comparative Audit of Blood Transfusion)	Yes	Yes

Statements of assurance from the Board continued

South Devon Healthcare NHS Foundation Trust continued	Eligibility	Participation
Health promotion		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No
End of life care		
Care of dying in hospital (NCDAH)	Yes	No
National Confidential Enquires		
Patient Outcome and Death (NCEPOD)	Yes	Yes
Suicide and Homicide by People with Mental Illness	No	Not applicable
National Review of Asthma Deaths	Yes	Yes
Child Health programme	Yes	Yes

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

- Bronchiectasis (British Thoracic Society) – the decision not to take part in this audit was made because of the difficulty in capturing the data required.
- Cardiac arrest – the specialty concerned decided not to take part in this audit as there was a cost implication.
- Non-invasive ventilation (COPD) – the speciality declined to take part.
- Parkinson's disease – the speciality declined due to workload.
- Potential donor – the speciality had taken part in a previous audit but due to small numbers felt that there was little benefit in taking part again this year.
- IBD (Biologics) – the decision not to take part was due to problems with the national data audit system and the lack of availability of site specific data in the national report.
- Risk factors (Health promotion) – the audit was organised by Stockport NHS Trust and was considered not to be useful and therefore a decision was made not participate in the audit.
- Care of the dying in hospital – the decision was taken to undertake local audits instead.

The national clinical audits and national confidential enquiries that South Devon Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

South Devon Healthcare NHS Foundation Trust	Cases submitted	% cases
Peri and Neonatal		
Neonatal intensive and special care (NNAP)	359	100
Children		
Paediatric pneumonia (British Thoracic Society)	15	100
Paediatric asthma (British Thoracic Society)	9	45
Feverish Children	50	100
Pain management (College of Emergency Medicine)	50	100
Childhood epilepsy (RCPCH National Childhood Epilepsy Audit)	25	100
Inpatient audit of children with Diabetes	Not Known	
Diabetes (RCPCH National Paediatric Diabetes Audit)	116/130	89
Acute care		
Emergency use of oxygen (British Thoracic Society)	10	90
Adult community acquired pneumonia (British Thoracic Society)	50/20	250

Statements of assurance from the Board continued

South Devon Healthcare NHS Foundation Trust	Cases submitted	% cases
Severe sepsis & septic shock (College of Emergency Medicine)	30	100
Non-invasive ventilation (NIV) Adults (British Thoracic Society)	14/20	70
Neck of femur (College of Emergency Medicine)	50	100
Adult critical care (ICNARC Case Mix Programme)	679	100
Renal Colic (College of Emergency Medicine)	14/50	28
Long term conditions		
Diabetes Inpatient audit (HQIP)	40/50	80
Heavy menstrual bleeding (RCOG National Audit of HMB)	112	100
Chronic pain (National Pain Audit)	53	100
National audit of dementia	40	100
Parkinson's disease (National Parkinson's Audit)	21	70
Adult asthma (British Thoracic Society)	21/20	105
Elective procedures		
Hip, knee and ankle replacements (National Joint Registry)	683	100
Coronary angioplasty (NICOR Adult cardiac interventions audit)	350	100
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Not Known	
Carotid interventions (Carotid Intervention Audit)	31	100
Cardiovascular disease		
Acute Myocardial Infarction & other ACS (MINAP)	474	99.2
Heart failure (Heart Failure Audit)	359	150
Acute stroke (SINAP)	537	100
Stroke care (SNNAP) (Organisation only)	Not known	
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	189	100
Cancer		
Lung cancer (National Lung Cancer Audit)	201	100
Bowel cancer (National Bowel Cancer Audit Programme)	223	100
Head & neck cancer (DAHNO)	70	100
Oesophago-gastric cancer (National O-G Cancer Audit)	52	100
Trauma		
Hip fracture (National Hip Fracture Database)	438	100
Severe trauma (Trauma Audit & Research Network)	265	100
Blood transfusion		
Blood sampling & labelling (National Comparative Audit of Blood Transfusion)	35	100
Platelet use (National Comparative Audit of Blood Transfusion)	26	100
National Confidential Enquires		
Are We There Yet? A review of organisational and clinical aspects of children's surgery	1	100
Knowing the risk - A review of the peri-operative care of surgical patients	86	100
Bariatric surgery for weight loss	Not Known	

Statements of assurance from the Board continued

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

Ref	Recommendations / actions
ND0046	**Acute Myocardial Infarction & other ACS (MINAP) - (Quarterly reports)**
	• Data collection evaluation • Improvement in drugs documentation.
ND0055	**Acute Stroke (SINAP)**
	• Report received March 2013. Response pending.
ND0030	**Adult Asthma (BTS)**
	• Ensure blood gases are performed on all patients with low Sa02 • Oral steroids to be given promptly to all patients with acute asthma • Peak flow recordings to be recorded in all asthmatic patients at least 12 hourly. • Outpatient appointments to be offered to all patients admitted under medicine with acute severe asthma.
ND0071	**Adult Community Acquired Pneumonia (BTS)**
	• First dose of antibiotics to pneumonia patients - Junior Doctors to undertake • Re-emphasise local antibiotic guidelines for pneumonia
ND0053	**Bowel Cancer Audit (NBOCAP)**
	• Check data accuracy and ensure accurate coding. • APER rate incorrectly stated as 100%, correction requested.
ND0066 - Cardiac arrhythmia (Cardiac Rhythm Management Audit)	
	• No specific actions.
ND0074 - Carotid Intervention Audit	
	• Multi-factorial reasons for the delay between patient symptoms and surgery. • Areas to explore further include where services (e.g. TIA) fragmented across Trust , consultant job plans , staffing
ND0064 - Childhood Epilepsy Audit (Epilepsy 12)	
	• Design local guidelines for children seen in A & E, children's wards and referred by GP with a first febrile seizure.
ND0038 - Chronic pain - Organisational audit of pain services (2010/12)	
	• Report received Dec 2012, Response pending.
ND0049 - Coronary Angioplasty: (NICOR Adult Cardiac Interventions audit) – BCIS	
	• More detailed examination of outcomes after primary PCI for patients with cardiogenic shock or other adverse risk factors • On-going monitoring of trends in D2B times to be included in quarterly PCI audit meetings.
ND0049 - Coronary Angioplasty: (NICOR Adult Cardiac Interventions audit) – BCIS	
	• No action plan required.

Statements of assurance from the Board continued

ND0047 - Data for Head and Neck Oncology (DAHNO)

- Improve recording of staging, performance status and co-morbidities,
- Timetable adjusted to enable Restorative Dentistry consultant to attend MDT which will improve identification of appropriate patients for assessment –
- Pre-treatment clinic improving figures for patients receiving swallow and dietetic assessments pre treatment.

ND0028 - Dementia audit

- Include dementia assessment & referral on discharge summary
- Design care pathway.

ND0065 - Diabetes (RCPH National Paediatric Diabetes audit)

- Development of multidisciplinary team
- High HbA1c policy to be ratified and followed for all patients not currently achieving HbA1c levels within target range.
- Review protocols and guidelines relating to the care of children with diabetes

ND0037 - Emergency use of Oxygen (BTS)

- Incorporate oxygen prescribing into VITALPACK observations.

ND0060 - Feverish children (CEM)

- Report received February 2013. Response pending

ND0092 - Fractured neck of femur (CEM)

- Report received February 2013. Response pending

ND0039 - Heart Failure Audit

- Appoint integrated Heart Failure Nurse (HFN) Team.
- Identify all patients admitted with heart failure whilst on EAU (BNP and Echocardiogram).
- Improve use of proven therapies (ACE/ARB, b-blockers, MRA) in patients identified with systolic heart failure (target >80%).
- All patients with heart failure require management plan and HFN follow up.

ND0054 - Heavy Menstrual Bleeding (HMB) (RCOG)

- No Trust level data in report. No identifiable actions required.

ND0043 - Hip Fracture (NHFD)

- Improve the completeness of the data submitted to the NHFD particularly 30 day and 120 day data.
- All patients admitted with a fall and fragility fracture to be referred to FLS and infoflex MFFRA completed.
- All patients with a hip fracture to have AMTS recorded on admission and post operatively.
- Improve the % of patients achieving the BPT of time to theatre within 36 hours
- Set up clinical pathway group to review Hip Fracture Pathway to reduce community hospital length of stay

ND0042 - Hip, Knee and Ankle Replacements (NJR)

- No action plan required.

ND0051 - ICNARC: Adult Critical Care (Case Mix Programme)

- No action plan required.

Statements of assurance from the Board continued

ND0090 - Inpatient Diabetes Audit (Adults)

- Development of business case to provide more podiatry input to inpatients with diabetic foot ulcers.
- Modification of drug chart to include dose validation for insulin prescription.
- Educational initiative for foundation doctors wrt insulin prescribing including e-learning module.
- Implementation of 'think glucose' programme.

ND0044 - Lung Cancer (National Lung Cancer audit)

- No action plan required.

ND0093 - National comparative audit of blood transfusion programme (Blood Sampling and Labelling

- Report received January 2013. Response pending

ND0093 - National comparative audit of blood transfusion programme (Platelet use)

- Threshold for prophylactic platelet transfusions agreed

ND0035 - National Neonatal Audit Programme (NNAP)

- NNAP results to shared to paediatric staff
- Data entry into the Badger system to be reviewed to ensure its accuracy and robustness - weekly case notes audit to be undertaken
- Separate form for communication to be included in Admission pack.
- SCBU - new magnetic board has been installed with an aim to highlight relevant issues.
- Data for follow-up at age two years to be included. Re-audit in 6 months.

ND0012 - Non Invasive Ventilation (BTS)

- Improve current NIV data collection sheet.
- Provide oxygen alert cards for all patients who have received NIV in hospital.

ND0086 - Oesophago-gastric cancer (National O-G Cancer Audit)

- No action plan required.

ND0041 – Paediatric Asthma (BTS)

- Report received Feb 2013. Response pending

ND0040 - Paediatric Pneumonia (BTS)

- Create Paediatric Community Acquired Pneumonia Guideline.

ND0083 - Pain Management (CEM)

- PGD for analgesia prescriptions for nursing staff.
- Posters in Emergency Department.
- Pain assessment education for nurses

ND0011 - Parkinson's Disease (Parkinson's UK)

- Service Development – Parkinson's – Trust/Commissioner action
- Improve provision of written information
- Trial the non motor questionnaire
- End of life care - develop paperwork to enable better communication between patients and GPs.

ND0062 - Renal Colic (CEM)

- Report received February 2013. Response pending

Statements of assurance from the Board continued

ND0082 - Severe Sepsis and Septic Shock (CEM)

- Sepsis lecture as part of mandatory junior doctors' teaching (for each rotation block)
- Introduction of 'Red box' for high amber scored ED patients to ensure patients seen in priority order.
- Alter Sepsis stickers to better reflect important audited parameters including urine output.
- Use magnetic markers on emergency department patient board to identify priority patients with high amber scores.

ND0026 - Severe Trauma (TARN) Clinical Report III (Head and Spinal Injuries) Nov 12

- Report received Dec 2012. Response pending

ND0026 - Severe Trauma (TARN) TARN - Torbay Hospital Trauma Report II, August 2012 (Orthopaedic Injuries)

- Review Trauma team activation criteria
- Improve data completeness
- Review trauma data 3 times a year

ND0026 - Severe Trauma (TARN) TARN – Torbay Hospital Trauma Report I (Abdominal Injuries, Shocked patients)

- Trauma calls – new protocol re leadership designed
- Improve timeliness of CT scan

ND0027 - Stroke care (National Sentinel Stroke audit)

- Report received Dec 2012. Response pending.

ND0027 - Stroke care (National Sentinel Stroke audit) - National Sentinel Stroke Clinical Audit 2010 - Supplementary report on Therapy intensity March 2012

- Improved accuracy of contact time data will be measured via the SNAP audit tool
- Audit appropriateness for 45 minutes therapy and code variance.
- Audit patients who are appropriate for 45 minutes therapy and do not receive it Identify a lead therapist to co-ordinate the therapy team
- Reliable 7 day therapy working. Business case to be developed.

ND0031 - Ulcerative colitis & Chrohn's disease (National IBD audit) (Biologics)

- Report received June 12. Report not applicable as data incorrect & no local report produced.

Statements of assurance from the Board continued

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

Ref	Recommendations / actions

6149 Initial Assessment of Self harm and Overdose in the Emergency Department (ED)

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

6183 Nutrition Risk Screening

- Introduce MUST scoring sheet into EAU clerking pro-forma
- Re-education of EAU nursing staff on the risks of malnourishment and the importance of using MUST tool through staff training sessions
- Improve access to scales within EAU

6203 Head Injury [CG-56]

- Continue to review assessment/ triage and monitor the impact of the new IT system
- Education for head injury management/ documentation to junior doctors, paediatric staff and emergency nurse practitioners
- Revision of adult head injury advice leaflet to include advice regarding post-concussion syndrome and services available

6222 Identification of 'At Risk' Children in A&E – 2012

- Consultant team to target the Middle Grade doctors for ad hoc teaching, (to include paediatric liaison referrals and MASH (Multi-Agency Strategic Hub) referrals).

6242 Nutrition and Dietetics Record Keeping for Domiciliary Visits

- No specific changes can be made to documentation to aid completion.

6188 Intra Hospital Patient Transfer

- Present audit and proposed changes to a Monday 'medical' meeting.
- Modification of Kettering document on Clinical Governance approval.
- Produce a quick checklist for transfer personnel to do and to call an anaesthetist if needed.

6139 False Negative Triple Assessment

- No plan is required but continue with on-going monitoring to ensure that we are working to national guidance and providing an effective triple assessment service.

6181 Diagnosis, treatment and management of urinary tract infection (UTI) in infants and children (CG- 54)

- No action required

Statements of assurance from the Board continued

6195 Paediatric Rapid Access Clinic: Referrals from the Emergency Department (ED)

- Re-evaluation of the process of Rapid Access clinic referrals involving Consultant triage
- Creation of more specific criteria for referral to Rapid Access clinic
- Training for Middle Grade doctors regarding the Rapid Access process
- Training for ED staff regarding Rapid Access process

6105 Safeguarding Children (Torbay)

- Arrange dates to attend committees and team meetings to discuss audit results, recommendations and actions.
- Prepare staff briefing for inclusion in Staff Bulletin.
- Present staff briefing at team meetings.
- Supervision Standard Operating Procedure (SOP) to be revised.
- Training on supervision SOP to be developed.
- Training on supervision SOP to be delivered.
- Develop training for staff on how to write a comprehensive report covering all areas of Child Protection identified through audit.

6137 Community Diabetic In-patient foot care

- A flyer will be sent to all community hospitals giving details of the next toe nail cutting training courses and recommending that two members of staff from each attend
- Produce a new guideline for the management of diabetic foot ulcers specifically in community hospitals,
- Set up a 'training update' on diabetic foot checks and referral pathways

6148 Care Trust Note Keeping 2011/12

- No action taken other than individual team plans against their own results

6185 Prescribing in Community hospitals

- Discuss results with the Medical Director (MD) of T&SDHC Trust
- Disseminate copies of report and the Trust Medicines policy to prescribers via MD
- Present report at the Medicines Governance Group
- Produce and issue a "Top tips for Community hospital prescribing" aide-memoire

6194 Community Hospital Infection Control

- No plan required

5989 Certolizumab pegol for the treatment of Rheumatoid Arthritis (RA) (NICE TA-186)

- No action plan required

6058 Management of Acutely Unwell Patients with Anorexia Nervosa (AN) in Torbay Hospital

- Developing expertise in the Medical Service
- Identify an Eating Disorders Nutrition Physician
- Psychiatric input links with medicine
- Improve dietetic input and liasion with Nutrition Support Teams
- Pathway redesign
- Nasogastric feeding – guidelines
- Managing risks of re-feeding and Underfeeding Syndrome – risk stratification – use purpose designed admission pro-forma
- Families - In admission pro-forma include section to show that plan has been discussed with family.
- Criteria for transfer to SEDU

Statements of assurance from the Board continued

6129 Acute management of hyperkalaemia

- Trial of charts through patient safety initiative.

6134 Patients with negative Troponins at six hours who then had a Troponin at 12 hours

- Raise awareness through ED Clinical Effectiveness meeting (CEM) that negative Troponin should not re-assure patient is risk free
- Two ECG's should be routinely performed

6150 Insulin Prescribing

- Insulin education to junior doctors

6154 Waiting times for Multiple Sclerosis (MS) from GP referral to time of diagnosis

- Increase the number of MS Clinic slots,

6180 Monitoring of Paediatric IBD Patients who are taking Azathioprine or 6-Mercaptopurine

- Produce a drug information leaflet for patients

6182 GP Referrals to Transient Ischemic Shock/ Attack (TIA) Clinic

- Re-structuring of TIA clinics to initially create a five day walk in clinic
- Further re-structuring to create a seven day walk in clinic
- Ensure GPs aware of any new structuring, through best mechanism of GP to hospital discussions and commissioning meetings

6192 Management of Diabetes Ketoacidosis (DKA) in adults

- Introduce revised DKA guideline

6246 Use of blood cultures prior to administration of antibiotics

- Disseminate results to all Clinical Directors
- A reminder is needed in the antibiotic section on the drug chart

6247 NICE BCA - Rituximab for the treatment of relapsed or refractory chronic lymphocytic leukaemia (TA-193)

- No action required

6249 NICE BCA - Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell

- No plan required, compliance demonstrated

6258 Metastatic Spinal Cord Compression (MSCC)

- Compliance achieved in four of the five standards, Standard one will be re-audited in another registered audit project ref: 6244

6260 - NICE BCA - Dronedarone for the treatment of non-permanent atrial fibrillation (TA197)

- No action required

Statements of assurance from the Board continued

6273 NICE BCA - Rituximab for the first-line treatment of chronic lymphocytic leukaemia (TA-174)

- No action required

6151 Management of Acute Surgical Admissions

- Discuss the possibility of 5 pm post take ward round by consultants of all new admissions.
- Senior review on EAU

6166 Inappropriate Abdominal Radiograph Requests in Surgical Emergency

- Produce new guidelines agreed between Radiology and General Surgery.

6186 Emergency Repair of Femoral Hernias

- Continue with on-going education programme
- Involvement of Care of the Elderly (COTE) in early post-operative period

6103 Five year oral cancer survival following surgery

- No action required

6202 Consenting lower third molar surgical removal

- Produce a pre-written/ 'bespoke' Consent form for lower 3rd molar removal

6204 Referral guidelines for CT scanning in sinusitis

- Laminate guidelines for distribution to raise awareness of guidance

6085 Inter Agency Communication Forms

- Present findings and highlight areas of improvement at Obstetrics and Gynaecology audit meeting, Midwifery Team Leaders meeting

6093 Contacting Clients Post Administration of Emergency Hormonal Contraception (EHC)

- Review EHC template and EHC SOP.
- Simplify the process – alterations to both SOP and Lillie (computer system) templates.

6107 Use of General Anaesthetic (GA) for Colposcopy Treatment

- After 3 months all cases performed under GA will be reviewed and each discussed with the appropriate surgeon.
- All surgeons performing this procedure to be contacted to advise of the requirement for tissue depth to >7mm for ectocervical lesions.

6138 Maternity CNST Fetal Blood Sampling (FBS)

- Change wording on policy from 'stapled' to 'attached'.
- Ensure medical staff aware of requirement to document timing of repeated FBS'.
- Findings to be disseminated to all midwives via Team Leaders
- Email all midwives with Stork guidance and reinforce on Delivery Suite.
- Publish findings in Clinical Governance newsletter.
- Laminate notice on FBS trolley to remind doctors to document requirements for further tests.

Statements of assurance from the Board continued

6145 Outcome following Injection of Botulinum Toxin to Bladder for overactive bladder (CG-40)

- No action required

6146 Effectiveness of Antenatal Communication SCBU Form

- No action required

6171 Maternity CNST Intermittent Auscultation

- Highlight to midwives the importance of palpating and documenting the maternal pulse at the onset of labour, through Team Leaders meeting and Clinical Governance newsletter.

6172 Maternity CNST CTG

- Results to go to Delivery Suite sub-group to formulate an action plan.
- Highlight via the newsletter the requirement of those giving an opinion and any intrapartum event to be documented.
- Laminated signs to be produced and placed in clinic rooms as a prompt to sign antenatal obstetric notes.
- Discuss achievement of hourly 'fresh eyes' at Delivery Suite sub-group meeting.
- Findings to be disseminated to all midwives via Team Leaders.
- Findings to be published in Clinical Governance newsletter.

6173 Maternity CNST Use of Oxytocin

- Policy 461 needs to be updated with minor amendments to reflect current practice in regards to documentation of a plan prior to Oxytocin in low risk women.
- Highlight to staff the importance of documenting when oxytocin should be stopped by disseminating to midwives via Team Leaders meeting and minutes.
- Findings to be published in the Clinical Governance newsletter.

6174 Maternity CNST Caesarean section

- Undertake a check of the clocks on the ward, theatre and Galaxy to assess any discrepancies.
- Highlight to the Co-ordinators the need to check and correct the times on the CTG machines every day.
- There needs to be clear documentation that the decision to do emergency caesarean section is joint with a Consultant (P16 yellow birth notes).
- Audit forms to be completed at time of delivery notes.
- Need to ensure that the correct classification is used.
- Share findings with midwives through Team Leaders meeting and minutes
- Publish results in the Clinical Governance newsletter.
- Raise at Delivery Suite Clinical Governance sub-group

6175 Maternity CNST Induction of Labour

- Raise awareness of areas showing poor compliance with the Meridian staff working on John MacPherson ward and also highlight at the Team Leaders meeting.
- Highlight to Midwives the importance of:
- Induction at Term +12 for post maturity - Documenting maternal pulse every 6 hours during induction (may be 8 hourly overnight) through Team Leaders meeting and minutes and the Clinical Governance newsletter.

6176 Maternity CNST Shoulder Dystocia

- Incident forms to be stapled to the pro-forma to encourage completion.
- Shoulder Dystocia pro-forma to be ratified and added current Trust policy.

6177 Maternity CNST Operative vaginal delivery

- Highlight and raise the profile of the use of fluid balance.
- Findings to be disseminated to all midwives via Team Leaders.
- Findings to be taken to Delivery Suite Clinical Governance sub-group.
- Findings to be published in the Clinical Governance newsletter.

Statements of assurance from the Board continued

6178 Maternity CNST Perineal Trauma

- Ensure old pro-formas previously being used have been removed from the unit and the master copy destroyed.
- New prompt sticker produced.
- Disseminate findings to all midwives via Team Leaders meeting and minutes.
- Highlight audits at Delivery Suite Clinical Governance sub-group

6179 Maternity CNST Care of women in labour

- Results to be taken to Delivery Suite sub-group to formulate an action plan
- Actions from Delivery Suite sub-group:
- Posters to be placed around unit
- Highlight on newsletter
- Take results to Team Leaders meeting.
- Cascade findings
- Raise at Delivery Suite Clinical Governance sub-group meeting

6189 Management of Suspected Ectopic Pregnancy

- Review Trust policy (0468 - Early pregnancy management/ suspected ectopic pregnancy):
- Update and amend flowchart to make it clearer
- Change the urine test follow up from 2 to 3 weeks post miscarriage
- Undertake a re-audit after the new NICE recommendations for Early Pregnancy Patients are released.

6197 Pre-operative pregnancy assessment prior to sterilisation

- Letter to be sent to DSU to inform that all women undergoing laparoscopic sterilisation will need to have a urine pregnancy test done prior to the procedure.

6207 Maternity CNST Eclampsia

- No action required.

6208 Maternity CNST Venous Thromboembolism

- Share findings

6209 Maternity CNST Severe Pre-Eclampsia

- To highlight the requirement to document:
- The BP 15 minutely until BP <160/100
- Clear lines of communication with Consultant Anaesthetist and Paediatrician
- Share the use of magnesium of sulphate and why not used
- Disseminate findings to all midwives via Team Leaders meeting and minutes
- Findings to be discussed at Delivery Suite Clinical Governance sub-group
- Findings to be published in Clinical Governance newsletter

6210 Maternity CNST Referral When a Fetal Abnormality is detected

- Review and update existing Obstetric Paediatric Referral Communication form, which will include a formal process for ensuring paediatric communication, is received, returned or acted on. This will also be highlighted and initiated at the next perinatal meeting.
- Present findings at Paediatric audit meeting.

6211 Maternity CNST Pre-Existing Diabetes

- Audit meeting minutes to be disseminated to all staff including diabetic multidisciplinary team
- Add findings to newsletter and circulate to diabetes team.
- Raise at Antenatal and Postnatal Clinical Governance sub-group.
- Disseminate to maternity staff through team leaders meetings and minutes

Statements of assurance from the Board continued

6212 Maternity CNST Postpartum Haemorrhage (PPH)

- New pro-forma for the documentation of PPH to be introduced. To be available in delivery Action rooms and also on the PPH trolley.
- Policy 1127 to be amended.
- Draft pro-forma to be trialled for two months.
- Pro-formas to be available for use in theatre (particularly theatres 1 and 4).
- Remind staff of requirement to:
- Complete pro forma if PPH in theatre
- Complete Incident Form for all PPH of 1500ml
- Findings to be disseminated to all midwives via Team Leaders.
- To disseminate findings to Team Leaders and via the Newsletter and also Delivery suite Clinical Governance Sub-group.
- Policy to be updated with guidance about documentation if the Consultant Anaesthetist and Obstetrician are not required, if the bleeding has been managed.

6213 Maternity CNST Postnatal Care

- Highlight via the newsletter the need to document on individual postnatal care plan including relevant factors from the antenatal, intrapartum and postnatal period.
- Highlight via Team Leaders the importance of completing all relevant sections on the front and back pages of the notes.
- Add findings to Clinical Governance newsletter and circulate to Obstetric, Midwifery and Paediatric teams and Paediatric teams
- To present at SCBU Governance
- Disseminate findings through Team leaders meeting and minutes
- To discuss the pilot and introduction of NEWS chart at SCBU Clinical Governance

6214 Maternity CNST Patient Information

- Highlight at Team leaders meeting to ensure all staff are aware of the patient information policy
- Findings included in Clinical Governance newsletter
- Raise at Antenatal Clinical Governance sub-group

6215 Maternity CNST Obesity

- Disseminate to the Consultant Anaesthetists the requirement of them to document any discussions with women.
- Disseminate findings to all midwives via Team Leaders meeting and minutes.

6216 Maternity CNST Non-Obstetric Emergency Care

- Findings disseminated to all midwives via Team Leaders.

6217 Maternity CNST Newborn Feeding

- Findings to be disseminated to all midwives via Team Leaders meeting.
- Discuss at Antenatal Clinic / Postnatal Clinical Governance sub-group.

6218 Maternity CNST Newborn Life Support

- Daily date sheets to be implemented on delivery suite.
- Findings to be fed back to Team Leaders.

6219 Maternity CNST Multiple Pregnancy & Birth

- A 'plan of care for twins' pro-forma has been developed which will include provision of information, discussion and documentation of the planned and agreed place and timing of birth and management of the second stage.
- Findings to be disseminated to all midwives via Team Leaders meeting and minutes.
- Findings to be discussed at Antenatal Clinic/ Postnatal Clinical Governance sub-group.
- Findings to be discussed at the Delivery Suite Clinical Governance sub-group.
- Findings to be published in the Clinical Governance newsletter

Statements of assurance from the Board continued

6220 Maternity CNST Missed Appointments

- Review policy and amend non-attendance flow-chart.
- Disseminate to midwives via Team Leaders meeting and minutes
- Highlight findings and above in Clinical Governance newsletter.
- Raise at Antenatal Clinical Governance sub-group

6221 Maternity CNST Mental Health

- Revise awareness on the Health and Safety mandatory training day (2012) around documentation of risk assessments.
- Present the audit at Team Leaders meeting.
- Update Mental Health guideline to change the Whooley questions, now to be asked at booking and in 3rd trimester.
- Disseminate findings through Team Leaders meeting and minutes.
- Discuss at Perinatal Mental Health Clinical Action Governance meeting.
- Discuss findings at mandatory obstetric update day.
- Publish findings in Clinical Governance newsletter.
- Discuss at Antenatal Clinical Governance sub-group

6223 Maternity CNST Maternal Antenatal Screening Tests

- Disseminate results to Team leaders meeting and minutes.
- Review the process of checking results for clinics held with no intranet access.
- Remind staff to document results by the 16 weeks appointment in the Clinical Governance newsletter
- Raise at Antenatal Clinical Governance sub-group.
- Women to be given written results whether positive or negative for all screening tests.

6224 Maternity CNST Immediate Care of the Newborn

- Disseminate to Obstetric, Midwifery and Paediatric teams via newsletter (Group B Strep)
- Present at SCBU Governance & Audit meeting
- Present meconium findings at Paediatric audit meeting
- Findings of meconium audit to be disseminated to all midwives via Team Leaders
- Discuss the pilot and introduction of NEWS chart at SCBU Clinical Governance

6226 Maternity CNST Examination of the Newborn

- Present at Paediatric audit meeting.
- Ensure all trained midwife practitioners are aware of complete documentation, individual newsletter and minutes to be emailed.

6227 Maternity CNST Bladder Care

- Disseminate findings to staff via Team Leaders meeting and minutes
- Publish findings in Clinical Governance newsletter
- Results to be discussed at the Antenatal and Postnatal Clinical Governance sub-group

6228 Maternity CNST Clinical Risk Assessment (Labour)

- Disseminate findings to all staff via Team Leaders meeting and minutes
- Publish findings in Clinical Governance newsletter
- Raise at Delivery Suite Clinical Governance sub-group

6229 Maternity CNST Admission to Neonatal Unit

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

Statements of assurance from the Board continued

6230 Maternity CNST Clinical Risk Assessment (AN)

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

6231 Maternity CNST Recovery

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

6232 Maternity CNST Support for Parent(s)

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

6233 Maternity CNST Maternity Records

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

6234 Maternity CNST Booking Appointments

- Ensure all staff are aware of policy, through Team Leader meeting and minutes.
- Findings published in Clinical Governance newsletter
- Raise and discuss at Antenatal Clinical Governance sub- group.

6235 Maternity CNST Severely Ill Women

- Highlight the requirement to document the following via the newsletter, Team Leaders and Delivery Suite sub-group:-
- Respiratory rate
- The totalling of red and yellow scores
- The referral to Obstetrics Registrar when appropriate
- MEOWS chart to be correctly filed chronologically behind Obstetrics and Gynaecology divider.
- Findings to be disseminated to all midwives via Team Leaders.
- Findings to be sent the Midwife Education Lead so they can be incorporated into the Obstetrics and Gynaecology mandatory day ' Early Recognition of the Severely Ill Pregnant Women' session for 2013.
- To be taken to Delivery Suite Clinical Governance sub-group.
- Publish findings in Clinical Governance newsletter.

Statements of assurance from the Board continued

6236 Maternity CNST Maternal Transfer by Ambulance

- To highlight at Team Leaders all the documentation requirements for transfers in Action from the community.
- Disseminate findings to Team Leaders via the newsletter and also Clinical Governance sub-group.

6237 Maternity CNST Handover of Care (Onsite)

- Findings will be disseminated to all Midwives and Midwifery Care Assistants (MCAs) via Team Leaders.
- Findings to be sent to the A&C manager for dissemination to all ward clerks.
- To be discussed at Delivery Suite Clinical Governance sub-group.
- Publish findings in Clinical Governance newsletter.

6238 Maternity CNST Vaginal Birth after Caesarean Section

- Findings will be disseminated to all midwives via Team Leaders.
- Findings will be discussed at the Antenatal Clinic and Post Natal Clinical Governance sub-group.
- Findings will be discussed at the Delivery Suite sub-group.
- Audit findings to be published in the Clinical Governance newsletter.

6239 Maternity CNST High Dependency Care

- Highlight to anaesthetists the need to complete an SBAR form.
- Highlight to obstetric medical staff the requirement to complete an SBAR handover if women go directly to ICU form maternity services. To include this requirement in the April newsletter and the Clinical Governance sub-group meeting.
- Reminder to midwifery and obstetrics staff to complete SBAR transfer form via Team Leaders meeting and minutes.
- Findings to be discussed at the Delivery Suite Clinical Governance sub-group.
- Findings to be published in Clinical Governance newsletter.
- To include SBAR handover as a trigger on the WHO Maternity Safety checklist.

6022 Tissue Donation - Eye Retrieval

- No plan implemented

6030 Intravitreal Injection of Lucentis (Ranibizumab) for Neovascular Age Related Macular Degeneration (ARMD) by Ophthalmic Nurse Practitioners (NP)

- No plan required

6132 Diabetic Retinopathy Screening Service (DRSS)

- Funding for image management software is needed to implement 'virtual clinics' for service provision.

6152 Accuracy of Horizontal Squint surgery

- No action required

6190 Glaucoma (CG 85)

- Ensure full assessment of patients is carried out, to include;
- IOP measurement using Goldmann applanation tonometry (slit lamp mounted)
- CCT measurement
- peripheral anterior chamber configuration and depth assessments using gonioscopy
- visual field
- Review and amend current patient information leaflet.
- Highlight the importance of accurate documentation, through team meetings

6196 Surviving Sepsis

- Amend managing sepsis bundle pending issue of updated guidelines
- Education/ Training of medical and nursing staff re the correct implementation of 'bundle'
- Update of 'Surviving Sepsis' local guidelines when international update available

Statements of assurance from the Board continued

6191 Incidence and Subsequent Outcome of B1 Breast Biopsies

- No action required.

6198 Reporting Accuracy of Chest Radiographs in Patients Subsequently Shown to have Lung Cancer

- No action required.

6205 Uterine Artery Embolisaton for the Treatment of Fibroids (IP-367)

- No action required

6240 PET/ CT Correlation with Pathology in Lung Cancer Staging

- T-staging needs to be improved, this will be achieved by reviewing previous cases to look for learning points then feedback to and discuss with the 'team'.

6140 Femoral reamings and histology - Post operative follow up

- Add histology section to patient details section of trauma list
- Remind all staff through Clinical Effectiveness meeting that histology should be chased and clearly documented in the notes
- Histology/ Reamings documentation on consent form
- Add Histology/ Reamings to operating list
- Documentation of positive/ negative histology result should be added to Infloflex summary

6170 Follow-up of children who have failed to attend fracture clinic appointments

- Re-distribute guideline to all staff to ensure they are familiar with the policy
- DNA sheets used at the end of clinic need to have age of patient printed on them to prompt clinician to review case notes
- All DNAs to be dictated in future

6261 Prophylactic antibiotic guideline for fracture of hip repair to minimise clostridium difficile (C.diff) infections

- No action required

6029 Negative pressure wound therapy (NPWT) for the open abdomen (IP-322)

- No action required

6096 Infoflex Care Planning Summaries (CPS) - Safeguarding Children

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

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

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

Statements of assurance from the Board continued

6135 Liverpool Care Pathway (LCP) ~ 2011/ 2012

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

6136 Note keeping 2011/ 2012

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

6169 Safeguarding Adults - Form 4 Consent

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

Anaphylaxis Awareness (CG-134)

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

Statements of assurance from the Board continued

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

ND0106 - Are We There Yet? A review of organisational and clinical aspects of children's surgery

- Guideline for the care of the critically ill and injured child being ratified compliant with PICS standards, Regional HDU and Regional Surgical Network Standards.

ND0098 - Bariatric surgery for weight loss

- Development of follow-up guidelines for patients discharged back to primary care after bariatric surgery and follow-up in the Level 3 service.

ND0103 - Knowing the risk - A review of the peri-operative care of surgical patients

- No action plan required.

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 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1798.

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

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

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

As well, in the last three years, more than 28 publications have resulted from our involvement with the National Institute Health Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

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

Ophthalmology

The INTREPID study

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

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

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

Diabetes

The EXPLORER study

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

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

Cancer

The Stanford V study

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

Statements of assurance from the Board continued

CQUIN payment

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

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

In 2012/13 the potential value of the CQUIN payment was £4,519,547 and income subsequently received was £4,360,278 (tbc). In 2011/12 the potential value of the CQUIN payment was £2,543,000 and the income subsequently received was £2,487,054.

In 2013/14 the value of the CQUIN payment is £4,000,000 (tbc).

Care Quality Commission

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

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

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

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

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

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

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

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

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

Data quality

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

Statements of assurance from the Board continued

NHS number and general practitioner registration code

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

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

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

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

Information governance

South Devon Healthcare NHS Foundation Trust Information Governance Assessment report overall score for 2012/13 was 84% 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 treatment coding (clinical coding) were:

Neonatal disorders

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

Thoracic procedures and disorders:

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

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 2012/13

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

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

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

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

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

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

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

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

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

  The following indicators were audited:

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

  No errors were identified in the samples tested.

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

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

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

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

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

Statements of assurance from the Board continued

Improving the overall experience for patients

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

  Several additional Board level audits were undertaken including:

NHS Litigation Authority Audit

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

The objectives of the audit were to:

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

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

Clostridium Difficile

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

The following were tested to confirm that:

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

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

Accident and emergency 12 hour trolley wait

The Trust is required to report any incidences where a patient waited more than 12 hours in the Accident & Emergency (A&E) Department, from the time the decision was made to admit the patient or when treatment in A&E is completed.

An audit was undertaken in Spring 2012 to review the number of patients admitted to A & E to establish whether there had been any incidents where a patient may have breached the 12 hour waiting time, which had not been reported as required.

The results of the audit indicated that there were/were not x number of patients waiting for longer than 12 hours. It was also noted that the processes monitoring waits could be further improved and a new A & E system is being implemented in 2013/14 which will support improved monitoring.

Statements of assurance from the Board continued

Data quality improvements: looking back 2012/13 continued

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

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

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

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

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

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

Statements of assurance from the Board continued

Data quality improvements: looking forward 2013/14

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

- Giving clinicians access to information as part of service line reporting to support their clinical duties and also help identify and resolve any data quality issues.
- Publish the Information and IT Strategy by summer 2013 with a heavy emphasis to implement systems which support data quality.
- Start to implement the new Emergency Department IT system which will involve paperless working by August 2014
- Implement fully patient held records system (Patients Know Best) for the Diabetic service providing patient's visibility of data, errors or omissions which can be feed back to the areas concerned. Sharing laboratory results, Care Plan Summaries, Outpatient Outcome letters.
- Implement UltraGenda, enterprise wide laboratory scheduling for clinicians by producing events, clinical pathway required for Oncology by December 2013. The system automation minimises manual errors.
- Create a test environment for a clinical portal by summer 2013 and when fully tested start to roll out to 80% of the clinical teams by March 2014. This will enable the clinical teams to analyse data and improve practices e.g. reviewing laboratory results alongside other data from four other clinical systems in a central view per patient.
- Electronic Document Management: continue to develop the use of this product and support areas with paperless/paperlight working. Pilot using the iPad for outpatient data capture will be undertaken by Speech & Language Therapy.
- Deployment of clinical mobile devices based on the Apple iPads and iphone will support clinicians to record and review information on wards at the patient's bedside using systems such as VitalPAC to record vital signs observations
- Roll out additional software modules of VitalPAC around infection prevention and automatic doctor escalation and feedback.
- Continue the roll out of the Surgical Operation Note to enhance patient care and make information available to all clinicians via the clinical portal. Eleven specialties are live with the Surgical Operation Note, with three still to go live, although one of the three is Trauma and Orthopaedics one of the largest surgical areas.
- Act on the recommendations from the External Auditor of the three nationally mandated data quality audits for 2012/13 Quality Accounts. These are:

External Data quality audits 2012/13

Clostridium difficile

Measurement criteria: All infections which occurred in an individual aged 2 years old or older, where a specimen is taking at least three days after admission.

62 Day Cancer Wait

Measurement criteria: 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.

Patient safety incidents

Measurement criteria: All unintended or unexpected incidents that could or did lead to harm of a patient - with severe harm and death - being resulting in permanent harm or death.

Mandated quality indicators

Quality Indicators

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

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

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

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

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

Mandated quality indicators

Patient safety

Quality indicator	Source	Benchmark (National or Local)	2012/13	2011/12	2010/11	End of year performance against Benchmark
VTE risk assessed	UNIFY	90% (National)	92%	Not applicable	Not applicable	

- *In 2012/13 quarter 3 the lowest performing Trust was 84.6% and the highest was 100%*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this %, and so the quality of its services, by capturing information electronically rather than through case note audits. This has allowed accurate reporting and timely feedback to clinical teams about their performance.

Number of clostridium difficile cases (rate per 100,000 bed days)	Health Protection Agency (6a)	19.8	17.5	19.5	21.1	

- *In 2011/12 the worst performing trust rate was 51.6 and the best performing trust rate was 0.*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number, and so improve the quality of its services, by the management of C diff using electronic white boards and EDDs to identify patients with CDT / GDH positive and PCR positive that are being discharged. This allows the deep cleaning team time to arrange for the rooms to be bioquelled .This has given added assurances to the standard of cleaning as well as ensuring areas are returned back to operational use in the shortest time .
- The bioquell system has also been used for norovirus outbreaks reducing further risks of acquisition of C diff. The trust continues to have effective infection control processes which are always under review to meet the challenges of a complex and changing operational system.

Number of never events	Safeguard	0	2	0	0	

- South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number through reviewing the never event framework and what processes and polices we have in place to prevent these incidents.
- With regards to the two never events in 2012/13 , a standard operating procedure (SOP) is in place for the insertion of prosthesis in theatres and a surgical style swab count has been successfully implemented in the non theatre intervention suites to ensure the safety and quality of our patient care

Number of patient safety incidents	Safeguard	Not applicable	4506	4854	4577	Not applicable

- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by encouraging all staff to record and report incidents on the Trust's internal Safeguard risk management and therefore we set no reduction target as this may have a negative effect on reporting.
- The NRLS actively encourage organisations to report more incidents to ensure organisations have a clear picture of what incidents are taking place.

Mandated quality indicators continued

Patient safety continued

Quality indicator	Source	Benchmark (National or Local)	2012/13	2011/12	2010/11	End of year performance against Benchmark
Number & % of such patient safety incidents that resulted in severe harm or death.	Safeguard					
Number			25	50	79	
%		10% reduction yr on yr	0.55%	1.03%	1.7%	

- *Of this figure, NRLS report for the six month April '12 to September '12 had 2000 incidents, of which 13 reported were severe harm or death.*
- *Nationally, 67% of all incidents are reported as no harm and just under1% as severe harm or death.*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to reduce this number and so improve the quality of its services by undertaking a root cause analysis investigation on all major and catastrophic incidents.
- The Trust, through its safety work uses this data to help improve the quality and safety of its systems and services and is seeing a year on year reduction. The ultimate aim of the trust is to remove all avoidable harm from the system.

Mandated quality indicators continued

Patient experience

Quality indicator	Source	Benchmark (National or Local)	2012/13	2011/12	2010/11	End of year performance against Benchmark
Patient Reported Outcome measures	PROMS online	April - Dec 2012	April - Dec 2012			
Groin hernia surgery		0.09	0.089	0.089	-	
Varicose vein surgery		n/a low number	n/a low number	n/a low number	-	
Hip replacement surgery						
Knee replacement surgery		0.321	0.298	0.317		

- *PROMS are a measure of patient perceived health gain based on patient survey results before and after treatment. The high/ low scores reported by trusts in 2011-12 are groin hernia 0.153 / 0.017 varicose vein 0.167/0.047, hip 0.532/0.306 and knee 0.385/0.180.*
- *For varicose veins the number of patient surveys completed is so low that is not statistically significant. However, form the surveys completed 50% of patients (3) reported a health gain and 50% (3) reported no change following the procedure.*
- South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve this rate, and so the quality of its services, by ensuring that patients are fully engaged in the PROMS process and data is returned to inform these rates. The results of completed survey will be used and disseminated to relevant doctors.

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

- *In 2012/13 the best performing acute trust scored 4.08. No score has been published for the worst performing trust.*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by engaging with staff to understand issues and to work proactively to improve the quality of care.

Number of patient safety complaints	Safeguard	Not applicable	227	173	170	Not applicable

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

Our performance against mandated quality indicators

Patient experience continued

Quality indicator	Source	Benchmark (National or Local)	2012/13	2011/12	2010/11	End of year performance against Benchmark
Overall patient experience	NHS Inpatient survey	7.1 Lowest performer	8.1	Not applicable	Not applicable	

- *In 2012/13 the best performing trust scored 9.0 and the worst performing trust scored 7.2.*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by capturing real time patient feedback promptly and ensuring there are robust mechanisms to respond to complaints, any improvements required and providing ongoing feedback to staff.

Our performance against mandated quality indicators

Clinical effectiveness

Quality indicator	Source	Benchmark (National or Local)	2012/13	2011/12	2010/11	End of year performance against Benchmark
% of patients aged readmitted to hospital within 28 days	Dr Foster					
•0-14		5.8%	4.0%	4.2%	4.4%	
•=>15		7.4%	4%	7.4%	7.6%	
Relative risk* for all ages		100*	97.9	98.4	98.7	

- *In 2012/13 the best performing trust in the Strategic Health Authority catchment area scored 48.5% and the worst performing trust scored 5.7%.*
- *With regards to relative risk, in 2012/13 the best performing trust in the Strategic Health Authority catchment area scored 89 and the worst performing trust scored 107 against the 100 benchmark.*
- *Dr Foster relative risk benchmark – this is a benchmark against the national average. The figure of 100 represents the national average performance. Scores lower than 100 represent better than average performance.*
- South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by working with consultant teams and community services to audit and undertake root cause analysis of patients who have been readmitted to hospital. Where this identifies potential areas for improvement these will be used to form the basis of an ongoing action plan and future service developments

Summary hospital mortality indicator (SHMI)	Dr Foster	100	Oct 11-Sept 12 95.45	94.08	94.9	
Hospital Standardised Mortality rate (HSMR)	Dr Foster	100*	87.5	89.7	96	

- *With regards to SHMI relative risk, in 2011/12 the best performing trust scored 75.7 and the worst performing trust scored 121.*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services by maintaining a proactive approach to patient safety. This is managed through the Patients Safety Committee and its subcommittees so that regular reviews of all clinical incidences are completed as well as taking action if any alerts are received from Dr Foster.

Our performance against mandated quality indicators

Clinical effectiveness

Quality indicator	Source	Benchmark (National or Local)	2012/13	2011/12	2010/11	End of year performance against Benchmark
% of patient deaths with palliative care coded at either diagnosis or speciality speciality level	Dr Foster	Oct 11-Sept 12				
Relative risk		100	90.6	97.4	83.2	
%		N/A	14.3%	14.0%	13.8%	

- *With regards to % of patient deaths coded, in 2011/12 the best performing trust scored 37.6% and the worst performing trust scored 8.56%*
- South Devon Healthcare NHS Foundation Trust has taken the following actions to maintain this rate by identifying all patients clearly for the clinical coding department. There are internal audits to ensure that all the identified patients have been coded correctly. The benchmarking data shown above gives assurance that these cases are being appropriately coded and that rates are at expected levels.

OUR PERFORMANCE IN 2012/13

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 governance arrangements in place to monitor our organisational performance and to make sure that annual national and local agreed standards and targets are met. This includes five governance work streams which report to the Trust Board.

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

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

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

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

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

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

Monitor - Risk ratings at a glance – 2012/13

Finance

Governance

KEY

1= Highest risk

5= Lowest risk

Red = Highest risk

Green= lowest risk

Source: Monitor website: 09/4/2013

Our performance against key national priorities

Monitor

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

Indicator/Target	Target 12/13	2012/13	2011/12
C.difficile year on year reduction	20	21	24
MRSA - Meeting the MRSA objective	1	1	0
Cancer 31 day wait from diagnosis to first treatment	>96%	98%	98%
Cancer 31 day wait for second or subsequent treatment: surgery	>94%	97%	97%
Cancer 31 day wait for second or subsequent treatment: drug treatments	>98%	100%	100%
Cancer 31 day wait for second or subsequent treatment: radiotherapy	>94%	98%	97%
Cancer 62 day wait for first treatment (from urgent GP referral)	>85%	88%*	90%
Cancer 62 day wait for first treatment (From consultant led screening service referral)	>90%	96%	93%
Cancer two week wait from referral to first seen date	>93%	97%	97%
Cancer breast symptoms two week wait from referral to first seen date	>93%	98%	100%
A & E – total time in A & E	95% <4hrs	96%	98%
Referral time to treatment time, admitted patients	90%<18 weeks	92%	93%
Referral time to treatment time, non admitted patients	95%<18 weeks	96%	97%

**Audit of the 62 day target from the national data collection system (Open Exeter) returns 89%. There is mismatch in data due to reporting dates. There are no data accuracy issues.*

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:

Other National and local priorities	Target 12/13	2012/13	2011/12
Smoking during pregnancy	19.4%	15.0%	15.8%
Breastfeeding initiation rates (% initiated breast feeding)	76.3%	76%	74.6%
Mixed sex accommodation breaches of standard	0	1	9
Cancelled operations on the day of surgery	0.8%	1.2%	0.7%
DNA rate	6%	5.5%	5.7%
Diagnostic tests longer than the 6 week standard	1%	1%	1.5%
Rapid access chest pain clinic waiting times: seen in 2 weeks	98%	100%	100%
Primary PCI within 150 minutes of calling	68%	85%	88%
Patients waiting longer than three months (13 weeks) for revascularisation	0.1%	0%	0%
Stroke care: 90% of time spent on stroke ward	80%	79%	89%
Diabetic retinopathy screening	95%	92%	97%
Ethnic coding data quality	80%	94%	95%
Patient Environment Action Team Assessment (PEAT) Experience	Good	Good	Good

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

Annex 1

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

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

Annex 2

Engagement in developing the Quality Accounts

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

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

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

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

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

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

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

South Devon and Torbay Clinical Commissioning Group

Quality Accounts 2012-13 Commissioner commentary

South Devon and Torbay CCG (SDT CCG) has taken over from NHS Torbay as the lead commissioner for South Devon Healthcare NHS Foundation Trust (SDHFT) and is pleased to provide a commentary on these Quality Accounts.

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 is commended.

We note the clinical audits that the Trust report involvement with, and those they were unable to participate in. 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.

A number of incentive schemes under the CQUINs this year have been agreed with commissioners, which demonstrate the organisation's determination to continually improve the quality of care.

Looking Back

We, as commissioners were pleased to support the priorities selected by the Trust last year. In particular we are pleased to note the success of the Productive Ward initiative and the reported improvements although we feel that the report would have been enhanced by the inclusion of more information about the improved outcomes in terms of patient experience, patient safety and efficiencies.

The improvement in information about medicines was a response to patient feedback and the review of patient leaflets is welcomed, as is the work with young people moving from children's health services to adult services. Commissioners are pleased to note the development of a new transition pathway of care, and the outcomes so far in terms of a new framework and positive relationships. We look forward to the evolution of this initiative across other long term conditions and improved outcomes and experiences for more young adults.

Excellent 'End of Life' care is important for people and their families, and we are pleased with the reported success of last year's project 'Routes to Success', and in particular the increased awareness of End of Life issues across the Trust, and improved communication with other parts of the health care system. We are pleased to see that this work will continue next year.

The initiative to improve communication with patients and their GPs is important in terms of patient experience and safety and we are pleased to note the progress being made in this area and we look forward to continual improvement over the coming year. Timeliness of communication to GPs is also important to patient safety and we note and commend the improvements made by the Trust.

It is pleasing to note that the majority of Trust staff would recommend the Trust as a place to work or to receive treatment, and that the Friends and Family test is being used by the Trust to measure patient satisfaction with services. We also commend the Trust for the 'i-Torch project'.

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

South Devon and Torbay Clinical Commissioning Group continued

Looking Forward

The CCG is happy to support the five quality improvement priorities chosen for next year as set out in the Quality Account.

The goal of reducing the prevalence of pressure ulcers for patients is an important one, as they can severely impact on patient's lives, as well as increasing their risk of infection. Pressure ulcers occur in between 4 and 10% of hospital patients and nationally cost the NHS up to £2bn per annum, as well as untold misery to patients and carers. We believe that staff engagement and improved knowledge is key to improving incidence of Pressure Ulcers and we applaud the focus of the Pressure Ulcer Steering Group, and look forward to seeing a reduction in the numbers of pressure ulcers during the next year.

The very successful 'enhanced recovery' programme is due to be rolled out into medicine next year, and it will be exciting to see if the success reported within surgery can be repeated on medical wards, with improved outcomes for patients and carers. We very much look forward to seeing the results through the year ahead. Commissioners are also fully supportive of the integrated heart failure service initiative and its potential for improving quality of care across the community for patients with heart failure, both in terms of patient experience and also improved survival rates.

The final priority about seeing whether weekend ward clerk cover could release more time to care supports the drive to move to effective seven day care and is therefore welcomed. It will be interesting to see the impact of the test of change over the coming months.

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. 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.

However we do feel that the Trust could have mentioned the two Never Events that occurred during the year within the section on 'Looking Back' and used that section of the report to describe the learning from those two incidents so that patients and the wider public are provided with evidence of the Trust's determination to learn from experience and to continuously improve.

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

NHS South Devon and Torbay Clinical Commissioning Group

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

Trust Governors

Governor Statement against the 2012/2013 Quality Accounts

The Governors' Statement begins by placing on record its recognition of the Trust's considerable achievements during the year. In December 2012 Paula Vasco-Knight was named as the best in her field at this year's prestigious NHS Leadership Recognition Awards and the Trust's Board was a finalist in the Board of the Year category. In March 2013 Torbay Hospital was ranked as the 10th highest performing Hospital Trust in the country in a new report by independent health think-tank, MHP Health Mandate.We extend our thanks and congratulations to the Chief Executive Officer and all her staff; never has it been more apparent that they are indeed our most valuable resource.

Front line staff and services have continued to focus on patient needs, and to learn from the patient experience. This year we have seen the successful completion of the 'productive ward' work with clinical teams redesigning their services to enable more direct care at the bedside. The improved services to support children transitioning from paediatric services to adult services is proving to be successful as it has been designed through listening and working with children and their families.

In 2013/14 this focus on releasing clinical time for extra patient care continues to be a theme with the extended use of ward clerks into the evenings and weekends. This is one of the priorities identified for the coming year by the Stakeholder Quality Engagement Committee, which included two Governors.

The Governors have also welcomed the work on dementia and look forward to improvement in dementia case finding, risk assessment and referral in 2013/2014.

The Quality and Compliance Committee has continued with its remit of ensuring that a cadre of Governors is fully conversant with the Trust's attention to the Care Quality Commission and its operation, and, with the co-operation and goodwill of the five Workstreams (to which has now been added the Audit & Assurance Committee), receives at each of its quarterly meetings a report from the respective Governor Observer on the matching of their respective CQC Outcomes, assigned functionally, with supporting evidence. This has the added benefit of constituting the first source of information for unscheduled CQC visits.

The Committee has it in mind to develop the role and responsibility of the Workstream Observers, partly to contribute to the delivery of the additional responsibility placed on Governors of "holding the Non-Executives, collectively and individually responsible for the performance of the Board", and partly to re-enforce the objective of ensuring individual Workstream compliance with the need to observe the CQC Outcomes.

The Committee has occasionally invited speakers to give presentations, and these have included officers from the CQC itself, as well as in-house speakers.

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

Torbay Council's Health Scrutiny Board

Statement from Torbay Council's Health Scrutiny Board on South Devon Healthcare NHS Foundation Trust's Quality Account 2012/2013

South Devon Healthcare NHS Foundation Trust's Quality Accounts for 2012/2013 has been considered by Torbay Council's Health Scrutiny Board. The Board welcomes the clarity with which the Trust has explained how it has met its priorities for 2011/2012 and what its priorities are for the forthcoming year.

Throughout the year, the Board have been focussed on how organisations can work together to reduce the demand for acute services especially in light of the growing ageing population in Torbay. The Quality Account highlights how the Trust is also taking account of these issues.

In being able to consider the Quality Accounts from all of the Trusts that it works with at the same time, the Board has been able to easily identify the inter-relationships between the different initiatives of the different Trusts.

The priority for the coming year of testing the cost:benefit of employing ward clerks during the evening and at weekends will aim to increase the number of discharges which can be made during these times. Whilst it will have a positive impact on some other services, medical staff, social care staff and carers need to work closely together to ensure that the home-based care is in place.

The Board commends South Devon Healthcare NHS Foundation Trust for its openness and transparency of its operations. Given the reducing availability of resources in the public sector, the Board would seek to ensure that all Trusts continue to work together for the benefit of the whole Torbay community.

May 2013

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

Devon County Council Health and Wellbeing Scrutiny Committee

Commentary on the South Devon Healthcare NHS Foundation Trust Quality Account

Due to Council elections and the timing of its submission for comment, Devon County Council's Health and Wellbeing Scrutiny Committee has been unable to consider the South Devon Healthcare NHS Foundation Trust Quality Account this year

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 approach Devon County Council's Health and Wellbeing Scrutiny Committee will welcome a continuation of the positive engagement process from South Devon Healthcare NHS Foundation Trust in the coming year.

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

Healthwatch Torbay

Healthwatch Torbay response to South Devon Healthcare NHS Foundation Trust Quality Accounts 2012/13

This extensive report is very encouraging. The particular references on the need to focus on quality improvement, patient needs, the patient experience and to work together to achieve this focus is very promising.

At Healthwatch Torbay we share the aim to achieve a high quality service and experience for patients, and look forward to the chance to share feedback and work together to achieve this focus and build a strong relationship with the Trust.

With this in mind, the significant improvements highlighted on wards in the awareness and understanding of how you currently perform, improved medicine management, more efficient handovers and the quality of end of life care provision are particularly positive. The Trust should also be commended for the notable results of the NHS inpatient survey of overall patient experience.

Their continuous work on improving patient safety, clinical effectiveness and patient experience is also encouraging and we look forward to seeing further positive feedback over the next 12 months, particularly the results of the 'friends and family test' .

With the much publicised issues with growing demand in A&E departments, we also look forward to the new A & E system to support improved monitoring (p49) and are keen to see how it develops.

Healthwatch Torbay welcomes the recommended improvements highlighted in the account and also the outlining of its key priorities for the coming year. We are anxious to mutually share any patient feedback with each other and look forward to continue working with the Trust over the next 12 months

Annex 2

Statements from Commissioners, Governors, OSCs and Healthwatch

Healthwatch Devon

Commentary provided by Healthwatch Devon for South Devon Healthcare NHS Foundation Trust's Quality Account 2012/13

Healthwatch Devon welcomes the opportunity to respond to South Devon Healthcare NHS Foundation Trust's (SDHCFT) Quality Account for 2012/13.

Healthwatch Devon commends SDHCFT for its continued commitment to improving the quality of care for patients on the ward, in particular through directly involving patients and carers in the handover process and enabling more time to be dedicated to the delivery of front line patient care. SDHCFT's focus on improving the experience for patients and carers is illustrated clearly through what has been achieved as a result of the various work strands, specifically through the end of life care project, the productive ward programme, the ready, steady, go approach and 'observations of care'. This work is extremely valuable in taking forward a commitment to improve the quality of care for the patient and carers and their overall experience of the service.

A key function for Healthwatch Devon is to collect the views and experiences of patients and the public about local health and care services and these will 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 during the coming months to ensure that all experiences and views that are captured, that relate to services delivered by SDHCFT, will be fed back to SDHCFT to inform any work that is being undertaken to improve services for patients 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 2012-13*;
- 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 2012 to May 2013
  - Papers relating to quality reported to the Board over the period April 2012 to May 2013
  - Feedback from the Commissioners, South Devon and Torbay Clinical Commissioning Group dated 28/05/2013
  - Feedback from Governors dated 17/05/2013
  - Feedback from local Healthwatch organisations dated 24/05/2013 and 28/05/2013.
  - Feedback from other stakeholders involved in the sign off of the Quality report dated 21/05/2013
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated November 2012
  - The 2012 national inpatient survey dated 16/04/2013
  - The 2012 national staff survey dated 28/02/2013
  - Care Quality Commission quality and risk profiles dated March 2013
  - The Head of Internal Audit annual opinion over the trust's control environment dated April 2013
- 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

28.05.2013  **Peter Hildrew**, Chairman

28.05.2013  **Paula Vasco-Knight**, Chief Executive

Available in large print on request

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NHS Foundation Trust

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