South Devon Healthcare NHS
NHS Foundation Trust

Quality Account 2013/2014

PATIENT SAFETY
CLINICAL EFFECTIVENESS
PATIENT EXPERIENCE

ABOUT THIS DOCUMENT

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

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

Our 2013/14 quality account is an annual report of:

- How we have performed over the last year against the quality improvement priorities which we laid out in our 2012/13 quality account.
- Statements about quality of the NHS services provided.
- How well we are doing compared to other similar hospitals.
- How we have engaged staff, patients, commissioners, governors, Healthwatch and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year.
- Statements about quality provided by our commissioners, governors, OSCs, Healthwatch and trust directors.
- Our quality improvement priorities for the coming year (2014/15).

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

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 account. If you are interested in commenting or seeing how you can get involved in providing input into the trust's future quality improvement priorities, please contact susan.martin@nhs.net or telephone 01803 655701.

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INTRODUCTION & STATEMENT OF QUALITY FROM INTERIM CHIEF EXECUTIVE

We focus on providing safe, high quality services so that our patients, staff and public experience the best possible care from South Devon Healthcare NHS Foundation Trust.

As a practising consultant gastroenterologist with over 20 years' experience at Torbay Hospital, I am passionate about improving the quality of care for our local population and believe that the development of an integrated health and care system for South Devon and Torbay is essential to deliver this.

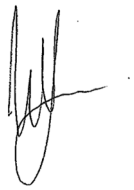
In 2013/14 we secured 'Pioneer' status. This means the government has approved our health and care community as a national pilot for developing ground-breaking integrated services. One of the immediate priorities for our trust is to merge with Torbay and Southern Devon Health and Care NHS Trust to develop a single integrated care organisation. Our shared ambition is to provide the most streamlined and person-centred care in the country. Whether the issue is people moving between different health and care services, the standard of hospital food, nursing care or providing life-saving surgery, we believe our patients, families and carers deserve the very best quality services.

This quality account sets out progress against our quality improvement targets for 2013/14 and takes a look ahead to our priorities for the coming year. We do not set these targets in isolation: they reflect local, regional and national priorities and the feedback we receive from our patients and their representatives, staff and commissioners.

Our approach has always been to work with our partners to deliver quality improvement. For example, reducing the incidence of pressure ulcers in hospital was a priority for us last year. We will continue to progress this work in 2014/15, and are working with our colleagues in the community to target pressure ulcers acquired at home or in care homes. This joined-up approach to quality is vital if we are to continue to improve services and really achieve transformational change.

We know that 2014/15 will be a challenging year and we are already thinking of new ways to meet the challenges ahead. One of the most exciting projects for us in the coming months is the development of the new Horizon Institute. This new initiative brings together our knowledge, skills and expertise in quality improvement and innovation.

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



Dr John Lowes, Interim Chief Executive

PRIORITIES FOR IMPROVEMENT

Looking back: 2013/14

In our 2012/13 quality account we reported that we would focus on five priority areas for quality improvement in the period 2013/14. These were all locally agreed priorities based on national best practice and best clinical evidence.

Patient safety

Priority 1: To reduce the prevalence of hospital acquired pressure ulcers

Pressure ulcers, sometimes known as bed sores or pressure sores are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure with another area of skin over a short period of time, or when less pressure is applied over a longer period of time.

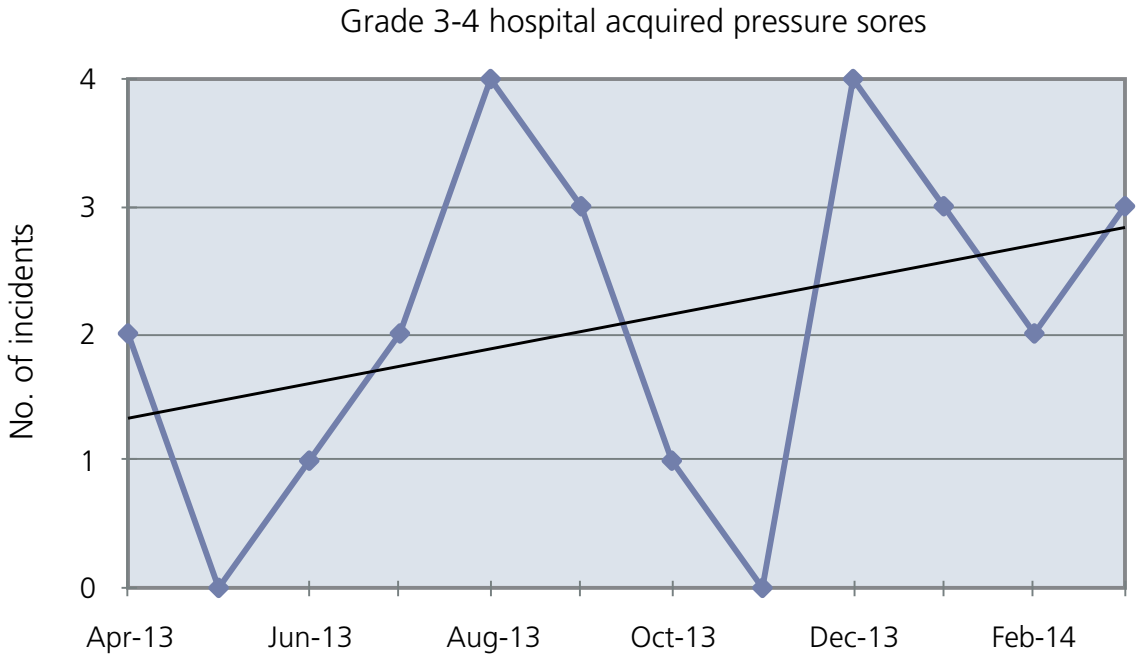
This pressure disrupts the flow of blood through the skin. Without a blood supply, the affected skin becomes starved of oxygen and nutrients and begins to break down, leading to an ulcer forming. These ulcers are classified according to their severity, grade 3 and grade 4 being the most severe.

Pressure ulcers tend to affect people with health conditions who have difficulty moving, such as people who are lying in a bed or sitting for prolonged periods of time. It is estimated that about half a million people in the UK will develop at least one pressure ulcer in any given year. This is usually people with an underlying health condition. For example, around one in 20 people who are admitted to hospital with a sudden illness will develop a pressure ulcer. For this reason pressure ulcers are taken very seriously

We use equipment to protect vulnerable parts of the body. The Trust has invested in ensuring that 100% of its beds are electric, making them easily adjustable, and all have special mattresses. We also have pressure-relieving equipment such as cushions and heel protectors. In addition our staff are supported with training packages and videos to ensure they are highly trained in the detection and prevention of pressure ulcers.

We also record the number of hospital acquired pressure ulcers via internal incident reporting and through the Department of Health's Safety Thermometer. The chart below is a record of the hospital acquired grade 3 and grade 4 pressure ulcers for the period 2013/14 recorded on our internal incident reporting system.

There have been in total 25 grade 3 and grade 4 over the last 12 months. This equates to 1.8 pressure ulcers per 10,000 bed days.



Patient safety continued

Priority 1: continued

Although we have seen a slight increase in reported incidences, despite all the improvement work undertaken, this can be explained in part by increased pressure ulcer reporting which we have been encouraging in 2013/14.

Unfortunately, even with the highest standards of care, it is not always possible to prevent pressure ulcers, particularly in vulnerable people.

In 2014/15 in order to drive change more, we have recently joined the local Pressure Ulcer Collaborative with the aim of reducing the number of hospital acquired pressure ulcers and reducing the risk of pressure ulcers across our local care system.

Clinical effectiveness

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

Enhanced recovery in medicine is a new approach to caring for patients admitted as a medical emergency to Torbay Hospital. This approach involves patients and their families/carers in decisions about their care to ensure our patients leave hospital safely and at the right time. Key to enhanced recovery in medicine is that patients are partners in their own care. This helps patients get better sooner and improves the experiences of patients, families and carers.

The principles of enhanced recovery include:

- Drinking plenty of fluids and energy drinks to keep hydrated and boost calorie intake.
- Getting dressed in day clothes rather than nightwear to maintain dignity and regain independence.
- Getting up as soon as possible to prevent muscles weakening through lack of use.
- Being involved in plans to ensure everything is in place for leaving hospital.
- Discussing prescribed medication with the pharmacy team to ensure patients get the optimum benefit from the medication.

Following a successful pilot on two emergency assessment unit wards in 2012/13, the programme has been rolled out to a cardiac and respiratory ward (Dunlop) and two elderly care wards (Cheetham Hill and Simpson)

The hospital has, as a result of the improvement work, invested in a stock of day clothes for patient use if they do not have relatives, friends or carers to bring in day clothing for them. This initiative has supported patients to get up and about earlier, prevent muscle weakness and improve their privacy and dignity.

On one ward, before the project started, less than 10% of patients were out of bed and dressed in day clothes. After the enhanced recovery principles were adopted, an average of 45% of patients were up and about sooner and dressed in day clothes

All patients on the enhanced recovery in medicine wards are offered an energy drink on a daily basis to boost their calorie intake. Between 50%-60% of our patients accept the drinks on a daily basis.

Patients are now offered the opportunity for their carer/principle family member to attend the morning consultant ward round. This enables joint care planning and decision making between the patients, carer and healthcare professionals, improving the patient's experience of being in hospital and enabling a smooth discharge from hospital.

Clinical effectiveness continued

Priority 2: continued

For staff as well as patients, carers and families, this new approach has been beneficial:

> "IT HAS HELPED US TO CHANGE THE WAY WE LOOK AFTER PATIENTS SO THAT THE INEVITABLE ANXIETY AND STRESS OF AN EMERGENCY ADMISSION IS REDUCED AS MUCH AS POSSIBLE. THE WHOLE CARE TEAM, INCLUDING DOCTORS, NURSES AND THERAPISTS, ARE ENTHUSIASTIC ABOUT THE PROJECT, WHICH PROMISES TO CHANGE OUR VALUES TO EMBRACE A MORE PATIENT-CENTRED APPROACH."
>
> Nurse

> "OUTSTANDING CARE. MY MOTHER WAS ENCOURAGED TO SIT RATHER THAN LIE IN BED AND TO WEAR HER OWN CLOTHES. THE CONSULTANT EXPLAINED EVERYTHING. THEY WERE ALL PROFESSIONAL. THEY SMILED AND THEIR MANNERISMS PUT ME AT EASE."
>
> Carer

During 2014/15 the aim is to continue to embed these principles into the wards that have already started to apply enhanced recovery in medicine.

We also plan to roll out enhanced recovery in medicine scheme to all remaining appropriate medical wards. The trust Enhanced Recovery Group will oversee and monitor this project.

Clinical effectiveness

Priority 3: Implement the integrated heart failure service

In the UK, heart failure accounts for a total of 1 million inpatient 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.

Over recent years the hospital has participated in the national audit of patients admitted with heart failure. Although this and previous peer reviews of our heart failure services has attracted praise there is certainly more we could do to improve the situation.

In June 2013 the trust appointed five heart failure nurses to identify and care for patients across our health and social care community. Our heart failure nurses are unique in the UK as they work across the hospital and the community and provide seamless integrated care for these patients and their families.

In its first year, this new service has already:

- Improved early diagnosis.
- Increased cardiology input and multi-disciplinary care.
- Provided better treatment.
- Improved patient education.
- Improved planned discharge.
- Improved hospital coding.
- Improved follow-up of these vulnerable patients.

For example:

We have asked our patients about the new service and they have told us:

> 'NURSES EXPLAIN SYMPTOMS AND TREATMENTS IN SIMPLE TERMS. THEY ARE FLEXIBLE WITH APPOINTMENTS AND FRIENDLY AND APPROACHABLE'
>
> Heart failure patient – 68yrs old
>
> 'VERY CARING. BRILLIANT THAT THE NURSE CAN VISIT ME AT MY HOME AT MY CONVENIENCE'
>
> Heart failure patient – 79yrs old

		Pre-integration 2013	Post-integration 2014
Seen by cardiologist		48%	74%
Seen by heart failure specialist		81%	88%
Readmissions		25%	21%
Heart failure follow up appointments		28%	65%
Echocardiogram		72%	80%
Left ventricular systolic dysfunction (LVSD) treatments			
	ACE/ARB	62%	95%
	B-Blockers	50%	81%
	MRA	50%	54%

Clinical effectiveness continued

Priority 3: continued

In addition the trust is testing a pioneering tele-health project to identify those patients showing signs of deteriorating health at home. The pilot was started in September and will run initially for 12 months. Over 80 patients from our community have been enrolled on the scheme so far.

The success of the scheme will be measured on improved self-management of the condition and a reduction in avoidable hospital admissions.

Within the next year we aim to:

- Introduce a blood test to help identify patients earlier with heart failure who come into hospital.
- Set up heart failure clinics in every community hospital.
- Help GPs validate their heart failure registers within their own practices.

Over the next few years we hope that our unique integrated heart failure service, led by our cardiology team, will develop further both within Torbay Hospital and across the community and act as a model for others on how to provide the best care for patients with heart failure.

Patient experience

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

The provision of high quality end of life care continues to be a priority for Torbay Hospital. In 2013/14 we aimed to build on the foundations laid in the national 'Routes to Success in End of Life Care in Acute Hospitals' project in which Torbay was a pilot site.

In 2012/13 the project identified that attendance of ward staff at the Enhanced Palliative Care Skills Course at Rowcroft Hospice was valuable in increasing awareness and confidence in delivering end of life care in hospital, as well as improving links and communication with community staff. (See 2012/13 quality account for more information at http://www.sdhct.nhs.uk) Since the original five nurses completed the course, a further three staff have attended this training.

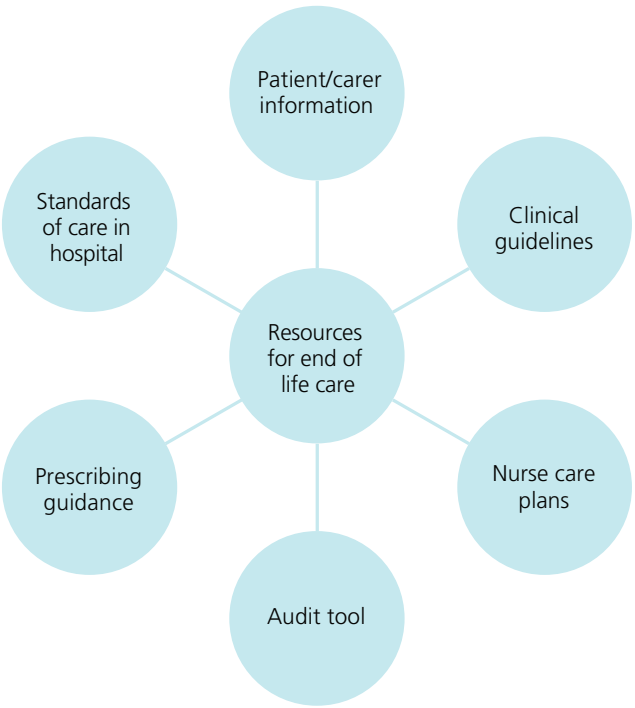
The ward nursing staff involved in the project have continued to be supported and mentored by the hospital palliative care team and have helped shape the proposed improvements for end of life care in the hospital by giving a ground level view of the measures.

The hospital palliative care team has continued the rolling programme of ward-based education for end of life care to maintain knowledge and skills of frontline staff.

In response to the national planned withdrawal of the Liverpool Care Pathway in July 2014, the local End of Life Care Pathway Group has been developing new measures to support good end of life care into the year ahead and beyond.

This 'bundle' of resources includes:

- Clinical guidelines for good end of life care.
- Nursing care plan for dying patients.
- Prescribing guidance for symptom control.
- Standards for care of dying patients in the hospital setting.
- An audit tool.
- Patient/carer information.



The measures will be launched across the whole healthcare community in early 2014. The aim of these measures is to support staff to work together with patients and families to develop tailored plans of care to best meet the individual's needs.

The resources are underpinned by an emphasis on good communication with patients and families and standards which can be audited to monitor the quality of care provided. The trust End of Life Care Group will oversee the implementation and monitoring of these new measures.

In 2014/15 we will also undertake a quality improvement project on our bereavement services and signposting for families and carers who have been bereaved. The details and measures can be found in the next section of the quality account as this will be a 2014/15 trust-wide quality improvement priority.

Patient experience

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

Ward clerks are an integral part of the ward team and undertake a range of administrative tasks to support the doctors, nurses and allied health professionals going about their daily work to care for patients.

Currently, with the exception of the A&E department which is staffed seven days a week, most ward clerks work Monday to Friday between 8.30am and 4.30pm. We know that demand for healthcare is rising. Administrative work does not stop at weekends or in the evenings as health care is a 24/7 service.

Over the last 12 months we have been running a pilot Sunday multidisciplinary ward round to ascertain the value of an additional ward round. This includes assessing whether there is improved continuity of care and increased discharges.

The 22 week pilot is due to finish at the end of spring 2014. The findings so far include:

It is helpful to have a ward clerk supporting the additional ward round to undertake the range of administrative tasks.

The ward clerk is more efficient if it is their 'home' ward as they are familiar with the teams they are working with and the ward processes.

An activity analysis of ward clerk work is due to start in May 2014. The results of this will supplement the findings of the pilot. The trust will then review the ward clerk post to ensure that the ward teams are effectively supported seven days a week.

Continuous quality improvement in 2013/14

In our last year's quality account 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. The next section is a snapshot of our progress from a number of our continuous quality improvement programmes reported to the board, including Commissioning for Quality Improvement and Innovation (CQUIN), a payment framework which enables commissioners to reward excellence by linking a proportion of the trust's income to local quality improvement goals.

Patient experience continued

CQUINs 2013/14

The trust has been involved in delivering nine CQUIN goals covering safety, clinical effectiveness and patient experience. Some of these goals are nationally mandated whilst others are locally agreed

A breakdown of the 2013/14 CQUINs can be found in annex 2. Two key goals described in more detail are:

Friends and Family Test

The Friends and Family Test was introduced nationally in 2013 by the Department of Health to enable patients to give feedback on the quality of care they have received by answering a simple question – 'would they recommend the ward, A&E or maternity services to their friends and family?'

During 2013/14 the trust has worked hard to set up and embed the friends and family test. Patients receive a questionnaire on discharge, have the opportunity to complete it anonymously and then return it by post or by dropping it into a friends and family post box located in different parts of the hospital.

The trust analyses the returns reporting the results both internally and externally. We aim to increase the number of returns as the process becomes more embedded into the organisation and patients become more aware of the importance of the test.

Over the last 12 months over 8,000 people have responded to the test. The majority of patients have responded that they are likely or extremely likely to recommend us to friends and family if they have treatment. Taking February as an example, the feedback is very positive:

Q 'How likely are you to recommend our ward to friends and family if they needed similar care or treatment?'

A "I found my treatment excellent. The way the doctors and staff explain what you are about to experience, puts your mind at rest, and I found I was able to be quite relaxed. Full marks to the NHS and your hospital. Thank you."

Cromie Ward

Ward	% of respondents said that they were: - extremely likely or likely to recommend us
Accident & Emergency	89%
Ainslie Ward	75%
Allerton Ward	100%
Cheetham Hill Ward	93%
Coronary Care Ward	100%
Cromie Ward	93%
Dunlop Ward	90%
EAU3 Ward	100%
EAU4 Ward	94%
Ella Rowcroft Ward	98%
Forrest Ward	93%
George Earle Ward	82%
Louisa Cary 16+ Ward	100%
McCallum Ward	100%
Midgley Ward	100%
Simpson Ward	93%
Turner Ward	100%

We also act on comments received by sharing positive and negative feedback with the ward teams from the friends and family test, letters and comments received as well as responses from our weekly patient survey.

To ensure patients, families and carers are aware that we do listen to feedback we have instigated a 'you said, we did' campaign.

You said: 'Some of the wards are noisy at night'

We did: 'Changed some of the noisy equipment and undertook observations of care to understand more of the issues'

Patient experience continued

CQUINs 2013/14 continued

Objective 2014/15: Friends and Family Test

In 2014/15 we will continue to focus on improving the response rate of our Friends and Family Test in A&E and on the wards. By the end of 2014/15 we aim to have improved our response rate from 6% to 20% in A&E and from 25% to 30% on our wards. We will also implement the test in new areas including outpatients. We are currently working with Healthwatch to see if we should develop an 'app' to help patients complete the question. We will continue to act on the feedback received.

Dementia

South Devon and Torbay has a higher proportion of older people than the national average. Currently 25% of the population is aged 65 or over. The elderly proportion of the population continues to grow and is estimated to increase to 30% by 2025.

With an older population, conditions such as dementia are more prevalent. Locally there is estimated to be about 5,000 people with dementia. Over the last year the trust has designed a new screening tool to enable us to identify patients over 75 who are admitted as an emergency who may have dementia. Alongside this tool, we have a comprehensive dementia educational programme and a clinician providing the leadership to ensure this tool to find, assess and refer patients is embedded into the organisation.

Implementing this tool trust-wide has been a significant challenge. Currently over 1000 patients who are over 75 and admitted as an emergency need to be screened monthly. Whilst we have made good progress in ensuring that once screening has started patients are assessed and referred, we still need to develop a reliable system to ensure all appropriate patients are screened initially.

Dementia*	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Find	36.19%	37.21%	38.21%	28.87%
Assess	15.27%	63.82%	57.75%	77.78%
Refer	57.14%	46.67%	100.00%	100.00%

**Dementia national target for find, assess & refer is 90% by end of year*

Objective 2014/15: Dementia

In 2014/15 we will continue to focus on increasing the use of the screening tool through ensuring the tool is available on all appropriate wards, making electronic completion of the dementia data fields' mandatory and providing training to junior doctors starting in August 2014. Our aim is to ensure that by the end of 2014/15 90% of these patients are screened, assessed and referred, where appropriate.

We will also continue with our educational programme focusing in 2014/15 on achieving 'purple angel' status. This is an indicator to the public that we are a dementia-friendly hospital. More information about 'purple angel' can be found at http://www.purpleangel.org.uk/.

Patient experience continued

Continuous improvement programme (CIP)

The continuous improvement programme (CIP) plays a significant role in improving quality and ensuring that the services are delivered are cost effective.

Examples of work undertaken in 2013/14 include:

- **Theatre productivity**
  The trust is undertaking a significant programme of work to improve the efficiency and capacity of our operating theatres. This has many advantages including shorter waiting times for patients and saving money through not having to pay for procedures to be performed by other organisations.

  The work undertaken to date this year has meant that the number of patients waiting over 40 weeks for their operation has reduced from 70 to fewer than 20. We have also seen improvements in the number of patients treated within 18 weeks. Currently over 95% of patients are seen within this time period.

- **Estates and Facilities**
  A variety of initiatives have been run to improve efficiency and reduce costs. These include re-organising catering and portering services to increase flexibility.

  In June 2013 the new Bayview Bistro was opened serving hot food and beverages for staff, patient and families until 8.00pm.

  A new IT system called menu mark is also being introduced which will enable patients to select their meals closer to meal times. This will reduce the level of food waste whilst increasing patient satisfaction.

Patient experience continued

Continuous improvement programme (CIP) continued

- **Nurse and ward workforce rostering**
  High quality treatment and patient care is paramount to the trust. In order to ensure this we have completed a trust-wide review of nursing numbers, which has been led by the Director of Nursing. The findings and resultant actions from this review assure us that we have the right level of registered nurses and health care assistants in the right place at the right time to meet recommended guidelines.

- **Patient safety**
  Patient safety is important to us and our work to reduce falls, pressure ulcers, and infection control issues are just a few examples of some of the areas of work we are involved in.

  'Never events' are serious, largely preventable patient safety incidents, and across the NHS the aim is to have zero never events. Unfortunately over the last year, the trust has reported two never events, both occurring in ophthalmology and both involving the insertion of correct lenses with the wrong strength into an eye.

  To rectify this we have improved processes by completing the World Health Organisation checklist and when measurements are taken (biometry stage) as well as before inserting them.

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 2013/14 annual report.

PRIORITIES FOR IMPROVEMENT

Looking forward: 2014/15

The trust has identified five quality improvement priorities for 2014/15. These have been developed through discussions with clinical teams, our commissioners and the senior clinical and business leaders in our organisation. We have taken into account the views of our key stakeholders when discussing and agreeing the priority areas for 2014/15 (see Annex 2). These priorities have been signed off by the trust board.

In brief, the improvement projects are:

Patient safety

Priority 1: improve the recognition, timeliness and reliability of the management of severe sepsis

Sepsis is a time-critical condition that can lead to organ damage, multi-organ failure, septic shock and eventually death. It is caused by the body's immune response to a bacterial or fungal infection.

In the UK approximately 102,000 cases of sepsis arise annually, with 36,800 deaths as a result.

Objective 2014/15: Implement the severe sepsis bundle

Over the next year we will design and test a severe sepsis bundle in order to improve the recognition, timeliness and reliability of treatment for all patients, including the elderly and children, presumed to have acute sepsis. Work will include:

- Developing and testing the bundle.
- Identifying sepsis champions across the hospital.
- Developing an educational programme to improve people awareness, knowledge and skills with regards to sepsis.
- Setting a baseline for severe sepsis from which to then agree our improvement trajectory - how much improvement by when.

Our plan will be to focus first on A&E, paediatrics and the hospital's emergency assessment units. The Director of Patient Safety will lead this work and progress will be monitored through our Patient Safety Committee.

Patient safety

Priority 2: Pressure ulcers and falls

The trust currently records a high level of harm-free care 97% (Safety Thermometer). Two areas of further improvement work have been identified for 2014/15 as although the numbers are small, serious falls and severe pressure ulcers have the potential to be life-changing, moving people in some instances from independence to dependence.

Objective 2014/15: Reduce the number of grade 3 and 4 pressure ulcers by 25%

This builds on the work undertaken in 2013/14 which has already been described in the first part of this quality account. Work in 2014/15 will include:

- Continuing to assess all patients on admission and during their hospital stay for pressure ulcer development.
- Continuing to utilise pressure relieving equipment.
- Continuing to ensure patients are turned regularly whilst on a bed.
- Following a successful pilot on Simpson ward, we will roll out our 'skin bundle' onto all remaining inpatient wards.
- Continuing working as part of a cross-community pressure ulcer collaborative which focuses on prevention and rapid intervention.

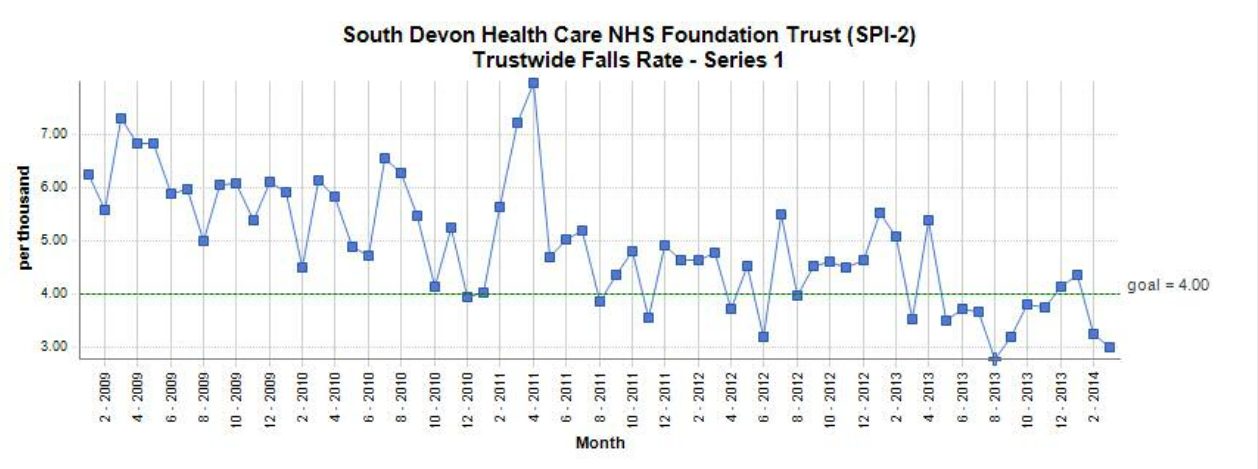
The work will be supported by the trust safety lead working with the hospital's Pressure Ulcer Group. The progress of this work will be monitored through our Patient Safety Committee.

Patient safety

Priority 2: Pressure ulcers and falls continued

Objective 2014/15: Reduce the number of hip fractures acquired in hospital by 25%

Nationally, falls in hospital are the most common patient safety incident, with reported rates ranging from 3 to 14 per 1000 bed days. Falls can cause physical and psychological harm, are associated with impaired rehabilitation, increased length of stay and poor patient experience, thus making this area a key target for patient safety. The trust has a falls nurse and falls multi-disciplinary steering group which has systematically worked over the years to reduce the falls risk.



In 2014/15 in order to reduce harm from falls resulting in a hip fracture we will:

- Test a new floor surface which absorbs energy through a fall.
- Continue to ensure high-risk patients are supported when mobile.
- Undertake a blood pressure project to reduce the risk of people falling due to postural hypotension.

The Falls group will oversee this work and information will be reported via our Patient Safety Committee.

Clinical effectiveness

Priority 3: Frailty

Torbay and Southern Devon has a rapidly ageing population. Older adults make up about half of Torbay's inpatient stays currently. Evidence suggests that elderly frail people who are assessed by specialist staff as early as possible on admission tend to have a shorter stay.

Objective 2014/15: Complete the roll out of Enhanced Recovery in Medicine and research, pilot and evaluate a frailty scoring tool

The aim over the next year will be to:

- Complete the rollout of the enhanced recovery in medicine programme which was successfully started last year.
- Research a frailty scoring tool for use across our care system, pilot it in one area of the hospital and evaluate and share the learning within our care system.

The first project will be overseen by the enhanced recovery in medicine group, led by an acute physician. The frailty project will be overseen by an ortho-geriatrician consultant reporting through our Patient Safety Committee.

Clinical effectiveness continued

Priority 3: Frailty continued

We will also continue to focus on improving dementia care including identifying, assessing and supporting patients, carers and their families.

Objective 2014/15: Deliver specialist training to improve the care of those with dementia and develop a companionship service for patients in hospital with dementia.

Dementia, as already noted in this quality account, is an important issue for South Devon and Torbay due to a rapidly ageing population and its increasing prevalence within a rapidly ageing population.

We recognise the need to increase the level of specialist training in our care community and have developed a new dementia and safe handling course.

The course starts with two hours of information regarding dementia. Topics covered include, role of the 'Special', communication, responding to strong feelings and challenging behaviour. The remainder of the course is spent teaching physical skills to staff which includes breakaway and safe holding techniques. All the techniques are taught using a framework from General Service Association and ensure the least amount of restriction is used at all times.

In 2014/15 we will:

- Train four trainers to deliver this programme. They in turn will train the 70 staff working on Cheetham Hill and Simpson ward in the same year as well as providing training to staff in the 11 community hospitals and all new bank nursing staff from summer onwards.

We are also working with a number of volunteer agencies such as Age UK and the Royal Voluntary Service to train volunteers to provide a companionship service on our care of the elderly wards. The VICTOR scheme (Volunteering in Care in Torbay) started in 2013/14 and will be progressing throughout 2014/15.

In 2014/15 we will:

- Implement VICTOR volunteer companions into Simpson, Cheetham Hill and Ainslie ward and evaluate the project.

This dementia improvement work will be managed by the trust Dementia Steering Group. Periodic updates will be provided to our Patient Experience and Community Partnerships Committee.

Patient experience

Priority 4: Bereavement

The death of someone can be a devastating experience and it is important at this difficult time that services and support provided are timely, family/carer centred and effective. As a result of analysing our patient experience feedback and from discussions with our commissioners and our stakeholders, this is a priority area for 2014/15.

Objective 2014/15: improve the support provided to the bereaved

- Improve the timeliness of sending information to GP about patient deaths.
- Review our current processes for informing GPs, understand how the information gets delayed or not sent and then develop new processes to improve reliability and the timeliness.
- Improve the quality of information available and signposting to external bereavement support services including counselling for the people of Torbay and South Devon.
- We will measure the success of this project against the feedback we receive from our national and local patient feedback systems. We will monitor the on-going comments and review it again once the improved information has been embedded in the organisation.

The work will be led by the trust's experience and engagement lead working with a small group of service users, clinicians and patient support services. The work will be monitored through the Patient Experience and Community Partnerships Committee.

Priority 5: Discharge planning and carers

Carers play an important role in many patients' lives. They are often the people who know the patient/client best and are best positioned to provide the help and support needed. To inpatient carers work in 2013/14 including the enhanced recovery in medicine programme, the trust will aim to:

Objective 2014/15: improve the support provided to the bereaved

Carers play an important role in many patients' lives. They are often the people who know the patient/client best and are best positioned to provide the help and support needed. Building on inpatient carers work in 2013/14 including the enhanced recovery in medicine programme, the trust will aim to:

- Improve the involvement and support of carers in the discharge planning process. We will identify the top three priorities as identified through our patient and carers' feedback and incident reporting systems and then develop a plan to improve services.

Our Deputy Director of Nursing will lead this work, working closely with our cross- community carers group, the trust's Head of Operations and ward teams, as appropriate. Progress will be monitored through the Patient Experience and Community Partnerships Committee.

Patient experience continued

Quality improvement work in 2014/15

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. These include:

- Creating a fully functioning assessment area where medical patients who may not need to be admitted can be assessed, treated within 4 hours of registration and discharged before 7.00pm in order to improve care outcomes, patient safety and experience.
- Implementing a staff friends and family test as well as increasing the response rate for the patient friends and family test.
- Working with our commissioners through their 'yellow card scheme' to investigate and act on emerging trends which GPs are reporting to them.

The results of this work will be published in next year's accounts as well as shared during the year through our various publications. Progress will be monitored at board level.

IN 2014/15 the trust will also be developing the Horizon Institute with the aim of ensuring there is consistent focus on quality improvement and innovation.

Horizon Institute

Our vision is to create an open culture where quality is part of our health and care system's DNA and as a result, there is a continual and relentless focus on quality.

The Institute's three main functions are to:

1 Work with teams and services across our care system to redesign care in order to ensure the delivery of the highest quality joined-up care.

2 Enhance the culture and skills needed to enable innovation and improvement and the 'joy of work'.

3 Create an academic base from which to undertake operational research into care system improvements, measure and evaluate the changes and learn from them.

Statements of assurance from the Board

Review of services

During 2013/14 South Devon Healthcare NHS Foundation Trust provided and/or sub-contracted 44 relevant health services.

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

The income generated by the relevant health services reviewed in 2013/14 represents 77% of the total income generated from the provision of relevant health services by South Devon Healthcare NHS Foundation Trust for 2013/14.

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

Statements of assurance from the Board continued

Participation in clinical audits

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

During 2013/14, 46 national clinical audits and five national clinical audit and national confidential enquiries covered relevant health services that South Devon Healthcare Foundation NHS Trust provides.

During 2013/14 South Devon Healthcare Foundation NHS Trust participated in 85% national clinical audits and 75% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that South Devon Healthcare NHS Foundation Trust participated in during 2013/14 are as follows:

National Audits	Eligibility	Participation
Acute coronary syndrome or acute myocardial infarction	Yes	Yes
Adult cardiac surgery audit	No	Not applicable
Adult community acquired pneumonia	Yes	No
Adult critical care (Case Mix Programme)	Yes	Yes
Bowel cancer	Yes	Yes
Bronchiectasis (paediatric)	Yes	No
Cardiac arrhythmia	Yes	Yes
Chronic kidney disease in primary care	No	Not applicable
Chronic obstructive pulmonary disease	Yes	Yes
Congenital heart disease (paediatric cardiac surgery)	No	Not applicable
Coronary angioplasty	Yes	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes No	Inpatient diabetes Yes Adult diabetes Not applicable
Diabetes (paediatric)	Yes	Yes
Elective surgery (National PROMs Programme)	Yes	Yes
Emergency use of oxygen	Yes	Yes
Epilepsy 12 audit (childhood epilepsy)	Yes	Yes
Falls and fragility fractures audit programme, includes national includes national hip fracture database	Yes	Yes
Head and neck oncology	Yes	Yes
Heart failure	Yes	Yes
Inflammatory bowel disease	Yes	Yes
Lung cancer	Yes	Yes
Moderate or severe asthma in children (care provided in emergency departments)	Yes	Yes
National audit of dementia	Yes	No
National audit of schizophrenia	No	Not applicable
National audit of seizure management (NASH)	Yes	Yes
National cardiac arrest audit	Yes	No

Statements of assurance from the Board continued

National Audits continued	Eligibility	Participation
National comparative audit of blood transfusion	Yes	Yes
National emergency laparotomy audit	Yes	Yes
National joint registry	Yes	Yes
National vascular registry, including CIA and elements of NVD	Yes	Yes
Neonatal intensive and special care	Yes	Yes
Non-invasive ventilation (adults)	Yes	No
Oesophago-gastric cancer	Yes	Yes
Ophthalmology	Yes	Yes
Paediatric asthma	Yes	Yes
Paediatric intensive care	No	Not applicable
Paracetamol overdose (care provided in emergency departments)	Yes	Yes
Prescribing observatory for mental health (POMH-UK) (Prescribing in mental health services)	No	Not applicable
Prostate cancer	Yes	Yes
Pulmonary hypertension	No	Not applicable
Renal replacement therapy (Renal Registry)	No	Not applicable
Rheumatoid and early inflammatory arthritis	Yes	Yes
Sentinel stroke national audit programme (SSNAP), includes SINAP	Yes	Yes
Severe sepsis and septic shock	Yes	Yes
Severe trauma (Trauma Audit and Research Network)	Yes	Yes
Specialist rehabilitation for patients with complex needs		Not known yet

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Eligibility	Participation
National review of asthma deaths	Yes	Yes
Child health programme	Yes	Yes
Maternal, infant and new-born clinical outcome review programme	Yes	Yes
Medical and Surgical programme: national confidential enquiry into patient outcome and death	Yes	Yes
Mental Health programme: national confidential inquiry into suicide and homicide for people with mental illness	No	Not applicable

Statements of assurance from the Board continued

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

- **Adult community acquired pneumonia**
  British Thoracic Society has confirmed that data collection for this national audit will not take place in 2013/14.

- **Bronchiectasis (paediatric)**
  Unable to identify patients for this audit, this has been fed back to the national organisers.

- **National audit of dementia**
  Healthcare Quality Improvement Partnership confirmed that the dementia audit will not be collecting data in 2013/14.

- **National cardiac arrest audit**
  Cost attached to participation. Decided not to participate in 2013/14.

- **Non-invasive ventilation (adults)**
  British Thoracic Society has confirmed that data collection for this national audit will not take place in 2013/14.

- **National review of asthma deaths**
  Healthcare Quality Improvement Partnership have confirmed that no data collection will take place in 2013/14.

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 2013/14, 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
Acute coronary syndrome or acute myocardial infarction	Data collection not finished	100
Adult critical care (Case Mix Programme)	Not reported yet	100
Bowel cancer	Not reported yet	100
Cardiac arrhythmia	Data collection not finished	100
Chronic obstructive pulmonary disease	Data collection not finished	
Coronary angioplasty (BCIS) (Calendar year 2013)	423	100
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Not reported yet (inpatient)	
Diabetes (paediatric)	Not reported yet	88
Elective surgery (National PROMs Programme)	On-going data collection	100
Emergency use of oxygen	8/10	80
Epilepsy 12 audit (childhood epilepsy)	Not reported yet	
Falls and fragility fractures audit programme, includes national hip fracture database	30/40	75
National Audit of Inpatient Falls	40/30	75
Head and neck oncology	Not reported yet	100
Heart failure	Data collection not finished	100
Inflammatory bowel disease	Not reported yet	
Lung cancer	Not reported yet	100
Moderate or severe asthma in children (care provided in emergency departments)	Data collection not finished	
National Audit of Seizure Management (NASH)	Not reported yet	
National comparative audit of blood transfusion	Not reported yet	
National emergency laparotomy audit	Data collection not finished	
National Joint Registry	Not reported yet	100

Statements of assurance from the Board continued

South Devon Healthcare NHS Foundation Trust	Cases submitted	% cases
National Vascular Registry	Not reported yet	100
Neonatal intensive and special care	Not reported yet	100
Oesophago-gastric cancer	Not reported yet	100
Paediatric asthma	15/5	300
Paracetamol overdose (care provided in emergency departments)	Data collection not finished	
Prostate cancer	Data collection not started	
Rheumatoid and early inflammatory arthritis	Data collection not finished	
Sentinel stroke national audit programme (SSNAP), includes SINAP (total includes all Stroke, TIA and cases transferred in from other hospitals)	Band A Data collection not finished	100
Severe sepsis and septic shock	Data collection not finished	
Severe trauma (Trauma Audit and Research Network)	109	100
Head and Spinal Injuries		

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Eligibility	Participation
Child health programme	Not reported yet	Yes
Maternal, infant and new-born clinical outcome review programme	Not reported yet	Yes
National confidential enquiry into patient outcome and death	Not reported yet	Yes

Statements of assurance from the Board continued

The reports of 27 national clinical audits were reviewed by the provider in 2013/14 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 and other ACS (MINAP)	
	• No action plan required
ND0071 - Adult community acquired pneumonia (BTS)	
	• Improve adherence to local antibiotic guidelines by applying the severe sepsis pathway appropriately. This will form part of the presentation of the pneumonia audit results.
ND0053 - Bowel cancer audit (NBOCAP)	
	• Draft response received. Actions pending
ND0066 - Cardiac arrhythmia (cardiac rhythm management audit)	
	• Report received February 14 – response pending
ND0074 - Carotid intervention audit	
	• Review provision of TIA clinics with stroke physicians • Assess provision of carotid duplex slots for TIA clinic • Assess availability of anaesthetic and theatre teams to provide urgent carotid surgery
ND0038 - Chronic pain - organisational audit of pain services (2010/12)	
	• No action plan required
ND0049 - Coronary angioplasty: (NICOR adult cardiac interventions audit) – BCIS	
	• Report received February 14 – response pending
ND0047 - Data for Head and Neck Oncology (DAHNO)	
	• No action plan required
ND0065 - Diabetes (RCPH National Paediatric Diabetes audit)	
	• Local report received April 14, actions pending
ND0037 - Emergency use of oxygen (BTS)	
	• Continue attempts to capture oxygen prescribing within VITALPAC
ND0039 - Heart failure (HF) audit	
	• All heart failure admissions should receive input from cardiology team • All heart failure patients should have had an echo nine or other cardiac imaging within last six months • All heart failure REF should be discharged on ACE/ARB, B-blockers and MRA (unless contra-indicated) • All heart failure patients should be seen within two weeks of discharge by a member of the integrated heart failure nurse team
ND0054 - Heavy menstrual bleeding (HMB) (RCOG)	
	• No actions required

Statements of assurance from the Board continued

ND0043 - Hip fracture supplement report 2012 (NHFD)

- Reduce super spell by targeting length of stay in community hospitals - look at options that joined up care with community may produce.

ND0043 – Hip fracture report 2013 (NHFD)

- Improve % of patients that achieve best practice tariff with view to time to theatre <36 hrs. Work on-going with Exeter business school and PenCHORD
- Improve % of patients admitted to Ainslie trauma ward within four hours
- Review anaesthetic adherence to AAGBI guidelines after current 'SPRINT' audit
  Development of hip fracture programme using Quality Improvement methodology initially using Paignton cohort of hip fractures

ND0042 - Hip, knee and ankle replacements (NJR)

- No action plan required

ND0051 - ICNARC: adult critical care (Case Mix Programme)

- All unit deaths reviewed by Consultant. All deaths with acute physiology and chronic health evaluation ll (APACHE II) or Intensive care national audit and research centre (ICNARC) predicted mortality <20% presented for peer review by senior nurses and consultants. All deaths with APACHE II or ICNARC predicted mortality <20% presented for peer review by senior nurses and consultants.
- Case review and discussion of a difficult case each month to support consistent decision making across the consultant body.
- Data used in:
  - workforce planning,
  - activity planning
  - budget setting
  - support capacity increase to nine beds and support case for surgical high care area

ND0044 - Lung Cancer (National Lung Cancer audit)

- No action plan required

ND0072 - National comparative audit of blood transfusion programme (Audit of use of blood in adult medical patients)

- Report received July 2013 - insufficient data collected to be included in report. No actions

ND0035 - National neonatal audit programme (NNAP)

- Action plan received and under review

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

- Quality improvement project is being undertaken based on all cases of oesophago-gastric cancer during the audit period. This will focus on the patient journey to diagnosis (qualitative) and the proportions of patients who underwent CT/EUS first review/ cycle by Nov 2013.

ND0012 – Non Invasive ventilation

- As on previous occasions our numbers entered into this national audit are small. This makes comparison with National figures difficult and open to significant bias. This is especially true when it comes to some of the subset questions. Also it is important to recognise that some of the audit questions are matters of opinion and not of fact and so are subject to the views of the person collecting the data.
- Suggested areas for improvement:-
  Collect more patient numbers at next NIV audit.
  Continued provision and education regarding oxygen alert cards for our patients with chronic obstructive pulmonary disease who are at risk of oxygen toxicity.

Statements of assurance from the Board continued

ND0040 - Paediatric pneumonia (BTS)

- Produce paediatric community-acquired pneumonia guideline

ND0033 – Vascular Surgery – Outcomes after elective repair of infra-renal abdominal aortic aneurysm

- No action plan required

ND0026 - Severe Trauma (TARN) - TARN Clinical Report 1 – Thoracic, Abdominal and Shocked

- Review the four cases of non-isolated chest trauma in respect of time to CT scan
- Discuss with chest physicians the skill-set needed to enable open chest drains to be inserted when necessary
- Continue to question validity of the probability of survival calculation especially in the elderly
- Work towards an interim CT reporting system to ensure rapid reporting of time critical injuries

ND0026 - Severe Trauma (TARN - Torbay Hospital Trauma Report II, Core and Orthopaedic)

- No action plan required

ND0026 - Severe Trauma (TARN – Torbay Hospital Clinical Report III, Head and Spinal Injuries)

- Report received and actions pending

ND0027 - Stroke care (National Sentinel Stroke audit) SSNAP

- Domain 1 - Scanning - To improve emergency scanning time. Nurse led CT request for acute stroke, Training A/E
- Domain 2 - Adherence to stroke admission and operational policy including bed fencing, education and dissemination of the policies especially during hospital bed crisis
- Domain 3 - Thrombolysis - Directorate level out-of-hours cover for thrombolysis being sorted
- Domain 4 - Specialist cover out-of-hours and weekends. As in domain 3
- Domain 6 - Documentation of Physiotherapy sessions over the weekends
- Domain 7 – Speech and Language Therapy this is a national issue and very much resource related and yet a solution needs to be identified
- Domain 8 – Multidisciplinary Team. Overall depend on domain 6 and 7, but as well need improvement in documentation
- Domain 9 - Standards by discharge, to improve on lack of documentation and appropriate answering of questions in the audit
- Domain 10 - Discharge process. Agreed on a joint social and health care plan on discharge.

Statements of assurance from the Board continued

The reports of 76 local clinical audits were reviewed by the provider in 2013/14 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions

6259 Occupational therapy assessment standards

- Interim head of occupational therapy to share results with team leads who will share results with their teams
- Moving and handling training and documentation across Devon is being reviewed by expert moving and handling advisors. The funding of these posts is temporary at present but in order to improve standards funding is needed to continue the posts and improve standards in both practice and recording
- Supervisors of staff will be encouraged to use the audit tool in supervision with all staff members. (It could also be used as part of peer review)
- Advocate for continued implementation of single community care record or amendment to 'Paris' computer system as an alternative

6201 Early diagnosis and intervention (EDI) efficiency

- No further action required pending introduction of new process from the 1st April 2013

6266 Teignbridge early detection and intervention (EDI) Service

- A 'control' spread sheet/file has been set up to enable the team to monitor progress of their patients through the system and to monitor performance against their standards for timeliness
- Hold discussions with the psychology team to review team workloads to ensure deadlines met and information not lost to the system

6282 Antidepressant prescribing reviews

- Present results separately to both teams and produce individual plans that are relevant directly to both Haytor and Beech. The re-audit can then be completed using the standards agreed and implemented by each team

6283 Clozapine clinic and physical monitoring

- Discussions with GPs to highlight the results will when presented to them offer further opportunities to improve
- Use different colour paper for each year's required testing

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

- Consultant team to target the middle grade doctors for ad hoc teaching, (to include paediatric liaison referrals and MASH (Multi-Agency Strategic Hub) referrals
- Medical supervisors to feedback re general expectations regarding emergency department documentation and use actual examples of work produced as evidence

6245 Unplanned re-attendances to the Emergency Department (ED)

- Educate juniors during teaching:
  - Discharge planning
  - Realistic prognosis and disease progression
  - What to do if no improvement - GP/ return
  - Document in notes - Discharge plan verbal/ written
- Ensure there is a clinic for those returning for fracture manipulations/ reductions
- Ensure nurse practitioners/ doctors understand that dressings need to be booked onto the dressings clinic
- Improve Information cards for patients - adding analgesic advice/ expectant progression and signposting if things not improving

Statements of assurance from the Board continued

- Create general minors discharge card with general information on analgesia/ expectant management for minor injuries and signposting for when patients have concerns
- Educate the juniors - Create a poster with above information in emergency department minors - Present at junior doctors teaching session

6318 Electrocardiogram (ECG) Aming in A&E

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

6154 Waiting times for multiple sclerosis (MS) from GP referral to time of diagnosis

- Increase the number of multiple sclerosis clinic slots, this has been achieved by starting an extra clinic on alternate weeks at Newton Abbot Hospital. (Commenced on 10th January 2013)

6168 Intravenous immunoglobulin (IVIg) usage

- Introduction of a clinical outcome form
- Re-launch of new guidelines with updates
- Dose adjustment needed by ideal best weight, this has been shown to be just as effective and saves money - publicised at general medicine audit meeting

6206 Prothrombin complex (PCC) use for emergency reversal of warfarin

- Highlight to staff the importance of weighing patients - done at presentation
- Ensure on-call haematologist consultant is contacted for specific haemostatic management - done at presentation
- Aim to make Octaplex dose easier for everyone to prescribe. (Amend protocol but awaiting results of further evidence for appropriate dose)

6243 Two week wait referrals for suspected thoracic malignancy

- Present findings to primary care with the aim to reduce inappropriate referrals
- Clear referral pathways for patients needing urgent review where cancer is not suspected.
- Raise primary care awareness of same through lung cancer workshop for GPs and commissioners scheduled for October 2013.

6244 Malignant spinal cord compression (MSCC) - compliance with current clerking proforma and guidelines

- Raise awareness at medical meeting that oncologists are able to review MRIs to determine whether it's appropriate to speak to a spinal surgeon
- Raise awareness that Exeter oncologists can be contacted out of hours including weekends
- Raise awareness that Torbay's spinal cord co-ordinator is available between 9-5pm
- Senior clinician needs to determine whether it's MSCC so patient can be treated urgently

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

- No plan required

6248 NICE BCA - Capecitabine for the treatment of advanced gastric cancer (TA191)

- No plan required, compliance demonstrated

6249 NICE BCA - Gefitinib for the first-line treatment of locally advanced or metastatic nonsmall-cell lung cancer (TA-192)

- No plan required, compliance demonstrated

6250 NICE BCA - Tuberculosis (TB) (CG117)

- HIV testing to form part of the routine assessment of all patients diagnosed with TB
- Improve documentation of risk assessment for drug resistance to include all the risk factors highlighted in audit

Statements of assurance from the Board continued

6251 A lcohol-use disorders: physical complications (CG-100)

- Source or develop a patient advice and support hand-out. Ensure documentation of patient being offered written information is recorded in patient's notes.
- Liaise with alcohol cessation teams to ensure better documentation of alcohol cessation plan.

6252 N ICE BCA - Diabetic foot problems (CG-119)

- An agreement has been set up with the elderly care physicians on Simpson ward that patients admitted to hospital with a diabetic foot infection should be admitted to Simpson ward under shared care between a named ward consultant and a diabetes consultant
- Introduce the Ipswich touch toe test for all patients with diabetes on admission to hospital. This comprises a foot inspection and risk assessment for development of neuropathic ulcers in hospital.
- Develop a business plan to increase clinical and podiatry time on the wards, to include funding for an HCA which will enable us to identify patients earlier. Part of the remit of this post will also be educating ward staff to conduct risk assessments using the touch toe test and providing help and support in using adequate pressure relief/ offloading for ulcerated patients and those at risk.

6254 Complication rates and patient experience after cutaneous surgery by the dermatology department

- Continue to wipe down couches before each patient
- Care of suture material falling outside of sterile field
- Use of scrubs in operating room
- Wearing of hats for operations
- Increase contact time of antiseptic to aim for two minutes pre-operatively
- Dedicated shoes to be used in operating room
- Not to routinely stop antiplatelet agents pre-operatively
- Aim to put patients with leg ulcers at the end of the list (whenever possible)
- No need for topical antibiotic post operatively, use vaseline/paraffin

6256 NICE BCA - Crohn's disease - infliximab (review) and adalimumab (TA-187)

- No plan required, compliance demonstrated

6257 NICE BCA - Infliximab for acute exacerbations of ulcerative colitis (TA163)

- No plan required, compliance demonstrated

6258 Metastatic spinal cord compression (MSCC)

- No action plan required

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

- No action plan required

6272 Endoscopic retrograde cholangiopancreatography (ERCP)

- Improvement with outpatient pre-procedure bloods needed - highlighted to staff at meetings

6273 NICE BCA - Rituximab for the first-line treatment of chronic lymphocytic leukaemia

- No plan required

6278 Assessing the appropriateness of antifungal prescribing for patients admitted to ICU or Turner

- An algorithm will be produced to allow clinicians to easily prescribe the correct antifungal for patients' needs
- Re-evaluate the neutropenic complications guideline

Statements of assurance from the Board continued

6316 NICE BCA - Rituximab for the first-line maintenance treatment of follicular nonhodgkins lymphoma (TA-226)

- No plan required

6322 NICE BCA - Bortezomib and thalidomide for the first-line treatment of multiple myeloma

- No action plan required

6253 Completeness of electronic anaesthetic records (PICIS)

- All staff reminded about record keeping at Anaesthetic Clinical Audit meeting.

6280 Therapeutic hypothermia after cardiac arrest

- ICU Team to assign lead nurse for cooling
- 'Push' adherence to local guidelines through awareness and education (Presentations ongoing)

6303 Hand hygiene and antibiotic prophylaxis in theatre

- Ensure alcohol gel is available in most anaesthetic rooms or on the entrance to the anaesthetic rooms.
- Alcohol gel to be made available in all theatres
- Time of antibiotic administration to be added to the anaesthetic briefing proforma

6321 Anaesthesia in outside areas

- Allocate anaesthetic consultant leads for each area.
- Nerve stimulator to be purchased and added to the emergency bag, so readily available.
- Emergency Department to develop guidelines for intubation for senior Emergency Department staff.
- Induction for trainee anaesthetists to include familiarisation with the non-theatre areas in which anaesthesia may be provided, including availability and location of equipment and drugs.
- Provision of appropriate anaesthetic monitoring in the cardiac catheter lab to be investigated.

6204 Referral guidelines for CT scanning in sinusitis

- Guidelines have been laminated for distribution to raise awareness of guidance
- Undertake re-audit as soon as possible using a new standard of antibiotics being taken for 3 weeks not 12 as per current literature, this is agreed as 'local consensus'.

6187 Time to surgery in high risk patients undergoing emergency laparotomy

- No changes required

6281 Early cholecystectomy and 24 hour ultrasound in patients with acute pancreatitis

- On appointment of new upper GI consultant, introduce an 'upper GI hot-week' every other week.

6293 Laparoscopic pyeloplasty (IP-046)

- No plan required

6295 Time from acute urinary retention (AUR) to transurethral resection of prostate (TURP)

- Consideration will be given to the role in the process of an acute urinary retention nurse perhaps to produce a register/ database of relevant patients and to track them through the system/ process
- Undertake a full review of the theatre lists with a view to setting up extra clinic(s) to clear waiting list and consider setting up a 'regular' list for these patients

Statements of assurance from the Board continued

6199 Electrolysis sessions and eyelash follicle destruction

- Expedite annual assessment of competence for qualified nurse practitioner to enable her to assess the two other NPs undertaking this procedure
- Patients attending for electrolysis will now be discharged from the clinic after their treatment and not be reviewed at 6-8 weeks unless the 'pink notes' indicate that they attend for another ophthalmic reason(s) and could therefore not be safely discharged.
- Patients listed for cataract surgery but found to have in growing lashes should still be given a date for cataract surgery and electrolysis arranged pre-cataract surgery. Any lone lashes seen on the day of cataract surgery should be epilated and the patient relisted for electrolysis post-cataract surgery.

6279 Outcomes of descements stripping automated endothelial keratoplasty (DSAEK)

- No plan required

6287 Local macular hole surgery outcomes

- No plan required

6288 ROP screening 2011-2012

- No actions required although closer investigation of and discussion around proposed CQUIN is required

6269 Selection of dental osseointegrated implant patients

- Consent - Recall the notes of patients where consent was not immediately obvious to ensure this is not an issue. It will be covered in the department re-audit of consent due later this year
- Coding - The cases reviewed within the project that were not identified via the hospital computer system should be reviewed to ensure they are correctly coded

6285 Blood glucose recording of all odontogenic infection referrals

- Discuss with endocrinologist, proposal to use HbA1c for all patients rather than random blood glucose. This has been discussed with endocrinologist suggesting we continue with the random blood glucose screen at present.
- Remind all junior staff of the importance of glucose testing by this presentation and teaching in January 2014. This will also be included in local Induction
- All oral and maxiofacial surgical senior house officers instructed to add a written note concerning blood test results to clearly evidence review through this presentation and teaching in January 2014. This will also be included in local Induction

6286 Restorative care for head and neck cancer patients

- Discussions will take place with ear, nose and throat about their larynx cancer patients to raise awareness of the dental screening requirement, possibly this could be dealt with by having a mandatory Infoflex field. This will also be covered at the head and neck cancer business meeting.
- Records of oral healthcare products/ items issued may be improved by considering the use of a stamp or template at the screening appointment
- The issue of patients 'lost to the system' will be reviewed, especially making sure that patients cancelling are re-booked at the time of cancellation
- Discussions around the hygienist indicate that availability is not currently an issue but perhaps the day of attendance could be reviewed

5793 Open femoro-acetabular surgery for hip impingement syndrome (IP-203)

- No action required

Statements of assurance from the Board continued

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
- Did not attend sheets used at the end of clinic need to have age of patient printed on them to prompt clinician to review case notes
- All future did not attend letters to be dictated

6261 Prophylactic antibiotic guideline for fracture of hip repair to minimise clostridium difficile infections

- No action required

6305 Management of severe open lower limb fractures

- No plan required

6315 Compliance rates of butrans patch use post total knee replacement (TKR)

- No plan required

6241 Oral nutritional supplements in Torbay Hospital

- Feedback to medicines optimisation team, Torbay CCG
- Discuss report with associate director for therapies, to consider taking report to patient safety group
- Contact IT about including nutritional information on Infoflex template
- Take report to nutrition steering group for discussion
- Send report to nutrition team pharmacist regarding pharmacy involvement

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

- No action required

6267 Start smart then focus

- Drug chart will be amended to require a signature for review of antibiotics
- Presentation to be given to as many meetings as possible. This will include medical unit meeting, post graduate meeting, F1 teaching session, medical student teaching and SDHCFT and TSDHCT pharmacy/ prescribing group.
- Continue to raise awareness amongst all staff: - Posters for re-launch of drug charts (to coincide with junior doctor rotation) and screen saver prompt on computer screens

6268 Malnutrition universal screening tool (MUST) completion

- Purchase weighing equipment to minimise sharing between wards
- Organise annual calibration of weighing equipment in the trust
- Organise and increase availability of laminated MUST charts on all wards
- Edit MUST proforma so original MUST score is clearly dated

6270 Re-admissions from the community into the acute trust

- The whole process will be reviewed across acute and community hospitals and involving the local commissioning group
- Education of all staff involved with these patients after full testing of process and use of insitu simulation to assess the way forward.

6271 Consent 2013

- There is a need to raise awareness and reinforce the policy, as well as present and disseminate the results of this audit. All areas are reminded of the policy, as well as the outcomes of this audit to be fed back to teams/ areas. Meetings attended with orthopaedics, general theatres and A&E. Email sent to all clinical directors and governance leads to ensure the report is disseminated to teams.
- Encourage documented, auditable information by email sent to all clinical directors and governance leads to ensure the report and learning is disseminated to teams.

Statements of assurance from the Board continued

- Junior trainees need to be individually authorised to consent, email sent to all clinical directors and governance leads to ensure the report and learning is disseminated to teams.
- Presented to safety committee. Results of the audit and learning from this audit shared with the committee. Actions agreed and will feedback final action plan to committee.

6139 False negative triple assessment

- Continue with ongoing monitoring to ensure that we are working to national guidance and providing an effective triple assessment service

6255 NICE BCA - Critical illness rehabilitation (CG83)

- Plans to provide appropriate discharge information to patients. Trial giving patients full medical discharge summary compared to specific patient/ family centred information summary

6088 Repeated attendances in children

- Frequent attenders – identify appropriate consultant during ward rounds – creation of a ward round prompt/ checklist
- Call for notes when senior house officer notifies emergency department team of referral
- Ensure list of previous attendances pulled
- Publicise criteria for referral to paediatric liaison nurse and put in prominent place in emergency department and Louisa Cary. Leaflet for parents?
- Update paediatric emergency assessment documentation
- Teaching session for all new emergency department and middle grade doctors to be introduced to target all safeguarding issues, using case reviews

6193 Paediatric sepsis

- Revise sepsis bundle in the light of 2012 International Surviving Sepsis Guideline and audit results
- Education and further information regarding sepsis bundle to be given to emergency department and paediatrics
- Ongoing training for child health and emergency department staff via induction, advanced paediatric SOS and simulation (paediatric emergency training in the simulator)

6225 Children allergy service referrals

- Raise awareness of referral criteria and pathway throughout primary care, this will take place during our GP awareness day (September 2013)
- Develop one page summary of referral criteria for consultants and display on intranet along with patient leaflets

6291 Paediatric head injury

- Education of head injury management and documentation to junior doctors, paediatric staff and emergency nurse practitioners
- Revision of head injury advice leaflet to include advice regarding post-concussion syndrome and the services available
- Liaison with regional neurosurgical centres to establish/ ensure local agreement has been formalised
- Posters produced of NICE indications for CT are displayed in minors and paediatric areas.
- Flash cards produced and given to junior doctors

6292 Coeliac disease in children

- Protocol for diagnosis of coeliac disease to be published on trust intranet site
- Diabetic team to review the requests they make for type I diabetics, review should include HLA typing and IgA as well as tTG.
- Inform/ educate staff that when requesting a coeliac screen they must ensure that this includes a serum IgA level
- All positive results to be referred to named consultant for action. If tTG >100, to be referred with request for further diagnostic testing to include EMA and HLA typing as well as repeat TTG if initial TTG > 100
- Consultant to present results to the biochemistry team.

Statements of assurance from the Board continued

6107 Use of general anaesthetic (GA) for colposcopy treatment

- After three months all cases performed under general anaesthetic 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.

6264 Termination of pregnancy

- Consent forms stamped with risks/complications, this is an interim measure until re-printed consent form available
- Produce bespoke consent forms. Work started on first draft for printers, this will include EIDO leaflet number
- Patient information – Ensure all information given is recorded on Lilie template for surgical treatment as currently with medical treatment. Adjusting surgical treatment template.
- Review policy for medical management three week follow up. Consider changing pregnancy test to 30 days post 2nd part as recommended by Royal College of Obstetricians and Gynaecologists. Ensure patient information states - we will try on three occasions at different times, then patient will be discharged.
- Investigate the viability of encouraging patients to phone with result on designated phone number.

6265 Unborn baby protocol

- Present the results at obstetrics and gynaecology audit meeting, Team leaders and trust executive safeguarding children's committee.
- Await updated unborn baby protocol, then re-launch.
- Remind staff about documentation of handover and the importance of face-to-face communication with GP/ health visitor and documentation of this through the team leader meetings.

6276 Standards for safeguarding children <16 years by Torbay Sexual Medicine Service

- No actions needed.

6284 Antenatal and post-natal mental health

- Take results to team leaders meeting.
- Circulate results to all midwives' enforcing the need to ask the post-natal questions and complete the appropriate section of the purple notes at discharge.
- Feedback results to health visitors.

6307 NICE BCA - Sacral nerve stimulation for urge incontinence and urgency-frequency

- No action plan required

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

6262 20 Week obstetric scans

- Saving images to PACS is something we need to improve - remind all staff at end of session to check all six images are saved

6289 Inpatient angiography turnaround times

- No plan required

6294 Pre-operative localisation of parathyroid adenomas using ultrasound and sestamibi scans

- No plan required

Statements of assurance from the Board continued

6297 U se of paediatric gonadal shielding in hip and pelvis radiographs

- No plan required

6306 Adequacy of imaging the cervical spine (C-Spine) in trauma referrals from emergency department

- Highlight importance that complete set of adequate views is needed - importance raised at audit meeting
- Recommended that radiologists advise that further imaging is needed and then to document this - highlighted at audit meeting
- CT request forms from the emergency department need to document discussion has taken place with the Radiologists

6310 Radiological wire localisation of breast lesions

- Ensure all radiology staff document skin markings have been made on CRIS - present findings to radiology staff

The report of one national confidential enquiry was reviewed by the provider in 2013/14 and South Devon Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

ND0097 – Death following a diagnosis of alcohol-related liver disease (NCEPOD)

- All patients presenting to hospital should be screened for alcohol misuse
- All patients presenting with a history of harmful drinking should be referred to alcohol support services
- The hospital should have a 7-day alcohol specialist nurse service
- The hospital should have a multidisciplinary alcohol care team lead by a consultant with dedicated sessions
- Patients with de-compensated alcohol related liver disease should be seen by a gastroenterologist within 24 hours (72 hours)
- Escalation of care should be pursued for alcohol-related liver disease patients who deteriorate acutely

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 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1293.

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 354 clinical research studies during 2013/14 in 30 medical specialities.

63 clinical staff participated in research approved by a research ethics committee at South Devon Healthcare NHS Foundation Trust during 2013/14. These staff participated in research covering 30 medical specialties.

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

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

2013-14

RCHOP vs 1421
Immunochemotherapy with rituximab and cyclophosphammdie, doxorubicin, vincristine and prednisolone (R-CHOP) has become the standard of care for elderly patients with diffuse large B-cell lymphoma. A national multicentre study was conducted to see if a dose dense R-CHOP regimen over 14 days instead of the standard three week schedule was better? The results published showed the two week dose-dense R-CHOP regimen did not improve efficacy compared with the three week standard schedule.

BC2001
Torbay participated in a national multicentre study and was part of the trial management group looking at the treatment of muscle invasive bladder cancer; testing whether reducing radiation dose to uninvolved bladder while maintaining dose to the tumour would reduce side effects without impairing local control. The results showed that reduced high dose volume radiation therapy did not result in a statistically significant reduction in late side effects compared with standard whole bladder radiation therapy and other endpoints such as loco-regional control could not be concluded formally. However low rates of clinically significant toxicity combined with low rates of invasive bladder cancer relapse confirm that (chemo)radiation therapy is a valid option for the treatment of muscle invasive bladder cancer

PICCOLO study
A study looking at adding Panitumumab (a targeted therapeutic antibody) to standard chemotherapy with Irinotecan did not improve the overall survival of patients with wild type KRAS tumours in advanced colorectal cancers.

START
Results after 10 years following data from the national study looking at hypofractionation for treatment of early breast cancer has showed that "appropriately dosed hypofractionated RT is safe and effective for patients with early breast cancer" This supports the continued use of 40Gy in 15 fractions which is our standard treatment.

Statements of assurance from the Board continued

Research continued

UNITED Study
Torbay was one of participating centres in the UNITED study; led by a team at Exeter. To date guidelines for management of paediatric patients with diabetes assumes the majority are c-peptide negative. This study which showed that endogenous insulin production within paediatric populations is common and not restricted to the honeymoon period. This has implications for diagnosis, management and patient education and has provided some useful insight into aspects of paediatric diabetes.

Reference for Alström chapter in The Ciliopathies
Richard Paisey; Alström syndrome: Chapter 2: pages 8-29; 2014. In Ciliopathies; edited by Thomas D Keeny and Philip Beales; Oxford University Press ISBN 978-0-19-965876-3

The ciliopathies are a group of rare diseases that often affect multiple systems within the body and are caused by defects in the function or structure of cilia, leading to profound consequences. Alström Syndrome is one such disorder. Following internationally recognised research work lead by Torbay over many years a chapter on Alström's syndrome was written by experts from Torbay providing a clinical overview and reference to this disorder providing in depth discussion, including the latest scientific research together with a description of the features, practical guidelines on diagnosis and therapy options etc. This provides a reference for clinicians involved in the care of patients with Alström Syndrome

Service Delivery and Organisational Research:
A study led by Kings College London and the Universities of York and Oxford reviewed the development of the assistant practitioner role at SDHFT; involving interviews with relevant staff, which constituting one of six case studies conducted into innovative practices relating to nurse support roles in acute trusts. Torbay was selected; as the post had already been embedded in the trust for some years and therefore was ahead of the game. This provided the opportunity to explore and examine the role and its development in more depth. The primary aim was to develop a deeper understanding of the development of new practice in a trust, providing insight into influence of context as well as details into how and why it emerges and evolves.

Statements of assurance from the Board continued

CQUIN payment

A proportion of South Devon Healthcare NHS Foundation Trust income in 2013/14 was conditional on achieving quality and improvement and innovation goals agreed between South Devon Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Details of the 2013/14 CQUINs can be found in this report and are available online through the trust website.

In 2013/14 the potential value of the CQUIN payment was £3,793,615 and income subsequently received was £3,300,073. In 2012/13 the potential value of the CQUIN payment was £4,519,547 and the income subsequently received was £4,360,278.

In 2014/15 the value of the CQUIN payment is £3,900,850.

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.
- Termination of pregnancy.

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

The Care Quality Commission has not taken enforcement action against South Devon Healthcare NHS Foundation Trust during 2013/14.

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 no unannounced visits from the Care Quality Commission during 2013/14 as part of its routine monitoring programme.

Data quality

Data quality is a key enabler in delivering high quality services. Data and information which is accurate, timely and relevant allows 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 and a more detailed data book.

Over the last 12 months, work has been undertaken to improve the range of data quality indicators with the data book. The data book now also includes complaints, clinical incidents, level of 'harm free' care and hospital-acquired pressure ulcer rates.

Statements of assurance from the Board continued

NHS number and general practitioner registration code

South Devon Healthcare NHS Foundation Trust submitted records during 2013/14 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 2014 (Month 11), which included the patient's valid NHS number was:

- 99.6% for admitted care.
- 99.7% for outpatient care.
- 98.2% for accident and emergency care.

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

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

Information governance

South Devon Healthcare NHS Foundation Trust information governance assessment report overall score for 2013/14 was 88% 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:

Cardiac procedures and cardiac disorders.

Clinical coding					
Area	% clinical codes incorrect	% diagnoses incorrect		% procedures incorrect	
		Primary	Secondary	Primary	Secondary
Cardiac procedures	3.6	8.0	3.9	0.0	1.7
Cardiac disorders	6.9	6.0	6.5	12.5	33.3

Urological and male reproductive system procedures and disorders

Clinical coding					
Area	% clinical codes incorrect	% diagnoses incorrect		% procedures incorrect	
		Primary	Secondary	Primary	Secondary
Urological and male reproductive system procedures and disorders	12.4	9.0	11.2	6.4	29.6

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 2013/14

South Devon Healthcare NHS Foundation Trust 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.**

  Over the last year seven specialities have been provided with service line reporting training and are now using service line reporting to understand the cost of their services. These specialities are radiology, dermatology, rheumatology, trauma and orthopaedics, cancer services, obstetrics and gynaecology.

  Finance is continuing to rollout service line training and working with clinical teams to ensure that any data quality issues are resolved. In the next 12 months 20 of the 35 remaining specialities will be provided with information and trained on using and interpreting the data.

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

  The ICT strategy was published in July 2013. Core to this strategy is improving data quality through reducing the level of duplication of information whether this is from paper to an IT system or an IT system to another IT system.

  The trust is in the process of procuring a clinical portal to ensure that information is not unnecessarily duplicated and clinical teams have access to real time information no matter where they work.

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

  The new IT system is planned to go live in August 2014 and clinical teams have been working with IT colleagues to ensure the new paperless system captures the right information, at the right time in close proximity to where the patient is being treated.

- **Implement fully patient-held records system for the diabetic service providing patient's visibility of data, errors or omissions which can be fed back to the areas concerned. Sharing laboratory results, care plan summaries, outpatient outcome letters.**

  Patient Knows Best has now been set up for use by anyone with diabetes in Torbay and South Devon. Work has been progressing to share information generated by the hospital such as outpatient letters and laboratory results. This work has not been completed within the year so will remain a priority for 2014/15.

- **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.**

  UltraGenda has now been implemented in the inpatient service in oncology.

- **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.**

  Over the last 12 months a clinical portal test environment has been developed which has allowed clinicians to provide feedback on the development of the portal. A detailed specification has been developed and the trust has now gone out to procure a system. The priority for 2014/15 will be to fully implement the system within Torbay Hospital.

- **Electronic document management: continue to develop the use of this product and support areas with paperless/paper light working. Pilot using the iPad for outpatient data capture will be undertaken by speech and language therapy.**

  The pilot in speech and language therapy has been completed and further improvement potential to the iPad software identified. The improvements have been incorporated into the product development roadmap and additional pilot areas have been undertaken, for example in physiotherapy. A full business case for full deployment of iPads for outpatient data capture is currently being developed.

Statements of assurance from the Board continued

Data quality improvements: looking back 2013/14 continued

- **Deployment of clinical mobile devices based on the Apple iPad and iPhone to record and review information on the wards and at the patient's bedside using systems such as VitalPAC to record vital signs observations**

  To date over 145 Apple iPod touches and 80 iPads have been deployed across the hospital to enable clinical staff to take vital signs observations and act on the information received. The devices are used by the patient's bedside with information recorded in real time.

- **Rollout additional software modules of VitalPAC around infection prevention and automatic doctor escalation and feedback.**

  VitalPac has a number of additional modules including blood clot assessment, infection control and doctor escalation. The blood clot module is being piloted from spring 2014 and a decision is currently being taken whether to use the surveillance component of the infection control module. The trust is not using the doctor escalation software and alternative products are being considered.

- **Continue the rollout 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.**

  The surgical operation note has been rolled out to all surgical specialities in all theatre areas.

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

  The health informatics governance team have introduced a programme of data quality spot checks and audits on the hospital's databases and IT systems. The outcome of these checks/audits and subsequent actions are reported to the information governance group whose role is to assure good data/information processes.

- **Act on any recommendations from the external audit of the 2012/13 quality account.**

  Price Waterhouse Coopers undertook three data quality audits as part of the 2012/13 quality account requirements.

  The following indicators were audited:

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.

Findings: No issues identified

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.

Findings: Two issues identified, neither of which had an impact on the external auditor providing a limited assurance report.

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 - resulting in permanent harm or death.

Findings: No errors identified in sample tested. One control issue identified.

For the 2013/14 quality account the external auditor has agreed to undertake the following audits. The trust will act on the findings when information is published.

- Clostridium difficile
- 62 day cancer wait
- Dementia: find (data quality indicator chosen by the trust governors)

Statements of assurance from the Board continued

Data quality improvements: looking back 2013/14 continued

- **Act on the recommendations of four data quality audits undertaken from the trust board's performance dashboard indicators**

  Internal audit have undertaken two data quality audits from the trust's dashboard. One data quality audit (dementia) has formed part of the external auditor's work for 2013/14. One audit has been deferred until 2014/15.

Internal Audit Data quality audits 2013/14

Referral to Treatment Time (RTT) - % of incomplete pathways

Summary: A total of 100 electronic patient records were reviewed to confirm that each had been correctly recorded and reported as an incomplete pathway, and that the waiting time from referral had been correctly calculated. Positive assurance can be provided for the data quality for this indicator, based on the sample findings, as it was confirmed that both the status of incomplete pathway and the calculated waiting time for each patient record was accurate for 98% of those records reviewed.

Recommendations: None

Early warning trigger tool

Summary: The completion of the Early Warning Trigger Tool (EWTT) is a subjective process and, as such, is liable to potential inconsistencies within the data submitted. The trust has issued guidance regarding the completion of the EWTT, which includes identifying data sources for each question contained therein. It was found, within the areas reviewed, that the data sources identified within the guidance were used for an average of 69% of the submitted responses.

The process of consolidating the individual EWTT reports into the master EWTT, which informs trust performance reporting, is a manual task. This was reviewed and it was found that 67% of the individual ward/area reports (six out of nine) were consistent with the master EWTT report.

Recommendations: The trust may wish to review the Early Warning Trigger Tool (EWTT) Guidance Procedure (December 2010) to confirm that the Data Sources listed therein are appropriate, current and suitably defined. Particular attention should be given to the Data Sources listed against Questions 2, 3 and 4 (vacancy rate, unfilled shifts rate and sickness absence rates respectively) as these were not used by any of the ward/areas reviewed.

The trust should ensure that the master Early Warning Trigger Tool reconciles exactly to the locally completed returns, to allow for accurate and consistent performance reporting.

Actions: The Patient Safety Lead is taking forward the recommendations with an updated report to the Audit Committee in due course.

Diagnostic tests longer than 6 weeks

Due to insufficient resources this audit has been deferred until 2014/15.

Statements of assurance from the Board continued

Data quality improvements: looking forward 2014/15

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

- Implement the new emergency department IT system by August 2014.
- Implement the clinical portal across the hospital to support clinical teams accessing patient information by March 2015
- Procure clinical coding audit software to facilitate the increasing the number of coding audits undertaken in a year and define a further detailed coding audit programme by September 2014
- Act on the recommendations of the three data quality audits undertaken from the trust board's performance dashboard indicators and the three data quality audits undertaken by the external auditor as part of the trust's annual quality account.

Mandated quality indicators

Quality Indicators

The trust continues 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	National target	2013/14	2012/13	2011/12	2010/11	End of year performance against target
VTE risk assessed	UNIFY	95%	94%	92%	n/a	n/a	

In 2013/14 the lowest performing trust was 63.2% and the highest was 100%. The national average was 98%

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

- Monitoring performance on a weekly basis and working with the clinical areas and clinical teams to improve the process of recording VTE assessment. One of the challenges is that the electronic recording of data does not pick up all of the actual assessment done.
- The operational teams have streamlined the business process to improve completion rates however there is further work to be dome in 14_15. This will focus on supporting migration to electronic clinical recording using vital pack and then the e-prescribing system when this is implemented.
- Clinical coding - Clinical coding will be piloting coding VTE assessment information from the drug charts as part of the coding process.

Number of clostridium difficile cases (rate per 100,000 bed days)	Health Protection Agency (6a)		9.6	17.5	19.5	21.1	

The Rate for 2013_14 is based on the period between December 2012 and November 2013. The rate of 9.6 / 100,000 bed days is based on 12 Cdiff infections in the 12 month period

In 2013/14 the worst performing trust rate was 37.5/100,000 bed days and the best performing trust rate was 2.4. The national average rate was 1

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

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

Number of never events	Safeguard	0	2	2	0	0	

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

- Checking that the lenses are the correct strengths at the biometry stage (stage when measurements are taken) as well as at the pre-insertion stage through completing the WHO checklist.

Mandated quality indicators continued

Patient safety continued

Quality indicator	Source	National target	2013/14	2012/13	2011/12	2010/11	End of year performance against target
Number of patient safety incidents	Safeguard	n/a	5188	4506	4854	4577	n/a

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

- Actively encouraging the reporting of incidents via the online safeguard system. During clinical induction the importance and relevance of this is explained and a simple on line video of 'how to report and incident' is available
- Reviewing all incidents by the ward/area managers which are then signed off by the Divisional Clinical Governance Leads with appropriate actions.

Quality indicator	Source	National target	2013/14	2012/13	2011/12	2010/11	End of year performance against target
Number & % of such patient safety incidents that resulted in severe harm or death.							
Number	Safeguard		13	25	50	79	n/a
%	Safeguard	10% reduction yr on yr	0.1%	0.55%	1.03%	1.7%	n/a

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

- Reviewing all serious incidents. This includes the ward manager, matron and divisional governance coordinator. This results in a root cause analysis (RCA) being undertaken which results in lessons learned and an action plan. This RCA is presented to the trust Serious Adverse Events Review Group. The Groups monitor progress against the actions.

Mandated quality indicators continued

Clinical effectiveness

Quality indicator	Source	Benchmark (National)	2013/14	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			3.75%	4.39%	3.11%	4.28%	
Relative risk for patient 0-14		100*	69.24	78.02	57.36	73.76	
• =>15			7.65%	7.82%	7.53%	7.92%	
Relative risk for patients => 15		100*	96.36	98.31	99.65	101.1	

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

The national average benchmark is 100

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

- Continuing to monitor clinical outcome benchmarks led by the director of patient safety to maintain and improve this percentage, and so the quality of its services.

Summary hospital mortality indicator (SHMI)	Dr Foster	100*	92.91	95.58	96.97		
Hospital Standardised Mortality rate (HSMR)	Dr Foster	100*	94.5	92.6	95.0		

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

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

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

SHMI data is published in arrears so the latest data is for the period July 2012 to June 2013

The highest SHMI score = 115. The Lowest Trust score = 65. National average = 100

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

- Continuing to monitor clinical outcome benchmarks led by the director of patient safety.
- On-going quality improvement programmes to build on our work with the wider health community and integrated care model
- Maintaining strong clinical governance systems with peer mortality review programme

Our performance against mandated quality indicators

Clinical effectiveness

Quality indicator	Source	Benchmark (National)	2013/14	2012/13	2011/12	2010/11	End of year performance against benchmark
% of patient deaths with palliative care coded ateither diagnosis or speciality speciality level	HSCIC		Oct 12-Sept 13	April 12-	April11-		
SDHFT coding %			16.9%	15.5%	14.0%		

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

Between Oct-12 –Sept 13 the highest trust rate was 44.9% and the lowest was 0%. The national average palliative care coding rate was 21.1%

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

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

Mandated quality indicators continued

Patient experience

Quality indicator	Source	Benchmark (National)	2013/14	2012/13	2011/12	2010/11	End of year performance against benchmark
Patient Reported Outcome measures	HSCIC		April 13-Dec 13	April 12-Mar 13	April11-Mar 12		
Groin hernia surgery National average=0.086 Highest rate= 0.157 Lowest rate= 0.0134			0.053 adjusted average health gain	0.083 adjusted average health gain	0.089 adjusted average health gain		
Varicose vein surgery			n/a due to low number	n/a due to low number	n/a due to low number		
Hip replacement surgery National average=0.439 Highest rate= 0.527 Lowest rate= 0.301			0.443 adjusted average health gain	0.437 adjusted average health gain	0.392 adjusted average health gain		
Knee replacement surgery National average=0.330 Highest rate= 0.416 Lowest rate= 0.193			0.368 adjusted average health gain	0.329 adjusted average health gain	0.309 adjusted average health gain		

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

- Reviewing participation rates to ensure good sample size to support confidence in outcomes
- Sharing PROMS data with clinical teams

Staff recommendation of the trust as a place to work or receive treatment	Friends and Family Q12D	n/a	82	3.85	3.79	3.57	

The 2013/14 score is a new national score and related to CQUIN payments for acute trusts participating in the national NHS Staff Survey. The average score for acute trusts is 68.

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

- KF 10 Percentage of staff receiving health and safety training in the last 12 months.
- KF 18 Percentage of staff experiencing bullying, harassment or abuse from patients, relatives or the public in the last 12 months
- KF 27 Percentage of staff believing the trust provides equal opportunities for career progression or promotion
- KF 28 Percentage of staff experiencing discrimination at work in the last 12 months

Our performance against mandated quality indicators

Patient experience continued

Quality indicator	Source	Benchmark (National)	2013/14	2012/13	2011/12	2010/11	End of year performance against benchmark
Overall patient experience	NHS Inpatient survey	n/a	8.4	8.1	n/a	n/a	

In 2013/14 the best performing trust scored 10 and the worst performing trust scored less than 8. There is no national average.

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

- Acting on feedback received
- Acting on emerging trends

F and F: Inpatients	Friends and Family test		69	n/a	n/a	n/a	

The Friends and family data is published data for March 2014. This is the latest national published dataset as of May14. Since March the trust has continued to improve its score. The trust currently scores 72 (inpatients) and 55 (A&E).

In March 2014 the lowest performing trust (inpatients) was 28 and the highest was 100. The national average was 73. The lowest performing trust (A&E) was 1 and the highest was 89. The national average was 54.

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

- Increasing the response rate
- Acting on feedback received

OUR PERFORMANCE IN 2013/14

Performance

Overview

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

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

To ensure that we deliver high quality care we have robust arrangements in place to monitor our organisational performance 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, a data dashboard and a detailed data book indicating our latest performance and actions to address issues. We meet with commissioners to share information provide updates and to review our performance monthly and we provide information to Monitor on a quarterly basis.

Ratings at a glance

Continuity of services rating

4

Monitor Risk rating. Downloaded 10/4/14 from http://www.monitor.gov.uk/

Governance rating

Green: No evident concerns

Good governance, sound financial management and high clinical standards are at the heart of ensuring we are performing well.

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	Quality Indicator	Target 13/14*	13/14	12/13	11/12
C.difficile year on year reduction	Safety	18	17	21	24
MRSA - Meeting the MRSA objective	Safety	0	1	1	0
Cancer 31 day wait from diagnosis to first treatment	Effectiveness	96%	98%	98%	98%
Cancer 31 day wait for second or subsequent treatment: surgery	Effectiveness	94%	98%	97%	97%
Cancer 31 day wait for second or subsequent treatment: drug treatments	Effectiveness	98%	99%	100%	100%
Cancer 31 day wait for second or subsequent treatment: radiotherapy	Effectiveness	94%	97%	98%	97%
Cancer 62 day wait for first treatment (from urgent GP referral)	Effectiveness	85%	90%	88%*	90%
Cancer 62 day wait for first treatment (From consultant led screening service referral)	Effectiveness	90%	97%	96%	93%
Cancer two week wait from referral to first seen date	Effectiveness	93%	95%	97%	97%
Cancer breast symptoms two week wait from referral to first seen date	Effectiveness	93%	96%	98%	100%
A&E – total time in A&E	Experience	95%	96%	96%	98%
Referral time to treatment time, admitted patients	Experience	90%	90%	92%	93%
Referral time to treatment time, non admitted patients	Experience	95%	96%	96%	97%

**These are Monitor mandatory targets applicable to all Foundation Trusts*

Mandated quality indicators

These are reported in part 2 of the Quality Account.

Our performance against key national priorities

NHS Operating Framework and local priorities

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

Indicator/Target	Quality Indicator	Target 13/14*	13/14	12/13	11/12
Smoking during pregnancy	Effectiveness	15%	16.8%	15.0%	15.8%
Breastfeeding initiation rates breast feeding)	Effectiveness	76%	75%	76%	74.6%
Mixed sex accommodation breaches of standard	Experience	0	12	1	9
Cancelled operations on the day of surgery	Effectiveness	0.8%	1.1%	1.2%	0.7%
DNA rate	Effectiveness	6.0%	5.9%	5.9%	6.0%
Diagnostic tests longer than the 6 week standard	Effectiveness	1.0%	0.6%	1%	1.5%
Rapid access chest pain clinic waiting times: seen in 2 weeks	Effectiveness	98%	98%	100%	100%
Primary PCI within 150 minutes of calling	Effectiveness	68%	90%	85%	88%
Patients waiting longer than three months (13 weeks) for revascularisation	Effectiveness	0%	0%	0%	0%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	79%	79%	89%
Summary hospital mortality indicator (SHMI)	Safety	100	92.91	95.58	96.95
Ethnic coding data quality	Experience	80%	95%	94%	95%
Patient Environment Action Team Assessment (PEAT)	Experience		Good	Good	Good

In 2014/15 we will continue to use a range of metrics to measure the quality and performance of the organisation. We also have named leads taking forward actions where we are currently underperforming. We will continue to make this more accessible to the public through our website and various publications.

Annex 1

Engagement in developing the Quality Accounts

Prior to the publication of the 2013/14 quality account we have shared this document with:

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

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

This year we broadened the engagement event to include carers, with local carers from different age ranges included for the first time. We also shared the outcomes of our improvement work from the previous year with the stakeholders with presentations from clinicians. The feedback from the event continues to be positive with stakeholders feeling engaged in the development of the quality account.

In 2014/15 we will continue to share our progress against the quality improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Devon County Council's Health and Wellbeing Scrutiny Committee on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014

Devon County Council's Health and Wellbeing Scrutiny Committee has been invited to comment on the South Devon Healthcare Foundation Trust Quality Account 2013/14. All references in this commentary relate to the reporting period 1st April 2013 to 31st March 2014 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account 2013-14 and believes that it is provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge. The Scrutiny Committee welcomes the progress made against the five priorities for improvement over the last year and congratulates the Trust in having consistently high percentages of patients who were extremely or very likely to recommend the service to their friends and family. The Committee also commends the very positive outcomes achieved with the implementation of the integrated heart failure service. In light of the improvement in pressure sore reporting, but not number, the committee looks forward to the continuation of the focus to decrease the incidence.

The Francis Review provoked a significant challenge to public organisations involved in providing, commissioning, evaluating and improving health care throughout the country. Local Authority scrutiny was specifically criticised for a lack of oversight and rigor in holding NHS organisations to account. The Health and Wellbeing Scrutiny committee undertook a spotlight review earlier this year to further consider how to hear the voice of vulnerable people and maintain an active challenge in order to ensure that the work of scrutiny is as effective as it possibly can be. The review demonstrated that it is only by working with other agencies and sharing information that scrutiny can identify and work in partnership to improve areas that are underperforming. The challenge is laid at the door of the County Council the NHS and other partners to work with the mechanisms of democracy to help develop services from a person centred perspective. The Committee would like to further explore with the Trust how this may be possible, including regular sight of NHS Friends and Family test data and mortality rates for example.

The Committee fully supports the five priorities for improvement in 2014/15 and looks forward to continued partnership working.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Torbay Council's Health Scrutiny Board on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014

South Devon Healthcare NHS Foundation Trust's Quality Accounts 2013/2014 has been considered by representatives of Torbay Council's Health Scrutiny Board. The clarity with which the Trust has explained how it has met its priorities for 2013/2014 and what its priorities are for the forthcoming year is welcomed.

It is encouraging that there are references throughout the Quality Account which highlight the enthusiasm for pursuing the creation of an Integrated Care Organisation to serve the population of Torbay. This now needs to be turned into a reality in order to help further partnership working across health and social care.

The Quality Accounts for each of the Trusts operating in Torbay were considered at the same time and this allowed for the inter-relationships between the different initiatives in different Trusts to be examined, in particular the priority around reducing the incidences of pressure ulcers. It is encouraging that there are consistent themes across all of the Quality Accounts.

The Board met with representatives of South Devon Healthcare NHS Foundation Trust, South Western Ambulance Service NHS Foundation Trust and South Devon and Torbay Clinical Commissioning Group in February 2014 to discuss services at the Emergency Department of Torbay Hospital. It was clear that all organisations were working together to improve services to the public. This partnership working needs to be embedded throughout all health and social care organisations in Torbay. It should include more timely communications between the hospital professionals, GPs and social workers to ensure a truly joined-up approach for residents and visitors.

Looking forward to the priorities for the coming year, it is highlighted that there appears to be a lack of post-bereavement support in Torbay, especially amongst those with no family living close by. This could be addressed under Priority 4: Bereavement.

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 2014

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from South Devon and Torbay Clinical Commissioning Group on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014

South Devon and Torbay Clinical Commissioning Group (SDT CCG) is lead commissioner for South Devon Healthcare NHS Foundation Trust (SDHFT) and is pleased to provide our commentary on the Trust's Quality Accounts for 2013-14.

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

We 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 Commissioning for Quality and Innovations (CQUINs) this year have been agreed with commissioners, which demonstrate the organisation's determination to continually improve the quality of care.

Looking Back

We were pleased to support the priorities selected by the Trust last year and in particular the initiative to reduce the numbers of patients who developed pressure ulcers whilst staying in the hospital. Pressure ulcers cause pain and discomfort, and can cause infection. Preventing them from starting, and healing them quickly when they begin, is an important patient safety priority. We note that the Trust has seen a small increase in the numbers of grade 3 and 4 pressure ulcers, which is disappointing but which may demonstrate better reporting of such incidents. It is encouraging to see that the Trust is collaborating with other organisations to share learning across the local care system, and we will continue to monitor the incidence of pressure ulcers very closely.

The initiative to roll out the 'enhanced recovery in medicine' onto three further wards is noted. The CCG is very supportive of the principles of enhanced recovery. We would be very interested in hearing more next year about how the programme is improving the patient and carer experience.

The Trust reports improvements in the care of patients with heart failure, as a result of the integrated heart failure programme. The CCG is pleased to see the focus within the Trust on patients with heart failure, in this novel initiative, although it is not very clear in the account what the real benefits for patients are. We look forward, therefore, to seeing over the next year exactly how the five heart failure nurses and the telehealth project are improving patient and families experiences of care and outcomes.

The Trust reports that it is developing new ways of supporting patients and their families at the end of life, and that eight members of staff have now attended Enhanced Palliative Care Skills course, which is commendable, as is the newly developed bundle of resources. The CCG is keen to see the care for people at the end of life really enhanced, and their families experiences also similarly improved, and we look forward to seeing the measures used across the local care community during the next year, where the background work done last year will then become more apparent.

In particular we are pleased to note the apparent success of the pilot to test seven day services. We look forward to the analysis of the pilot and the way in which the Trust will use the results to inform future

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from South Devon and Torbay Clinical Commissioning Group on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014 continued

working arrangements. We are very supportive of initiatives that mean efficient, seven day services for patients across the hospital.

With respect to the CQUINS for 2013-14, we note that the Trust has reported in some detail on two of the nine schemes. One of these, the friends and family test (FFT) is of particular interest both nationally and locally as the NHS seeks to embed the FFT throughout the system. We are encouraged to see the positive comments from patients and note the good scores that the Trust has achieved for feedback. However, it is disappointing to note that the Trust has not been able to achieve the level of patient feedback needed in A&E during the year. We support the Trusts renewed focus on achieving the target for FFT across the hospital, and with staff in the coming year, and we will continue to monitor the achievements against target in all departments.

We also note the results of the Trust's performance in respect of the Dementia CQUIN, which has been a challenge for the organisation. The Trust rightly states that it needs to implement a more reliable system for the initial identification of patients with dementia and we support their stated continued focus on increasing the use of the screening tool. We will be monitoring this CQUIN as well as all the others through our CQUIN panel process.

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 patient safety focus on sepsis, pressure ulcers and falls is particularly welcome. Sepsis is a very real threat to adults and children, and early recognition and treatment in all age groups can be a real life saver. The Trust proposes to implement a sepsis bundle across the organisation, which is very welcome, and the CCG will be fully supportive of this initiative. The Trust is already working with partner agencies on the development of a care pathway for sepsis in children and their contribution to date has been invaluable. We have already noted the work across the care community to improve pressure ulcer prevalence and it is pleasing to see that this remains a priority for 2014-15.

The CCG has a focus on frailty, and is fully supportive of the Trust's plan to instigate a frailty scoring tool as part of the enhanced recovery in medicine initiative as well as on improving dementia care. We are pleased to see a focus on bereavement support and timeliness of information being sent to GPs when a patient dies. We are also pleased to see discharge planning is also receiving more focus in the year ahead, with plans to improve the support given to carers.

General Comments

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

We feel that the Trust's attention to quality and safety is highly commendable and we are pleased to note the continued focus on patient safety. We note the 2 Never Events that occurred in ophthalmology and the learning the Trust has taken as a result of these unfortunate patient safety incidents, and we would caution that this learning needs to be embedded across the whole organisation.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from South Devon and Torbay Clinical Commissioning Group on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014 continued

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

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

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Governors on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014

The Council of Governors has continued to work closely with the Board, and though the year has been marked by some challenges within the Trust's governmental structure, the governors have been assured that these have had no impact of any kind on the very high standards of treatment and patient care that were publicly recognised and acclaimed in previous governors' statements.

During the year, governors have continued to consider ways in which the non-executive directors (NEDs) of the Board can be held to account, as presaged in last year's statement, and mechanisms have been devised to support this responsibility. A buddying system has been put in place, and each member of the governors' Nominations Committee is partnered with one of the NEDs. The indications are that this is working well, and informal meetings between buddies are happening. In addition, the lead governor has been identified as the principal functional link between the NEDs and the governors in general and members of the Quality and Compliance Committee in particular are invited to communicate any matters related to their performance for inclusion in the annual appraisal of NEDs which is conducted jointly by the chair and the lead governor. The indications are that this too is working satisfactorily, and it is worth noting that attendance by governors at national events shows that most trusts are experiencing uncertainty about delivery of this responsibility. At South Devon we have found a meaningful way forward.

The operation of the five workstreams (and the Audit and Assurance Committee), which provide assurance on the quality of services offered at Torbay, includes at each meeting a governor observer. The governor observer's role is to provide evidence that the workstream has considered the appropriate Care Quality Commission (CQC) outcomes as part of their meeting. The governor report is shared with the workstream and presented to every meeting of the Quality and Compliance Committee. The portfolio of reports thus accumulated forms a part of the documentation which will be presented to the CQC inspectorate on the occasion of a visit. It also enables the Quality and Compliance Committee to gain a better overview of patient safety and quality. This governor observer role continues to be central to the governors' engagement with the quality and safety agenda and the organisation's many facets of work, a feature which we believe to be unique to this Trust, and one which has been highly commended by CQC inspectors.

As governor observers are being progressively added to other operational committees, including the Pharmacy Manufacturing Board and Infection Control, there are plans, subject to Council of Governors and Board approval, to include reports from those sources within the Quality and Compliance Committee remit.

With regards to the annual quality account, representatives of the Council of Governors have again taken part as stakeholders in the annual process for the designation of priorities. After some uncertainty in the previous year, because of a change in the national policy, governors are pleased to have had a restoration of the ability to designate a data quality indicator for inclusion in the Trust's Quality Accounts for 2014/15. As will be seen elsewhere in this document, the governors have nominated dementia as their chosen data quality indicator to be audited.

The practice of inviting speakers to the Quality and Compliance Committee has continued through this year. The Director of Nursing, Professional Practice and Peoples Experience spoke especially about the management of complaints, a topic which emerges from time to time in the governors' annual survey of members. It is worth noting however that the numerical total is encouragingly small, but each is a matter of concern, and any may point to an underlying problem. It is positive to see the Trust's proactive approach to managing the root causes of these complaints.

The governors are again able to confirm that they continue to receive full assurance of the Trust's commitment to and delivery of improvement in the standard of quality.

Annex 1

Statements from commissioners, governors, OSCs and Healthwatch

Statement from Healthwatch Torbay on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014

At Healthwatch Torbay we welcome this extensive report and share the aim to achieve a high quality service experience for patients; and look forward to the chance to share feedback and work together to achieve this focus with the Trust.

With this in mind, we commend the Trust on its commitment to the friends and family test (FFT), and in particular, the new 'you said, we did' campaign. To help improve the response rate and implement the FFT in new areas, we would hope that Healthwatch Torbay can help achieve this collaboratively with the help of our own innovative new 'rate & review' system, which will also allow for up-to-date and accurate public performance data. This could hopefully be an advantage to the Trust's clinical teams when making informed decisions about patient care and service delivery.

We also applaud the Trust for its foresight at catering for the region's rapidly ageing population, even highlighting improvements in the Trust's priorities for the next 12 months. We welcome new training implemented by working with a number of volunteer agencies such as Age UK and the Royal Voluntary Service, particularly the drive to achieve 'purple angel' status and become a 'dementia-friendly' hospital.

Overall the local reputation of the hospital is strong and we receive much positive feedback. Having said that we are aware of the pressures within Accident and Emergency and hope to see some improvement in the near future. We must also highlight the ongoing challenge of re-shaping of health and social care services in Torbay and how difficult it is to face this without a permanent Hospital Chief Executive. We very much hope this situation is resolved quickly, because the planned merger of the two Trusts will need strong leadership in place to help shape it for the future.

Healthwatch Torbay sincerely hopes that the former pressure and latter challenge are not being felt in other areas of the hospital; contributing to the lower FFT scores for Ainslie and George Earle Wards, significant increase in mixed sex accommodation breaches of standard, slight increase in reported incidents pressure ulcers and two occurrences of 'Never events' - but we commend the Trust for highlighting these in the report and also the subsequent actions taken to rectify these. We look forward to gathering public opinion on how these perform over the next 12 months.

In that respect, Healthwatch Torbay believes that the way in which we all gather patient experience information could be improved, without the need to duplicate information (as outlined in the Trust's ICT strategy - p46). Although partners like the Trust clearly work hard to capture patient views and act upon them, there is still overlap and duplication between partner organisations which could be eliminated through more comprehensive engagement.

We believe this could be achieved via use of our new innovative 'rate & review' system and the information analysis and reporting tools that come with it. Using a transparent and familiar means of capturing data quality information would - we believe – ensure public views are heard in an independent way that is clearly making a significant difference, whilst also providing partners such as the Trust with a wealth of patient quality data that could go a long way to improving services for all.

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 1

Statements from Commissioners, Governors, OSCs and Healthwatch

Statement from Healthwatch Devon on South Devon Healthcare NHS Foundation Trust's Quality Account 2013/2014

Thank you for your invitation to comment on the Quality Account for the South Devon Healthcare NHS Foundation Trust.

At the end of its first year of operation, Healthwatch Devon has prioritised two Quality Accounts for formal response – Devon Partnership Trust and the Royal Devon and Exeter NHS Foundation Trust. We have chosen these because we have existing partnership agreements in place, and working relationships that enable us to give an informed response to their reports.

For our second year, we are keen to be able to respond to all Quality Accounts for the area we cover. In order to prepare for this, our aim is to secure partnership agreements with relevant providers, and to develop staff and volunteer representation on appropriate engagement and liaison groups. This will enable us, through the year, to become familiar with provider issues and challenges, and to ensure that our responses to 2014/15 Quality Accounts are based on good knowledge and understanding.

Annex 1

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.

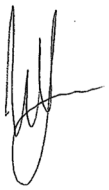
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013-14;
- 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 2013 to June 2014
- Papers relating to quality reported to the Board over the period April 2013 to June 2014
- Feedback from the Commissioners (South Devon and Torbay CCG) dated 20/5/14
- Feedback from Governors dated 21/05/14
- Feedback from local Healthwatch organisations dated 21/5/14 and 28/5/14
- Feedback from other stakeholders involved in the sign off of the Quality report dated 19/05/2014
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated January 2014
- The 2013 national inpatient survey dated April 2014
- The 2013 national staff survey dated February 2014
- Care Quality Commission intelligence monitoring reports dated March 2014
- The Head of Internal Audit annual opinion over the trust's control environment dated tbc
- 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

28.05.2014  **David Allen,** Acting Chair

28.05.2014  **Dr John Lowes,** Interim Chief Executive

Annex 2

CQUIN 2013/14 performance - full details & outcome available at www.sdhl.nhsuk

			Q1	Q2	Q3	Q4
FRIENDS and FAMILY	ROLLOUT	PATIENT SURVEY FEEDBACK				
		OBSERVATIONS OF CARE				
		FRIENDS and FAMILY UPDATE				
	INCREASED RESPONSE RATE					
	IMPROVED SCORE (STAFF)					
SAFETY THEMOMETER	DATA COLLECTION					
	PRESSURE ULCER IMPROVEMENT					
DEMENTIA		FIND				
		INVESTIGATE				
		REFER				
		UNIFY RETURN				
	CLINICAL LEADERSHIP					
	SUPPORT FOR CARERS					
VTE RISK	RISK ASSSESSMENT					
	ROOT CAUSE ANALYSIS					
ENHANCED RECOVERY						
PRODUCTIVE DISCHARGE						
CARE PLANNING SUMMARIES	WEEKDAY and WEEKENDS					
CLINIC LETTERS						
TRANSFER OF INFORMATION (MIG)						
HEART FAILURE						
ALCOHOL						
MISSED DOSES						
SHARED DECISION MAKING						

Available in large print on request

South Devon Healthcare NHS
NHS Foundation Trust

South Devon Healthcare NHS Foundation Trust
Headquarters
Hengrave House
Lawes Bridge
Torquay
TQ2 7AA
Switchboard: 01803 614567
HQ Fax: 01803 616334
www.sdhct.nhs.uk