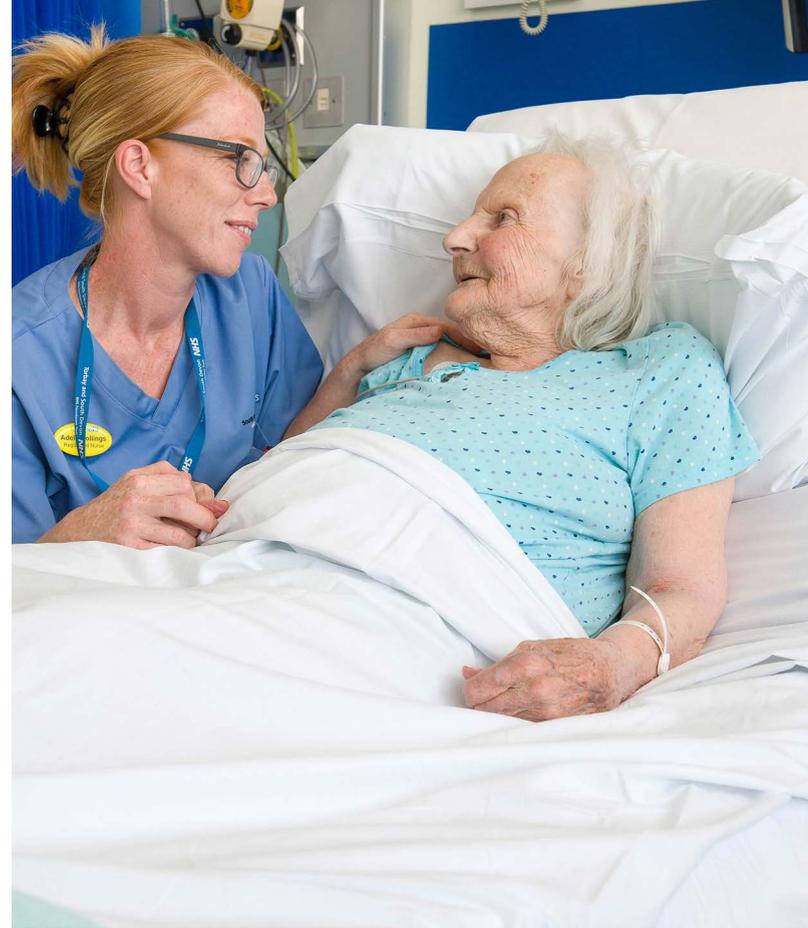


PATIENT SAFETY
CLINICAL EFFECTIVENESS
PATIENT EXPERIENCE



QUALITY ACCOUNT 2015/16

Torbay and South Devon 
NHS Foundation Trust

ABOUT THIS DOCUMENT

WHAT IS THE QUALITY ACCOUNT AND WHY IS IT IMPORTANT TO YOU?

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

Our 2015/16 Quality Account is an annual report which shows:

- How we have performed over the last year against the quality improvement priorities which we laid out in our 2014/15 Quality Account.
- The 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 (2016/17).

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

DO YOU NEED THE DOCUMENT IN A DIFFERENT FORMAT?

This document is also available in large print, audio, braille and other languages on request. Please contact the equality and diversity team on 01803 656680.

GETTING INVOLVED

We would like to hear your views on our Quality Account. If you are interested in commenting or seeing how you can get involved in providing input into the Trust's future quality improvement priorities, please contact susan.martin@nhs.net or telephone 01803 655690.

CONTENTS

INTRODUCTION AND STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE	4
PRIORITIES FOR IMPROVEMENT - LOOKING BACK 2015/16	7
- LOOKING FORWARD 2016/17	28
STATEMENTS OF ASSURANCE FROM THE BOARD	35
OUR PERFORMANCE IN 2015/16	84
ANNEX 1	
ENGAGEMENT IN THE QUALITY ACCOUNT	92
STATEMENTS FROM COMMISSIONERS, GOVERNORS, DEVON HEALTH AND WELLBEING SCRUTINY, TORBAY COUNCIL SCRUTINY BOARD, TORBAY HEALTHWATCH, DEVON HEALTHWATCH	94
ANNEX 2	
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS	101
ANNEX 3	
CQUIN PERFORMANCE 2015/16	103

INTRODUCTION AND STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE



INTRODUCTION

2015 was a particularly exciting year, as on 1st October we launched our integrated care organisation bringing together South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care Trust into a new Trust – Torbay and South Devon NHS Foundation Trust. A fundamental principle in establishing our new Trust is the commitment to safe, high quality care and the best possible experience for people who need our health and social care.

Our aspirations are high. Our vision is a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care we have choice about how our needs are met, only having to tell our story once.

In the current financial climate, all public sector services are grappling with how to meet the increasing, and increasingly complex, needs of a changing population with the limitations on funding. We believe the best way to secure sustainable, effective and high quality services is through delivering our new care model. This means a significant change in how we deliver care and will take time to achieve – at least three years.

Since October, we have started to put in place some of the foundations on which our future model of care will be based. We have engaged with our staff to design our locality model for integrated care closer to home, and are working with our GPs on how we co-locate and work better together at local level. We have engaged with the voluntary and private sectors to talk about their contribution to local care and how we can support more joined up working. We are now supporting our Clinical Commissioning Group in a public consultation about the exact shape and location of clinical hubs for more specialist services, community bed based care and Minor Injury Services in each of our five localities. Over the next year we will see these changes taking place.

Our greatest challenge over the past 12 months has been in providing timely urgent care services, particularly the responsiveness of our Emergency Department and the efficient flow of patients through our hospitals. These pressures, coupled with some recruitment challenges, have affected performance in some areas of planned

care. We know that our staff are working as hard as they can under real pressure, and we are sorry that some people are having to wait longer for their treatment than we would like, which can at times result in a poor experience of care.

At every level in the Trust we are committed to improving this performance and many initiatives are already making a difference - we have opened an Acute Medical Unit, which has helped us to reduce overcrowding in the Emergency Department and improve the overall experience for urgent patients referred to Torbay Hospital for expert advice by their GP. We have also extended the use of our short stay Paediatric Assessment Unit to include weekends, providing an alternative to the Emergency Department when clinically appropriate. Additional staff are being recruited to enable this to be consolidated.

When the Care Quality Commission visited us in February 2016, inspectors witnessed the challenges we were facing. They asked us for an action plan identifying how we would address the issues in our Emergency Department to ensure that concerns were addressed. They were satisfied with the action plan we produced. We are now working hard to implement all the service changes that will enable us to improve the patient experience in the Emergency Department. At the time of writing, the Care Quality Commission had not published its inspection report, but the Emergency Department will remain a priority area for us during 2016/17.

Other quality priorities for us in the coming year are to fully integrate our stroke service to move closer towards the national standards for excellent care and thus improve patient outcomes, to strengthen our organisational learning from complaints, and to improve

our communication with patients, carers and service users. Good communication is vital to delivering great care and will underpin our new care model and the changes to the way we deliver services in the future.

This report provides information on progress against our quality targets for the past year, and sets out our quality improvement priorities and plans for 2016/17.

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



Mairead McAlinden

Chief Executive



LOOKING BACK: 2015/16

In our 2014/15 Quality Account we reported that we would focus on five priority areas for quality improvement in the period 2015/16. These were all locally agreed priorities based on national best practice and best clinical evidence.

PRIORITIES FOR IMPROVEMENT

PATIENT SAFETY

PRIORITY 1:

Redesigning the reliability, accuracy and timeliness of information at the point of handover to enable an effective and safe transfer at each and every juncture.

CLINICAL EFFECTIVENESS

PRIORITY 2:

Improve multi-agency working across Torbay and South Devon through developing and extending the existing multi-disciplinary teams working across the community.

PRIORITY 3:

Create a reliable and consistent ambulatory emergency care service available seven days a week for patients

PATIENT EXPERIENCE

PRIORITY 4:

Establish a single point of contact for people to access community based health and social care services in Torbay

PRIORITY 5:

Improve the involvement of carers in the management of medications on admission and at discharge in Torbay Hospital and in our community hospitals

PRIORITY 1:

REDESIGNING THE RELIABILITY, ACCURACY AND TIMELINESS OF INFORMATION AT THE POINT OF HANDOVER TO ENABLE AN EFFECTIVE AND SAFE TRANSFER AT EACH AND EVERY JUNCTURE.

During a patient's stay, it is often necessary to transfer the care of that patient to another ward, to a care agency or another hospital to continue their care.

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

We set ourselves the goal of creating and testing a 'transfer of care bundle' with direct patient/carer involvement. This is part of a three year transfers of care initiative ensuring that any transfer is understandable for everyone involved, it is timely and completed successfully every time.

Individual objectives for the first year included:

- Understanding the volume, complexity and scope of transfers within the health and care community and the issues that affect the transfer.
- Ensuring patient, relative and carer involvement in the design.

- Designing a 'transfer of care bundle' and testing extensively to inform future changes.
- Ensuring the whole team is involved in the transfers of care bundle development and implementation.

The project started with senior nursing staff across acute, community hospitals and community teams setting out to understand what should 'always' happen for a good transfer of care. Their clinical improvement group forum was then used to develop this work.

Initially a transfers of care bundle was developed and a 'plan, do, study, act' approach was taken to test this out across a range of settings.

The bundle included identifying key information requirements about the transfer including:

- name,
- reason for transfer,
- patient informed of transfer
- planned time of transfer,
- next of kin informed,
- medication/equipment (sourced or informed location of)
- care needs in first 36 hours post transfer.

Patient groups including the Engagement & Experience Committee and a community hospital patient forum were asked to contribute to and review the proposed bundle.

Feedback from the above areas demonstrated that some of the information being gathered was duplicating clinical handover information already being collected by clinical staff.

Further discussion at the clinical improvement group also identified the same duplication of information with handover. The group felt that the aim of understanding what is important to patients, families and carers at the point of transfer needed more focus. As a result of this, the clinical improvement group designed a patient experience survey. A simple feedback sheet with two questions was agreed:

- What went well with the transfer?
- What would have made the transfer better?

The patient survey was distributed to 100 patients. The number of patients who completed the survey was 76 (response rate 76%) and there were two main problems identified from the feedback:

We set ourselves the goal of creating and testing a ‘transfer of care bundle’ with direct patient/carer involvement...



- Too much time waiting for patient transport for transfer to take place.
- Too many drop off stops made during the transport journey.

Surprisingly, patients commented that they had no concerns around communication between NHS staff and families/carers or around medications, equipment and any special requirements.

The information requirements to enable a successful transfer of care were passed to another Trust project group which is looking at improving clinical handover using information technology. The IT system purchased is called Nerve Centre and the project scope of the group and IT system has been extended to include transfers of care.

With regards to the patient transport comments this has been fed back to the patient transport team and they are reviewing this information with the aim of undertaking an improvement project in 2016/17.

The transfers of care project is now awaiting the launch of Nerve Centre. This is due to start on three wards during May 2016. The project lead for transfers of care is now part of the Nerve Centre project group.

Year two will focus on rolling out Nerve Centre onto all the wards in Torbay Hospital.

PRIORITY 2:

IMPROVE MULTI-AGENCY WORKING ACROSS TORBAY AND SOUTH DEVON THROUGH DEVELOPING AND EXTENDING THE EXISTING MULTI-DISCIPLINARY TEAMS WORKING ACROSS THE COMMUNITY.

The needs of people living in Torbay and South Devon has changed and our local care services need to change too. As part of creating one integrated care organisation, we have developed a new model of care which includes the formation of five health and wellbeing teams. The teams will provide care in the community to local people. The health and wellbeing teams comprise our community health and social care professionals integrated with other agencies such as volunteers, housing officers and mental health professionals. By collectively working together we will offer better health promotion, illness prevention, treatment and rehabilitation services to people in Torbay and South Devon.

The new care model is very different to the way we have provided services in the past. We are moving away from reactive, bed based services to preventive and proactive services with more care at home. Importantly this means that additional investment will be made into community teams to help look after people in their own homes. People tell us that the 'best bed is their own bed' and so we want to move resources into the community where people can receive as much local care as possible and use hospital beds only where it is appropriate.

In our 2015/16 Quality Account we set ourselves a range of objectives including:

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

Our progress since the integration has been both challenging and rewarding.

We have now established five health and wellbeing teams across our five localities which cover Torbay and South Devon. These are:



- Moor to Sea
- Coastal
- Newton Abbot
- Paignton & Brixham
- Torquay

People tell us that the ‘best bed is their own bed’ and so we want to move resources into the community where people can receive as much local care as possible

The bringing together of the acute and community services has removed organisational barriers and has resulted in us forging closer links between our community teams, GPs and clinical specialists in Torbay Hospital. We have also been working with our teams to consider how we best support different professions to work together in a more integrated, multi-disciplinary way to provide seamless and holistic care to people

In the Torquay locality we have developed an enhanced model of intermediate care working in an integrated way with GP and pharmacy colleagues to support individuals with very complex needs, outside of hospital.

We have also designed a new service for people with multiple long-term conditions, which offers a ‘one stop shop’ approach in the community which works closely with GPs and clinical specialists. This means access to advice, support and monitoring from a team comprising of a doctor, specialist nurse and wellbeing coordinator, in a community setting. The team can support people with a wide range of conditions. This means that people will no-longer have to attend lots of different outpatient clinics, often travelling significant distances. We will begin implementing this service firstly in the Coastal and Brixham & Paignton locality in summer 2016.

Another change we plan to implement in the summer 2016 is the introduction of wellbeing coordinators employed by our voluntary sectors partners. This is a new role which aims to support people in identifying ways which support their whole wellbeing, not just their health and care needs.

This could include finding activities or groups in the local community which a person could connect in to, in order to feel less lonely, or to do activities they enjoy and

improve their well-being. It could also mean helping people to find peer support, make lifestyle changes or learn about self-management of a long-term condition. We have been working closely with our voluntary sector partners in both Torbay and South Devon to design the new service, as we know that voluntary sector and local community organisations will be key to providing some of the answers which meet people’s wider needs in this way.

The coordinators will be employed by the voluntary sector, but will be part of the multi-disciplinary teams within all of our localities. They will help to not only support individuals in improving their wellbeing, but also to build closer links with community organisations and identify where there is unfulfilled need in the local area, so that services can be developed to meet it. They will also be able to challenge our ways of working and help to build stronger links between our teams and the voluntary sector.

Aside from continuing to develop and implement these changes over the course of 2016, we also intend to work in a more joined up way with other organisations, who provide services which support the wellbeing of the local population. This includes local housing officers, the police and the fire service. Early conversations are talking place to understand what this could mean. We have already made good progress in doing this with our voluntary sector partners, as the implementation of the wellbeing coordinators demonstrates.

We are also working collaboratively with Plymouth University in order to understand how we can best measure and evaluate the broad range of changes we are making. This won’t just include measures about who

accesses our services, where, and how frequently. It will also include important measures such as patient experience, people’s confidence to manage their own health and care, and whether more seamless care is being delivered.

2015/16 has been a challenging year to move at pace. We have spent time building the basic infrastructure of the health and wellbeing teams and engaging with our communities to ensure there is continuous conversation about how future services are developed. In 2016/17 we will continue to consult with communities and increase the pace of change making real differences to the services available to people and their families.

PRIORITY 3:

CREATE A RELIABLE AND CONSISTENT AMBULATORY EMERGENCY CARE SERVICE AVAILABLE SEVEN DAYS A WEEK FOR PATIENTS

Over the last 12 months the Trust has been developing an ambulatory emergency care service with the ultimate aim of being able to provide a consistent service seven days a week.

Individual objectives for the project included:

- Providing an ambulatory emergency care unit comprising eight chairs and four trollies within two bays on an emergency assessment unit that will be open seven days a week.
- Reducing the proportion of medical patients requiring an overnight stay when safe and appropriate to do so.
- Improving the experience of emergency care for medical patients seen within the ambulatory emergency care unit.
- Reducing the number of people needing a hospital bed who have an ambulatory sensitive condition e.g. cellulitis.
- Contributing to an improvement in patient flow through the emergency department as measured by achievement against the four hour standard

In spring 2015 an Acute Medical Unit (AMU) which incorporated ambulatory emergency care was opened on one half of EAU 4, one of our two emergency assessment wards. The unit was created by removing 10 beds from two bays and two side rooms and creating 12 patient

spaces typically occupied by eight chairs and four trollies with the two side rooms utilised as consultation and assessment space.

The unit was operational 24 hours a day seven-days a week and took both GP referred medical patients and medical patients referred from the emergency department.

The unit had an immediate positive impact on improving patient flow and reducing over-crowding in the emergency department. Whilst the positive impact on flow and the four hour target was not sustained for many complex reasons, feedback from the emergency department team and patients remained positive.

Other things that went well included:

- Huge commitment, enthusiasm and engagement from the nursing and medical workforces.
- Support from radiology and labs (for x-rays and test results) and portering.
- Doctors and nurses reported that they believed it provided safer patient care because medical patients requiring a consultant review were being managed in a single space.
- More efficient and effective use of our doctors;

particularly the acute medicine and on-call teams, as a result of working in one area.

Early on into the project we realised that we had not clearly communicated to patients about the time people may need to wait and how the unit operated. A patient information leaflet was designed and all team members greeted people attending with clear communication about how long they should expect to be on the unit.

Other challenges which were less easy to overcome included:

- It was difficult to maintain chairs and trollies in the ambulatory area when the Trust has a high number of admissions. The space would be used for hospital beds.
- The environment did not support the maintenance of people's privacy and dignity.
- There was very little space and no waiting area; people frequently attended supported by friends or relatives.
- The unit worked most efficiently when there was a dedicated Acute Physician; this was not always possible due to a very small team and an inability to recruit.
- It was really difficult to effectively measure what we were doing because we didn't have an effective way to monitor the changes from beds to chairs/trolleys.

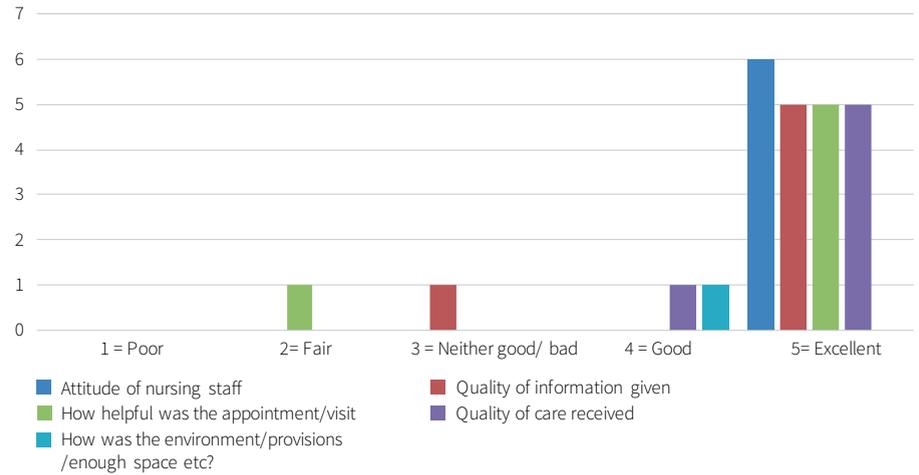
From setting up the unit over the year we learnt that patient feedback was predominantly good. A sample of patient feedback for October is shown in the chart.

Comments from patients included:

“Really impressed by care and attentiveness of staff and very quick assessment/turn around”

“This was my first experience of EAU4 having been sent here by my GP. I found it a more effective system rather than spending hours at A&E. The staff were very attentive and kept me informed at every stage. I was assessed and had the necessary tests really quickly. Thank you all who helped me today”

AMU Clinic Patient Feedback

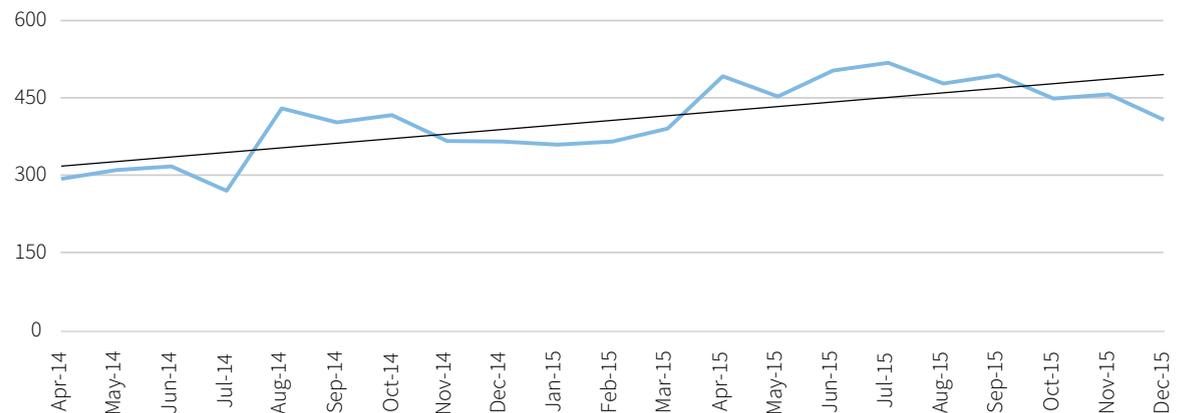


The impact on the overall utilisation of beds in Torbay Hospital by people with ambulatory care sensitive conditions was slight.

Between April and September there was an increase in the number of patients not staying overnight and in the number just staying one night, followed by a decrease between October and December 2015. This coincided with a prolonged period when the unit was frequently converted to beds overnight and the unit was therefore shut to ambulatory care.

Overall the new unit was seen as a positive step with the potential to support the management of patient care in a way that provided a better patient experience whilst having a positive impact on patient flow through the

Number of discharges for non elective ambulatory classed medical patients with length of stay 0 or 1 day



PRIORITY 3 / CONTINUED

Emergency Department and the wider health and care system. Its limiting factor was seen to be the inability to keep the unit open consistently.

In recognition of the potential for improving patient care, reducing the number of admissions and increasing flow through the hospital, the Trust Executive made a commitment towards providing a dedicated space for an acute medical unit which could not be used for other purposes.

On 21st March 2016 the acute medical unit moved to level 2, a floor below where it was previously located and immediately below the Emergency Department. It is within 100 metres of a main hospital entrance providing easy access to patients and ambulance crew. It has a dedicated waiting area within the unit and seven rooms for assessment and treatment, ensuring privacy and dignity for all patients.

Currently the unit is only open Monday-Friday 09:00-21:00 pending recruitment and there is an ambition to open the unit seven days a week, when the trust has the right workforce numbers.

This separate location has also created the opportunity to support a pathway for patients clinically identified as frail who require a holistic assessment and care planning.

Since opening the unit in March the feedback has been positive and the teams are working with GPs to ensure the right medical patients with an urgent care problem are seen in the acute medical unit.



PRIORITY 4:

ESTABLISH A SINGLE POINT OF CONTACT FOR PEOPLE TO ACCESS COMMUNITY BASED HEALTH AND SOCIAL CARE SERVICES IN TORBAY

The range of services on offer to our communities is broad, which means that individuals often find it difficult to ‘navigate’ the health and care system in order to access the information, advice and support they need in a timely way. We know that this needs to be simpler and faster in order to ensure we can deliver the right care, in the right place and at the right time.

People in Torbay and South Devon should have clarity about where and how they contact us so they only tell their story once to us. Our community should have a single telephone point of contact as a place of entry into our services. Our response should always be prompt and customer focused and the number of hand-over points through any individual’s journey should be kept to the minimum.

To this end we set ourselves a number of objectives in 2015/16 to move towards a single point of contact across Torbay and South Devon.

We said we would:

- Set up a single point of contact for Torbay.
- Set up a Directory of Services that contains up to date information about the services and support which are available to people in Torbay.

This directory will be created and run by voluntary sector organisations and will be available to the public on the internet.

- Measure and monitor the changes and evaluate the first year of its operation. People who use this service will be involved in the evaluation process.
- Develop linkages between the single point of contact service and specialist long term condition services based at Torbay Hospital.
- Improve the understanding of the aims of the single point of contact service and Care Direct Plus service with the Torbay Hospital ward teams and the long term condition specialist teams.

Within Torbay we ran one pilot over two sites (Torquay, Paignton & Brixham) to look at improving and better co-ordinating our response to calls and initial contacts from the public so they have a common and standard experience.

We focused on changing the demand for services through increased signposting to alternative services, more telephone assessments and one off visits. The aim was to improve our responsiveness to any problems. From the pilot we found that 70% of work could be resolved over the phone within twenty four hours of the initial contact

and 30% of calls still needed to be referred onto assessment teams who support people with longer term needs.

We also set up a new online directory of services alongside running the two pilots. The directory is managed by Torbay Community Development Trust and is now available to the public on the internet at: www.torbayorb.com. The orb provides, in a single place, access to a wealth of information about health, social care and wellbeing services available to people living and working in Torbay.

From the pilot work we are now in the process of setting up one Single Point of Telephony Contact. The planned go live date for the new service with a single telephone number is June 2016.

We recognise that we do need to do build into the implementation plan a system to formally collect feedback from both staff and service users. The pilot period evolved over a period of time and was refined through operational learning over some months. Therefore it was not technically possible to measure an evolving set of changes in a definitive fashion. However we did note empirically an improvement in telephone

PATIENT EXPERIENCE

People in Torbay and South Devon should have clarity about where and how they contact us so they only tell their story once to us. Our community should have a single telephone point of contact as a place of entry into our services.



answer response times in Torquay. We will develop a communication plan to increase awareness of services to stakeholders, including hospital staff, in line with our go live plan early summer.

We are exploring with Devon County Council the feasibility of whether the Care Direct function can also manage Torbay telephone calls. If this approach is possible this means we could provide a single telephone number for everyone living in Torbay and South Devon with access to services local to where they live.

In the fullness of time this integration could be potentially further extended, building on the learning from the Care Direct services currently offered in South Devon and the newly integrated Single Point of Contact service in Torbay. The long term aim is a high quality, responsive, consistent and seamless service for everyone living in Torbay and South Devon.

PRIORITY 5:

IMPROVE THE INVOLVEMENT OF CARERS IN THE MANAGEMENT OF MEDICATIONS ON ADMISSION AND AT DISCHARGE IN TORBAY HOSPITAL AND IN OUR COMMUNITY HOSPITALS

This piece of work was started as a result of carers' feedback about their experiences whilst the person they cared for was in hospital. They felt that patients were often discharged without family members being aware of any changes in medication or of side effects to be aware of after discharge.

We set ourselves the aim of testing the process for identifying and involving carers in medicines reconciliation and planning medication regimes for discharge.

Our individual objectives focused on:

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

The first part of the project focused on more reliably identifying carers when patients were admitted to a

hospital ward. The term IRIS was developed with carers and staff, standing for Identify, Record, Involve and Support. A carers 'Buzz' video session was developed for staff training to promote why they should identify, record, involve and support carers. A full roll-out of training and awareness programme is planned over the coming year, particularly linked with Carers Week in June.

The second part of our project focused on improving carers' involvement in discussions about people's medication. We started by testing a process on one ward of Torbay Hospital where a pharmacist would speak to patients and their carers soon after admission to help with 'reconciliation' – matching up the records held by GP and Hospital about which medications someone was taking. Whenever these patients were about to be discharged home, the pharmacist would again have a conversation about any changes to the medication.

Due to the low number of patients with carers who were discharged directly home from this ward, the pilot was extended to other wards. Where possible, those patients who were discharged home were given a written record about their medication so that they and their carers would be clear exactly which medications were to be taken after discharge.

Evaluation of the project at Torbay Hospital showed that 86% of carers had a conversation about medication and 44% were given a medication sheet before discharge which they all found useful or very useful.

Based on the results, we decided to sign up to the national 'My Medication Passport' which includes all the medication information both at admission and pre-discharge and is especially useful for people on multiple medications.

For carers and patients using our local community hospitals, the evaluation has showed that conversations about medication are not happening as regularly; just 22%, of the time. As a result staff guidance and training is being arranged.

In addition to promoting the need to have conversations with carers about medication, concerns had been raised by young carers and young adult carers about the medication that their parents were taking. The Trust medicines management team have met with this group to discuss the various medications, side-effects and triggers. A system is now set up for the group to meet regularly with this team to increase knowledge and awareness for everyone concerned.



CONTINUOUS QUALITY IMPROVEMENT IN 2015/16

Improving our services is a key to ensuring we consistently provide high quality, safe care. Over the last 12 months the single biggest change has been the integration of our health services delivered at Torbay Hospital through South Devon Healthcare NHS Foundation Trust with our local community services delivered by Torbay and Southern Devon Health and Care NHS Trust.

This integration of our services into one care organisation in October has resulted in us being able to change and improve the way we deliver care more effectively, such as the development of local health and wellbeing teams whilst continuing to improve effectiveness and governance through the development of one Trust Board across Torbay and South Devon responsible for all health services and adult social care services. The number of Governors and members has also changed to reflect the geographical footprint of the new organisation. This ensures that everyone in Torbay and South Devon has the opportunity to be involved in the further development of the new organisation.

In terms of quality and quality improvement, there is now a Director of Strategy and Improvement and one single quality improvement group co-chaired by the Medical Director and Chief Nurse. The group includes patient/carer and governor representation as well as care professionals. This group reports via the Executive Team to the Quality Assurance Committee, a smaller group of non-executive and executive directors and a governor observer. The role of the committee is to monitor, review and report on the quality of clinical and social care provided by the trust and identify any key issues and risks requiring a decision or discussion by the Trust Board.

The Quality Improvement Group has been involved in the development of the annual Quality Account, as well monitoring the delivery of the quality strategy which is available online at www.torbayandsouthdevon.nhs.uk. This includes the delivery of CQUINs (Commissioning for Quality and Innovation), areas identified for improvement by the Trust, as well as ensuring people using our services see quality in all that we do (SEE = safety, effectiveness, experience). The following section highlights a selection of some of our improvement work this year:

CQUINS 2015/16

In 2015/16 the Trust has been involved in delivering eight CQUINs covering safety, patient experience and clinical effectiveness. As in previous years these are a mixture of national and local improvement priorities.

A breakdown of the 2015/16 CQUINs can be found in annex three.

Two CQUIN examples are described in more detail below.

Patient experience

The patient experience CQUIN is a local CQUIN and for the first time, the improvement objectives have been agreed and implemented across all the South Devon health and care providers, supported by the local clinical commissioning group (CCG). This is an innovative way of delivering a CQUIN and South Devon and Torbay Clinical Commissioning Group has been the first nationally to pilot this approach.

The collaborative has worked together to improve communication. This includes: embedding a range of initiatives into all local organisations and learning from each other as the projects have been implemented. These include:

- ‘Hello my name is’

This is part of the national campaign initiated by Dr Kate Granger, who made a number of observations about her experience whilst a patient. One of these observations was what a positive difference it made when staff introduced themselves.



Within the Trust we have worked with all our staff to ensure they are aware of the importance of introducing themselves to patients, relatives and carers. We have used established training opportunities, such as clinical induction, corporate induction, and junior doctors training to reinforce ‘hello my name is’.

Staff now have the hello my name is logo next to their name and role as part of their email signature and everyone is encouraged to start a conversation introducing themselves first. The executive directors photographs displayed in all the hospitals now have the logo attached and all their blogs start with “hello my name is “.

All front line staff and many other staff now have yellow badges to clearly identify themselves and their role. In our real time patient experience survey we continue to monitor if people have introduced themselves and if they have been clear about their role. Over the last 12 months there has been an improvement from 88% to 91% when patients have been asked if the staff introduce themselves.

- ‘You said we did’

This was started by the Trust in 2014/15 as a means of providing better feedback too patients. This initiative has now been extended to include staff as well as patient feedback

Recent examples include the changes in the Acute Medical Unit which now means improved dignity and privacy for patients. Increased number of car parking spaces for patients and the pay on exit system.

- Social media and technology

People are increasingly using a range of social media to provide us with feedback about our services. To this end, we have tested over the last 12 months a software product that enables us to feedback using the social media format that a person has contacted us by e.g. facebook. In principle, this means that feedback should be more timely and accessible to the person sending the feedback. In 2016/17 we aim to continue with this service.

We have also been involved with the local commissioning group in testing out a patient leaders programme with the aim of increasing the patient voice at a more strategic level. For a number of internal reasons we failed to get a patient leader onto one of our strategic groups. We are now trying alternative approaches which include ensuring that there is a patient/carer representation on any committee whose focus is quality improvement.

CQUINS 2015/16 / CONTINUED

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. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 35,000 deaths attributed to sepsis annually.

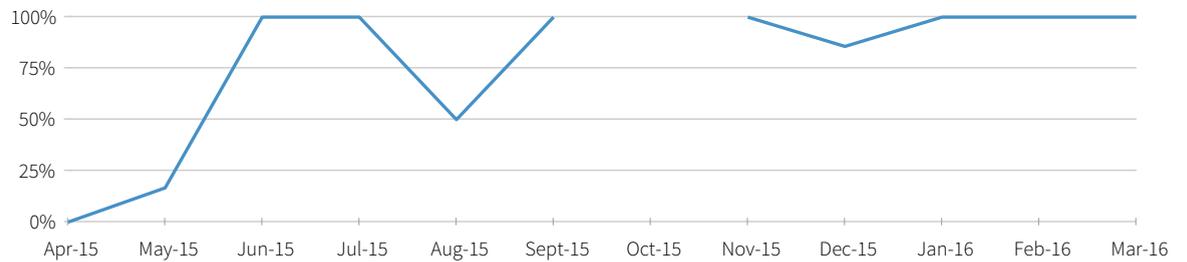
In recognition of the importance of this condition and the need for prompt treatment with antibiotics, the Department of Health made sepsis improvement a key priority for all hospitals in England in 2015/16. They asked all trusts to undertake a monthly audit of screening and antibiotic administration for patients arriving via the Emergency Department.

We have been undertaking the Department of Health audits and sending the information to the Department of Health. We have also been continuing to undertake our own monthly case note audits which we have now been running for several years.

With regards to the Department of Health screening audit, we have been showing an overall improvement based on the audit sample.

Our audits of antibiotic administration have been poor because of our inability to collect timely data. We have recognised that we need to do further work on this and as a result, we have been making improvements to capture severe sepsis screening and antibiotic administration on our new Emergency Department IT system 'Symphony'.

% of patients in the Emergency Department who met the criteria of the local protocol for sepsis screening & were screened for sepsis & for whom screening is appropriate



This includes making fields mandatory and ensuring the sepsis protocol is available to all staff on the Emergency Department computers. In addition all our staff working in the Emergency Department have undertaken refresher training.

In 2016/17 sepsis will remain a national CQUIN and it will also continue to be a Quality Account priority captured in priority 3 which focuses on improving the timeliness to be seen within the Emergency Department.

CQUINS 2015/16 / CONTINUED

Sign up to safety

Sign up to safety is a national initiative aimed at helping NHS organisations to improve patient safety. The Trust signed up the campaign in 2014 with an Executive Director accountable for driving patient safety forward.

Over the last year, as well as sepsis, we have focused our safety improvement work on:

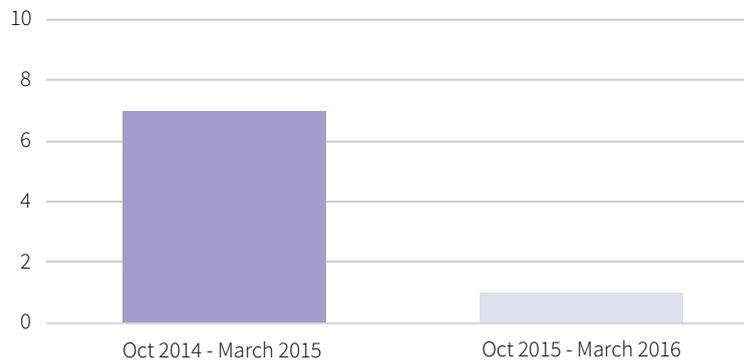
- **Acute kidney Injury**

Acute kidney injury simply means a sudden reduction in kidney function resulting in a difficulty to maintain the natural fluid, electrolyte and acid-base balance of the body. The term has replaced ‘acute renal failure’ and includes earlier stages of kidney issues other than just ‘failure’. The diagnosis of acute kidney injury and its staging is based on acute changes in a blood test and/or a reduction in urine output. It is not a traumatic injury to the kidney as the name may imply, rather a clinical syndrome with many different underlying causes.

To meet the changes required to diagnose acute kidney injury the Trust’s laboratory computer system has been configured to generate these stage of acute kidney injury, based on a simple blood test. Once an acute kidney injury stage has been triggered an acute kidney injury bundle is available, outlining the various treatments and monitoring options available. The first and often simplest action is to increase the amount of fluid the person is receiving.

The Trust, through the acute kidney injury group, has created a bundle of care which has been shared with all

Serious harm from falls October 2014 to March 2016



relevant staff and is available online and in a summery credit card sized format. A suite of leaflets, including patient education leaflets, and an education short video on the management of acute kidney injury are also available and in use. This information is also included on the discharge plan of all patients recorded with an acute kidney injury. The discharge plan also includes what follow up blood tests are required and how often.

- **Falls – Torbay Hospital focus**

Falls in hospital are the most frequently recorded safety incident within the NHS. They are can be very minor in nature but can also have devastating impacts and tend to

National improvement initiatives

Every year the Trust gets involved in and implements a number of national health and care initiatives. Two of the most significant developments have been improving patient safety through the Sign up to Safety Campaign as well as quality of care through fully implementing the Duty of Candour regulations which came into force in spring 2015.

rise in the October to March period. In order to prevent in-hospital falls during this time span a falls awareness campaign was launched with particular emphasis in the winter months. Assessment methods, actions to take and ways of improving communication have all formed part of the campaign.

From October 2015 to March 2016 the number of falls at Torbay Hospital has reduced from over 70 to fewer than 40. The falls resulting in serious harm have also reduced, in comparison to the same time period the previous year. (see chart)

CQUINS 2015/16 / CONTINUED

- Pressure ulcers - community focus

The reduction in pressure ulcer prevalence remained a Trust priority for 2015/16. To support this work the collaborative pressure ulcer prevention initiative was disseminated across all community service areas within the Trust.

From April 2015 the Trust target has been a 50% reduction in avoidable grade 3 and 4 pressure ulcers across all community hospitals and zones included in the collaborative roll out.

To date all community teams and community hospitals have now been co-opted onto the collaborative pressure ulcer prevention work stream, including providing education and support with the aim of embedding pressure ulcer prevention into everyday work.

The introduction of a core set of patient risk assessment and care planning tools to promote early identification of patients at risk and the use of preventative care strategies is an integral aspect of the collaborative patient safety programme.

Compared with the previous year's performance to date there has been a decrease of one grade 3 or 4 ulcer in the community hospitals and a decrease of 14 grade 3 or 4 pressure ulcers for the community nursing teams.

In 2016/17 our safety improvement work will focus on:

- **Acute kidney Injury**

Continue the work undertaken in the acute hospital setting in its recognition and treatment based on the acute kidney injury bundle and spread this work to the community and primary care settings. This work will involve recognition, education and advice leaflets once an acute kidney injury and its stage have been identified.

- **Sepsis**

This will continue to be a key focus and is both a national CQUIN and a Quality Account priority (see page x). The on-going work will include the new updated guidance due to be released in May 2016.

- **Medication**

With the advancement of technology in healthcare particularly within the medicines field, the Trust is moving to an e-prescribing system. This exciting progression will revolutionize the way prescriptions are generated, recorded and administered, which will offer real safety benefits to our patients. The launch date for testing the system is autumn 2016 with full implementation across the Trust by autumn 2018.

- **Pressure ulcers and falls**

Due to the nature of our population, its frailty and age these areas are always going to be key performance indicators for the Trust and will remain a key focus through 2016/17.

Duty of candour

There is a requirement for all providers of care to be open and transparent with people who use their services; specifically when harm is caused to a person during care. Best practice guidance about Being Open when a patient safety incident occurs was published by the National Patient Safety Agency, as a result of which we produced policy guidance for staff in fulfilling this obligation. The Care Quality Commission (CQC) has now formally adopted the duty of candour into its regulatory framework and is reviewed as part of the CQC inspection regime.

We have included a duty of candour prompt in our incident reporting and incident investigating documentation. Our investigations of serious incidents also include any particular questions the patient or family have in relation to the incident. We have also updated our internal guidance for staff.

We will be continuing to develop and improve our central recording of adherence to the duty of candour regulation during 2016. Our performance will be monitored through the Quality Improvement Group and through learning and changing practice following serious adverse event reviews.

CQUINS 2015/16 / CONTINUED

Local improvement initiatives

Every year the Trust every year sets itself a number of corporate objectives as well as those set by care teams working together to improve their own services. The outcomes of the annual corporate objectives are provided in detail within the Trust annual report which sits alongside the annual Quality Account. Detailed below is a small selection of front line improvement projects:

Bereavement

In our 2014/15 Quality Account we reported that we had made improvements in ensuring that GPs were informed quickly about a patient death in hospital. In 2015/16 we have continued with bereavement improvement work focusing on death certification.

Our objective has been to ensure, by April 2016, that 95% of all death certification paperwork is completed within two working days of the time of death.

In order to achieve this aim, a project team was formed, which was clinically led by a palliative care consultant supported by the bereavement office team. The project team carried out an information gathering exercise, to understand how well the current death certification paperwork process runs. We gathered information from families/carers that had previously used the service, which demonstrated a varied experience of how quickly the necessary paperwork was completed. We asked our ward doctors how they felt the process ran currently. We measured the times it took for death certification paperwork to be completed (up to six working days following a patient's death).

The project team discovered that the current process for completing death certification was not as efficient as it could be, that it relied on many handovers between clinical and non-clinical teams and involved lots of duplication. These delays in generating the death certification paperwork resulted in unnecessary waits for the family and potential delays in being able to plan their loved one's funeral/service. Patients' comments included:

"It was distressing it took nearly 4 days to produce the death certificate"

"Get death certificate paperwork out quicker. Had to chase for this as could not register his death"

A new process was implemented to speed up generating the paperwork for families. This involved setting up a "one stop shop" for death certification paperwork completion which included a dedicated doctors' area in

the bereavement office with a computer, phone, and access to bereavement office team guidance and advice. Crucially, this was not in a ward area, enabling doctors to complete the death certification without any interruptions.

A communications exercise was carried out, to make staff aware of the new process, which included an email and poster campaign and floor walking on the wards by the bereavement office team. The project team measured throughout the project, to see if the changes resulted in improvements to death certificate timeliness.

After running the new death certification process for only a month, the timeliness of death certification was improving dramatically, which therefore benefitted families/carers.

	Before the change	After the change
% of death certificates that were completed within the same working day of the patient's death	8%	39%
% of death certificates that were completed within 2 working days of the patient's death	78%	97%

CQUINS 2015/16 / CONTINUED

There was also a significant improvement in accuracy.

% of errors found on death certification BEFORE the change	% of errors found on death certification AFTER the change
64%	0%

The new death certification process is now embedded as business as usual and families/carers continue to receive paperwork in a much shorter timescale.

Lower limb therapy service

Leg ulcers affect around 1 in 500 people in the UK and it is estimated that 1% of the population (and 3.6% of people older than 65) will suffer from leg ulceration during their life. Our ageing population means that demand for leg ulcer assessment, treatment and healing services is set to rise substantially over the coming years.

During 2015, working in partnership with the Torbay and South Devon Clinical Commissioning Group, we have introduced a lower limb therapy service. The aim of this nurse-led service is to improve the quality of care for patients with leg ulcers.

The service has clinics in nine different locations across Torbay and South Devon. These all offer assessment, specialist treatments such as compression therapy and also provides education and support to patients, their families and carers. Our specially trained nursing staff develop individualised care management plans for all patients dependent on the type of leg ulcer they have. We can improve symptoms associated with leg ulcers

such as pain, exudate and odour and also improve healing rates through the use of appropriate treatments.

By providing a consistent approach and a standardised clinical pathway we are also reducing unnecessary or inappropriate use of dressings and wound care products and where required we ensure onward referral to other specialist services such as dermatology and vascular teams.

Since the service has started, it has received over 500 patient referrals. Currently at any one time over 200 patients are benefitting from the new lower limb therapy service. The healing rates for venous ulcers are on average 10 weeks. This is exceeding the commissioner's initial target of 24 weeks.

Trauma triage

Historically, all patients who attended Accident and Emergency or a minor injury unit with a fracture would be given a follow-up appointment at the fracture clinic run at Torbay Hospital. Some of these fractures often require no further treatment than that already prescribed at A&E or the minor injury unit. As a result, a number of patients have made unnecessary trips and for the Trust this has increased the demand on services such as x-ray as well as there being poor use of clinic time in fracture clinic.

The virtual fracture clinic pilot which began in July 2014, aimed to reduce the numbers of patients returning to fracture clinic by virtually reviewing those with five specific fractures. Patients were contacted by telephone and only booked an appointment in person if deemed necessary by the consultant.

This pilot was well received by both patients and staff and reduced the numbers requiring follow up appointments without compromising the quality of care.

Learning from other sites, such as NHS Greater Glasgow and Clyde and building on the success of the initial pilot it was decided to develop this pathway further and in October 2015 trauma triage was launched.

Patients attending A&E or a minor injury unit with a fracture now go through one of the following pathways:

- Those with one of the initial five fractures identified in the virtual fracture clinic pilot are discharged directly from A&E with appropriate treatment and advice.
- Those requiring surgery are either admitted to a bed or advised when to return for their surgery.
- All other fracture patients are directed to the trauma triage service.

Trauma triage clinics are led by an orthopaedic consultant and registered nurse and run Monday to Friday between 0900 and 1000. The team review all case notes and x-rays of those patients who attended within the previous 24 hours and a decision is made about their treatment and ongoing plan of care. The nurse then contacts patients by telephone and either advises them of their ongoing care or arranges a necessary appointment with the correct clinician.

Early results show that approximately 25% of fracture patients are now discharged from A&E and require no further treatment or hospital appointments and a further 20% are discharged following trauma triage.

CQUINS 2015/16 / CONTINUED

Those patients who require an appointment are then seen in a time appropriate clinic and by the correct professional. There has been positive patient feedback:

“Pleased not to have to come back unnecessarily”

“So good not to have unnecessary appointment when I’m a busy mum”

In 2016/17 the service will continue to run and develop.

Cost improvement and innovation

As well as local quality improvement initiatives, we also focus on cost improvement programmes and innovation initiatives. The latter may solve a local or national problem as well as bringing much needed revenue into the Trust. Two examples of this type of work are described below.

Printing project

This is an environmentally friendly cost improvement project with the aim of reducing the amount of paper and electricity used as well as providing a significant saving by deploying modern devices procured at the best possible price.

Over the last 12 months we have checked over 400 printers and associated devices within the main acute hospital site and community locations. Over 100 older, inefficient printers have been replaced with newer, faster, more efficient models that use less power. These new machines also almost half our rental and printing costs. A print education programme has been running in parallel

to reduce the volume of printing undertaken and to switch from colour to black and white wherever possible.

The Trust prints around 20 million A4 sheets per year and spends £750,000 per annum on printers and printing. The Trust has saved £100,000 to date. Continuation of the programme over the next four years should release a further £200,000 per annum as older printers are replaced.

Product innovation

The Trust has a small team providing innovation support to care professionals interested in product or service innovation. In our 2014/15 Quality Account we reported that one of the early successes was a bedpan designed by a junior doctor. This inspired the company involved in this innovation, HPC, to create a new bedpan in conjunction with Clinnel, a leading commode supplier.

Another innovator discovered the material had possible other uses and HPC have now developed a wider range of kit made out of what is called thermoform material. This includes kidney dishes, theatre procedure trays and other disposable equipment. Thousands of these types of products are used every day in the NHS and currently they have to be sent to landfill once they have been used. With thermoform products they can be macerated on site which means it is both cheaper and more environmentally friendly. There is also a possibility that the waste could be turned into bio fuel.

This product innovation has significant national and international potential which can benefit the Trust as well as HPC who are developing this product range.



Telephone consultation with patient to virtually review fracture



LOOKING FORWARD: 2016/17

The Trust has identified five quality improvement priorities for the year. These have been developed through discussions with health and care teams working within the newly established integrated care organisation, senior clinical, care and business leaders in our organisation, commissioners and our public.

In recognition of the development of a joined-up care system we have worked closely with our other health and care partners to develop a shared set of improvement priorities. We have also taken into account the views of key stakeholders when discussing and agreeing the priorities for 2016/17 as well as the recently formed Quality Improvement Group. (See annex 1)



LOOKING FORWARD: 2016/17

In brief the improvement projects are:

PRIORITIES FOR IMPROVEMENT

PATIENT SAFETY

PRIORITY 1:

To improve the consistency and reliability of complaint investigations and associated systems for organisational learning across the care system now within the integrated care organisation.

PRIORITY 2:

To integrate two existing early warning trigger tools developed by Torbay Hospital and community services into one trigger tool which can be used across any health and care setting supported by the integrated care organisation.

CLINICAL EFFECTIVENESS

PRIORITY 3:

To improve the timeliness of assessment of within the Emergency department.

PRIORITY 4:

To improve the stroke pathway across our organisation through improving stroke coordination and remapping the whole pathway, focusing first on the acute elements of the pathway. The outcome will be improved performance against the national standards.

PATIENT EXPERIENCE

PRIORITY 5:

Test the impact of using the 'Institute of Health Improvement's teach back' method to improve communication between patients, families and health and care professionals.

PRIORITY 1:

TO IMPROVE THE CONSISTENCY AND RELIABILITY OF COMPLAINT INVESTIGATIONS AND ASSOCIATED SYSTEMS FOR ORGANISATIONAL LEARNING ACROSS THE CARE SYSTEM NOW WITHIN THE INTEGRATED CARE ORGANISATION.

We have reviewed two recent national reports in relation to complaints. The first of these 'A Review into the quality of NHS complaints investigations' was produced by the Parliamentary and Health Service Ombudsman. The report examined the quality of NHS complaints investigations, especially when the complaint is concerned with incidents of serious or avoidable harm being caused to people during their care. We also reviewed 'Breaking down the barriers: Older people and complaints about healthcare'.

Clearly it is important to ensure a complaint investigation is robust and fully reviews the issues identified so that a full explanation can be provided to the person or their family. Very often when people have cause to complain, they tell us that they do not want the same thing to happen to anyone else. We therefore have a responsibility to undertake a robust investigation and that we learn and share lessons when something has gone wrong. We also need to ensure the relevant information and support is available to people who wish to complain about the service they have received.

Our objectives for 2016 are:

- To review the information we currently provide to people who use our services, and to make it more easily accessible. We will undertake this review in the first quarter of the year and identify any remedial action via the Learning from Complaints Group. We will additionally strengthen the governance and reporting framework following a complaint, with particular regard to learning from the findings. This will form, part of the reporting process to the Quality Improvement Group.
- To review the training we provide for our staff, with a particular emphasis on staff awareness of the potential issues experienced by older people in making a complaint. We will begin this review in quarter one and provide a report to the Quality Improvement Group in July.
- To roll out the complaint investigation documentation devised in the community across our integrated care organisation.
- To re-evaluate the training requirements for those undertaking complaint investigations and complete a training needs analysis for staff. We will complete the analysis in quarter two.

The work will be led by the Deputy Director of Nursing (Quality & Experience) with Board level support provided by the Chief Nurse. Quarterly progress reports will be shared with the Trust's Quality Improvement Group.

PRIORITY 2:

TO INTEGRATE TWO EXISTING EARLY WARNING TRIGGER TOOLS DEVELOPED BY TORBAY HOSPITAL AND COMMUNITY SERVICES INTO ONE TRIGGER TOOL WHICH CAN BE USED ACROSS ANY HEALTH AND CARE SETTING SUPPORTED BY THE INTEGRATED CARE ORGANISATION.

Currently the Trust uses two complementary early warning trigger tools designed to help clinical teams identify the trigger points where the quality of patient care could be compromised depending on a number of factors. These can include staffing levels, clinical leadership, multi-disciplinary team working and day to day operational demands. These early warning tools allow prompt effective targeted action to be taken by the senior nurses to ensure that the quality of care for patients is not compromised.

By integrating the early warning trigger tool from both Torbay Hospital and the community services, this will allow a more sensitive tool to be developed which can be used in any health and care setting across Torbay and South Devon, To achieve this improved tool, our individual objectives are:

- In quarter one within surgical services to develop specific service sensitive questions in collaboration with ward matrons and to pilot these for each surgical ward.
- In quarter two within medical services to develop specific service sensitive questions in collaboration with ward matrons and to pilot these for each medical ward. In this quarter surgical services will start to complete the new tool monthly.
- In quarter three within the women's, children's, therapies and diagnostics services to develop specific service sensitive questions in collaboration with ward matrons and to pilot these for each ward. In this quarter medical services will start to complete the new tool monthly.
- By the end of quarter four all the services will be completing the new early warning trigger tool.

This work is being led by the Deputy Director of Nursing (Professional Practice) with Board level support provided by the Chief Nurse. Quarterly progress reports will be shared with the Trust's Quality Improvement Group

PRIORITY 3:

TO IMPROVE THE TIMELINESS OF ASSESSMENT OF WITHIN THE EMERGENCY DEPARTMENT AS DEMONSTRATED THROUGH RELIABLE ACHIEVEMENT OF:

- TIME TO TRIAGE, INITIAL ASSESSMENT AND VITAL SIGNS FOR ALL APPROPRIATE PATIENTS (15 MINUTE STANDARD)
 - TIME INITIAL MEDICAL REVIEW (60 MINUTE MEDIAN STANDARD)
 - COMPLIANCE WITH SEPSIS BUNDLE
-

The Trust has not achieved its performance against the four hour wait target for patients in the Emergency Department. An action plan is in place that acknowledges this as challenge across our entire organisation but the target is measured in the Emergency Department and this is where patients can wait for excessive periods to be seen, leading to a poor patient experience.

At times of greatest pressure the clinical risk associated with patients not being seen in a timely manner by the right clinician increases. Individual objectives against which we will measure ourselves are:

- To ensure that vital signs are taken and recorded at the point of ambulance handover for all 999 patients presenting at ‘Major’s’. The best practice standard is carry out the first set of observations within 15 minutes.
- To have a nurse present in the emergency department waiting area 24/7 to ensure vital signs are taken and recorded in a timely manner. The best practice standard is to carry out the first set of observations within 15 minutes.
- To trial the allocation of a doctor to the nurse-led rapid assessment area to ensure timely reviews of all ‘Major’s’ patients.
- To ensure all patients seen by the Emergency Department clinicians are see promptly (60 minute median standard)
- Improve sepsis screening and compliance against the sepsis six bundle

The work will be led by the Clinical Director in the Emergency Department supported by the Medical Director. Operationally the work we be led by the Acute and Community Care system Manager and Matron supported by the Chief Operating Officer. The team will provide monthly reports to the Board, as this is a key performance indicator, as well as quarterly updates to the Trust Quality Improvement Group.

PRIORITY 4:

TO IMPROVE THE STROKE PATHWAY ACROSS OUR ORGANISATION THROUGH IMPROVING STROKE COORDINATION AND REMAPPING THE WHOLE PATHWAY, FOCUSING FIRST ON THE ACUTE ELEMENTS OF THE PATHWAY. THE OUTCOME WILL BE IMPROVED PERFORMANCE AGAINST THE NATIONAL STANDARDS.

Prior to the formation of the integrated care organisation there were two stroke services; Torbay Hospital provided an acute stroke service based on George Earl ward led by Consultant Stroke Physicians. The Community Trust provided stroke rehabilitation based on Teign Ward at Newton Abbot Hospital led by a Consultant Therapist with medical support provided by a GP. The teams worked very closely together but did not experience the benefits that full integration could bring to patient care.

In 2016/17 our objectives are to:

- Map the stroke pathway for people presenting with a stroke or suspected stroke; clarifying roles and responsibilities for ensuring patients get timely and effective care focussing on targets identified in SSNAP domains 1 and 2. This is a set of national quality stroke standards which we are measured against.

- Identify the requirements to ensure robust, proactive and consistent co-ordination of the stroke pathway and begin to implement the improvements required
- Fully scope and plan the steps required to create a single fully integrated stroke service that supports patients, their families and carers.

Priority 4 has been developed in recognition of the need to improve our stroke performance and through working in an integrated way this will improve patient, family and carer experience.

Managerially the work will be led by the Acute and Community Care System Manager with clinical leadership provided by the Stroke Consultant and the Consultant Therapist in Stroke. Board level support will be provided by the Chief Operating Officer with the team providing quarterly reports against their improvement plan to the Trust Quality Improvement Group.

PRIORITY 5:

TEST THE IMPACT OF USING THE 'INSTITUTE OF HEALTH IMPROVEMENT'S TEACH BACK' METHOD TO IMPROVE COMMUNICATION BETWEEN PATIENTS, FAMILIES AND HEALTH AND CARE PROFESSIONALS.

Clear communication between health and social care staff is an important aspect of people's experience of care. Teach back is a simple method of asking the person to repeat back what they have understood of the discussion. In this way if the first communication has not been clear enough there is the opportunity to correct any misunderstanding or fill in gaps. It is also a practical way for health and social care staff to assess and make improvements to their style of communication.

In 2016 we will test out our approach to utilising this method across three areas:

- As part of the patient flow (SAFER) bundle work on one area we will use the methodology to improve our communication and planning of discharge from hospital.
- As part of our feedback and engagement team work plan, we will test out this method when people contact us by telephone.
- As the care model progresses we will select one care pathway to trial the teach back method in clinical assessment.

The work will be led by the Deputy Director of Nursing (Quality & Experience) supported by the Trust Feedback and Engagement Team. Board level support will be provided by the Chief Nurse. Progress against these objectives will be monitored through the Quality Improvement Group, reporting quarterly.

STATEMENTS OF ASSURANCE FROM THE BOARD

REVIEW OF SERVICES

During 2015/16 Torbay and South Devon NHS Foundation Trust provided and/or sub-contracted 51 relevant health services.

Torbay and South Devon NHS Foundation Trust has reviewed all the data available to it on the quality of care in 51 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 87% of the total income generated from the provision of relevant health services by Torbay and South Devon NHS Foundation Trust for 2015/16.

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

PATIENT SAFETY

CLINICAL EFFECTIVENESS

PATIENT EXPERIENCE

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 2015/16, 30 national clinical audits and 3 national confidential enquiries covered relevant health services that Torbay and South Devon NHS Foundation Trust provides.

During 2015/16 Torbay and South Devon NHS Foundation Trust participated in 90% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

National Audits	Eligibility	Participation
Acute coronary syndrome or acute myocardial infarction (MINAP) (NICOR)	Yes	Yes
Adult cardiac surgery audit (ACS) (NICOR)	No	N/A
Adult critical care (Case Mix Programme) (ICNARC CMP)	Yes	Yes
Bowel cancer (NBOCAP) (NHS IC)	Yes	Yes
Cardiac rhythm management (HRM) (NICOR)	Yes	Yes
Chronic kidney disease in primary care	No	N/A
Chronic obstructive pulmonary disease (COPD) (RCP)	Yes	Yes
Congenital heart disease (CHD) (Paediatric cardiac surgery) (NICOR)	No	N/A
Coronary angioplasty (NICOR)	Yes	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) (ANDA) (NHS IC)	Yes No	Inpatient Yes Adult N/A
Diabetes (Paediatric) (NPDA) (RCPCH)	Yes	Yes
Elective surgery (National PROMs Programme) (NHS IC)	Yes	Yes
Emergency oxygen (BTS)	Yes	No
Falls and fragility fractures audit programme, includes national hip fracture database (FFFAP) (RCP)	Yes	Yes

National Audits	Eligibility	Participation
Heart failure (NICOR)	Yes	Yes
Intermediate care	No	N/A
Inflammatory bowel disease (IBD) (RCP)	Yes	Yes
Lung cancer (NLCA) (RCP)	Yes	Yes
National cardiac arrest audit (NCAA) (ICNARC)	Yes	No
National comparative audit of blood transfusion (NHS BT)	Yes	Yes
National complicated diverticulitis audit	No	N/A
National emergency laparotomy audit (NELA) (RCA)	Yes	Yes
National joint registry (NJR)	Yes	Yes
National vascular registry, including CIA and elements of NVD (NVR) (RCS)	Yes	Yes
Neonatal intensive and special care (NNAP) (RCPCH)	Yes	Yes
Oesophago-gastric cancer (NAOGC) (RCS)	Yes	Yes
Paediatric asthma (BTS)	Yes	Yes
Paediatric intensive care (PICANet)	No	N/A
Parkinsons disease (NPA)	Yes	No
Prescribing observatory for mental health (POMH-UK) (Prescribing in mental health services) (RCP)	No	N/A
Procedural sedation in adults (CEM)	Yes	Yes
Prostate cancer (NPCA) (RCS)	Yes	Yes
Pulmonary hypertension (NHS IC)	No	N/A
Renal replacement therapy (Renal Registry) (NHS BT)	No	N/A
Rheumatoid and early inflammatory arthritis	Yes	Yes
Sentinel stroke national audit programme (SSNAP), includes SINAP (RCP)	Yes	Yes
Severe trauma (Trauma Audit & Research Network) (TARN)	Yes	Yes
UK cystic fibrosis registry	No	N/A
Vital signs in children (CEM)	Yes	Yes
VTE risk in lower limb immobilisation (CEM)	Yes	Yes

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Eligibility	Participation
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 (NCISH)	No	N/A

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

- Emergency oxygen (BTS) – Directorate decision due to staffing issues.
- National cardiac arrest audit (NCAA) (ICNARC) – £1000 subscription fee. Trust therefore decided not to take part.
- Parkinsons disease (NPA) – No clinician available to lead within service

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation participated in, and for which data collection was completed during 2015/16, 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.

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Cases submitted	% Cases
Acute coronary syndrome or acute myocardial infarction (MINAP)	TBC	100
Adult community acquired pneumonia (BTS)	23	115
Adult critical care (Case Mix Programme) (ICNARC CMP)	Report not published	
Assessing for cognitive impairment in older people (CEM)	100	100
Bowel cancer (NBOCAP) (NHS IC)	222	100
Cardiac rhythm management (HRM) (NICOR)	Report not published	
Chronic obstructive pulmonary disease (COPD) (RCP)	TBC	100
Coronary angioplasty (NICOR)	Report not published	
Diabetes (Adult) ND(A), includes national diabetes inpatient audit (NADIA)	Report not published	
National pregnancy in diabetes	5	100
Diabetes (Paediatric) (NPDA) (RCPCH)	Report not published	

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Cases submitted	% Cases
Falls and fragility fractures audit programme (FFFAP), includes		
Inpatient falls (RCP)	30	100
National hip fracture database	471	100
Heart failure	507	100
Inflammatory bowel disease (IBD)	24	100
Initial management of the fitting Child (CEM)	10/50	20
Lung cancer (NLCA) (RCP)	178	100
Mental health in the Emergency Department (CEM)	50	100
National comparative audit of blood transfusion (NHS BT)		
- 2015 Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery	29	100
National emergency laparotomy audit (NELA) (RCA)	TBC	
National joint registry (NJR)	814	100
National vascular registry, including CIA and elements of NVD (NVR)		
- National vascular organisational audit	1	100
Neonatal intensive and special care (NNAP) (RCP CH)	340	100
Oesophago-gastric cancer (NAOGC) (RCS)	151	100
Paediatric asthma (BTS)	Report not published	
Procedural sedation in adults (CEM)	44/50	88
Prostate cancer (NPCA) (RCS)	100	100
Rheumatoid and early inflammatory arthritis	TBC	
Sentinel stroke national audit programme (SSNAP), includes SINAP (RCP)	634	100
- SSNAP Post-Acute Organisational Audit	1	100
Severe trauma (Trauma Audit & Research Network) (TARN)		
- Thoracic & abdominal Injuries & shocked, March 2015	255	100
- Core Measures for all patients, Boast 4 eligible fracture, open limb fractures, severe pelvic fractures	348	100
- Core measures for all patients - Head & neck spinal injuries	349	100349
Vital signs in children (CEM)	50	100
VTE risk in lower limb immobilisation (CEM)	50	100

National Clinical Audit and Patient Outcome Programme incorporating National Confidential Enquires	Cases submitted	% Cases
Child health programme	TBC	TBC
Maternal, infant and new-born clinical outcome review programme	TBC	TBC
Medical and surgical programme: National confidential enquiry into patient outcome and death		
- Gastrointestinal haemorrhage	2/5	40
- Just say sepsis	5	100

The reports of 44 national clinical audits were reviewed by the provider in 2015/16 and Torbay and South NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Ref Recommendations / actions

0071 (BTS) Adult community acquired pneumonia

- Coding to be contacted to include coding information after case selection of next year's audit.
- Patient admission times to hospital should be considered locally - earlier admissions are better than later during the day.

134 (CEM) Assessing for cognitive impairment in older people

- Disseminate amongst nursing staff the importance of documenting not only observations but also an early warning score.
- Liaise with IT team to ensure recorded observations assist with/enable automatic calculation of early warning score.
- Liaise with IT team to ensure an automated prompt for patients over 75 presenting by ambulance for an AMT-10 cognitive assessment tool is included within the triage section of the IT programme.

0132 (CEM) Initial management of fitting child

- Develop and introduce a 'Fitting Child' leaflet for parents (completed)

Ref Recommendations / actions**0133 (CEM) Mental health in the Emergency Department**

- Greater awareness of mental health triage tool for medical and nursing staff through education at induction for the new doctors in August and teaching for the established doctors/nursing staff.
- Re-audit data when mental health triage tool has been introduced. (Triage tool introduced end of 2015 & r- audit planning taking place spring 2016)
- Consideration of 24/7 triage by matron by Dec 15.

0047 (DAHNO) Data for head and neck oncology

- Liaison over where the data is collected and reported, needs to be streamlined so as to avoid any double reporting and to allow accurate future surgeon reporting. Work led by Lead for Health & Neck cancer & Oral & maxio-facial consultant.

0043 (NHFD) National Hip Fracture database

- Rethink strategy to enable surgery on the day of, or day after, admission - possible options are to promote prompt starts and diverting TCI trauma to day surgery.
- Improve % of patients admitted to Ainslie trauma ward within 4 hours - via fast track admissions and ring fencing, 'hip fracture' beds on Ainslie - need executive operational support and ongoing audit of reasons patients not admitted to Ainslie within 4 hours.
- Ensure community rehab services are represented at clinical governance meetings.
- Development of hip fracture programme using quality improvement methodology initially using Paignton cohort of hip fractures.
- Establish early supported discharge scheme.
- Add whether a fascia Iliaca nerve block done to the data collected in our national hip fracture database for 2016.

0075 (SAMBA) A day in the life of an Acute Medical Unit (AMU)

- Acute Medicine Consultant input into all GP referrals to see if there is an alternative to acute admission.
- The opening of a clinical decision unit on EAU3 to free up space in the Emergency Department.
- The opening of a dedicated Acute Medicine Unit on EAU 4 to allow direct admissions to this ward and to provide a location for ambulatory care.
- The employment of additional clinical staff (Trust-grade doctors and a healthcare assistant) to staff these "new" clinical areas.
- Acute Medicine consultant presence on the AMU during daytime hours to allow early post-take review and facilitate prompt discharge where possible.

Ref Recommendations / actions**0027 (SSNAP) Stroke care - SSNAP Summary report of acute organisational audit results Sentinel - Stroke National Audit 2014 Report**

- Domain One: A) Review of nursing establishment across the pathway
- Domain One: B) Specialist doctor ward rounds. Being considered as part of Trust wide consultant weekend working.
- Domain one: C) Direct admission to stroke unit. Meeting with Emergency Department/Reinforce ring fencing policy with Executive.
- Domain two: Check agreement with podiatry regarding review within 5 working days and access to diabetic/non-diabetic patients.
- Domain three: 6-7 day therapy working. Being considered as part of cross-organisational therapy review
- Domain 4: TIA clinic. Dependent on recruitment of additional Stroke Consultants and being considered as part of 7 day service (see Domain One A above).
- Domain 5: Forthcoming Integrated Care Organisation (ICO) offers opportunity for joint education across the acute and community trusts. Need to consider in-house training/hosting.
- Domain 6: Ensure patient version of local standards is available across pathway.

27 (SSNAP) Post-acute organisational audit public report: phase 2

- Patients in all geographical areas should be able to access stroke rehabilitation services seven days each week.
- There is currently OT and physiotherapy access in Teignbridge, Totnes & Dartmouth but not Torbay localities or with speech therapy. The current plan is to integrate these therapy staff into a single team to then enable seven day services across all geographical areas and professions.
- All other expected standards were met.

0039 National heart failure audit report April 13-March 14

- Improve data collection (we have been through this data and our figures are significantly better once data cleaned with those in whom meds are contra-indicated).
- Improve heart failure nurse involvement in HFPEF (heart failure with preserved ejection fraction) by more involvement on peripheral wards and automatic alert if known heart failure patient. admitted into the Trust.
- Key worker alert to let heart failure nurse team know of the admission of a known heart failure patient.

44 National lung cancer audit report 2015

- Our performance generally falls within acceptable practice but we need to be vigilant regarding obtaining tissue diagnoses and offering surgical resection to appropriate patients by raising awareness at the multidisciplinary team meeting
- The proportion of patients being seen by a clinical nurse specialist also needs further investigation in order to understand whether
- The published data for our Trust is a true reflection, and if so how this can be improved. Emailed Information department to ask if he can explain the discrepancy between the published number seen by lung clinical nurse specialist and our local figures.

Ref Recommendations / actions**0135 Multi-centred audit of quinsy**

- No further action required.

0093 National comparative audit of blood transfusion programme - Survey of red cell use audit of blood transfusion

- No actions required.

0093 National comparative audit of blood transfusion programme - 2013 Audit of Anti-D immunoglobulin prophylaxis

- All eligible RhD negative pregnant women delivering RhD positive babies receive anti-D Ig prophylaxis post-delivery.
- (PD) at the correct time and the correct dose - Although 100% achieved there were 17% not timed we have now introduced a 'tag return' system and all doses are now accurately recorded. Any tags not completed are returned and the information obtained retrospectively.
- All RhD negative pregnant women receive anti-D immunoglobulin prophylaxis after a potentially sensitising event (PSE) in pregnancy - no data available from the audit report for our site, however changes were made to Anti-D policy (0193) to clarify PSEs and doses - new policy was published July 2014.
- A dose of at least 250 IU anti-D Ig before 20 weeks and at least 500 IU anti-D Ig after 20 weeks gestation is given within 72 hours of the PSE- Anti-D 'When and how much' posters and fact cards ordered from NHSBT and distributed to midwife teams leaders.
- All RhD negative women are given information about anti-D Ig prophylaxis and consent to receive the anti-Dig is documented. Only 60% of patients were documented as receiving the leaflets although it is policy to give it, we suspect this was a documentation issue rather than a lack of compliance. There is a tickbox in the documentation to say leaflet given - midwife education required to ensure that this is completed. Although this has been actioned locally, already a further newsletter will be used to remind staff - this will become a regular feature of the newsletter.
- In the event that anti-D prophylaxis is declined, the reason is recorded - similarly with documentation relating to consent - only 85% had documentation of consent.

0093 National Comparative audit of blood transfusion programme - 2015 Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery

- Pre-operative anaemia management: Along with current NICE Guideline NG 24 Blood Transfusion this has already been targeted by the PBMG (Patient Blood Management Group). A meeting has been requested by the HTT representatives (JP & PS) with the key stakeholders in both the pre-assessment areas in the Trust namely Day Surgery and Pre-Assessment level 2 (Consultant lead and Nurse lead for each area) 11/12/2015. These six key stakeholders will be responsible for implementing the new NICE guidance and these recommendations under the auspices of the PBMG. Presentations to T&O (23/02/2016), Anaesthetics (23/02/2016), O&G (04/02/2016) and Surgery (04/02/2016)
- Intra-operative use of single unit red cells transfusions intra-operatively - this is covered under the action plan for use of single unit red cells transfusions post-operatively
- Post-operative transfusion Hb trigger points - Although our policies and guidelines are compliant with this recommendation; practice is not. New paperwork has been presented to the Health records committee (14/12/15) which will make the supporting information more readily available; has been referred back to JP/PS to liaise with VC – meeting scheduled for 18/12/2015.

Ref Recommendations / actions

- Meeting already scheduled with Senior Nurse Strategy Group (19/2/2016) to discuss and to 'empower' nursing staff to question decisions that do not meet the recommendation. Increased education and awareness.
- Medical lead needed to ensure compliance amongst prescribers meeting with RD (07/01/2016).

0086 National oesophago-gastric cancer audit 2014

- No action plan required

0086 National oesophago-gastric cancer audit 2015

- NHS providers, individually and within local Networks, should ensure that the management guidelines for patients who are not suitable for curative treatment include a clear statement about the indications for palliative chemotherapy and its potential benefits and harms for older patients or patients of low performance status - The oncology team will review outcomes in their patients receiving palliative chemotherapy and feedback to the MDT group.
- NHS trusts/ Health Boards should assess the data collection process for patients who receive an endoscopic/ radiological palliative intervention and adapt the process to improve levels of data completeness - All members of MDT, endoscopic team and MDT co-ordinators have been reminded of local protocols. An extra copy of all stent procedure reports will be now sent directly to the MDT co-ordinator post procedure to ensure that they are recorded in the patient record.

0033 National vascular registry 2015 annual report

- The main thrust of this audit is to support the further development of a centralised arterial centre. This should serve a minimum population of 800,000. This requires the movement of elective and emergency arterial surgery to Royal Devon and Exeter Hospital. Torbay Hospital is well aware of this move and is closely involved in development. Emergency cases will be moved to Royal Devon and Exeter in April 2016.
- It is likely that elective arterial services will be moved to Exeter over the coming years. Work streams are already in place to develop working patterns to develop this move.

105 Tonsillectomy complication audit (SWAP)

- Presentation of audit results at local M & M meeting.
- Collection of comparative data from rest of region
- Ongoing audit of coblation complications.

0108 (CEM) Asthma in children

- Training for nursing staff/triage nurses on the use of asthma pathway in children (emphasise documentation).
- Asthma pathway publicised at morning handover meetings.

Ref Recommendations / actions

- Training for medical staff on use of the asthma pathway in children with particular emphasis on documentation and discharge decisions.

0109 (CEM) Paracetamol overdose

- Emergency Department guideline to be re-designed.
- Teaching sessions for junior medical staff.
- Guideline to be displayed in triage.

0047 (DAHNO) Data for head and neck oncology

- Liaison over where the data is collected and reported, needs to be streamlined so as to avoid any double reporting and to allow accurate future surgeon reporting.

0051 (ICNARC): Adult Critical Care (Case Mix Programme)

- No actions required

0045 (MBBRACE-UK) Centre- Congenital diaphragmatic hernia

- Antenatal care pathway and patient information as appendix to updated Fetal Medicine Policy (GO875) to confirm current provision

0045 (MBBRACE-UK) Centre - Perinatal mortality surveillance report - UK perinatal deaths for births from January - December 2013

- Actions included within full Trust response.

0046 (MINAP) Acute MINAP public report 2013-14

- Actions included within full Trust response.

0095 (NAP5) Accidental awareness during general anaesthesia in the UK - Accidental awareness during general anaesthesia in the UK & Ireland Report & Findings Sept 14

- Develop practice guideline for use of depth of anaesthetic monitors - this is currently agreed but informal.
- Develop practice guideline for use of propofol infusions outside of theatre for general anaesthesia.
- Implement pathway for management of Awareness under General Anaesthesia.

Ref Recommendations / actions

- Establish department database for cases of awareness, review and learn from future cases through case analysis.
- Establish clear route of referral to clinical psychology for support in event of potential post-traumatic stress disorder, following awareness.
- Present report findings to anaesthetic department for further discussion and agreed actions.

0053 - (NBOCAP) Bowel cancer audit - National bowel cancer audit 2014

- No actions required

0128 (NCEPOD) Gastrointestinal Haemorrhage (GIH) Study - Time to get control - A review of the care received by patients who had a severe gastrointestinal haemorrhage.

- Actions included within full Trust Response.

0101 (NCEPOD) Remedial factors in the care of patients who have died following lower limb amputation

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

Ref Recommendations / actions**0129 (NCEPOD) Sepsis Study - Just say sepsis - A review of the process of care received with patients with sepsis**

- Actions included within full Trust response.

0107 (NELA) National emergency laparotomy audit - The first Patient Report of the National Emergency Laparotomy Audit - The First Patient Report of the National Emergency Laparotomy.

- Actions included within full Trust response.

0026 (TARN) Severe Trauma -TARN clinical report I - Thoracic & abdominal Injuries & shocked, March 2015

- Actions included within full Trust response.

0026 (TARN) Severe Trauma-TARN Clinical Report II - Core measures for all patients, Boast 4 eligible fractures, open limb fractures, severe pelvic fractures

- Actions included within full Trust response

0066 - Cardiac arrhythmia management audit- National audit of cardiac rhythm management devices –National audit of cardiac rhythm management devices 2013-14

- Actions included within full Trust response

0065 Diabetes (RCPH National paediatric diabetes audit) NPDA experience survey for children & young people 2-13/14 (PREM)

- To increase to 100% our newly diagnosed patients with an HbA1c of less than 58mmol/mol by one year from diagnosis by initiating a care pathway for patients in the first two years of diagnosis.
- To increase the number of our patients with an HbA1c of less than 58mmol/mol to 20% by March 2016 through education.
- To equip our young people with the skills to confidently care for their diabetes in adult life and to audit this process.
- To ensure we focus on a patient centred service where involvement and feedback from patients and families is guiding us on shaping the service in the forthcoming year.

0065 Diabetes (RCPH National paediatric diabetes audit) National paediatrics diabetes report 2013/14

- To increase to 100% our newly diagnosed patients with an HbA1c of less than 58mmol/mol by one year from diagnosis by initiating a care pathway for patients in the first two years of diagnosis

Ref Recommendations / actions

- To increase the number of our patients with an HbA1c of less than 58mmol/mol to 20% by March 2016 through education
- To equip our young people with the skills to confidently care for their diabetes in adult life and to audit this process.
- To ensure we focus on a patient centred service where involvement and feedback from patients and families is guiding us on shaping the service in the forthcoming year.

0110 Multi-regional comparative audit of blood transfusion in liver cirrhosis - Multi regional audit of blood - Component use in patients with cirrhosis

- No actions required.

0064 National childhood epilepsy audit (Epilepsy 12) - Epilepsy 12 national audit round 2 – Torbay

- Improve documentation of first clinical assessment which should include description of the episodes, frequency and timing of episodes and documentation of general and neurological assessment - present at Departmental Audit Meeting.
- 2/2 children who met the criteria for a MRI scan did not have it - review of NICE guidelines and presentation at Departmental Audit meeting.
- Percentage of children diagnosed with epilepsy with evidence of communication regarding water safety - No documentation in 2/2 patients - action - presentation at Departmental Audit Meeting.
- PREM: - Overall 83% of patients who answered the questionnaire were satisfied with the care received from the epilepsy service compared to 88% across the UK. Patients feel they are not seen often enough, not enough time in the clinic. Action: If feasible increase follow up appointment time from 20 minute to 30 minutes. Better distribution of patients amongst the 2 consultants with special interest in epilepsy. Consultant to discuss with clinical manager.

0120 - National chronic obstructive pulmonary disease (COPD) audit programme - Clinical audit of COPD exacerbations admitted to acute units in England and Wales 2014

- No action required.

0116 National prostate cancer audit - NPCA first year annual report - Organisation of services & analysis of existing clinical data

- With respect to data collection for the prospective audit: Senior clinicians and other members of the MDT should ensure that complete and accurate data can be submitted to the NPCA for every patient with newly diagnosed prostate cancer, including data on cancer stage and tumour grade.
- We already are active with regular collection of WHO and ASA scores, staging and grading by enhancing the collection of data at the MDT meeting.
- Would need to expand formal collection of presentation symptoms, source of referral, biopsy technique, planned radiotherapy type and adjuvant androgen suppression. This should be achievable within 6 months.

Ref Recommendations / actions**0116 National prostate cancer audit -National prostate cancer audit: second year annual report 2015**

- No actions required.

0042 (NJR) National joint registry 12th annual report 2015

- Actions included within full Trust response

0035 National neonatal audit programme – National audit report 2015

- Actions included within full Trust response.

The reports of 61 local clinical audits were reviewed by the provider in 2015/16 and Torbay and South Devon NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref Recommendations / actions**6412 Safeguarding hub enquiry forms**

- Trust staff will receive the results of the audit and be reminded to include 'the voice of the child'
- The Safeguarding children team will provide community staff with a briefing paper on the importance of facilitating meaningful involvement of children in the child protection system.

6423 Five priorities of care at end of life (Community - Community nursing teams)

- The end of life team to provide training to all community staff in relation to the 'One Chance to Get it Right' document and the five priorities of care of the dying person.
- The end of life team to repeat training to all community staff with regards to the palliative and end of life care plan and how it relates to the five priorities.
- Managers to ensure that all staff are released to attend training.

Ref Recommendations / actions

6435 Nail re-growth following surgery

- No action plan required.

6441 Five priorities of care at end of life (Community - Community hospital teams)

- The end of life team to provide training to all community staff in relation to the 'One Chance to Get it Right' document and the five priorities of care of the dying person.
- The end of life team to repeat training to all community staff with regards to the palliative and end of life care plan and how it relates to the five priorities.
- Matrons/ Managers to ensure that all staff are released to attend training.

6358 The management of pain for femoral neck fracture in the Emergency Department (CG-124)

- To resource regional nerve block kit in the Emergency Department to ensure staff have the right equipment to hand so regional nerve blocks can be performed.

6407 Management of renal colic in the Emergency Department

- Education programme for junior doctors
 - Incorporate renal colic management section at Induction for new junior staff to improve compliance with guidelines.
 - Poor documentation - staff reminded that pain scores need documenting not only on attendance but after analgesia given.
 - Patients over 60 should have AAA excluded - education needed to ensure over 60s are screened.

6413 Intravenous (IV) cannulation documentation in the Resuscitation Department

- Implementation of Symphony should improve documentation but will be checked out by completing re-audit.

6338 Acute upper gastrointestinal (GI) bleeding - (QS-038)

- Remind junior doctors to complete the Blatchford score through presentation.
- Dedicated upper GI bleeding service on weekend that does not coincide with medical rota.
- Opportunity to perform endoscopy in theatre on Saturday and Sunday with dedicated staff.
- Band ligation training for all endoscopists.
- Resubmit business case for endoscopy nurse on call rota.

Ref Recommendations / actions**6359 Continuation of anti-platelet therapy following upper gastrointestinal (GI) bleeds in patients (CG-141)**

- Ensure patient is discussed with appropriate speciality to determine if antiplatelets should be re-started.
- Review text in Scorpio reporting to include recommendation that NSAIDs are re-evaluated in seven to ten days, after discussion with appropriate specialist team before re-commencing.
- Review Upper GI bleed Trust guideline regarding NSAID continuation.

6386 Clinical benefit analysis of quantitative neutrophil counts in diagnosis and management of spontaneous bacterial peritonitis (SBP)

- Improve our method of diagnosing SBP by sending an ethylenediaminetetraacetic acid (EDTA) bottle (purple top) with ascitic fluid during each diagnostic tap or drain and by including a request for WCC differential in the analysis of ascitic fluid.
- Improve our interpretation of this result, through education, so that samples with a neutrophil count $>250 \times 10^3/L$ are treated as SBP.
- Remind staff to chase the differential, highlight at audit meeting.
- Ensure more appropriate referrals for liver transplant are considered and decision documented in notes.

6419 NICE BCA - Human growth hormone (Somatropin) in adults with growth hormone deficiency (TA-064)

- No plan required.

6364 Perioperative management of patients taking anti-platelet therapy

- Review Trust policy and update as required.

6388 Completion of venous thromboembolism (VTE) assessments on ITU Prescription Chart

- Re-design the ITU inpatient prescription chart incorporating the re-positioning of the VTE assessment and anticoagulation prescription.

6405 Pre-operative pregabalin prescribing in total knee replacement patients

- Pregabalin dosing guidance will be amended to simplify prescribing; patients under 75 years will receive 150mg and those over 75, 75mg.

6406 Prescribing and administering pre-medication on the Surgical Admissions Unit

- Change in practice - pre-meds when not in use are now to be placed inside the same blue boxes provided for patient notes.

Ref Recommendations / actions

6263 Reverse Ileostomy

- No action plan required.

6331 Preoperative preparation for major amputation surgery

- Consider including current pain documentation on clerking/ pre assessment.
- Agree/ Set an appropriate level of pain to trigger pain team referral.

6377 Elective inguinal hernia repairs in Torbay

- No action plan required.
- 6369 Yttrium Aluminium Garnett (YAG) - Pre and Post procedure advice and follow up
- Remind clinicians that all cases should be discharged back to optician unless they are being followed up for other eye conditions.
- Provide information leaflet to all patients before their attendance for the treatment so that they are aware of complications including retinal detachment. In case of direct referrals from optician, the leaflet will be posted along with the appointment letter.
- Remind clinicians that there is no need to prescribe steroid eye drops unless there are risk factors such as previous uveitis.
- All optician referrals should be booked directly for laser clinic rather than general clinics.

6401 Surveillance of systemic health in diabetic eye care

- Consider the introduction of an ink stamp or check box in 'MediSoft' for systemic disease indicators.
- Develop referral protocol in conjunction with endocrinologists.

6414 Surgery for rhegmatogenous retinal detachment (RD)

- No action plan required

6415 Contact lens

- No action plan required

Ref Recommendations / actions**6420 Accuracy of horizontal squint surgery**

- No action/ change required to current practice

6376 Dental radiographs

- Training to improve quality of radiographs with particular emphasis on periapical and occlusal images
- Try/ consider increasing the number of sessions with dental radiology run by specialist dental nurse (Mornings)
- Investigate the recording of and reasons for repeat x-rays.

6378 "Start" records

- The following information must be annotated on the diagnostic and sticky “treatment explanation” sheets (s) or hand written (w) in the notes for each patient:
 - o Presenting complaint (w)
 - o MH (s)
 - o Diagnostic summary (w)
 - o OH status (s)
 - o IOTN (s)
 - o Suitable radiograph taken (w)
 - o Radiographic report (w)
 - o Imps taken for study models (w)
 - o Risks explained (s)
 - o Risk factors specific to patient (e.g. small roots) (w)
 - o Type of appliance (w)
 - o Extraction if necessary (s)
 - o Consent (s)
- Existing pro-formas are to be used for every case and, where items are not covered by these, written entries are to be used for each new assessment of all patients. This will help to summarise and clarify this process.
- Amend and add audit criteria for re-audit.

6432 Osteoradionecrosis (ORN)

- No action plan required

Ref Recommendations / actions

6308 Evaluation of the diagnostic adequacy and safety of shoulder ultrasound

- Share results with Radiology.
- Musculoskeletal (MSK) radiologists to meet up with the three upper limb surgeons to come up with a unified way of reporting.
- To set up a prospective audit of the report and post- operative pictures.

6361 Infection in arthroplasty

- No action plan required

6362 Mortality in total knee arthroplasty

- No action plan required

6381 Elective consent on the Surgical Admissions Unit

- Present findings to surgical directorate.
- Present findings to trauma & orthopaedic directorate.
- Liaise with trauma & orthopaedic consultant to make improvements.

6422 Five priorities of care at end of life

- Increase education using teaching sessions around enquiry and documentation of LPA and ADRT.
- Continued education around eliciting and documenting spiritual, cultural and religious needs.
- Undertake a review of the way that chaplaincy input is captured in the hospital setting.
- Emphasis in teaching on recording of symptoms and response to medications.

6442 Note Keeping (2015/ 16)

- Results will be fully discussed at the Health Records Committee on 12-Jan-16 when a full, itemised action plan will be agreed to work on specific weaknesses

6345 Amblyopic patients achieving a 'Good Result' following occlusion therapy

- Produce and implement Torbay local amblyopia patching guidelines

Ref Recommendations / actions

- Introduce a summary sheet as an aid for refraction follow up and to stop occlusion when VA stable. Sheet to be authorised through the Health Records Committee
- Present audit to main Ophthalmology Governance and Audit meeting.

6327 Local recurrence following neoadjuvant chemotherapy and breast conserving surgery

- No action plan required

6374 Weight of benign biopsies in breast surgery

- No action plan required

6383 Autism (assessment) in children and young people (CG-128)

- No action plan required

6384 Diarrhoea and vomiting in children (CG-084)

- Implement revised guideline and fluid management tool with parental information sheet.

6394 Weight loss management in the new-born

- Present findings at the Supervisors of midwives meeting.
- Formal training sessions to take place during May 2015 to highlight the importance of following the weight loss policy for Maternity and SCBU staff.
- Amend weight loss policy ref: 0905 to include that high risk babies be weighed on day two.

6395 Neonatal Jaundice (CG-98)

- Raise awareness by presenting findings during the nursing group meeting on 10-Jun-15.
- Explore feasibility of adding "information given and six hourly bilirubin monitoring" box to the Badger net system.

6397 Strategy, location and timeliness of child protection medicals

- To enable more photos to be taken obtain a camera and accessories.
- Store images appropriately - obtain Caldicott Guardian approval.

Ref Recommendations / actions

- Produce protocol for the use of the camera.
- Arrange more daytime assessments by the use of dedicated clinic space & reorganisation of clinics.
- Present audit data to Torbay Social Services and Devon Social Services.

6404 Neonatal Sepsis (CG-149)

- NEWS charts now available for preterm babies at various levels of dependency. (Completed)
- Explore option of adding sepsis information leaflet to standard discharge pack and feasibility of adding "information given" box to the Badger net system.

6242 Inpatient Care of Young Persons with Eating Disorder

- Inform nursing staff that they must weigh patients on admission rather than rely on weight from previous clinic.
Share results with nursing staff during training meetings.
- Amend guideline to include a more detailed vitamin supplement regime.

6425 Paediatric Head Injury (CG-176)

- Liaise with SD (Ward Manager) to arrange informing/ education of nursing staff about standards for neurological observations in head injury, in particular the frequency of observations.

6426 Headaches in young people (CG-150/ QS-42)

- Develop local headache guideline incorporating NICE recommendations for:
 - the use of a headache diary
 - combination therapy with triptan and either a non-steroidal anti-inflammatory drug (NSAID) or paracetamol (young people aged 12-17 years a nasal triptan should be considered in preference to an oral triptan)
 - use of an anti-emetic
- Develop an information leaflet for patients with a primary headache disorder to highlight the risk of medication overuse.

6389 Vaginal mesh for prolapse

- No actions required

Ref Recommendations / actions**6402 Clomid (CG-156)**

- No actions required

6403 Assisted vaginal birth

- Educate post natal ward staff about:
 - o Bladder care - documentation to include time and volume
 - o Documentation of leaflets given to patient
- Educate SHOs and Registrars re debrief and documentation of leaflets given by emailing all relevant staff.
- Discuss which patients need a fluid balance chart at governance.
- Discuss at delivery suite clinical governance meeting the discharging of women who have had an epidural before 12hrs.
- Review debrief stickers.

6417 Antibiotics for Neonatal Infection

- Highlight the use of NEWS chart at team leaders meeting.
- Highlight the use of NEWS chart by addition to the clinical governance newsletter.
- Clarify process for verbal orders of antibiotics in emergency situation.

6428 Multiple Pregnancy and Birth (CG-129)

- Proforma to be updated regarding documentation of discussions/ information given to patient.
- Consideration of aspirin to be added to proforma.
- Proforma to be started at 12/40 scan appointment.
- Add the preferences for delivery to the proforma – to be updated as preference changes.
- Update cord gases policy.
- Add FBC at 20 and 28 weeks to proforma.

6429 Management of gestational diabetes

- No actions required

Ref Recommendations / actions

6430 Recurrent miscarriage

- No actions required

6449 Administration of second Propess

- Finalise the update of the induction of labour policy. (0252)
- Consider possible use of balloon dilation of cervix more often e.g. Foley catheter or Cook balloon device before giving another Propess.
- Disseminate findings to staff through team leaders meeting.
- Disseminate to staff via mandatory training.
- Include in the next clinical governance newsletter.

6363 Accuracy of imaging metal-on metal hip prostheses and their complications

- Discuss/ share results with Orthopaedics, establish, if happy with accuracy, to move away from ultrasound.
- If above agreed, to change Trust policy to MRI on the new scanner and stop doing US.

6367 Management of scaphoid fractures in Emergency Department

- Education needed to ensure Emergency Department doctors are requesting MRI as second imaging choice.

6372 Evaluating the performance of the 18+ to 20+6 weeks fetal anomaly scan

- No action plan required.

6398 Safe and effective use of 'ExperGuide' biopsies

- No actions required.

6409 Special Care Baby Unit (SCBU) Radiology

- Education for paediatric doctors regarding request of routine SCBU Chest X-Rays and repeat intervals.
- Training for SCBU nursing staff to improve positioning and decrease holders hands.

Ref Recommendations / actions

- Refresher neonatal portable chest training for radiographers to reinforce guidelines.
- Training package for all new Radiology staff.

6438 Benign breast disease: Imaging classification in the symptomatic service

- No actions required.

6439 Malignant breast disease: Imaging classification in the symptomatic service

- No actions required.

6393 Management by Torbay Sexual Medicine Service of patients diagnosed with gonorrhoea

- Change local practice in terms of first line treatment. Consensus to be reached & disseminated accordingly.
- Lilie (computer system) template to be created to help structure management and ensure good practice.

6396 Management of complainants of sexual assault within Torbay Sexual Medicine Service

- Revise templates on Lilie and amend to ensure that drop-downs have appropriate options.
- E-mail all clinicians to reiterate the need for all patients:
 - o To see health advisor. If they decline, record the reason why
 - o To have a mental health assessment
 - o Under 18 to have appropriate safeguarding assessment
- Organise for an external speaker to attend lunch time meeting to talk about mental health assessments.
- Feedback results to outreach team.

The reports of 3 national confidential enquiries were reviewed by the provider in 2015/16 and Torbay and South Devon NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref Recommendations / actions

0045 (MBBRACE-UK) Centre - Perinatal mortality surveillance report - UK perinatal deaths for births from January - December 2013

- To continue with the stillbirth audit.
- To highlight to all staff the importance of offering a Post-mortem examination and the rationale-Newsletter.
- To review data from the perinatal institute on local detection rates of SGA – antenatal and postnatal clinical governance meetings.

0128 (NCEPOD) Gastrointestinal haemorrhage (GIH) Study - Time to get control - A review of the care received by patients who had a severe gastrointestinal haemorrhage.

A detailed Trust response to the report was provided. Actions include:

- A care pathway/ guideline for lower gastrointestinal bleeding.
- Improve transfer and repatriation of patients requiring TIPS to manage variceal bleeding.
- Improve case findings of all deaths from gastrointestinal bleeding within 30 days of admission.

0129 (NCEPOD) Sepsis Study - Just say sepsis - A review of the process of care received with patients with sepsis

A Trust response looking at all of the report recommendations was provided but most of the actions relating to the recommendations were already in hand. The actions that needed to be implemented are shown below

- A rapid assessment area is now being utilised to improve the time to first set of observations and first assessment.
- The Health community are devising as single entry point to acute and intermediate care pathways that uses EWS as a standard dataset to ensure adequate assessment of sepsis risk.
- Pilot work is currently being undertaken on Midgley ward looking at approaches to a more standardised Mortality and Morbidity approach that reviews all in hospital deaths.
- Junior doctors completing death certification should always discuss with a senior colleague to clarify exactly what should be on the death certificate.

RESEARCH

The number of patients receiving relevant health services provided or sub-contracted by Torbay and South Devon NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1,503.

Participation in clinical research demonstrates Torbay and South Devon 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.

Torbay and South Devon NHS Foundation Trust was involved in conducting 322 clinical research studies during 2015/16 in 31 specialities.

During 2015/16 76 clinical staff participated in approved research at Torbay and South Devon NHS Foundation Trust. These staff participated in research covering 31 specialities.

In the past year more than nine 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 Torbay and South Devon 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.

Selection of research studies: 2015/16

PD REHAB: A national multicentre randomised controlled trial to assess the clinical and cost effectiveness of physiotherapy and occupational therapy in Parkinson's disease.

The study showed that NHS physiotherapy and occupational therapy did not produce immediate or long-term clinically meaningful improvements in activities of daily living or quality of life in mild to moderate Parkinson's disease. This evidence does not support the use of low dose, patient centred, goal-directed physiotherapy and occupational therapy in patients in the early stages of Parkinson's disease and recommends future research should include the development and testing of more structured and intensive physiotherapy and occupational therapy programmes in patients with all stages of Parkinson's disease.

The ProFHER study: a national multicenter randomised controlled trial evaluating the clinical and cost-effectiveness of surgical compared with non-surgical treatment for proximal fracture of the humerus in adults

Torbay Hospital was one of 33 UK centres to take part in this national study. Fracture of the proximal humerus (the top part of the upper arm bone) is common, particularly in older adults; but there is considerable variation in the management of displaced proximal humeral fractures involving the surgical neck. The study showed there was no significant difference between surgical treatment compared with nonsurgical treatment in patient-reported clinical outcomes over 2 years following fracture occurrence and therefore does not support the trend of increased surgery for patients with displaced fractures of the proximal humerus.

Selection of research studies: 2015/16

Clavical Trial: a national multicentre randomised controlled trial of conservative management vs. open reduction and internal fixation of midshaft clavicle fractures

This is the largest and to date most conclusive research study undertaken. The study showed that open reduction and internal fixation (ORIF) for displaced, midshaft clavicle fractures is a safe and effective treatment with improved early outcomes with significantly higher union rates (at 9 months) and patient satisfaction compared with non-operative treatment. The results support the indication for surgery in these fractures.

CATHETER study: A national multicentre randomised controlled trial comparing antimicrobial catheters for the reduction of symptomatic urinary tract infections in adults requiring a short term catheterisation in hospital.

Catheter associated urinary tract infection (CAUTI) is a major preventable cause of harm for patients in hospital. The study was looking at whether short term use of antimicrobial catheters reduced the risk of such infections compared to standard polytetrafluoroethylene (PTFE) catheterisation. Participants were randomly allocated to receive a silver alloy-coated catheter, a nitrofurantoin-impregnated catheter or a PTFE catheter (control group). The results showed the anti-microbial (silver alloy) catheters were not effective for reducing incidence of symptomatic CAUTI. The reduction noted in CAUTI associated with nitrofurantoin impregnated catheters was less than that regarded as clinically important. Routine use of antimicrobial catheters is not supported by this trial.

UK MRC QUARTZ trial: a national multicentre randomised controlled trial evaluating whole brain radiotherapy for brain metastases from non-small cell lung cancer

The only large randomised trial looking at the addition of Whole Brain Radiotherapy (WBRT) to current best optimal supportive care with dexamethasone therapy; for patients with brain metastases from Non-Small Cell Lung Cancer (NSCLC). The study showed that it was possible to collect detailed Quality of Life (QoL) data in this poor prognostic group; but that WBRT provides no additional clinically significant benefit compared to optimal best supportive care plus dexamethasone alone, showing similar overall median survival (9.3 weeks vs. 8.1 weeks) and similar Quality Adjusted Life Years (QALYs) (43.3 days vs. 41.4 days).

The IRIS study: An international multicentred randomised controlled trial

Patients with Ischemic stroke or Transient Ischemic Attack (TIA) are at an increased risk for future cardiovascular events despite current preventative therapies. The identification of insulin resistance as a risk factor for stroke or myocardial infarction raised the question could Pioglitazone, a drug which improves insulin sensitivity, benefit patients with cerebrovascular disease or not. The results from this international study showed that the risk of stroke or myocardial infarction was lower among patients who received the drug pioglitazone than among those who received placebo. Pioglitazone was also associated with a lower risk of diabetes but with higher risks of weight gain, edema and fracture. The study shows the importance of considering individual treatment preference and risk of drug related adverse events in addition to potential benefits when making patient specific decisions regarding therapy.

Selection of research studies: 2015/16**Measurement of serum nitrate concentration for the diagnosis of infective gastroenteritis**

This single centre study led by and conducted at Torbay Hospital aimed to investigate whether the increase in nitrate concentration in patients with gastroenteritis is related to a bacterial or viral pathogens being present in stool samples. The study results suggest that serum nitrate concentration is a specific marker for bacterial gastroenteritis, suggesting that the spectrophotometric method could serve as a high throughput assay to screen patients for bacterial infective gastroenteritis, particularly Campylobacter, and where serum nitrate reflects the severity of symptoms..

CQUIN PAYMENT

A proportion of Torbay and South Devon NHS Foundation Trust income in 2015/16 was conditional on achieving quality and improvement and innovation goals agreed between Torbay and South Devon 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.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available in annex 3 or electronically at: www.torbayandsouthdevon.nhs.uk

Details of the 2015/16 CQUINs can be found in this report.

In 2015/16 the potential value of the CQUIN payment was £4,727,000 and income subsequently received was £4,600,000. In 2014/15 the potential value of the CQUIN payment for the acute trust was £4,449 000 and the income subsequently received was £4,409 000.

In 2016/17 the value of the CQUIN payment is £4,643 000.

CARE QUALITY COMMISSION

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

- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures.
- Family planning services.
- Management and supply of blood and blood derived products.
- Maternity and midwifery services.
- Personal Care
- Surgical procedures.
- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.
- Termination of pregnancy.

Torbay and South Devon NHS Foundation Trust has no conditions on registration.

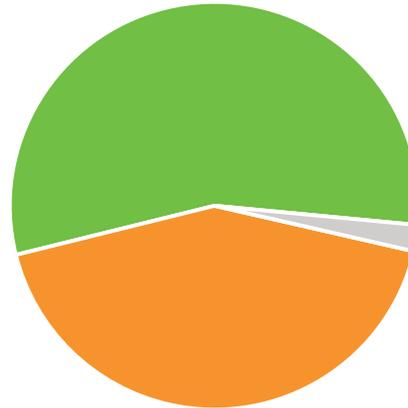
The Care Quality Commission has not taken enforcement action against Torbay and South Devon NHS Foundation Trust during 2015/16.

Torbay and South Devon NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust received two unannounced visits from the Care Quality Commission during 2015/16 as part of its routine monitoring programme.

The Trust received a comprehensive inspection in February 2016. The Trust has received initial feedback and also a requirement notice relating to concerns raised

Torbay and South Devon Foundation Trust – self assessment



Services

Not Assessed	11
Inadequate	1
Requires Improvement	225
Good	293
Outstanding	0
Not Applicable	0
Total	530

in our Emergency Department at the time of sign off of the Quality Account by the Board.

The areas of concern in our Emergency Department focused on three areas:

- Time to initial triage and assessment
- Monitoring & action regarding early warning scores and sepsis
- Staffing within the resuscitation area and paediatric area

The Trust has responded to this notice and has submitted a robust and accepted action plan to CQC which has also been shared with the Trust Board and our local commissioning group.

The Trust's self- assessment at this current time of writing this report remains as it was at the time of the CQC inspection in February and is as follows:

CQC Domains

Domain	Not Assessed	Inadequate	Requires Improvement	Good	Outstanding	Not Applicable
1. Is it safe?	2	0	50	54	0	0
2. Is it effective?	2	0	51	53	0	0
3. Is it caring?	2	0	12	92	0	0
4. Is it responsive?	2	1	53	50	0	0
5. Is it well led?	3	0	59	44	0	0
Total	11	1	225	293	0	0

The Trust will continue to provide further CQC updates Trust actions via our website:
www.torbayandsouthdevon.nhs.uk/

DATA QUALITY

Providing accurate data is a pre-cursor to driving evidence-based change in health and social care. Data underpins our ability to measure how well we are doing and where we need to improve. By monitoring, understanding and continually improving the quality of our data, we can place increased confidence in the decisions based upon them. As the pace and scale of change required of the NHS increases, the relative importance of ensuring a reliable, stable and trusted data repository also increases.

Torbay and South Devon NHS Foundation Trust has formed an Information Assurance Group to monitor, assess and recommend actions to improve the quality of our data assets. Reporting to executive directors, through a standing committee of the Board, this group includes senior representatives from the clinical, operational, finance and performance-information professions. Its remit is to provide assurance that information reported is fit for purpose; is accurate and that any risks to reporting are captured, managed and clearly communicated.

As care pathways grow ever more complex, they increasingly span multiple information systems and organisations. The process of managing data quality therefore has to evolve. The Information Assurance Group is therefore also tasked with:

- Understanding the consistency of data representation between systems.
- Building assurance that data processing streams maintain the integrity of the data processed.
- Ensuring that information systems owners manage the lifespan of their data and reference tables effectively.
- Accurately capturing how services are represented by data are accurately captured.

NHS NUMBER AND GENERAL PRACTITIONER REGISTRATION CODE

Torbay and South Devon NHS Foundation Trust submitted records during 2015/16 to the Secondary Users' service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

which included the patient's valid NHS number was as:

- 99.6% for admitted care.
- 99.8% for outpatient care.
- 99.3% for accident and emergency care.

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

- 100.0% for admitted care.
- 100.0% for outpatient care.
- 99.5% for accident and emergency care.

Data reported as of January 2016 (Month 10).

INFORMATION GOVERNANCE

Torbay and South Devon NHS Foundation Trust information governance assessment report overall score for 2015/16 was 84% and was graded green. The Trust will take the following actions to improve the score including:

- Developing a more formal information security risk assessment and management programme.

- Offering a range of different delivery methods for information governance training.
- Understanding how our information and data is used post integration by undertaking a more detailed data mapping exercise.

CLINICAL CODING

Torbay and South Devon NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

DATA QUALITY IMPROVEMENTS: LOOKING BACK

Torbay and South Devon NHS Foundation Trust committed to take the following actions to improve data quality in 2015/16 which are noted alongside the actions taken below.

2015/16 data quality objectives

- Implement the new emergency department IT system by August 2015.

The new IT system was introduced in July 2015. Work is ongoing to ensure that everyone within the Emergency Department is using the system

- Implement the clinical portal across the hospital to support clinical teams accessing patient information by October 2015.

The clinical portal has been deployed for clinical assurance to the heart failure team. This will result in full rollout in 2016/17..

- Review health record documentation used on the wards and introduce standardised forms for admission and discharge by October 2015. The creation of a central corporate clinical documents forms library will also be undertaken as part of this activity.

We incorporated the community element as part of the integrated care organisation. This is in pilot with wards. After the pilot and feedback has been collected and actioned, we will roll out standardised forms across the Trust.

- Integrate the performance reports combining both acute and community information by March 2016.

At board level, the Trust now receives an integrated performance report. It is also shared at senior clinical and management meetings.

- Publish a business intelligence strategy for the newly developed integrated care organisation by October 2015. This will include a review of data quality.

We have established a business intelligence reporting group which is led by the Director of Strategy and Improvement. The group is finalising the business intelligence strategy which will be implemented in the next 12 months.

- Reduce the number of clinical coding errors by acting on the audit recommendations from the clinical coding audit and re-auditing in autumn 2015.

The audit recommendations have been implemented. This has resulted in an overall improvement with a 9.1% improvement in secondary procedures.

- Undertake three data quality audits in 2015/16 reporting provisional findings by April 2016. These data quality audits are reported below.

Internal Audit data quality audits 2015/16**Cancer – 31-day wait for second or subsequent treatment – Drug****Audit conclusion:** Low risk

The Infoflex system monitors the “Cancer – 31-day wait for second or subsequent treatment – Drug” indicator using dates in line with the HSCIC guidance. The data within the Infoflex system was supported by the data held within PAS for all appointment dates and for 95% (38/40 cases) of decision to treat dates. Although data is reported consistently between the different internal and external reports, the figures reported did not match the source data provided as part of the audit for the two months checked. An investigation of this discrepancy is suggested to establish if there was any underlying issue with the data provided.

Audit recommendation:

The Trust should follow up on discrepancies between the source data within Infoflex reports provided as part of the audit and the corresponding figures reported. The cause for the discrepancies should be reviewed to establish if this was just an anomaly or indicative of a bigger issue.

Cancer – 62-day wait for first treatment – from consultant screening service referral**Audit conclusion:** Low risk

The Infoflex system monitors the “Cancer – 62-day wait for first treatment – from consultant screening service referral” indicator in line with the HSCIC guidance. The data used to monitor the indicator within Infoflex, was found to match the source data as recorded within PAS for the majority of cases (44/45 cases). We identified a discrepancy between the treatment start dates recorded within the two systems for a single case. The impact of this was negligible as the referral date within Infoflex was recorded at an earlier date than the referral date within PAS and the use of either date would not have caused a breach. The reporting of this indicator was found to be appropriately and consistently reported between internal and external sources

Audit recommendation:

The Trust should follow up on the single identified discrepancy between the referral received dates as recorded within PAS and Infoflex, make any required changes and identify the cause to establish if this is a one-off case or if it may be indicative of a bigger issue.

Cancelled patients not treated within 28 days of cancellation**Audit conclusion:** Low risk

The data used to populate the performance indicator for “cancelled patients not treated within 28 days of cancellation” is collated accurately and reported correctly and consistently both internally and externally. The process used to collate this data includes some manual steps as there are some data inaccuracies and lack of completeness/clarity within the reason and assigned responsibility fields as recorded within PAS.

Audit recommendations:

The Trust should ensure that the assigned responsibility for cancelled appointments as recorded within PAS is accurately completed. Consideration should be given to applying fixed fields to both assigned responsibility and cancellation reason that are linked. i.e. if the assigned responsibility is recorded as the hospital, then there could be a selection of possible reasons included within a dropdown list.

The Trust should ensure that the reason for cancellation within PAS is completed to a sufficient level of detail.

DATA QUALITY IMPROVEMENTS: LOOKING FORWARD

Torbay and South Devon will be taking the following actions to improve data quality in 2016/17:

- To publish and implement the business intelligence strategy.
- Create a baseline audit of information asset owner data-quality awareness and maturity by quarter two 2017 (repeat every 12 months)
- Create a data vault 'one version of the data' to warehouse the different information which we collect. This will enable us to create many different timely reports to support improvement and change.
- Act on the recommendations of three quality audits undertaken by the external auditor in May 2016 as part of the Trust's annual Quality Account.
 - o Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.
 - o Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.
 - o Percentage of carers assessments completed for all people who received support services in the community (Target 40% and achieved 43%) - Governor indicator.

MANDATED QUALITY INDICATORS

As part of the annual Quality Account the Trust is required to report against a number of mandatory quality indicators. These are described below.

The summary hospital-level mortality Indicator, or SHMI, is a measure of the number of patients that have died in hospital or within 30 days of being discharged from hospital. SHMI takes into account a number of factors including a patient's condition.

The SHMI score is measured against the NHS average which is 1.0. A score below 1.0 denotes a lower than average mortality rate and indicates good, safe care. The SHMI data is published in arrears.

The highest Trust score is 1.17 and the lowest Trust score is 0.65. There is no national average.

The Trust is performing better than the national benchmark. The SHMI calculation for this latest period is based on the new ICO organisation reflected in the increased number of inpatient spells recorded against the latest published data.

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

- Compliance with data standards for this indicator
Torbay and South Devon NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services through:
- Monthly monitoring through the Quality Improvement Group who maintain oversight of mortality and clinical coding exceptions that may be identified from Dr Foster benchmarking.

Domain 1 Preventing people from dying prematurely

Summary hospital level mortality indicator

	October 14 - September 15	October 13 - September 14	October 12 - September 13
SHMI TSD - Benchmark national benchmark 1.00	0.812	0.995	0.925
National High - Low	1.17 - 0.65	1.19 - 0.59	1.18 - 0.63
Band (Band 2 = as expected Band 3 = lower than expected)	3	2	2
Observed deaths	1866	1632	1589
Expected deaths	2298	1640	1716
Spells	45336	38875	38883

Source of information: HSCIC

MANDATED QUALITY INDICATORS

The number of deaths recorded as coded to palliative care within the Trust has remained within normal range and is below the national average. The latest palliative care figures is based on the new ICO organisation. There has been no measurable impact.

The highest Trust score is 53.3% and the lowest Trust score is 0.2%. The national average is 26.6%.

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

- Compliance with data standards for this indicator
Torbay and South Devon NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services through:

- Monthly monitoring through the Quality Improvement Group who maintain oversight of mortality and clinical coding exceptions that may be identified from Dr Foster benchmarking.

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

- Monthly monitoring through the Quality Improvement Group who maintain oversight of mortality and clinical coding exceptions that may be identified from Dr Foster benchmarking.

Palliative care coding (contextual indicator for SHMI)

	October 14 – September 15	October 13 - September 14	October 12 - September 13
Palliative care coding % deaths	18.9	18.6	16.9
England average	26.6	25.4	20.9
High	53.3	49.4	44.9
Low	0.2	7.5	2.7

Source of information: HSCIC

MANDATED QUALITY INDICATORS

Domain 3 helping people to recover from episodes of ill health or injury

PROMS – Patient Reported Outcome measures

	April 14 - March 15	April 13 - March 14	April 12 - March 13
Hip replacement			
Adjusted Health gain score	0.422	0.417	0.437
National average	0.0437		
Highest Trust performance	0.33		
Lowest Trust performance	0.523		
Knee replacement			
Adjusted Health gain score	0.309	0.338	0.329
National average	0.315		
Highest Trust performance	0.418		
Lowest Trust performance	0.204		
Groin Surgery			
Adjusted Health gain score	* Low numbers data not published	0.073	0.083
National average	0.083		
Highest Trust performance	0.148		
Lowest Trust performance	0.02		
Varicose Vein surgery not published			
	* Low numbers - Trust data not published	* Low numbers - Trust data not published	* Low numbers - Trust data not published

Source of information: HSCIC

MANDATED QUALITY INDICATORS

The PROM data is published nationally in arrears. Against the published data the patient reported outcomes for the Trust April 14 – March 15 are all close to the national average. The highest, lowest and national average figures are all shown in the table above.

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

- Information is collected and reported by the Department of Health.

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

- Continuing to support patient participation in the national PROM survey. We maintain regular contact with the contractor conducting the PROMS survey and work with them to ensure participation rates are achieved and maintained.

MANDATED QUALITY INDICATORS

Patients readmitted to a hospital within 28 days of being discharged

	April 14 - March 15	April 13 - March 14	April 12 - March 13
0-15 years old			
% readmissions	6.96%	5.63%	5.37%
Benchmark national benchmark 100	94.38	82.06	78.71
=>16 years old			
% readmissions	7.47%	7.52%	7.98%
Benchmark national benchmark 100	95.17	94.37	97.37

Source of information: Dr Foster

There is no high or low rate for a Trust or an average. The benchmark is 100.

Although the benchmark rate for all age groups remains better than the national average, the 0-15 age group has seen an increase in the percentage of patients readmitted within 28 days. This is in part as a result in the setting up of the paediatric short stay assessment unit where there is an increased likelihood of admission. This has led to an overall increase in paediatric admissions and a small number of readmissions.

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

- Compliance with national data standards.

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

- Ensuring clinical discharge and admission thresholds are maintained.
- Ensuring safe staffing levels.

MANDATED QUALITY INDICATORS

Domain 4 Ensuring people have a positive experience of care

Overall patient experience

• Inpatient survey

Between September 2014 and January 2015, a questionnaire was sent to 850 recent inpatients. The survey was published in December 2015 and overall performance is shown on this page.

There is no comparator with previous years as this is the first inpatient survey as an integrated care organisation. There is no worst or best performing trust or a national average

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

- o Information is reported nationally and to the Trust Board.

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

- o Learning from feedback received and action changes
- o Using real time feedback to augment the national inpatient survey

We also received the results of two other national health care surveys:

• Maternity survey

During the summer of 2015 a questionnaire was sent to all women who gave birth in February 2015. The survey was published in December 2015 and overall performance is shown below

• Children & young people

A questionnaire was sent to all children and young people who received inpatient or day case care during July, August and September 2014. The survey was published in summer 2015. The overall performance is shown below. Only one area has been identified as needing improvement and this was privacy.

Inpatient survey	Patient experience	Compared with other trusts
Overall view of inpatient services (for feeling that overall they have a good experience)	8.2/10	About the same

Source of information: CQC

Maternity survey	Patient experience	Compared with other trusts
Labour & birth	9.2/10	About the same
Staff during labour & birth	8.7/10	About the same
Care in hospital after birth	7.7/10	About the same

Source of information: CQC

Children & young people survey	Patient experience	Compared with other trusts
Overall experience (children saying overall experience is good)	8.0/10	About the same
Overall experience (Parents and carers saying their child's overall patient experience was good)	8.4/10	About the same

Source of information: CQC

MANDATED QUALITY INDICATORS

Staff survey: staff recommendation of the Trust as a place to work or receive treatment

Staff survey – unweighted results	2015
Torbay and South Devon NHS Foundation Trust	3.91
England average score	3.72

Scoring scale

1= strongly disagree
5= strongly agree

Source of information: CQC

There is no Trust comparison for previous years as this data is for the new integrated care organisation. In 2015/16 the national average for acute Trusts is 3.72. The best score for all Trusts is 4.26. The lowest performing Trust is 3.02.

The Trust is performing better than the average England score.

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

- Information is reported nationally and to the Trust Board.

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

- Detailed action plan developed for areas of improvement

MANDATED QUALITY INDICATORS

Staff survey: % of staff believing that the Trust provides equal opportunities for career progression & promotion

Staff survey – unweighted results	2015
Torbay and South Devon NHS Foundation Trust	88%
England average score	86%

Source of information: CQC

In 2015/16 the national average for acute Trusts is 86%. The highest score for all Trusts is 95%. The lowest performing Trust is 60%. There is no Trust comparison for previous years as this data is for the new integrated care organisation.

The Trust score is 88% in 2015 and the survey was undertaken as the integrated care organisation. There is no comparative data therefore for previous years.

The Trust is performing better than the average England score.

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

- Information is reported nationally and to the Trust Board.

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

- Detailed action plan developed for areas of improvement.

MANDATED QUALITY INDICATORS

Staff survey: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Staff survey – unweighted results	2015	2014
Torbay and South Devon NHS Foundation Trust	24%	n/a
England average score	25%	

Source of information: CQC

In 2015/16 the national average for all Trusts was 25%. The best score for all Trusts was 13%. There lowest performing Trust was 42%.The Trust score was 24% in 2015. This is the score from the newly integrated care organisation. There is no comparative data therefore for previous years

The Trust is performing better than the average England score.

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

- Information is reported nationally and to the Trust Board.

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

- Detailed action plan developed for areas of improvement.

MANDATED QUALITY INDICATORS

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients admitted to hospital who were risk assessed for venous thromboembolism

	Q3 2015-16	Q4 2014-15	Q4 - 2013-14
% VTE assessed UNIFY return	96%	87%	94%
National standard	95%	95%	95%
Highest performing	100%		
Lowest performing	61.50%		

Source of information: HSCIC

The Trust is achieving the required the standard for the assessment of VTE on admission to hospital.

The highest performing Trust is 100% and the lowest performing Trust is 61.5%. The national standard is 95%.

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

- Information is reported nationally and to the Trust Board.

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

- Local case note audits have supported improved reporting.
- Data quality checks have allowed further case note audits to be undertaken to ensure that the discharge summaries are updated for reporting purposes.

MANDATED QUALITY INDICATORS

Rate of C. difficile infection

C.difficile rate per 100,000 bed days – 2yrs and over	April 14 - March 15	April 13 - March 14	April 12 - March 13	April 11 - March 12
South Devon Healthcare NHS Foundation Trust	17.7	12.6	16.9	19.9
Nationally set target for the trust	15.1	14.7	17.4	22.2
Best performing	2.6	1.2	1.2	1.2
Worst performing	62.2	37.1	31.2	58.2

Source of information: HSCIC. Data is published in arrears-no 15/16 data yet available via the HSCIC portal

In 2014/15 the C.difficile rate per 100,000 bed days increased to 17.7 from 12.6 the previous year and exceeded the overall national rate. The national rate also increased in for the first time after a period of steady reduction year on year.

The best performing trust was 2.6 and the worst performing trust as 62.2. The national average is 15.1.

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

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

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

- Each of these cases undergoes a root cause analysis and is classified as either a 'lapse in care' or 'no a lapse in care'. The root cause analysis where a lapse in care is identified is used to inform the infection control group for onward action.

MANDATED QUALITY INDICATORS

Number of patients safety incidents recorded

	April 15 - March 16	April 14 - March 15	April 13 - March 14	April 12 - March 13
Number of incidents reported	6979	5546	5188	4506

Source of information: safeguard/datex

The number of incidents reported over the last 12 months has increased as we included the community and acute incidents together from October 2015.

From April 2012 to March 2015 this is Torbay Hospital information only.

There is no highest or lowest performing trust or national average.

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

- Information is recorded on trust incident reporting systems.

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

- Continue to positively promote incident reporting within the Trust to all staff.

MANDATED QUALITY INDICATORS

Number and % of patient safety incidents that have resulted in severe harm or death

	October 14 March 15	April 14 -Sept 14	October 13 - March 14	April 13 - September 13
Number of incidents severe harm or death	7	1	3	4
Rate per 100,000 population	0.11	0.02	0.01	0.16
% of all incidents	0.24%	0.05%	0.16%	0.16%

Source of information: HSCIC

Nationally, published data has been released to March 2015 and shows pre integrated care organisation incidents and rates. The information shown is for Torbay Hospital only.

For the period Oct 14 - March 15 the highest performing acute (non-specialist) trust for incidents resulting in severe harm or death was 2.93 and the lowest was 0.0. The average was 0.28.

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

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

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

- The Trust continuing to work with all teams to ensure all incidents are reported accurately and in a timely way and that all national reporting requirements are complied with.
- All incidents of 'major' and 'catastrophic' harm are formally reviewed with action plans monitored through the serious adverse events group.

OUR PERFORMANCE IN 2015/16

PATIENT SAFETY

CLINICAL EFFECTIVENESS

PATIENT EXPERIENCE



OVERVIEW

Torbay and South Devon NHS Foundation Trust was formed in October 2015 as a result of the acquisition of Torbay and South Devon Health & Care Trust by South Devon Healthcare NHS Foundation Trust. The new integrated care organisation 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 across Torbay and South Devon. Currently, we are accountable to:

- Monitor, our regulator.
- The Care Quality Commission (CQC).
- The commissioners via the various health contracts.
- The Local Authorities for social care.
- 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.

Performance reports are provided monthly to the Finance Committee and the Board. These reports cover all the key national and local performance standards to provide assurance to the Board about the quality of our care. From October 2015 we now include a range of community and social care indicators such as timeliness of adult social care placements and children with a child protection plan.

We have established four service delivery units covering medicine, surgery, community and women, children, diagnostics and therapies. Each of these units meet with the executive team on a two monthly basis to review their quality and performance dashboards. Areas for improvement are identified and issues escalated to the Board where necessary.

We meet with commissioners to share information, provide updates and to review our performance monthly. Our regulator 'Monitor' requires a quarterly performance assessment against the performance standards set out in their risk assessment framework. This is published on the internet for the public to view.

Monitor rating at a glance for the trust

Financial sustainability risk rating 2



Governance rating Green

Source: Monitor website 13/4/16

Ratings key:

Financial 1-4 . 1= most serious risk

OVERVIEW OF THE QUALITY OF CARE BASED ON TRUST PERFORMANCE

With the integration and the creation of a new care organisation, the Trust is required to report against an additional community indicator on data completeness.

Currently compliance against this standard is not being reported as the information systems required to provide the assurance are not in place.

Performance against Monitor's requirements

Indicator/Target	Quality Indicator	Source of information	Target 2015/16	2015/16	2014/15	2013/14
C.difficile year on year reduction	Safety	Trust Infection Control team	11	10**	4**	17
Cancer 31 day wait from diagnosis to first treatment	Effectiveness	Monthly National Cancer Return	96%	98%	98%	98%
Cancer 31 day wait for second or subsequent treatment: surgery	Effectiveness	Monthly National Cancer Return	94%	94.7%	97%	98%
Cancer 31 day wait for second or subsequent treatment: drug treatments	Effectiveness	Monthly National Cancer Return	98%	100%	100%	99%
Cancer 31 day wait for second or subsequent treatment: radiotherapy	Effectiveness	Monthly National Cancer Return	94%	96.3%	98%	97%
Cancer 62 day wait for first treatment (from urgent GP referral)	Effectiveness	Monthly National Cancer Return	85%	89.6%	89%	90%
Cancer 62 day wait for first treatment (From consultant led screening service referral)	Effectiveness	Monthly National Cancer Return	90%	96.9%	93%	97%
Cancer two week wait from referral to first seen date	Effectiveness	Monthly National Cancer Return	93%	96.3%	96%	95%
Cancer breast symptoms two week wait from referral to first seen date	Effectiveness	Monthly National Cancer Return	93%	97.4%	95%	96%
A&E – total time in A&E	Experience	Symphony	95%	87%	87%	96%
Referral to treatment incomplete pathways	Experience	IHCS	92%	91.6%	93%	96%
Data completeness: community services	Effectiveness	n/a	50%	Not reported		

** c-diff - Only cases confirmed as lapse in care count towards target (New measure 2014/15). Figures from 13-14 to 14-15 are South Devon Healthcare NHS Foundation Trust figures prior to integration

OVERVIEW OF THE QUALITY OF CARE BASED ON TRUST PERFORMANCE

Performance exceptions in 2015/16

In 2015/16 the Trust has reported underperformance against the following monitor risk assessment framework indicators:

1. Four hour standard from Emergency Department arrival to admission or discharge in 15-16 was 87%.
2. Referral to Treatment (RTT) incomplete pathways. The target is for 92% or more of patients waiting for treatment to be waiting less than 18 weeks from referral.
3. Data completeness: community services. Currently this is not reported.

Total time in Emergency Department as measured against the four hour standard

The four hour standard has remained a challenge throughout the year with timely access to hospital beds being the most significant problem.

A number of initiatives are being introduced to streamline assessment processes to ensure patients can be seen by a senior doctor and vital signs are taken promptly by the clinical team. Work has been ongoing to improve discharge processes and a new IT system has been introduced in summer 2015 to improve the quality of clinical and management information recorded.

The improvement work is being led by the Chief Operating Officer to increase capacity and improve the flow of patients through all our hospital beds. The aim is to achieve the national standard of 95% for October 2016.

Referral to treatment times for RTT incomplete pathways.

Waiting list for treatment in ophthalmology, upper gastroenterology and orthopaedics have been the main challenges. Action plans to manage both the demand and capacity for cataract procedures including use of outsourcing has resulted in some rapid improvement. In relation to orthopaedics and gastroenterology we have arranged for patients to be treated by the independent sector. Additional staff have been recruited in orthopaedics and a business case is being developed to support surgery. This will increase capacity to meet the RTT standard in upper gastroenterology. This work is being led by the chief operating officer with regular meetings with operational teams.

Mandated quality indicators

These are reported in part 2 of the Quality Account.

OVERVIEW OF THE QUALITY OF CARE BASED ON TRUST PERFORMANCE

NHS Operating Framework and local priorities

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

Other National and local priorities	Quality Indicator	Source of information	Target 2015/16	2015/16	2014/15	2013/14
Smoking during pregnancy	Effectiveness	STORK	19%	15.6%	16%	17%
Mixed sex accommodation breaches of standard	Experience	Trust Clinical Effectiveness Team	0	4	3	12
Cancelled operations on the day of surgery	Effectiveness	IHCS	0.8%	1.0%	1.2%	1.1%
DNA rate	Effectiveness	IHCS	6.0%	5.6%	5.6%	5.9
Diagnostic tests longer than the 6 week standard	Effectiveness	DMO	1.0%	1.9%	1.3%	0.6%
Stroke care: 90% of time spent on stroke ward	Effectiveness	SSNAP	80%	80%	64%	79%
Timeliness of social care assessment*	Effectiveness	PARIS	74%	69%	n/a	n/a
No of children with child protection plan*	Safety	PARIS	157	147	n/a	n/a
Safeguarding adults % case conferences (30 days)*	Safety	PARIS	80%	65%	n/a	n/a

*Indicators reported since we have become an integrated care organisation

OVERVIEW OF THE QUALITY OF CARE BASED ON TRUST PERFORMANCE

In 2015/16 we have underperformed on a number of indicators.

Actions taken:

- **Mixed sex accommodation.**
We continue to monitor all incidents to minimise the number of breaches.
- **Cancelled operations on day of surgery.**
We undertake monthly reviews of the reasons for cancellation. Beds being unavailable are the main reason for cancellations. We are working on improving access to beds through our patient flow work, including increasing the number of discharges earlier in the day.
- **Diagnostic tests longer than 6 weeks.**
The Trust is outsourcing CT & ultrasound test to the independent sector and staff are working additional sessions to meet the demand.
- **Stroke care.**
Stroke care will continue to be an area of focus for us and this is the reason it is a Quality Account priority.
- **Timeliness of social care assessment.**
There have been a number of social care vacancies and the Trust is in the process of recruiting to these vacancies. This is set against a backdrop of increasing referrals and more complex cases

- **Safeguarding adults.**

This improvement work is being led by the Safeguarding Adult's Board with an action plan to address a wide range of issues including client engagement and availability of statutory services e.g. police.

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

The creation of the integrated care organisation in October 2015 is enabling the redistribution of resources in a way that optimises patient care in non-hospital settings and ensures all patients receive safe and timely care. These plans will be further developed and implemented in 2016/17. We will report our progress on our internet site www.torbayandsouthdevon.nhs.uk as well as in our annual report and Quality Account.



ANNEX 1

ENGAGEMENT IN DEVELOPING THE QUALITY ACCOUNT

PATIENT SAFETY

CLINICAL EFFECTIVENESS

PATIENT EXPERIENCE

ANNEX 1 – ENGAGEMENT IN DEVELOPING THE QUALITY ACCOUNT

Prior to the publication of the 2015/16 Quality Account we have shared this document with:

- Our Trust governors, commissioners and Board
- Healthwatch.
- Torbay Council Health Scrutiny Board.
- Devon County Council’s Health and Wellbeing Scrutiny Committee.
- Trust staff.
- Carers Group.

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

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

In 2016/17 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.

STATEMENTS FROM HEALTHWATCH, COMMISSIONERS, OSCS AND GOVERNORS

STATEMENT FROM HEALTHWATCH (TORBAY) ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16

Healthwatch Torbay continuously collects feedback about the delivery of our local health and social care services. This is done through a programme of direct contact with the public, telephone and drop in to the Healthwatch office in Paignton library. On-line comment is possible at any time by using our Rate and Review service. With over 300 reviews about the Trust in the last year, it is pleasing to report that the overall star rating has remained high showing public confidence in their hospital service. Staff attitude has many appreciative comments, confirming this to be one of the most important aspects of the care received. Experience of the discharge process and medication information has the most negative comments.

Healthwatch Torbay is encouraged to share their intelligence of local patient and public experience through membership of various engagement committees and regular review meetings with the Trust Chief Executive. There is good communication with the Patient Advice and Liaison service with constructive progress reports for the concerns we refer.

As stakeholders and representative of the public, we were able to share our opinion of the proposed priorities for improvement in the coming year. Although the detail of the approach is decided internally, the way forward is supported by Healthwatch as it reflects the concerns we know to be important to the public. Initiatives around improving communication, recognising the issues faced by older people and driving up the quality of complaints handling are all commended.

The reflection on improvement priorities for the last year 2015/16 gives an honest appraisal. We would agree that all are not quick fixes. The extensive public engagement on future ways of working is probably the most detailed that has ever taken place. Seemingly small things make a big difference as shown by the feedback on shortening the time to generate a death certificate.

The transition to an Integrated Care Organisation seems to have been seamless in that the public has made little comment to Healthwatch about this seismic change in the organisation of care. But they do raise concerns about the standards and organisation of care at home following a transfer from a hospital. There are reports that information is lacking and cases of low regard for the person's real need, when not a standard "package". The Quality Account shows that these concerns are not being ignored. There is still a long way to go, but recognising that the person at the centre of care can work in partnership with the Trust to improve their experience, is a significant step in the right direction.

Thank you for making this Quality Account a very readable document for the general public. As Healthwatch we look forward to our future work together.

ANNEX 1 – ENGAGEMENT IN DEVELOPING THE QUALITY ACCOUNT

STATEMENT FROM HEALTHWATCH (DEVON) ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16

Healthwatch Devon commends the Trust for arranging a stakeholder engagement event earlier in the year and for involving us in the development of their priorities for this year's quality account. We attended the event and felt it to be a very useful session in which we could recommend which priority areas should be considered going forward, based on the evidence we hold in relation to patient experiences.

We are pleased to see that complaints handling, investigations and organisational learning is one of the chosen areas that the Trust intends to focus on this year, particularly as this is a topic that we are due to publish a report on, entitled Patients in the Picture. We hope that our report will help to inform any work that the Trust undertakes in this area of service delivery.

The Trust invited us to review this document prior to publication and to provide a statement, but unfortunately due to time restraints and limited capacity we were unable to fully review the document in order to provide an effective response. We do however welcome any opportunity to work with the Trust on this year's priority areas and will continue to feedback patient experience data to them on a regular basis.

STATEMENTS FROM HEALTHWATCH, COMMISSIONERS, OSCS AND GOVERNORS

STATEMENT FROM SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16

South Devon and Torbay Clinical Commissioning Group (SDT CCG) is lead commissioner for Torbay and South Devon Healthcare NHS Foundation Trust (TSDFT) and is pleased to provide our commentary on the Trust's Quality Account for 2015-17.

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

We are pleased to comment on the Trusts first quality accounts as an integrated care organisation following the joining of services delivered by South Devon Healthcare NHS Foundation Trust (Torbay Hospital) and Torbay and Southern Devon Health and Care NHS Foundation Trust who delivered community services. As a CCG we have worked alongside the Trust during their amalgamation, and in the development of the new care model to deliver secure sustainable and effective high quality care to our increasingly complex population.

We note the reference to the Care Quality Commission (CQC) visit in February, and acknowledge the work that has been undertaken in the Emergency Department (ED) to try and reduce overcrowding and facilitate patient flow throughout the hospital and beyond. We are aware that the issue of increasing demand for urgent care may mean

that people are waiting longer than they should in ED, which is not conducive to a good patient experience, and we look forward to continuing to work with the Trust to improve this.

The Quality Account refers to the CQUINs for 15_16. The Trust were part of an initiative to deliver local CQUINs very differently with providers across the health and care footprint for SDT CCG to improve patient and staff experience, improve nutrition and hydration and improve incident investigation through collaborative working.

We would like to particularly commend the Trust for the work they have undertaken with the 'Hello My Name' is campaign, part of a national campaign led by Dr Kate Granger, who as a patient noted that the things that made a positive experience for her were the simple things, such as staff introducing themselves to her.

Looking Back

We were pleased to support the quality priorities selected by the Trust last year in particular the patient safety priority of redesigning the reliability, accuracy and timeliness of information at the point of handover to enable an effective and safe transfer at each and every juncture. We know from hearing from patients, and being patients, that it is at the point of transfer of care that often information isn't shared with the right people, or there is miscommunication about a plan of care.

We look forward to hearing how the IT system Nerve Centre will continue to improve transfers of care, and ask the Trust that they continue to ask patients and carers what should 'always' happen for them.

Healthcare is complex and rarely uni-professional. Improving multi-disciplinary working can only benefit both the patient and staff experience. We support the Trust in the move away from reactive bed based care to preventative and proactive services, and will work alongside the Trust, and with our population through public engagement to develop the new care model. We agree that for all 'the best bed is our own bed' however this has to be achieved with patient safety a priority.

We are delighted that this report highlights the introduction of the wellbeing co-ordinators- a new role designed to support people to identify ways to support their whole wellbeing, not just their health and care needs. We are pleased to recognise the organisations invaluable contribution and commitment to the development of joint approaches to prevention, wellbeing and self-care at system level.

In order to ensure success we have to be able to evaluate the impact of service changes, and we are pleased to see that the Trust will work with Plymouth University to evaluate both the quantitative and qualitative data, of which patient experience plays a vital part.

CONTINUED

ANNEX 1 – ENGAGEMENT IN DEVELOPING THE QUALITY ACCOUNT

STATEMENT FROM SOUTH DEVON AND TORBAY CLINICAL COMMISSIONING GROUP ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16 CONTINUED

Looking Forward

We are happy to support the five quality improvement priorities that the Trust has developed through discussions with health and care teams working within the newly established integrated care organisation, and with the CCG.

The desire to improve the consistency and learning from complaint investigations and associated systems for organisational learning across TSDFT is very welcomed. It is by learning from patient experience, and sharing that learning that we can ensure quality improvement in service delivery, and, as most complainants desire, reduce the risk of this happening to anyone else.

The development of the two existing early warning trigger tools into one tool to be used across any health and care setting supported by the integrated care organisation, ensuring quality of care for patients is not compromised will be reviewed with interest by the CCG Quality team.

The Trust has not achieved against the four hour wait target for patients in the Emergency Department leading to a poor patient experience, and we are in no doubt that this is one of the priority areas for the Trust next year. We know that at times of greatest pressure, the clinical risk associated with patients not being seen in a timely manner by the right clinician increases. We have a

particular interest in the sepsis work that the Trust are doing, and have worked closely with the Trust to improve sepsis awareness, recognition and treatment across both adults and children. 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 is fully supportive of this initiative.

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. TSDFT 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 work that has been undertaken to reduce falls and pressure ulcers across the Trust, and are pleased to see the reduction that they have achieved in both the number of falls and the severity of falls. We agree that this needs to stay a priority area for 16_17.

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 TSDFT 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 TSDFT for its continuous focus on quality of care.

STATEMENTS FROM HEALTHWATCH, COMMISSIONERS, OSCS AND GOVERNORS

STATEMENT FROM TORBAY COUNCIL'S HEALTH OVERVIEW AND SCRUTINY BOARD ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16

Members of Torbay Council's Overview and Scrutiny Board have considered the draft Quality Account 2015/2016 for Torbay and South Devon NHS Foundation Trust.

The creation of the Trust as an integrated care organisation for Torbay and South Devon is welcomed. Board members are encouraged by the information provided on the work around multi-agency working and establishing a single point of contact. The Trust and partner agencies must continue to work together to build on the successes we have seen over the years brought about by integrating health and social care.

The Board recognise the challenges that the Trust faces in providing timely urgent care services and notes the actions which have been put in place over the past year and the plans for the coming year. The Board would urge the Trust to continue to work with South Western Ambulance Service NHS Foundation Trust to ensure that best practice and innovations across both organisations lead to better patient outcomes and experience.

The Board commends Torbay and South Devon 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 and partner organisations continue to work together for the benefit of the whole Torbay community.

ANNEX 1 – ENGAGEMENT IN DEVELOPING THE QUALITY ACCOUNT

STATEMENT FROM DEVON COUNTY COUNCIL'S HEALTH AND WELLBEING SCRUTINY COMMITTEE ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16

Devon County Council's Health and Wellbeing Scrutiny Committee has been invited to comment on the Torbay and Southern Devon Healthcare Trust Quality Account 2015/16. All references in this commentary relate to the reporting period 1st April 2015 to 31st March 2016 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account 2015-16 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge. The trust presented to the Committee in September 2015 regarding their achievement of Foundation Trust status.

The Committee looks forward to seeing the progress made towards a joined-up care system.

The Committee welcomes a continued positive working relationship with the trust in 2016/17 and beyond to continue to ensure the best possible outcomes for the people of Devon.

STATEMENTS FROM HEALTHWATCH, COMMISSIONERS, OSCS AND GOVERNORS

STATEMENT FROM GOVERNORS ON TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST'S QUALITY ACCOUNT 2015/16

The year 2015/2016 has been an exciting and challenging period with a number of key developments.

Firstly, the Council of Governor's formally approved the formation of the new integrated care organisation, Torbay and South Devon NHS Foundation Trust which was established in October 2015.

A detailed review was undertaken of organisational structures and processes to reflect the organisation's wider responsibilities and services.

The governor observer role continues, as members of both statutory and strategic committees. This is central to ensuring governor's engagement with the safety and quality agenda and in providing assurance on the quality of services provided within the Trust.

Governor's continued to review the actions of committees against the CQC (KLOE) outcomes and provides formal feedback to the Quality and Compliance Committee.

This ensures matters related to non-compliance including NED performance is highlighted to the chairman and the lead governor for inclusion in the annual appraisal of NED's which is jointly undertaken.

The buddying system whereby each member of the governor's Nomination Committee is partnered to a NED continues, with the lead governor continuing as the principle functional link with the NEDs.

Secondly the Trust was inspected by the Care Quality Commission in February of 2016. The Trust, is still awaiting the final report, but inspectors were able to witness the key challenges facing the organisation. Following the initial feedback an action plan has been developed to support changes that they recommended.

Two particular challenges for the Trust during the year has been the failure to achieve the accident and emergency (A&E) four-hour target and 18-weeks in aggregate referral to treatment (RTT) time for incomplete pathways. Governors are pleased that the Trust continues to perform well against all cancer targets with compliance being maintained throughout the year.

With regard to the annual quality account, representatives of the Council of Governors have again participated as stakeholders in the annual process for agreeing Trust priorities. The governors support the objectives for 2016/17.

As part of the Independent Auditor's Limited Assurance Report on the Annual Quality Report to the Council of Governors, the Trust's external auditors have reviewed several performance indicators. The governors have selected as part of the quality account the completion of the Carer's assessment data quality indicator for review by the external auditors.

The governors are again able to confirm that they continue to receive assurance of the Trust's commitment to, the provision of safe high quality responsive health and social care. We recognise and support the key challenges facing the Trust in delivering new models of care within a very tight financial framework and look forward to continuing to be active participant's working together in the future.

ANNEX 2

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

PATIENT SAFETY

CLINICAL EFFECTIVENESS

PATIENT EXPERIENCE

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 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:

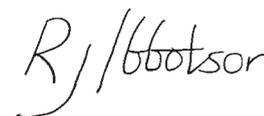
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015-16; and supporting guidance
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2015 to May 2016
 - Papers relating to quality reported to the Board over the period April 2015 to June 2016
 - Feedback from the Commissioners (South Devon and Torbay CCG) dated 23th May 2016
 - Feedback from Governors dated 19th May 2016
 - Feedback from OSCs dated 18th may and 23rd May 2016
 - Feedback from local Healthwatch organisations dated 18th and 23rd May 2016

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated February 2016
- The 2015 national inpatient survey dated 21st May 2015
- The 2015 national staff survey dated March 2016
- The Head of Internal Audit annual opinion over the Trust's control environment dated 25 May 2016
- Care Quality Commission intelligence monitoring reports dated May 2015
- 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



Sir Richard Ibbotson, Chair

Date 25.05.16



Mairead McAlinden Chief Executive

Date 25.05.16

ANNEX 3

CQUIN 2015/16

PATIENT SAFETY

CLINICAL EFFECTIVENESS

PATIENT EXPERIENCE

CQUIN 2015/16

Indicator Number	Indicator Name	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1.1	Acute kidney injury - improvement in recording diagnosis, treatment & plan of care after dischargePart met		Part met		Part met
2.1	Sepsis - sepsis screening & antibiotic administration			Part met	Part met
3.1	Dementia -Find, Assess, Investigate and Refer - target 90% Find & Assess	<60%	80%	75%	<50%
3.2	Dementia - staff training				
3.3	Dementia & carers				
4.1	Unplanned emergency care- reducing the proportion of avoidable emergency admissions to hospital				
4.2	Unplanned emergency care - Improving Diagnoses and Re-attendance Rates of Patients with Mental Health Needs at A&Eof Patients with Mental Health Needs at A&E				
5.1	Improving nutrition & hydration				
6.1	Improving incident investigation				
7.1	Improving patient experience			Part met	
8.1	Improving staff experience				

Available in large print on request

Torbay and South Devon 
NHS Foundation Trust

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