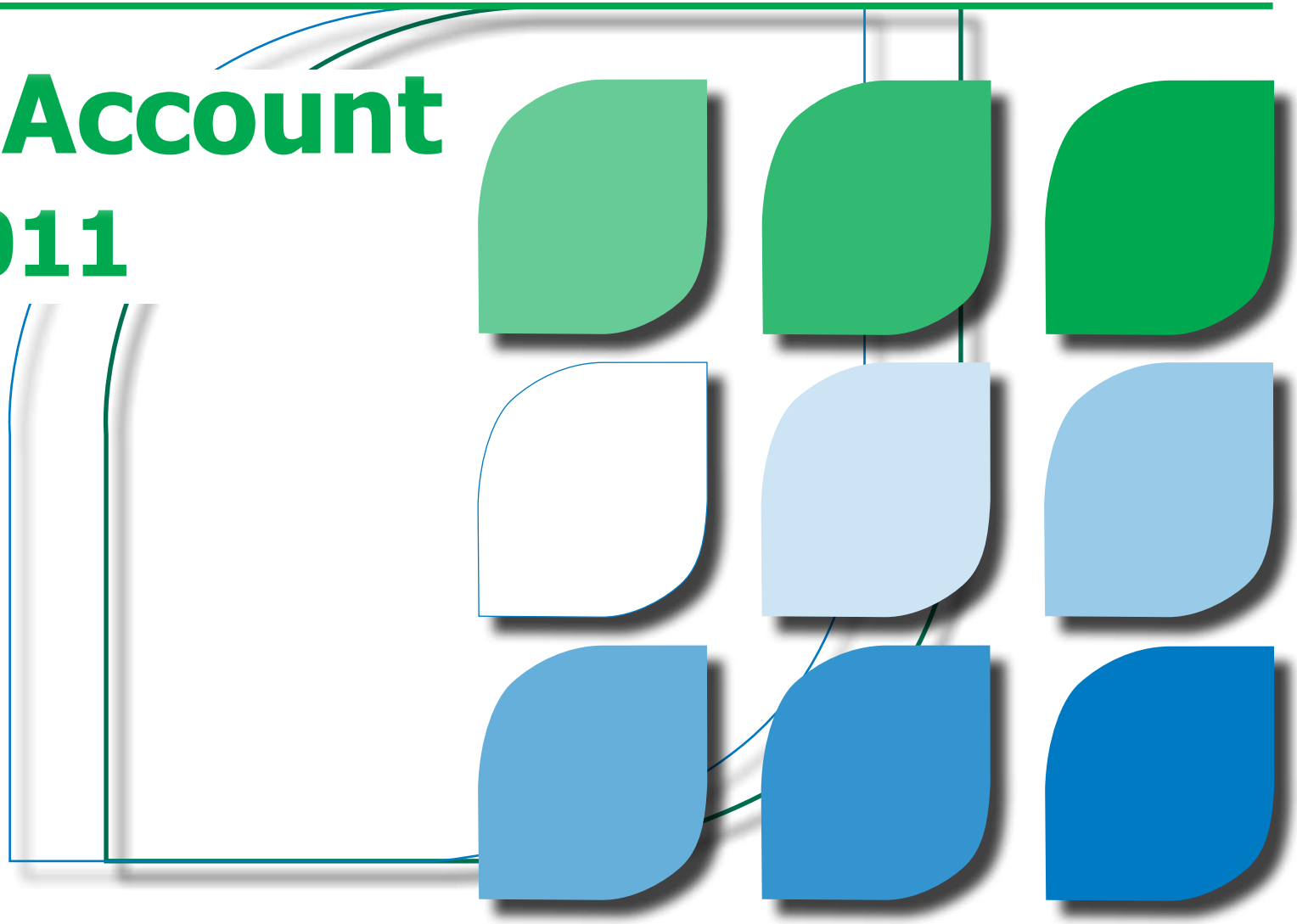
Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

Quality Account
2010 - 2011



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Presented to Parliament as part of the 'Annual Report and Accounts 2010-11' pursuant to the National Health Service (Quality Accounts) Regulations 2010 and Schedule 7, paragraph 25(4) of the National Health Service Act 2006

Introduction

Northern Devon Healthcare NHS Trust provides healthcare services to local residents and the thousands of visitors that the area receives every summer.

Until 31 March 2011, the Trust was responsible for the management of, and services provided from, the following bases:

- Barnstaple Health Centre
- Bideford Community Hospital
- Holsworthy Community Hospital
- Lynton Resource Centre
- North Devon District Hospital, Barnstaple
- South Molton Community Hospital
- Torrington Community Hospital
- Tyrrell Community Hospital, Ilfracombe

In April 2011, the Trust also took over responsibility from Devon Provider Services for community services across Exeter, East and Mid Devon, under the Government's Transforming Community Services (TCS) scheme. Since April 2011, the Trust has provided services to more than half of Devon's residents (484,000) across an area greater than half of the county (1,300 square miles).

This Quality Account is split into three sections. Part one introduces the Trust and explains changes since last year. Part two sets out priorities for 2011/12 and the reasons why our staff and stakeholders felt there were areas that needed improvement. Part three looks back at our progress against last year's Quality Account's priorities.

Trust at a glance

- Staff working in acute services

1,630

- Staff working in community

1,770

- Acute beds

341 at North Devon District Hospital

- Community beds

303 across 17 community hospitals

- 14 complex care teams

Because the community services in Exeter, East and Mid Devon were not part of the Trust last year, their performance last year is not addressed. However, the priorities for this year cover the whole Trust.

For more information, visit our website at www.northdevonhealth.nhs.uk/

Part 1- Statement on quality from the Chief Executive and Chair

For most people, quality in the NHS means providing friendly and proficient care, in clean environments. We know from speaking to patients and listening to their feedback that they greatly value our services and generally report positively about their experiences.

This is the second Quality Account produced by the Northern Devon Healthcare NHS Trust, and we welcome the opportunity to reflect on and share with you the progress we made in improving the care provided to our patients last year. The Trust is firmly committed to improving patient care, patient experience and clinical outcomes, and sees the Quality Account as one of the ways to help us achieve this goal.

Last year our staff worked very hard to improve services, some of which is outlined in part three of this report. In addition, we achieved nearly all the NHS key performance targets and have been particularly pleased with the national recognition we received for the quality of our services for stroke, orthopaedics and general surgery.

We have also invested significantly in new equipment and improving our buildings to provide modern healthcare.

The Trust made great progress in preventing and controlling healthcare-acquired infections last year, exceeding expectations despite significant pressures on services over winter. The only downside was three unexpected cases of MRSA against a limit of one. With regard to Clostridium difficile infection, by the end of 2010/11 we had recorded just 27 cases, eight under our set limit of 35.

The Trust continues to have one of the strongest safety reporting cultures in the country. Compared to other organisations of a similar size, this Trust comes out top for reporting its incidents, in terms of both the speed (within 30 days) and the number. The National Patient Safety Agency, which compiles data on all Trusts, recognises and commends us as a learning organisation that makes every effort to reduce harm to patients and to improve the quality and safety of care.

As part of our work to echo the national commitment to patients, 'No decision about me, without me', the Trust last year set up an Involving People Steering Group to make sure patients' voices are always heard and acted upon, as we develop proposals for improving services.

Where performance is not as strong as we would like, we have explained what actions we will be taking to improve that performance over time. We feel that our chosen priorities for this year reflect the specific healthcare needs of our local population and we will do all we can to meet expectations. Our other quality priorities for improvement are based on enhancing patient safety, and link initiatives under the Commissioning for Quality and Innovation (CQUIN) scheme.

These are just a few examples of the work that went on last year. We are proud of the fact that the Trust and all its staff have taken the quality agenda to heart. This Quality Account reflects our ambition and determination to challenge ourselves and to deliver real improvements in the quality of care for our patients.

This Quality Account has been developed by our staff and in consultation with local partners including LINk (Local Involvement Network) and our commissioners, NHS Devon. We hope you will find it interesting.

The data contained within this Quality Account is, to the best of our knowledge, accurate.

Jacqueline Kelly
Chief Executive

Roger French
Chair

June 2011

Our vision and values

Our values underpin our high expectations for service delivery. We are a people-centred service and aim to make our patients, their families and visitors, as well as our own staff, feel important in everything we do.

Our vision

Our Trust will deliver safe and effective healthcare to the local population through a partnership with staff, patients, the public and other organisations.

Our values

Integrity	We will act with integrity and openness
Diversity	We will treat others fairly and equally and value diversity
Compassion	We will demonstrate care and compassion
Support	We will listen and support others and make time to do so
Excellence	We will strive for excellence in all that we do

Our corporate objectives for 2011-15 are currently being reviewed/revised with staff and stakeholders, but we know they will centre on providing high-quality, safe care for patients, continuing the development of local services by working in clinical networks with neighbouring Trusts, and creating an integrated care organisation capable of achieving Foundation Trust status by 2012.

Part 2: Priorities for improvement 2011/12

We use 'quality indicators' to tell us whether we have made improvements to a service. These indicators can be based on data, reports, complaints and feedback on a range of issues. We can build a good picture of the quality of our services from looking at data such as the number of patients acquiring an infection in hospital, the length of time people stay in hospital and complaints about a particular service or the number of cancelled operations. We then know where to focus our efforts to improve the quality of service received by patients.

As outlined in part three of this report, we made great progress in improving quality last year through a comprehensive programme of quality and patient safety projects. However, we recognise that there are some areas in which we can do better.

We have identified these by looking at each of the quality indicators, drawing up a long-list of potential improvement projects, and ensuring that we focus on priorities which reflect the views and needs of our local population. Our staff, patients, the public and other stakeholders were all consulted.

This year, we will therefore focus on the following priorities to improve quality across the Trust, including our new community services in Exeter, East and Mid Devon:

Priority 1: Nutritional assessment and care planning
Making sure patients get the right food and drink

Priority 2: Reducing pressure ulcers acquired in hospital
No avoidable skin damage while patients are in our care

Priority 3: Reducing falls that occur in hospital
Making sure we keep patients safe from falls in hospital

Priority 4: Improving continence care
Ensuring good care for patients who have bladder or bowel problems

Priority 5: Improving the standard of record-keeping
Making sure our staff keep better notes about the care they give to patients

Priority 6: Safeguarding
Looking after vulnerable people and keeping them safe

Priority 7: Fewer moves between wards
Looking after our patients on the right ward

Priority 8: Improving care for patients with dementia
Looking after our confused patients and the people who care for them

Priority 9: Feedback
'You said … we did'

Some of these priorities are also represented in the contract with our commissioners, NHS Devon under the Commissioning for Quality and Innovation Scheme.

Responsibility for ensuring the actions outlined in this report are achieved lies with the Quality and Patient Safety Improvement Programme, which is in turn accountable to the Board.

The following pages set out the steps that we propose to take to achieve the priorities during 2011/12.

Making sure patients get the right food and drink

FOOD

Priority 1. Nutritional assessment and care planning

1.1 What is the issue?

Estimates put the cost of malnutrition in the UK (NHS and Social Care) at over £13 billion, while evidence suggests that 28% of patients admitted to UK hospitals are malnourished 'or at risk of malnutrition'.

Therefore it is essential that we quickly establish whether a recently-admitted patient is at risk of malnutrition, so we can tailor our care accordingly.

1.2 Why is it a priority?

People who are malnourished are also in hospital on average 1.4 days longer than those who are better nourished. This means there are clear benefits in identifying people at risk of malnutrition, especially those with long-term conditions and problems such as stroke, pressure ulcers or falls injuries.

We want to ensure that all our patients in wards get the best possible care. This includes making sure we establish their nutritional needs when they are admitted to hospital by using a malnutrition screening tool. Doing this for the majority of patients means we can quickly identify those patients who are at risk of malnutrition, and makes sure they have a care plan in place with clear actions to manage that risk.

1.3 How did we do in 2010/11?

We have been monitoring our compliance with using the malnutrition screening tool on a monthly basis as part of our Quality and Patient Safety Improvement Programme. In March 2011, 81% of patients admitted to wards had a nutritional assessment and care plan completed on admission. Of these, 86% had all relevant sections of the screening tool completed, and in 90% of cases we recorded that we had taken appropriate actions to ensure patients got the care they needed.

While there was a real improvement during the course of last year, work is needed to increase further our completion rates and use of the nutritional screening tool, which will ensure that patients at risk are identified and cared for appropriately.

1.4 What do we aim to do in 2011/12?

We aim to ensure that at least 95% of patients cared for in a ward have a nutritional assessment shortly after being admitted and have a care plan in place which reflects the actions coming out of the assessment.

1.5 How will we monitor progress?

Progress will be monitored through a monthly audit of the number of patients who have a nutritional assessment and have a care plan in place. These figures will be reported as part of our Quality and Patient Safety Improvement Programme 'dashboard' – a range of indicators – to the Patient Safety Committee and Trust Board.

Director responsible: Carolyn Mills, Director of Nursing

No avoidable skin damage while patients are in our care

Pressure Ulcer

Priority 2. Reducing the number of pressure ulcers acquired in hospital

2.1 What is the issue?

Pressure ulcers can occur in any patient, but are more likely in high-risk groups, including people who are obese, elderly, malnourished or have underlying conditions such as diabetes.

They are caused when pressure is placed on a particular part of the body and interrupts the blood supply. The body's natural defence against pressure ulcers is to keep moving, something which hospital patients can't always do independently.

Ulcers are graded according to seriousness. Of particular concern are grades 3 and 4, which place the patient at high risk of infection and prolong their stay in hospital.

2.2 Why is it a priority?

Whilst the number of patients who develop significant pressure ulcers in our care might be small, they cause a significant deterioration to the patients' quality of life, can significantly prolong the length of time a patient stays in hospital and are linked with an increased risk of infection.

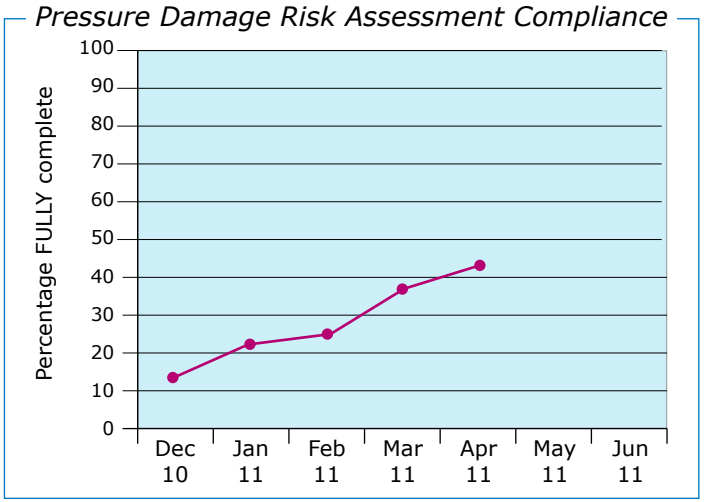
Evidence suggests that between 4% and 10% of patients admitted to district hospitals in England develop a pressure ulcer. Community figures are more difficult to obtain, but it has been estimated that 20% of people in nursing and residential homes may be affected, and up to 30% of the general population.

Pressure ulcers are avoidable, so when patients get them in our care, it reflects a level of care that we believe is not acceptable.

2.3 How did we do in 2010/11?

Last year the Trust, and the community services in Exeter, East and Mid Devon that it has since incorporated, recorded 19 significant hospital-acquired pressure ulcers.

As part of our Quality and Patient Safety Improvement Programme, we have put in place a series of tools and steps to help our staff accurately assess the risks to their patients of developing skin damage. However, we know that these assessments are not always completed, as shown by the chart below.



2.4 What do we aim to do in 2011/12?

We aim to reduce by 40% the number of patients who develop pressure ulcers graded 3 and 4 on the European Pressure Ulcer Advisory Panel Grading System, which is developed in line with NICE guidance.

This is a challenging target, but one which is in line with an Institute for Healthcare Improvement target of an 80% reduction over two years.

2.5 How will we monitor progress?

Progress will be monitored through a monthly audit of the number of patients who develop a hospital-acquired pressure ulcer grade 3 or 4. These figures will be reported as part of our Quality and Patient Safety Improvement Programme dashboard to the Patient Safety Committee and Trust Board.

Director responsible: Carolyn Mills, Director of Nursing

Making sure we keep patients safe from falls

Falls

Priority 3. Reducing the number of falls that occur in hospital

3.1 What is the issue?

Some 208,000 falls are reported in English and Welsh acute hospitals every year, and 38,000 in community hospitals.

Even minor falls can cause distress, pain, injury, loss of confidence and loss of independence, as well as the anxiety caused to patients' relatives and carers.

The causes of falls are complex. Hospital patients are particularly vulnerable because there may be side-effects to their medication, because they may have problems with their balance, strength or mobility, and because of their medical condition, such as delirium, or cardiac, neurological or muscular-skeletal conditions.

Problems like poor eyesight or poor memory can create a greater risk of falling because the patient is out of their normal environment on a hospital ward and they are less able to spot and avoid any hazards.

Patients are also vulnerable to falling while making urgent journeys to the toilet.

In hospital, falls can also indicate that a patient's underlying medical condition might have deteriorated, and might merit urgent medical review regardless of injury.

3.2 Why is it a priority?

Whilst it is not possible to prevent every single patient fall whilst in hospital, we want to be sure that we have done everything possible to prevent patients from falling and injuring themselves whilst in our care.

From data we already collect, it is clear that patients would benefit from a 'fall assessment' very quickly after being admitted to a ward. This means we can put an appropriate plan of care in place and reduce the likelihood of their falling and sustaining an injury.

3.3 How did we do in 2010/11?

The Trust saw 33 medium and high-level incidents recorded last year where patients fell and injured themselves whilst in hospital.

We introduced the 'Falls Risk Assessment Tool' in October 2010 (see chart below). Every patient being admitted to our wards should be assessed and we monitor the completion rate on a monthly basis as part of our ongoing Quality and Patient Safety Improvement Programme.

We introduced a trial on one of our wards, working with patients who were at high risk of falling. Nurses reviewed the patients every hour as part of a 'comfort round', checking whether the patients were in pain or needed the toilet, for example. The trial lasted for three months, during which time we saw a 40% reduction in the number of falls.

3.4 What do we aim to do in 2011/12?

In the coming year we aim to duplicate the success of the falls trial in all our wards by introducing the same system of comfort rounds to deliver a 30% reduction in events where patients were injured as a result of a fall in hospital.

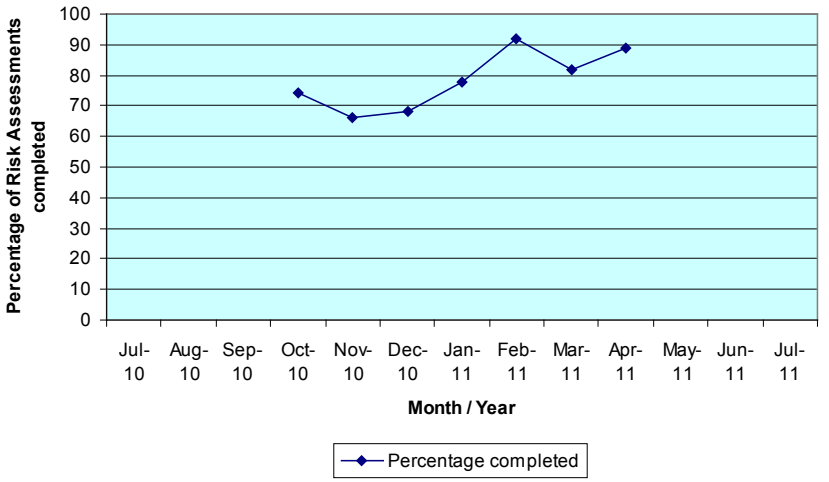
We will ensure that staff have access to a range of resources and training. In addition, we will place emphasis on the actions immediately following a fall to ensure that we quickly detect and treat any injury, reducing the degree of long-term harm caused to the patient.

3.5 How will we monitor progress?

The incidence of patients falling whilst in hospital will be audited through the local incident reporting system and monitored through the Quality and Patient Safety Improvement Programme dashboards which are presented to the Patient Safety Committee and Trust Board.

Director responsible: Carolyn Mills, Director of Nursing

Falls Risk Assessment Compliance



Ensuring good care for patients who have bladder or bowel problems

Continence

Priority 4. Improving continence care and reducing the number of catheter-associated infections

4.1 What is the issue?

National evidence indicates that patients are often given catheters when there are other treatment options available to them that would have reduced the risk of getting an infection.

4.2 Why is it a priority?

From data that we are starting to collect, we recognise that some of our patients develop infections as a result of having a catheter. This infection is unpleasant for patients as it means they need antibiotics and increases the time they have to stay in hospital.

4.3 How did we do in 2010/11?

We started to collect data last year on catheter-acquired infections. Although we do not yet have a baseline from which to measure, we recognise that this is an area where improvement is needed.

4.4 What do we aim to do in 2011/12?

The aim is to reduce catheter-acquired infections by 50% over two years.

We have drawn up plans for reducing the number of catheter-acquired infections.

Steps include:

1. Reduce the number of catheters in use
2. Look at whether there might be a better alternative to a catheter
3. Measure the appropriate use of catheters and the quality of care for patients with catheters
4. Carry out an audit of notes for patients who acquired infections from use of a catheter
5. Monitor the prevalence of catheters on the wards
6. Analyse data to identify and understand patterns of catheter usage

4.5 How will we monitor progress?

We will monitor ourselves against the six steps outlined above and conduct monthly audits of catheter use.

Our performance and progress will be reported through the Quality and Patient Safety Improvement Programme dashboard to the Patient Safety Committee and Trust Board.

Director responsible: Carolyn Mills, Director of Nursing

Making sure our staff keep better notes about the care they give to patients

Notes

Priority 5. Improving the standard of record-keeping

5.1 What is the issue?

Patient notes are used to record medication, diagnoses, previous treatments, care plans, risk assessments (such as nutrition and falls) and the results of any tests.

In their perfect form, patient notes should record every medical intervention, observation and conversation that we have performed on the patient's behalf whilst in our care.

5.2 Why is it a priority?

In order to demonstrate that the quality of care provided is excellent and safe that care must be fully recorded in the notes.

We use patient notes to improve the care we provide and aid communication between clinical teams, doctors and nurses. For example, we can use the notes to audit the quality of care of stroke patients to see whether the same diagnosis tools were used for all patients and see whether patients received treatment within the same time frames. We can then compare these results with the outcome for each patient, to see where improvements are needed.

All this relies on excellent clinical record-keeping and we will work towards improving this.

5.3 How did we do in 2010/11?

We do not have enough information to know how well we performed last year. However, when we have carried out reviews or investigations into things that went wrong, a common theme is that record-keeping could be improved.

We regularly conduct audits on each service and most look at the standard of record-keeping. The audits are monitored centrally by the Patient Safety and Clinical Audit and Effectiveness teams, who look at and review whether an action plan for improvement is in place and being followed.

In 2011, we will expand this to include audit of the whole patient record.

5.4 What do we aim to do in 2011/12?

We will implement a clear plan for auditing our patients' clinical records, to identify how and where we need to improve practice. This information will be shared with the staff who enter information into patients' clinical records.

5.5 How will we monitor progress?

There will be monthly audit of a selection of patients' clinical records, monitored through the monthly Quality and Patient Safety Improvement Programme dashboards which are presented to the Patient Safety Committee and Trust Board. The audit will also be scrutinised by the Patient Documentation Group.

Directors responsible:
Carolyn Mills, Director of Nursing
Dr Alison Diamond, Medical Director

Looking after vulnerable people and keeping them safe

Safeguarding

Priority 6. Improving our care of adult patients who require safeguarding

6.1 What is the issue?

A commonly used definition of a vulnerable adult is: 'someone aged 18 or over who is, or may be, in need of community care services because of mental or other disability, age or illness and is unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'.

It is everyone's responsibility to protect vulnerable adults, but as healthcare professionals providing care we are in a unique position and have a responsibility to recognise and report any suspicion of abuse or neglect.

6.2 Why is it a priority?

The duty of care for vulnerable adults is enshrined in law. Healthcare professionals should have the skills to recognise and manage situations where they suspect a person in their care is at risk of harm, abuse or neglect, including as a result of poor practice.

6.3 How did we do in 2010/11?

Last year training in the following areas was made available to all staff:

- Dementia
- Mental Capacity Act
- Deprivation of Liberty Safeguards
- Safeguarding Adults

Data on the number and percentage of eligible staff who have completed training is not complete, but we are aware that numbers are generally low. A significant amount of work is under way by the Workforce Development Team to produce an accurate picture.

6.4 What do we aim to do in 2011/12?

This year, we aim for 80% of our staff to complete training in each of the areas listed above.

6.5 How will we monitor progress?

In order to monitor progress, training data will be entered onto the Electronic Staff Record, which will audit the percentage of eligible staff who actually receive training in safeguarding adults. This will be monitored through the Strategic Workforce Development Committee and the Joint Safeguarding Adults Board.

Director responsible:
Maureen Bignell, Director of Workforce and Development

Looking after our patients on the right ward

Ward moves

Priority 7. Fewer moves between wards

7.1 What is the issue?

Moving patients between wards is sometimes necessary so we can provide the correct medical and nursing care.

We try to admit patients to the right ward when they arrive either via A&E or for a planned operation. Unfortunately, sometimes there are no beds available in the most suitable ward. The patient still requires our care, so we will admit them to a different ward, but with immediate plans in place to transfer them to the most appropriate ward as soon as a bed becomes free.

7.2 Why is it a priority?

We know that we could do more to reduce the number of times that we transfer patients between wards, for non-clinical reasons.

Patient feedback and evidence shows that safety, quality of care and patient experience are adversely impacted when patients are moved between wards unless clinically essential.

7.3 How did we do in 2010/11?

We started collecting data on ward-to-ward moves in February 2011.

The data we look at does not include transfers for clinically-sound reasons - for example transfers from A&E or our Medical Assessment Unit. We also do not count transfers to wards such as the Acute Stroke Unit, Central Delivery Suite or Intensive Care Unit where clearly the move is for a medical reason.

According to ward transfer data collected over three months, 89.7% of patients were moved once during their stay, and 10.3% moved between 2-4 times without good medical reason.

7.4 What do we aim to do in 2011/12?

We feel that one move between wards during a patient's admission is reasonable.

Currently, 10% of our patients are moved more than once and we feel this is unacceptable. In the coming year we aim to ensure that no patient is moved more than once without a legitimate reason.

We will seek to understand the reasons why patients are moved. This will better enable us to reduce the number of times patients are moved for non-clinical reasons.

7.5 How will we monitor progress?

Progress will be monitored through weekly reviews of the number of patient moves between wards and of the reasons for those moves. Data will be reported through the Quality and Patient Safety Improvement Programme dashboard to the Patient Safety Committee and the Trust Board.

Director responsible: Kate Lyons, Director of Operations

Looking after our confused patients and the people who care for them

Dementia

Priority 8. Improving care for patients and their carers for patients with dementia

8.1 What is the issue?

Up to a quarter of in-patient beds are occupied by people with dementia, with incidence rising markedly with age.

Within Devon it is likely that the proportion is higher because of the demographic profile of our population. For example, North Devon has an ageing population, with an expected 40% increase in the 60-80 year old age group by 2021. Whilst there is a general, incorrect belief that dementia is a natural consequence of ageing, there is a proven correlation between prevalence of dementia and age.

8.2 Why is it a priority?

We believe that all people admitted to a general or community hospital run by the Northern Devon Healthcare NHS Trust should receive services which are sensitive to their needs, respect their dignity and support their onward care in a suitable setting.

In 2010/11 the Department of Health identified four priority areas which support local delivery of the National Dementia Strategy. The four priorities are:

1. Good quality early diagnosis and intervention for all
2. Improved quality of care in general hospitals
3. Living well with dementia in care homes
4. Reduced use of anti-psychotic medication

As a Trust we are committed to improving the quality of care offered to patients with dementia by meeting these four priorities.

8.3 How did we do in 2010/11?

Last year, an analysis of formal complaints and issues raised through the Patient Advice & Liaison Service revealed two trends:

1. That relatives and carers of patients with dementia felt we did not meet all the patients' needs
2. That staff lacked specific knowledge about caring for patients with dementia.

On reviewing several cases involving elderly, confused patients, we found that many staff did not have the necessary knowledge and skills to care for them.

Based on the National Dementia Strategy, we launched a local Dementia Care Improvement Plan in October 2010. This outlined how we would address each of the key national objectives to improve our service.

Close working with the Devon Partnership Trust led to the successful introduction of a dementia liaison post. We also introduced training for all staff groups about the Mental Capacity Act 2005. The Trust's Safeguarding Adults Group provided advice and support to staff on managing the needs of someone with dementia if they believed there were issues of vulnerability.

8.4 What do we aim to do in 2011/12?

As an integrated Trust that provides acute, community and social care, we take seriously our role in ensuring that all staff within our services have a high awareness of dementia.

This awareness will prevent any discrimination in the treatment of patients with dementia and ensure that our dementia patients receive the best-possible care.

As part of our dementia strategy we will:

- Identify a clinical 'champion' for dementia care
- Develop awareness training for all our staff groups to ensure that people with dementia are treated with dignity and respect in every contact with our services
- In conjunction with specialist dementia services (Older People's Mental Health), we will develop training for staff who regularly work with people with dementia, covering issues such as the management of confusion, difficult behaviours and lack of self-care

8.5 How will we monitor progress?

A monthly review will be carried out of the numbers of eligible staff who have undertaken dementia training. This will be monitored through the Strategic Workforce Development Committee.

Director responsible: Kate Lyons, Director of Operations

'You said, we did'

Feedback

Priority 9. Developing new ways of feeding back to patients actions taken as a result of their feedback

9.1 What is the issue?

Last year patients, service users and members of the public commented that they were not always aware of actions we had taken as a result of what they had told us.

Receiving and acting on feedback is an essential element of improving our services to meet the needs of patients.

9.2 Why is it a priority?

The Trust is required to demonstrate that it listens and responds to patient feedback and uses feedback information to improve the experience of patients receiving our services.

The Commissioning for Quality and Innovation payment framework, the Quality, Innovation, Productivity and Innovation programme and the Care Quality Commission require us to gather data on our patient experience and show that we have materially improved services as a result of applying the feedback.

Many service improvements already include some form of patient/user involvement but there are few that focus on drawing out specific experience of patients and staff and even fewer that use an improvement in this experience to measure the success of a service.

It is important that our local community feels able to have a voice in the way services are run.

9.3 How did we do in 2010/11?

There are several routes for providing us with feedback about our services:

Complaints: We thoroughly investigate every complaint. Once concluded, we send a letter or hold a meeting to go through the findings and discuss what steps we commit to taking to improve the service.

Patient Advice and Liaison Service (PALS): We run a busy and effective PALS service which commits to resolving issues on the spot, where possible. When issues are too complex, we suggest following the complaints procedure to ensure that we can properly investigate the concerns.

Media: Occasionally, patients choose to raise issues, good and bad, via the local media. It is usual that part of our response will include the steps taken to resolve any problems identified.

Audit: We conduct regular patient surveys both by service and by area – out-patients, for example. We encourage each service to conduct its own surveys, with the Clinical Audit and Effectiveness team assisting with data-collection, analysis and subsequent action plans.

Involving patients: In 2010 we established the Involving Patient Steering Group (IPSG), whose membership comes from Trust staff and representative organisations across Devon, such as LINk. The purpose of the group is to allow patients and carers to feed

issues into the Trust for discussion and action. In 2010, for example, the IPSG tackled signage at North Devon District Hospital, access to services for patients with sensory impairment, the redesign of the women's and children's unit, and the experience of dementia patients.

Learning from patients: In 2010 we also established the Learning from Patient Experience Group (LPEG), whose membership comes from management and from those teams involved in receiving patient feedback, such as audit, complaints and PALS. The aim is to prioritise our efforts in improving services and show how we have responded to patient feedback.

One theme common in all these routes is that we do not always ensure that our teams have used the feedback to improve the way we provide services.

9.4 What do we aim to do in 2011/12?

We would like to get better at telling you what we have done as a result of your feedback.

To do this, we will take a number of steps:

- develop and implement a patient experience strategy, which clearly sets out the steps staff and teams should take following any form of feedback
- support the success of the IPSG by developing members' involvement in more projects
- support the success of LPEG by demonstrating the rewards and effectiveness of developing well as effective groups
- provide more information on our website about what we have done and why

The patient experience strategy aims to ensure that we design and provide good services. It places patient experience on an equal footing with more-technical issues such as performance and consistency.

The strategy has four cornerstones:

1. Capture the experience
2. Understand the experience
3. Improve the experience
4. Measure the improvement

9.5 How will we monitor progress?

Reviews of the information we feed back to patients and the public will be carried out on a quarterly basis, and monitored through the Learning from Patient Experience Group.

Director responsible: Andy Robinson, Director of Finance and Deputy Chief Executive

Statements of assurance from the Board

Review of services

During 2010/11, Northern Devon Healthcare NHS Trust provided and/or sub-contracted 30 acute and 20 community NHS services (at discrete specialty level).

Northern Devon Healthcare NHS Trust has reviewed all the data available to it on the quality of care in all 50 of these NHS services.

The income generated by the NHS services in 2010/11 represents 93.3 per cent of the total income generated from the provision of NHS services by the Northern Devon Healthcare NHS Trust for 2010/11.

Participation in clinical audits

During 2010/11, 41 national clinical audits and six national confidential enquiries covered NHS services provided by the Northern Devon Healthcare NHS Trust

During that period, Northern Devon Healthcare NHS Trust participated in 85% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.

The audits and enquiries in which the Trust was eligible to participate during 2010/11 were as follows:

- Perinatal Mortality (CEMACH)
- Neonatal Intensive and Special Care (NNAP)
- Paediatric Pneumonia (BTS)
- Paediatric Asthma (BTS)
- Paediatric Fever (CEM)
- Paediatric Intensive Care (PICANet)
- Diabetes (RCPH National Paediatric Diabetes Audit)
- Emergency Use of Oxygen (BTS)
- Adult Community Acquired Pneumonia (BTS)
- Non Invasive Ventilation [NIV] – Adults (BTS)
- Pleural Procedures (BTS)
- Cardiac Arrest (National Cardiac Arrest Audit)
- Vital Signs in Majors (CEM)
- Adult Critical Care (ICNARC Case Mix Programme)
- Potential Donor Audit (NHS Blood & Transplant)
- Diabetes (National Adult Diabetes Audit)

- Heavy Menstrual Bleeding (RCOG National Audit of HMB)
- Chronic Pain (National Pain Audit)
- Ulcerative Colitis and Crohn's Disease (National IBD Audit)
- Parkinsons Disease (National Parkinsons Audit)
- COPD (British Thoracic Society/European Audit)
- Adult Asthma (British Thoracic Society)
- Bronchiectasis (British Thoracic Society)
- Hip, Knee and Ankle Replacements (National Joint Registry)
- Elective Surgery (National PROMs Programme)
- Coronary Angioplasty (NICOR Cardiac Interventions Audit)
- Peripheral Vascular Surgery (VSGBI Vascular Surgery Database)
- Carotid Interventions (Carotid Intervention Audit)
- Familial Hypercholesterolaemia (National Clinical Audit of Management of FH)
- Acute Myocardial Infarction & Other ACS (MINAP)
- Heart Failure (National Heart Failure Audit)
- Acute Stroke (SINAP)
- Stroke Care (National Sentinel Stroke Audit))
- Renal Colic (College of Emergency Medicine)
- Lung Cancer (National Lung Cancer Audit)
- Bowel Cancer (National Bowel Cancer Audit Programme)
- Hip Fracture (National Hip Fracture Database)
- Severe Trauma (Trauma Audit & Research Network)
- Falls and Non-Hip Fractures (National Falls and Bone Health Audit)
- Negative Blood Use (National Comparative Audit of Blood Transfusion)
- Platelet Use (National Comparative Audit of Blood Transfusion)
- CMACE/CEMACH:
  - Paediatric Head Injuries
  - Maternal Mortality
  - Obesity in Pregnancy
- NCEPOD:
  - Peri-Operative Care
  - Cardiac Arrests
  - Paediatric Surgery

These 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.

Project category	Project title	NDHT took part	Cases submitted	Total number of cases
Peri and Neonatal	Perinatal Mortality (CEMACH)*	Yes	Not available	Not available
	Neonatal Intensive and Special Care (NNAP)*	Yes	262	262
Children	Paediatric Pneumonia (BTS)	Yes	14	14
	Paediatric Asthma (BTS)	Yes	10	10
	Paediatric Fever (CEM)	Yes	51	50
	Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)*	N/A		
	Paediatric Intensive Care (PICANet)*	N/A		
	Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit)*	N/A		
	Diabetes (RCPH National Paediatric Diabetes Audit)*	Yes	70	70
Acute Care	Emergency Use of Oxygen (BTS)	No		
	Adult Community Acquired Pneumonia (BTS)	No		
	Non Invasive Ventilation [NIV] – Adults (BTS)	No		
	Pleural Procedures (BTS)	No		42
	Cardiac Arrest (National Cardiac Arrest Audit)*	No		
	Vital Signs in Majors (CEM)	Yes	50	50
	Adult Critical Care (ICNARC Case Mix Programme)*	Yes	398	398
	Potential Donor Audit (NHS Blood & Transplant)*	Yes	123	123
Long Term Conditions	Diabetes (National Adult Diabetes Audit)*	No		
	Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	0	0
	Chronic Pain (National Pain Audit)*	Yes	0	0
	Ulcerative Colitis and Crohn’s Disease (National IBD Audit)	Yes	4	4
	Parkinsons Disease (National Parkinsons Audit)	Yes	23	23

Project category	Project title	NDHT took part	Cases submitted	Total number of cases
	COPD (British Thoracic Society/European Audit)	Yes	61	61
	Adult Asthma (British Thoracic Society)	Yes	20	20
	Bronchiectasis (British Thoracic Society)	No		
Elective procedures	Hip, Knee and Ankle Replacements (National Joint Registry)*	Yes	704	712
	Elective Surgery (National PROMs Programme)*	Yes	Not available	Not available
	Cardiothoracic Transplantation (NHSBT UK Transplant Registry)	N/A		
	Liver Transplantation (NHSBT UK Transplant Registry)	N/A		
	Coronary Angioplasty (NICOR Cardiac Interventions Audit)	N/A		
	Peripheral Vascular Surgery (VSGBI Vascular Surgery Database)	Yes	68	68
	Carotid Interventions (Carotid Intervention Audit)	Yes	18	18
	CABG and Valvular Surgery (Adult Cardiac Surgery Audit)	N/A		
Cardiovascular Disease	Familial Hypercholesterolaemia (National Clinical Audit of Management of FH)	Yes	0	0
	Acute Myocardial Infarction & Other ACS (MINAP)	Yes	555	555
	Heart Failure (National Heart Failure Audit)	Yes	257	257
	Pulmonary Hypertension (Pulmonary Hypertension Audit)	N/A		
	Acute Stroke (SINAP)	Yes	351	351
	Stroke Care (National Sentinel Stroke Audit)	Yes	60	60
Renal Disease	Renal Replacement Therapy (Renal Registry)	N/A		
	Renal Transplantation (NHSBT UK Transplantation Registry)	N/A		
	Patient Transplant (National Kidney Care Audit)	N/A		
	Renal Colic (College of Emergency Medicine)	Yes	41	50

Project category	Project title	NDHT took part	Cases submitted	Total number of cases
Cancer	Lung Cancer (National Lung Cancer Audit)*	Yes	571	920
	Bowel Cancer (National Bowel Cancer Audit Programme)*	Yes	125	141
	Head and Neck Cancer (DAHNO)*	N/A		
Trauma	Hip Fracture (National Hip Fracture Database)*	Yes	236	250
	Severe Trauma (Trauma Audit & Research Network)*	Yes	29	29
	Falls and Non-Hip Fractures (National Falls and Bone Health Audit)	Yes	50	50
Psychological Conditions	Depression and Anxiety (National Audit of Psychological Therapies)	N/A		
	Prescribing in Mental Health Services (POMH)	N/A		
	National Audit of Schizophrenia (NAS)	N/A		
Blood Transfusion	O Negative Blood Use (National Comparative Audit of Blood Transfusion)	Yes	17	17
	Platelet Use (National Comparative Audit of Blood Transfusion)	Yes	6	6

National Confidential Enquiries

Project category	Project title	NDHT took part	Cases submitted	Total number of cases
CMACE/CEMACH	Paediatric Head Injuries	Yes	Not available	Not available
	Maternal Mortality*	Yes	Not available	Not available
	Obesity in Pregnancy*	Yes	Not available	Not available
NCEPOD	Peri-Operative Care	Yes	Pre 1/4/10	Pre 1/4/10
	Cardiac Arrests	Yes	3	3
	Paediatric Surgery	Yes	0	0
	Parenteral Nutrition	Yes	7	11

* Ongoing data collection/monitoring

Comparisons: 2009/10 and 2010/11

Category	2009/10	2010/11
Total number of national audits	46	54
Total number of national audits applicable to NDHT	32	41
Number of national audits not applicable to NDHT	14	13
Number of national audits NDHT taken part in	22 (69%)	33[1] (80%)
Total number of national audit NDHT cases	3381	
Total number of national audit cases NDHT submitted	2657 (79%)	
Total number of national confidential enquiries	10	7
Total number of national confidential enquiries applicable to NDHT	9	7
Number of national confidential enquiries not applicable to NDHT	1	0
Number of national confidential enquiries NDHT taken part in	9	6
Total number of national confidential enquiries NDHT cases	181	Not available
Total number of national confidential enquiries cases NDHT submitted	136 (75%)	Not available
Other national audits NDHT taken part in	12	6

[1] There are also 2 BTS audits with data collection periods ending May 31, 2011. If the Trust takes part in these, the final total will be 35 i.e. 85%.

Key actions arising from national audits

Local results from a total of 14 national clinical audits were reviewed in 2010/11:

- Acute Kidney Injuries (NCEPOD)
- Fractured Neck of Femur (College of Emergency Medicine)
- MINAP: How the NHS Manages Heart Attacks
- National Audit of Falls and Bone Health for Older People (Round 2 – Organisational)
- National British Society of Rheumatologists Osteoarthritis Audit
- National Care of the Dying Audit (Round 2)
- National Carotid Endarterectomy (Round 2)
- National Chronic Obstructive Pulmonary Disease
- National Heart Failure Audit
- National Inflammatory Bowel Disease (2008)
- National Lung Cancer Audit [LUCADA]
- National Maternity Survey
- Parenteral Nutrition (NCEPOD)
- Repeat use of O Negative Blood

The results were compared against our standards locally and we have taken steps to implemenent the following recommendations using the findings from the following audits:

1. Fractured Neck of Femur (College of Emergency Medicine)

1. Pathway implemented.
2. Nurse- requested x-rays now part of practice.
3. Pathway updated.
4. Re-audit when CEM requires it.

2. National Care of the Dying Audit (Round 2)

1. Proportion of wards using the Liverpool Care Pathway: 100% compliant - no action required.
2. Anticipatory prescribing for key symptoms: 96% compliant – action: review one non compliant case as preliminary action.
3. Completion of the LCP: 92% compliant – action: review 2 cases.

Action 1: Cascade Liverpool Care Pathway ‘coping with dying’ leaflet to all clinical areas

Action 2: Undertake six monthly ongoing audit of pathway variances*

Patient level key findings:

Monitor non completion of after death section on pathway. If still requires improvement, roll-out further education.

The following action plan has been completed:

1. Key performance indicators for care of the dying should be measured, monitored and managed as part of the organisation's corporate performance dashboard
2. All hospitals should have clear programme for continuous quality improvement for care of the dying to drive up performance and quality
3. Named facilitator in organisation to take formal responsibility for ICP and change agent for care of the dying
4. Median prescribing dose medication dose for agitation and restlessness low
5. Local audit of care of the dying includes assessment of views of bereaved carers
6. Optimising knowledge and information re care of the dying leaflets for patients' relatives and carers
7. Identification of poor performance re goals and variance documentation and outcome. Appropriate ongoing education re palliative care and care of the dying available
8. Care after death documentation in LCP
9. Participation in 2 yearly National Care of the Dying Audit Cycle
10. All hospitals should have the LCP compliant with version 12

3. National Carotid Endarterectomy

Thr surgical team is looking into ways of speeding up the time to surgery.

4. National Falls and Bone Health (Round 2 – Organisational)

The local results of the national audit were incorporated into a wider regional review of falls and bone health services.

5. Falls, Fractures and Bone Health Action Plan

The action plan below has been formulated in response to the South West Falls, Fractures and Bone Health review in September 2009 and the findings and recommendations on actions for improvements in the subsequent report published in November 2009.

Key Finding 1: Emergency Department / Fracture Clinic

Action

1. Introduce Falls and Bone Health Risk Assessment tools
2. Introduce a referral pathway for patients at risk of falls
3. Introduce a referral pathway for patients with a bone health risk
4. Reduce time for transfer from A&E to ward.

Key Finding 2: Orthopaedic / NHFD

Action

1. Theatre capacity for trauma
2. Utilise Fractured neck of femur pathway
3. Participate in NHFD

Key Finding 3: Orthogeriatrician

Action

1. Appointment to third geriatrician post.
2. Increase therapy resource for inpatient beds in community to provide rehabilitation.

Key Finding 4: Community Fragility Fracture Service

Action

1. Employ second Rheumatology Consultant with interest in bone health
2. Bone health pathway
3. Establish secondary care prevention service and establish a liaison nurse role

Principal Issue 5: Community Falls Service

Action

1. Establish strength & balance classes across community bases.
2. Links with leisure services
3. Public health
4. Work with care homes
5. Specialist medical assessment in community – consultant
6. Establish falls clinics across district
7. Introduce communication with patients regarding sharing of information between GP & CCT

Principal Issue 6: Partnership and whole systems working

Action

1. Attend meeting
2. Establish falls and bone health group
3. Commissioner involvement

6. National Heart Failure Audit

Local results have yet to be fed back for this year. Nonetheless, readmissions for those patients using the service are regularly audited. The numbers are reassuringly low.

The Specialist Heart Failure Nurses have also been collecting data on patients' place of death and end of life support. The numbers are small, hence it is difficult to say whether there has been any improvement. However, 40% of their patients who died in 2010 were supported within their usual place of residence.

The challenge associated with identifying end stage heart failure from an episode of decompensation is well recognised. However, the national Gold Standards Framework data shows that they have accurately identified end stage heart failure and helped to coordinate end of life care for 36% of those patients who died during the last year. These outcomes reflect the activity of the Heart Failure and Cardiology services which includes valuable Consultant support.

7. National Lung Cancer Audit

The local Multidisciplinary Team (MDT) review the data on 9 key indicators on a quarterly basis, to identify ways of improving compliance where possible/necessary:

Patients first seen

Key indicator	1.1.10 - 31.3.10		1.4.10 - 30.6.10		1.7.10 - 30.9.10	
	Standard	%	Standard	%	Standard	%
Patients discussed at MDT	95%	95%	95%	97%	95%	84.6%
Patients with a histological diagnosis	75%	73%	75%	65%	75%	73.1%
Patients seen by nurse specialist	80%	86%	80%	100%	80%	84.6%
Nurse specialist present at diagnosis	80%	50%	80%	74%	80%	57.7%
Patients receiving CT before bronchoscopy	90%	89%				
Patients having active treatment	54%	59%	54%	45%	54%	57.7%
Patients receiving surgery all cases	11%	27%	11%	0%	11%	19.2%
Patients (PSO-1, Stage IIIB or IV Non-small cell lung cancer) receiving chemotherapy	48%	0%				
Patients with small cell lung cancer receiving chemotherapy	62%	75%	62%	67%	62%	100%

8. National Maternity Survey

In a survey published on 2 December 2010 for the Care Quality Commission , new mums praise standards of maternity care provided by Northern Devon Healthcare NHS Trust.

The care during labour and birth was described as excellent or very good by 94% of women who gave their views this summer, well ahead of the average of 84% among other trusts surveyed by the same team.

Care during pregnancy was rated as excellent or very good by 89%, compared to the average of 76%. And care after birth was rated as excellent or very good by 76% of mothers, against the average of 67%.

Among the highlights:

- 92% of women were given the choice of a home birth (average = 70%)
- 72% saw the same midwife every time or most times for antenatal check-ups (average = 59%)
- 82% were always given the help they needed by the midwife (average = 72%)
- 89% were always treated with kindness and understanding (average = 78%)
- 78% got the pain-relief they wanted (average = 65%)
- 77% felt their length if stay in hospital was about right (average = 70%)

Report received in October 2010

Green – Better than other Trusts and improvement on 2007 results
Amber – Same as other Trusts and no improvement on 2007 results
Red – Worse than 2007 results.

Area of Assessment		Recommendations from the Survey
Early pregnancy		**Ensure** that information is given about the choices available to women on where to have their baby. **Increase** the number of women who are given a choice of where to have their baby including the choice of a home birth. **Ensure** that all women who need one are given a copy of The Pregnancy Book. **Ensure** that all women are given information about the NHS Choices website.
Antenatal check ups		**Ensure** that women are given as much choice as is possible about where they have their antenatal check-ups and who will do them.
		Increase continuity of care from midwives so that women see the same midwife as often as possible. **Look** at ways of increasing the continuity of care from hospital doctors so that women see the same doctor as often as possible.

Area of Assessment		Recommendations from the Survey
Tests and Scans		**Ensure** that all women have a choice about whether they have a screening test for Down's syndrome. **Take** action to improve explanations about the reasons for testing for Down's syndrome. **Ensure** that women get clear explanations about the reasons for dating scans and mid-trimester scans and feel they have a choice about having these scans.
During Pregnancy Rating of care during pregnancy excellent / v. good 89%		**Ensure** that all women are given a contact number in case they are worried during their pregnancy. **Ensure** that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
		Ensure that all women are treated with respect and dignity, kindness and understanding during their pregnancy. **Ensure** that women are involved as much as possible in decisions about their care.
Antenatal Classes		**Review** the provision of NHS antenatal classes given the high proportion of women not attending NHS classes and in particular, those not attending any classes at all. **Examine** alternative times and places for classes given the number of women saying they were not convenient.
		Ensure that women are told when partners / others can attend classes with them. **Ensure** that there are enough classes to meet women's needs.
During Labour		**Ensure** that women are given a choice as far as is possible about whether they are induced. **Examine** ways of increasing the number of women able to move around and choose the position that makes them most comfortable during labour. **Ensure** that women are given pain relief in a timely manner to meet their needs.
The Baby's Birth		**Consider** whether the Trust's level of caesarean sections can be brought down.

Area of Assessment		Recommendations from the Survey
The Staff		**Ensure** that women are cared for by the same midwives as far as is possible during labour and the birth of their baby and if possible by midwives they have met previously.
		Ensure that husbands and partners are able to be present for the whole of labour and the birth of the baby if requested.
		Examine reasons why some women feel they are left alone at times which they find worrying.
		Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
		Ensure that all women are treated with respect and dignity, kindness and understanding during labour and the birth of their baby.
		Examine ways of increasing the number of women who feel involved in decisions about their care during labour and the birth of their baby.
Post-natal Hospital Care		**Examine** reasons why some women think their stay in hospital was too short.
		Ensure that women are given all the information they require about their own recovery after the birth of their baby.
		Ensure that both verbal and written information is easily understood by women, and that all the information and explanations required are given.
		Ensure that all women are treated with respect and dignity, kindness and understanding during their postnatal stay in hospital.
Feeding Baby		**Ensure** that women have infant feeding discussed with them during their pregnancy by midwives.
		Ensure that women are given full support and encouragement, practical help and consistent advice about feeding their baby, particularly in relation to breast feeding.
		Look at ways of increasing the number of women breast feeding their babies.

Area of Assessment		Recommendations from the Survey
Care at Home after Birth		Some of the lowest "excellent" category ratings but still higher % s than the National Average, postnatal care is acknowledged as the "Cinderella service" It is the only time women do not get individualised care and this often reflects in the feedback
		Ensure that women have a contact number in case they are worried by anything when at home after the baby's birth.
		Review the number and frequency of midwives visits in the light of respondents' views.
		Review the provision of information about looking after baby in the light of the number of women who say they either did not get information or that they only got it to some extent.
		Ensure that all women have postnatal check-ups for their own health.

9. Parenteral Nutrition (NCEPOD)

NCEPOD Self-assessment checklist: Paediatrics

Recommendations	Is it met? Y/N/Partially/ Planned	Action required	Timescale
Careful and early consideration should be given to the need for PN in neonates and once the decision to commence PN is made it should be started without undue delay. (*Consultants*)	Partially	Finish process and guideline for use of standard bags	Sept 10
The first PN given must be appropriate to the neonate's requirements. (*Consultants*)	Partially	Finish process and guideline for use of standard bags	Sept 10
Close monitoring of the patient must be achieved so that metabolic complications can be avoided. (*Consultants*)	Yes		
Neonatal Units should have an agreed policy for nutritional requirements and use a proforma that includes this information which is tailored for each infant and placed in the case notes. (*Clinical Directors*)	Planned	Network action. Make the network aware	Oct 10
Hospitals in which neonates are cared for should develop a team approach to ensure safe and effective nutritional support, recognising that this should be a multidisciplinary exercise with sharing of expertise. Depending on the type of institution and availability of personnel, the composition of these teams may vary but could include neonatologists, paediatricians, paediatric surgeons, pharmacists, dietitians and experts in nutrition. This team could also provide support to other clinical areas caring for children and have a role in education and training for those involved in PN care. (*Medical Directors*)	N/A*		Oct 10
There is an urgent need for Neonatal Units across the UK to have a consensus on best PN practice based on current scientific evidence. (*Consultant Neonatologists*)	N/A*	Network action. Make the network aware	Oct 10

Recommendations	Is it met? Y/N/Partially/ Planned	Action required	Timescale
Neonatal units should undertake regular audit of PN practice which should include the complications of PN. (*Clinical Directors*)	Planned	Await network guidance*, then develop audit	1 year*
The National Institute for Health and Clinical Excellence should develop guidelines on nutritional support for neonates and children in a similar manner to their recommendations for adults. (*NICE*)	N/A		
CVC insertion is an invasive procedure with well recognised risks. Insertion should be clearly documented in the case notes including: – The designation of the operator – The type of CVC – A description of the insertion technique – The use of imaging – Confirmation of the position of the catheter tip (*Consultants*)	Planned	Develop sticker for recording this information, similar to that in use for peripheral intravenous cannulae across the Trust. Work with patient safety lead	1 year
All hospitals must have policies on the management CVCs which should include: – Insertion of CVC – Care of indwelling CVC – Detection and management of complications – Monitoring and audit, including adherence to the policies (*Medical Directors*)	N/A		

Recommendations	Is it met? Y/N/Partially/ Planned	Action required	Timescale
There must be improved education around CVC insertion and management; as well as the recognition and management of CVC complications. (*Clinical Directors*)	Planned	Develop guidance with peninsular neonatal network. Include topic in departmental education programme	1 year
Nutrition teams have an important role in ensuring quality control around the initiation, supply and monitoring of PN. Whilst the data from this study did not show a clear correlation between overall care and the involvement of a nutrition team it was not designed to do so and no adverse inference should be made from this. All hospitals involved with PN should have a multidisciplinary nutrition team involved in both enteral and parenteral nutrition. (*Medical Directors*)	N/A		
All hospitals should keep a central record of where and to whom PN has been supplied. (*Medical Directors and Heads of Pharmacy*)	Y		
All hospitals should have policies on initiating PN to avoid inappropriate use and safe prescribing. (Medical Directors)	N/A		
All hospitals should have a dedicated CVC/PICC service to ensure high-level expertise is practised within this interventional area. (*Medical Directors*)	N/A		
Surgical teams are high volume users of PN. As such they need to engage more in clinical nutrition issues and increase their profile within nutrition teams. (*Medical Directors and Clinical Directors*)	N/A		

Some key actions arising from local audits

The reports of 128 local clinical audits were reviewed by the provider in 2010/11 and Northern Devon Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided:

1. Analgesia following breast surgery: The patients' perspective

Recommendation	**Actions to Achieve**	**Progress**	**Evidence/ Success Criteria**
To discontinue the use of PCA post breast surgery	Present the project findings and discuss with the multi-disciplinary team to achieve consensus	Completed	Re-audit and survey to commence immediately
Administer local anaesthetic to the wound site	Breast surgeons agreement to do this peri-operatively	Completed	
Administer Oromorph to post op patients as part of the normal medication regime on Petter Ward	Nurses to administer Oromorph as prescribed by Anaesthetist	Completed	

2. NICE Clinical Guideline number 47: Feverish Illness in Children

Recommendation	**Actions to Achieve**	**Progress** (completed on 01.06.10)	**Evidence/ Success Criteria**
A two sided folder insert with traffic light signs and appropriate actions for all children under 5 years of age admitted with febrile illness could be introduced. (*in line with NICE CG47 Guidelines Implementation Advice, p10*) [cross ref Audit 763 re. admission documentation]	**Design and introduce folder insert**		
Completion of BMJ E-learning module for NICE CG47 could be added to induction training.	**Add E-learning module to induction training**		

3. North Devon Physiotherapy Musculo-Skeletal Service Consent for Acupuncture Audit

The consent form has been redesigned to include the necessary information. It was taken to the North Devon Acupuncture Group and has been agreed by the staff involved. It is now in use. Staff were informed at this meeting about the need to countersign if being treated by a different therapist. The plan is to re audit after a year to see if this has improved compliance.

4. NICE Technology Appraisal Number 155: Age-related Macular Degeneration Treatment

1. Direct referrals via urgent fax number publicised to GPs
2. Referrals via the wrong pathway are constantly monitored. If they occur an incident report form is completed and the RNIB/RCO fax referral form is sent on to the referrer.
3. In May 2010 a personal email from the project lead was sent to all North Devon GP practices including the referral form to remind them of the direct referral pathway.
4. The referral pathway has been updated.
5. Patients with visual acuity (VA) too good for treatment are brought back every four weeks and if their VA drops to treatable levels, they are then started on treatment.
6. A similar approach applies in patients with VA too poor for treatment (< 6/96). However, those tend to have permanent structural damage and no case so far had to be put forward for an exceptional funding request.

Participation in clinical research

A total of 1,275 patients receiving NHS services provided or sub-contracted by Northern Devon Healthcare NHS Trust in 2010/11 were recruited during that period to participate in research approved by a research ethics committee.

Participation in clinical research demonstrates the 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.

Northern Devon Healthcare NHS Trust was involved in conducting 78 clinical research studies across specialty areas during 2010/11.

The Trust currently supports NIHR (National Institute of Health Research) multi-centre trials, which all feed into NICE guidelines to improve patient care. The significant increase of patient recruitment into clinical trials from 565 patients in 2009/10 to 1,275 patients in 2010/11 demonstrates that the organisation's commitment to clinical research leads to better treatments for patients.

46 clinical staff participated in research approved by a research ethics committee at Northern Devon Healthcare NHS Trust during 2010/11. This research covered 17 medical specialties.

In the last three years, the Trust's involvement in NIHR research and providing data from patient recruitment to our sponsor sites has contributed to a number of publications, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS. The Trust requires final project reports from the Chief Investigators and this condition is stipulated in Trust approval and Clinical Trials Agreements.

Our engagement with clinical research in randomised controlled trials in the specialty areas of cancer, stroke and diabetes also demonstrates Northern Devon Healthcare NHS Trust's commitment to testing and offering the latest medical treatments and techniques.

Goals agreed with commissioners

A proportion of Northern Devon Healthcare NHS Trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available on request.

Statements from the Care Quality Commission (CQC)

Northern Devon Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is licensed to carry out the following activities:

- Maternity & Midwifery
- Diagnostic and Screening
- Family Planning
- Nursing Care
- Surgical Procedures
- Termination of Pregnancy
- Treatment of Disease, Disorder and Injury
- Management of Supply of Blood and Blood-Derived Products

Northern Devon Healthcare NHS Trust has no conditions on registration.

The Care Quality Commission did not take enforcement action against Northern Devon Healthcare NHS Trust during 2010/11.

Northern Devon Healthcare NHS Trust participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2010/11.

- CQC Special Review – Stroke
- CQC Special Review - support for families with disabled children

These reviews were national CQC reviews and not specific to the Trust.

The Special Review for Stroke produced a national report which the Trust will review its current Stroke Service against. Any nationally recommended improvements will be managed as a Devon-wide improvement project. The report for the Support for Families with Disabled Children will be published in spring 2011.

Data quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will thus improve patient care and improve value for money.

Northern Devon Healthcare NHS Trust will be taking the following actions to improve data quality:

NHS Number and General Medical Practice Code Validity

The Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.2% for admitted patient care
- 99.3% for out patient care
- 96.6% for accident and emergency care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.9% for admitted patient care
- 99.7% for out patient care
- 100.0% for accident and emergency care

Information Governance Toolkit (IGT) attainment levels

Northern Devon Healthcare NHS Trust's Information Governance Assessment Report overall score for 2010/11 was 57% and was graded red in accordance with the IGT Grading Scheme.

Clinical coding error rate

Northern Devon Healthcare NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect : 10.7%
- Secondary Diagnoses Incorrect : 12.9%
- Primary Procedures Incorrect : 30.7%
- Secondary Procedures Incorrect : 12.2%

Part 3 - Review of quality performance 2010/11

This part of the Quality Account looks back at last year's priorities and assesses our progress.

In 2010, the Trust set four priorities for improving quality:

1. Keeping our patients safe from infections acquired in hospital
2. Keeping our patients safe from the risk of blood clots
3. Making sure patients, their families and carers have the best-possible experience when using our services
4. Improving the way in which we discharge patients from hospital

1. Keeping our patients safe from infections acquired in hospital

What was the issue?

A hospital-acquired infection is an infection acquired during hospital care which was not present or incubating when the patient was admitted. Infections which occur more than 48 hours after admission are considered to be hospital-acquired.

The best-known infections are MRSA and Clostridium difficile. MRSA (sometimes referred to as a superbug) stands for methicillin-resistant Staphylococcus aureus.

About one in three of us carries Staphylococcus aureus (SA) on the surface of our skin or in our nose without developing an infection. Clostridium difficile (C. difficile) is a bacterium found in the large intestine of approximately three to five per cent of healthy adults along with normal, 'good' bacteria. It also produces spores which can survive for a long time in the environment.

Both MRSA and Clostridium difficile can cause serious illness.

Evidence shows that reducing the number of hospital-acquired infections is one of the most important factors that patients consider prior to coming into hospital.

Good hygiene is essential in helping to prevent the spread of infections. Thorough hand- washing and drying between caring for people is imperative in helping to reduce cross-infection.

What we did in 2010/11

We tackled this priority in the following four ways: MRSA screening, antibiotic prescribing, learning from cases of infection and monitoring infection after surgery.

1a. MRSA screening

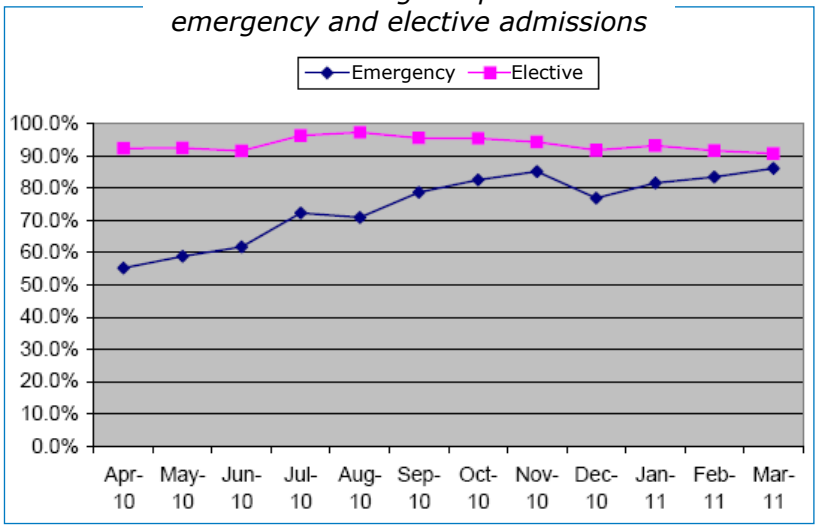
Aim: To test all patients for MRSA, including those admitted as emergencies as well as those coming in for planned surgery. This was designed to help us reduce the likelihood of patients developing MRSA infection.

Outcome: By year-end, screening of elective admissions had been consistently greater than 90% and compliance with emergency admission screening had climbed to greater than 80%.

The target to screen all patients coming into hospital is monitored for both elective and emergency admissions every month at the Infection Prevention & Control Operational Group.

How we will continue to improve and monitor quality: We can identify individual patients where screening did not take place. Following this up with clinical managers allows shared learning between teams and enables us to put plans in place to increase screening compliance to 100%.

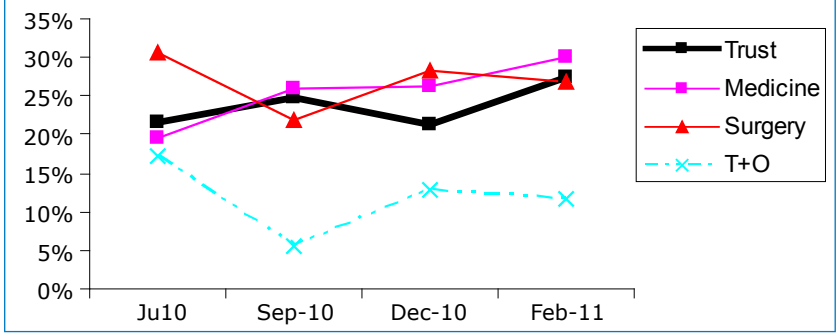
MRSA screening compliance for emergency and elective admissions



1b. Antibiotic prescribing

Aim: To improve the prescribing of appropriate antibiotics to patients to help keep them safe from infection.

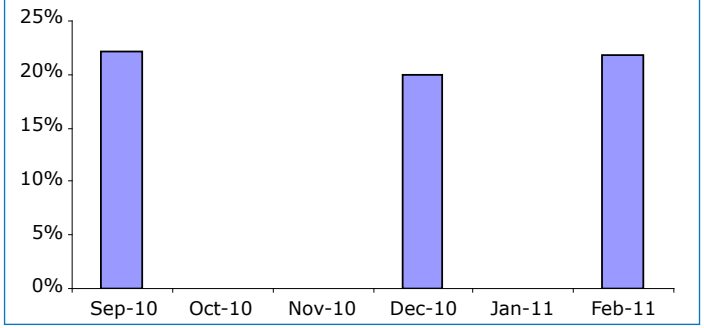
The percentage of patients in hospital on antibiotics



Antibiotic usage across the Trust lies between 21% and 27% of all patients over the past year – typical rates in other Trusts are about 30%.

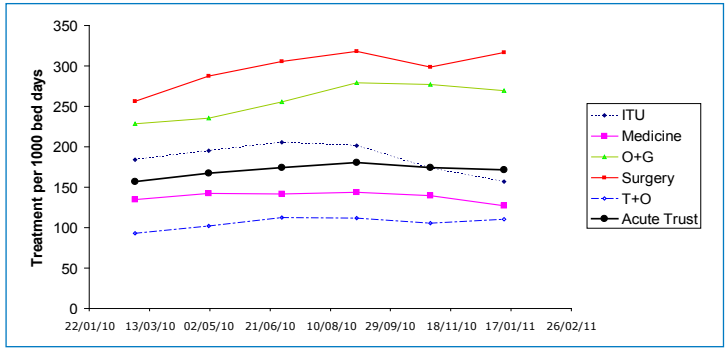
(Data derived from quarterly cross-sectional survey of all hospitalised patients)

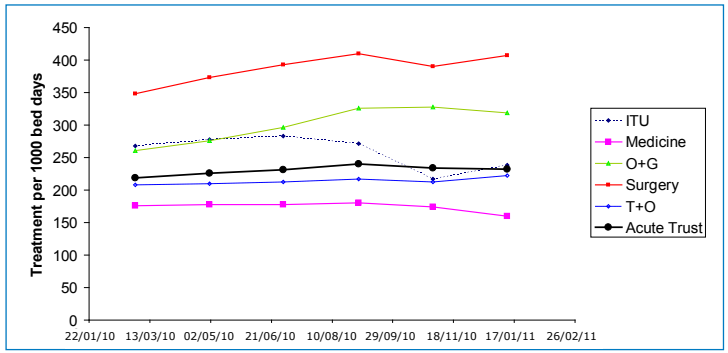
Percent of antibiotic prescriptions that were for HAI



Key: T+O - Trauma and Orthopaedics
O+G - Obstetrics and Gynaecology

Outcome: Usage of antibiotics that are high risk for causing C.difficile remains fairly constant across the Trust, although it has increased in surgery and obstetrics/ gynaecology. Co-amoxiclav accounts for most of the high-risk prescribing, as shown in the charts below.





Antibiotic prescribing is closely monitored through the Antibiotic Prescribing Working Group and Patient Safety Committee. The Antibiotic Management Team reviews prescribing of antibiotics that are restricted and high risk for C difficile every day, while the C difficile Multidisciplinary Review Team monitors the treatment of all patients with C.difficile on a weekly basis.

All doctors are given quick reference guidelines on antibiotic prescription and taught sessions by consultant microbiologists. The Trust's prescription chart for every patient has been updated and includes a separate section for antibiotic prescription to ensure tighter control of these important drugs.

How we will continue to improve and monitor quality: We will continue to review the use of Co-amoxiclav and consideration of alternatives in protocols. All antibiotic guidelines are currently under review for re-launching in 2011/12.

Our staff also reduced prescribing of the antibiotic Meropenem by 50% last year, which is a huge achievement and bucks the national trend of ever-increasing usage. Meropenem is the antibiotic of last resort, and frequent use reduces its effectiveness over time. Antibiotic resistance is a growing problem that makes the management of infection increasingly difficult.

1c. Learning from cases of infection

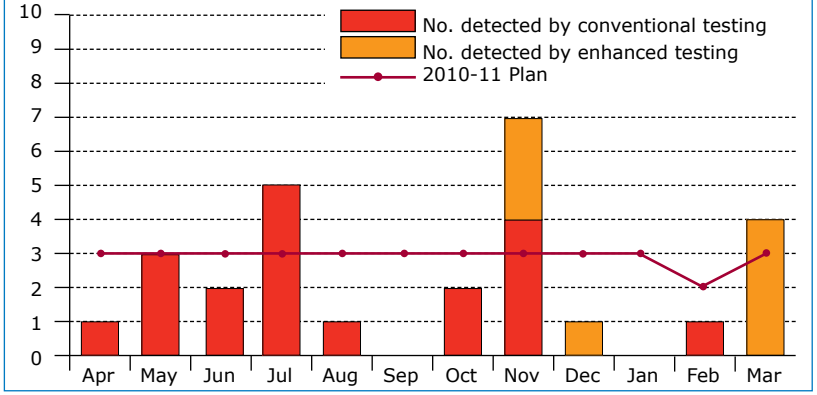
Aim: To make sure we learn from cases where patients do acquire an infection whilst in hospital by looking closely at some cases of specific infections, to identify any changes that might protect patients from infection in the future.

Outcome: A process of root-cause analysis is used to examine all cases of bloodstream infection from MRSA and cases of C. difficile infection. The aim is to learn as much as possible about how the infection occurred, and instigate action plans to reduce the likelihood of future cases. These action plans are monitored monthly at Patient Safety and Infection Prevention and Control Operational Group.

As a result of national learning from cases of C. difficile infection, from October 2010 we introduced enhanced testing which has improved our detection rates and enabled us to commence treatment earlier.

How we will continue to improve and monitor quality: All incident forms relating to antibiotics – for example, missed and delayed doses, adverse effects, non-formulary antibiotic choices and allergy - are being reviewed by the Antibiotic Management Team in order to extract as much learning as possible to prevent recurrence of incidents.

Monthly numbers of cases of Clostridium difficile cases for NDDH (> 3 days from admission)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010-11 actual	1	3	2	5	1	0	2	7	1	0	1	4
No. detected by conventional testing	1	3	2	5	1	0	2	4	0	0	1	0
No. detected by enhanced testing							0	3	1	0	0	4
2010-11 Plan	3	3	3	3	3	3	3	3	3	3	2	3

1d. Monitoring of infection after surgery

One of the essentials in reducing infection is to understand the scale of the problem. We therefore carried out a surveillance exercise last year of patients who had undergone operations.

Surgical procedure	No. of operations	No. of infections	NDDH infection rate (%)	National infection rate (%)
Small bowel surgery	29	1	3.4	8.3
Large bowel surgery	52	1	1.9	10.9
Hip replacement	102	1	1.0	0.8

Such surveillance is very labour-intensive, so each type of surgery was monitored for three months.

The small numbers of operations and infections in each category mean it is difficult to be confident about any comparisons between the infection rate at North Devon District Hospital and the national rate. However, on this limited basis, the infection rates for small and large bowel surgery were below the national average, while the rate for hip replacement was slightly above the national rate.

2. Keeping our patients safe from the risk of blood clots

What was the issue?

A blood clot, also known as a deep vein thrombosis (DVT) or venous thromboembolism (VTE), forms within a vein deep in the body. Most occur in the lower leg or thigh, but they can occur elsewhere. The clot blocks the normal flow of blood through the veins either partially or completely, causing swelling and tenderness. If a clot breaks off it travels to the lung and causes a pulmonary embolism (PE), which can be serious and occasionally fatal. A PE can occur without any symptoms or signs of a blood clot.

A blood clot is a potentially-serious condition. Although not all clots can be prevented, the risk of developing a VTE can be significantly reduced if we assess each patient for the risk and then prescribe preventive treatment. Anti-embolic stockings, which apply graduated compression to the leg, reduce the risk of blood clots and are used on many patients after assessment by nursing staff. The use of a blood-thinning agent reduces the risk of a DVT by up to 50% and the risk of PE by 65%.

What we did in 2010/11

We tackled this priority in the following three ways:

2a. Risk assessments for all admitted patients

Aim: To assess the risk of developing blood clots for all patients, including those attending for day surgery, as part of the admissions process. This included looking at a patient's past medical history, for example.

Outcome: Through a process of staff education, Trust-wide communication and a change in patient documentation making it easier to record the risk assessment, the Trust has made significant progress month on month with the percentage of patients who have a risk assessment completed for VTE within 24 hours (see table below). Overall compliance in March 2011 was measured at 83.76%.

Risk assessments are commenced, for elective patients, in the pre-operative assessment clinic, and reviewed post-operatively by medical staff, who prescribe the most appropriate preventative measures. The Trust has developed a patient information leaflet that explains how patients can help to stop DVTs and PEs, both whilst in hospital and when they are at home; we aim to give a copy to every patient.

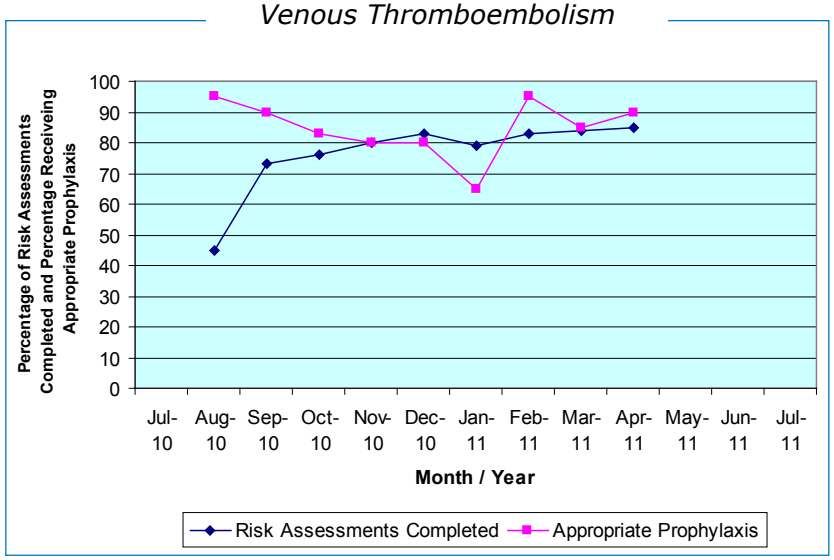
If a patient in our care develops a DVT or PE, we undertake a review of the patient's care to establish whether we could have done anything differently, and whether there are any lessons that can be learnt and shared across the Trust.

Table - Percentage of patients who have a risk assessment completed for VTE within 24 hours

	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Arterial and vascular surgery	89	75	72.7	88.8	100
Breast surgery	76.2	83.3	88.2	88.4	95.5
Cardiology	46.2	62.5	33.3	66.6	37
Care of the elderly	88.2	92.3	85.6	91.5	93.4
Colorectal surgery	71.2	84.3	77.2	76.7	77.2
Ear, nose and throat	80	90.3	78.3	82.3	86.8
General medicine	86	87.2	84.3	85.4	88.1
General surgery	77.2	85.2	72.6	80.8	87.9
Gynaecology	76.4	78.1	69.8	77.5	73.5
Hepatobiliary pancreatic surgery	78.6	85.2	68.8	75	92.2
Midwifery episodes	70.2	68.1	67.9	66.9	63.5
Obstetrics	67.9	64.6	68.3	67.5	63.2
Ophthalmology	96.9	96.7	98.1	95.2	97.8
Orthopaedics and trauma	83	81.4	71	81	86.8

How we will continue to improve and monitor quality: We will continue to review the record of every adult patient on discharge, to establish what percentage of our patients had a full and appropriate risk assessment completed within 24 hours of admission. We will continue to share this information widely amongst staff, and will ask senior staff to develop action plans for those services that need to improve assessment of their patients. We will continue to work collaboratively with other Trusts across the South West to share best practice and learning resources.

Venous Thromboembolism



2b. Checking that appropriate preventive treatment is prescribed

Aim: To continue to monitor prescribing practice closely, because the prescribing of preventive treatment is so crucial in trying to prevent blood clots.

Outcome: Our patients consistently receive appropriate preventative treatment, whether this is a medicine by injection or tablet form, or by giving patients anti-embolic stockings to wear whilst they are inpatients (and sometimes following discharge). The pharmacy team undertake daily monitoring of inpatient prescription charts to ensure that patients continue to receive the correct preventative treatment, and we continue to work closely with our GP colleagues to ensure that patients in our community hospitals receive the same level of care. There is generally an upward and improving trend against our goal of 95% compliance. In March 2011, 85% of our patients received appropriate preventative treatment.

How we will continue to improve and monitor quality: We will continue to monitor a group of patients every month to ensure that the correct preventative medication is being prescribed. Our Tissue Viability Nurse, Senior Nurses, and Matrons will continue to monitor the assessment for and application of antiembolic stockings, to ensure they are being used appropriately and checked regularly. When a patient in our care does develop a DVT or PE, we undertake a review of the patient's care to establish whether we could have done anything differently, and whether there are any lessons that can be learnt and shared across the Trust.

2c. Reviewing various preventive treatment options for surgical patients

Aim: To look at various types of preventive treatments, in order to ensure that patients who have surgery receive the best possible treatment to prevent blood clots.

Outcome: During surgery, and where it is considered appropriate, most patients have calf pumps and/or anti-embolic stockings in place, and will continue with one of these mechanical preventative measures when they return to the ward. All surgical patients have their risk assessments commenced when they come to the pre-operative admission clinic, and a doctor will review this when the patient is admitted to the ward after surgery. This makes sure that patients are prescribed the correct preventative medicines for DVTs and PEs. Some patients, such as those undergoing an orthopaedic procedure, may be required to continue using a medicine to prevent DVTs and PEs once they leave hospital; where this is considered appropriate, our nursing and pharmacy staff will work with patients to ensure they understand how to administer the medicine and for how long. Our orthopaedic team are continuously reviewing the preventative medications they prescribe patients, and work closely with pharmacy staff to ensure the most appropriate types are used.

How we will continue to improve and monitor quality: The VTE Steering Group will continue to work closely with clinical teams and will monitor the preventative measures used for surgical patients. The VTE Steering Group will also work to ensure that any changes are communicated fully to all staff. When a patient in our care does develop a DVT or PE, we undertake a review of the patient's care to establish whether we could have done anything differently, and whether there are any lessons that can be learnt and shared across the Trust.

3. Making sure patients, their families and carers have the best possible experience when using our services

What was the issue?

Our patients are at the heart of everything we do. We want to improve the experience of patients and ensure that their visit or stay is as pleasant as possible.

A Trust-wide comment card scheme, 'Tell us what you think', covers all public areas of the Trust, and can be used by patients, their relatives or carers, and visitors. The scheme is also available on the Trust's website. A number of national and local patient surveys are also carried out each year to find out what people think of our services and where improvements could be made.

We use the information from the 'Tell us what you think' scheme and patient surveys to make changes to improve quality for patients, relatives and visitors.

Listening to what our patients, their families and carers tell us, and using this information to improve their experiences, is a key part of the Trust's work to raise quality.

What we did in 2010/11

Our 'Tell us what you think' comment cards and the results of the National Inpatient Survey told us that patients and their families wanted us to focus on six patient experience priorities in 2010/11:

3a. Staff attitude and communication skills

Aim: To carry out a piece of work to improve the caring attitude of some of our staff, as patients have sometimes felt that the attitude of staff and their skills in communicating with patients could be better.

Outcome: Customer care training, which addresses communication issues specific to patient experience, concerns and complaints, has been implemented to reflect the importance of good communication. A customer care improvement plan aims to change the ethos and culture within the organisation, and to improve the experience of patients using our services.

Following discussions and reviews, a varied model of customer care training has been implemented, and is continually being reviewed and revised. It builds on nationally recognised models such as iCARE, which was developed at the Yeovil District Hospital NHS Foundation Trust.

How we will continue to improve and monitor quality: Increased awareness among staff about the importance of good communication should produce a corresponding reduction in the number of formal complaints and Patient Advice & Liaison Service issues involving poor attitude of staff or communication. This will continue to be monitored by the Customer Relations Team and through the Quarterly Patient Experience Report, which is presented to the Learning from Patient Experience Group and Trust Board.

3b. Patient and public engagement

Aim: To set up a group to advise us on the best way to involve our users, made up of at least 75% members of the public, with 25% Trust staff.

Outcome: The Involving People Steering Group (IPSG) was established following a public engagement meeting in March 2010 which sought the views of local people on how we could best engage them in the work of the Trust. The IPSG was set up to make sure patients' voices are always heard and acted upon, as we develop proposals for improving services. The approach reflects work over the past year to update our Patient and Public Involvement Strategy, echoing the national commitment to patients: 'No decision about me, without me.'

The first bi-monthly meeting of the IPSG was held in August 2010 at North Devon District Hospital. The group has 12 user representatives drawn from and nominated by voluntary groups representing different sections of the community including children, older people, people with learning disabilities, people with visual impairment and LINk Devon (the Local Involvement Network). There are also four staff members on the group, including the Director of Nursing who is the Trust's executive lead for patient and public engagement.

The Group is already having an impact on patient care. For example, we had discussions about a variety of feedback raising concerns from patients and carers that we were not meeting the needs of dementia patients. As a result dementia focus groups were set up to better understand what our dementia patients and their carers expect and need. Following a joint event run by the Royal National Institute for the Blind and LINk Devon , attended by more than 100 visually-impaired patients, we received feedback on how we could improve the services we offer for this group of patients. Members of the IPSG are also involved in determining the priorities for the annual quality accounts.

How we will continue to improve and monitor quality: The impact of the Group on continuous quality improvement will be monitored through evidence that its contribution and feedback have resulted in actions being taken.

3c. Cancelled appointments

Aim: To review the way our systems worked in order to reduce the number of cancelled outpatient appointments.

Outcome: We have audited the number of cancelled appointments to spot trends in the causes, for example mail drops, incorrect /out-of-date demographic details.

We are also working closely with the Devon Access and Referral Team to ensure that our directory of services is correct and that appointments made are with the right clinician and in the right place, and don't have to be cancelled and re-booked. Appointment slots and capacity are regularly reviewed to ensure that we are maximising the capacity and filling every available slot. We also maintain a list of patients who can attend at short notice, to ensure we use any vacant slots.

In April 2011, patients began to receive telephone reminders about their outpatient appointments under a new pilot project. Calls are made in the week before patients are due at the clinic to make sure they are still planning to attend. Patients are also offered the option of cancelling or rearranging during the call.

The aim is to reduce the numbers of patients who fail to turn up, many because they have forgotten.

How we will continue to improve and monitor quality: Continuous audit of cancelled appointments together with regular reviews of appointment slots and capacity.

3d. Copies of letters

Aim: To ensure that all patients received copies of letters about their care, if they wish. Sending copies of letters between the hospital and GPs or other hospitals can help patients feel properly informed about their condition, treatment and plan of care.

Outcome: In October 2010 we re-launched a Trust-wide initiative to ensure that all patients were offered the opportunity of having a copy of the letter that was sent to their GP as a result of their outpatient appointment.

How we will continue to improve and monitor quality: We will undertake regular audits of the patient's medical record to ensure that the doctor is writing in whether the patient wishes to receive a letter or not. In addition, the question as to whether or not patients were offered the opportunity of receiving a letter when they attended their appointment will be included in future patient surveys.

3e. Acting on feedback

Aim: To become more effective in capturing feedback from patients by developing methods such as electronic questionnaires. At the same time, the new methods would improve the way we analysed the results, meaning that we became better able to act and respond.

Outcome: The Trust has invested in a patient experience system which enables us to capture electronically what people think about our services. Questionnaires can be completed using handheld computers and fixed kiosks so that patients can give us feedback during their stay. It is anticipated that these will be operational in summer 2011. They will allow quick analysis so we can quickly pinpoint areas that need improvement, but will also highlight those areas where our patients feel happy with the care and service they receive.

Remembrance garden

A project was set up in response to suggestions from bereaved parents that a Remembrance Garden would be a valued facility at North Devon District Hospital. The Remembrance Garden was opened in January 2011 and is providing a place for quiet reflection for patients, their families and carers, and staff.

Integrated Women's and Children's Unit

Over many years the Trust has been particularly active in approaching parents and user groups to gather their feedback on the women's and children's services to find out what they liked and what could be improved.

The plans for the development of an Integrated Women's and Children's Unit are close to reaching fruition; users have been involved throughout to finalise the plans.

How we will continue to improve and monitor quality: An annual rolling programme of patient feedback initiatives across the Trust, approved at Board level, will be put in place to ensure that:

- The patient/carer feedback agenda is responsive to the changing needs of the Trust and those of the service users
- Improvements are sustained are carried out in a timely way

3f. Looking at the experience of patients in specific services

Outcome: During the past year a total of 24 individual patient surveys were completed focussing on patient experience in specific services, together with a number of surveys carried out by external bodies, for example:

- Breast surgery - effectiveness of post-operative pain control
- Cataract one-stop clinic - delays and patient information
- Chemotherapy Day Treatment Unit - waiting times, treatment rooms and privacy for discussions
- Urology Service – patient support and advice, clinic environment and copy letters
- Orthopaedic Surgery Inpatients – patient information, organisation, facilities, communication, hand-washing
- Maternity Services Day Assessment Unit – communication, appointment delays
- Ophthalmology Age-related Macular Degeneration (AMD) Service – information for patients, post-treatment contact
- Radiology General – customer care, privacy and dignity
- Colposcopy Service – clinic environment and facilities

The findings from a selection of these included the following:

Chemotherapy Unit

With one in three people being diagnosed with cancer at some point in their lifetime, it is a disease which affects nearly all families. The North Devon District Hospital (NDDH) Chemotherapy Service treats nearly 5,000 Northern Devon residents a year, and on average sees up to 22 diagnosed patients every day.

When talking to patients, we hear many fantastic things about the support and advice offered by staff and the way they frequently go above and beyond the call of duty to help patients. But something everybody agrees on is that the building housing the service needs updating to reflect the outstanding care and dedicated people who work there. In order to address these shortcomings, in February 2011 we launched a fundraising appeal to create a new, purpose-built chemotherapy and day treatment unit at NDDH.

Orthopaedic Surgery

A survey of orthopaedic in-patients at NDDH – the first of its kind –showed high levels of patient satisfaction. Nursing staff on Lundy/Roborough handed out 500 questionnaires to people when they were discharged following elective surgery. Some 351 responses were received, with overall care described as good or excellent for 96% of nurses, 88% of physiotherapists and 92% of anaesthetists. Overall care from surgeons was rated good or excellent in 95% of cases (with individual surgeons scoring between 79% and 100%).

Shortcomings identified were headed by: information-giving, organisation of admission, organisation of discharge; food and pain. These will be addressed to ensure improvements are made.

Ophthalmology AMD Service

The Trust's ophthalmology team has been recognised for the excellence of its new service for patients with Wet Age-Related Macular Degeneration – a major cause of sight-loss. Comparisons with other hospitals in the South West show that the improvement in patients' sight at NDDH is amongst the best in the South West. Patient satisfaction is also very high.

A local survey carried out with our patients identified the need to improve information given to patients prior to attending clinic, and to ensure that patients have details on who to phone if they need any help or advice after treatment. Both these actions have been addressed.

How we will continue to improve and monitor quality: There is an on-going programme of patient surveys as part of our annual audit programme, designed to look at the experience of patients in specific services. Action plans are followed up to ensure that where areas for improvement have been identified, the appropriate changes are made.

4. Improving the way in which we discharge patients from hospital

What was the issue?

Making sure our patients are safely discharged from hospital at the right time, with the right support in place and with the right information, is an important part of providing high-quality care.

Results of the 2010 National Inpatient Survey had revealed a number of areas where we could improve the way we discharge patients from hospital.

What we did in 2010/11

Feedback from our patients had identified four priorities relating to discharge, on which we focused last year:

4a. Information on medication

Aim: To improve the verbal and written information that we gave to patients on discharge. The information we give about common or important side effects of medication should be simple, clear and memorable.

Outcome: All patients receive the company's patient information leaflets with their medicines and a copy of their discharge letter. In addition all labels include the Pharmacy Department's telephone number so that patients can ring with any queries after discharge.

When patients are on a ward at North Devon District Hospital, they are visited by pharmacists and medicine management technicians who can explain why they are on certain medicines and answer any questions. There is also a process for identifying patients with learning difficulties so that their specific needs can be identified.

Some other actions are planned this year to further improve information for patients on medication, including looking into the need for further generic patient information leaflets; re-issuing guidance to patients on the need to bring their medicines into hospital; and supplying an additional copy of the discharge summary for patients to take to their community pharmacy to improve communication and prevent the re-issue of medicines that may have been stopped during their inpatient stay. In addition, this year we will be rolling out a new process for patients who need a monitored dose system to assist them in taking their medicines.

How we will continue to improve and monitor quality: Information for patients about their medication will continue to be reviewed regularly. All assessments for people requiring MDS will be audited to ensure they meet the jointly agreed criteria.

4b. Planning discharge from hospital

Aim: To improve the way we planned for a patient's discharge from hospital, we would review re-admission rates and individual cases to look at whether patients were discharged safely and appropriately.

Outcome: We have been monitoring readmission rates and have reviewed a number of specific cases to establish if the discharges were appropriate. We have set up a multi-disciplinary working group to undertake detailed work on discharge planning; this is ongoing.

How we will continue to improve and monitor quality: We will complete the work on discharge planning to ensure we have robust systems and processes in place to ensure the timely and safe discharge of patients. We will review readmission rates through the monthly clinical performance report and undertake more detailed investigation where we identify significant changes in rates within any specialty.

4c. Information about discharge

Aim: To ensure that patients had sufficient information on what to do on discharge and about who to contact if they had any concerns or queries.

Outcome: The Trust has further developed a 'Leaving Hospital' leaflet, which includes sections on what to do if a patient has worries or concerns about discharge, and what to do if they think that they won't be able to cope or need specialist equipment or support at home. They are also given details about who to contact if they have problems (health or social) after discharge, and a list of contact phone numbers. This discharge leaflet is given to patients as soon as is appropriate after admission, to allow both patients and visitors/carers to start thinking about discharge arangements.

How we will continue to improve and monitor quality: We will continue to monitor this via patient feedback and through any complaints that might relate to post-discharge information. We will also use the Trust's Involving People Steering Group to gain feedback on issues.

4d. Reducing medication delays on discharge

Aim: To work with our doctors to ensure that medicines for patients to take home were prescribed in a timely fashion and that the pharmacy teams worked to reduce delays in dispensing medicines.

Outcome: Work has been done with our doctors to ensure that when patients are due to be discharged, any prescriptions for medication to take home are written as early as possible, to reduce delays.

The Pharmacy Department has also worked hard to make the process easier and to reduce delays for dispensing medicines for patients to take home. Staff working hours have been altered to cope with the regular late evening increase in prescriptions.

How we will continue to improve and monitor quality: The numbers of prescriptions written on the day of discharge are monitored by the pharmacy team on a weekly basis. This number should fall as discharge planning improves and prescriptions are written up in a more timely manner.

Statements from our stakeholders

NHS Devon

Written Statement for the Northern Devon Healthcare NHS Trust Quality Account from NHS Devon

Northern Devon Healthcare NHS Trust has worked extremely hard to ensure that its focus on the continuous improvement of quality of care is at the centre of the services it provides, and as lead commissioner NHS Devon is pleased to work in partnership with the Trust to support this approach. The Quality Account for 2011/12 describes the achievements, priorities and planned actions to drive forward quality improvement focusing on national, local and regional priorities as well as those areas which we know are important to patients. The Quality Account also recognises the importance of not only traditional aspects of quality but also the issues of consistency and productivity that underpin quality improvement. NHS Devon is happy to support the development of the Trust's quality and safety improvement programme through the use of CQUIN, which has provided incentives to ward clinicians to continuously respond and improve care based on patient experience and best evidence.

The Trust has demonstrated improvement on the priorities identified with last year's account with some areas of outstanding performance and areas which can be further improved during this year. MRSA targets were unexpectedly not achieved, however three cases against a challenging target of one is an achievement in itself.

Good progress has also been made in terms of screening elective and emergency admissions for MRSA in this year. C. difficile targets have again this year been achieved and excelled, and the Trust's focus on the elimination of avoidable infections is obvious throughout the report and the priorities for action described. In addition, the Trust have implemented the new enhanced testing regime which ensures there is earlier detection and treatment.

During 2010/11 there has been marked improvement in the assessment and appropriate prophylaxis for prevention of venous thrombo-embolism in line with national best evidence and learning. The Trust has also demonstrated significant improvement in capturing and acting upon patient experience with the introduction of comment cards and surveys, supported by systems for patient engagement, which has ensured that quality improvement has been built upon feedback from patients. Overall in the year 2011/12 we would agree with the progress on quality improvement described within the Quality Account, and we have been witness to the absolute commitment of the trust to put quality of care at the heart of everything it does.

The 2010/11 priorities described by the Trust are consistent with the priorities agreed with NHS Devon in improving the experience of patients in the care they receive, working to increase reliability and productivity, ensuring patient safety and forwarding clinical excellence. NHS Devon has also worked with the Trust to support these improvements through CQUIN where possible. In

particular, the focus on prevention of pressure ulcers and improvements in the nutritional needs of patients is supported by NHS Devon, as we know that these are issues which can make a significant difference to the outcome for patients both clinically and in terms of their experience.

The alignment of the Trust's philosophy for quality of care with NHS Devon's is critical as it is only a partnership of commissioner and provider and its managers and clinicians that will drive improved outcomes for patients. The description of the achievements made in 2010/11 and the focus on quality during 2011/12 demonstrate in absolute terms the commitment of the Trust from ward to board in improving quality of care and we continue to support the approach the trust has taken the principles for quality improvement it has adopted and its priorities for the future.

Jenny Winslade
Director of Nursing
for the cluster of NHS Devon, Plymouth and Torbay

Devon Overview & Scrutiny Committee

Devon County Council's Health and Adults' Services Scrutiny Committee (SC) determined to comment on the Northern Devon Healthcare NHS Trust's (NDHT) Quality Account 2011-12. All references in this commentary relate to the reporting period 1 April 2010 to 31 March 2011 and pertain only to the NDHT's relationship with the SC. The NDHT has been engaging regularly with the SC throughout the reporting period.

The SC believes that the Quality Account 2011-12 is a fair reflection of the services provided by the NDHT and gives a comprehensive coverage of the provider's services, based on the knowledge the SC has of NDHT. In particular the SC would like to commend the NDHT on the overall standard of care as recognised by the Care Quality Commission.

Over the past year the NDHT has been more involved at committee, specifically reporting on Transforming Community Services in March 2011 and Ear Nose and Throat Services in June 2010. NDHT has also reported promptly on the Rural Access to Health Task Group and the Older People's Mental Health Task Group.

The SC would like to highlight, however, the following concerns about service areas which it considers need additional consideration.

Five of the recommendations of the Support for Carers Task Group which concluded in March 2011 were specifically directed at the NDHT. The SC would like to have greater dialogue with NDHT on this issue as they have not yet received a satisfactory response to these recommendations.

Scrutiny Members were disappointed to find that there was no reference to patient transport in the Quality Account. The SC identified the importance of patient transport in the Rural Access to Health Task Group; a key finding was that transport associated with Health provision would benefit from more comprehensive support from Healthcare Trusts.

Scrutiny Members would also like to have seen more detailed plans on how to reduce medication delays on discharge.

Cornwall Overview & Scrutiny Committee

Cornwall Council's Health and Adults Overview and Scrutiny Committee (HAOSC) agreed to comment on the Quality Account 2011-2012 of Northern Devon Healthcare NHS Trust. All references in this commentary relate to the period 1 April 2010 to the date of this statement.

Feedback to the Committee is that there is a good service; however, there is a feeling of distance to services due to the geographical nature of the Cornish population using the Trust. This is for both those receiving treatment and for those visiting patients.

The HAOSC believes that the Quality Account is a good reflection of the services provided by the Trust, and gives a comprehensive coverage of the provider's services and would like to develop further links with the organisation in the coming year.

Local Involvement Network Devon

Local Involvement Network (LINk) Devon's remit is to promote and support the involvement of people in the commissioning, provision and scrutiny of their local health and care services. To this end, LINk Devon welcomes the opportunity to provide a statement to Northern Devon Healthcare NHS Trust (NDHT) for their Quality Account. The LINk's response is based on involvement with and knowledge of NDHT to date.

LINk Devon has taken every opportunity to regularly feed back comments or concerns via NDHT's patient and public involvement structures. These views have been received through community engagement activities and events and LINk's own surveys, and LINk Devon undertakes to continue this activity. The LINk's community engagement worker for North Devon and Torridge has built up a good working relationship with NDHT and jointly organised a Patient and Public Involvement (PPI) strategy planning event in 2010 in partnership with NDHT. In turn, The Trust's PPI representative was invited to the LINks annual review last year to talk about collaborative working. The formal as well as informal contact between the ND engagement worker and NDHT has proved an easy route to raise concerns and receive feedback.

With regard to patient and public engagement, LINk Devon is represented on the Involving People Steering Group (IPSG) and any concerns raised by the LINk are referred to the Learning from Patients Experience Group (LPEG) for action and subsequent monitoring.

LOGO (LINk Devon's group for young people) have also attended that group and provided input from the young person's perspective. NDHT is in support of training for IPSG representatives to develop their skills and the LINk welcomes the prospect of representation training for the IPSG. This will hopefully enable the group to roll out the original concept of it being a group that facilitates and enables wider community/Trust communication and involvement, with more room for community content and issues on the agenda. A model for this might be the excellent liaison between the Trust, via Moses Warburton and the LOGO group on the redesign on the women's and children's services. As well as having a representative on the consultation group meeting at NDDH, plans were provided to be discussed at a locality LOGO group meeting. They provided a report of their views and have subsequently been invited to join one or more of the sub groups currently being formed to oversee this process.

In the spring, LINk Devon, the See Hear Centre in Barnstaple and Sensory Team combined to put on a 'Sight Matters' event for 86 participants with a visual impairment. The collaborative working with the Trust, and considerable support from Trust staff at the event itself, was very positive. Contributions from participants on the 'Losing Patients' consultation, focussing on the difficulties they continue to experience in receiving information in an accessible format, was responded to positively. There was an immediate update on the actions already being taken and an invitation extended to assess the facilities at the hospital. The ability to follow up these issues through the Sensory Impairment Task Group is also appreciated.

The inclusion of LINk participants as well as the community engagement worker on this group has been discussed and would be a significant step forward.

LINk Devon is encouraged by NDHT's commitment to improving quality and of the progress that was made against last year's priorities, in particular progress relating to the patient experience and the discharge of patients from hospital.

Feedback that LINk has received from the public has provided the basis for project work that LINk Devon has carried out relating to 'Leaving Hospital' and NDHT has provided information on request and circulated surveys to support this work. The LINk is soon to report their findings and therefore welcome a joint approach to any development work that may arise from the recommendations that LINk Devon makes.

The LINk fully supports NDHT's pledge to improve quality based on its key priorities outlined for 2011/12. Priority 9 in particular is specific to the interests of LINk Devon, as a main priority for LINks is to report any outcomes that occur as a result of LINk activity, to the wider LINk and the public. Last year LINk Devon did receive feedback to the recommendations made within both the Mole Patrol report and feedback relating to audiology services at North Devon District Hospital, with the opportunity to develop further joint work in the future. At the individual level, communication between the Trust and the LINk is excellent. However where issues require consultation within the Trust it can take too long for a response to be passed on, for example with the concerns of the hearing group.

By the time feedback reached this group several were no longer attending. LINk Devon has recently submitted their Have your Say! survey report and is currently awaiting feedback from NDHT in response to this work.

LINk Devon will continue to engage with NDHT, in particular by highlighting to them, on a regular and ongoing basis, any concerns people raise within the network that concern NDHT. LINk Devon will also continue to produce reports and recommendations where specific issues are raised by participants and the wider network, thus enabling communities to represent their views about the quality and standard of services provided through NDHT.

LINk Devon is proactive at circulating information provided by NDHT to encourage greater involvement, such as for their Quality Account and the dementia focus group. At this point the LINk should congratulate the Trust for taking the trouble to provide the Quality Accounts information in various accessible formats.

How we decided on content

We were very keen to engage as many individuals and groups as possible in determining our priorities for improvement in the coming year. The areas covered in this Quality Account were decided after extensive consultation with staff, patients and the public, our Involving People Steering Group and LINk Devon.

A long list of contenders for inclusion was drawn up which were derived from three sources: the Trust's performance over the past year against its quality and safety indicators; national or regional priorities; and 'horizon-scanning'.

We felt that the list of contenders for 2010/11 needed to be in areas which fulfilled most or all of the following criteria:

1. Where the Trust genuinely had a desire or need to drive improvement
2. Known improvement strategies so that the Trust could deliver tangible improvement in a defined timeline
3. Have measures either in place or in development
4. Capable of historic or benchmark comparison

The list plus the rationale for selection were then discussed and consulted on extensively with groups of internal and external stakeholders, through a number of meetings and through targeted questionnaires which were made available through our Trust website, our intranet and on paper.

The feedback helped identify the shortlist of priorities on which we will focus our attention in the coming year, and which are included in this document.

Your feedback

We want our Quality Account to be a dialogue between Northern Devon Healthcare NHS Trust and our patients, members of the public and other stakeholders.

To let us know what you think of the account, or to tell us what you think we should be prioritising, please contact us in one of the following ways:

Via our website: www.northdevonhealth.nhs.uk

By email: QUALITYACCOUNTS@ndevon.swest.nhs.uk

By post: Communications Department
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