Quality Account
2018/19

Respect for staff
Value to the ‘person we care for’
Teams able to drive improvements
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Chief Executive Statement

It gives me great pleasure to present University Hospitals Plymouth NHS Trust’s annual Quality Account, representing our report on the quality of services we provided in 2018/19 and our key quality priorities for improvement in 2019/20.

The pressures facing the NHS continue to be the subject of a considerable amount of political, media and public interest. Whilst the Care Quality Commission’s ‘Annual State of Care’ report for 2017/18 showed that most people receive a good quality of care, people’s experiences are often determined by how well different parts of local systems work together.

It is important to remember that the challenges facing our health and social care system can have a very real impact on people’s lives both in terms of those who need our care and those who provide it.

We have much to be proud of in the care we provide and what has been achieved in 2018/19. Despite the challenges posed by increasing demands on our services, we have managed to make substantial progress in a number of critical areas including:

- Securing significant additional funds for capital investment in a new Emergency Department, new diagnostic scanners and digital histopathology which will benefit patients across Devon and Cornwall. This comes on top of funding already received and used to upgrade our resuscitation and children’s areas in the existing Emergency Department.

- Rollout of the #PeopleFirst programme, a national scheme which we applied to be part of jointly with Livewell Southwest, our colleagues providing community care. The #PeopleFirst methodology brings a scientific approach to team-driven improvement and is already making an impact, through projects such as changes to our heart failure service.

- Joining up care for people, particularly those with more complex needs on leaving hospital. By working more closely with other organisations providing NHS services, care homes and the voluntary sector, among others, we have been able to significantly reduce the number of patients who are subject to delayed transfers of care.

We also continued to make progress in providing a rewarding and supportive environment in which to use the results of the National Staff Survey, which showed further improvements since last year.

All of this has been achieved against a background of growing demand, which puts pressure both on services and the staff who provide them. We have seen particular increases in patients attending as emergencies and those referred under the two week wait pathway for some specialties.

We know we have more work to do to reduce waits for patients, particularly those waiting too long for planned care and this is a key focus for us in 2019/20.

We continue to work hard to support staff in a number of ways, from promoting team-driven improvement, to specific health and wellbeing initiatives, often run from our Derriford Centre for Health and Wellbeing.

Our thousands of staff and hundreds of volunteers remain our greatest asset and we remain committed to supporting them in their working lives, through training, development and wellbeing. In doing so, we enable and support them to provide the best possible care to patients and families, and if they are not frontline staff themselves, to support their colleagues who do so.

We remain, as ever, appreciative of all they do and I would like to take this opportunity to say a formal ‘Thank You’ for their continued dedication and incredible compassion.

I am therefore pleased to present our annual Quality Account for 2018/19, which I believe to be a fair and accurate report of our quality and standards of care.

Ann James
Chief Executive
Review of 2018/19

Our commitment to quality

Our vision is to provide excellent care, with compassion, wrapped around people’s individual needs to the population of Plymouth and surrounding areas. We are committed to placing quality at the heart of everything we do ensuring that we build quality into all parts of our service and rigorously focus on its delivery.

We aspire to make a difference as the major provider of acute and specialist services in the south west peninsula. We will invest in the future through teaching, research and continual improvement and work within a highly collaborative and integrated health and social care system.

Our mission is to play our part in an inclusive society which addresses the social causes of ill health and empowers people to live healthy independent lives. We will support people to take responsibility for their own health, wherever possible, and provide access to high quality medical care.

We do many amazing things yet sometimes we do not always achieve the high standards to which we aspire. We deliver highly complex, specialist treatment every day but we do not always get the simple things right.

During 2018/19 we finalised our strategic direction for improving the quality of care delivery. Our key aims focus on people, quality, sustainability, partnerships and impact, these are set out in the diagram below.

In terms of our more specific priorities for 2019/20, we have completed a consultation process with patients, staff and other key stakeholders to identify key areas of focus for the coming year.

A number of key documents were considered when selecting the priorities including our Operational Plan 2019/20, Board Assurance Framework, Quality Improvement Strategy, Care Quality Commission Report and NHS Improvement areas of focus.

Our aim is to be a safe and effective hospital which is highly rated by our patients and one in which staff are happy to work. In achieving this, we seek constantly to improve our services, shaped by what our patients tell us, and be quick to respond to problems and fix underlying causes.

Building Capability

University Hospitals Plymouth and Livewell Southwest continue to work together to improve patient care, support closer working and provide better outcomes for patients.

In 2018 University Hospitals Plymouth NHS Trust and Livewell SW were successful in our joint bid to become one of seven national hospitals to partner with NHS Improvement in a programme of work we have termed our People First Programme.

With help and support from the national team we are changing the way we work to improve the quality of care we offer, making our services safer, more effective and patient centred. By removing waste, putting the best ideas of our front line staff into practice and by focusing on what our patients really want, we will deliver better services.

Using a single approach to build quality improvement right through our organisations is helping us create a common purpose which we are all working towards and provides the opportunity for our staff at all grades to make a contribution.

Our executive team has been trained to use this approach and we have started a programme of training for our staff which will run over the next
three years. This training will focus on how our staff can work to continuously improve how we deliver care. More detail can be found in Annex G.

Care Quality Commission

The Care Quality Commission (CQC) is the organisation which regulates and inspects health and social care services in England. All NHS hospitals are required to be registered with the CQC in order to provide services and are required to maintain specified fundamental standards of quality and safety in order to retain their registration. As part of its role the CQC is required to monitor the quality of services provided across the NHS to make sure they provide people with safe, effective, compassionate, high-quality care and to take action where standards fall short of the fundamental standards. Their assessment of quality is based on a range of diverse sources of information about each Trust in addition to its own observations during periodic, planned and unannounced inspections.

The Trust has registered its locations against the relevant regulated activities with the CQC with no additional conditions applied to its registration.

Planned Inspection

We were the subject of a planned CQC inspection in April-May 2018. During this inspection we were rated as ‘Requires Improvement’ overall.

The inspection report contained a number of Requirement Notices (Must Do actions). 56% of the actions designed to address these Requirement Notices are now complete. The significant ongoing open actions relate to redesign and rebuild of the Emergency Department; mandatory training; ensuring that patients presenting with possible sepsis are recognised, started on a treatment pathway and administered antibiotics within 60 minutes; and delivery of operational performance standards.

In addition to the Requirement Notices, the Trust received two Section 29A Warning Notices, one for Pharmacy and one for Diagnostic Imaging. These Warning Notices stated that:

- Significant improvement was required to ensure that patients suspected of having cancer had timely access to initial assessment, test results and diagnosis in diagnostic imaging.
- Significant improvement was required to ensure that systems and processes for safely managing medicines were operating correctly both within the pharmacy services and across the Trust, and were effectively governed so that people are given the medicines they need, when they need them and in a safe way.

We were required to make these significant improvements by Friday 26 October 2018. The key work streams to address these areas of concern had already started before receipt of the report, and in a number of cases had started before the inspection itself.

Follow up inspection

The CQC conducted a follow-up inspection in December 2018 focused solely on the improvements required within the two warning notices.

In Diagnostic Imaging the CQC found that:

- There was improving performance for patients waiting longer than six weeks for a routine scan.
- There were plans to improve process and efficiency with booking appointments.
- There was improved management of governance within the Imaging Department.
- There had been an internal review of risks on the risk registers and actions were progressing well.
- Improvements had been made in the management structure for senior staff in the Imaging Department.
- In CT the most urgent scans were reported on in a timely way.
However, the CQC felt that insufficient progress had been made in addressing the concerns in the 2018 Warning Notice and on 25 January 2019 they reassessed the existing notice stating that; “significant improvement is required to ensure patients suspected of having cancer have timely access to initial assessment, test results and diagnosis in diagnostic imaging”.

The key three areas of concern highlighted by the CQC are as follows:

- The Diagnostic Imaging Service was not meeting the seven-day internal target for the imaging of patients suspected of having cancer in CT, MRI or ultrasound.
- Radiographers consistently told inspectors that managers within diagnostic imaging were not addressing poor behaviour or attitudes displayed by some modality leaders.
-Band five radiographers consistently felt unable to speak with departmental managers and / or freedom to speak up guardians to escalate their concerns due to fear of repercussion.

The Trust was required to make the significant improvements in relation to the first point by 24 April 2019 and for the other issues by 24 July 2019.

Pharmacy: The CQC recognised the clinical pharmacy service had improved its access to clinical areas for routine pharmacy input. The service had been reinstated on 1 October 2018, reducing several risks identified in the Warning Notice from a previously restricted service. They also recognised that governance structures for pharmacy had been changed since the last inspection, although not yet embedded to enable the CQC to evidence their effectiveness.

One area of concern highlighted by the CQC was the limited assurance that sufficient priority or resources had been allocated by the Board to address and rectify issues in pharmacy, or that adequate support had been provided to the interim chief pharmacist to ensure a continued presence of support in the department. This has now been addressed following the appointment of a former chief pharmacist who now provides senior leadership support 2-3 days per week.

The CQC found we had not fully addressed or sufficiently acted on some of their concerns in the warning notice and the full warning notice, noting actions taken needed better executive oversight. However, they recognised some progress was being made and that a cultural shift would take time.

We were therefore not issued with a further warning notice for pharmacy; instead the report set out a number of requirement notices which do not have a specified time limit in which they should be addressed.

Our actions to improve both services are set out in the tables below.

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<th>Core Service</th>
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| Diagnostic Imaging    | Ensure that 85% of patients suspected of having cancer are scanned within seven days as per the Trust target. | • We have implemented daily cancer admin huddles to improve booking scans and introduced an escalation in-box for admin staff.  
• We will appoint a 2 week wait co-ordinator.  
• We are reviewing admin cover by day of the week and considering options to deliver an extended working day.
• We are auditing reasons for breaching the 7 day scanning standard.
• We will review and improve booking processes for the Planned Investigation Unit/Lynd.
• We will identify complex booking issues. |
## Review of 2018/19

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|              | Ensure the management team addresses poor leadership and manages attitudes and behaviours shown by some of the team. | For band 7 and 8 staff we have:  
- Met to discuss behaviours and responsibilities and will send an open letter to the band 7 and 8 radiographers reinforcing expectations.  
- Implemented enhanced management arrangements for plain film.  
- Transferred the management of the rota into the service line office.  
- Clarified arrangements for rota swaps and reduced band 7 on call duties.  
In addition:  
- We will conclude current formal Investigation/s.  
For band 5 staff:  
We arranged a meeting to inform staff about the actions we are taking following the meeting in December 2018 and are arranging regular meetings to update them about progress and provide an opportunity to give feedback. |
|              | Ensure that staff satisfaction improves, and that staff are confident to raise concerns with managers. | For radiographers we are:  
- Arranging to meet with Freedom to Speak up Guardians to discuss how they can support staff.  
- Securing support from Financial Improvement Group to uplift the radiographic establishment to improve capacity to lead.  
- Developing a leadership development plan for radiographers with leadership responsibilities, in conjunction with organisational development.  
- Moving CT and plain film teams to Agenda for Change contracts, terms and conditions.  
- Developing a team based approach to improvement with support from the ‘PeopleFirst’ programme.  
For consultants we are:  
- Securing support for recruitment into approved and projected vacancies in advance.  
- Co-ordinating feedback and actions to the stress survey.  
- Agreeing which additional consultant posts will be appointed following the business planning process.  
For administration staff we are:  
- Addressing the leadership structure.  
- Reviewing staff survey actions (All staff).  
- Using group meetings with modality leads to inform improvement actions.  
- Arranging for feedback from SCORE Survey. |
### Review of 2018/19

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| Pharmacy     | Ensure there is a clear process within wards, pharmacy and transport, to safeguard patients receiving their critical medicines at discharge. Ensure patients are being appropriately counselled on their medicines. | • We are rolling out set criteria for discharge for all patients who do not have their medicines to take home i.e. not just critical medicines.  
• We are setting up a task and finish group with Heads of Nursing, Director of Winter & Communications to ensure the required action plan has been shared with care group clinical and operational leads. |
|              | Ensure that we have assurance and can evidence processes, through review of data, that patients being discharged without their critical medicines receive them in a timely manner. | A process is now in place and data is reported to the executive team weekly.                                                                                                                                                           |
|              | Review staffing establishment and skill mix for the pharmacy department to ensure staffing meets capacity and demand. | We are undertaking a workforce review as part of a broader project including service review (development) across the Trust.                                                                                                           |
|              | Review training and competency of staff and ensure staff are not working above their role and competencies. | • Senior education and training lead commences in post 1 April 2019.  
• We are reviewing requirements for part-time technician training post.  
• We are reviewing competencies and training.  
• Human resources to undertake review of banding for staff. |
|              | Ensure capacity for leadership and ongoing support is available in the pharmacy department. | • Experienced pharmacist started in March to support the medication safety and governance work streams.  
• Communications describing the new structures and proposed reporting lines will be circulated to staff.                                                                                                                            |
|              | Ensure risks are identified, recorded and mitigated, with a clear record for this. | • We will review and update the risk register in full.  
• We will ensure regular review of the risk register by Pharmacy Board.  
• We will review the work programme generated by the gap analysis against the Royal Pharmaceutical Society Standards and ensure that this links to risk management.                                 |
|              | Ensure there is robust oversight of governance for pharmacy and medicines trust-wide. | • Pharmacy Board now meets monthly. Fortnightly oversight meetings to be held with the lead executive director.  
• Terms of reference for Medicines Utilisation and Assurance Committee (MUAC) have been reviewed and we are establishing relevant sub-groups to focus                                                                 |
### Core Service CQC required that we: What are we doing to put this right?

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<td>more effectively on medicines management, new medicines and medicines safety.</td>
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<td>• We are implementing key performance indicators and reporting structures.</td>
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<td>• Quality Management System meetings will feedback to the chief pharmacist on a fortnightly basis.</td>
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<td>• Pharmacy will report to Trust Management Executive on a regular basis</td>
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<td>• Internal pharmacy incidents will be reviewed at fortnightly Pharmacy Quality Management Group and monthly Pharmacy Board.</td>
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<td>• Trust wide medicines related incidents will be reviewed and monitored by appropriate senior pharmacy staff and reported through MUAC via the Medicines Management Sub Group.</td>
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Monthly updates on the implementation of our actions and ongoing programmes of work to address the issues raised by the CQC have been provided to the CQC, NEW Devon Clinical Commissioning Group and NHS Improvement.

**Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Inspection**

CQC inspectors conducted a short-notice announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiology service at Derriford Hospital in December 2018. The inspection was focused on the action plan produced following a full comprehensive inspection which took place in November 2017.

The inspection reviewed the reasons why some of the actions around revision and ratification of the employer’s procedures required under schedule 2 of IR(ME)R 2017 had not been undertaken. However, the team were able to demonstrate that a new action plan was in place with a final date for implementation of March 2019.

Since December, all of our procedure documents have been reviewed and updated to IR(ME)R 2017 and an extensive training programme has commenced. We were re-inspected in April 2019 in response to the recommendations made by the CQC during their December 2018 inspection. The Trust received confirmation from the CQC on 29 April 2019 that they were now satisfied that their concerns regarding compliance with IR(MER) were met and the inspection file was closed as now fully compliant.

We continue to monitor compliance across all of the fundamental standards and are on a journey of continuous improvement. We continue to monitor, review and constantly improve the quality of care across the services that we provide.
Review of 2018/19

Our overall performance in 2018/19

The Trust has found the Emergency Department 4 hour standard difficult to achieve for several years. Following external reviews it has now been recognised that the infrastructure to manage the workload is inadequate both in terms of space and workforce.

Work to expand and reconfigure the paediatric and the resuscitation areas was completed in March 2019. Work is also in progress to increase the workforce numbers enabled by £2.5m investment.

Demand and acuity of patients presenting at the Emergency Department continues to increase. To help address this increase improvements to support patient flow through the hospital, such as reduced delayed transfers of care and patients with extended lengths of stay, have helped us to reduce the number of patients who are cancelled.

During the first quarter of 2018/19, our diagnostic waiting times deteriorated considerably largely driven by lack of capacity and increased demand for imaging. Actions were put in place including additional scanning facilities and improved patient treatment management, plus successful recruitment to vacancies resulted in the reduction of patients waiting for diagnostic appointments. Performance improved from 24% of patients waiting over 6 weeks in July 2018 to 7% in March 2019.

Demand for elective care has continued to exceed our capacity, with the number of patients referred for treatment increasing by 4.2%, resulting in longer waits for treatment. Plans designed to improve our performance have been successful, including increased use of outpatient clinics, the Care UK partnership which started in November 2018, improved administration functions and a reduction in diagnostic waiting times.

Disappointingly other plans have not had the desired effect. These include the delayed opening of our third cath lab and recruitment of medical consultants, new appointments were successful but other staff have resigned since resulting in no increase.

Despite the pressure of increasing demand, we have made progress in reducing the number of patients waiting over 52 weeks for treatment. We have reduced the number of patients waiting over 52 weeks from 167 in June 2018 to 48 at the end of March 2019.

Cancer Standards

Performance against our cancer standards was variable in 2018/19.

Our 2 week wait performance recovered from August 2018 onwards following an in depth review of demand and capacity, booking processes and pathways.

62 day performance continues to be a challenge for the Trust and our plan to improve the position has been unsuccessful. Whilst the number of patients waiting had reduced during the autumn, mainly due to improving 2 week waits and diagnostic performance, with the onset of winter and surgical cancellations, the backlog soon started to grow again. Key pressure areas are in urology and colorectal services. Recruitment is underway to increase the consultant workforce manage the increasing activity going forward.

The core quality metrics we have used and reported throughout 2018/19 are shown in Annex A.

Review of Services

During 2018/19, University Hospitals Plymouth NHS Trust continued to provide (or sub contract) 64 NHS services. The Trust has reviewed all of the data available to them on quality of care in all these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by University Hospitals Plymouth NHS Trust for 2018/19.
Goals agreed with Commissioners

An element of University Hospitals Plymouth NHS Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. The Trust received the majority of CQUN funding in 2018/19 on the basis of good levels of achievement of milestones.

A number of CQUIN schemes will continue into 2019/20 with others becoming part of normal contractual requirements. There are a number of new CQUIN schemes for 2019/20. Further information on CQUINs can be found on the NHS England website, which included below. www.england.nhs.uk/nhs-standard-contract/cquin/

Assurance Statements

Underpinning quality in the organisation we have a series of assurance statements, a summary of each is set out below, with further details included within Annex C Assurance Statements.

- **Clinical Coding**: This is the process by which patient diagnoses, treatments and comorbidities recorded in the patient’s written clinical notes and on accompanying systems are translated into codes using a standardised code-set. The accuracy of clinical coding is a fundamental indicator of the accuracy of patient records and drives the income received for each patient’s stay in addition to providing data to numerous national indicators including mortality

- **Data Quality**: Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement

- **Duty of Candour**: The Trust ensures Duty of Candour requirements are implemented following any ‘moderate harm’ or above graded incident once it has occurred. Where a patient safety incident has caused harm, an apology is offered to the relevant person, which is a sincere expression of sorrow and regret for the harm and distress caused

- **Revalidation**: Medical & Nursing - Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field and able to provide a good level of care. Nursing and midwifery revalidation also requires all Nursing & Midwifery Council registrants to revalidate every 3 years in order to maintain their registration

Clinical Audit

Clinical audit provides a means of measuring how well care is being provided compared to expectations of good practice. It underpins several quality improvement areas for the Trust, particularly:

- Demonstrating clinical governance
- Promoting and enabling best practice
- Improving patient experience and outcomes
- Facilitating corporate learning
- Encouraging staff development
- Provides a platform for ongoing quality improvement

The Trust has a yearly programme of clinical audits which are categorised into the following priorities:

Priority 1 - External must do (national audit)
Priority 2 - Corporate must do (for example clinical record keeping audits)
Priority 3 - Service Line must do (for example compliance with NICE guidance)
Priority 4 - Specialist Interest

During 2018/19 the Trust participated in 100% of open, relevant national audits as defined by Healthcare Quality Improvement Partnership (HQIP). These audits are detailed in Annex D.

During 2018/19 hospitals were eligible to enter data for five National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies,
which are detailed in Annex D. University Hospitals Plymouth NHS Trust submitted data for two studies. The remaining studies are ongoing.

In 2018/19 we also completed 23 planned Priority 2 audits including clinical record keeping and Ionising Radiation (Medical Exposure) Regulation (IRMER), 57 Priority 3 audits, 40 Priority 4 audits and 36 Service Evaluations. A number of improvements have been made as a result of these audits, examples of audits and associated improvements are summarised in Annex E.

Follow-up Backlogs

Patients often require a ‘follow up’ appointment with a healthcare professional following an initial consultation, operation or procedure. These appointments can include a discussion about test results, an assessment of how a patient is progressing in recovering from or living with a disease, how a patient is responding to a drug therapy treatment or how they are progressing following surgery. Additionally patients will receive follow up care such as physiotherapy, speech and language therapy, occupational therapy and care from a dietician.

Despite the fact the hospital completed around 400,000 follow up consultations in 2018-19 there were still a large number of patients who did not receive their follow up appointment by the appropriate date clinically indicated. Timely appointments are important to avoid associated risks when delaying to a date later than originally deemed appropriate. It also represents a commitment made to the patient that has not been met by the hospital.

At the end of March 2019 the number of patients who had not received their appointment by the date indicated was 35,260 compared to 34,867 in March 2018. We have an electronic system of ‘flagging’ patients as being ‘time critical’ for follow up, which includes a date by which the patient should be seen or may be at risk of harm if they wait longer. This allows for prioritisation of appointments to the highest risk patients.

The number of time critical patients who have waited past their see by date stands at 7,698 at the end of March 2019. The services that account for the largest number of patients are ophthalmology, neurology, gastroenterology, hepatology and rheumatology. A combination of competing clinical priorities, including pressure to achieve waiting times for new patients and reduced clinic capacity, means current arrangements need to be reviewed as a priority.

The number of ophthalmology patients in the higher risk categories has reduced by approximately 1,000 in the past 12 months, and accounts for 33% of the overall at risk numbers, compared to 43% at the end of March 2018. The service is the largest outpatient based service in the hospital and accounts for around 8.5% of total routine referrals. To manage the increased demand and release capacity the service line continues to work through the comprehensive action plan to reduce the number of patients who have waited past their see by date.

Moving forward, services are working together with clinicians from both the community and the hospital to develop alternative ways of providing follow up care. Changes to the patient’s pathway will provide follow up care in the most appropriate place for the patient, which may not be a hospital based appointment. We will also improve our clinical administration processes to support timely decision making around patient management and to prevent unnecessary delays in appointments.

Learning from Deaths

Background

The Care Quality Commission (CQC) published its report ‘Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England’ in December 2016, which make recommendations about how learning from deaths could be standardised across the NHS. The Secretary of State accepted all these recommendations and asked the National Quality Board (NQB) to develop a framework for the NHS on identifying, reporting, investigating and learning from deaths in hospital
The NHS has a long tradition of learning from care provided to patients. The framework builds on that tradition but recognises that the NHS can do better particularly in relation to the care of vulnerable people.

The key findings of the CQC report were as follows:

- Families and carers are not treated consistently well by the NHS when someone they care about dies.
- There is variation and inconsistency in the way that trusts become aware of deaths in their care.
- Trusts are inconsistent in the approach they use to determine when to investigate deaths.
- The quality of investigations into deaths is variable and generally poor.
- There are no consistent frameworks that require trust boards to keep deaths in their care under review and share learning from these.

The CQC’s recommendations have been translated into seven national work streams. The Department of Health (DH) has set up the Learning from Deaths Programme Board to support their implementation. Each work stream is led by the relevant healthcare body. The first step in this programme was the publication of the new Learning from Deaths Framework in March 2017. The new guidance identifies how NHS providers should learn from the deaths of people in their care. In particular this identifies a need to focus on learning from the care provided to patients with learning disabilities and severe mental health needs who die in NHS care. Most of these deaths will occur in acute settings.

**Our performance**

The following section shows the indicators we are using to track hospital mortality. We remain committed to preventing avoidable deaths by monitoring mortality and learning lessons from unexpected deaths.

Total number of in-patient deaths (including Emergency Department deaths for acute Trusts).

There have been a total of 1831 inpatient deaths for the year April 1st 2018 – 31st March 2019 including patients who have died in the Emergency Department.

During 2018/19, 1831 patients died, (of which 7 were neonatal deaths, 18 were still births, 6 were people with learning disabilities).

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 473 in the first quarter (of which 0 were neonatal death, 3 were still births, 3 were people with learning disabilities).
- 421 in the second quarter (of which 4 were neonatal death, 6 were still births, 1 was people with learning disabilities).
- 447 number in the third quarter (of which 0 were neonatal death, 3 were still births, 2 were people with learning disabilities).
- 490 number in the fourth quarter (of which 3 were neonatal death, 6 were still births, 0 number were people with learning disabilities).

The Trust has a process to screen deaths to help identify problems in service delivery, during the same period a total of 1145 deaths have been investigated using the Trust’s screening tool.
Review of 2018/19

- 295 deaths screened in quarter 1
- 332 deaths screened in quarter 2
- 259 deaths screened in quarter 3
- 259 deaths screened in quarter 4

Of the total number of deaths in 2018/19 a further 29 have been subject of a case record review using the Royal College of Physicians Structured Judgement Review (SJR)

Summary Hospital-Level Mortality Indicator (SHMI) & Hospital Standardised Mortality Ratio (HSMR)

SHMI - The number of deaths in hospital is captured through the Summary Hospital-level Mortality Indicator (SHMI). SHMI is the ratio between the actual number of patients who die following admission to hospital and the number who would be expected to die, based on average figures for England, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days of discharge.

HSMR - The HSMR scoring system works by taking the hospital's base mortality rate and adjusting it for a variety of factors such as population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these factors into account for each hospital, it is possible to calculate two scores, the mortality rate that would be expected for any given hospital and its actual rate. It is the difference between these two rates that is important when it comes to HSMR.

Deaths with associated incident investigations

During 2018/19 a total of 19 deaths for University Hospitals Plymouth NHS Trust have been reported on the Strategic Executive Information System (StEIS) as a serious incident requiring further investigation.

Reviewing and understanding our performance

Given our headline indicators for SHMI and HSMR were higher than expected, we established two specific work streams to review and improve our understanding of the reasons for the variance.

- Increased number of consultant episodes
- Variation in capturing mortality information, e.g. clinical coding
As part of this work we identified a number of areas that we believed were affecting our HMSR and SHMI figures.

**Episodes of Care Coding**
The new information system Salus made it easier to transfer a patient from consultant to consultant.

The effect of this has been additional coded episodes of care for each patient, which affected how each death is coded. In some cases this resulted in an increase in deaths coded against the initial diagnosis as opposed to the definitive diagnosis.

We believe this has negatively impacted on our mortality data and are working with an external company to see if any analysis is possible to understand the effect and compensate for it.

**Palliative Care Coding**
Patients on palliative care are normally excluded from the HSMR data. The palliative care team provide a list of patients each month to ensure that the coding team accurately reflect palliative care team contact. This will ensure that this cohort of patients is excluded from the data submission each month.

The Trust is working with the clinical coding teams from other organisations to ensure similar practice across the wider health community in Devon is being followed.

The graph below shows the latest quarter’s rate has increased which we believe will improve our HMSR position, this will need to be monitored over the coming months.

**Ambulatory Care**
Previously some patients would be admitted for a limited period, of less than one day. These patients are now treated through our new Acute Assessment Unit (AAU) which is not included in the national data set. The introduction of our AAU resulted in this cohort of patient being removed from our data submission which was previously diluting/concentrating our mortality ratios.

In 2018/19 the patients treated in our AAU was not submitted onto the national system a plan to resubmit this data in 2019/20 is in place. It takes 2-3 months for the data to be reflected on the national mortality tools.

**Learning from Reviews**
- Transferring patients to wards that are not optimum for the patients’ needs due to volume of demand for services.
- Delayed imaging for inpatients.
- Poor documentation – notes are disorganised.
- Timely escalation of deteriorating patient

**Quality Improvement Projects resulting from Learning from Reviews of Deaths**

We continue to identify and act upon learning from deaths, for example:

- **Abscess management**: We have produced a new pathway to ensure timely imaging in cases where an abscess is present or uncertainty exists. Teaching has been provided regarding management in situations where uncertainty of diagnosis exists in cases of mastitis/abscess formation.

- **National Early Warning Score (NEWS)**: Recognising and responding to patient deterioration relies on a whole system approach and the revised National Early Warning Score (NEWS2), published by the Royal College of Physicians in December 2017, and reliably detects deterioration in adults, triggering review, treatment and escalation of care where appropriate. NEWS2 is an improvement on the original NEWS, in use since 2012, in key areas including better
identification of patients likely to have sepsis, improved scoring for patients with hypercapnia respiratory failure and recognising the importance of new-onset confusion or delirium. News 2 has been fully implemented at UHP.

- Discharging Patients without Critical Medications: Following two serious incidents in 2017/18 we have reviewed the actions taken to prevent a patient leaving the hospital without a critical medication. We have introduced improved processes for monitoring returned critical medications to pharmacy as well as improved ward processes.

Patient Feedback

Friends and Family Test Patients

Our Inpatient & Daycase results have remained steady throughout 2018/19, although Emergency Services were less consistent. All results are published monthly on the Trust website. Further detail is shown in Annex B Core Indicators.

<table>
<thead>
<tr>
<th>% of patients recommending by month</th>
<th>Inpatient &amp; Daycase</th>
<th>Emergency Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2018</td>
<td>97.57%</td>
<td>94.60%</td>
</tr>
<tr>
<td>May 2018</td>
<td>96.66%</td>
<td>94.61%</td>
</tr>
<tr>
<td>June 2018</td>
<td>96.66%</td>
<td>91.43%</td>
</tr>
<tr>
<td>July 2018</td>
<td>95.47%</td>
<td>94.07%</td>
</tr>
<tr>
<td>August 2018</td>
<td>96.22%</td>
<td>93.41%</td>
</tr>
<tr>
<td>September 2018</td>
<td>96.63%</td>
<td>90.99%</td>
</tr>
<tr>
<td>October 2018</td>
<td>96.58%</td>
<td>98.91%</td>
</tr>
<tr>
<td>November 2018</td>
<td>96.09%</td>
<td>91.07%</td>
</tr>
<tr>
<td>December 2018</td>
<td>97.35%</td>
<td>94.34%</td>
</tr>
<tr>
<td>January 2019</td>
<td>97.16%</td>
<td>95.16%</td>
</tr>
<tr>
<td>February 2019</td>
<td>97.17%</td>
<td>94.65%</td>
</tr>
<tr>
<td>March 2019</td>
<td>97.24%</td>
<td>96.32%</td>
</tr>
</tbody>
</table>

Patient Reported Outcome Measures (PROMs)

A summary of our PROMs results in 2018/19 is shown in Annex B. PROMs are used to assess the quality of care delivered to patients from their perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using surveys from before and after the operation. The four procedures are hip replacements, knee replacements, groin hernia and varicose veins.

PROMs describe a patient's health status or health-related quality of life at a single point in time, and are collected through short questionnaires. The health status information is collected from patients before and after a procedure and provides an indication of the outcomes or quality of care delivered to our patients.

Participation rates have improved overall for hips and knees, but have reduced for hernia and varicose veins. The latest figures at March 2019 are shown below:

<table>
<thead>
<tr>
<th>Participation Rate Hernia</th>
<th>Participation Rate Hip</th>
<th>Participation Rate Knee</th>
<th>Participation Rate Vein</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>89%</td>
<td>97%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Seven Day Working

The aim of the 7 day standard is to end current variations in outcomes for patients admitted to hospital at the weekend.

Every 6 months, the Trust is required to self-assess its performance against the four priority national standards and report this to Trust Board.

The latest report was submitted on 1st March 2019 with the following results;

- **Standard 2 – Time to first consultant review**
  88% of sampled patients were seen by a consultant within 14 hours of admission during the week and 75% on the weekend. The target standard is 90% which the Trust did not meet.

- **Standard 5 – Access to diagnostics tests**
  Hospital inpatients have access to seven-day emergency diagnostic tests and the Trust meets the standard.

- **Standard 6 – Access to consultant directed interventions**
  Patients have access to 24/7 emergency interventions and the Trust meets the standard.
Review of 2018/19

Standard 8 – Ongoing review by consultant twice daily if high dependency, daily for others
97% of sampled patients were reviewed daily by a consultant during the week and 73% on the weekend. The target standard is 90% and the Trust did not meet the standard for the weekend.

A Senior Working Group, chaired by the medical director, continues to meet to identify and implement improvements.

Staff Feedback

Having a compassionate, skilful and dedicated workforce is central for delivering outstanding care to our patients. Every interaction between patients and staff should build our reputation and help deliver great care.

We are working hard to understand the experience of our staff – both when things are going well and when things require improvement. We embed the importance of quality improvement for all staff from the time they start in the Trust. Staff are encouraged to be involved in improvements within their team.

The Human Resources & Organisational Development Team (HR & OD) have worked closely with colleagues across various teams throughout the Trust, including service improvement, communications and the Learning from Excellence Team to build a culture that helps staff make changes through their ideas and feedback. The culture supports staff both to speak up if they have concerns and to celebrate the work and care that is going well.

National Staff Survey

The National Staff Survey helps the Trust to understand the experience of staff in our organisation. In 2018, 3577 out of 6817 staff responded, equating to 52.5% response rate, providing highly reliable data.

Nationally, the survey data from NHS Employers shows a service struggling to provide care against increasing demands. Staff in our Trust have reported improvements in a number of areas when compared to 2017.

The survey is now reported in 10 themes and our performance is shown below:

Out of the 10 themes for University Hospitals Plymouth NHS Trust:

- 2 statistically significantly improved between 2017/2018
- 7 stayed the same between 2017/2018
- 1 not comparable between 2017/2018
- 5 better than average in 2018
- 3 same as average in 2018
- 2 lower than average

Although a number of aspects of the survey have improved, such as the sense of being valued and the support from line managers there are still areas of significant concern from staff about the quality of care they can give and that they aspire to.

Our rate of improvement remains greater than the average of acute trusts.
2 Review of 2018/19

Staff have told us things such as:

“I find my managers very supportive and professional, the whole multi-disciplinary team are inspiring to work with.”

“I have always felt valued working in the NHS, yes sometimes as all jobs anywhere it has its pressures, but I have always felt supported and valued. I love working in the NHS.”

“I am very lucky as I love my job and I feel that this is as a direct result of working within a department where I feel well supported and that the staff are focused on doing an excellent job.”

“I feel positive changes are happening and the department is moving forwards.”

Your Voice

Your Voice is the opportunity for staff to take part in conversations with the senior leaders and leaders within their teams.

Your Voice has developed this year to be the method for hosting local conversations as well as those with senior leaders. Staff have been sharing their views and local leaders taking forward plans to work on the solutions and actions arising.

Valuing our staff and Learning from Excellence

Our ‘Say Thank you and Help us Learn from Excellence’ programme of work has continued to grow.

In the last 12 months we have received 1881 Say Thank you and Learn from Excellence nominations, the number of nominations has doubled over the last 12 months and this is now over 3000 since we started.

This year, a fifth of our Say Thank You and Learn from Excellence nominations have come from patients, their family and friends.

Learning from these nominations demonstrates that what matters most to colleagues, patients and their families is positive and supportive behaviour.

Our staff are regularly thanked for being kind, giving time and supporting us in times of pressure or when we are feeling vulnerable. The seemingly little things such as being friendly and approachable, smiling, helping out with ‘no fuss’, really do make the difference.

Included below are some recent examples of feedback sent to staff:

“Thank you for being so friendly and approachable but also pushing us to be the best we can be. We have loved having you join the ward family and we’re grateful to know you will always be there if we need you. We want you to know how much we appreciate you.”

“Thank you for the warm welcome following my operation. It was greatly received and quickly put me at ease.”

The work is progressing to inform our approaches to leadership development and creating a culture where compassion and civility play a key part.

Big Conversations

Following on from the previous years’ successes, the Big Conversations took place for a third year.

Keeping the appreciative tone of the previous years’ style of questioning, we again focused on a small number of specific areas for improvement. Working collaboratively with teams across the Trust we visited departments and wards, giving staff the opportunity to share good practice and specifically, what works well.

Nearly 700 staff participated in the conversations focusing on the following areas:

- Equality and Diversity: ensuring a ‘just’ culture through a diverse workforce that approaches processes, particularly career progression, in a fair manner
Review of 2018/19

- Feeling Safe to Speak Up: understanding how to continue supporting staff in feeling safe to speak up and what a ‘safe’ route looks and feels like
- Staff Wellbeing: understanding how best to support staff with their wellbeing; be it accessibility or determining what is actually needed, whilst also continuing our focus on supporting stress
- Quality of Care: understanding the ability to give good care. With a particular focus on resourcing (people and physical)

The focus areas are determined through the National Staff Survey data, and include areas that require improvement or areas where we want to continue to improve.

Three of the four of these areas of focus, when grouped together as a theme, sit above the national average in the 2018 National Staff Survey.

Freedom to Speak Up Guardian

Following the publication of Sir Robert Francis’s recommendations in the Freedom to Speak Up Review in 2015, the NHS contract 2016/2017 specified that NHS Trusts should appoint a nominated Freedom to Speak Up Guardian (F2SUG) by 1 October 2016.

The purpose of the F2SUG role is to work alongside the leadership team to support a more open and transparent place to work, where all colleagues are actively encouraged and enabled to speak up safely. The Trust has now appointed four F2SUGs who continue working across all staff groups to raise awareness and report directly to the chief executive and Trust Board.

Our Guardian Team

Our F2SUGs have varying experience and professional backgrounds, each operates independently, impartially and objectively to support all staff within our organisation to raise any genuine concerns they may have. Our diverse team work one day a week as a guardian and the rest of the week in other roles in the Trust.

Accessibility

The F2SUG Team have been allocated a dedicated space which allows staff the opportunity to share their concerns in a safe space. In addition to this there are a number of different methods allowing staff to make contact with the Guardian team, including:

- Drop-in to the office or a pre-arranged meeting
- Telephone, with voicemail facility
- Email
- Staffnet page – this option allows for staff to record a concern anonymously or to leave their contact details

All concerns raised are confidential.

Concerns Raised

During 2018/19, 62 concerns were received by the F2SUG Team, an average of 16 concerns per quarter, which is an additional 3 per month from 2017/18. This indicates that more staff are aware of the role and feel confident in raising their concerns to the team.

![Number of concerns raised by theme 2018 / 2019](chart.png)
Response Times
The team has a clear process for how quickly it respond when somebody wishes to share their concern with us.

We want to ensure access to the F2SUG Team is equitable and responsive, and this is something we are able to measure.

Recruitment
Having the right staff with the right skills is a commitment that the Trust has given and is absolutely paramount in the delivery of quality patient care. There remain national shortages in key staff groups and the persistence of certain hard to recruit to areas has led to alternative workforce models and the development of several new roles. The size of the financial challenge remains considerable and the Trust will need to continue to adapt to both the new healthcare workforce landscape and continue to deliver significant efficiencies in order to maintain financial robustness.

Significant effort has been made to reduce the Trust’s reliance on temporary staffing. However temporary staffing across the Trust remains an issue and, whilst bank, agency and locum spend is necessary to maintain safe services, departments have developed new ways of working.

The past 12 months have seen a high level of nursing preceptees welcomed into the Trust. However, competition for preceptees in the short term will be fierce due to the number of students registering for higher education places and the impact of the loss of the nursing bursary.
Progress against 2018/19 priorities

During 2018/19 we continued to focus on quality improvement. Our strategy has been to focus on key priorities for the organisation and to oversee these through the Quality Improvement Committee. We continue to develop the capability of our staff within the organisation, enabling them to improve the quality of care they offer. We have continued to foster the links between hospitals and other organisations to work together to improve the quality of care to patients across the community.

Last year we identified three priority areas for improvement as follows, achievement against each of these priorities is set out below:

- **Priority 1: Staffing**
- **Priority 2: Working with other providers to ensure patients are treated in the right place at the right time**
- **Priority 3: Reduce the number of patients who suffer harm while under our care**

### Priority 1: Staffing – Improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills

**Background**

Having the right nursing staff in the right place at the right time is a fundamental element to the delivery of safe, high quality care. Organisations must ensure the level of nursing staff, including registered nurses midwives and support staff, are correct for the acuity and dependency needs of our patients.

**What we did well**

We have continued our work to consider the challenges faced in nursing and midwifery staffing. The outcome of this work has been shared nationally and includes guidance on ensuring staff rosters are produced as efficiently as possible using an electronic system, the use of agency and temporary staffing and reviewing some nursing roles.

Nursing and midwifery staffing levels are monitored and reported monthly via NHS Choices and the Trust website. This information will continue to be submitted and inform our nursing dashboards and shared with matrons and senior nurses. Staffing reports are produced and presented at our Nursing and Midwifery Operational Committee with key performance indicators included from our ward dashboards and model hospital data.

We publish our staffing levels for each shift on a patient and visitor information board at the entrance to our wards and a poster in each bay stating the name of the nurse responsible for each patient’s care and the nurse in charge of each shift. The information displayed also includes information on key quality metrics such as falls, infection rates and pressure ulcer incidents as well as Friends and Family Test scores and comments. This helps to demonstrate transparency in terms of the relationship between the care and experience our patients receive.

Ward dashboards are available monthly for each ward to review the quality metrics against workforce measures. The dashboards are RAG rated (red, amber and green), and cover the domains of the CQC assessments of Safe, Well Led and Effective Care.

The E-rostering system which interfaces with our Safe Care System continues to enable us to effectively redeploy nursing hours across the adult wards in the hospital. Patient acuity and dependency scores are recorded in real time. This ensures we accurately match staffing levels to the needs of the patients in our care. This is calculated in the form of Care Hours per Patient Day (CHPPD) and helps to inform the decision making when moving staff from one ward to another.

A new approach to daily staffing meetings has been adopted within the adult inpatient areas. Matrons for medicine and surgery care groups meet separately to oversee their own staffing needs, helping to reduce the number of cross care group redeployments whilst still supporting the organisation in balancing staffing risk.
Progress against 2018/19 priorities

Daily safety brief sessions introduced in 2017, in our admission areas, are now in place across the Trust. These sessions provide an opportunity for staff to be aware of times when we have not provided patients with the best care and also to celebrate and learn from those occasions when we get it right.

Within maternity an adaptation of the Trust’s safe care acuity tool has been developed for the central delivery suite (CDS).

The Neonatal Unit staffing model is delivered using standards from the British Association of Perinatal Medicine (BAPM), which defines care levels and staffing requirements.

Within paediatrics a care level assessment is used to measure acuity of each patient which is mapped against the establishment. This gives an overview of the CHPPD. There is a new tool for acuity developed by the Shelford Group for Paediatrics. This will be implemented over the coming months.

We actively continue to train band 3 staff into band 4 assistant practitioner (AP) and nursing associate (NA) roles as part of developing our workforce. The first NA cohort successfully qualified in January 2019 and these members of staff are now on the NMC register and are in substantive positions across the organisation. Three of the NAs have commenced the Nurse Degree Apprenticeship course; as have four APs.

The Degree Nurse Apprenticeship programme started at the University of Plymouth in September 2018. These posts will be funded by the Trust for 18 months to 2 years and on qualifying the individuals will work as Band 5 registered nurses.

Levy funded apprenticeships started in 2017 for nursing associates, assistant practitioners and degree nurses. A recent OFSTED monitoring visit relating to the Healthcare Support Worker level 2 apprenticeship programme was undertaken in February 2019. The findings report “reasonable progress” across all 3 themes reviewed, indicating a high level of quality of training is being delivered. Apprentices have learning placements in various services within the trust, including paediatrics.

The hospital website nursing and midwifery pages, launched in 2017/18, continues to be published. The website is user friendly, attractive and enables the user to access the current vacancies. The web pages include professional development and specialist areas for nurses to consider as a career.

What we need to work on

An annual nurse staffing establishment review was undertaken in October 2018 and an assurance report was published in March 2019. Both recorded occasions when although the wards are suitably established, due to the number of vacancies across the Trust and the high bed occupancy rate they are not necessarily staffed to the required demand. Bed occupancy does exceed 100% during periods of high demand.

The trend in CHPPD data over the past 6 months for both registered nurses and care support workers has seen a narrowly fluctuating picture with only a slight downturn overall during 2018/19. The overall monthly fill rate ranges from 83.6% to 89% (Sept 18 to Feb 19). We continue to be supported by bank and agency staff and a recent incentive scheme has helped to maintain a degree of stability during the winter period.

Nurse vacancies remain a challenge and recruitment continues to be a priority with a greater focus on our retention strategies; including international recruitment. We already provide a high quality 12 month preceptorship programme and in partnership with our military partners, are developing a pilot for an 18 months rotation offer to band 5 nurses. In addition we continue to work with our wider STP regional programmes to address nursing shortages.

Next steps

We recognise the importance of ensuring that we have the right staff, in the right place and at the right time. We continue to adopt innovative approaches to the recruitment of clinical staff but face challenges in recruiting staff in some key service areas. We are developing a stronger plan for addressing these issues on a sustainable basis which includes:
Progress against 2018/19 priorities

- Undertaking a review of rostering practices
- Developing the preceptees rotation plan
- Engaging with the Strategic Transformation Plan (STP) in relation to a rolling programme of recruitment in India, United Arab Emirates and the Philippines. There is an ambition to recruit 70 registered nurses, with the first 20 expected to start with us by the end of 2019
- Continued development of the nursing associate role, which has been designed to bridge the gap between our healthcare assistant workforce and registered nurses. This is a stand alone role which will also provide a progression route into graduate level nursing

Priority 2: Ensure all patients receive high quality care by working with other providers to ensure that their care is provided by the right staff in the right place and at the right time

Background

Patients with complex care needs have the right to timely safe discharge care which is in line with best practice. The Trust has recently experienced difficulties with capacity which resulted in cancellations for patients and longer waits for treatment than we would like.

We recognise that good end of life care enables people to live in as much comfort as possible until they die and to make choices about their care and where to spend their last days.

Maternity Services should maximise the opportunity for women to be fully involved in making well informed decision about their care.

What we did well

We have much to be proud of in the quality of care that we give to our patients. We continue to perform well in many areas but face a significant challenge in providing responsive services and improving our performance against a number of key national standards.

Both University Hospitals Plymouth and our community partner, Livewell Southwest, have joined the national NHS Improvement Lean Transformation Programme which is branded locally as ‘People First’.

People First is a cultural change programme with people and improvement at its heart. It brings people together in small groups called ‘huddles’ to define and solve problems and make improvements, big and small.

Visual Metrics and Plans

Our staff are using visual metrics and plans as a mechanism to track improvements. An example of which is the new Weekly Improvement of Safety Huddle (WISH) led by our Head of Quality Governance, which brings together some of the important safety topics to ensure we learn weekly and apply learning to improve care.

Building Improvement from the Frontline

A growing number of areas now have direct practice support from the People First team. The team have been working with Monkswell Ward who now hold a daily multi-disciplinary team improvement huddle including plans to improve care.
Another example is the great work being done on shared handover ‘clinician patient list’ and ward-based prescribing on respiratory wards from their weekly huddle. Pharmacy and the ward team have been working together to understand patient waits for medications and test some solutions. Both topics will make a big impact on patient care, flow and how we work together.

We continued to improve the process for referring complex discharge patients and for reviewing patients care requirements post-discharge.

Next steps

We have further developed our improvement strategy and associated programmes into a main workstream ‘Peoplefirst’.

Our recent CQC inspection highlighted that we still have significant challenges in providing responsive services, but also highlighted significant concerns across Imaging and Pharmacy.

- In 2019 we will move into our first full year of our ‘People First Improvement Practice, our quality improvement programme working with NHSI as part of the national Lean Transformation Programme.
- The Trust’s quality improvement plan is focused on addressing the risks associated with operational pressures, safe staffing and medicines management.
- The Trust continues to make good progress in meeting national 7 day service standards.
- The Trust is proactively engaging in other national quality priorities such as learning from deaths, infection control and national early warning scores.
- Our existing Quality Impact Assessment process is being replaced with a new Quality Equality Impact Assessment (QEIA) process and we have an ongoing piece of work to further develop this approach.

Priority 3: Reduce the overall number of patients who suffer harm whilst under the care of the hospital

Background

We take patient safety as a key priority in the hospital setting and our aim is to keep patients safe and avoid increasing their length of stay.

There are some key incidents which can occur during a patient’s admission to hospital such as falls and pressure ulcers. Having knowledge of this allows us to apply our best practice efforts to reduce the incidence of harm.

In addition infection can lead to a more serious condition called sepsis which can make the patient very unwell and in rare cases lead to death. We will continue to implement systematic screening and treatment for these patients.

What we did well

Sepsis
The year has seen a focus on educating our staff and sharing the learning from our acute admission areas with those wards where the highest incidences of sepsis are likely.

Over the last 12 months it has become increasingly apparent that our focus in acute admission areas needs to continue on ensuring effective care delivery when the system is hard pressed.

Deteriorating Patients
We defined the high level metrics which provide assurance to the organisation that we are minimising risk to patients. The graphs below show cardiac arrest and medical emergencies per 1000 bed days.
Progress against 2018/19 priorities

We have a policy that sets out the minimum standards for patient observations and monitoring, which we regularly audit. We have implemented NEWS2 as our escalation tool, in-line with national guidance.

**Scan4Safety**

In January 2016, the Department of Health announced that University Hospitals Plymouth NHS Trust had been selected to act as one of six sites across the UK to pilot a project called Scan4Safety.

Scan4Safety is a project that aims to increase patient safety, improve patient experience and to reduce operational costs by introducing new global standards for traceability, known as GS1 standards.

**How are GS1 standards making a difference in Plymouth?**

Using barcodes will lead to safer patient care and improved processes. By providing our patients with barcoded identity wristbands, which are then scanned along with any products linked to their care we are able to accurately track all elements of a patient’s care in a more efficient way, saving time and reducing errors. These include product recall, catalogue management and paying suppliers electronically.

There are three core elements we needed to implement to lay down the foundations of Scan4Safety to identify every place, every product and every person.

- **Location Coding (Place)** - defined by a Global Location Number (GLN) being assigned to all locations across the Trust both physically and in the electronic property management system is now complete.
- **Catalogue Management (Product)** – this is defined by a Global Trade Item Numbers (GTIN) being assigned to all products and services held within the product catalogue system and is now complete.
- **Patient Identity (Person)** – This is defined by all patients being identified by a Department of Health compliant Global Service Relationship Number (GSRN) wristband, which is associated with their patient records – ongoing.

The Trust continued with its implementation of Scan4Safety. All hospital areas are now identified using barcodes.

Through collaboration with our workforce and suppliers, and other trusts on the Scan4Safety programme, we have a system that can help ensure that every product used in hospital is assigned to the right location, to the right patient, and is backed up by the right purchase orders and invoices. This will benefit Plymouth and the wider NHS as it delivers efficiencies that will help enhance the quality of care we can provide.

A barcode has now been added to the existing identity wristbands which then enable it to positively identify a patient within systems that have been enabled to electronically capture patient details. In no way is patient confidentiality compromised.

**Next steps**

- **Scan4Safety**: continues to work on implementation of plans to use standards created for Product, Patient & Place (location) within new systems. We are working with clinical staff to ensure every inpatient area complies with 100% printed patient identity band on admission.
- **Build on 2018 achievements in the management of sepsis and improve the reliability of our data collection**
- **Further reduction of pressure ulcers and falls by 20%**
Celebrating our successes

Whilst we faced a number of key challenges in 2018/19 there is much to be proud of. During the year we improved the quality of our services in many areas, some of our key achievements are described below.

Cancer services

University Hospitals Plymouth NHS Trust continues to work across all areas to ensure the best quality, timely and efficient care and treatment in line with local need and national guidance. Throughout the last 12 months there have been a number of key improvements within cancer services including:

- Implementation of the new lung pathway in 2018, which has demonstrated a reduction in length of wait from referral to diagnosis and improved patient experience for those with lung cancer
- Continued improvement of our National Cancer Patient Experience Survey results
- Successful implementation of the recovery package in line with national taskforce objectives for 2018/19 such as holistic needs assessment and health and wellbeing events
- Working with St Mark and St John University we have implemented exercise programmes for patients preoperatively and pre radiotherapy
- Implementation of a new triage pathway, by our Oncology Advanced Clinical Practitioner, to support patients contacting the hospital out of hours and keep patients dealing with cancer safe and reduce emergency admissions.

The Mustard Tree Cancer Support Service was also awarded national recognition for its outreach cancer care service to the prison service.

We are very grateful to our local and national charities such as the Plymouth and Cornwall Cancer Fund, Macmillan Cancer Support, Teenage Cancer Trust, Mesothelioma UK, Trust Charitable Fund who continue to support patients and staff to improve cancer care delivery.

Carers

At University Hospitals Plymouth NHS Trust we recognise the important role carers have in the effective and safe delivery of treatment and care of patients in hospital. This role will often cross the boundaries between the patient’s home and hospital setting. We have been working hard to identify, involve and support carers in hospital in order to get the care of the patient right.

We promote the patient carer relationship; ensuring the carer is able to continue in the caring role to improve patients wellbeing. For some patients the involvement of their carer is critical to the delivery of care in hospital, e.g. children, patients with dementia, those with a learning disability and patients who are approaching the end of their life.

Caring for Carers Plymouth Service

In liaison with Plymouth Caring for Carers, a member of their team works closely with our Integrated Hospital Discharge Team attending discussions which identify patients who are due for discharge. Patients who have a carer are identified to ensure appropriate support is in place and that they have access to information and guidance as required.

In addition, we are working with the Defence Medical Welfare Service (DMWS). A liaison officer is available on site to visit our military veteran patients and their carers five days per week. Working with Caring for Carers Plymouth staff they ensure early identification, signposting and appropriate support is available for our veterans.
Celebrating our successes

Carers Card
The Carers Card has been developed to distinguish and identify informal carers on the ward. Once a carer is identified and their role agreed, the ward sister will issue a Carers Card to ensure they are clearly recognisable by the ward team.

Meal Vouchers
Ward staff can provide meal vouchers for informal carers who are contributing to the delivery of care whilst in hospital.

Parking Arrangements
Free car parking is available for informal carers who have agreed to contribute to the care of the patient (cared for person) during their hospital stay.

Our Patient Council is committed to the overall improvement of carer support whilst in hospital and as such have included this within their Patient Council Strategy and annual work plan.

Children’s Services
The children’s wards continue to improve the environment for children and young people with the donation of a bubble machine to entertain the children whilst they wait for treatment or assessment on the Children’s Assessment Unit.

We are privileged to have been given a vein viewer which aids medical staff in identifying suitable veins for cannulation. This means children are treated quickly and accurately.

Welcome Bags have been introduced for all new patients on the wards. The bag contains a parent information leaflet, age appropriate reading materials, activity books, a small toy for young children and some mindfulness information for our older children. The trial has been well received and will now be rolled out to all paediatric wards.

The Children’s Community Nursing Team have also been working with our clinical commissioning group (CCG) to promote Personal Health Budgets for eligible families so they can have a more responsive care service at home for their children. These are children who require either 24 hour or overnight care due to complex health needs.

Our paediatric consultant team are providing electronic advice and guidance to GPs which helps to ensure referrals are timely and appropriate. GPs can now contact a paediatrician with a query or a request for guidance on how to manage a paediatric condition. Appropriate referrals to the hospital can be facilitated, or guidance given to prevent unnecessary referrals and manage the condition in the community.

A huge number of our staff were nominated and received Paediatric Awards for Training Achievements (PAFTA), which are awarded by the Royal College of Paediatrics and Child Health (Devon and Cornwall). These awards provide a welcome opportunity to reward those who work tirelessly to improve the care of children and are a fabulous boost to morale:

Defence Medical Welfare Service (DMWS)
DMWS is an independent charity providing practical and emotional support to the armed forces community when they receive medical treatment.

Any hospital treatment whether planned or unplanned can be stressful and brings with it feelings of isolation, stress and worry, all of which may hamper recovery. DMWS Welfare Officers provide practical and emotional support to ensure that no military family goes through the worry of
injury or illness alone. They work with patients when their medical needs are being met but when other issues, problems or social influences may be distracting them from their recovery.

The DMWS have specialist knowledge, rooted in operational experience, which means the welfare officers have a deep understanding of working with Armed Forces personnel, veterans and their families.

Since May 2018, they have supported around 70 patients admitted to Derriford Hospital and the Royal Devon and Exeter Hospital and 60 additional family members from the armed forces community that have benefited from support in hospital and at home.

The team is working closely with the Veterans Mental Health (TIL) Service to refer patients who are showing signs or symptoms of post traumatic stress disorder (PTSD), which has resulted in faster diagnoses and support.

By working closely with volunteering projects in the community, DMWS have reduced the amount of alcohol related injuries through engaging patients in volunteering projects to reframe the mind and in turn reduce boredom, isolation and depression.

Bereavement support is also in place for patients or family members, DMWS have been able to secure funding for funeral costs and referred patients onto further support groups during an upsetting time filled with grief, anger, depression.

Dementia friendly award

University Hospitals Plymouth NHS Trust is partners in the Plymouth Dementia Action Alliance (PDAA) and have been working with other agencies, organisations and businesses towards improving the lives of people living with dementia in Plymouth. The Trust has a multi-agency Dementia Steering Group which leads the developments in care and services provided to people with dementia in hospital.

The steering group has led on a number of developments, including an accreditation scheme for dementia friendly wards and departments including a range of ways in which to make care in hospital more person-centred and help improve the environment. This year we have awarded dementia accreditation to seven departments.

Staff training on dementia is included in the mandatory training programme and includes induction training, dementia friends awareness sessions, and specialist dementia continuing professional development education.

We are also involved with the National Audit of Dementia Care in Hospital programme and are proud of the developments made to the standards of care for patients with dementia and the support of their families. We will continue as active members of the PDAA and with the recommendations from national audit and our work towards the dementia improvement plan, to identify further ways in which hospital services and care for people with dementia can be improved.

Emergency Department - Resuscitation Unit

In early March building work began to improve the resuscitation unit within our Emergency Department. The work doubled the size of the resuscitation unit, increasing it from four to seven resus bays. This forms part of a £2m upgrade to the existing Emergency Department announced in September last year.
Celebrating our successes

#EndPJparalysis

From 17 April 2018 onwards, we took part in a 70 day national campaign, led by Professor Brian Dolan, to get one million patients dressed in their own clothes and up and moving.

Increased activity whilst staying in hospital can help recovery, reduce muscle wastage, maintain independence and lead to patients getting home sooner.

We asked relatives, family and friends to help us #endPJparalysis by encouraging loved ones in hospital to get up and get moving as soon as they are able to. They can do this by ensuring patients have the following items with them:

- well-fitting footwear
- day clothing
- night clothing
- glasses and/or hearing aids
- walking aid
- toiletries

The campaign was a huge success and we managed to achieve a remarkable 14,948 patients up, dressed and mobile during the 70-day challenge. Going forward, we remain committed to ensuring patients maintain independence as we know this reduces the risks associated with deconditioning and the need for ongoing or long-term care outside of the hospital.

My discharge from hospital was delayed for more than 2 hours

During my hospital stay I was asked to give my views on the quality of care

In addition, patients scored us below the average when compared to other Trusts, in relation to discharge from hospital and information given to patients on discharge, for 14 of the 15 related questions. We decided that these concerns should become the focus for improvement across the Trust and the Making Every Experience Excellent – Let’s Talk About MEEE campaign was launched @MeeeUhp.

The purpose of the campaign was to actively listen to our staff and patients and act on their ideas for improvement. This would mirror the methodology and learning from the ‘Big Conversation’ staff engagement sessions used by our Learning and Organisational Development Team.

Groups of staff and patient volunteers conducted the MEEE face to face survey 21 to 25 January 2019. People wore bright green t-shirts and armed with their tea trolleys visited every inpatient area to ask three simple questions. The survey collected 284 feedback forms which held in excess of 850 streams of intelligence from which a review was compiled.

Following the thematic review of the data from both staff and patients several similarities emerged which would make overall experience better, more efficient and safer for patients, visitors and staff.

Whilst the MEEE survey did not reveal any new areas for improvement, it did show the similarities in ideas which operational staff and patients share to improve our services and conditions. Staff and patients recognised areas where significant improvements could be made to improve inpatient conditions, particularly overnight and to the discharge process.

Making Every Experience Excellent

Following review of the 2017 National Inpatient Survey results we decided to focus attention on three core areas where there had been a negative shift of 5% or more:

- I was bothered by noise at night by hospital staff
We have been working to implement a number of improvements:

- Information banners are now on display across the hospital, which detail the findings of each project and maintain momentum
- Patients sleep at night is moving forward. The Trust has agreed to fund sleep packs for patients which will include eye masks and ear plugs. The packs will be tested shortly on Torcross and respiratory wards
- A wider sleep group has been established to support the roll out, look at good work in other organisations that we could replicate and start working on a patient and staff charter to promote behaviours and conditions to allow for a peaceful night’s sleep
- Discharge working group established and a discharge leaflet for patients is being trialled on Bickleigh Ward
- Patient Experience Ambassadors (PEAs) have been identified in each service line and from our Patient Council to champion improvements and share good practice
- Patient Experience Ambassador enamel pin badges will be available shortly for staff to wear with pride

**Learning Disabilities Team**

We believe people with learning disabilities (LD) have an equal right to healthcare. It is important to provide services and staff which enable people with learning disabilities to use our services. Through the Derriford User Group (DUG) we aim to provide those with learning disabilities a greater say on improving the patient experience in an acute care setting.

**Hospital Passport**

The Learning Disability Liaison Team together with our Independent Learning Disability Advocate hosted three focus groups around Plymouth to gather feedback on the new hospital passport add on pages. The hospital passport is a document that holds vital information about the person that is useful for staff to read when they come into hospital. Examples of the hospital passport can be found in the learning disability section of the Trust website.

Self-advocates from Pluss Plymouth reviewed a draft passport for patients with epilepsy, Yourway Support looked at a passport for people with Autism and The Regard Partnership surveyed a passport for people with mental health issues.

Feedback is vital to ensure we use terminology that patients with a learning disability can understand. A few simple suggestions and changes can make one document so much more accessible.

In addition the new passport will be shared throughout the community by our colleagues in the Community Learning Disability Team.

**Annual Champion and DUG Awards**

Another exciting Champions and DUG annual event was held in November 2018, attended by members of the Derriford User Group (DUG) and the Learning Disability Link Practitioners.

The event was organised to provide an opportunity to say thank you to hospital staff, wards and
departments who have provided an exemplary service for patients with a learning disability, or specifically to an individual who has made a significant contribution to their care.

DUG members themselves were also given special ‘thank you’ awards for their excellent work during 2018.

Celebrating 100 years of Learning Disabilities
In February 2019 the Learning Disabilities Liaison Team celebrated 100 years of learning disability nursing by hosting a stand outside the Goodness at Greens restaurant, level 7, Derriford Hospital to share information about the work the team do in hospital and the wider range of other roles they have in the community.

Making mealtimes matter
The hospital embarked on the annual Making Mealtimes Matter (MMM) campaign to coincide with the national Nutrition & Hydration Week 11 - 17 March, which aims to raise awareness of the importance of nutrition to aid patients’ recovery.

This year, the campaign ran alongside the work to implement the new International Dysphagia Diet Standardisation Initiative (IDDSI) regulations. The IDDSI have published international standardised terminology and definitions for texture modified foods and thickened liquids for people with dysphagia. The framework consists of a continuum of eight levels (0-7) and includes descriptors, testing methods and evidence for both liquid thickness and food texture levels. The MMM campaign was a timely opportunity to highlight the work to implement the new regulations.

As part of the campaign patients, visitors, staff and members of the public were given the opportunity to sample dishes from the inpatient menu and to talk to staff about the importance of nutrition & hydration to patients’ recovery. The Speech & Language team were on hand to raise the profile of the care of patients with dysphagia, discuss the new regulations and the provision of modified texture food and fluids. The campaign was generously supported by a number of our local suppliers and retailers in order to illustrate our partnership working. The event was a huge success, even busier than in previous years and the feedback was extremely positive.

All wards were invited to join in with the fun and important messages of the week starting on the Monday with an invite to all ward managers to lead out the lunch trolley. Throughout the week, ward staff were encouraged to use the trust social media to post photos of their meal service, nominate members of the team who went the extra mile to ensure a positive patient meal experience and generally ensure the message of the week was widely shared. During the week, manual handling visited wards to raise awareness for the correct sitting position at mealtimes and providing guidance around the correct use of hoist scales. Once again both our student nurses, staff and mealtime volunteers provided sterling support to the initiative.

The MMM campaign was well supported by our suppliers and retail partners. A generous donation of clotted cream enabled our patients to enjoy a Devonshire cream tea on Global Tea Party afternoon, an annual event in the nutrition and hydration calendar. Likewise, another supplier kindly donated bottled water to support the campaign to highlight the importance to patients of keeping hydrated to aid recovery from illness and treatment.

The hydration theme was also extended to staff with the provision of a tea trolley round to all wards on the Thursday, highlighting the importance of hydration in maintaining good health and supporting our staff who really seemed to value this opportunity to have a breather and a cup of tea made just for them to enjoy.
To complete the week, several prizes, some donated by one of our retail partners, were awarded, categories included best team mealtime selfie, individual award for the person who goes the extra mile to help with the patient meal service and ward of the week based on our data (Friends & Family, Nutrition audit and PLACE).

This year’s campaign was a huge success which very clearly illustrated the trust’s commitment to strive for excellence in this area and also our staff’s commitment to embrace wholeheartedly opportunities improve patient care and the overall patient experience through their resounding participation in what proved to be a joyful week. This serves as a huge motivator to continue identifying and pressing for improvements through the continued work of our Nutritional Steering Group.

**Maternity Services**

**Argyll Ward Champions**
Midwifery Ward Champions have commenced on Argyll Ward. This is a developmental band 6 position for midwives and will ensure the antenatal and postnatal area is staffed with a senior midwife to lead each shift. The Champions will offer a long term commitment to improving care and facilitate learning on the ward. The focus is very much centred on the principles of continuity of carer, to ensure sufficient numbers of midwifery champions are available in key areas to maintain high standards by cascading skills and good practice.

**Professional Midwifery Advocacy (PMA)**
The A-Equip model (Advocating for Education and Quality Improvement), supports a continuous improvement process that aims to build personal and professional resilience of midwives, enhance quality of care for women and babies and support preparation for appraisal and professional revalidation. Alongside these components is the important element Restorative Clinical Supervision, which has been shown to have a positive impact on the immediate wellbeing of staff, influence a significant reduction in stress, and help staff feel ‘valued’ by their employers for investing in them and their wellbeing.

Our midwives are offered restorative clinical supervision either on a one to one basis or as part of a group session. Feedback has been good and there is an appreciation of the benefits of staff having time to share and understand each other’s job roles, impacting positively on patient care and job satisfaction.

Plymouth currently has four trained PMAs and one midwife currently undergoing the PMA course at Plymouth University. They represent University Hospital Plymouth NHS Trust at national and regional events.

**Plymouth Obstetric Anal Sphincter Injury (OASI) Project**
The implementation of the OASI project has had a consistent positive impact upon the women for whom we provide care. An audit of OASI rate completed in December 2018 demonstrated Plymouth has a low OASI rate compared to national figures and local figures have also reduced.

The introduction of OASI patient information leaflets and education tools for midwives and obstetricians will continue to improve care and reduce the number of women who experience this type of trauma.

Midwifery and obstetric training relating to the use of and evidence base for episcessors has been incorporated as part of the mandatory training schedule. The addition of a weekly postnatal perineal clinic launched in November 2018 supports the on-going work for all women sustaining perineal trauma or postnatal complications not exclusive to those sustaining OASI.

**Better Births**
The report of the National Maternity Review set out a vision for maternity services in England which are safe and personalised; that put the needs of the women, her baby and family at the heart of care; with staff who are supported to deliver high quality care which is continuously improving.
4 Celebrating our successes

At the heart of this vision is the idea that women should have continuity of the person looking after them during their maternity journey, before, during and after the birth. This continuity of care and relationship has been proven to lead to better outcomes and safety for the woman and baby, as well as offering a more positive and personal experience; and was the single biggest request of women of their services that was heard during the review.

We are due to commence our plans to support all women booking onto a pathway to receive Continuity of Care on 24 June 2019.

We have appointed some specialist midwifery posts. A midwifery led care Implementation Lead Midwife was appointed to lead on all aspects of the maternity agenda supporting the matrons and the Director of Midwifery with the implementation of the relevant aspects of “Better Births”, as mentioned above.

An Infant Feeding Lead who will work within the maternity service to promote excellence in the provision of infant feeding advice and support. In addition to working directly with patients, staff and volunteers, they will work at a strategic level to ensure that the UNICEF UK Baby Friendly Initiative standards are successfully implemented and our commitment to the Plymouth City Council’s Breastfeeding Strategy remains high on our public health agenda.

Finally, a Specialist Mental Health Midwife was appointed who will act as the link professional between maternity services and other services involved in mental health care, provide additional support to women with severe mental health problems and act as a point of contact for health professionals involved in the care of women who are pregnant or have recently given birth.

Snowdrop Launch
February saw the launch of the plans for the Snowdrop Suite. Doctors, midwives and families who have used the current bereavement suite were able to view the new plans. Families were able to have their say on the colours, layout, design, signage and furniture that will all go some way to providing a homely environment for women and their families whilst in the Snowdrop Suite. Families also articulated how we could improve the care to them whilst experiencing bereavement.

Neonatal Services

ATAIN
ATAIN (avoiding term admissions into neonatal units) is a programme of work led by clinical experts to reduce harm leading to avoidable admission to a Neonatal Unit for infants born at 37 weeks or more. This project was led by NHS England due to increased numbers of term babies being separated from their mothers at birth and resulted in a patient safety alert. We have worked with maternity teams to achieve below the 6% target ensuring babies are not separated from their mothers.

Kaiser Permanente Early Onset Sepsis Calculator
Our Neonatal Intensive Care Unit (NICU) subscribed to antimicrobial stewardship which hoped to reduce the number of new-born babies receiving antibiotics in hospital. After liaising with NHS England we received permission to deviate from NICE guidelines, and demonstrated that we could reduce antibiotic administration to new-born babies by 80%. This resulted in a change in practice and guidelines. NICU implemented the Kaiser
Permanente Early Onset Sepsis Calculator and developed an ‘EOS sticker’ which is included in the patient’s notes.

vCreate
It is recognised that one the highest moments of stress for parents are when they are not with their baby which is what happens when their baby is admitted to NICU. vCreate is a free secure video messaging service that allows NICU staff to keep families up to date with their babies progress when they are away from the unit. Parents can share the videos with family and friends which supports the involvement of family and siblings to ensure wellbeing and support attachment with their sick new-born baby.

PReCePT
NICU hosts the specialist neonatal service for Devon and Cornwall, caring for the most preterm and sick new-born babies. NHS Improvement implemented a project to administer magnesium sulphate to mothers at risk of delivering extreme preterm babies to reduce the incidence of cerebral palsy. NICU in collaboration with maternity services have achieved 100% compliance which is evidenced on a national database.

Enhanced Neonatal Nurse Practitioners (ENNP)
We established a partnership with the University of Plymouth to deliver advanced practice neonatal nursing including Enhanced Neonatal Nurse Practitioners (ENNP) and Advanced NNP (ANNP).

The first cohort of ENNPs qualified in September 2018 and has had a positive impact on the service enhancing the assessment of sick and preterm new-born babies. The partnership will ensure succession planning for our neonatal services and has attracted candidates from all over the country.

Neonatal Transitional Care
In 2018, NHS England requested all hospitals in England demonstrate they had an established Neonatal Transitional Care as part of the Clinical Negligence Scheme for Trust (CNST). University Hospital Plymouth NHS Trust achieved all 10 required actions, thereby securing funding to develop services. We continue to attract other health professionals from all over the world and are seen as an exemplar for excellent service ‘keeping right baby in the right cot at the right time’.

Patient Experience National Network Awards (PENNA) 2018
At the end of January 2019 the Trust submitted six applications to the Patient Experience National Network Awards (PENNA). In February 2019 we were very pleased to discover that all six applications had been shortlisted.
Celebrating our successes

We had even more to celebrate when we won one and was runner up two further categories.

Winners
PENNA Category: Patient Experience Transformer of the Year

Runner up
SALUS Patient Care Manager
PENNA Category: Innovative Use of Technology, Social and Digital Media

Caring for Those who Serve
PENNA Category: Partnership Working to Improve the Experience

Shortlisted
vCreate
PENNA Category: Communicating Effectively with Patients and Families category

Mealtime Staff Volunteers
PENNA Category: Staff Engagement and Improving Staff Experience

ACEMobile App
PENNA Category: Using Insight for Improvement – Staff Feedback

Interventions Team is now part of the safeguarding team and plans are in place to grow this service to support staff and patients. This service aims to increase availability of conflict resolution and physical interventions support. Training for all staff is increasing to meet the need to offer reliable and adequate support for staff under pressure from physical and verbal patient challenge.

Safeguarding training is revised annually and available for staff at all levels, on-line or face to face for levels 1 and 2, with more complex level 3 multi-agency training available to staff who require safeguarding children level 3 training. Safeguarding Adult and Children level 1 and 2 training complies with the skills for health and intercollegiate document recommendations, plans are developing to offer safeguarding adult level 3 training.

The process for referral into the safeguarding team continues to be revised and improved to ensure it is evolving with service need. Further simplification of referral processes are in development. The team is available to offer support and advice Monday-Friday 08:30 – 16.30 and is based within the hospital alongside multi-agency partners to ensure children and adults at risk are safe.

Revision of referral processes and further training in implementation of DoLS (deprivation of liberties) have resulted in continued increase in both safeguarding adult at risk and DoLS applications to the local authority.

This year has seen the implementation of the Child Protection - Information Sharing project (CP-IS), which enables health and social care staff to share information securely to protect the most vulnerable children. The CP-IS project links IT systems used across health and social care to help organisations share information securely.

The safeguarding team continues to support our staff and collate information to identify themes and trends. It works closely with colleagues from other agencies, including Local Safeguarding Adult and Children’s Boards (Partnerships) to ensure compliance with standards.

Safeguarding

Our safeguarding service continued to improve and evolve in 2018/19 and a think family approach is promoted within the Trust. The new Physical Interventions Team is now part of the safeguarding team and plans are in place to grow this service to support staff and patients. This service aims to increase availability of conflict resolution and physical interventions support. Training for all staff is increasing to meet the need to offer reliable and adequate support for staff under pressure from physical and verbal patient challenge.

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Celebrating our successes

Moving Forward 2019/2020

Our new strategy is based on the five year forward plan and works towards health and social care integration. We also have a new Nursing Midwifery Framework which sets out vision for nursing and midwifery and the principles to support its delivery. We aim to continuously develop ourselves and seek to improve the quality of care and services we deliver.

Carers Booklet
Development of a new Carers Pack will be pivotal in providing additional information about the support we can provide for our carers. This will help to ensure they are treated as equal partners in care delivery for patients.

Maternity Voices
Our Maternity Voices group is being launched in spring 2019 and will provide a forum for staff and women to work together, ensuring that health professionals listen to and take account of the views and experiences of those who use our maternity services.

Better Birth Focus Group
Better Births focus groups are held once a quarter. The first group met in January and gave an overview of the local maternity system and work stream priorities, including new ways of working to provide a service that meets the Continuity of Care agenda and delivery of recommendations on the Better Births agenda.

Group Antenatal Care
Last year a number of women opted to receive their antenatal care in a group setting, giving vital space and time for women to form relationships with others who were at a similar point in their pregnancy. As well as receiving the antenatal check, each session provides plenty of time to find out about how to keep well during pregnancy and prepare for childbirth and parenthood. There was also time for women to meet with their midwife individually to answer any personal questions or concerns. Following evaluation of the pilot we hope to adopt a similar model for all women.

Facebook launch
This spring sees the launch of Derriford’s Maternity Services Facebook page. We aim to be able to share news and information to women and their families.

Support at mealtimes project
Our Mealtime Volunteering Campaign provides our non-clinical staff, who do not normally work in patient facing roles, an opportunity to undertake interesting and rewarding duties to support patients a mealtimes. We aim to continue the project with the aim of developing the role further to actively include carers and relatives at mealtimes.

A member of the PALS team joined the mealtime volunteer project in 2018 and continues to visit Braunton Ward every week to support patient need assistance. The campaign increases social interaction for patients who may not have visitors as well as encouraging them to eat, thereby supporting the patient’s wellbeing and recovery.

The feedback from patients has been very positive, and they enjoy speaking to different members of staff and appreciate the extra support at mealtimes.
In order to deliver our improvement priorities we must be an organisation which embraces continuous improvement and is fully committed to greater staff and patient engagement and participation. In order to capture the creativity and knowledge of our staff, we need to provide support in identifying problems, developing and testing solutions and sharing knowledge. Our core purpose is to deliver excellent care, with compassion, wrapped around people’s individual needs to the population of Plymouth and surrounding areas. We seek to do this through our Trust Values:

- Put patients first
- Take ownership
- Respect others
- Be positive
- Listening, learning and improving

We have the ambition of creating an authentic improvement culture at Plymouth Hospitals NHS Trust. That means getting ideas and actions from wards, theatres, admin areas, patients and service users.

As defined within our strategic direction, our key areas of focus will be:

To ensure care is provided closer to people’s homes where possible, so that people have care wrapped around them and have to tell their story only once.

To provide safe and effective hospital care, working to deliver the national constitutional standards.

To offer high quality care as the major trauma centre for the peninsula, invest in research and develop our specialist services.

To bridge the gaps between primary and secondary care for the benefit of local people.

Our Quality Improvement Strategy

In 2019 we will move into our first full year of our ‘People First Improvement Practice’.

University Hospitals Plymouth NHS Trust and Livewell SW were jointly chosen as one of seven NHS organisations to take part in the National Health Service Improvement Service (NHSi) Programme, the aim of which is to create a culture of continuous improvement by empowering staff to develop their own improvement ideas and lead on their own projects.

This programme will continue to build on our strong existing quality improvement work which aims to implement ideas from all of our staff, clinical and non-clinical, and also from our patients and service users to ensure the delivery of health care which is safe, effective and patient-centred.

We aim to:

- Ensure all our staff understand our clear and concise plan that describes our common goal and improvements in the services we will provide over the next three years and their role in it. We have revised our strategy and focus which we will be using to guide us.
- Provide the support and conditions that will enable that to happen at every level in the community and in the hospital – through spread of training and improvement huddles.
- Strive to ensure the patient’s voice is integral to all our improvement work, with the establishment of a dedicated group focusing on patient involvement in improvement.
Provide our staff with the skills they require to bring about such change. Training in local team based improvement skills, and coaching of teams.

Our aim is to deliver care of the highest standard in line with that delivered by the best health care systems in the world.

Priority 2 - Improve Responsiveness - Ensure all patients receive timely, high quality care by working with other providers to ensure care is provided by the right staff in the right place at the right time.

The Trust has recently experienced difficulties with capacity which resulted in cancellations for patients and longer waits for treatment than we would like. We aim to improve performance in a number of areas including:

- Increasing our ability to treat patients quickly in the Emergency Department
- Treatment within 18 weeks
- Cancer treatment in line with national standards
- Reduce the discharge delays from critical care beds to wards
- Reduce patient cancellations
- Reduce waits for diagnostic procedures

We recognise that arrangements for leaving the hospital are just as important and will focus on improving discharge care for those patients with complex care needs to ensure they have a timely safe discharge care which is in line with best practice. This will include a focus on good end of life care which enables people to live in as much comfort as possible until they die and to make choices about their care and where to spend their last days.

Priority 3 - Patient communication and information – improve the quality of communication and information provided before, during and after their care

Patients frequently leave hospital uninformed about the details of their hospital stay, limited ability to accurately state their diagnosis and their ongoing management after discharge. We will enable patients to understand key aspects of their care by providing accurate and understandable information enabling them to take greater control, potentially reducing readmission rates and unplanned visits to secondary care, whilst providing safer care and improving patient experience.
Our Plans for 2019/20

Carers have an important role in the effective and safe delivery of treatment and care of patients in hospital. It is important to identify, involve and support carers in the clinical setting in order to get the care of the patient right.

We recognise there can be adverse consequences resulting from delays in diagnostic reporting and we will drive forward improvements to eradicate delays.

A more detailed analysis of our current position in each of these areas and our plans for improvement are set out in Annex F.

Safety Initiatives

The national Sign up to Safety initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible has now been fully embedded into the organisations safety initiatives.

We will now continue working on our safety initiatives to give patients reassurance and confidence that we are doing all we can to ensure the care they receive will be safe and effective at all times. Our work will continue to be around the following key areas:

- Creating lasting change so that patients, and those who care for them, are free from avoidable harm?
- Creating a safety culture that leads to lasting change? We will continue to focus on how we work together, how we lead, make decisions, how we adjust and adapt and behave every day. We will continue to work towards a balanced approach to safety, creating a culture where staff and patients are treated with empathy and kindness. When things go wrong, we can learn more about what we can do differently to make care safer.
- If the solutions and proven interventions exist already, we can support staff with examples of evidence based interventions and tools to inspire and motivate them to use best practice to treat every patient
- Capturing data and learning from incidents and investigations effectively. If we do this we will have a good chance of preventing things from going wrong in the future?
- Learn from what is going well by capturing those moments that make a difference to patients, and the staff that care for them, then share what makes a difference.

Additional detail is described in Annex G.
## National metrics

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<th>Description</th>
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<th>2018/19</th>
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<td>37</td>
<td>43</td>
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<td>Achieved in 0 out of 12 months</td>
<td>Achieved in 0 out of 12 months</td>
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</tr>
<tr>
<td>Maximum time in ED of four hours from arrival to admission, transfer or discharge</td>
<td>85.2%</td>
<td>84.3%</td>
<td>83.8%</td>
<td>81.14%</td>
<td>95%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>All cancer two week wait</td>
<td>89.8%</td>
<td>93.2%</td>
<td>92.2%</td>
<td>93.4%</td>
<td>93%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>Two week wait for symptomatic breast patients (cancer not initially suspected)</td>
<td>44.5%</td>
<td>77.5%</td>
<td>27.7%</td>
<td>87.1%</td>
<td>93%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>31 day (diagnosis to treatment) wait for first treatment: all cancers</td>
<td>96.9%</td>
<td>95.8%</td>
<td>95.7%</td>
<td>95.1%</td>
<td>96%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: surgery</td>
<td>92.9%</td>
<td>90.9%</td>
<td>92.5%</td>
<td>89.1%</td>
<td>94%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: anti-cancer drug treatments</td>
<td>99.6%</td>
<td>99.3%</td>
<td>99.4%</td>
<td>99.7%</td>
<td>98%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>31 day wait for second or subsequent treatment: radiotherapy treatments</td>
<td>93.5%</td>
<td>96.7%</td>
<td>87.3%</td>
<td>72.8%</td>
<td>94%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>62 day (urgent GP referral to treatment) wait for first treatment: all cancers</td>
<td>81.1%</td>
<td>79.2%</td>
<td>79.3%</td>
<td>73.8%</td>
<td>85%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>62 day consultant upgrade wait for first treatment: all cancers</td>
<td>80.8%</td>
<td>78.6%</td>
<td>77.3%</td>
<td>72.0%</td>
<td>85% Local Target</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>62 day wait for first treatment from consultant screening service referral: all cancers</td>
<td>90.6%</td>
<td>86.9%</td>
<td>86.9%</td>
<td>90.2%</td>
<td>90%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>Access to genito-urinary medicine clinics (48 hours)</td>
<td>100%</td>
<td>100%</td>
<td>99.92%</td>
<td>100%</td>
<td>100%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>Cancelled operations by the hospital for non-clinical reasons on the day of or after admission</td>
<td>3.51%</td>
<td>3.03%</td>
<td>3.24%</td>
<td>2.85%</td>
<td>0.80%</td>
<td>Lower % is better</td>
</tr>
<tr>
<td>Cancelled operations by the hospital for non-clinical reasons on the day or after admission, who were not treated within 28 days</td>
<td>16.1%</td>
<td>15.3%</td>
<td>14.3%</td>
<td>17.1%</td>
<td>5%</td>
<td>Lower % is better</td>
</tr>
</tbody>
</table>
### Other local metrics

<table>
<thead>
<tr>
<th>Description</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Target</th>
<th>What this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of C-diff per 100,000 bed days (patients aged 2 years and over)</td>
<td>14.3</td>
<td>12.3</td>
<td>14.4</td>
<td>9.37</td>
<td>-</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Hand hygiene compliance rates</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>94%</td>
<td>95%</td>
<td>Higher % is better</td>
</tr>
<tr>
<td>Patient falls resulting in harm or death (moderate harm and above)</td>
<td>36</td>
<td>39</td>
<td>44</td>
<td>36</td>
<td>Reduce by 10%</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Incident reporting rate – per 100 admissions</td>
<td>11.6</td>
<td>11.1</td>
<td>11.07</td>
<td>12.50</td>
<td>-</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Percentage of reported patient safety incidents resulting in severe harm or death</td>
<td>0.43%</td>
<td>0.24%</td>
<td>0.31%</td>
<td>0.35%</td>
<td>-</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Total Number of patient Safety Incidents reported to NRLS (includes No Harm through to Serious Harm &amp; Death)</td>
<td>13,591</td>
<td>13,169</td>
<td>14,936</td>
<td>15,619</td>
<td>-</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Number of Never events</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>0</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Number of complaints</td>
<td>646</td>
<td>609</td>
<td>563</td>
<td>709</td>
<td>Reduce by 10%</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Number of PALS enquiries</td>
<td>4672</td>
<td>4127</td>
<td>4432</td>
<td>4982</td>
<td>-</td>
<td>Lower is better</td>
</tr>
<tr>
<td>Grade 2, 3 &amp; 4 pressure Ulcers</td>
<td>181</td>
<td>135</td>
<td>174</td>
<td>199</td>
<td>Reduce by 20%</td>
<td>Lower is better</td>
</tr>
<tr>
<td>% stroke patients spending 90% of their stay on Acute Stroke Unit</td>
<td>72%</td>
<td>74%</td>
<td>73.3%</td>
<td>81%</td>
<td>80%</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Fractured NOF – delays to surgery &lt; 36hrs</td>
<td>71%</td>
<td>71%</td>
<td>68%</td>
<td>69%</td>
<td>85%</td>
<td>Higher is better</td>
</tr>
<tr>
<td>Delayed transfers of care</td>
<td>-</td>
<td>-</td>
<td>6.73%</td>
<td>3.41%</td>
<td>3.5%</td>
<td>Lower is Better</td>
</tr>
</tbody>
</table>

#### 2019/20 Performance Trajectories

We are mindful of the importance of developing and agreeing robust improvement trajectories for the each our key operational standards. The graphs below detail our improvement trajectories for the coming year, including our performance for the previous year.

**Emergency Department 4hr standard**

We have developed an initial improvement trajectory for the 4 hour A&E wait standard, shown in the graph below.
RTT Incomplete Pathways

We are planning to reduce the number of patients waiting longer than 18 weeks for treatment and achieve a standard of 79% by March 2020. Our planned improvement trajectory is shown in the graph below:

The graph below shows the expected number of incomplete pathways:

52-Week Waits

We are also committed to reducing the number of 52 week waits.
Annex A
Quality Metrics

Diagnostic Waits

Our planned improvement trajectory achievement will be dependent on a number of critical factors including equipment developments, continued outsourcing and productivity improvements.

Cancer 62-Day Standard

We are planning to meet the national standard of at least 93% of patient seen within 2 weeks following a referral for suspected cancer and also for breast symptomatic patients in every month.

This trajectory is based on reducing the backlog of 62 day patients in line with the reduction levels experienced since August 2018.
Annex B

Core Indicators

Comparative Core Quality Account Indicators

Core Indicator 12 – Summary Hospital Level Mortality Indicator
(a) The value and banding of the summary hospital-level mortality indicator (“SHMI”) for the Trust for the reporting period
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period

<table>
<thead>
<tr>
<th>SHMI (Summary Hospital-Level Mortality Indicator)</th>
<th>Oct 15 – Sep 16</th>
<th>Oct 16 – Sep 17</th>
<th>Oct 17 – Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth - SHMI Value Banding</td>
<td>0.9866</td>
<td>1.0306</td>
<td>1.0835</td>
</tr>
<tr>
<td>National highest – SHMI Value Banding</td>
<td>1.1638</td>
<td>1.2473</td>
<td>1.2635</td>
</tr>
<tr>
<td>National lowest – SHMI Value Banding</td>
<td>0.6897</td>
<td>0.7270</td>
<td>0.6907</td>
</tr>
<tr>
<td>NHS trust average - SHMI Value</td>
<td>1.0034</td>
<td>1.0050</td>
<td>1.0000</td>
</tr>
</tbody>
</table>

% of patient deaths with palliative care coded at either diagnosis or specialty level

<table>
<thead>
<tr>
<th>Plymouth</th>
<th>Oct 15 – Sep 16</th>
<th>Oct 16 – Sep 17</th>
<th>Oct 17 – Sep 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>National highest</td>
<td>20.7</td>
<td>20.2</td>
<td>18.6</td>
</tr>
<tr>
<td>National lowest</td>
<td>56.3</td>
<td>59.8</td>
<td>59.5</td>
</tr>
<tr>
<td>NHS trust average</td>
<td>29.7</td>
<td>31.5</td>
<td>33.6</td>
</tr>
</tbody>
</table>

*The palliative care indicator is a contextual indicator.

Core indicator 18 - Patient Reported Outcome Measures (PROMS)
(i) hip replacement surgery
(ii) knee replacement surgery

Pre-operative participation and linkage
Participation from April 2017 – March 2018

<table>
<thead>
<tr>
<th>Eligible hospital procedures</th>
<th>Pre-operative questionnaires completed</th>
<th>Participation Rate</th>
<th>Pre-operative questionnaires linked</th>
<th>Linkage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Procedures</td>
<td>620</td>
<td>580</td>
<td>93.5%</td>
<td>386</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>297</td>
<td>279</td>
<td>93.9%</td>
<td>185</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>323</td>
<td>301</td>
<td>93.2%</td>
<td>201</td>
</tr>
</tbody>
</table>

Post-operative issue and return
Participation from April 2017 – March 2018

<table>
<thead>
<tr>
<th>Pre-operative questionnaires completed</th>
<th>Post-operative questionnaires sent out</th>
<th>Issue Rate</th>
<th>Post-operative questionnaires returned</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Procedures</td>
<td>580</td>
<td>577</td>
<td>99.5%</td>
<td>390</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>279</td>
<td>276</td>
<td>98.9%</td>
<td>184</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>301</td>
<td>301</td>
<td>100%</td>
<td>206</td>
</tr>
</tbody>
</table>
University Hospitals Plymouth NHS Trust has taken the following action to improve its PROMS activity:

- Continue to monitor response rates
- Reporting to the Clinical Effectiveness Group

Next steps will include review of outcome data against other similar organisations and local monitoring of our patients reported health gains.

**Core Indicator 19 – Readmission with 28 days**

Percentage of patients re-admitted to hospital within 28 days of being discharged

(i) 0 to 15 year olds
(ii) 16 year olds and over

<table>
<thead>
<tr>
<th>Compared to other Large Acute Trusts</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Patients readmitted to hospital within 28 days of being discharged for 0 – 15 year olds</td>
<td>10.46</td>
<td>10.43</td>
<td>12.18</td>
</tr>
<tr>
<td>National highest</td>
<td>15.35</td>
<td>14.11</td>
<td>14.94</td>
</tr>
<tr>
<td>National lowest</td>
<td>6.04</td>
<td>6.41</td>
<td>6.40</td>
</tr>
<tr>
<td>NHS trust average</td>
<td>9.76</td>
<td>9.96</td>
<td>10.02</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compared to other Large Acute Trusts</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Patients readmitted to hospital within 28 days of being discharged for 16 year olds and over</td>
<td>10.29</td>
<td>9.65</td>
<td>9.50</td>
</tr>
<tr>
<td>National highest</td>
<td>13.18</td>
<td>14.06</td>
<td>13.80</td>
</tr>
<tr>
<td>National lowest</td>
<td>8.95</td>
<td>9.20</td>
<td>9.34</td>
</tr>
<tr>
<td>NHS trust average</td>
<td>11.12</td>
<td>11.38</td>
<td>11.44</td>
</tr>
</tbody>
</table>

Please note that these indicators were last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.

**Core Indicator 20 - Trust’s responsiveness to the personal needs of its patients**

Patient experience as measured by scoring the results of five questions from the National Inpatient Survey focusing on responsiveness to personal needs. The scores shown below represent a composite of the five questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
Annex B  Core Indicators

- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Responses</th>
<th>NHS Digital Workforce (Headcount)</th>
<th>Work</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Percentage Recommended</td>
<td>Percentage No Recommended</td>
</tr>
<tr>
<td>University Hospitals Plymouth NHS Trust</td>
<td>192</td>
<td>7,004</td>
<td>47%</td>
<td>27%</td>
</tr>
<tr>
<td>NHS Trust Average - England</td>
<td>130,555</td>
<td>1,149,726</td>
<td>64%</td>
<td>17%</td>
</tr>
<tr>
<td>National highest</td>
<td>3,493</td>
<td>20,502</td>
<td>61%</td>
<td>19%</td>
</tr>
<tr>
<td>National lowest</td>
<td>7</td>
<td>6,030</td>
<td>57%</td>
<td>14%</td>
</tr>
</tbody>
</table>

University Hospitals Plymouth NHS Trust continues to monitor performance against these questions in its local survey programme, using the meridian system. This is shared with matrons and ward sister / charge nurse. A dedicated piece of work started in 2018/19 to improve information at the point of discharge, where patients have been asked to meet with staff to redesign information provision.

Core Indicator 21 – Friends and Family Test Staff
The percentage of staff employed by, or under contract to, the trust for quarter 2 of 2018/19 who would recommend the Trust as a provider of care to their family or friends

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Responses</th>
<th>NHS Digital Workforce (Headcount)</th>
<th>Work</th>
<th>Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Percentage Recommended</td>
<td>Percentage No Recommended</td>
</tr>
<tr>
<td>University Hospitals Plymouth NHS Trust</td>
<td>192</td>
<td>7,004</td>
<td>47%</td>
<td>27%</td>
</tr>
<tr>
<td>NHS Trust Average - England</td>
<td>130,555</td>
<td>1,149,726</td>
<td>64%</td>
<td>17%</td>
</tr>
<tr>
<td>National highest</td>
<td>3,493</td>
<td>20,502</td>
<td>61%</td>
<td>19%</td>
</tr>
<tr>
<td>National lowest</td>
<td>7</td>
<td>6,030</td>
<td>57%</td>
<td>14%</td>
</tr>
</tbody>
</table>

University Hospitals Plymouth NHS Trust monitors the recommended scores for all Friends and Family test areas.

Core indicator 21.1 – Friends and Family Test Patients
Percentage of patients discharged following an inpatient stay or emergency treatment for February 2019 who would recommend the trust as a provider of care to their family or friends.

<table>
<thead>
<tr>
<th>Description</th>
<th>Inpatient &amp; Daycase</th>
<th>Emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Response Rate</td>
<td>Percentage Recommended</td>
</tr>
<tr>
<td>University Hospitals Plymouth NHS Trust</td>
<td>42.39% (2,449)</td>
<td>97.14%</td>
</tr>
<tr>
<td>NHS Trust Average - England (excluding Independent Sector Providers)</td>
<td>24.24%</td>
<td>95.51%</td>
</tr>
<tr>
<td>National highest</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>National lowest</td>
<td>1.86%</td>
<td>76.33%</td>
</tr>
</tbody>
</table>

The Friends and Family Test is in place across all areas of the Trust and provides valuable feedback from our patients, encompassing all adult, children and carers including inpatient, emergency care, maternity, outpatient and day case across both hospital and community based locations.
Core Indicators

Patients are asked ‘How likely are you to recommend our ward to friends and family if they needed similar care or treatment’ based on the following potential responses:

1. Extremely likely
2. Likely
3. Neither likely nor unlikely
4. Unlikely
5. Extremely unlikely
6. Don’t know

Through the qualitative feedback element of Friends and Family Test we ensure patients views are heard and shared. Whilst the recommender score provides a gauge of overall patient satisfaction, the qualitative feedback gathered through the Friend and Family Test provides an opportunity to understand our successes and areas for improvement in more detail.

Using a number of collection methods helps maintain our response rates and the paper based approach also allows real time feedback to staff through our red post box system. Each ward and department has a board to display results in view of patients, staff and visitors showing the number of patients seen during the period, number of survey responses along with the recommender score and examples of comments.

Core Indicator 23 - Venous Thromboembolism
Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during 2018-19.

<table>
<thead>
<tr>
<th>Description</th>
<th>University Hospitals Plymouth</th>
<th>National highest</th>
<th>National lowest</th>
<th>NHS trust average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1 April 2018 to June 2018</td>
<td>95.91%</td>
<td>100%</td>
<td>67.04%</td>
<td>95.18%</td>
</tr>
<tr>
<td>Quarter 2 July 2018 to September 2018</td>
<td>97.10%</td>
<td>100%</td>
<td>75.84%</td>
<td>95.62%</td>
</tr>
<tr>
<td>Quarter 3 October 2018 to December 2018</td>
<td>96.23%</td>
<td>100%</td>
<td>68.67%</td>
<td>95.44%</td>
</tr>
<tr>
<td>Quarter 4 January 2019 to March 2019</td>
<td>95.87%</td>
<td>100%</td>
<td>54.85%</td>
<td>95.60%</td>
</tr>
</tbody>
</table>

* During previous years the Trust’s auditors for the Quality Account have found discrepancies when comparing the paper hospital record and our electronic discharge system for VTE. Although the error rate is low the Trust believes that the indicator does represent our performance and is working to correct the issue with the introduction of e-prescribing.

Core Indicator 24 – C.difficile
The rate per 100,000 bed days of trust apportioned cases of C.difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period.

<table>
<thead>
<tr>
<th>Description</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospitals Plymouth NHS Trust</td>
<td>12.3</td>
<td>14.3</td>
<td>12.3</td>
<td>14.4</td>
</tr>
<tr>
<td>National highest</td>
<td>62.6</td>
<td>67.2</td>
<td>82.6</td>
<td>91.0</td>
</tr>
<tr>
<td>National lowest</td>
<td>0*</td>
<td>0*</td>
<td>0*</td>
<td>0*</td>
</tr>
<tr>
<td>NHS Trust average</td>
<td>15.0</td>
<td>14.9</td>
<td>13.2</td>
<td>13.7</td>
</tr>
</tbody>
</table>

*The Trust is advised by NHS Digital that zero recorded here may be due to missing data from other trusts reported to the centre.

Core Indicator 25 – Patient Safety Incidents* (Comparison data against all Acute non specialist / Trusts)

<table>
<thead>
<tr>
<th>Number and rate of patient safety incidents reported within the Trust during the reporting period</th>
<th>Plymouth Hospitals</th>
<th>National highest</th>
<th>National lowest</th>
<th>NHS trust average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient safety incidents: Rate per 1,000 bed days Apr 2016 to Sep 2016</td>
<td>41.9</td>
<td>71.8</td>
<td>12.1</td>
<td>40.8</td>
</tr>
<tr>
<td>Patient safety incident: number</td>
<td>6246</td>
<td>13485</td>
<td>1485</td>
<td>4955</td>
</tr>
</tbody>
</table>
Patient safety incidents: Rate per 1,000 bed days

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number</th>
<th>Rate per 1,000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2016 to March 2017</td>
<td>6245</td>
<td>41.4</td>
</tr>
<tr>
<td>Apr 2017 to Sep 2017</td>
<td>14506</td>
<td>42.5</td>
</tr>
<tr>
<td>Oct 2017 to Mar 2018</td>
<td>15228</td>
<td>47.7</td>
</tr>
</tbody>
</table>

Patient safety incidents: Rate per 1,000 bed days

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number</th>
<th>Rate per 1,000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 2016 to Sep 2016</td>
<td>25</td>
<td>0.17</td>
</tr>
<tr>
<td>Oct 2016 to March 2017</td>
<td>98</td>
<td>0.13</td>
</tr>
<tr>
<td>Apr 2017 to Sep 2017</td>
<td>92</td>
<td>0.14</td>
</tr>
<tr>
<td>Oct 2017 to Mar 2018</td>
<td>121</td>
<td>0.24</td>
</tr>
</tbody>
</table>

* UHP has an open reporting system which allows any member of staff to report an incident and we do not want to discourage incident reporting. UHP do not validate every No Harm and Minor Harm incident prior to reporting to NRLS we allow our staff to make that decision based on their clinical opinion however all Moderate Harm, Serious Harm and Death Caused by Incidents are validated. We do recognise the need to continue to educate staff around what is a reportable incident and what is not, as well as investigate the opportunity to simplify our incident reporting system.

Core Indicator KF 26 – Percentage of staff personally experiencing harassment, bullying or abuse at work from managers in the last 12 months

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Percentage</th>
<th>Total Percentage</th>
<th>Total Percentage</th>
<th>Total Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td>Acute Trusts Average</td>
<td>13.6%</td>
<td>12.9%</td>
<td>13.2%</td>
<td>13.7%</td>
</tr>
<tr>
<td>National Best</td>
<td>6.5%</td>
<td>6.8%</td>
<td>7.3%</td>
<td>8.0%</td>
</tr>
<tr>
<td>National Worst</td>
<td>27.3%</td>
<td>22.6%</td>
<td>23.8%</td>
<td>24.1%</td>
</tr>
<tr>
<td>University Hospitals Plymouth NHS Trust</td>
<td>13.1%</td>
<td>11.6%</td>
<td>11.7%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

Core Indicator KF 26 – Percentage of staff personally experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months

<table>
<thead>
<tr>
<th>Description</th>
<th>Total Percentage</th>
<th>Total Percentage</th>
<th>Total Percentage</th>
<th>Total Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
<tr>
<td>Acute Trusts Average</td>
<td>19.3%</td>
<td>18.6%</td>
<td>19.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>National Best</td>
<td>12.5%</td>
<td>12.2%</td>
<td>13.6%</td>
<td>11.7%</td>
</tr>
<tr>
<td>National Worst</td>
<td>30.1%</td>
<td>27.6%</td>
<td>27.4%</td>
<td>28.4%</td>
</tr>
<tr>
<td>University Hospitals Plymouth NHS Trust</td>
<td>19.0%</td>
<td>16.9%</td>
<td>16.5%</td>
<td>19.3%</td>
</tr>
</tbody>
</table>
Clinical Administration Programme

The Clinical Administration Programme has been established for some time now and has a remit to support the service lines with the delivery of a high quality and cost effective clinical administration service. In the past patients have experienced some issues associated with our administration including:

- Difficulties contacting clinical services
- Booking a new outpatient appointment
- Cancellation of clinic appointments
- Data quality issues affecting the management of patient pathways

A recent review of the remit of the programme has confirmed its focus as:

1. Implementing new technologies to help develop more efficient services
2. Agreeing the clinical office model in light of the pilots and further feedback from clinical areas
3. Ensuring an active programme of training and development for our staff, particularly around the leadership of our administration teams
4. Establishing clearly defined and well communicated service standards so that administration teams know what is expected of them
5. Stabilising some of our corporate departments to make them more responsive to service line needs

The Trust has invested heavily in new technologies and a number of these have been implemented with the benefits of each now being realised.

**Digital Dictation**
The implementation of this solution has provided greater visibility of workload, activity and performance which has enabled a continued reduction in the delays around transcription and authorisation of clinical correspondence. Utilisation currently sits in excess of 100% of clinic attendances. Next steps will be to enhance our mobile device functionality and speech recognition capabilities.

**Enhanced Telephony and Reminder Services**
The enhanced telephony system has been successfully implemented across a number of areas including the Outpatient Management Centre, Imaging and PALS. In addition to this the programme has implemented an improved outpatient appointment reminder service. The key benefits of this project have been to improve patient experience in contacting the hospital, reduced levels of non-attendance (DNA) and patient reschedules and reduced wastage costs.

**Electronic-outcomes**
Our electronic clinic outcome system is now live across all areas in the Trust. To date in excess of 8,500 clinic outcomes are being processed weekly through this system. There are now only a handful of clinicians that are not yet trained on the system. Feedback to date from clinicians using the system has been generally positive though there remains concern such as business support and the number of electronic systems and supporting IT infrastructure.

This project is now being prepared for closure with a number of benefits being realised including:

- Improved level of data quality therefore contributing positively to the management of the patient journey
- Reduction in paper usage for paper copy forms
Annex C  Assurance Statements

- Minimises missing information so improving patient safety
- Reduced waiting times
- Reduced time needed on reception
- Improved Referral to Treatment (RTT) times

**Electronic Communication to GPs**
The Trust has purchased a system which, at the point of approval by the relevant clinician, automatically sends outpatient clinic letters to the patient’s GP practice. Following a successful pilot we are currently undertaking a roll-out programme to ensure that all GP practices across Devon and Cornwall are able to access letters about their patients in this way. The pilot also evidenced a reduction in delivery times of clinic letters to GPs of up to five days. All specialties are now sending their clinic letters to the relevant GP practices.

Paper copies of letters to GP practices, in Devon and Cornwall were officially “switched off” on 1 September 2018 for all specialties that produce their correspondence via the Trust standard digital dictation system. To date over 133,000 letters have now been sent electronically to GP practices this generates not only savings in terms of stationary but also in staff time and in the courier service.

**Communication to Patients**
The Trust has been looking for some time to make more efficient the way in which it manages its written communications to its patients. In terms of correspondence with patients we intend to give patients the choice of email, web based or paper copy depending on their individual requirements.

The Trust has completed the necessary work to identify a suitable patient portal-hybrid mail solution. This approach will significantly improve patient choice in terms of being able to choose the method of communication to suit their needs. This solution will also support compliance with national requirements to support accessible communication for all and to include patients in our clinical correspondence.

The web-portal element will also offer the Trust and its patients an opportunity to manage follow-up appointments differently. It will allow the remote management of stable routine patients either with chronic long term conditions or through the minimisation of post-operative follow-up. This will reduce the demand in our follow-up clinics and therefore support the programme of reducing our follow up backlog and ensuring that available capacity is used for more clinically urgent patients.

As a reminder these are the qualitative and clinical benefits:

- Patients have the ability to communicate at a time that suits them
- Patients can be seen when they need to be seen and not offered an appointment when they are well
- Patients’ are empowered with the confidence and knowledge to control their own condition better
- Enables early recognition of flare-ups by patients and clinicians
- Provide an early alert system with instant management advice
- Allow early intervention, aimed at preventing urgent outpatient appointments/hospitalisation
- Allow remote management by the specialist clinical teams
- Allow pre-emptive and directed individualised therapy
- Improves patient satisfaction
**Annex C  Assurance Statements**

**Workforce Structures**

We need to improve our clinical administration, for our patients and also for our staff who work in administration. One of the things we want to do is create an attractive career pathway in clinical administration. This element has been developed well with the new Outpatient Management Centre arrangements. Last year we introduced the role of clinical administration manager which provides an ideal next step for team leaders and medical secretaries. We also need to ensure that we have the right number of staff at the right grade delivering a high quality service to our patients and the clinical teams. For this reason the programme will be assessing, in conjunction with the service lines, what the staffing requirement is for individual teams and ensuring that we have the right staff doing the right jobs.

**Training, Improved Supervision and Delivery of Service Standards**

The Trust has invested in a clinical administration training function with the intention of providing a more sustainable approach to ensuring our staff have the right tools and knowledge to enable them to do their jobs. This is being supported by the Clinical Administration Manager role mentioned above. The key deliverables for this are to:

- Ensure that all staff have received adequate training and support to enable them to effectively carry out the role that is expected of them
- Ensure all staff receive adequate and effective supervision to ensure the achievement of service standards
- Development of a set of agreed service standards along with action planning to ensure that individual departments achieve what is required of them

In order to achieve this, the Trust agreed a corporate training strategy which significantly broadens capacity and capability to deliver effective training and education to our staff.

During the last year a significant number of staff attended training sessions across the modules being offered. These modules include Elective Access Policy, RTT Basics, RTT Masterclass. Primary Target Lists (PTLs), the Data Quality Handbook and Administrative Process Notes (APNs).

The team also provide support for the development of workplace tools such as a resource page on our internal website, e-learning to supplement the class room based training and the development of a dedicated e-mail inbox to support staff with queries.

**Clinical Coding**

Clinical Coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes which reflect the activity that happens to patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records and drives the Trust’s income.

University Hospitals Plymouth NHS Trust was subject to a successful Information Governance Clinical Coding audit, undertaken in February 2018, by Rosalind Ward for the period Apr-Oct 2017. The error rates reported in the latest published audit for that period for diagnoses and treatment coding are detailed in the table below. The Trust was previously subject to an Information Governance Clinical Coding audit by D&A Consultancy in September 2013 and 2014 and Rosalind Ward in October 2015 and October 2016. The Trust is still achieving Level 2.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis incorrect (%)</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>10%</td>
<td>8%</td>
<td>10%</td>
</tr>
</tbody>
</table>
## Annex C  Assurance Statements

<table>
<thead>
<tr>
<th></th>
<th>2.29%</th>
<th>4.9%</th>
<th>4.9%</th>
<th>13.53%</th>
<th>12.41%</th>
<th>13.25%</th>
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<tbody>
<tr>
<td><strong>Secondary diagnosis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incorrect (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary procedures</strong></td>
<td>2.78%</td>
<td>2.5%</td>
<td>1.4%</td>
<td>5.79%</td>
<td>4.71%</td>
<td>6.25%</td>
</tr>
<tr>
<td>incorrect (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Secondary procedures</strong></td>
<td>0.86%</td>
<td>5.1%</td>
<td>3.9%</td>
<td>11.83%</td>
<td>8.33%</td>
<td>11.38%</td>
</tr>
<tr>
<td>incorrect (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Data Quality

Clinicians and managers need ready access to accurate and comprehensive data to support the delivery of high quality care. Improving the quality and reliability of information is therefore a fundamental component of quality improvement.

The Trust monitors the accuracy of data in a number of ways including the monthly Data Quality Steering Group (DQSG), chaired by the Business Intelligence Manager. This group utilises the Trust’s internal data quality summary reports and external dashboards to monitor key indicators. Within the Performance & Information Management Department is an RTT validator who carries out the data quality actions from the DQSG and a number of analysts support data quality reporting.

Each service line area in the Trust has one or more data quality champion, usually the clinical administration managers. These operational data quality leads ensure their area is performing in accordance with the required standards. As well as internal data quality summary reports, there is a variety of data quality reports used by the operational teams to validate and correct issues.

All data quality reports, guidance and summaries are coordinated by the data quality handbook, an electronic handbook providing a central point for all information. The data quality champions and their operational teams have detailed guidance to support them with undertaking data quality work and access to Administrative Procedure Notes (APNs) which explain the operational processes.

In 2018 internal audit completed a data quality audit pertaining to the RTT Performance Standard. This audit and previous audits on the A&E 4 hour standard, stroke and cancer waiting times provide assurance against these essential performance indicators.

In 2018/2019, the Performance Information Team and Patient Access Team held a number of data quality training sessions for administrative support managers and team leaders. This covered the rationale behind why good data quality is essential for patient care, patient safety, operational performance standards and income. Over the next few months training to all administration posts will be completed.

### National Data Quality Validity and Benchmarking

The Trust provides submissions to the Secondary Uses Service (SUS). This is a single source of comprehensive data which enables a range of reporting and analysis in England and is run by NHS Digital.

The table below shows the percentage of valid records in the published data at month 10 2018/2019 for two key indicators:

<table>
<thead>
<tr>
<th>Patient Pathway</th>
<th>Valid NHS Number</th>
<th>Valid GP Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patient care</td>
<td>99.1%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>99.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Accident &amp; emergency care</td>
<td>98.4%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The Trust remains top in the peninsula for data quality assurance on the SUS Data Quality Dashboards with a total combined score of 99.4.
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**Duty of Candour**

The Trust ensures duty of candour requirements are implemented following any ‘moderate harm’ or above graded incident once it has occurred. There are key steps in the process as shown in the diagram below.

Where it is felt a ‘candour conversation’ is required, it is important to identify the most appropriate person to conduct such a conversation, which in most circumstances would be the clinician with whom the patient has an active clinical relationship.

We ensure an accurate account of the incident is provided, containing all the facts known about the incident at the date of the notification, particularly including what happened, why and how and what can be learned to prevent a further occurrence.

We ensure the person(s) communicating with the patients and/or relevant person:

- Has a good understanding of the facts relevant to the case
- Has excellent interpersonal skills, including being able to communicate with patients and/or relevant persons in a way they can understand, avoiding excessive use of medical jargon
- Is willing and able to offer an apology, reassurance and feedback to patients and/or their carers
- Is able to maintain a medium to long term relationship with the patient and/or their carers, where possible, and to provide continued support and information
- Is culturally aware and informed about the specific needs of the patient and/or their carers
- Where a patient safety incident has caused harm, an apology is offered to the relevant person, which is a sincere expression of sorrow or regret for harm and distress caused

**Duty of Candour Diagram**
Infection Control

The Trust has made significant progress towards modernising the service it offers and meeting the challenging new agenda being set at both local and national levels. The Infection Prevention and Control Team has dramatically changed the way it has worked in order to deliver a more clinically-orientated and relevant service. This approach has been effective in both improving clinical practice and reducing rates of hospital-associated infection.

Over the last few years, there have been significant improvements in hand hygiene compliance and clinical practice audit scores, such as the Saving Lives High Impact Interventions. Infections due to meticillin-resistant and susceptible Staphylococcus aureus (MRSA and MSSA), Escherichia coli and Clostridium difficile have fallen, as have rates of surgical site infection. Considerable Trust-wide effort is required to maintain and continue these improvements, particularly if the Trust is to continue to achieve the MRSA bacteraemia and C. difficile reduction targets.

Progress towards achieving key targets for 2018/19 was as follows:

- Reduce MRSA bacteraemias in line with agreed local and national targets. Between April 2018 and March 2019, there were 6 MRSA bacteraemias (Target: no cases for the year).
- Reduce Clostridium difficile in line with agreed local and national targets. Between April 2018 and March 2019, 30 cases of hospital-apportioned Clostridium difficile were recorded, of which one was considered avoidable and 29 non-avoidable (Target: fewer than 34 avoidable infections).
- Achieve a 5% reduction in all cases of MRSA. Between April 2018 and March 2019, there were 31 new cases of MRSA compared to 22 the previous year.
- Achieve a 5% reduction in all MSSA bacteraemias. Between April 2018 and March 2019, there were 39 MSSA bacteraemias compared to 25 the previous year.
- Maintain the mean ward closure time due to epidemic gastroenteritis below 7 days. Between April 2018 and March 2019, there were no ward closures due to norovirus.
- Reduce other infections according to national and local priorities. The Trust recorded 68 E. coli bacteraemias, 18 Klebsiella bacteraemias and 2 Pseudomonas aeruginosa bacteraemias.
- Comply with current and new national mandatory surveillance requirements. Compliant.
- Support and assist in the implementation of screening high-risk patients for meticillin-resistant and susceptible S. aureus (MRSA and MSSA). Compliant.
- Continue to follow local and national guidance to control and reduce Resistant Gram-negatives including Carbapenemase-Producing Enterobacteriaceae (CPE). Compliant.
- Support and assist in the screening of patients for CPE. Complete.
- Continue to perform surgical site surveillance, including post-discharge surveillance, on all major procedures. Complete.
- All wards to perform at least a monthly Hand Hygiene audit with compliance of at least 95%. Between April 2018 and March 2019, the overall Trust hand hygiene compliance was 94%.
- All wards to perform at least monthly Saving Lives High Impact Intervention audits for in use medical devices and score 100%. Data available on balanced scorecard.
- All wards to achieve compliance with Infection Prevention and Control audits. Data available on balanced scorecard.
- Maintain availability of alcohol hand gel in clinical areas as close to 100% as possible. Between April 2018 and March 2019, the availability of alcohol hand gel in clinical areas was 95%.
- Continue to develop and update the IPC website. Completed.
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- To comply with national legislation and guidance including the Health and Social Care Act (Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance), Care Quality Commission Essential Standards, Winning Ways and national guidance on the management of MRSA and C. difficile. Compliance reviewed and evidence folders updated.

Information Governance Toolkit - Data Security & Protection Toolkit


The ten data security standards are:

- Personal Confidential Data
- Staff responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

Within these standards, there are 32 mandatory assertions and eight non mandatory assertions. Each of these contains a number of statements the Trust must record compliance against.

The Trust has published the 2018/19 Data Security and Protection Toolkit with all standards met in March 2019.

Research and Development

Plymouth has had a very challenging financial year partly due to a significant cut in the National Institute for Health Research (NIHR) budget. However despite these challenges, and managing a higher than usual number of staff changes, we have managed to exceed our recruitment target to non-commercial portfolio badged studies. This has left an imbalance to commercial recruitment which is reflected in the commercial drop in income and will be a key work stream to be addressed in the coming year.

There are currently 360 research projects (open to recruitment) ongoing in the Trust. We have recruited 4896 patients into research projects this financial year with our retention rate remaining above average. 127 new research projects opened in the year, 41 commercial and 86 non-commercial, a significant growth on the previous period.

We continue to have a varied and mixed portfolio of research projects. This includes Phase 1-4 clinical trials (drug studies), ranging from complex interventional first in human studies to observational studies testing patient related outcomes. Apart from enhanced patient outcomes and reduced admissions and outpatient appointments, commercial interventional studies deliver the additional benefit of significant drug saving to the Trust which will support the New Excess Treatment cost arrangements. Plymouth
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continues to build collaborations within the healthcare community, particularly successes have been with Care UK and Livewell SW.

Our highly skilled research delivery and administration workforce continues to streamline the setup of studies to ensure that we are able to deliver to the NIHR high level objectives and bring the most up-to-date treatments to patients at the earliest opportunity. This year the delivery of research on the Lind Research Unit has benefitted from the support of 2 Clinical research doctors that has helped manage the challenge of sharing the research accommodation with the Planned Investigation Unit in support of winter pressure delivery. This collaborative working has built relationships and helped to further embed research in the core business of the Trust.

We continue to add to commercial research as an active member of the IQVIA Peninsula Prime Site Consortium and now part of the Pfizer Inspire SW Prime site. The Peninsula Prime Site has received IQVIA’s Certificate of Achievement for the last three years. This award is only given to top-performing sites in IQVIA’s Prime and Partner program that have demonstrated excellence in clinical research performance and quality.

The importance of our key relationships with the wider healthcare community including Livewell, primary care, public health, Peninsula Clinical Research Network, Peninsula Academic Health Science Network continue to be recognised. The launch of the Research College, a joint initiative with the University of Plymouth and University Hospitals Plymouth NHS Trust sees the two organisations building stronger links to deliver both early phase translation medicine projects and delivery of late phase programme grant funded research. Research and development continues to take advantage of all research opportunities available for the benefit of our patients, the Trust and the wider healthcare community.

In 2018/19 we extend the remit of the department to incorporate Research, Development and Innovation (RD&I), building on the significant innovation growth and success the intra-vitreous injection guide for ophthalmology; episiotomy guide scissors, proprietary multiple sclerosis and severe asthma severity scales; a trans-oesophageal pacing technique for non-invasive cardiac ablation; and the patient bridge for use in imaging. Innovation continues to be a key theme harnessing staff innovation for the benefit of the healthcare environment, and the wider NHS audience.

Plans are moving forward at a pace to convert the Lind Research Centre to a 24/7 facility which will support an application in 2019 to be a High Throughput Centre for late phase 3 and 4 studies. An overnight facility will further support an application in 2020 to become an accredited clinical research facility attracting new research particularly early Phase 1 and first in to man studies.

Conclusion
University Hospitals Plymouth NHS Trust remains committed to its research agenda, and has just published its new 5 year strategy, to make available to its patients the most innovative treatments at the earliest opportunity and further support the public health agenda through education and training.
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Medical Revalidation

Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice in their chosen field and able to provide a good level of care. This means that holding a licence to practice is becoming an indicator that the doctor continues to meet the professional standards set by the General Medical Council (GMC) and the specialist standards set by the medical Royal Colleges and Faculties.

Revalidation aims to give confidence to patients that their doctor is being regularly checked by their employer and the GMC. Licensed doctors have to revalidate usually every five years, by having annual appraisal based on the General Medical Council’s core guidance for doctors, Good medical practice.

Revalidation and medical appraisal are led in the organisation by Dr Philip Hughes, Medical Director and Responsible Officer. He is supported by a medical appraisal lead, a senior manager and an appraisal administrator.

The appraisal and revalidation team participate in quarterly regional network events, ensuring they are aware of current developments and best practice in the field. The Trust submits quarterly returns as required by NHS England, as well as a detailed annual audit.

The Annual Medical Appraisal and Revalidation Report was presented to and approved by the Trust Board in September 2018.

Nursing Revalidation

Nursing and midwifery revalidation requires all Nursing & Midwifery Council (NMC) registrants to revalidate every 3 years in order to maintain their registration.

The Chief Nurse and Director of Clinical Professions is the appointed Responsible Officer, who is leading on the management of revalidation for Nursing & Midwifery Council registrants. The Trust has a Revalidation Policy which outlines individual’s roles and responsibilities, the support available to registrants and confirmers and the Trust’s monitoring and compliance arrangements.

The administration function is designed to provide advance notice to registrants and their managers of revalidation dates and detail what associated support and guidance is available. Revalidation completion rates are monitored and escalation arrangements are in place for those who are approaching their registration date and have not completed revalidation, or where registration has lapsed.

During the last year, the Trust confirmed revalidation for all registered nursing and midwifery staff who were due for revalidation.
## National Clinical Audits

<table>
<thead>
<tr>
<th>Audit Name</th>
<th>Status</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>• COPD</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>• Adult asthma</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>National Lung Cancer Audit</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>National Gastrointestinal Cancer Programme</td>
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<td>N/A</td>
</tr>
<tr>
<td>• Oesophago-gastric Cancer</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>• Bowel Cancer</td>
<td>Continuous data collection</td>
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</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>Continuous data collection</td>
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</tr>
<tr>
<td>National Cardiac Audit Programme</td>
<td>Continuous data collection</td>
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</tr>
<tr>
<td>• Cardiac Rhythm Management (CRM)</td>
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<tr>
<td>• Acute Coronary Syndrome or Acute Myocardial Infarction</td>
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</tr>
<tr>
<td>• Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>• Adult Cardiac Surgery</td>
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</tr>
<tr>
<td>• National Heart Failure Audit</td>
<td>Continuous data collection</td>
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</tr>
<tr>
<td>National Vascular Registry</td>
<td>Continuous data collection</td>
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</tr>
<tr>
<td>Diabetes (Paediatric) (NPDA)</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td>National Diabetes Audit (NDA) – Adults - National Inpatient Audit (NaDIA, NDIP)</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>Falls and Frailty Fractures Audit programme (FFFAP)</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>• Inpatient Falls</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>• National Hip Fracture Database</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>In progress</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older People</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis</td>
<td>In progress</td>
<td>N/A</td>
</tr>
<tr>
<td>National End of Life audit</td>
<td>Completed</td>
<td>100%</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme</td>
<td>Completed</td>
<td>100%</td>
</tr>
<tr>
<td>• Cancer in Children, Teens and Young Adults</td>
<td>Completed</td>
<td>100%</td>
</tr>
<tr>
<td>• Perioperative Diabetes</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td>• Pulmonary Embolism</td>
<td>Completed</td>
<td>100%</td>
</tr>
<tr>
<td>• Acute Bowel Obstruction</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td>• Long Term Ventilation (includes children and young people as part of the Child Health Clinical Outcome Review Programme)</td>
<td>Completed</td>
<td>N/A</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>Completed</td>
<td>100%</td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
<tr>
<td>Neonatal Intensive and Special Care (NNAP)</td>
<td>Continuous data collection</td>
<td>N/A</td>
</tr>
</tbody>
</table>
## Non NCAPOP audits

<table>
<thead>
<tr>
<th>Audit</th>
<th>Status/Stage</th>
<th>Data Collection</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Mix Programme (CMP)</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>In progress</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Adults Non-Invasive Ventilation -</td>
<td>In progress</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>BAUS Urology Audits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Radical Prostatectomy Audit</td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Nephrectomy audit</td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Percutaneous Nephrolithotomy (PCNL)</td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Cystectomy</td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>RCEM – Feverish Children</strong></td>
<td>Completed</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>National Bariatric Surgery Registry</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>RCEM – Vital Signs in Adults</strong></td>
<td>Completed</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>RCEM – VTE risk in lower limb immobilisation</strong></td>
<td>Completed</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Neurosurgical National Audit Programme</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Major Trauma Audit</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>National Comparative Audit of Blood Transfusion programme</strong></td>
<td>Completed</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Management of massive haemorrhage</td>
<td>Completed</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Management of Maternal Anaemia</td>
<td>Completed</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>National Cardiac Arrest Audit (NCAA)</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Elective Surgery (National PROMs Programme)</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Unilateral Hip Replacement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unilateral Knee Replacement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National Joint Registry (NJR)</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Serious Hazards of Transfusion (SHOT)</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) – NHS England CQUIN</strong></td>
<td>Quarterly data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>• Antibiotic Consumption</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antimicrobial Stewardship</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inflammatory Bowel Disease (IBD) Programme/ IBD Registry</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)</strong></td>
<td>Completed</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>National Mortality Case Record Review Programme</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Seven Day Hospital Services</strong></td>
<td>Completed</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Site Infection Surveillance Services</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>UK Cystic Fibrosis Registry - Adult</strong></td>
<td>Continuous data collection</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
National Confidential Enquiries

During 2018/19 hospitals were eligible to enter data into five NCEPOD studies. The Trust submitted data for two studies, equating to 100% participation for completed studies. Full details of national confidential enquiries can be found at www.ncepod.org.uk. Details are listed below:

<table>
<thead>
<tr>
<th>Title of Study</th>
<th>Status</th>
<th>Number (%) of cases included</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer in Children, Teens and Young Adults</td>
<td>Completed</td>
<td>100%</td>
<td>The Cancer in Children, Teens and Young Adults report was published on the 13th December 2018. The responsible leads reviewed the report recommendations and stated full compliance with all relevant recommendations.</td>
</tr>
<tr>
<td>Perioperative Diabetes</td>
<td>Completed</td>
<td>100%</td>
<td>The Perioperative Diabetes report was published on the 13th December 2018. The responsible leads reviewed the report recommendations and stated full compliance with all relevant recommendations.</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>In progress</td>
<td>N/A</td>
<td>All cases have been reviewed and now awaiting the final report publication.</td>
</tr>
<tr>
<td>Acute Bowel Obstruction</td>
<td>In progress</td>
<td>N/A</td>
<td>The selected cases are currently under review.</td>
</tr>
<tr>
<td>Long Term Ventilation</td>
<td>In progress</td>
<td>N/A</td>
<td>The selected cases are currently under review.</td>
</tr>
</tbody>
</table>
## Annex E  Example Outcomes from Clinical Audits

### Audit Description | Comments
---|---
**PRIORITY 1: Mandatory National Audits**
**The National Neonatal Audit Programme (NNAP)** | All metrics are within expected ranges with the exception of the following being within the top quartile or a positive outlier for the following:
- Mothers who deliver babies below 30 weeks gestation given Magnesium Sulphate in the 24 hours prior to delivery.
- Documented consultation with parents/carers by a senior member of the neonatal team within 24 hours of admission.
- Babies with gestation at birth less than 30 weeks who had received documented follow-up at 2 years gestationally corrected age.

**National Diabetes Audit** | The score for patients visited by a member of the Diabetes Team dropped during winter pressures when the team were encompassed within the general medical work rota. In addition, the data collection for the foot care assessment was adversely affected by the transition to a new podiatrist which meant that less data was submitted.

However the overall results demonstrate that the Trust is a positive outlier, scoring below the national average for medication and insulin errors. The Insulin Safety Group has contributed to this pleasing score and helped to reduce errors by reviewing incidents and providing education.

### PRIORITY 2: Corporate Must Do Audits
**Clinical Record Keeping – Surgical Notes Audit** | The purpose of this audit was to assess the standard of clinical record-keeping on surgical wards and measure the time taken to find the current clinical entry. Baseline data revealed a poor standard of filing and record-keeping: 94% of notes contained loose pages; 60% were not in chronological order; 59% did not have the required patient identifiers; and 23% had no date/time recorded. During ward rounds, up to 12 minutes was spent looking for clinical notes.

A new filing system was introduced on Wolf ward, using a separate folder to hold the current clinical admission. A subsequent re-audit revealed significantly improved standards (only 5% with loose pages, 13% not chronologically ordered, 30% without required patient identifiers, and 10% with no date/time recorded). Access to notes was also significantly improved, with the average time to find the current clinical entry per patient being only 20 seconds. This simple and cost-effective intervention was welcomed by medical and nursing staff alike, and was adopted by another surgical ward, via the Matron, due to the visible success.

**Ionising Radiation (Medical Exposure) Regulation (IRMER)** | A rolling audit programme is being implemented across specialties where agreements have been made for clinicians to evaluate a patient’s films within the patients’ clinical record rather than awaiting a formal radiologist report.

All relevant specialties required to undertake this audit are in the process of completing this audit. Current results indicate that the clinical evaluation is present in 93% of the audited records.

Non-compliance is being monitored through the Radiation Safety Committee.

### PRIORITY 3: Service line must do clinical audits
**Prospective Audit of use Kaiser Permanente Neonatal Sepsis calculator tool as an aid to clinical decision making** | Since the introduction of National Institute for Health and Care Excellence (NICE) guidance CG149 (Neonatal Infection (early onset); antibiotics for prevention and treatment) in August 2012, there has been a substantial increase in term admissions to Neonatal Intensive Care Units (NICU) in the UK. The extended hospital stay for this population of new-born term infants has resulted in babies being exposed to early antibiotic therapy which interferes with normal gut flora, and separation from mother after birth, leading to delayed breast feeding. Audits undertaken by clinicians identified that of those babies, treated with antibiotics for risk factors only (and not clinically unwell) there was no proven infection. The Kaiser Permanente Calculator was proposed as an alternative decision-making tool as it takes into consideration antenatal septic risk factors and the infant’s clinical condition.
### Example Outcomes from Clinical Audits

<table>
<thead>
<tr>
<th>Audit Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>This audit assessed 100 infants after the introduction of the “Changing approach” pathway in combination with the new sepsis calculator. Results indicated that there was a significant (87%) reduction in term babies routinely receiving antibiotics, with no blood culture positive results or late onset sepsis identified. There was also a reduction in hospital stay for the babies who were not treated with antibiotics (35 days over three months). Based on these results the NICU team requested to derogate from the NICE guidance; this decision was supported by NHS England and subsequently agreed by the Trust’s Clinical Effectiveness Group.</td>
<td></td>
</tr>
<tr>
<td><strong>An Audit of the Assessment and Management of Paediatrics and Adults Burns Patients (re-audit)</strong></td>
<td>The reviews of burns patients presenting to the Plastics department in Derriford Hospital in May 2017 were audited against the standards of the Royal College of Surgeons’ Good Surgical Practice, and the International Burns Injury Database. After the first audit cycle, a burns assessment proforma was designed and introduced. Further audits were completed a month and three months later, and a questionnaire was utilised to evaluate the response of staff to the new proforma. Results demonstrated that Advanced nurse practitioners (ANPs), Plastics senior house officers (SHOs) and non-Plastics junior doctors were the main users of the proforma, while Plastics registrars and consultants primarily used free-text documentation. The burns assessment proforma was found to facilitate high-quality assessment of patients and their injury, despite time of day and clinical experience. SHOs and Plastics ANPs found the burns proforma to be an effective learning tool that improved the efficiency and quality of their clerking. The success of the proforma was felt to be dependent on it being easily accessible in the Emergency Department, Trauma room and Outpatients, and that regular staff input and modification would enhance engagement and use. The lead noted that given the complexities of burn care, and the potential medico-legal ramifications of burns injuries, this tool helps to optimise the quality of burns reviews and documentation of the assessment.</td>
</tr>
<tr>
<td><strong>PRIORITY 4: Specialist Interest Audits</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Audit of Patient Satisfaction and Complications in patients who underwent Muscle or a Nerve and Muscle biopsy</strong></td>
<td>The muscle and nerve biopsy service at Derriford hospital is attended by patients from across Devon and Cornwall and from further afield, meaning that patients often have to travel long distances to attend for a biopsy. In contrast with other hospitals where patients have their biopsy undertaken after general anaesthesia and stay 2-3 nights in hospital, the biopsies at Derriford are performed under local anaesthesia as day case procedures. As well as assessment of patient satisfaction with the biopsy service, this audit also assessed the complication rate for patients undergoing muscle biopsy or nerve and muscle biopsy. Results from 41 patient questionnaires, from 108 sent out, identified a generally positive response: all patients had confidence in the neuropathologist and had adequate explanation for the biopsy and its risks; all patients rated the service good or better, with 50% (muscle biopsy) and 63% (nerve and muscle biopsy) giving the top rating of excellent; and post-operative complications such as wound infection and excessive bruising were rare. Based on these findings, the lead noted that undertaking biopsies as day case procedures under local anaesthesia appears to be safe. No significant concerns were raised but some areas for improvement were identified, including ensuring that patients receive the information sheet and detailed travel directions in advance of the appointment, choices are offered for the operation date, results are clearly explained in a timely manner, and that nursing staff warn all patients of danger signs before discharge. The service will be re-audited in 6-12 months as part of a rolling audit plan.</td>
</tr>
<tr>
<td><strong>Nationwide audit of delirium assessment and prevalence in older people admitted acutely to hospital</strong></td>
<td>As part of a national audit on World Delirium Awareness Day (14th March 2018) participating hospitals were asked to screen all patients who met a set criteria using the 4AT screening tool, proceeding to a full delirium assessment with a 4AT score of 4 or greater. Results indicated a delirium prevalence at Derriford of 19.2%, in line with the expected 20-30%, with demographics (age, gender, frailty) being comparable to national data. A key success was that delirium is being correctly identified at Derriford in 60% of patients versus 36.5% nationally. However, this means that it is likely that approximately 40% of cases of delirium are missed in</td>
</tr>
</tbody>
</table>
**Annex E  Example Outcomes from Clinical Audits**

<table>
<thead>
<tr>
<th>Audit Description</th>
<th>Comments</th>
</tr>
</thead>
</table>
| acute admissions. Additionally, the Trust was found to only be communicating delirium to primary care in 25% of cases, which is significantly short of the NICE guidance (CG103) which states that all diagnoses should be relayed to primary care on discharge. The lead also noted that there is no robust method for identifying high risk patients and ensuring that screening takes place.  
As a consequence, a comprehensive action plan has been put in place, including the introduction of a delirium bundle, the set-up of a delirium steering group and the implementation of routine inpatient screening for high risk patients during their hospital stay.  |

**Service Evaluations**

<table>
<thead>
<tr>
<th>Service Evaluations</th>
<th></th>
</tr>
</thead>
</table>
| **Pre-pectoral implant breast reconstruction with BRAXON mesh at Derriford Hospital; an evaluation of a new technique** | This audit evaluated the outcomes and safety of the first twenty-one pre-pectoral implant breast reconstructions using BRAXON Acellular Dermal Matrix at Derriford Hospital. The decision to launch the service was driven by the evidence of outcomes comparable, if not better than, the gold standard sub-pectoral reconstruction, and the introduction of BRAXON.  
The surgeon’s experience with BRAXON-based pre-pectoral reconstruction was found to be largely successful. The procedure was judged to be safe and associated with high levels of patient satisfaction. Complication rates met the required standard and all parameters represented an improvement from the national average. Patient selection was found to be important, as a higher complication rate is expected in smokers and patients with thin skin or very dense breasts where modification of the technique may become necessary. The experience of the only patient who had had a previous sub-pectoral implant, was that this procedure, combined with chest wall re-construction, can be ideal for salvage surgery.  
Going forward, there is a plan to set-up a prospective database and to re-audit the subsequent 30 pre-pectoral reconstructions, including an objective measure of cosmetic outcome and patient satisfaction. |

* ED Physiotherapy audit (7 day service)  
* Physiotherapy Late shift Audit (re-audit)  
* AAU Rapid Response Team Audit  
* Rapid Response Team (RRT) Outreach Pilot  

| • ED Physiotherapy audit (7 day service)  
• Physiotherapy Late shift Audit (re-audit)  
• AAU Rapid Response Team Audit  
• Rapid Response Team (RRT) Outreach Pilot | The Emergency Care Team was nominated for a thank you card through the learning from excellence scheme due to their dedication to making positive change and continuously reviewing outcomes. The key achievements from undertaking these audits are as follows:  
• The Community Crisis Response Team (CCRT) will only see patients in crisis and the Community Rehab Team (CRT) has a waiting list of approximately 6-12 weeks. Patients needing therapy input but not yet in crisis situation were not seen by CCRT or CRT. This lead to the creation of the Rapid Response Team Outreach service for the trial period which filled a gap in the services available within the community and saved the Trust approximately 54 bed days which equates to £7,400. Of the 22 patients seen during the 4 month period, 85% remained at home and were not readmitted under a medical specialty within 3 months of discharge.  
• Acute Assessment Unit (AAU) Rapid Response Team audit assessed the effectiveness of using Physiotherapists and Occupational Therapists to reduce the length of stay for patients admitted to the AAU. Out of 338 patients referred, 294 patients (88%) were discharged on the same day and 44 patients (13%) were admitted to hospital for medical reasons.  
• A total of 496 patients were seen following the introduction of the Physiotherapy late shifts from December 2016 and December 2017. Of these, 368 patients (74%) were discharged from the hospital. The discharge destination included the patient’s home, placement or a community hospital. This means only 128 patients (26%) across the year were admitted to the main hospital to long-stay wards. There were 248 patients (50%) out of the total 496 who were discharged on the same day. |
Annex F  2019/20 priorities

Priority 1: Staffing – improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills.

Rationale
Having the right staff in the right place at the right time is a fundamental element to delivery of safe high quality care for our patients. Patient survey results show us patients do not always feel the wards are adequately staffed. It is essential we build highly effective teams and provide assurance to patients and the public that staffing on the wards are at the right levels. From a workforce planning perspective we need to ensure all staff proactively meet patient requirements in the most efficient and productive way possible.

Current Position
We have reviewed our current position based on information from the past 12 months and used this to set targets for the coming year.

<table>
<thead>
<tr>
<th>Description</th>
<th>2018/19 Performance</th>
<th>2019/20 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain agreed staffing levels for all wards in line with Safer Staffing</td>
<td>Overall Mar 19 -87.0%</td>
<td>Planned vs Actual &gt;90%</td>
</tr>
<tr>
<td>Reduce the overall staff vacancy factor</td>
<td>9.72%</td>
<td>-</td>
</tr>
<tr>
<td>Reduce the number of complaints which include an element relating to staff attitude and behaviour</td>
<td>177</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>Improve patient’s perception of staffing on our wards - In your opinion, were there enough nurses on duty to care for you in hospital? (Q29 National Inpatient Survey 2018 – Always / Nearly Always)</td>
<td>49%</td>
<td>&gt;66%</td>
</tr>
<tr>
<td>If you needed attention, were you able to get a member of staff to help you within a reasonable time? (Q43 National Inpatient Survey 2018 – Yes always)</td>
<td>54%</td>
<td>&gt;68%</td>
</tr>
</tbody>
</table>

How we will do it
- Continue with 6 monthly nursing staffing reviews to ensure workforce plans remain in alignment with the Trust’s financial and activity plans.
- Continue to explore transformational workforce change, whilst being mindful that the rollout of new roles is dependent on a range of different variables; including a move towards a multi-professional approach.
- Build on the successes of previous nursing recruitment open days and schedule future dates for 2019/20.
- Explore innovative recruitment solutions; including International recruitment drives and a Memorandum of Understanding between all organisations in the STP to enable the fast and seamless movement of staff across the patch.
- Develop improved retention solutions such as piloting an 18 months (3x6) rotational programme for band 5 nursing preceptees and piloting the implementation of a ‘transfer window’ to enable band 5 nursing staff to move between departments.
- Continue to utilise the hospital website in order to attract staff to the organisation and develop a prospectus to inform potential staff about our specialist areas and professional development opportunities.
- Continue with the New Deal programme relating to the apprenticeship career pathway for healthcare assistants and nursing degree course.
- Continue to collaborate with NHS Professionals in the provision of a quality flexible clinical workforce.

Measuring Progress
We will monitor and report on nurse staffing levels and incidents on a monthly basis to the Nursing & Midwifery Operational Committee. In addition, we will provide bi-annual updates to the Trust Management Executive and public Trust Board. External reports monitoring progress against staffing levels will be provided to our commissioners, NHS Improvement (NHSI) and the Care Quality Commission.

Table shows care hours and fill rate by registered and unregistered staff.
Jan 17 to Jan 19
Annex F 2019/20 priorities

Priority 2: Improve Responsiveness - Ensure all patients receive timely, high quality care by working with other providers to ensure care is provided by the right staff in the right place at the right time.

Rationale
We have experienced difficulties with capacity resulting in cancellations for patients and longer waits for treatment than we would like. It is equally important to increase our ability to treat patients quickly and safely in the Emergency Department, to do so we need to revolutionise and create an integrated emergency and urgent care hub.

Patients with complex support needs after discharge from hospital, have the right to expect the right care package available to them in the right location, which is in line with best practice.

We recognise that good end of life care enables people to live in as much comfort as possible until they die and to make choices about their care and where to spend their last days.

Current Position
We have reviewed our current position based on information from the past 12 months. We have then used this information to set targets for the coming year.

<table>
<thead>
<tr>
<th>Description</th>
<th>2018/19 Performance</th>
<th>2019/20 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients who are cancelled</td>
<td>2.85%</td>
<td>0.80%</td>
</tr>
<tr>
<td>A&amp;E Four hour waiting time or equivalent new standard</td>
<td>81.14%</td>
<td>95%</td>
</tr>
<tr>
<td>Referral to Treatment Times – increase the number of patients treated within 18 weeks</td>
<td>78.4%</td>
<td>79%</td>
</tr>
<tr>
<td>Referral to Treatment incomplete pathways - Reduce number of patients waiting over 52 weeks</td>
<td>48 at Mar 19</td>
<td>20 by Mar 20</td>
</tr>
<tr>
<td>Reduce the 6 week diagnostic waiting times</td>
<td>5.90% Mar 19</td>
<td>2.7%</td>
</tr>
<tr>
<td>Reduce delayed transfers of care</td>
<td>3.41%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

How we will do it
We are committed to working to deliver the best possible care for local people all of the time, through integrated provision. We will support our staff in being able to do this.

In line with our Operational Plan for 2019/20, we have developed detailed capacity plans and identified areas to delivery additional activity.

Further development of our Emergency and Urgent Care Hub will provide an opportunity to redesign our services to ensure they meet the needs of the community we serve.

Measuring Progress
We will monitor progress against the overall projects through the Quality Improvement Committee chaired by the Medical Director. The organisation is introducing weekly safety huddles at all levels from directors through to wards and departments to monitor and track improvements and issues at point of service delivery.
Annex F 2019/20 priorities

Priority 3: Patient communication and information – Improve the quality of communication and information provided before, during and after their care

**Rationale**

Patients frequently leave hospital uninformed about the details of their hospital stay, limited ability to accurately state their diagnosis and ongoing management after discharge. We will enable patients to understand key aspects of their care by providing accurate and understandable information enabling them to take greater control, potentially reducing readmission rates and unplanned visits to secondary care, whilst providing safer care and improving patient experience.

We are committed to ensuring carers are recognised as important partners in the care of patients and to promote a carer friendly culture. Carers have an important role in the effective and safe delivery of treatment and care of patients in hospital. It is important to identify, involve and support carers in the clinical setting in order to get the care of the patient right.

There can be adverse consequences resulting from delays to diagnosis and treatment.

**Current Position**

We have reviewed our current position based on information from the past 12 months. We have then used this information to set targets for the coming year.

<table>
<thead>
<tr>
<th>Description</th>
<th>2018/19 Performance</th>
<th>2019/20 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology acknowledgement within 48 hrs for inpatients</td>
<td>MRI– 34.9% US – 92%</td>
<td>80%</td>
</tr>
<tr>
<td>Number of complaints relating to information, communication and consent</td>
<td>562</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>National Inpatient Survey Q55 – When you left hospital did you know what would happen next with your care?</td>
<td>65.1%</td>
<td>68.4%</td>
</tr>
<tr>
<td>National Inpatient Survey Q62 – Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?</td>
<td>63.4%</td>
<td>67.0%</td>
</tr>
<tr>
<td>Carers Local Survey – Overall how satisfied are you with the support or services you and the person you care for have received in the last 12 months</td>
<td>83.65%</td>
<td>&gt;10%</td>
</tr>
</tbody>
</table>

Table showing Exam to Report Times within 48 Hours – Performance to date against target, which will be continued in the coming year.

**How we will do it**

We will develop a radiology acknowledgement improvement plan which identifies the various elements impacting on our ability to acknowledge and produce timely reporting for all radiology requests, thereby ensuring our clinicians take the necessary actions to address any findings. Our priority will be to ensure all inpatients results are acknowledged and actions taken by the team responsible for the patient within 48hrs of the report being available. For outpatients we will aim for reports to be acknowledged and actioned within 4 weeks.

The importance of clear and concise patient information cannot be underestimated and we will work towards publishing all our patient information leaflets on the Trust website, for patients, carers and families to download. In September 2018, the Trusts participated in a free six-month trial of patient information leaflets for informed consent. This was provided by EIDO Healthcare and sponsored by the Royal College of Surgeons. We are currently negotiating funding to extend the trial period to the end of 2019.

We will produce a Carers Welcome Pack which will contain useful and essential information on what help and support is available whilst they are caring for someone who is an inpatient at the hospital. The Carers Welcome Pack will include information for carers about where to access a statutory carers assessment and support available for carers in the local community.

**Measuring Progress**

We will monitor progress against the overall projects through the Quality Improvement Committee chaired by the Medical Director. The organisation is introducing weekly safety huddles at all levels from directors through to wards and departments to monitor and track improvements and issues at point of service delivery.
Safety Initiatives

The national Sign up to Safety initiative to help NHS organisations achieve their patient safety aspirations and care for their patients in the safest way possible has now completed its five year plan. However, we will continue working on our safety initiatives to give patients reassurance and confidence that we are doing all we can to ensure the care they receive will be safe and effective at all times. Our work will continue to be around six key areas.

University Hospitals Plymouth NHS Trusts has chosen to focus specific attention on six key safety initiatives which are monitored by executive team through their weekly executive huddle and through the Weekly Improvement Safety Huddle (WISH). The key safety initiatives have detailed programmes of work aligned to them and include:

- Radiology Acknowledgement
- Critical Medications
- Sepsis – focusing on emergency admissions
- Falls
- Pressure Ulcers
- Time Critical Backlogs

Radiology Acknowledgement

It is important to reduce the risk to our patients by ensuring all radiology patient results are reported within 48 hours and acknowledged and actioned by the team responsible for their care within a reasonable timeframe of the report being available for inpatients and within 4 weeks for outpatients.

Detailed improvement plans are being developed and will be tracked through our Quality Improvement Committee and weekly improvement huddles.

Critical Medications

On occasion patients are discharged from the hospital (inpatients) without their medications, these can include critical medicines. It is important to have a clear process trust wide, within wards, pharmacy and transport, to safeguard patients receiving their critical medicines when discharged. Further detail is included on page 8.

Sepsis

Sepsis is a time-critical medical emergency, if a patient presents with sepsis it is important they receive treatment within 60 minutes. If treatment is delayed it will affect their outcome.

One key step to improvement in the management of patients presenting with sepsis has been the introduction of NEWS2 observation charts, this has been introduced across the whole organisation with staff engaging in the national training programme.

We will continue to work towards ensuring all patients with sepsis received antibiotic treatment within the recommended 60 minutes, average treatment times to date are shown below.
Reduce falls leading to harm

In the 12 months since April 2019 we have had 1.04 falls with harm (minor, moderate or severe) per 1000 bed days and therefore did not achieve our target reduction by 10% to 0.95 falls per 1000 bed days. In this time period there have been 16 falls resulting in severe harm to the patient, of which 3 were head injuries and the remainder fractured neck of femurs. This is an improvement on the previous 12 months when we reported 23 inpatient falls resulting in severe harm. We recognise that there has been an increase in falls with harm over the winter months and have undertaken thematic analysis to aid our understanding of this variation. We have identified that often patients fall and sustain severe harm when they are mobilising unsupervised and have unaddressed risk factors.

Our actions to reduce harm from falls has focused on safe patient mobilisation, ensuring that there are interventions in place to address risk factors for patients. This includes an assessment of risk, performing a lying and standing blood pressure, safe footwear, access to walking aids, supervised mobilisation when required and a review of medications that increase falls risk. To supplement this we have piloted new non-slip footwear, implemented a standard procedure for recording lying and standing blood pressure, highlighted cohort bay nursing as a strategy and have rolled out an enhanced care and observation team.

In the following 12 months we will aim to reduce both falls with harm and severe harm by 10%.

Pressure Ulcers

Since April 2018 we have reported 0.67 pressure ulcers of category 2,3, or 4 per 1000 bed days. Disappointingly we reported 12 category 3 or 4 pressure ulcers as being acquired in hospital. Going forward we are acting on lessons learnt from these incidents to put actions in place to prevent severe pressure damage. This includes a focus on assessment of risk followed by interventions being implemented to reduce that risk including repositioning, offloading devices, addressing nutritional and toileting needs. We are working hard with our inpatient areas to ensure all patients have an appropriate skin assessment matching their needs and that our staff are identifying pressure damage at an early stage, following the
Annex G  Safety Initiatives

React to Red initiative. This initiative is a pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

Our aim in the next 12 months is to reduce total acquired pressure ulcers by 20% and also category 3 and 4 pressure ulcers by 50%.

![Graph showing Hospital acquired pressure ulcers per 1000 bed days]

Time Critical Backlog

We continue to experience difficulties with capacity which has resulted in patients being cancelled and being subjected to long waits for treatment. We recognise the importance of providing timely treatment for our patient and as such have implemented a robust approach to demand and capacity planning for the coming year. There is an expected 5.3% increase in outpatient appointments and 2.4% for our planned inpatient activity. In addition to fully meet our referral to treatment time for all specialties the Trust would also need to see an additional 7,575 non recurrent cases to clear the backlog.

Detailed plans have been agreed and are monitored at weekly improvement huddles for six key areas including:

- Neurology
- Thoracic Medicine
- Gastroenterology
- Ophthalmology
- Paediatrics
- Hepatology

People First

University Hospitals Plymouth NHS Trust and Livewell SW were jointly chosen as one of seven NHS organisations to take part in the National NHSi Improvement Programme, the aim of which is to create a culture of continuous improvement by empowering staff to develop their own improvement ideas and lead on their own projects which we are calling locally ‘People First’.

The People First Programme has 3 core principles:

- Respect for Staff- aiming to make time at work rewarding
- Seeking VALUE in the eyes of those we care for- what is important to them
- Helping teams to lead their own improvement practice based on things that Matter most to them and align to our goals.
Annex G  Safety Initiatives

It is a programme aimed at cultural change with people and will build capability through:

- Improving use of data and ‘problem on a page’ approach
- Training frontline staff in scientific learning practice known as ‘Kata’
- Developing our management system to be in focus, supportive in coaching and more visual
- Developing frontline coaches with improvement practice skills (practice coaches). As part of this all executive directors are doing the same
- Developing specialist coaches (facilitators) who can lead practice events (rapid events for change)
- Support local improvement huddles to face into improving patient care

The People First programme will run through and join together all the work we do, uniting all the different aspects of our Quality Academy Improvement work with our operational strategy and staff development.

Our ambition is to create a sustainable and effective health system, working with our patients and partners in our community which delivers safe high quality services.
Annex H  Statement of directors’ responsibilities

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Accounts) Amendments Regulations 2011 and 2012 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality Account, directors should take steps to assure themselves that:

- the Quality Account presents a balanced picture of the trust’s performance over the reporting period;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review;
- the Quality Account has been prepared in accordance with any Department of Health guidance.

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Richard Crompton
Chairman
Date: 30 June 2019

Ann James
Chief Executive
Date: 30 June 2019
Local Healthwatch (Plymouth, Cornwall, Devon and Torbay) continue to work with University Hospitals Plymouth NHS Trust to ensure that the patient voice is heard at service design and decision making level.

Healthwatch acknowledges that the level of operational pressure remains consistently high with the Emergency Department continuing to see a higher volume of patients compared to previous years. The ongoing infrastructure work at Derriford Hospital is welcomed as it demonstrates a commitment from the NHS to provide infrastructure that delivers seamless services. The recent improvements to the Emergency Department in resuscitation and paediatrics, plus further planned works too for emergency care improvements to patient flow in the Hospital should all help in managing the higher volume of patients seen at ED.

Patient feedback received around Derriford Hospital and its services continues to be generally positive, with most commenting on their experience of care received and the way that staff positively go about delivering that care. However, of concern are the continuing comments around waiting times for outpatient appointments and variable communication from service lines / departments.

We note the progress made against the 2018/19 Quality account priorities of:
- Priority 1: Staffing – Improve the patient experience by ensuring our wards and departments have the correct levels of staff with the appropriate skills.
- Priority 2: Ensure all patients receive high quality care by working with other providers to ensure that their care is provided by the right staff in the right place and at the right time
- Priority 3: Reduce the overall number of patients who suffer harm whilst under the care of the hospital

The challenges faced by the Trust in delivering against these priorities is also recognised, in particular the challenges in recruiting nurses (in common with the wider NHS). Equally the work in developing people related programmes into a main workstream; the People First programme, is welcomed particularly at a time when operational pressures are bringing additional risks to patients.

We hope the People First programme will continue to drive change and that work with partners in the wider health and social care community in 2019/20 will deliver more integrated services and care; this is fully supported by local Healthwatch.

We note and support the Trust’s priorities for 2018/19, particularly Priority 3, around:
- Priority 1: Staffing – Maintain safe staffing by ensuring that the right staff, are in the right place, at the right time.
- Priority 2: Improve Responsiveness - Ensure all patients receive timely, high quality care by working with other providers to ensure care is provided by the right staff in the right place at the right time.
- Priority 3: Patient communication and information – improve the quality of communication and information provided before, during and after their care.

Healthwatch Plymouth continues to be engaged with the Trust and associated providers around Complex Discharge pathways, helping to ensure that the patient remains at the centre of discharge conversation. This work is now expanding to look at all discharges from hospital with the inaugural meeting held in April 2019. With Healthwatch partners we will continue to feedback patient concerns from the people in Cornwall and Devon who are treated as inpatients at Derriford Hospital.

Local Healthwatch continues to work with University Hospitals Plymouth NHS Trust as a critical friend, where representatives from Healthwatch Plymouth and Cornwall attend the Patient Experience Committee. These meetings remain an effective way to allow health professionals to understand the concerns of patients that use their services. Likewise Healthwatch Devon continues to liaise directly with the patient experience lead via the regional patient experience network.
Both Healthwatch Cornwall and Plymouth continue to have a monthly presence at Derriford Hospital gathering the views of patients, relatives and carers.

**NHS Devon Clinical Commissioning Group**

NHS Northern Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) & South Devon and Torbay Clinical Commissioning Group, (SDT CCG) (as of 1st April 2019 known as ‘NHS Devon CCG’) is pleased to provide feedback on the Quality Account for University Hospitals Plymouth NHS Trust (UHPNT) 2018/19 and would like to offer the following commentary. UHPNT is commissioned by NHS Devon CCG as lead commissioner to provide a range of acute services. We review the quality of services throughout the year, including safety, effectiveness and experience and UHPNT has provided evidence of a commitment to high quality care.

As commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the commissioner over the 2018/19 period. This Quality Account summarises and reflects the evidence. The CCG is pleased to see the continued progress with aspects of the 2017/18 quality priorities.

We recognise the work undertaken by the Trust to address issues of long waiting times for treatment. The Trust continues to undertake clinical reviews of patients with extended waits and the backlog of long waits (over 52 weeks) has continued to fall, demonstrating the Trust’s commitment to improving patient care.

In respect to Cancer Services we recognise and welcome the Trust’s continued commitment to the ongoing re-design and review of both the cancer pathways and current workforce in order to support the needs of the local population.

**Care Quality Commission (CQC) Involvement**

We welcome and support the Trust’s continued open and transparent communication of their involvement with the CQC during 2018/19 in this quality account and note the issues highlighted by the CQC and the level of action taken by the Trust to address those issues.

The CQC report of May 2018 highlighted areas where improvement was required, and the Trust is demonstrating a commitment to make sustainable improvements through action plans and work programmes. We can confirm that, as a commissioner, we have worked closely with the Trust during 2018/19 and will continue to do so in respect to all key objectives for 2018/19. These include:

**Emergency Department Investment and Improvement**

We recognise that the Trust has found the emergency department 4-hour standard challenging to achieve for a number of years. Earlier this year the Trust undertook a programme of building work to expand and reconfigure the paediatric and resuscitation areas within the ED department. This has already had a positive effect on the overall patient experience and has helped improve patient flow through the hospital.

**National Staff Survey**

Despite extreme operational pressures, we commend the Trust’s success in significantly improving the participation rate of the staff survey and are able to demonstrate that they have a highly reliable data set relating to the 10 themes within the survey. The Trust’s rate of improvement remains greater than the average of acute trusts.

**Children’s Services**

NHS Devon CCG commends the development of the electronic advice and guidance to GP’s designed by paediatric consultants to ensure referrals are timely and appropriate. GP’s can now contact a paediatrician with a query or for guidance on how to manage a paediatric condition. Additionally, the Children’s
Community Nursing Team has been working closely with commissioners to promote Personal Health Budgets for eligible families who have children with complex health needs so they can have a more responsive care service at home.

**People First Programme**
The Trust is one of only 7 national sites chosen to partner with NHS Improvement in a programme of quality improvement work termed the People First Programme. The CCG is very supportive of the Trust in undertaking a comprehensive programme of activities to improve patient care and provide better outcomes and experiences for patients. Additionally, the Trust will use a single approach to build quality improvement right through the organisation with an ambition to join together all the different aspects of quality improvement alongside the operational strategy and staff development.

**Looking Forward**
Looking ahead, the CCG welcomes the specific priorities for 2019/20 which are highlighted within the report and consider that they are the most appropriate areas to target for continued improvement. The CCG is assured that these priorities were developed in conjunction with key stakeholders, including staff and patients.

It is felt overall that the report is well considered and reflective of quality activity and the CCG looks forward to our continued collaborative working to deliver safe and high-quality care across Devon.

Lorna Collingwood-Burke  
Chief Nursing Officer / Caldicott Guardian  
NHS Devon CCG

**NHS Kernow Clinical Commissioning Group**
NHS Kernow Clinical Commissioning Group is an associate commissioner of services at the Trust. The information contained within the report was reviewed and is considered an accurate summary reflection of the Trust’s performance during 2018/19.

NHS Kernow welcomes the opportunity to provide this statement and the approach taken in developing and setting out its plans for quality improvement in 2019/20. It has proved to be a busy year with rising demand, comprehensive Care Quality Commission (CQC) inspections in April/May and then a follow-up in December 2018 alongside challenges across the system. Although improvements were noted, CQC have said that concerns remain and we look forward to supporting you in the People First Improvement Practices launching in 2019. The quality account clearly articulates where the Trust has achieved progress and identifies areas where further improvements are required.

Of particular concern are the improvements required in meeting NHS constitutional standards and the follow up backlog. We note that the Trust has devised detailed action plans and we are pleased to be working with you this year. It is clear that patients are recommending the Trust as the friends and family test reflect high levels of satisfaction across all areas.

NHS Kernow endorses the commitment within the quality account to addressing the challenges of 2018/19. We support the identified quality priorities for 2019/20, and where these will continue from the 2018/19 foundation work. They aim to deliver high quality, safe and accessible services; maximise the potential of the workforce to deliver high quality patient care and to diversify/develop services that meet patient/commissioner needs and expectations.

Nikki Thomas  
Deputy Director of Nursing & Quality  
NHS Kernow CCG
NHS England - Specialised Commissioning, South East and South West
Thank you for sharing the University Hospitals Plymouth NHS Trust Quality Account with NHS England as the Specialised Commissioner for the Trust. This quality account provides a clear overview of the quality challenges the Trust is addressing and the improvements achieved during 2018/19.

NHS England Specialised Commissioning has significant concerns in relation to the performance and sustainability of some Specialties, workforce (capacity/capability) and of patient flow through the Trust as the main tertiary centre in the Peninsula.

Neurosurgery (complex); cardiac surgery and neurology are the specialties of particular concern. In all cases the service performance issues are well rehearsed, but there continues to be limited progress towards sustainable activity levels (agreed but not achieved in 2018/19) going forward. The Trust is advised to consider how it intends to deliver actions which deliver the required activity levels for 2019/20 whilst meeting patient waiting times, minimising risk and delivering good patient outcomes.

The quality implications of the ongoing poor performance cannot be underestimated and NHS England Specialised Commissioning expects the Trust to address these as part of its overall service delivery and quality improvement programme during 2019/20 and beyond.

Staffing remains a challenge within nursing and medicine and Specialised Commissioning endorses the work completed as a response to the CQC reports which highlighted concerns in the Diagnostic Imaging and Pharmacy services.

NHS England Specialised Commissioning is assured that significant work has been undertaken to achieve the improvements required to remove the two section 29A Warning Notices for Pharmacy and Diagnostic Imaging in 2019. It is also reassuring to see these workstreams will be further supported by the People First Programme.

NHS England Specialised Commissioning welcomes the specific priorities for 2019/20 which are highlighted within the report and considers these are appropriate areas to target for continued and sustained improvement.

Participation, follow-up and actions resulting from Peer Reviews are noted, while collaboration around understanding and responding to services on Specialised Services Quality Dashboards and in the Quality Surveillance Annual Declaration will be developed further in 2019/20 and may merit mention in a future Quality Account.

NHS England Specialised Commissioning endorses this Quality Account and looks forward to building upon the established collaborative working arrangements between the Trust and Devon CCG in order that improvements to the quality of care for patients accessing services from University Hospitals Plymouth NHS Trust will continue.

Wendy Cotterell
Regional Director of Nursing
Specialised Commissioning – South East and South West

Plymouth Caring Plymouth Scrutiny Panel
Unfortunately due to a conflict between the deadline set by the Department of Health for the submission of Quality Accounts and the Council’s municipal calendar the Health and Adult Social Care Overview and Scrutiny Panel has been unable to consider these Quality Accounts as part of a standard committee meeting.
Devon Health and Adult Care Scrutiny Committee
Devon County Council’s Health and Adult Care Scrutiny Committee has been invited to comment on the University Hospitals Plymouth NHS Trust’s Quality Account for the year 2018/19. All references in this commentary relate to the reporting period of the 1st of April 2018 to the 31st of March 2019 and refer specifically to the Trust’s relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2018-19 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee’s knowledge.

The Committee is pleased to see that improvements have been made since the 2018 Care Quality Commission (CQC) Warning surrounding Cancer Assessment and Pharmacy services. However, the Committee was disappointed to note that the Care Quality Commission felt that insufficient progress had been made in fully addressing the concerns in the 2018 Warning Notice. Of particular concern were the management issues within Radiography and the Diagnostic Imaging Service not meeting their targets.

In terms of the priorities for 2018-19 Members appreciate the work undertaken by the Trust in the improving of discharge care of patients. This has been an issue of importance to Members. The improvements to ward staffing are positive, but the Committee understands more time is needed to fully implement these changes. Nevertheless, the work done by the trust in this area with Lord Carter and the Department of Health has certainly been of great importance and it is pleasing that the results have been shared nationwide.

The Committee also notes the progress of the Trust in improving the treatment of conditions such as sepsis. The Committee is particularly impressed with the Trust’s use of Scan4Safety to improve patient care.

The Committee fully supports the Trust’s Quality priorities and goals for improvement in 2019/20. Staffing, improving responsiveness and improving patient communication and information are all crucial areas of work which will lead to an improved delivery of healthcare.

Members anticipate that regular information on the progress on the Trust’s goals for 2019/20 and the continued work to meet the areas of weakness noted by the CQC.

The Committee welcomes a continued positive working relationship with the Trust in 2019/20 and beyond to ensure the best possible outcomes for Devon residents.

Lay Chair of the Patient Experience Committee
I believe this Quality Account gives a fair and accurate description of University Hospitals Plymouth NHS Trust during the last year.

The progress and successes it has made are rightly celebrated. Other improvements, not documented here, have also been made which contribute to better patient care and experience in many areas, both clinically and socially. The improvements described in the Quality Account and its annexes give an encouraging glimpse into the way the hospital seeks to live its values.

The Quality Account does not seek to diminish the Trust’s problems and failings. These are not unique to University Hospitals Plymouth, or unusual among acute NHS Trusts. They are indications of the nationwide situation in provision of health and social care. The Trust has worked with external stakeholders to implement best practice, but not all improvements have given sustainable results. It is important the Trust works with national, regional and local partners to effect beneficial change; it is also important that the insight and expertise of frontline staff is used in forward planning.
Annex I  Statements from external stakeholders

The Quality Account provides evidence that University Hospitals Plymouth NHS Trust learns from both its successes and its failings. The increasing programme of research, development and audit gives assurances that aspirations go beyond words.

The Care Quality Commission inspection in 2018 highlighted some serious problems, on which considerable progress has been made to remedy the issues. Staff commitment to patients maintains the CQC assessment of outstanding for patient care.

Implementation of the priorities chosen for 2019/20 will further improve patient safety, outcomes, care and experience.

University Hospitals Plymouth NHS Trust remains my personal choice for hospital care.

Vera Mitchell
Lay Chair, Patient Experience Committee
Independent Practitioner’s Limited Assurance Report to the Board of Directors of University Hospitals Plymouth NHS Trust on the Quality Account

We have been engaged by the Board of Directors of University Hospitals Plymouth NHS Trust to perform an independent assurance engagement in respect of University Hospitals Plymouth NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- Rate of clostridium difficile infections per 100,000 bed days (on page 41 of the Quality Account)
- Percentage of patient safety incidents resulting in severe harm or death (on page 41 of the Quality Account)

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
Annex J  Independent auditor’s report

- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (“the Guidance”); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2018 to June 2019;
- papers relating to quality reported to the Board over the period April 2018 to June 2019;
- feedback from commissioners dated 13 May 2019 and 17 May 2019;
- feedback from local Healthwatch organisations dated 17 May 2019;
- feedback from the Overview and Scrutiny Committees dated 17 May 2019 and 24 May 2019;
- feedback from other named stakeholders involved in the sign off of the Quality Account dated 17 May 2019;
- national inpatient survey 2018;
- 2018 national NHS staff survey;
- Head of Internal Audit’s annual opinion over the Trust’s control environment dated 23 May 2019;
- annual governance statement dated 24 May 2019; and
- Care Quality Commission’s inspection report dated 16 August 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the “documents”). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of University Hospitals Plymouth NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and University Hospitals Plymouth NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
• limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
• comparing the content of the Quality Account to the requirements of the Regulations; and
• reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals Plymouth NHS Trust.

Our audit work on the financial statements of University Hospitals Plymouth NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as University Hospitals Plymouth NHS Trust’s external auditors. Our audit reports on the financial statements are made solely to University Hospitals Plymouth NHS Trust’s directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to University Hospitals Plymouth NHS Trust’s directors those matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of University Hospitals Plymouth NHS Trust’s financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than University Hospitals Plymouth NHS Trust and University Hospitals Plymouth NHS Trust’s directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

• the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
• the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
Annex J

Independent auditor’s report

- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Bristol

14 June 2019