NHS
Torbay and South Devon
NHS Foundation Trust

Quality Account 2023/24

BUILDING A Brighter Future
improving health & care in Torbay & South Devon

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Part 1: Our Chief Executive's statement on quality

I am proud to introduce our quality account for 2023/24. It has been an important year in which we have had to further adapt and transform in order to address the continuing impact of the pandemic.

We are working closer than ever before with our partners in the Devon health and care system with our people and teams exploring different ways of working to reduce the time that people are waiting for care, improve patient outcomes and experience and improve the sustainability of all our services, in particularly through our Peninsula Acute Provider Collaborative with other acute providers in Devon, Cornwall and the Isles of Scilly.

We have made significant progress in reducing waiting times in our planned care and cancer services. We have continued to see the benefits that working as an integrated care organisation brings with one of the lowest length of hospital stay in the country as well as consistently low numbers of people in our hospital beds who are well enough to go home.

However, demand for our urgent and emergency care services remained high throughout the year and our performance against key national targets remained below our expectations despite the hard work and dedication of our teams. This will remain a key area of focus for us. We are determined to improve further our performance in access to planned and emergency care and achieve the highest standard in our fundamental care and safety standards.

Our compassionate leadership approach is beginning to embed across our services and our inclusion training, #ItStartsWithMe, is supporting us to create a culture where people feel supported, healthy and safe. We are transforming how we respond and learn from patient safety issues, promoting a just and learning culture and ensuring compassionate engagement and involvement of those affected by patient safety incidents.

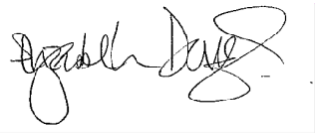
Recruitment and retention remain key issues and supporting our people to develop and grow is central to our work. We have taken further steps this year to widen participation for our local communities introducing volunteer to career and partnering with the Open University to offer nursing training with guaranteed local placements. We remain committed to supporting the health and wellbeing of our people so that we can deliver the best care we can.

Throughout everything we do, we continually strive to improve and deliver excellent, high quality, safe care to people who use our services in partnership with them. We passionately believe that the best way to care for people is by focusing on what matters to them, putting them at the centre of everything we do and integrating services around them. We believe that care as close to home as possible benefits everyone. This remains at the heart of our vision and our strategy.

I want to thank all of our people for their commitment to providing high quality care, particularly in busy and challenging times. It is because of their dedication and

passion that we have seen improvements over the last year and look towards 2024/25 with hope for a brighter future for our people and our communities.

I hope you will find this Quality Account interesting and informative in setting out what our teams and services have achieved over the past year and what we intend to do over the next 12 months.



Chief Executive

26 June 2024

Part 2: Priorities for improvement and statements of assurance from our Board of Directors

What is a quality account?

A Quality Account is an annual report that providers of NHS healthcare services must publish to inform the public of the quality of the services they provide. This not only tells people what we are doing to provide the best care we can but supports us to be open and transparent about the quality of our services, helps us focus on areas where we want to improve and aids us in embedding a culture of continuous quality improvement across our organisation.

Each year we collect a large amount of information on the quality of the service we provide within three areas defined by the Department of Health and Social Care: patient safety, clinical effectiveness and patient experience.

This information has been used to report on our progress against the priority areas we identified for improvement in 2023/24.

Our quality priority areas for next year, 2024/25, are also included. We have developed these in line with the CQC ‘we statements’ which are designed to put the person at the centre of their care.

2.1 Priorities for improvement 2023/24

Our priorities for 2023/24 were aligned to our four quality and patient safety goals and sought to embed improvements made the previous year.

For each quality goal we identified one or more quality improvement priorities.

These were:

Zero avoidable deaths: improve identification and management of sepsis

Continuously seek out and reduce harm: improve compliance around patient risk assessments with a focus on nutrition and hydration and a reduction in patient falls; nutrition and hydration.

Excellence in outcomes: improved identification of the deteriorating patient

Deliver what matters most to our people: improve experience for people being discharged home

What we did and how we did

Zero avoidable deaths: improve identification and management of sepsis

Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. All NHS organisations focus on ensuring that when a person presents with symptoms that may be related to sepsis, key clinical interventions are initiated in line with the national standards which as described as the 'sepsis bundle'.

Our aim was to improve our identification and management of people with sepsis to reduce the number of people in our communities who die from septic shock.

Our primary focus has been within our Emergency Department at Torbay Hospital.

What we did

- ✓ we strengthened the clinical leadership for our quality improvement programme
- ✓ we established our overarching sepsis improvement group and established our audit framework
- ✓ we introduced a new audit tool
- ✓ we commissioned a new training package for our clinical teams

How we did

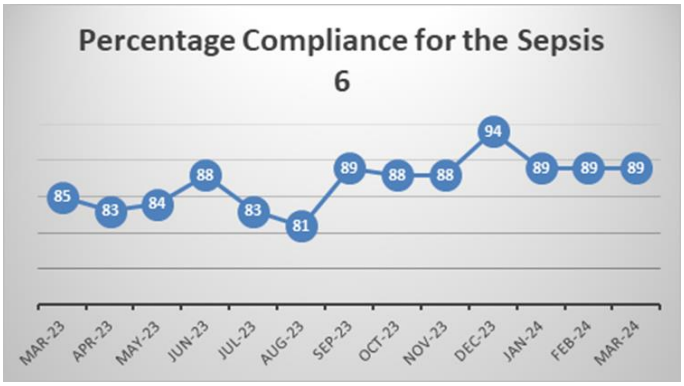
Against a goal of 100% compliance with the sepsis bundle, we achieved, on average, 86.9% in our Emergency Department.

In relation to the other key interventions, we have delivered each one. We now have a well-attended trustwide sepsis group, inclusive of strengthened clinical leadership with a designated senior nursing and medical lead.

The group's initial key deliverables were to bring together our first trustwide sepsis clinical policy. This policy covers adult and paediatric care in our acute and community setting and is live both on our internet page and microbiology guide.

We commissioned and rolled out a full sepsis awareness e learning package for adults, paediatrics and care workers. To date we have trained 3,122 clinical staff meaning we are 68.9% complaint with this training.

We will continue to prioritise our work to identify and manage patients at risk of sepsis promptly to reduce harm. This area will remain a priority for 2024/5.



Continuously seek out and reduce harm: improve compliance around patient risk assessments with a focus on nutrition and hydration and a reduction in patient falls; nutrition and hydration.

For us this means getting the fundamentals of care right every time. On admission to hospital and when being looked after in the community there are a range of risk assessments that must be undertaken to ensure we are identifying people at risk including falls, malnutrition and dehydration.

In doing so we can safely and appropriately put in place care interventions that are personal and most relevant to a person's need.

Our aims in 2022/23 were to:

- achieve 100% compliance with all risk assessments for people who are admitted to hospital
- reduce the number of frail people falling when in hospital
- ensure everyone is assessed for nutrition and hydration risks within 24 hours of admission to hospital.

Reducing falls

We recognised that there was a need to reduce the number of falls our people with frailty were sustaining when in our hospital care. Research has shown that multifactorial assessments and interventions that identify and treat the underlying reasons for falls can reduce falls by around 25%.

We had two aims associated with falls reduction this year. These were: to reduce the number of falls and to reduce the level of harm for any patient that sustains a fall whilst in hospital. Our falls specialists continue to work across both acute and community services to provide expert advice for all areas across our organisation and they provide education across in-patient areas. The falls steering group meets bi-monthly and is supported by an active service user.

The FallSafe audit does fluctuate depending on patient complexity, escalation and staff capacity but does demonstrate that lying and standing blood pressure (LSBP) measurements are being taken and the figure is maintained at around 70 -75%. Our wards are being briefed on new guidance and post fall bed-based training is being developed with greater competency and involvement from our Emergency Department colleagues; senior support to release ward-based staff is essential to gain engagement.

The falls incident management process of hot debrief/ after action review is being well received and governance are looking to produce timing data on this, across all in-patient wards. Falls training is ongoing, delivered through the fundamental skills study day, ward training provided as requested and as part of preceptorship training.

We focused on improving the measurement of recording lying and standing blood pressures with an ambition to achieve 50%.

We also committed to introducing a bedside visual assessment to ensure appropriate measures are taken for patients with visual deficits.

What we did

- ✓ fall safe bundle embedded including a 'lying and standing blood pressure'
- ✓ training in 'lying and standing blood pressure'
- ✓ piloting a visual assessment tool which will roll out and be added to the fall safe bundle
- ✓ piloting fall debriefing

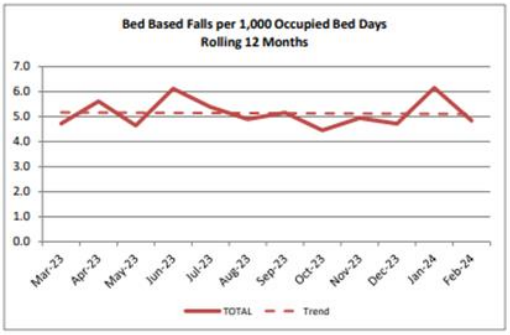
How we did

We are now achieving a 45% compliance against a national average of 39% for lying and standing blood pressure being recorded.

However, the reduction in falls we saw between 2021 and 2023 has plateaued despite success in increasing the number of people completing the fall safe bundle assessment.

There has been an increase in the number of hip fractures experienced by people when in hospital, rising from 12 in 2022 to 20 in 2023. The graph overleaf demonstrates the number of inpatient falls resulting in harm (moderate, severe and death) so while the falls rate trend per thousand bed days is holding steady around five, the harm-level is increasing. To draw the themes from the increase in hip fractures and the overall increased levels of harm reported, a deep dive review is being led by two of our consultants.

Monthly Summary



Year-on-Year Comparison

Bed Based Falls/1,000 OBDs By Caregroup - 2022/23 v 2023/24 YTD	*2022/23 Year-to-date*	*2023/24 Year-to-date*	*Difference*
Families & Communities	5.9	5.1	-0.8
Medicine & Urgent Care	5.2	6.6	+1.4
Planned Care	3.7	2.8	-0.9
TOTAL	**5.1**	**5.2**	+0.1

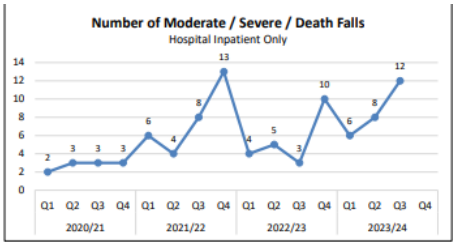
Notes

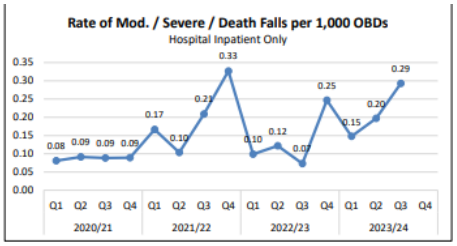
1 This report is concerned with falls regardless of whether or not they have been recorded as having been 'caused by us'. (Figures reported in the QIG Dashboard exclude these)
2 Please note that 'Bed Based' includes BOTH Hospital and I/C Care Home falls.
3 Louisa Cary ward is excluded.
4 The Bed Based Intermediate Care figures are only concerned with falls that have involved Patients occupying beds provided under an Intermediate Care contract at the time of their fall.

Monthly Figures

Bed Based Falls per 1,000 OBDs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	7.8	5.5	4.1	5.6	4.8	4.2	3.4	5.1	5.0	5.7	4.9	4.7
2023/24 Year-to-date	5.6	4.6	6.1	5.4	4.9	5.2	4.5	4.9	4.7	6.2	4.8	

Figures in the table above include both inpatient falls and falls in Care Homes while staying under an Intermediate Care contract





	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4 YTD	YTD
Falls per 1,000 OBDs	**6.2**	**5.3**	**4.8**	**5.5**	**5.8**	**5.6**	**5.3**	**6.3**	**5.7**
Number of Falls									
Total *number* of Falls	**250**	**219**	**197**	**222**	**235**	**228**	**216**	**169**	**848**
Number of Death Harm Falls	0	2	1	0	2	1	0	0	3
Number of Severe Harm Falls	2	1	1	5	2	2	9	1	14
Number of Moderate Harm Falls	2	2	1	5	2	5	3	5	15
Number of Low Harm Falls	71	56	50	64	87	71	83	77	318
Number of No Harm / Near Miss Falls	175	158	144	148	142	149	121	86	498

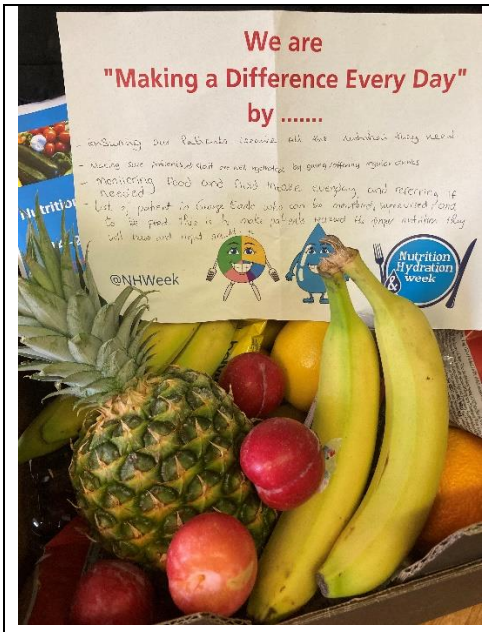
Notes

1 This report is concerned with falls regardless of whether or not they have been recorded as having been "caused by us'. (Figures reported in the QIG Dashboard exclude these)
2 Louisa Cary ward is excluded.

The Devon care coordination hub (Medvivo) pilot started on 20 December 2023. This has led to increased workload for community teams and concerns about managing more complex patients within the community. This then impacts the capacity of teams to be able to carry out multifactorial falls assessments and interventions that are evidence-based to reduce falls and the impact of falls. The falls team is working closely with our community teams to identify 'hot spots' and reduce risk where possible.

Community post fall training is well attended by care home and care agencies who are keen to attend and respond to their residents who have fallen without waiting for ambulances, where escalation is not required. For hospital staff who provide bed-based care it has been challenging to attend falls training, this training has now been revised to be more 'hands on' and the update has increased and remains and ongoing focus. Feedback from staff has been positive.

Nutrition and hydration



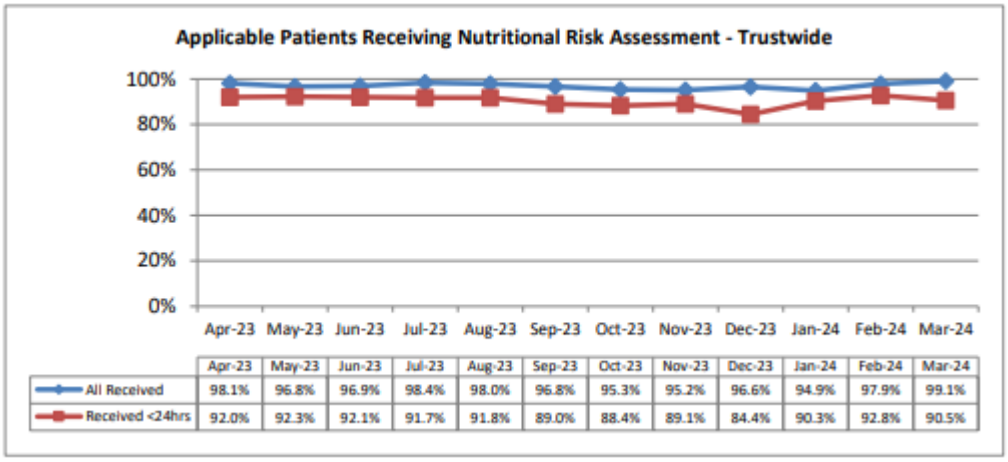
What we did

- ✓ five a day audit of patient notes
- ✓ daily review by a nurse in charge
- ✓ establishing our nutrition and hydration council to focus on improvement interventions
- ✓ launching our nutrition and hydration campaign in spring 2022
- ✓ relaunching protected mealtimes on our wards
- ✓ introducing greater daily monitoring in the 'five a day' audit
- ✓ increasing our mealtime companions (from eight to 42)
- ✓ introducing more robust governance processes

How we did

We achieved a 99.1% compliance for nutrition and hydration risk assessments being completed in March and an average of 96.8% compliance over 2023/24 however there is more we must do to ensure these are undertaken within the four-hour time scale of admission as this level of compliance is lower and while there has been a more sustained improvement in the last months of 2023/24, this still falls below the 100%.

We will now continue this work as business as usual with oversight via our care groups.



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
All Received	98.1%	96.8%	96.9%	98.4%	98.0%	96.8%	95.3%	95.2%	96.6%	94.9%	97.9%	99.1%
Received <24hrs	92.0%	92.3%	92.1%	91.7%	91.8%	89.0%	88.4%	89.1%	84.4%	90.3%	92.8%	90.5%

Excellence in outcomes: improved identification of the deteriorating patient
In 2023/24 we said we would focus on improving clinical outcomes by better supporting people whose condition is deteriorating when they are in hospital.

Our aim was for 100% of people to have physiological observations recorded at the time of admission or on their initial assessment. We committed to using the National

Early Warning Score (NEWS) to monitor and understand ongoing plans for the frequency of further observations. The aim of this priority is to improve clinical outcomes by better recognise and support people whose condition is deteriorating in hospital.

What we did

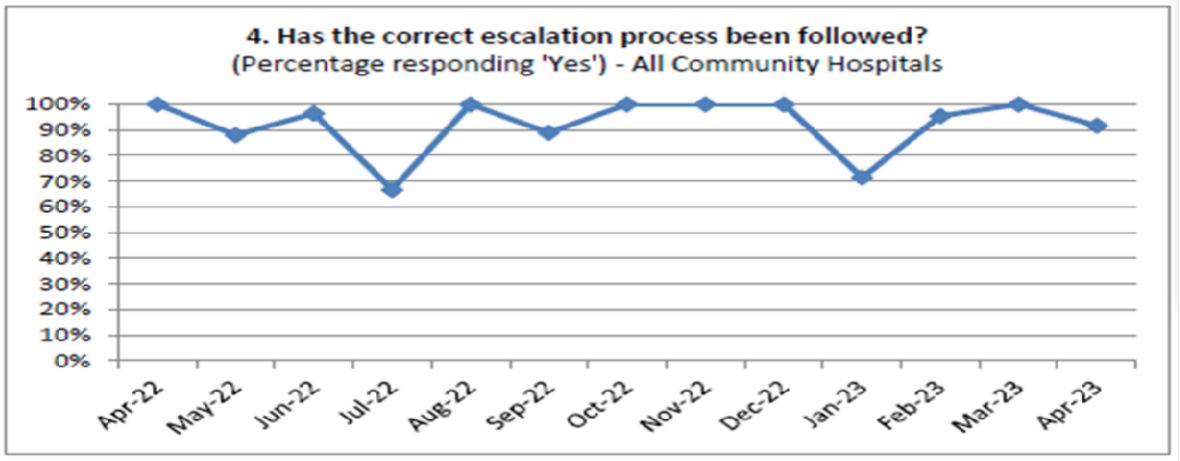
- ✓ strengthened and rolled out training in NEWs2, target uplift to 100%
- ✓ regular monitoring through our deteriorating patient group
- ✓ targeted support for wards where performance is low

How we did

Our compliance with recording vital signs monitoring is currently at 98%.

In March 2024 we achieved 89% compliance with the monitoring and timeliness of observations on 'vital pac' and we are providing targeted support for any areas who are not yet compliant.

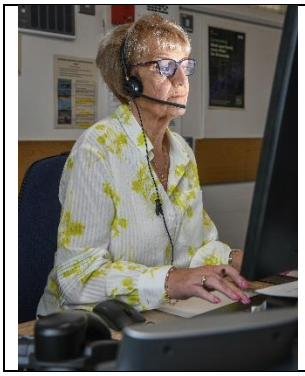
We continued to deliver training and education to our staff to support identification and escalation of the deteriorating patient. We have overachieved on our target of 85% of staff having attended training with 89.1% compliance. Audit of escalation processes shows 100% escalation across surgery in March 2024; we will continue to monitor to ensure consistency across all our inpatient services.



Deliver what matters most to our people: improve the experience for people being discharged home

How we better prepare people and their families to go home from hospital was a key priority are for us this year. We committed to ensuring that people are involved in decisions about their care and appropriate arrangements are in place to ensure that the transition home is safe, personal and compassionate to support wellbeing and

recovery. Staff will engage with social care staff to support safe discharge where required.



What we did

- ✓ introduced our home for lunch programme
- ✓ created our enhanced discharge lounge
- ✓ targeted support for wards where there was low performance
- ✓ undertook a review of preferred place of discharge
- ✓ follow-up with people to check on person-centred care

How we did

Patient feedback through the NHS patient survey 2023 showed we were performing in the top 5% for the following:

- information was given on who to contact on discharge if you were worried about your condition and treatment
- after leaving hospital did you get enough support

The survey provided assurance as no questions relating to discharge fell within the bottom 5%.

Home for lunch: in March 2024 25% of people were discharged before 12 noon, a 5.7% increase from same period 2023. Compared to 73.3% before 5pm, again an improvement of 6% on the same period for 2023. Annual achievement for 2023/24 pre 12 noon is 21.4% and pre 5pm 69.9%.

Enhanced discharge lounge – promoting a positive step to discharge - the number of people being supported home through our discharge lounge has doubled. In 2022/23 we supported 764 people through our discharge lounge. For 2023/24 we supported 7,030 people through our discharge lounge.

People's preferred place of discharge is considered from the very start of their admission. Data was not routinely collected regarding preferred place of discharge on starting the discharge work however, this has subsequently changed. For March 2024 71 % of people were discharged to their preferred place. This in an improving trend and one we will continue to monitor.

During the year we introduced a patient survey. Currently ten randomly selected people who have been supported home each month are being contact to collect their feedback on their experience of discharge to help us learn from their experience, make improvements and share good practice.

The task and finish group achieved the goals set out. This will no longer be a quality priority as it is now business as usual and will be monitored through our care groups governance.

2.2 Priorities for improvement 2024/25

During the past year we have taken the opportunity to review our four quality goals.

Our remote rural and coastal communities have some of the highest levels of deprivation in the country and, therefore, following feedback from colleagues, patients and carers we have revised our quality goals to focus on the impact of health inequalities for our people and communities.

Our quality improvement priorities are aligned with our revised quality goals and also with our priorities for patient safety incident investigation.

We have identified our improvement priorities for each of our quality goals using 'we statements'.

Reduce health inequalities:

We are committed to seeking out and reducing health care inequalities across our Devon health and care system while continuously improving the quality of care. The impact of COVID-19 has not only increased the pressure across all aspects of health and social care but those who live in our most deprived communities have seen an increasing gap in health inequalities.

We have asked each of our four care groups to identify their focus based on their identified and diverse needs, for example, reducing the prevalence of smoking or improving access to services, and to develop plans to address this impact.

Continuously seek out and reduce harm:

Priority one: we are committed to continuing our work to promote the early detection and treatment of sepsis. We will roll out our sepsis audit across the whole organisation. We will reach more than 85% compliance with sepsis awareness training consistently.

Priority two: we will strength the quality of our mental capacity act assessments. We will ensure documentation is fully completed and contains all relevant details. We will bring the recording of our mental capacity assessment in line with legislation and issue mental capacity assessment documentation across our services.

We will monitor improvements via both ward level audits and a trustwide audit which will be overseen by our mental capacity and safeguarding leads. The outcomes, learning and recommendations will be shared across all our services.

We are reviewing our safeguarding and mental capacity act training matrices and together with our practice education team we are looking at opportunities to increase our people's understanding of both the mental capacity act and safeguarding via bitesize and 'how to' sessions. This will be supported by face-to-face training led by mental capacity act and safeguarding leads. We will review our policies and processes to ensure that they meet legislative frameworks, are patient centred and safety focused.

Excellence in outcomes:
Priority one: We will reduce the number of falls across our services. We will reduce the harm sustained from falls across our organisation. We will achieve this via continued and consistent use of our falls safe bundle including visual assessment, lying and standing blood pressure and ensuring a rapid review occurs for any patients that falls.

Priority two: we will reduce long waits for urgent and emergency care. We will reduce ambulance handover delays greater than 15 minutes. We are committed to increasing the number of patients who are seen and have a decision made regarding onward care or discharge within four hours of attending or emergency department to 78%. We will reduce to zero the number of people waiting more than 12 hours to be seen in our Emergency Department. We will maintain our high performance on supporting people to get home as soon as they are medically fit to do so and have fewer than 5% of people in our hospitals who are ready to go home.

Priority three: we will reduce long waits for planned care. We will have no one waiting more than 78 weeks by the end of June 2024. We will have no one waiting more than 65 weeks by the end of September 2024. We will have no one waiting more than 52 weeks by the end of March 2025. We will treat 70% of people diagnosed with cancer within 62 days by the end of March 2025. We will give 77% of people referred for suspected cancer their diagnosis (or the all-clear) within 28 days by March 2025.

Harm relating to delays across our urgent and emergency care pathway and our planned care pathway have been identified as a priority for patient safety investigation in our patient safety incident response plan. Learning from these reviews will be shared to influence ongoing improvements.

Deliver what matters most to our people:
Priority one: Our people are vital to achieving our vision of better health and care for all. We know that when people feel empowered and safe to speak up, able to make decisions for themselves and are treated with dignity and respect, the better the outcomes and experience is for the people who use our services. By improving how it feels to work for us, we can improve the care and experience for everyone. We will continue our work to build a just learning culture where our people feel supported and empowered to learn from when things go wrong. We will work with our freedom to speak up guardian to seek feedback from our people and use data

from the NHS staff survey and other feedback mechanisms to understand how we are doing.

Priority two: We are committed to engaging patients and people who use our adult social care services and their families in safety reviews and investigations to ensure that we learn and improve when things go wrong. We will use data from the CQC patient and service user surveys, friends and family test data and complaints/ compliments and PALS data to help us to understand how we are doing.

Aligning our quality goals with our patient safety priorities we have identified our patient safety priorities for safety investigation:

- Delays across urgent and emergency care pathways (**excellence in outcomes)**
- Delays across planned care pathways (**excellence in outcomes**)
- Diagnostic pathway errors (**seek out and reduce harm**)
- Engaging patients and their families in safety reviews and investigations (**deliver what matters most to our people)**
- National standards for invasive procedures (NATSSIPs 2) (**seek out and reduce harm)**

2.3 Statements from our Board

Review and list of services provided by us

We are an integrated care organisation. We continue to work with and be accountable to:

- NHS England
- the Care Quality Commission
- the Devon Integrated Care Board and system partners
- the Local Authorities
- the people who use our services
- our local communities
- our staff, members and governors.

During 2023/24 we provided and/or sub-contracted 52 relevant health services. We have reviewed all available data relating to quality of care in 52 of these services. A full list of our services is available on our website.

Our governance is aligned to Tiers, this assists us to anchor our accountabilities, performance and risk management in a visual, accessible way. We have four primary governance Tiers:

- Tier 1: The Board of Directors and its Committees (corporate governance structure and legal structure) and meetings thereof
- Tier 2: Executive Governance (operational governance), led by the Chief Executive as the most senior Executive within our organisation and meetings thereof (Executive Committee and Recovery Group). Operating within the delegated authority of the Chief Executive.
- Tier 3: Trust senior leadership and meetings thereof (Trust Management Group)
- Tier 4: Functional leadership: care groups and professional services and meetings thereof. Reporting to Tier 3.
- Tier 5: Any group or meeting reporting into Tier 4.

The Tiers operate in oversight and assurance terms, as well as performance management and oversight; this information flow structure is supported by our accountability portfolio, which outlines line management and Executive portfolio accountability.

During the year we restructured our clinicals services to form four care groups and we continue to embed this structure and to strengthen our governance processes. These care groups are:

- Families and communities which includes adult social care
- Medicine and urgent care
- Planned care and surgery
- Children and Family Health Devon (provided in alliance with Devon Partnership NHS Trust)

Our governance process ensures our care groups hold their teams to account for quality, safety and value for money. We operate escalation reporting, whereby the standard form reports are provided by governance tier to each meeting and supplemented by any items for escalation from the tier below, or in response to a request for further review from the tier above.

Our Executive Committee reviews all information escalated to it as well as its own standard form reporting, agreeing the matters to be reported to the Board and Board-Sub-Committees, who in turn have agreed work plans aligned to the Business Assurance Framework, Risk Map and strategic priorities for the year.

Care Quality Commission (CQC)
We are required to register with the Care Quality Commission (CQC) to provide care and our current registration is to be able to deliver the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- family planning
- management of supply of blood and blood derived products
- maternity and midwifery services
- personal care
- surgical procedures
- termination of pregnancies
- transport services, triage and medical advice provided remotely
- treatment of disease, disorder or injury.

We have no conditions or restrictions attached to our registration.

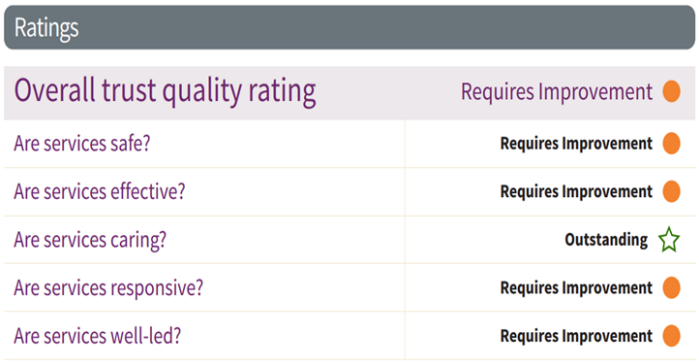
CQC will also be inspecting our adult social care services in 2024 as part of a new inspection regime, we are working closely with our partners at Torbay Council to ensure that we are delivering quality social care services.

During the year we had a CQC well led inspection. This process involved four core service inspections: urgent and emergency care, medical care, outpatient care and radiology and imaging. The process concluded with our trustwide well-led inspection. While we have retained our rating as outstanding rating for care, our overall rating has changed from good to requires improvement.

As a result of the inspection, we received 15 must do actions and implemented a robust action plan to address these. The action plan is overseen by our CQC quality assurance group which reports into the Executive Quality Group.

We also underwent a planned maternity inspection as part of the national CQC programme. While many improvements were noted by the inspectors, our rating for maternity services remains as requires improvement. In response to the inspection findings, we have put a robust action plan in place which is overseen by our CQC quality assurance group.

Our current CQC ratings are:



Our current full ratings, including the core services ratings from the last inspections, can be found on the CQC's website: https://www.cqc.org.uk/provider/RA9

Research and innovation
There is strong evidence showing a clear link between being a research active organisation and improved patient outcomes. Participation in clinical research demonstrates our commitment to advancing care through research, improving the quality of care we offer and contributing to wider system benefits and health improvements. Through active participation in research our clinical staff stay abreast of the latest possible treatments, we expand the opportunities available to develop our colleagues and we empower and engage the people we care for. Our mission is to embed clinical research as part of core business:

Our primary research business involves recruiting into national and international multi centre commercial and non-commercial studies as part of the National Institute for Health and Care Research Clinical Research Network (NIHR CRN) portfolio. In 2023/24 we recruited 2,801 participants to 75 NIHR CRN portfolio studies, across our clinical specialities. Supporting the life sciences sector is a key objective for the Government. We recruited 351 participants to 17 commercial trials.

We are the best performing trust for NIHR research activity (both for recruitment and studies recruited into) compared to similar sized organisations across England. (NIHR benchmarking data for 2023/24).

Our recruitment to time and target (RTT), measures whether a site has reached the contracted local target on trials and is a key NIHR metric (target 80%). In 2023/24 we improved on last year, achieving an RTT of 88% for non-commercial and 75% for commercial NIHR research across the 32 studies which closed within year.

We support academic research training through various schemes in partnership with higher education institutions, Health Education England, NIHR CRN, and the Torbay Medical Research Fund (TMRF) including two Predocs, five PhDs, one Postdoc, four CRN Research Associates and two Chief Nursing Research Fellowships. Additionally, a further four of our colleagues completed the NIHR Associate Principal Investigator training programme; gaining invaluable learning and the practical skills associated with leading clinical research delivery.

In response to England's Chief Nursing Officer's nursing research strategy and allied health professionals national research strategy and following a successful away day in March 2023, led by our Chief Nurse, we developed a new strategy for nursing, midwifery and allied health professionals (NMAHPs). This was approved in January 2024 and will be formally launched across our organisation in May 2024.

Other highlights this year include the pivotal role research is playing in how we are improving cancer care:

- nationally we are the second highest recruiting site into commercial cancer trials
- our oncology research has been nominated for an NHS parliamentary award for excellence in health care
- we were awarded NIHR capital funding worth £817K to support new radiotherapy equipment
- we recruited the first UK patient into six out of eight new commercial oncology studies which opened in 2023/24
- we were the only trust in the south west chosen to be a trial site for the pioneering BioNTech personalised cancer vaccine for the treatment of patients with colorectal cancer as part of a larger high profile and priority vaccine trials programme launched by the Government
- we were one of the highest recruiting sites to the national Symplify study. The results generated a lot of national news coverage, showing the potential of a new blood test which will hopefully help change the face of early diagnosis in cancer.

Operational performance

As an organisation we remain in National Oversight Framework 4 for performance and finances along with the other acute providers in Devon and the Devon health and care system as a whole. We have worked hard to meet the improvement targets set out by the national and regional NHS England teams and this remains a core area of focus for us for 2024/25.

We are committed to working together to address the critical and urgent need to ensure there is consistent and equitable access to safe, high-quality services across Devon. The COVID-19 pandemic has shone a light on issues of inequity in access, experience and outcomes which we are working to address both locally and as a system. The pandemic has also resulted in a significant rise in waiting times across both urgent and emergency and planned care and we are committed to delivering sustained improvements across our services to reduce the harm associated with delays in care.

We have maintained our focus on improving the quality and safety of all our clinical services. From urgent and emergency care to adult social care, from community services to planned care, from diagnostics to our laboratories throughout everything we do we strive to achieve excellence in receiving and providing care.

Throughout the year demand for our emergency, cancer and planned care services has remained high. In line with our commitment to continuous improvement we continue to explore new ways of working to seek to manage pressures and delays access to care following the COVID-19 pandemic. We have strengthened our partnership working across health and social care services to ensure we are better

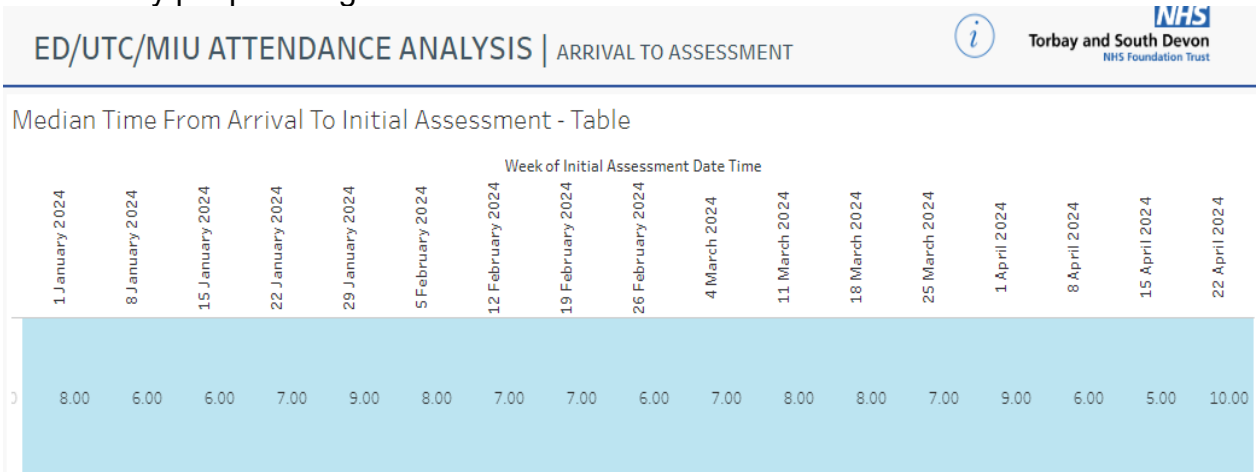
placed to address risks of delay in access to treatment including the One Devon Elective pilot.

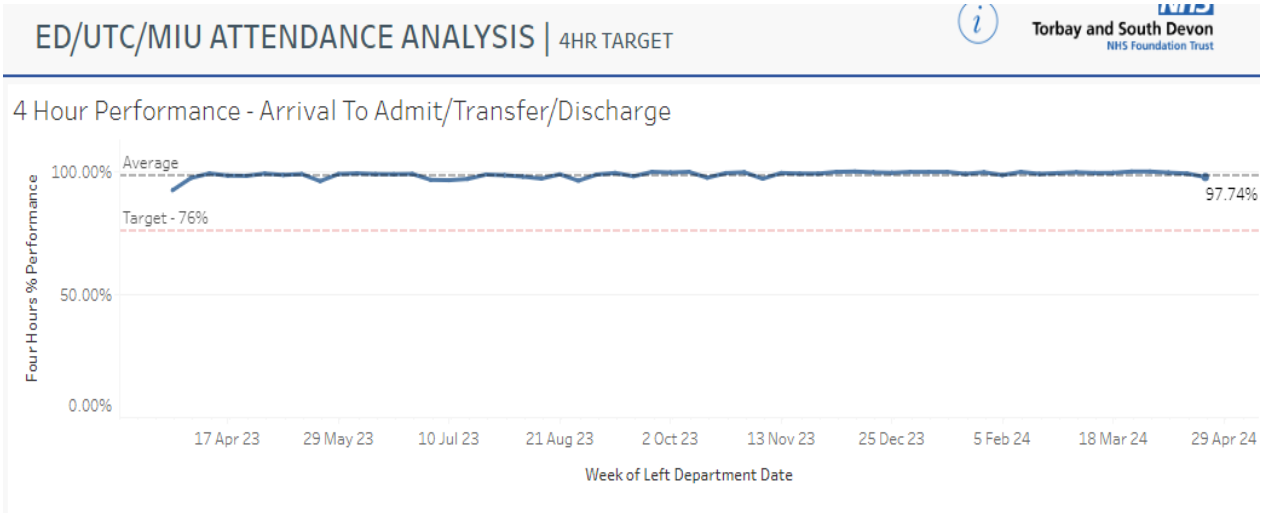
We have worked in collaboration with our health and care partners in Devon to improve outcomes and safety by:

- developing a shared control centre for urgent and emergency care to balance pressure and resources across organisations
- expanding the use of virtual wards to manage patient care remotely so that more people can stay at home
- continuing the development our frailty and fall services to improve outcomes and experience for people
- developing a Devon-wide waiting list system that will allow organisations to see people more equitably across different areas
- continue to promote advice and guidance services associated with patient-initiated follow-ups.

Our urgent and emergency care performance

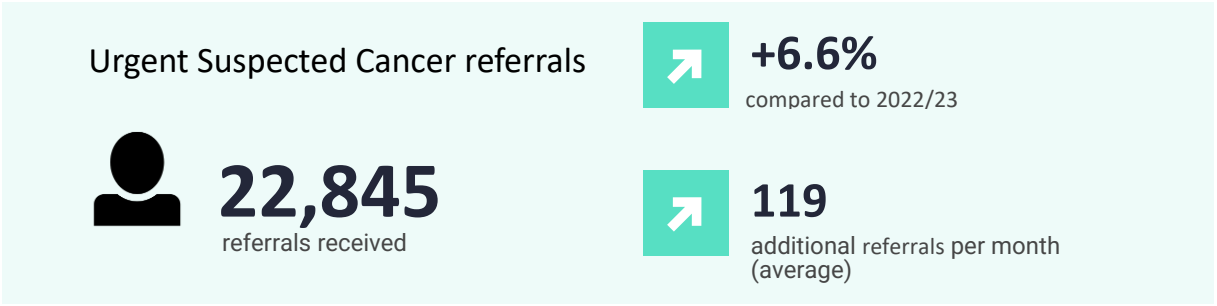
We continued to experience significant challenges in facilitating timely access for people needing urgent and emergency care. We have implemented a range of improvements that have begun to have a positive impact, including the substantiation of our Acute Medical Unit, significant sustained improvements in our time to assessment/triage (under 15 minutes) and sustained 95% four-hour performance across our urgent treatment centre and minor injuries units. During the year we were able to reopen Totnes and Dawlish minor injuries units which had been closed since the start of the pandemic. Both have reopened with bookable appointments, a new approach which has been working well and has been well received by people using the service.



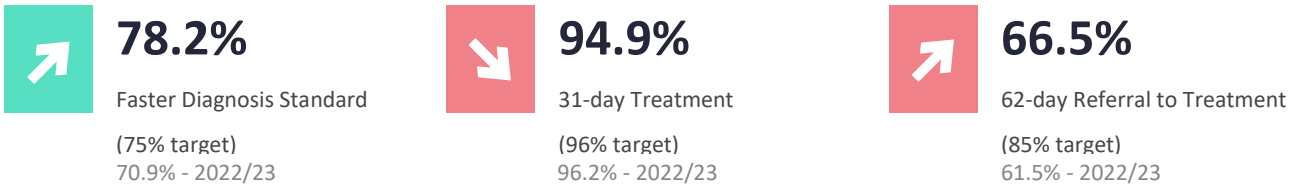


Our cancer care performance

During 2023/24 we received 22,845 urgent suspected cancer referrals – a 6.6% increase on the 21,423 received the previous year. This, on average, equates to an additional 119 referrals each month.

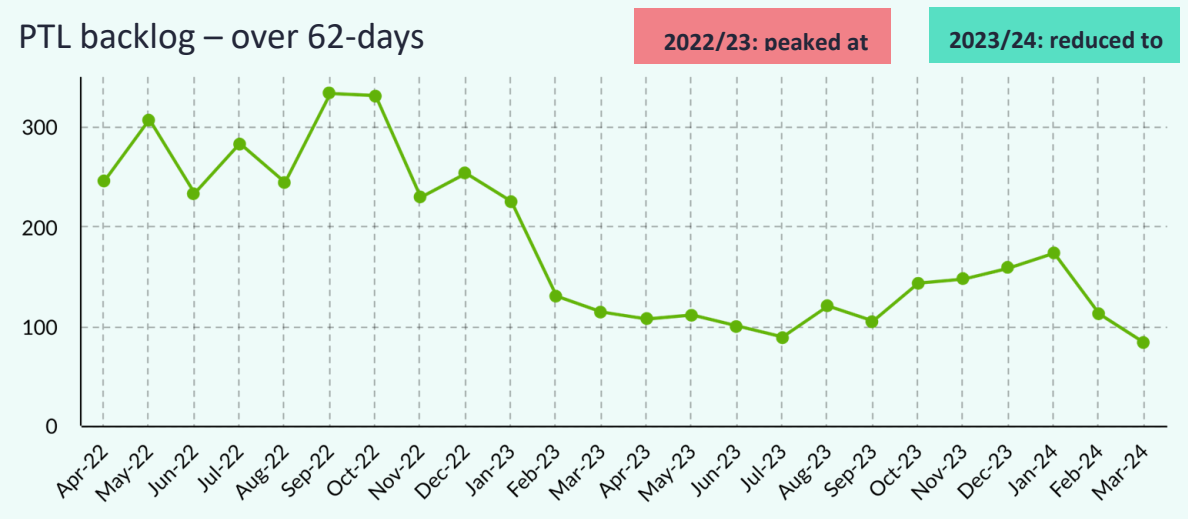


Despite this rise in referrals, our cancer teams have delivered improvements in our national cancer waiting time targets.



We were one of just 19 trusts nationally to achieve the faster diagnosis standard consistently over 14 months from February 2023. This means that nearly 80% of our patients are getting their cancer diagnosis (or the all-clear) within 28 days.

We are also very proud to have achieved our patient tracking list (PTL) backlog target. This measures the number of people currently waiting over 62 days on a suspected cancer pathway. As of 31 March 2024, this stood at 83 people against target of 138.



The annual national patient experience survey is commissioned and run by NHS England. It surveys all adult patients with a confirmed primary diagnosis of cancer who received cancer related treatment in the months of April, May and June 2022. The results were published in July 2023.

We received 439 responses, which was a 59% response rate (above the 53% national average)

Patients were asked to rate their overall care received Torbay and South Devon are **ranked 59 nationally**, with a rating of **8.91 / 10** (133 Trusts participated)

Based on the demographic data of the organisation, we have been given an 'expected range' for each of the 61 questions

We scored **above** our expected range in **7 questions**

We scored **below** our expected range in **no questions**

Our focus for the next twelve months is on improving early diagnosis to enable prompt treatment and better outcomes. We are aiming to:

- open a new non-specific symptom pathway to give an effective referral pathway for people who do not fit clearly into a single 'urgent cancer' referral pathway but who are nonetheless at risk of being diagnosed with cancer. We plan for this to be in place by the end of June 2024
- support the delivery of NHS-wide early diagnosis programmes by implementing targeted lung health checks for our communities. This will proactively screen

people using a dedicated mobile CT scanner to detect and diagnose lung cancers at an earlier stage. We hope to have this up and running by the summer.
- participate in the first phase of the national multi-cancer blood test programme which uses blood samples to screen for cancer. This is the cutting edge of cancer innovation and we hope to have this in place by September 2024.

Our planned care performance
We have worked hard to reduce long waiting times for planned outpatients and operations supported by a significant programme of quality improvements. We know that long waits for planned procedures or appointments have a significant impact on people's health and wellbeing and we are committed to continuing to drive this improvement further in 2024/25.

Our improvement programmes to address long waits and improve patient experience and outcomes include:
- offering more video and phone appointments, which frees up valuable clinic time for those who need face to face appointments
- working with other hospitals to make the best use of capacity across Devon – this means some people will be offered appointments at other hospitals if they can be seen sooner there than at Torbay Hospital
- investing in new facilities that will help us make better use of our space, our equipment and our staff time. We have built a new Acute Medicine Unit with 26 assessment spaces. We increased our endoscopy estate to facilitate greater capacity and reduce waiting times for diagnostic procedures. We have also completed the build of two additional theatres to reduce waiting times in both ophthalmology and our nationally recognised day surgery unit.

In March 2023, a total of 40,180 people were awaiting their first definitive treatment. However, by 31 March 2024, this number had decreased to 33,161, indicating a positive trend in reducing waiting times. Among these people, 27,921 are currently on an outpatient pathway, while 5,240 are awaiting a surgical procedure. Notably, the number of people waiting for more than 78 weeks has seen a significant improvement, now standing at less than 55 patients.

Throughout the year, we have upheld exemplary performance in our day surgery pathway. Nonetheless, we encountered some challenges during the construction phase of two new theatres, one of which is specifically dedicated to ophthalmology. These theatres became operational in February 2024, effectively enhancing the overall capacity of our theatres and facilitating earlier treatment for our population.

During the year we continued utilising the Nightingale Hospital Exeter to accommodate people who were waiting for orthopaedic and ophthalmology surgery. Additionally, later in the year, we leveraged the centre for eye excellence in Exeter to increase diagnostic capacity for patients. These are all part of the One Devon Elective Pilot. Outpatient care has been consistently delivered through both virtual and face-to-face settings, with weekend clinics implemented to further improve waiting times.

Our focus for the next twelve months remains on reducing waiting times, aiming to achieve three stages of recovery. No one wating more than 78 weeks by 30 June

2024, no one waiting more than 65 weeks by 30 September 2024 and no one waiting more than 52 weeks by 31 March 2025.

Our community services performance
Our community services progressed a range of quality initiatives during the year some of which included the following:

Lower Limb Therapy Service (LLTS): chronic venous leg ulceration (VLU) affects around one in 500 people in the UK and for patients over 80. This rises to one in 80 (NHS England). VLU's are caused by chronic venous insufficiency and are a major cause of morbidity and health-related inequality, with patients experiencing a repeated cycle of ulceration, healing, and recurrence. Leg ulcers are painful, restrict mobility, reduce self-care and can lead to social isolation for sufferers.

LLTS treats on average 340 patients in clinics improving VLU healing rates from 28 weeks to an average of just 12 weeks. A reduction in healing times ensures patients can return to life pre-ulceration: engage in activities and regain their quality of life. For us as an organisation, as well as delivering our vision of better health and care for all, this significantly reduces the financial burden associated with treatment, to ensure cost effective care is delivered safely and is sustainable for all our patients.

We have achieved these significant positive results for those in our care by developing a cohesive specialist nursing service delivering evidence based, standardised, and high-quality treatment. The well leg service and our social prescriber support each individual to maintain a healed limb, regain levels of activity, and rebuild self-confidence. Our goals and objectives are aligned with NHS England, the national wound care strategy programme to improve healing rates, reduce recurrence rates and the burden of leg ulcer care for all our patients.

Homeless wound care clinic: the homeless wound care clinic was set up at the Leonard Stocks Hostel in Torquay three years ago. It is a drop-in clinic for hostel residents, street homeless and vulnerably housed people with or without an addiction issue. Providing healthcare within this environment encourages people to engage with health professionals and reduce unnecessary admissions to hospital by identifying infections, etc, at an early treatable stage. Support is also given when people are admitted to hospital to better ensure compliance with treatment and prevent early self-discharges, improving people's experience and outcomes.

Trusted assessors: the introduction of two trusted assessors has improved people's experience and quality relating to discharge to care homes. Our trusted assessors have built up relationships with care homes in our localities which has resulted in them feeling confident in the assessments provided. It has developed further in that care homes are, at times, using our trusted assessors to provide an assessment to prevent any delays in assessment and acceptance. As a result, confidence in discharges to care homes has improved and people's experience has been enhanced. Given the success achieved, this this has been funded to continue.

Occupational therapy in-reach service: this initiative has allowed people to be reviewed prior to discharge from hospital to ensure they are on the correct pathway and will receive the right support on when they leave hospital. The impact has been

reduced length of stay, reduced deconditioning and better outcomes and experience for people leaving hospital.

Children and Family Health Devon: the service continues to strive towards a fully integrated clinical pathway of mental and physical health care. A major area of focus has been improving people's experience of our service, with the development of a new website, containing extensive information and useful resource for professionals, young people and families seeking support with health challenges. The referral process has also been simplified with an easily accessible form on the website.

A Devon County Council supported waiting list pilot project was successful in reducing the speech and language therapy waits by 69% by reviewing over 1,800 patients and cutting waiting times by 31%. We are now adopting some of these successful approaches in addressing long waits across the county.

The roll-out of the all-age first response service (now incorporating crisis response to children and young people out of hours) was consolidated and has been successful in establishing a platform for the exploration of an all age 111 mental health option for people with a mental health crisis need.

Our mental health support in school team were innovative in conjunction with BfB lab, in using therapeutic digital interventions- Lumi Nova (NICE guidelines) for primary age students. This was nominated as a finalist in the National Academic Health Science Network innovate awards, in the 'innovation helping address health inequalities' category. The assertive outreach team continue to ensure children and young people at risk of admission are looked after at home as much as possible, maintaining the lowest admission rate in the southwest region.

We have been successful in achieving a number of our quality priorities for the year, namely the appointment of a dedicated governance and quality lead, development of a learning from experience process, implementing a strong quality governance process and increasing our research activities. We have actively embraced participation by embedding young people and parents into many of our processes and creating participation champions role. Our newly created expert by experience group is co-chaired by a parent.

Our adults social care performance

Our adult social care improvement and transformation plan launched with a discovery phase into how we work to meet the needs of our communities. This gave us significant insights and opportunities for our joint and integrated partnership between the local authority and the NHS.

We continue to focus our efforts on high-impact areas, strengthening the community front-door and maximise the effectiveness of our reablement offers through our transformation efforts. We have worked to improve our offer to working age adults which became a key piece of work resulting in The Big Plan for people with learning disabilities.

A key area for development in our adult social care improvement plan has been our need to improvement contract and market management. For adult social care services in Torbay, effective contract management is paramount to mitigating risks, optimising relationships with care providers and ensuring compliance with regulatory requirements – good contract management supports safe care for our community.

The approach to adult social care in Torbay means we focus on ensuring we optimise the use of available resources and always take a strengths-based approach to adult social care assessments. Over the course of 2023/24 we committed to deliver £2.7M (in year) of savings through improvements and we delivered 103% of the target and while doing so ensured that our approach was strength-based and outcome focused.

Core indicators

In addition to reporting performance against the statutory indicators for regularly assessment a range of further quality indicators are reported to our Board of Directors.

Other national and local indicators	Quality indicator	Target2023/24	2023/24	2022/23	2021/22	2020/21	2019/20
Did Not Attend (DNA) rate	Effectiveness	5%	4.8%*	5.2%	5.6%	5.1%	5.1%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	77.4%*	57.5%	54.8%	77.3%	90.2%
Two-hour urgent community response	Effectiveness	70%	96.8%*	80%			
Mixed sex accommodation breaches of standard	Experience	0	42*	0	0	0	0
52-week referral to treatment incomplete pathways year end position	Experience	0	1817*	4427	3,199	2,049	53
Cancelled operations on the day of surgery	Experience	<0.8%	1.3%*	1.5%	1.5%	1.5%	1.3%
Never events	Safety	0	0*	3	0	4	2
Cancer 28-day Faster Diagnosis	Effectiveness	75%	78.4%*	70.7%	67.6%	75.6%	74%
Diagnostic waits greater than six weeks	Effectiveness	15%	21.3%*	31.2%	34.8%	42.1%	11.5%
Fractured neck of femur – time to theatre	Effectiveness	90%	76.9%*	57.7%	75.7%	78.8%	80%

* March 2024 position

Performance plans for 2024/25
We have submitted performance plans that meet the requirements of the Operating Framework for 2024/25. These plans are reliant on securing clinical capacity to meet the predicted demand across elective and emergency care.

The funding required to achieve this includes use of the Elective Services Recovery Funding (ESRF) and additional income gained from activity levels delivered above 103% of our 2019/20 baseline.

In 2024/25 we will benefit from increased theatre capacity (additional day case theatres completed in February 2023), new rooms for endoscopy (completed in November 2023) and the Community Diagnostics Centre which is due to open in Autumn 2024.

The key operational performance targets are:
- referral for treatment waiting times with no one waiting over 65 weeks by September 2024 and 52-week waits by March 2025
- reduce patient delays in the urgent and emergency care setting to achieve 78% of people seen within four hours
- improve diagnostic waits so 95% of people wait less than six weeks by March 2025
- meet the cancer standards for faster diagnosis (28 days) 77% and treatment within 62 days from urgent referral 70%.

SUS and DQIPS
We submitted records during 2023/24 to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number for inpatients is shown in the chart below:

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Admin Category (On Admiss)	98,296	0	0	100.0%	99.8%	99.9%	99.9%
Admin Method (Hosp Prov Spell)	98,296	0	0	100.0%	100.0%	100.0%	100.0%
Commissioner	98,296	0	2,217	97.7%	99.5%	99.8%	99.4%
Consultant	98,296	0	0	100.0%	48.0%	83.3%	96.7%
Disch Ready Date (Hosp Prov Spell)	81,499	81,499	0	0.0%	23.4%	11.8%	19.3%
Discharge Dest (Hosp Prov Spell)	81,499	0	0	100.0%	100.0%	100.0%	100.0%
Discharge Meth (Hosp Prov Spell)	81,499	0	0	100.0%	100.0%	100.0%	100.0%
Ethnic Category	98,296	0	1,392	98.6%	95.6%	92.9%	94.9%
Main Specialty	98,296	0	0	100.0%	100.0%	99.8%	99.8%
NHS No Status Indicator	98,296	0	6	100.0%	99.7%	98.4%	99.7%
NHS Number	98,296	158	0	99.8%	99.7%	99.8%	99.7%
Org of Residence	98,296	0	663	99.3%	99.8%	99.0%	96.4%
Patient Classification	98,296	0	0	100.0%	100.0%	100.0%	100.0%
Patient Pathway	26,298	85	0	99.7%	95.5%	66.8%	70.1%
Person Birth Date	98,296	5	0	100.0%	100.0%	100.0%	99.8%
Person Gender	98,296	0	0	100.0%	100.0%	100.0%	100.0%
Postcode	98,296	5	181	99.8%	99.9%	99.9%	99.9%
Primary Diagnosis	98,132	1,488	0	98.5%	89.3%	93.5%	95.5%
Primary Procedure	98,132	0	0	100.0%	99.9%	99.9%	99.9%
Registered GP Practice	98,296	0	1,324	98.7%	99.3%	98.9%	99.7%
Site Code of Treatment	98,296	0	0	100.0%	94.8%	98.1%	96.9%
Treatment Function	98,296	0	0	100.0%	100.0%	99.9%	99.8%
Overall	**2,039,795**	**83,240**	**5,783**	**95.6%**	**93.4%**	**94.2%**	**95.3%**

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Admin Category	444,104	0	0	100.0%	91.6%	85.1%	97.9%
Attendance Indicator	444,104	0	0	100.0%	100.0%	98.8%	99.6%
Attendance Outcome	422,267	0	0	100.0%	99.9%	85.1%	95.6%
Commissioner	444,104	0	13,564	96.9%	99.5%	99.8%	98.9%
Consultant	444,104	25	0	100.0%	40.2%	69.6%	86.6%
Ethnic Category	444,104	0	5,331	98.8%	95.2%	82.7%	91.2%
First Attendance	444,104	0	0	100.0%	100.0%	99.4%	99.8%
Main Specialty	444,104	2,599	0	99.4%	99.7%	98.0%	99.0%
NHS No Status Indicator	444,104	0	0	100.0%	99.8%	99.8%	99.9%
NHS Number	444,104	142	0	100.0%	99.8%	99.9%	99.7%
Org of Residence	444,104	0	435	99.9%	99.9%	98.7%	95.4%
Patient Pathway	436,168	2,671	0	99.4%	75.5%	66.2%	66.8%
Person Birth Date	444,104	0	0	100.0%	100.0%	100.0%	99.7%
Person Gender	444,104	0	0	100.0%	100.0%	100.0%	100.0%
Postcode	444,104	0	724	99.8%	99.9%	99.9%	99.9%
Primary Procedure	422,267	0	338	99.9%	99.9%	99.6%	99.5%
Priority Type	444,104	0	0	100.0%	76.8%	81.2%	93.1%
Referral Received Date	444,104	153,584	0	65.4%	71.2%	80.9%	94.0%
Referral Source	444,104	0	0	100.0%	76.8%	83.4%	96.3%
Registered GP Practice	444,104	0	7,034	98.4%	99.5%	99.7%	99.5%
Site Code of Treatment	444,104	0	0	100.0%	96.1%	91.1%	96.1%
Treatment Function	444,104	0	0	100.0%	100.0%	98.1%	99.0%
Overall	**9,718,678**	**159,021**	**27,426**	**98.1%**	**91.8%**	**91.7%**	**95.8%**

The percentage of records in the published data which included the patient's valid general medical practice code was:

- for admitted patient care – 98.7%
- for outpatient care – 98.4%

The data security and protection toolkit is an online self-assessment tool that allows organisations to measure their performance against the national data guardian's ten data security standards. All standards were met in 2023/24.

Clinical audit
The reports of 30 national clinical audits were reviewed by us between 01 April 2023 and 31 March 2024. See Annex 5 for the actions we intend to take to improve the quality of healthcare provided.

The reports of 24 local clinical audits were reviewed by us between 01 April 2023 and 31 March 2024. See Annex 5 for the actions we intend to take to improve the quality of healthcare provided.

Clinical coding performance
We have not been in receipt of a payment by results clinical coding audit by the Audit Commission. Instead, an annual data security protection toolkit audit of clinical coding has been completed. The audit was completed by an NHS Digital approved auditor.

Data security and protection toolkit (DSPT) audit results are:

Primary Diagnosis (% correct)	Secondary Diagnosis (% correct)	Primary Procedure (% correct)	Secondary Procedure (% correct)
97.09	91.68	94.08	93.01

Part 3: Our quality indicators

Patient safety

During 2023/4 year we made progress against our patient safety strategy in the following areas:

- transitioned from the serious incident framework (SIF) to the patient safety incident response framework (PSIRF) in February 2024. Our patient safety incident response plan is available on our intranet and externally for members of the public to review
- transferred to the new Risk Management System (RMS) Datix Cloud IQ which enabled us to report safety events and examples of good practice nationally to the national Learning from Patient Safety Event (LfPSE) system
- continued to focus on our ambition to roll out and embed a just learning culture, this work will continue to be prioritised in the coming year supported by our peoples and patient safety teams
- recruited two volunteer patient safety partners to support us to ensure that the voices of patients are central to patient safety reviews and investigations
- reviewed our governance structure to ensure clearer channels of communication and oversight regarding patient safety and quality improvement
- sought feedback from people who use our services to recognise and reward our people through the continued roll out the Daisy and Primrose awards and introduced our Allied Health Professionals, SAS doctor and junior doctor awards
- continued to champion the use of quality boards as a visual tool which displays our progress against quality improvement priorities in clinical areas to provide both focus and a way to recognise achievement.
- supported all our staff to complete the national patient safety syllabus training at level one via our central learning system (HIVE) to further embed our safety culture. Our Board and leadership team are working towards completion of the essentials for patient safety training for boards and senior leadership teams.

Learning from National Reports

Following the findings of the Fuller enquiry which identified failings within an NHS organisation we have caried out a gap analysis to identify any areas where we may have risks. Following this we created and implemented an action plan and have completed all of the actions on that plan which include installation of additional CCTV as well as tightening security access for staff members and reviewing access on a weekly basis via audit. These actions are embedded to protect the safety and dignity of our patients. Our viewing room has been refurbished to ensure a more improved environment for relatives to view their loved ones in.

We have responded to the Thirlwall enquiry and request for evidence, this request was sent to every hospital with a neonatal unit. Our chief medical officer submitted our response to the enquiry.

We have responded to two direct requests from infected blood enquiry.

Our patient safety ambitions for 2024/25

We will continue our work embed the national patient safety strategy into policy and practice. We will continue our work to ensure a positive safety culture, central to this work will be the just learning culture workstream which will be led by the

people directorate team and supported by our patient safety leads.

We will prioritise the National Safety Standards for Invasive Procedures (NatSSIPs) 2 which was released in 2023. These national standards cover all invasive procedures including those performed outside of the operating department. This approach aligns with the aims of the Patient Safety Strategy (2019) and the Patient Safety Incident Response Framework (PSIRF, 2022). We will establish a task and finish group to lead the introduction of NatSSIPs 2 and develop both the detailed workplan and measurable outcomes for this quality priority. This work will be overseen by the Patient Safety Group.

We will:

- continue to embed our transition to PSIRF with a focus on systemic and human factors to capture impactful learning
- recognise that meaningful learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. We are committed to rolling out our just learning culture programme which will be supported by compassionate leadership training for our colleagues
- strengthen our commitment to ensure that we prioritise compassionate engagement, involvement and support for those affected by patient safety incidents (both patients and staff) throughout any patient safety review or investigation
- continue to provide training to all colleagues on patient safety to support our safety culture
- continue to develop our expert patient safety incident investigators to conduct patient safety incident investigations (PSII). We will ongoingly review this resource to ensure we have the appropriate level of safety investor resource in line with PSIRF guidance
- encourage staff to capture examples of good care and to share via our safety and quality systems
- share learning from safety reviews, investigations and examples of good practice to promote learning and a positive patient safety culture
- ensure that feedback from patient complaints is captured as valuable insight to inform a proactive safety culture and our patient safety incident response plan
- participate in the national programme to implement Martha's Rule to ensure patients, families and colleagues 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
- Engage with our information team to support our electronic patient record project (EPR) to ensure that patient safety is central to decision making.
- We will continue to remain responsive to any national reports, guidance or enquiry.

Freedom To Speak Up (FTSU)

One of the recommendations made by Sir Robert Francis in the Mid Staffordshire NHS Foundation Trust Public Enquiry, was for every NHS trust to appoint a Freedom to Speak Up Guardian (FTSUG). During 2020 we appointed a dedicated FTSUG. The appointment of the dedicated guardian has resulted in a consistent service being provided to any member of staff who speaks up.

Guardians act in a genuinely independent and impartial capacity to support staff who raise any concerns. The FTSUG, reports directly to the Executive Lead for Speaking Up and has regular access to the Chief Executive, Chair and Lead Governor as required. The FTSUG reports directly to the Board of Directors formally twice a year.

The guardian also works alongside the senior leadership team, employee relations team and local Trade Unions to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged to speak up. The FTSUG completes and submits regular data reports to the National Freedom to Speak Up Guardians Office on a quarterly basis.

We have one full time Freedom to Speak Up Guardian, which is consistent with other organisations in the region. There has been an increase in the number of concerns being raised, with further support for the role being considered by the board. There is a process for confidentially logging cases and conversation had with the Freedom to Speak up Guardian and staff can also anonymously speak up through an electronic communication platform. The FTSU Guardian reports to the Board every six months with numbers of cases and themes. Between May 2023 and November 2023 there has been 82 cases, 35 of which related to bullying and harassment, 17 failure to follow process, four patient safety, six staff safety, 16 culture of organisation, three diversity and inclusion and one fraud.

Themes from the conversations colleagues have had with the Freedom to Speak Up Guardian included:

- poor professional behaviours
- breakdown in working relationships
- bullying and harassment including sexual harassment.

A regular theme was managers lacking interest or capacity in trying to find an early resolution and ignoring the problem rather than addressing it. There were pockets of racism and discrimination reported which were not always well managed with no solution or learning. Lack of resolution often led to formal complaints and grievances which were not always followed or completed in a timely way.

Failure to follow processes related to recruitment, culture of the organisation related to having a lack of flexibility and wellbeing support in place for teams. Patient safety concerns related to inconsistences in investigating patient deaths and competency of some international staff. Diversity and inclusion concerns related to lack of support for reasonable adjustments in the workplace and support for flexible working.

Many colleagues speak to the Guardian in confidence to help make sense of what they are feeling and experiencing, or to share anxieties in their working lives that is impacting on them being able to do the best they can in their work.

The Freedom to Speak Up role must be proactive in raising awareness but reactive to colleagues coming forward to speak up. Greater visibility within all sites and major departments is needed to share information about the service and how the Guardian can be accessed. If additional resource is identified in 2024/2025 then this work together with an enhanced speaking up procedure and signposting for support in

speaking up and how managers respond will help to make speaking up business as usual. Our ambition is to continue to support staff to speak up and we will continue to promote the freedom to speak up guardian role to support this important agenda.

Patient experience
The number of complaints received since 01 April 2023 to date stands at 140; this is lower than the same period last year by 29 complaints which equates a 17% decrease. The numbers received are consistently below the lower control limit (13) with an average of 11 a month. This has remained so since the beginning of the 2023/24 financial year. For the month of March 24, nine complaints were received.

Concerns received in March 2024 decreased by 23% compared to February 2024, from 147 in February to 113 in March. However, quarter four has seen an overall increase in concerns received compared to quarter three.

We achieved 66% compliance with three-day acknowledgment on receipt of complaints in March 2024 (an increase on February which was the first month it dropped below 100% to 45%). We achieved 88% compliance [average] with three-day acknowledgement on receipt of complaints in the financial year 2023/24.

The largest number of reported complaints and concerns this year relate to the surgical division. The themes identified relate to longest waits, treatment delays and timeliness of appointments with the top three themes being:
- communication
- effectiveness
- attitude of staff.

In response to these themes, we have:
- continued to monitor performance and we planned reductions for time to surgery is to be less than 62 weeks by spring 2024
- increased theatre activity by outsourcing some planned care using external NHS approved external contracted providers to support reducing waiting times, for example (Endoscopy Mobile unit on the Annex site, service delivered by external company, OPD clinics in some specialties using external companies to run additional clinics. We have also invested in new builds to improve capacity (Endoscopy/Day Surgery)
- written patients where there are long waits to offer support and to signpost should the condition deteriorate.
- supported staff to attend our compassionate leadership training to further support staff engagement and improve communication with patients and families, for example when managing conversations regarding long waits.

Our Associate Directors of Nursing and Professional Practice (ADNPPs) have been working hard with their teams regarding closing of complaints and this is reflected in the last 12 months where seven months have seen greater numbers closed than received.

By 31 March 2024 there were 60 complaints that remained active/ongoing. The largest proportion of these are with Surgery, Urgent and Emergency and Medicine.

This is reflected of the areas who receive the most complaints which are related to waits in Emergency Department, time to surgery and access to outpatients.

Patient and community engagement
Our communications and engagement team works in partnership with the feedback and engagement team and the membership office to ensure that there are sufficient and robust mechanisms in place to inform the public about, and involve them in, our work.

Together we are committed to ensuring that patients, carers, staff and the public are listened to and have the opportunity to feedback on their experiences while also raising concerns and asking questions about any of our current and future activities. We work closely with our partners in the Integrated Care System for Devon (ICSD) and any formal consultation is led by the ICSD with our support and involvement as appropriate.

Our engagement and communications strategy aims to support meaningful conversations with our people and communities while our patient and service user experience of healthcare strategy helps us to hear and learn better from patient and carer experience.

This year we have established our Teignmouth community stakeholder engagement group to agree how we involve Teignmouth communities in any plan around the future of the community hospital site, began the process to pilot a Youth Forum and Parent and Carers Forum (launching in April 2024), undertook engagement with children, young people and families on new branding and a new website for Children and Family Health Devon and worked in partnership with Torbay Council on user engagement to review the adult social care webpages and information.

We have also undertaken engagement with families receiving care in paediatric settings to find out about their experiences of accessing urgent care for their child as part of the work of the Peninsula Acute Provider Collaborative and supported engagement undertaken by Healthwatch to facilitate a series of focus groups to enable us to find out about people’s experiences of acute medical services.

In May, we supported the NHS Assembly's NHS@75 conversations with our people – across the country more than 700 conversations took place not only in health organisations but with patient groups, charities and partners in health and social care. Here in Torbay and South Devon we held a number of focus groups with colleagues from different professions and services and asked seven questions about the NHS' past, present and future. Ahead of the NHS' 75th birthday, the NHS Assembly published an independent report based on the conversations and the findings.

We have undertaken an accessibility audit on our website and we have made improvements to ensure compliance with the government’s web contact accessibility guidelines (WCAG 2.1).

A number of settings exist that allow the Board of Directors, Executive Directors and staff at all levels to communicate with key stakeholders, including formal Board to

Board and Executive to Executive meetings with local commissioners, local health and care providers, Health and Wellbeing Boards, Health Overview and Scrutiny Committees with our local authorities and regular meetings with local MPs and Healthwatch. We also have a growing number of patient and public engagement groups across our services which support us to listen to and learn from our people and communities, including our friends of Torbay and South Devon group (for our eight League of Friends and Torbay Hospital Nurses League), our coastal engagement group and the experts by experience group in Children and Family Health Devon.

These forums, supported by our other communications, engagement and feedback channels, provide a mechanism for any risks identified by stakeholders that affect us to be discussed for any action plans to be developed.

Early in 2024/25 we will launch our pilot Youth Forum for young people aged 13-20 with experience of using our acute paediatric inpatient and outpatient services and our paediatric emergency department. This pilot is being delivered in partnership with Young Devon. A similar pilot is due to launch for a Parent and Carer Forum for family members and guardians or carers of children and young people who use the above services. This pilot is being delivered in partnership with Parental Minds. Both aim to help us hear the voices and experiences of children, young people and their families better and work together to improve our services and their experience.

Clinical effectiveness

Over 2023/24 we have been working hard on a redesign of our mortality processes. This will ensure consistent and robust management of our mortality cases and embed these processes across our organisation and ensures that we are learning from any deaths that occur during our care. The new processes will link mortality cases from review by the Medical Examiners, through clinically led structured judgement reviews to more formal investigations and mortality and morbidity processes. This process will be held and monitored centrally by the patient safety team.

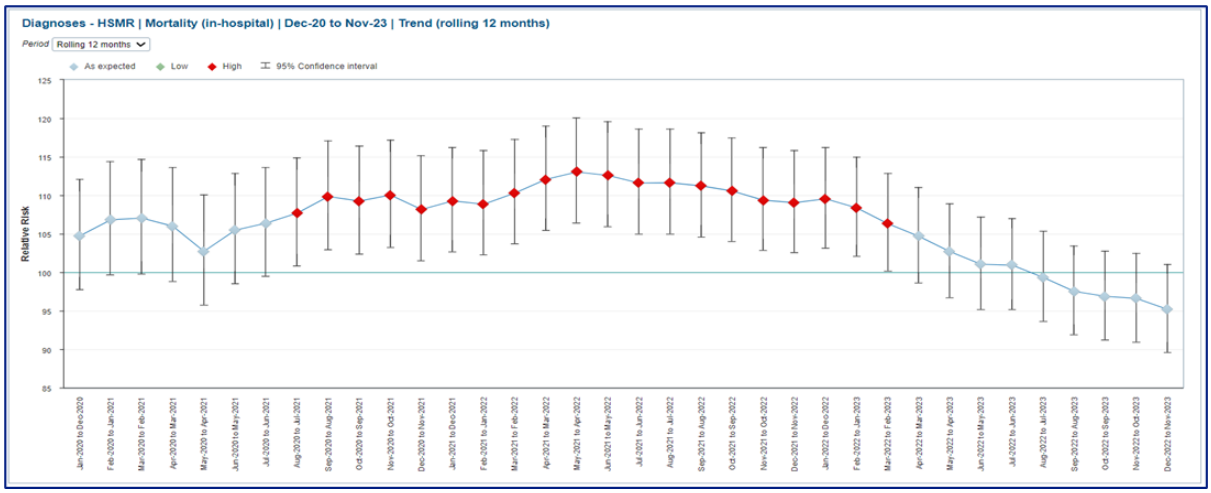
Mortality is reviewed each month by a multi-disciplinary team at our mortality surveillance group. A mortality scorecard is also presented to the Board of Directors bimonthly by the Chief Medical Officer.

We use analysis by Telstra (Dr Foster) to process hospital episode statistics (HES) data directly from NHS Digital to inform the monthly mortality review. The Hospital Standardised Mortality ratio (HSMR) is measured from the mortality arising from a standardised ‘basket’ of 56 diagnoses and includes all inpatient admissions for a rolling 12-month period and is benchmarked against other providers both nationally and locally.

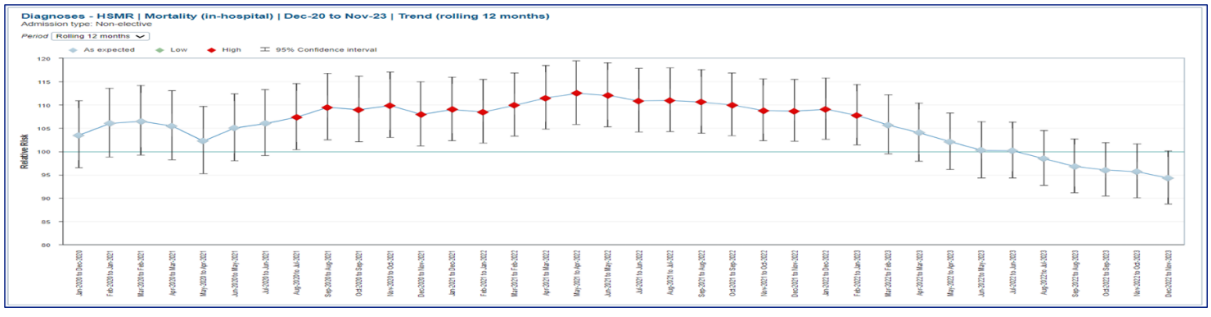
The current HSMR is 95.2 (89.6-101) - this is within the statistically expected range of mortality compared to hospital trusts nationally. Our current SHMI (Summary Hospital Level Mortality Indicator) is similarly within the expected range at 100.4 when compared to other trusts nationally.

Historically we were flagging as having an excess of deaths on our HSMR from July 2021 until February 2023. During 2023 we have undertaken a programme of work to understand the pattern of excess deaths which encompassed a review of coding, comorbidity and a robust review and analysis of clinical alerts, process and areas of increased mortality. It has been previously noted that we serve a population with an older demographic, high levels of comorbidity and high levels of social deprivation. All of these factors can impact on mortality statistics and it is vital that we continue to ensure that these are accurately captured going forward.

We are now demonstrating steady improvement with the HSMR below the benchmark for the last five data period as seen in the chart below.



In 2022 our patient safety team investigated 30-day mortality in patients admitted as an emergency comparing October 2019 figures with those in October 2022. Elderly and frail emergency patients appeared particularly sensitive to the adverse effects of waiting for a definitive in-patient bed. This work was repeated in October 2023 and showed a reduction in the mortality of emergency patients facing long waits for a hospital bed when compared to the previous year. This reduction is likely the result of work to improve admission alternatives, ongoing work on virtual wards and support for patients in the community and also initiatives to ensure that waits for elderly and frail patients for a hospital bed are, wherever possible, minimised. Our non-elective HSMR also demonstrates this improvement.



Coding for palliative care deaths for 2023/24 was 5.85%. This is an increase on previous years.

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2020/2021	10,317	392	3.80%	5.03%	4.51%
2021/2022	15,830	760	4.80%	4.92%	4.66%
2022/2023	16,331	946	5.79%	5.07%	4.83%
2023/2024	13,520	791	5.85%	4.96%	4.62%

While these statistics demonstrate an improvement, it is acknowledged that there is still room for improvement particularly in the elderly and frail sub-group of patients.

The Medical Examiner (ME) service

Medical Examiners continue to provide scrutiny of inpatient deaths in the acute and community hospitals. If any concerns are raised or potential leaning is identified the Medical Examiners refer this to us by raising an incident which is investigated in line with our policy.

Number of acute and community hospital deaths	Number of deaths reviewed by Medical Examiners	Number of deaths referred to HMC	Number of HMC investigations / inquest	Number of incidents raised for review
1,413	1,395	240	132	32

The learning disabilities mortality review (LeDeR) programme requires an independent case review following the deaths of people with learning disabilities. All deaths involving patients with a learning disability are reviewed through the LeDeR process. In 2023 created a new LeDeR process which established closer interaction monthly with the regional LeDeR team. In addition, due to the complex nature of LeDeR reviews take time to complete, we introduced Structured Judgement Reviews (SJR) for all patients with Learning Disabilities and / or autism who died in hospital to ascertain any learning at the earliest point possible.

Summary of LeDer referrals 2023/24

Location of death	**Number of deaths meeting LeDeR criteria**	**Structured judgement review (SJR) undertaken**	**LeDeR Reviews undertaken – closed with outcomes and learning provided**	**Awaiting LeDeR review outcomes**
Community	2	0	1	1
Hospital	14	13	0	14

The LeDeR review resulting in an outcome identified no lapses in care or learning.

The SJR's indicated 11 cases had no evidence of avoidability and two cases with slight evidence of avoidability. There were related to complex discharge planning and delay in receiving medication.

All 13 cases were recorded as receiving either adequate, good or excellent care with good family / carer involvement, speciality input from the Learning Disability Team and appropriate escalation of treatments and the involvement of palliative care.

National standards
This performance overview provides information about how we have performed against agreed operational planning objectives during the year.

We continue to work to recover from the pandemic and have seen a sustained improvement in planned care waiting times for our longest wait patients. Across urgent and emergency care performance, patient flow and bed capacity remained the main operational challenge and frequently having our emergency department and assessment units at full capacity. The four-hour standard and ambulance handover delays did not meet planned levels of performance.

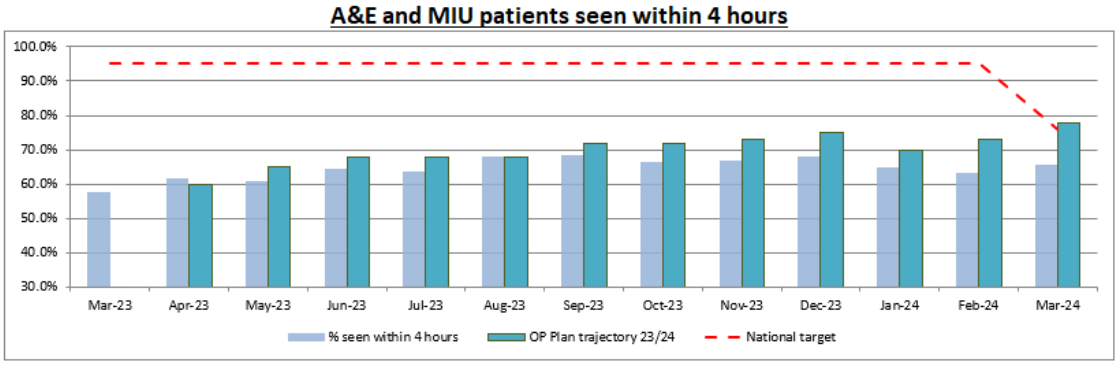
Along with other providers in Devon, we continue to comply with NHS England Tier 1 performance reporting for planned and urgent and emergency care. Tier 1 being the highest level of regulatory performance oversight. We are no longer in Tier 1 for cancer care.

The key performance indicators for 2023/24 are shown below:

	Target March 2024	Apr-23	Jun-23	Sep-23	Dec-23	Mar-24	Operational Plan trajectory March 2024
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA							
Urgent and Emergency Care							
Ambulance handovers - time lost over 15 mins - Actual (hours)	1110	796	1569	2579	2141	3667	1110
Percentage of Ambulance handovers greater than 3 hours		2.7%	7.5%	14.7%	12.5%	20.0%	Reduction
Total average time in ED (hours/minutes)		05:57	06:20	05:46	05:44	06:33	Reduction
ED attendances where visit time over 12 hours	0	568	797	686	622	844	Reduction
UEC 4-hour target (RAG against local trajectory to national target)	76%	61.7%	64.6%	68.4%	68.0%	65.7%	78%
% patient discharges pre-noon	33%	18.9%	19.9%	21.5%	23.7%	24.0%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	7.6%	7.0%	7.4%	6.4%	4.8%	5.0%
Elective recovery							
RTT 104 week wait incomplete pathway	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	166	123	187	165	58	0
RTT 65 week wait incomplete pathway	0	1244	1196	1161	840	470	0
RTT 52 week wait incomplete pathway	Reduction	4024	3938	3471	2258	1817	Reduction
Patient waits over 2.5 years	0	0	0	0	0	0	0
75% of GP referred patients diagnosed within 28 days	75%	75.0%	78.1%	77.8%	77.0%	78.4%	75%
Number of patients waiting longer than 62 days for treatment	138	107	100	105	158	83	138

2023/24 RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

Four-hour emergency department (ED) waiting times



Performance against the four-hour standard in our ED in 2023/24 has continued to reflect the challenges of capacity and managing daily patient flow. Long waits have continued to be experienced and ambulance handover delays have also been high due to the department, at times, reaching capacity.

Community Urgent Care - Urgent Treatment Centre (UTC) and Minor Injuries Unit (MIU) performance remains consistently above 99%.

Improving patient flow through our organisation is key to support ED waiting times and capacity. Effective discharge remains crucial in facilitating the timely return home or transfer to another care facility for our patients. We are meeting the target to have less than 5% of people in hospital with No Criteria to Reside. This is a significant achievement and reflects the work across the community to expedite the necessary step-down placements and packages of care to enable people to be discharged when no longer requiring the levels of care provided within the hospital setting.

Work continues to improve performance across the following areas to maintain patient flow:

- ensuring people with No Criteria to Reside are identified and discharge pathway in progress
- supporting people to get home from hospital before 12noon – Home for Lunch
- extending the Discharge Lounge hours
- utilising the Urgent Community Response resource to avoid admission
- the introduction of virtual ward pathways of care to support people to stay at home where we can safely do so, facilitate earlier discharge from hospital, and reduce admissions to ensure beds are available for those most in need on hospital care
- increase the number of Same Day Emergency Care (SDEC) discharges through the Acute Medical Unit and use of SDEC pathways
- streaming people to alternatives to our ED, for example, our Urgent Treatment Centre, Minor Injury Unit, pharmacies and self-care
- care co-ordination hub.

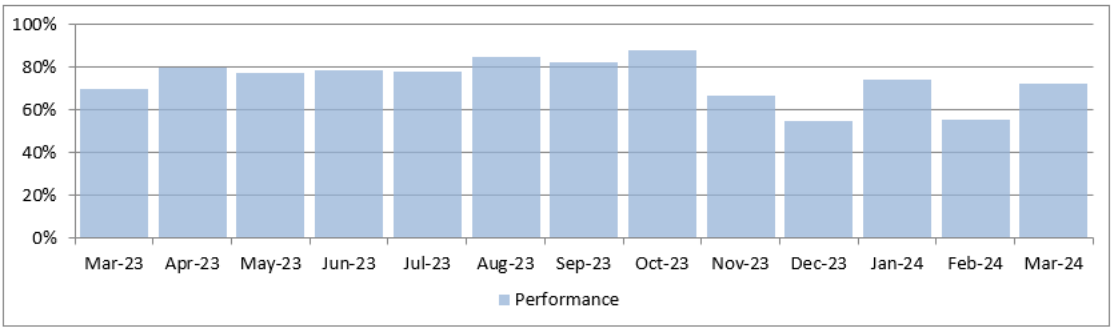
Ambulance handovers

Ambulance handover delays continue to be a challenge and the number of hours lost has increased over the year. Plans are in place as part of the wider ED performance recovery plan to facilitate increased handover capacity.

The plan for 2024/25 is to continue to build on the improvements around patient flow and length of stay to release bed capacity and improve flow from our ED and assessment unity that will reduce ambulance delays.

Percent of ambulance handovers over 15 minutes

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Performance	70%	80%	77%	78%	78%	84%	82%	88%	67%	55%	74%	55%	72%
Target	0	0	0	0	0	0	0	0	0	0	0	0	0

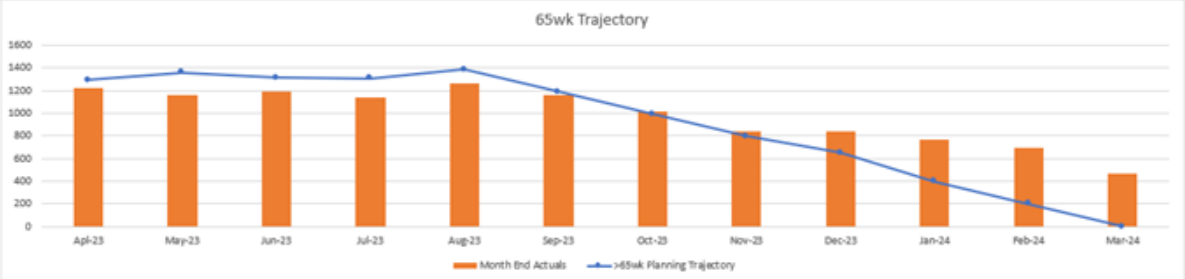


Referral to Treatment (RTT) access times

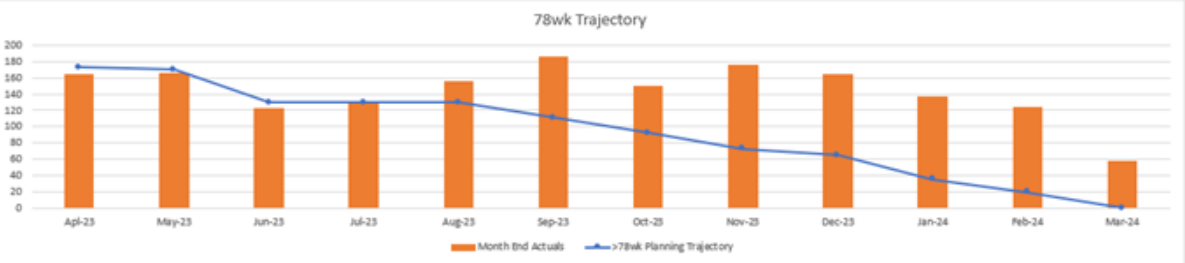
The number of people waiting for treatment decreased during the year with 33,483 patients waiting at the end of March 2024 for first definitive treatment, down from 40,060 in March 2023. We have no patients waiting over 104 weeks. We have not met the planned trajectory for people waiting 78 weeks and 65 weeks due to industrial action, however, the number of people waiting has continued to reduce.

The day surgery unit is a national exemplar for day case surgery completion rates and productivity. The additional eye theatre and day surgery unit theatre opened in February and will allow us to increase day case surgery capacity that, along with additional staffing, will see a continued reduction in waiting times.

	Apl-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
>65wk Planning Trajectory	1292	1362	1312	1307	1387	1189	991	793	650	397	199	0
Month End Actuals	1220	1163	1196	1136	1260	1161	1019	842	840	767	695	470
Revised FoT after Call to Action 08.12.2023 (does not inc. any Jan-24 IA impact)									823	766	628	489



	Apl-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
>78wk Planning Trajectory	173	170	130	130	130	111	92	73	65	35	19	0
Month End Actuals	165	166	123	129	156	187	151	176	165	138	125	58
Revised FOT after ask to resubmit Mar-24 final position with Feb-24 ia Impact										153	129	62



The operational plan for 2024/25 is to have no one waiting over 65 weeks for treatment by September 2024. These plans are supported by:

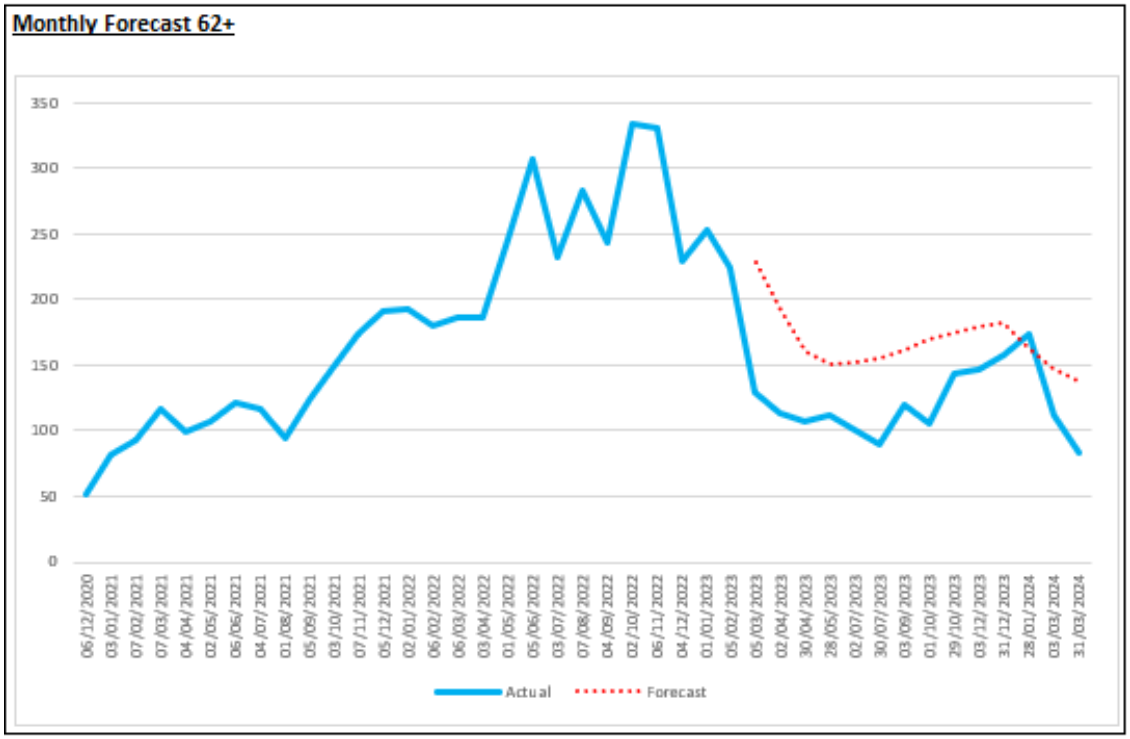
- delivering planned care productivity improvements across general theatres and outpatients
- utilising insourcing and outsourcing services to increase capacity in areas with greatest challenge
- opening of the community diagnostic centre to increase diagnostic capacity and reduce waiting times.

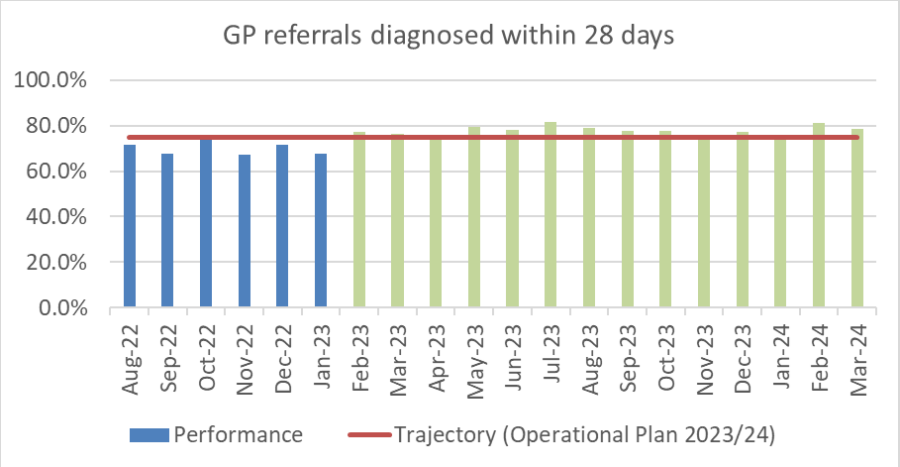
Cancer standards

We maintained our commitment to prioritise delivery of cancer treatments through periods of operational pressures and industrial action. In 2023/24 we met the cancer National Outcome Framework (NOF) exit criteria so is no longer required to be in the Tier 1 performance monitoring by NHS England.

March 2024 was the 14th consecutive month of achievement of the 28-day Faster Diagnosis Standard. This highlights our continued commitment to provide swift diagnosis for patients referred for suspected cancer and remains the focus of our efforts.

Number of people waiting longer than 62-days for cancer treatment:

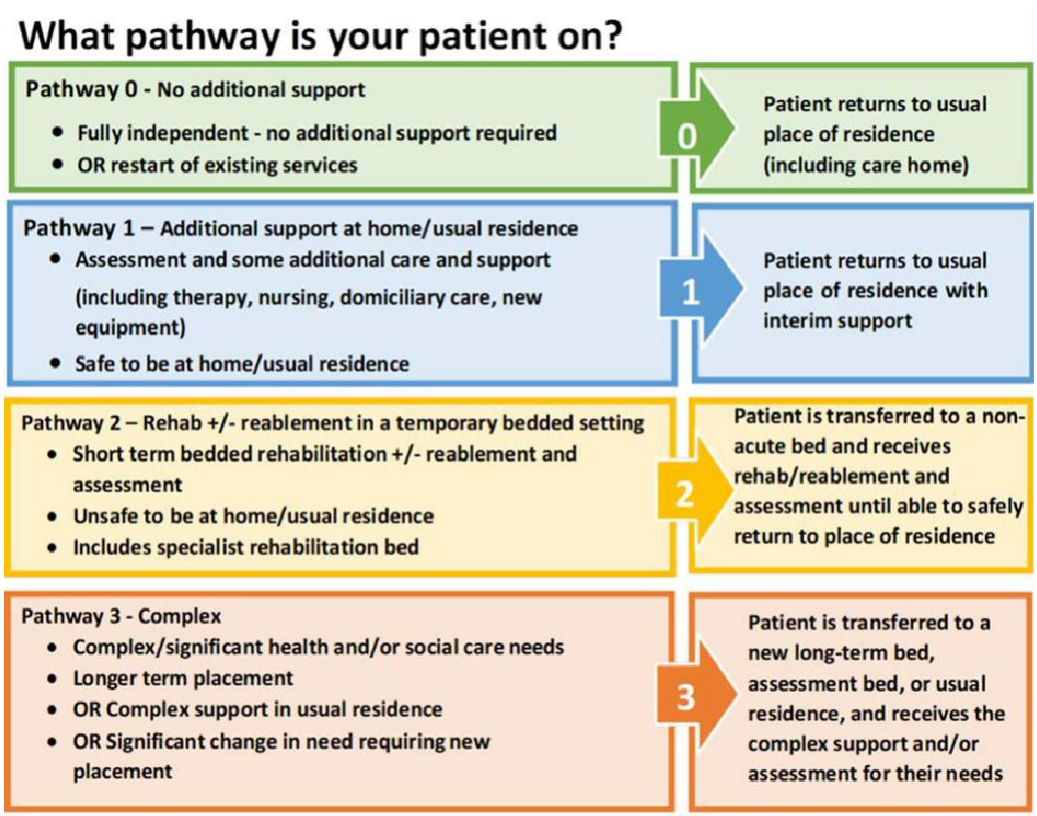




Equality of service delivery
We maintain our approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting people by telephone, as well as letter, to agree appointment dates and follow-up appointments when initial contact with people is unsuccessful. A rolling programme of clinical review and validation of longest waits is in place to identify and act as a safety net should a person's condition change or they fail to engage with offered appointments.

The Devon system is working together to ensure equitable waits are achieved and is supporting mutual aid across providers and access to the Nightingale Hospital Exeter as a system resource to support additional capacity for diagnostics, orthopaedic and ophthalmology treatments.

Complex pathway discharges
Pathways one to three are considered 'complex' as patients require support to enable a safe discharge. The total number of people discharged through pathways one to three has remained fairly consistent throughout most of the year.



Across the 12 months the following numbers of patients were discharged on pathways one to three (data Source E1004 Tableau Discharge Dashboard).

Pathway	% District general hospital (DGH)	Actual DGH	% Integrated care organisation (ICO)	Actual ICO
1	39.6%	1,916	44.4%	2,985
2	52.8%	2,553	49.2%	3,305
3	7.5%	364	6.2%	420

Average length of stay

The average length of stay (LOS) in 2023/24, on a rolling 12-month average, has decreased from 8.0 days in April 2023 to 7.1 days in March 2024. This remains higher than pre-covid levels of around 6 days, however, this is reflective of the national position. We are now again within the lowest quartile of trusts nationally for length of stay.

In 2024/25 reducing length of stay remains an ongoing key focus to support both elective and non-elective activity and as such has been recognised in improvement plans to target the longest stay patients with more frequent review and specifically centred on early morning discharge, discharges before 5pm, and at the weekend.

Stroke care

Patients presenting with suspected stroke require rapid assessment diagnostics and dedicated rehabilitation care. The sentinel stroke national audit programme (SSNAP)

measures the time critical processes of care provided across acute and community settings.

We did not meet the standards for the percentage of people admitted to a stroke unit within four-hours of arrival or the percentage of people spending 90% or more of their hospital stay on a dedicated stroke ward.

We have a stroke improvement plan to support patient outcomes and achievement of time critical standards. This plan is managed through the clinically led stroke governance meeting.

Maternity performance
Maternity assurance metrics are based on the required reporting as set out by NHS England Perinatal Quality Surveillance Model (2020) and Three- year Delivery Plan (2023)

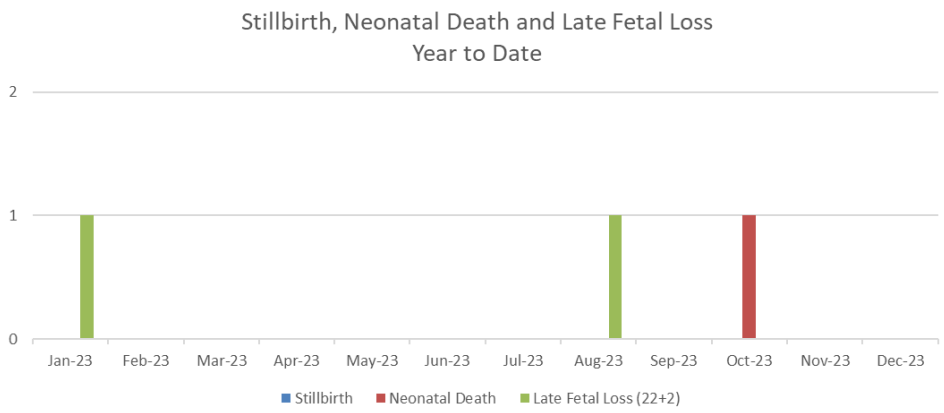
They are also based on the requirements set out in the maternity incentive scheme (MIS) as part of the clinical negligence scheme for trusts (CNST). A single Board reporting template is now in use for the maternity providers in Devon.

A monthly dashboard is produced which is monitored via our maternity governance and quality group. Metrics are shared via quality and safety assurance groups within the organisation. An integrated performance report is shared at the monthly Board of Directors meetings**.**

Birth rate
The number of births for 2023/24 was 1,760. This is a reduction from 2022/23 when it was 1,847 and reduction in birth rate is a national trend.

There continues to be an increasing complexity associated with pregnancy and birth due to several factors. These include demographics, health inequalities as well as being related to the standards that underpin safe care.

Perinatal mortality rate
The graph below shows the perinatal mortality detail for 2023/24. There were no stillbirths over 24 weeks in 2023. This compares to eight stillbirths in 2022/23. The service recorded two late fetal losses and one neonatal death in 2023/24.



Smoking rates
There has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically the SATOD data was 13-15%. With the introduction of the smoke-free pregnancy team this rate has dropped to 8.1% for the year 2023/24. This is below the national average of 8.6%.

Assurance and performance monitoring
Weekly assurance meetings are held with operational leads and the system care group directors reporting to the Chief Operating Officer.

These meetings are in addition to the monthly care group performance and accountability meetings with escalation to the Trust Management Group (TMG). The Board of Directors receives a monthly Chief Operating Officer report that highlights operational performance and actions being taken along with the Integrated Performance Report.

Annex 1: Statement of Directors' responsibilities for the Quality Account

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year.

The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

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

- the Quality Account presents a balanced picture of the organisation'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, is subject to appropriate scrutiny and review
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

Liz Davenport
Chief Executive

Date: 26 June 2024

Annex 2: Quality Account engagement

We presented a briefing on the draft quality account to our Council of Governors on 01 May 2024, providing an update on our progress against our four quality goals, sharing and discussing our revised quality goals and priorities, highlighting key priorities for our patient safety incident investigation for 2024/25 and putting the patient safety incident response framework in context within our quality and patient safety strategy.

The draft Quality Account was circulated to the organisations listed below for review and comment during the period commencing 22 May 2024 to 17 June 2024.

- Devon Integrated Care Board (ICB)
- Devon City Council Health Overview and Scrutiny Committee
- Torbay Council Health Overview and Scrutiny Committee
- Healthwatch Plymouth, Devon and Torbay

We would like to thank all of our external stakeholders for their review and all comments received have been included within Annex 3.

Annex 3: Statements from stakeholders and partners

Council of Governors

This year has continued to be a challenging one with the ongoing aftermath of the COVID pandemic and planning around the strikes by medical staff.

Some efficiency measures put in place during the pandemic have been retained as they were seen to improve the patient's experience and wellbeing.

While we appreciate these are challenging times, the Governors have been focused on holding the NEDs to account, with patient safety and wellbeing foremost in our minds.

Our Governor observers continue to sit in on key committee meetings, reporting back to the Council of Governors significant issues affecting quality of care and delivery of services.

The Council of Governors have agreed the quality goals and priorities meetings for 2024/25 with the focus on patient flow and waiting lists with key contributions from the Interim System Care Group Director and Cancer Services Manager.

The Trust has a strategic intent for their regain and renew plan which is:

- to deliver better health and care for all while meeting fundamental standards and quality of care.
- to care for and give time to care for people who use their services.
- to review their care model, building on what works and what they are proud of and taking it further to help support people and communities to live well
- to return to and exceed their pre-pandemic performance
- delivering better care at the right time and in the right place
- to work with partners to improve services, to more efficiently use the resources available.

The Trust has set out four quality goals, focusing on the next three years. These are:

- reducing healthcare inequalities
- continuously seeking to reduce harm
- excellence in clinical outcomes
- deliver what matters most to people.

The Trust has signed up to the SEND pledge part of this plan, they worked with children, young people and their families to create the pledge which sets out how they will treat people who use their services. The Torbay pledge says they should be honest, show they care, be thoughtful, be fair, be kind, and be friendly.

A Governor Working Group is in place to decide the process by which feedback would be obtained from Governors to inform the Chair/NED appraisal process this year. This formed several parts:

- NEDs were asked to complete a self-assessment template, which was shared with Governors
- Governors completed the attached feedback form, one each for the Chair/NEDs

- a workshop was held to consider all the feedback received and agreed what will be put forward to inform the appraisals

Our chairman Sir Richard Ibbotson is approaching the end of his tenure as Chair at the invitation of the Council of Governors.

On behalf of the Council of Governors I would like to wish him all the best for the future.

Andrew Postlethwaite
Lead Governor

Devon Integrated Care Board (ICB)

NHS Devon Integrated Care Board (ICB) would like to thank Torbay and South Devon NHS Foundation Trust (TSDFT) for the opportunity to comment on the quality account for 2023/24. TSDFT is commissioned by NHS Devon ICB to provide integrated care with an acute and community hospitals as well as multi-disciplinary health and social are teams within the community across Torbay and South Devon. We seek assurance that care provided is safe and of high quality, ensuring that care is effective and that the experience of care is positive.

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 2023/24 period.

Despite ongoing pressure on staff and services, this Quality Account has highlighted a number of positive results against key objectives for 2023/24. These include:

1/ Zero avoidable deaths - TSDFT committed to improving the identification and management of people with sepsis. We established a sepsis improvement group which has delivered the trustwide sepsis clinical policy for adults and paediatric care. The sepsis bundle audit framework was set up and a compliance rate of 86.9% against a goal of 100% was achieved. This area remains a priority for 2024/25.

2/ Continuously seek out and reduce harm - we focused on the fundamentals of care for inpatient settings. This included patient falls assessments, reduction in falls and improved nutrition and hydration.

Despite improving compliance within the FallSafe audit, particularly lying and standing blood pressure the reduction of falls has plateaued and harms have increased. To draw the themes from the overall increased levels of harm reported, a deep dive review is being led by consultants. This will remain a priority.

An average of 96.8% compliance for nutrition and hydration assessments was achieved and there have been additional advancements including an increase in mealtime companions from 8 to 42, establishing a focused council and launching the nutrition and hydration campaign.

3/ Excellence in outcomes - To use the National Early Warning Score, (NEWS) to improve identification of the deteriorating patient. Our goal was for 100% of patients to have physiological observations on admission, the current compliance is 98%. Targeted support is available for wards not achieving 100%.

4/ Deliver what matters most to our people - TSDFT committed to improving discharges home by involving patients and families into the discharge planning and ensuring safe, personal, and compassionate transitions from hospital to home. The NHS 2023 patient survey identified we were within the top 5% for discharge and after hospital support.

The ICB also notes and welcomes the 2024/25 priorities outlined by TSDFT in their Quality Account and will look forward to seeing achievements within the quality improvement priorities and revised quality goals. Each of these programmes will continue to evidence and improve quality and safety for the benefit of patients, families, carers and staff building on the lessons learned from 2023/24.

During the reporting period 2023/24 TSDFT underwent a Well-led CQC inspection which included four core service inspections: urgent and emergence care, medical care, out-patient care and radiology/imaging. Our overall rating has gone from “Good” to “Requires Improvement” although care as a domain remains outstanding. A planned maternity inspection as part of the national CQC programme was completed and services remained at “Requires Improvement”. As a commissioner, we have worked closely with TSDFT during 2023/24 and will continue to do so in respect of all current and future CQC reviews undertaken, to receive the necessary assurances that actions have been taken to support continued, high-quality care.

On review of this Quality Account, TSDFT commitment to continually improving quality of care is evident. The ICB looks forward to working with TSDFT in the coming year, in continuing to make improvements to healthcare services provided to the people of Devon.

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST QUALITY ACCOUNT 2023/24

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Torbay and South Devon NHS Foundation Trust Quality Account for the year 2023/24. All references in this commentary relate to the reporting period 01 April 2023 to the 31 March 2024 and refer specifically to the Trust's relationship with the Scrutiny Committee.

It is the view of the Scrutiny Committee that the Quality Account provides a comprehensive account and fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge.

Members appreciate the positive work that has been carried out by the Trust in reference to the 2023/24 priorities including reducing patient falls and improving compliance on patient nutrition and hydration. The Committee commend the focus on improving the experience for people being discharged home. Members also welcome the launch of the Patient Safety Incident Response Framework as part of the Trust ensuring a positive safety culture.

Members are concerned by the 2023 CQC rating the Trust received from its well-led inspection, with its overall rating changing from Good to Requires Improvement. Decisive action has been taken, which the Committee hopes will address these issues.

The challenges the Trust has facilitating timely access for people needing urgent and emergency care will hopefully be alleviated by the range of improvements that have been brought into assessment / triage and through the Acute Medical Unit. Members also recognise the continued challenges the Trust faces in terms of staffing retention and recruitment particularly in some specialist roles.

The Committee fully supports the Trust priorities for 2024/25 in their entirety, and welcome the necessary focus being given to these priorities. Reducing health care inequalities across the Devon health and care system is of paramount importance.

Members appreciate the continued challenges the Trust faces with significant periods of increased operational escalation and the focus on elective care recovery. Members expect the Trust to ensure patients and staff receive the best support possible. Members welcome the prospect of a continued positive working relationship with the Trust, and ongoing monitoring of progress against these priorities through the Quality Account Standing Overview Group of the Health and Adult Care Scrutiny Committee.

TORBAY COUNCIL

Torbay Council Health Overview and Scrutiny Committee

Thank you for inviting Torbay Council's Adult Social Care and Health Overview and Scrutiny Sub-Board to include comments in your draft Quality Account for 2023/2024. Due to the timing of the request we have been unable to present the report formally to our Sub-Board. Therefore, the following statement has been written by the Director of Adults and Community Services, Jo Williams in consultation with the Chairwoman of the Adult Social Care and Health Overview and Scrutiny Sub-Board, Councillor Tolchard on behalf of our health overview and scrutiny Board for inclusion in your report:

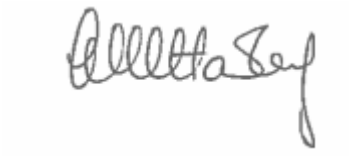
"Torbay Council welcomes TSDFT' S Quality Account and the priorities for improvement have benefitted the residents of Torbay.

Torbay Council values the long-standing partnership and supports the focus on quick and safe discharge. Joint arrangements are in place to provide Mental Capacity Assessments and Safeguarding, with a successful joint Safeguarding Adults Board in place across Torbay and Devon.

The Quality Account reflects the shared commitment to our Adult Social Care shared vision and priorities. We also strongly value our shared commitment to patient and community engagement and the 'amplifying people's voices in care' project TSDFT has undertaken. Co-production of the 'Big Plan' for Learning Disabilities has been a real achievement for our partnership with people with LD and their carers."

Members would welcome the opportunity for representatives of the Trust to come along to a future meeting of the Sub-Board to enable wider discussion on the issues contained within the report.

Yours sincerely



Anne Hawley

Senior Democratic, Overview and Scrutiny Officer

Healthwatch Plymouth, Devon and Torbay

Healthwatch Torbay is the independent consumer champion for people using local health and social care services in Torbay and South Devon. Our work covers all areas of health and adult social care. This includes GPs, hospitals, dentists, care homes, pharmacies, opticians and more. We listen to what local residents say about the healthcare services they use and make sure they are heard by the people in charge who have the power to improve services.

Healthwatch England, the national lead, has used feedback from service users to recommend improvements including an effective process for gaining a GP appointment to facilitate early diagnosis; improved communication and therapy support whilst on planned care waiting lists; personalised after-care support; greater involvement of families and carers in the discharge process and good signposting for follow up of discharge. Of growing concern is the need for education to support patients in the digital transformation, whilst being aware of digital inequalities.

This Quality Account reflects how the Trust plays its part in the patient journey to achieve these improvements including an aspiration to reduce waiting times; mechanisms to reduce patient's deterioration due to preventable falling; reducing the risk of deterioration whilst on the ward by a high performing discharge process for patients to return to their home; stronger connections across the whole health and social care system.

In addition, the Account demonstrates a desire to be proactive in obtaining experience feedback from patients, especially after discharge and to create a culture of honesty in learning from poor experiences. This includes working with local Healthwatch to identify what matters most to people in Torbay and South Devon. Mens' health awareness and use of emergency services when in crisis being two examples.

This Account is in the context of the complex demographic of our locality; the wide age profile weighted towards the elderly; financial inequalities and poor mental health challenges. But, encouragingly, there is a vibrant voluntary, community and social enterprise sector working hard to fill the gaps. Patients are appreciative of the care they receive from the Trust and from the people who give it. Positive feedback from patients is shared with individuals and teams to celebrate that their personal approach is what matters to those they care for.

Healthwatch Torbay is confident that this Quality Account represents a true picture of the challenges and achievements of the Trust and the staff and has a clear vision for 24/25.

Annex 4: National clinical audits (and number of local audits)
For the Quality Account, the National Advisory Group on Clinical Audit and Enquiries has published a list of national audits and confidential enquiries. Participation in these is seen as a measure of quality of any NHS organisation's clinical audit programme. The detail which follows relates to this list.

During 2023/24, 54 national clinical audits and three national confidential enquiries covered relevant health services that we provide.

During this period, we participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2023/24 follow.

National audits	**Eligibility**	**Participation**
Adult Respiratory Support Audit (BTS)	Yes	Yes
BAUS Nephrostomy Audit	Yes	No
Breast and Cosmetic Implant Registry	Yes	Yes
British Hernia Society Registry	No	N/A
Case Mix Programme (CMP)	Yes	Yes
Cleft Registry and Audit Network Database	No	N/A
Elective Surgery (National PROMS Programme)	Yes	Yes
Emergency Medicine QIPs (RCEM) A. Care of Older People B. Mental Health (Self Harm)	Yes	Yes
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes
Falls and Fragility Fracture Audit Programme (FFFAP) A. Fracture Liaison Service Database B. National Audit of Inpatient Falls C. National Hip Fracture Database	Yes	Yes
Improving Quality in Crohn's and Colitis	Yes	Yes
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review Programme)	Yes	Yes
National Adult Diabetes Audit (NPDA) A. National Diabetes Core Audit B. National Pregnancy in Diabetes Audit C. National Diabetes Footcare Audit D. National Inpatient Diabetes Safety Audit (Harms)	Yes	Yes

National audits	Eligibility	Participation
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) A. COPD Secondary Care B. Pulmonary Rehabilitation C. Adult Asthma Secondary Care D. Children and Young Peoples Asthma Secondary Care	Yes	Yes
National Audit of Cardiac Rehabilitation	Yes	Yes
National Audit of Cardiovascular Disease Prevention (Primary Care)	No	N/A
National Audit of Care at the End of Life (NACEL)	Yes	Yes
National Audit of Dementia (NAD)	Yes	Yes
National Audit of Pulmonary Hypertension	No	N/A
National Bariatric Surgery Registry	No	N/A
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Yes
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Cardiac Audit Programme (NCAP) A. National Adult Cardiac Surgery Audit B. National Congenital Heart Disease C. National Heart Failure Audit D. National Audit of Cardiac Rhythm Management E. Myocardial Ischaemia National Audit Project F. National Percutaneous Coronary Intervention G. National Audit of Mitral Valve Leaflet Repairs H. The UK Transcatheter Aortic Valve Implantation Registry	Yes	Yes
National Child Mortality Database (NCMD)	Yes	Yes
National Clinical Audit of Psychosis (NCAP)	No	N/A
National Comparative Audit of Blood Transfusion A) 2023 Audit of Blood Transfusion against NICE Quality Standard 138 B) 2023 Bedside Transfusion Audit	Yes	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes
National Emergency Laparotomy Audit (NELA)	Yes	Yes

National audits	Eligibility	Participation
National Gastro-intestinal Cancer Audit Programme a) National Bowel Cancer Audit b) National Oesophago-Gastric Cancer Audit	Yes	Yes
National Joint Registry	Yes	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes
National Maternity and Perinatal Audit	Yes	Yes
National Neonatal Audit Programme (NNAP)	Yes	Yes
National Obesity Audit	No	N/A
National Ophthalmology Database (NOD) National Cataract Audit	Yes	Yes
National Paediatrics Diabetes Audit (NPDA)	Yes	Yes
National Prostate Cancer Audit (NPCA)	Yes	Yes
National Vascular Registry	Yes	Yes
Out-of-Hospital Cardiac Arrest Outcomes	No	N/A
Paediatric Intensive Care Audit Network	No	N/A
Perinatal Mortality Review Tool (PMRT)	Yes	Yes
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes
Prescribing Observatory for Mental Health UK	No	N/A
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)	Yes	Yes
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes
The Trauma Audit and Research Network (TARN)	Yes	Yes
UK Cystic Fibrosis Registry	No	N/A
UK Renal Registry Chronic Kidney Disease Audit	No	N/A
UK Renal Registry National Acute Kidney Injury Audit	No	N/A

Patient outcome programme incorporating national confidential enquires	Eligibility	Participation
Child Health Clinical Outcome Review Programme (NCEPOD)	Yes	Yes
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes	Yes
Mental Health Clinical Outcome Review Programme	No	N/A

National clinical audit and patient outcome programme incorporating National Confidential enquires	Cases submitted	% cases
Adult Respiratory Support Audit (British Thoracic Society)	N/A	
Case Mix Programme (CMP)	N/A	
Elective Surgery (National PROMS Programme)	N/A	
Emergency Medicine QIPS (RCEM)	N/A	
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	N/A	
Falls and Fragility Fracture Audit Programme (FFFAP)	60	100
• National Audit of Inpatient Falls • National Hip Fracture Database	10 532	100 100
Improving Quality in Crohn's and Colitis	224	100
Leder – Learning from Lives and Deaths of People with A Learning Disability and Autistic People	N/A	
National Adult Diabetes Audit • National Pregnancy in Diabetes Audit	60	100
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	N/A	
National Audit of Cardiac Rehabilitation	N/A	
National Audit of Care at The End of Life (NACEL)	54	100
National Audit of Dementia (NAD)	N/A	
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	N/A	
National Cancer Audit Collaborating Centre – National Audit of Primary Breast Cancer	N/A	
National Cardiac Arrest Audit (NCAA)	45	100
National Cardiac Audit Programme (NCAP)	N/A	N/A
National Child Mortality Database	N/A	
National Comparative Audit of Blood Transfusion	N/A	
National Early Inflammatory Arthritis Audit (NEIAA)	12	100
National Emergency Laparotomy Audit (NELA)	147	100
National Gastro-Intestinal Cancer Audit Programme a) National Bowel Cancer Audit b) National Oesophago-Gastric Cancer Audit	281 139	100100
National Joint Registry	545	100

National clinical audit and patient outcome programme incorporating National Confidential enquires	Cases submitted	% cases
National Maternity and Perinatal Audit (NMPA)	N/A	
National Neonatal Audit Programme (NNAP)	31	100
National Ophthalmology Database – National Cataract Audit	1951	100
National Paediatric Diabetes Audit (NPDA)	N/A	
National Prostate Cancer Audit (NPCA)	264	100
National Vascular Registry (NVR)	N/A	
Perinatal Mortality Review Tool (PMRT)	N/A	
Perioperative Quality Improvement Programme	30	100
Sentinel Stroke National Audit Programme (SSNAP)	N/A	
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)	N/A	
Society For Acute Medicine Benchmarking Audit (SAMBA)	N/A	
The Trauma Audit and Research Network (TARN) Clinical Report 2 – Orthopaedic Injuries	641	100

Cases submitted to clinical audits and confidential enquiries
The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Patient Outcome Programme Incorporating National Confidential Enquires	Cases submitted	% Cases
Child Health Clinical Outcome Review Programme (NCEPOD)	N/A	
Medical And Surgical Clinical Outcome Review Programme (NCEPOD) 1. Community Acquired Pneumonia Study 2. Crohn's Disease Study 3. Transition from Child to Adult Services Study 4. Epilepsy Study	6 5 5 3	100 83 100 75
Maternal and Newborn Infant Clinical Outcome Review Programme	N/A	
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	16	100%

Our response to the findings of clinical audits

We reviewed the reports of 30 national clinical audits in 2023/2024 and we intend to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions
0974 (Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls	
	Pilot of hot debrief and 'After Action Reviews' (AAR) post fall to evaluate process. Look at trends - Four-week pilot on Cheetham Hill, Simpson, Templar and Teign wards. Evaluation forms - Involve Governance teams who are starting to use AAR. Post fall review policy and training in line with new (RCP) Royal College of Physicians supporting best & safe practice - Read document and review policy and bed-based falls training as appropriate. Continue to promote and embed training. Additional clinical Emergency Department expert. Record training video. Ensure standards in line with education charter and national documentation. Multi factorial risk assessment (MFRA) - L/S BP (Lying/ Standing blood pressure) increase uptake on acute wards - Increase training on wards from falls lead with project hours involving practice educators and QI improvement coach. Maintain focus through Fall safe audit. Multi factorial risk assessment (MFRA) - Ensure patients receive a vision assessment to check for any impairments - Add look out tool to new risk assessment booklet. Review results from Allerton pilot. Look at rolling out some form of visual assessment to inpatient areas. Involve Orthoptist. Non-executive director with specific responsibility for falls - Identify non-executive director. Attendance at FFSG (Falls and Fragility Steering Group) and support with fall prevention.
1102 (Falls and Fragility Fracture Audit Programme FFFAP) National Hip Fracture Database	
	No minutes taken to document the formal Hip Fracture Governance meetings - secure administration support. Long Emergency Department waits with poor figures achieving admission to an Orthopaedic ward within four hours - An Emergency Department 'sprint' audit looking at the efficiency aspects of ED care. Out of date guidance for bone protection post hip fracture - Update all hip fracture guidance to reflect current consensus recommendation.

1092 (NCMD) National Child Mortality Database Programme – Death of children and young people due to traumatic incidents

Recommendation 3
Develop and deliver regular education and training events, including simulation-based training, on children and young people presenting with penetrating injuries and cardiothoracic emergencies including damage control surgical training for all on call surgical consultants. This should be delivered to all clinical teams involved in the care of major trauma patients. All organisations involved in commissioning and delivering education and training for healthcare professionals should work together to deliver this recommendation.

Action required - Action for Bristol Childrens Hospital as the Major Trauma Centre for the Southwest. Paediatric Consultant TSDFT representative to support group and feedback any education requirements for Trust staff training.

Recommendation 6
Ensure that the importance of safe bathing techniques, including the adult always staying within arm's reach of young children at bath time, is a public health focus in accident prevention. This should include the updating of relevant training packages for professionals including community midwives and health visitors to ensure families are aware of safe bathing techniques. All organisations involved in commissioning and delivering education and training for healthcare professionals should work together to deliver this recommendation –

Action required - Action for Institute of Health Visiting.

TSDFT consideration by Professional Practice Service Lead for 0 to19 Torbay Public Health Nurses and Associate Director of Midwifery and Professional Practice (Head of Midwifery).

To consider current practice in midwifery and Health Visiting services and identify any improvements required.

Recommendation 16
Ensure universal delivery of programmes to reduce inequalities in line with the recommendations made in the NCMD thematic report on child mortality and deprivation. This should include implementation of the Healthy Child Programme and offers of intensive support to vulnerable families and those at higher risk identified in this report. All organisations involved in commissioning and delivery of relevant programmes should work together to deliver this recommendation –
Action required - Action for Integrated Care Boards and Local Authorities.
For consideration of TSDFT representative Professional Practice Service Lead for 0 to19 Torbay Public Health Nurses re implementation of the Health Child Programme.

Recommendation 17
Ensure sharing of information and learning within integrated care systems with support from Integrated Care Partnerships/ Integrated Care Boards to support targeted implementation based on local data (e.g., knife crime). All organisations involved in the commissioning and delivery of the Child Death Review process should work together to deliver this recommendation –

Action required - Action for Child Death Overview panels, Integrated Care Boards, Integrated Care Partnerships, National Child Mortality Database.
Paediatric Matron, Named Nurse for Safeguarding Children, Child Death review Coordinator and Named Doctor for Child Death review to review current reporting processes to ensure prompt Trust wide learning is shared from Child death review meetings.

1061 (NCMD) National Child Mortality Database Programme – Sudden and Unexpected Deaths in Infancy and Childhood

Safer sleeping is an important part of advice given to women and their families during pregnancy. It is important to give the appropriate advice and escalate vulnerable families to the Health Visiting Team. System One has triggers and options for sharing information - Share the report findings in the next Clinical Governance Newsletter.

1133 (NEIAA) National Early Inflammatory Arthritis (EIA) Audit

Improve audit recruitment in 2023/ 24 period - Oversee pathway detailed below and continue to advertise NEIAA and encourage engagement by whole team.

To ensure all patients triaged as 'query' EIA have a data collection proforma in their notes/ available at time of first assessment and three-month assessment - Medical secretaries to ensure proforma is attached to referral letter. Medical secretaries to ensure all clinic sites have spare proformas available. Medical secretaries to have spare proformas available to consultants on request.

Ensure all proformas fully completed at baseline for eligible patients - Proformas to be completed and returned to Medical secretaries office.

Ensure date DMARD (Disease-modifying antirheumatic drugs) started is entered on proforma and proformas are returned to Audit Team.

Flag patients in whom treatment is delayed - Medications team to add data. Report to consultant and weekly medication meeting if DMARD not started within three weeks of appointment for any reason. Send completed proformas to Audit Team.

Ensure all patient data is uploaded onto the National Database - Audit department to upload data and flag any incomplete forms.

Improve input of three-month patient data - Nurses to check booking of four month follow up appointment at time of RHEUM/VC appointment. Consultant to complete proforma. Consultant and med secs to receive reminder e-mail from NEIAA and to circulate as reminder to consultants. Med secs to ensure that all patients have their four month follow up booked and remind consultant just prior to that appointment that this is coming up.

Focus for 2023/4:
Number of patients seen within three weeks of referral - Continue to monitor supply and demand of EIA clinic appts. Flag issues to clinical lead/ in business meetings.

Number of patients starting DMARD within six weeks of referral - Continue to monitor time to treatment and flag any issues or delays to clinical lead/ business meetings. Flag all patients who have not started DMARD within three weeks of EIA

clinic to their consultant. Discuss any issues in weekly biologics meeting/ business meetings.

Continue to optimise EIA pathway and staffing - Implement changes as identified in the regional SWIFT project including purchasing of tablets to agree treatment on the day.

1140 (NNAP) National Neonatal Audit Programme

Review last 20 cases where antenatal steroid administration was suboptimal - Maternity case review.

Audit why mixed feed predominates over exclusive feeding - Audit of breast feeding.

Ref	Recommendations / actions
0930 (RCEM) Consultant Sign Off	
Symphony flag-up if possible - To discuss with the Symphony Change Group whether it is possible to flag up the Consultant Sign-off cases.	
0929 (RCEM) Pain in Children	
Time to pain assessment from arrival/ triage - carry out a local re-audit. Time to 1st dose of analgesia - carry out a local re-audit. Pain re-evaluation after 60 minutes - Audit +/- Symphony to flag the need for pain re-evaluation.	
1050 BASHH Management of Mycoplasma Genitalium (Mgen)	
Improve offer of written information - Highlighted to team at meeting that paper patient information leaflet is available within department. Create standard text with link to digital copy. Clarify procedure for reporting treatment failure - Look up sources and establish what pathway is within team. Report back at Clinical Governance meeting. Improve ease of testing requests - Ask Pathology to add on Cyberlab. Establish procedure re TOC (Test of Cure) - Review evidence and discuss at Clinical Governance meeting.	
1079 Birth Before Arrival at Hospital in the Southwest: an exploration of inequalities and call taker advice	
Review advice given to Mothers when phoning following a Birth Before Arrival. Practical ways of keeping the baby warm - To include in Clinical Governance Newsletter.	
1046 Devon Sexual Health 3-site audit of Emergency Contraception	
Better documentation of advice re follow up pregnancy testing - look into generating new emergency contraception pill with advice re follow up and quick starting after Ellone.	
1166 Endocrine and Thyroid National Audit	
Nuclear Medicine MIBI (Myocardial perfusion) scan provision for parathyroid patients - Maintenance and recommission the service ASAP. Ensure UKRETS registry and audit input for all cases in Torbay continues - Time in job plan to complete data input. Ensure minimum operative numbers for operation surgeon (x20 + per annum) - Allow x two designated thyroid surgeons.	
1059 Lynch Syndrome Audit	
Unreliable communication of genetic reports - streamline delivery of electronic reports to MDT (multidisciplinary team) members.	

Not meeting NICE 2017 guidelines for reactive MSI (Microsatellite Instability) testing on all new colorectal cancer diagnosis - Colorectal MDT to instigate reactive MSI testing for all new colorectal cancer diagnosis. Safety netting to ensure MSI completed on all new colorectal cancer diagnosis - Document MSI on MDT outcomes.
0963 National Audit into Management of Stevens Johnson Syndrome/ Toxic Epidermal Necrolysis (BAD)
No areas of deficiency identified, opportunity for education on this topic - local teaching on audit results.
0990 National Audit of Cardiac Rehabilitation
The report recommends that all patients taking part in cardiac rehabilitation exercise should have a baseline exercise test. This is not achievable as the Cardiac Rehab Team have been unable to recruit a Physiotherapist/ Trainer able to complete these assessments - Lack of baseline exercise test - Further exploration of causes required.

Recommendations / actions
1091 National Audit of Care at the End of Life (NACEL)
Identification/ documentation of preferred place of care (PPOC) for dying patients in both Torbay and Community Hospitals – Action – 1. NACEL Round 4 results presented to Medical Grand Round on 11th September 2023. 2. NACEL results discussed at End of Life Board August & September 2023 & results circulated to Senior nursing staff. 3. Email junior doctors re. main survey findings and action plan – encourage conversations about PPOC. 4. Palliative care team to increase exploration of PPOC when involved with patients' care. Documentation of indication for use of anticipatory drugs on medication chart in both Torbay and Community Hospitals – Action – 1.NACEL results presented at Grand Round 2.Email junior doctors to encourage complete prescriptions 3.Palliative care team to review PRN medications on drug charts to ensure completion. Discuss food and fluids at end of life with patients and families in Torbay – Action – 1.NACEL presented at Grand Round 2.Email junior doctors to encourage discussions/ documentation 3.Palliative care team to encourage discussions when involved 4. Discussion at Ambassadors training. Communicate to patients that they may be dying – Community Hospitals. Action – 1. NACEL results circulated to Senior Nursing staff 2. Email junior doctors to encourage more conversations. Assess spiritual/ religious needs at the end of life – Community Hospitals – Action – 1. Palliative Care CNS (Clinical Nurse Specialist) Lead for Education – To share results with Community Hospitals nursing staff/ Sisters and identify need for Chaplaincy team to provide teaching/ support/ input 2. Discussion at Ambassadors Training.
0972 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
Improvement of the documentation of the first paediatric assessment - Proforma for first paediatric assessment to be linked to "first fit" Trust guidelines (in the pipeline). Time since first request for EEG- NICE recommends within four weeks from request - To liaise with the Neurophysiology service at the Royal Devon and Exeter Hospital and

look at possible solutions.

1094 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)

Improvement of the documentation of the first paediatric assessment - Proforma for first paediatric assessment to be linked to "first fit" Trust guidelines (in the pipeline).

ECG in patients with convulsive seizures - First fit Trust guidelines (in the pipeline).

1054 National Benchmarking audit of Progesterone-only Pill Provision

Take part in Faculty of Sexual and Reproductive Health (FSRH) - Take part in FSRH re-audit when announced.

0996 National Cardiac Arrest Audit (ICNARC)

Lack of Amiodarone minijet on resus trolley - Ensure all resus trollies have amiodarone vials, monitor during cardiac arrest. Replace once minijet available.

Issues affecting cardiac arrest call bleeps - Monitor situation with switchboard.

1008 National Emergency Laparotomy Audit (NELA)

Low admission rates to post operative critical care for high-risk patients - Increase in commissioned number of critical care beds from 10 to 14.

Lack of access to geriatrician-led assessment of frail patients >65 years or >80 years - Commissioning of a perioperative team experienced in the management of frailty and older patients.

Timeliness of antibiotic administration - Internal clinical audit, action guided by findings, promotion of adult sepsis bundle.

1137 National Joint Registry (NJR)

National Joint Registry documented revision rates at five and ten years for Total Knee Replacement elevated - continue to liaise with NJR and perform bi-annual meetings to assess individual surgeon data. Raise issues if concerned.

1010 National Lung Cancer Audit Report

Breaches associated with 2 Week Wait clinic appointments - Increase Respiratory Consultant time to facilitate more clinics.

Breaches/ Long waits with surgical clinics - More clinic space required to accommodate surgical clinics.

Record smoking status - add field to MDT (multidisciplinary) proforma to record this better.

Surgical follow up clinics by Lung Cancer Specialist Nurse - LCNS to review long term surgical follow up patients - would require more LCSN time (post) and clinic room.

Lung Cancer Specialist Nurse job plan - Service understaffed in terms of LCSN time, look at recruiting LCSN.

Data uploading to National System - Identify (and rectify) a long-standing issue with the data that we send to National audit not matching the data that is issued in the report, particularly with regards patients seen by LCSN, surgical resection rates.
0514 National Maternity and Perinatal Audit - NHS Maternity Care for Women with Multiple Births and their Babies
Ensure data accuracy - request/ record data on the number of fetuses in the first trimester of pregnancy, in addition to number at birth. Review limitations of SystmOne - Make chronicity and amnionicity a compulsory data item in maternity information systems. Review SystmOne multiple births proformas - Include a compulsory field on planned mode of birth.
1142 National Ophthalmology Database Audit (National Cataract Audit)
Insufficient patient surveys - conduct Friends and Family surveys for surgical patients. Insufficient patient surveys - create a survey for surgical patients and audit quarterly.
1073 NPDA (RCPH National Paediatric Diabetes audit)
We need to continue to reduce the number of CYP (Children and Young People) with a high HbA1c over 80. Children from the most deprived families are over-represented in this group – Mindful of the cost both financial and in terms of time of clinic attendance is disproportionately born by those from the most deprived backgrounds, we are establishing community clinics to see these patients closer to home. Meaning less time missed out of school and less expenditure of public transport etc. We are focusing on access to technology such as the hybrid close loop pump that can dramatically improve diabetes management for those from deprived backgrounds. We have initiated group pump starts both to start as many children who really need this tech as quickly as possible but also so they have peer support and can learn and help each other.
1149 Perioperative Quality Improvement Programme (PQIP)
Mobilising on Day 1 - Will need more physio in level 1.5 care. Postoperative pain management - Involve Acute Pain team, ‘Allegro’ trial ongoing.
0870 Quality Outcomes in Oral and Maxillofacial Surgery (QOMS)
No Consultant Restorative Dentist as Core Member of Head & Neck MDT - Develop funding for Consultant Restorative Dentist as Core member of Head & Neck MDT. Not able to offer sentinel node biopsy for early-stage node negative oral SCC - Develop sentinel node biopsy service.

1068 Radiology Reporting of Osteoporotic Vertebral Fragility Fractures (VFFs) on CT Studies – A re-audit following the 2019 National RCR Audit
Re-audit of local data and compare to national audit.
0962 UK Parkinsons Audit
Documentation of medicines side effects - MDT discussion. ACP (Advanced Care Planning) discussions - Liaise with Palliative Care Teams, education. Therapy referrals - better documentation. Documentation of NMS (Non-Motor Symptoms) - possible trial of use of NMS questionnaire.
0947 (NCEPOD) Crohn's Disease
Poor record keeping of IBD MDTs - Record outcomes and distribute to MDT (multidisciplinary) members. Incident reporting of delay surgery - Emergency Crohn's Surgery of waiting list patients to be incident reported. Psychological and peer support for Crohn's patients - Consider improvements to access.
0860 (NCEPOD) Epilepsy Study
Lack of documentation in lifestyle and occupational advice - Information leaflets arranged, discussion in Neurology Clinical Governance Meeting. No standardised proforma for first seizure referral for the ward patients - First fit guidance on Microguide App. Not seeking witness account in all available cases - Discussion in Neurology Clinical Governance Meeting. No advice to video future events - Discussion in Neurology Clinical Governance Meeting.

We reviewed the reports of two national confidential enquiries in 2023/ 24 and intend to take the following actions to improve the quality of healthcare provided.

We reviewed the reports of 24 local clinical audits in 2023/ 24 and we intend to take the following actions to improve the quality of healthcare provided (six audit projects did not need any actions).

Ref	Recommendations / actions
6642	**Suspected physical abuse (SPA) - Radiology compliance with national guidance**
	- Contact other trusts to see if SPA cases remain low - Escalate concerns re low numbers to named doctors for Safeguarding children - Training – we need to train more staff. Investigate engaging in a simulation-based training package via Exeter University - Ongoing, monitored via a separate forum.
6679	**Paediatric suspected appendicitis pathway**
	- If appendicitis diagnosed: Make sure intravenous (IV) antibiotics prescribed, Record the decision to operate, in theatre if pus give gentamicin, post stop antibiotics, stop antibiotics if 3 days of IVs completed, longer term IV access if ileus suspected. Pre discharge checks.
6699	**Venous thromboembolism (VTE) prophylaxis: prescription of Enoxaparin for surgical patients**
	- Set up a 'Teaching session' for Junior and Middle Grade doctors regarding these guidelines - Design and display a poster about this information within the Surgical Receiving Unit - Discussion within Trust VTE team meeting for adding this information to the Drug chart/ VTE form
6701	**Management of suspected Gynaecomastia**
	- Introduce GP education webinars - Update Devon Formulary partnership - Investigate producing/ introducing Gynaecomastia flow pathway diagram
6732	**Documentation of Child and Adolescent Mental Health Service (CAMHS) assessments for paediatric inpatients**
	- Crisis team proforma developed incorporating data/ audit outcomes and requirements for appropriate written communication - Instigate a monthly review of five crisis cases assessing documented communication
6738	**Ultrasonography (US) findings in cases of abnormal Magnetic Resonance Cholangiopancreatography (MRCP)**
	- Conduct a peer review of common bile duct (CBD) images and measurement to check staff are using inner to inner technique - Ensure less ambiguity in the terminology used in sonographer reports to assist referring - Implement standardised reporting statement on protocol - Investigate and implement education for correct measuring of CBD, especially in older people
6739	**Adult hearing aid pathway**
	- 'Treatment to review' will be discussed with Head of Department and all staff

at the next meeting to devise a plan to improve. We are encouraged to follow the Patient initiated follow-up pathway (PIFU) now for most patients. We have amended our record keeping templates to allow staff to input if a review was offered/ declined as the patients that decline will not be included in the next audit
- QoL (part 1) - As these assessments were conducted over the phone this often got left out due to restrictions of discussing things with hearing impaired people over the phone. Now that assessments are completed Face to Face we should see an overall improvement to this for the next audit – Staff reminded at Team meeting
- QoL (part 2) - This low score runs in conjunction with the low review score action as these have not routinely been conducted and will be addressed at the next meeting.
- Real Ear Measurement (REM) completed as required - The timing of this audit fell around restrictions for Covid when we were advised not to complete REMs as it involves close patient contact in a confined area, also possibly triggering a cough reflex. Since restrictions have eased, we have advised all staff that these measurements should again be routinely completed on each patient, as appropriate, and document when it has not been done. Through our regular staff competency checks we can monitor this and have already seen a huge improvement overall from when this audit was conducted. Staff will be emailed and reminded at the next staff meeting to carry out REMs when possible

6742 Lipid lowering therapy for primary prevention of cardiovascular disease (CVD) in patients with type 1 Diabetes

- Introduce a patient information ‘App’ with leaflets and questionnaires
- Poster designed to display in clinic rooms to remind clinicians
- Investigate addition of an Infoflex prompt to remind clinicians to consider statins

6745 Documentation in surgical patients’ notes using the Surgical 'Hot Week' ward round pro-forma

- Highlight importance of clear documentation - Present at F1 teaching session
- Encourage use of Ward Round sheets and all the 'boxes' on them
- Discuss barriers to documentation to inform future cycles and review GMC guidance

6750 Blood Pressure (BP) management in Intracerebral Haemorrhage (IH) in Emergency Department (ED)

- Provide a teaching session within ED
- Introduce a new proforma within a 'stroke box' in ED rather than relying on access via Trust Intranet

6756 Venous Thromboembolism (VTE) assessment on Louisa Cary paediatric ward

- To continue risk assessment (RA) reminder in Safety Brief before handover,

including highlight for second time RA when the patient has to stay longer - Ensure on admission, every time before attaching treatment chart, check whether the second page of RA is correct
6760 Cerebral Palsy Integrated Pathway (CPIP) of hip surveillance
- Write a letter to Community Paediatricians and Head of Physiotherapy to highlight the issue that no one has overall responsibility – this needs ownership and effective leadership.
6764 Rational prescribing of oral antibiotics to treat paediatric Group A Streptococcus (GAS) infections

- Rationalise prescribing in suspected GAS:
  - Introduce 'FeverPAIN' score (sticker and/or a QR code) to Short Stay Paediatric Assessment Unit notes
  - Produce and launch a new GAS triage protocol
- Increase awareness to improve 'FeverPAIN' scoring and swab data correlation

6708 Non-steroidal anti-inflammatory drugs (NSAIDs) and Proton Pump inhibitor (PPIs) for trauma and elective orthopaedic patients
- Request ward pharmacists mention and discuss this with prescriber when doing drugs for discharge (TTAs) - Surgeons reminded to mention PPIs in op-notes if NSAIDs prescribed - Nurses have been made aware of protocol and can discuss with prescriber - NSAIDs are usually prescribed by anaesthetists in theatres - to raise the question with them if they can co-prescribe -
6770 Rectal Magnetic Resonance Imaging (MRI) staging vs histological staging for rectal cancer
- Introduce a reporting template - Provide additional MRI radiograph training to focus especially on obtaining five perpendicular slices through the tumour - Share change in guidance through audit meeting specifically, a node contacting the margin does not mean an involved margin
6776 Management of Scabies
- Team discussion regarding best source of information for leaflet (PIL) - British Association for Sexual Health and HIV (BASHH) PIL (Patient Information Leaflet) - Print copies of the BASHH Scabies PIL to have in clinic - Create text link to BASHH PIL
6779 Is one Occipito-Mental (OM) radiographic view enough to accurately diagnose a facial fracture?
- Produce a poster for display in Emergency Department's 'fishbowl' -
6782 Optimising intravenous (IV) antibiotic prescribing practices: A review of appropriateness and transition to oral therapy
- Teaching session for the FY1 doctors covering surgical wards about

reviewing patients on IV antibiotics within 48 hours and switch them to oral antibiotics according to blood results and clinical correlation.

1037 (SHOT) Serious hazards of transfusion: UK national haemovigilance scheme

We have undertaken a gap analysis of the main recommendations from ND1152 – The Annual Shot Report 2022, published by the Serious Hazards of Transfusion (SHOT) Steering Group and the Medicines and Healthcare products Regulatory Agency (MHRA).

The report details four main recommendations for all trusts to consider, including:

- appropriate management of anaemia and making safe transfusion decisions
- safe systems to ensure safe transfusions
- effective implementation of appropriate interventions following investigations
- learning from excellence and day-to-day events.

We are in the process of undertaking the actions from our improvement plan which includes:

- strengthening our standard operating policy (SOP) and processes for the investigation and reporting of SHOT incidents. Our SSPOT is continuing to work with the central patient safety team to improve processes and increase the number of trained staff who are involved in reviewing and investigating blood transfusion related incidents. The review of patient safety investigators is also being undertaken by the central patient safety team in line with the PSIRF recommendations
- re-invigorating our Hospital Transfusion Committee (HTC) which will allow for trust-wide sharing of decision making and responsibilities for the management of safe transfusion practices, implementation of appropriate interventions, governance and learning from excellence.

The following audits were reviewed during the year but did not require an action plan:

- 6734 Injuries to non-mobile babies (<1 year)
- 6759 Clinical and anatomical outcome of external dacrocystorhinostomy (DCR) surgery
- 6763 Identification of small for gestational age (SGA) babies
- 6777 Medical management of miscarriage
- 6787 Managing the initial care of babies cooled for Hypoxic-ischaemic encephalopathy (HIE) over the last two years
- 6788 Contraception in women over 40

Annex 5: Mortality and learning from deaths
Mortality figures and reporting

Ref	Information required	Our response
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2023/24, 1,413 of our patients died in the acute and community hospitals. This includes the Emergency department. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 366 in the first quarter • 322 in the second quarter • 346 in the third quarter • 379 in the fourth quarter.
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	During 2023/24, 1,395 case record reviews have been carried out by the Medical Examiners in relation to the number of the deaths included above. This comprised the following number of case scrutiny which occurred in each quarter of that reporting period: • 366 in the first quarter • 318 in the second quarter • 341 in the third quarter • 370 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	During 2023/24 nine cases for which the outcome was death were reported on the strategic executive information system (STEIS). All these incidents had reports produced which were communicated to NHS Devon and discussed at our serious adverse event group which meets on a monthly basis.

Annex 6: Mandatory indicators

Mandatory indicators are based on recommendations by the National Quality Board. These align closely with the NHS Outcomes Framework and are based on data that NHS trusts report on nationally.

	Prescribed information	**Comment**
12	(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the organisation for the reporting period; and	SHMI 1.0007 (Dec 22 to Nov 23) Statistically as expected.
	(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for our organisation for the reporting period.	Palliative care 5.85 %, additional work has been undertaken to ensure accuracy of coding
18	Our reported outcome measures scores for: Groin hernia surgery	National data no longer collected via patient reported outcome measures (PROMS)-therefore no national comparison available.
	varicose vein surgery	This surgery is not routinely undertaken in our organisation
	hip replacement surgery	No national data available
	knee replacement surgery	No national data available
19	The percentage of patients aged: (i) 0 to 14 and (ii) 15 or over readmitted to a hospital which forms part of our organisation within 28 days of being discharged from a hospital which forms part of our organisation during the reporting period.	No national data available
20	Our responsiveness to the personal needs of our patients during the reporting period.	Data from the CQC inpatient survey undertaken in April 2023 scored us in the following categories: • care and treatment scored 8.4/10 which is about the same as national average. • Respect and dignity 9.4/10 about the same as the national average • Overall experience 8.3/10 about the same as national average For maternity services: • Labour and birth scored as

		9.2/10-much better than average • Staff caring for you scored 8.6/10 about the same as the national average
21	The percentage of staff employed by, or under contract to, us during the reporting period who would recommend us as a provider of care to their family or friends.	Data from the national staff survey shows this metric has remained static for substantive staff at 59.105 in 2022 and 60.32% in 2023 For bank staff in 2022 60.9% would recommend us - this has increased in 2023 to 68.6%
21.1	Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2) Please note there is a not a statutory requirement to include this indicator in the quality accounts reporting but provider organisations should consider doing so.	
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96% April 2023-March 2024 local data
24	The rate per 100,000 bed days of cases of C. difficile infection reported within our organisation amongst patients aged two or over during the reporting period.	42.5 per 100,00 bed days local data
25	The number and, where available, rate of patient safety incidents reported within our organisation during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	12,091 patient safety incidents reported between 01/04/2023 and 31/03/2024. 1,064 near miss incidents [8.8%] 3,066 no harm incidents [25%] 1,628 low harm incidents [13.5%] 361 moderate harm incidents [3%] 44 severe harm incidents [0.36%] 36 death incidents [0.3%]

Glossary

Care Bundle: A set of interventions that, when used together, significantly improve patient outcomes.

Care Quality Commission (CQC): An independent regulator responsible for monitoring and performance measuring all health and social care services in England.

Clinical Audit: The process by which clinical staff measure how well our organisation performs against agreed standards. Action plans for improvement are often based on the findings of an audit.

Clinical Pathways: The standardisation of care practices to reduce variability and improve outcomes for patients.

Clostridium Difficile (C.Diff): A form of bacteria that is present naturally in the gut of around 2/3s of children and 3% of adults. On their own they are harmless, but under the presence of some antibiotics they will multiply and produce toxins (poisons) which cause illness such as diarrhoea and fever. At this point, a person is said to be infected with C. difficile.

Commissioning for Quality and Innovation (CQUIN): The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care.

DCIQ: web based clinical incident reporting and risk management software for healthcare and social care organisations.

Friends and Family Test (FFT): The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

Governance: The systems and processes by which health bodies lead, direct and control their functions in order to achieve organisational objectives and by which they relate to their partners and wider community.

Information Governance (IG): Information Governance allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

IG Toolkit: The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information, Governance policies and standards. It also allows members of the public to view information of participating organisations.

HIVE: Our organisation's e -learning platform

Microguide: The local medical guidance app for clinicians

Mortality Review: A process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care and identify learning, plans for improvement and pathway redesign where required.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD): NCEPOD assists in maintaining and improving standards of healthcare for adults and children by reviewing the management of patients and by undertaking confidential surveys and research.

National Early Warning Score (NEWS): NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. NEWS2 is the updated version of this tool.

National Institute for Health and Clinical Excellence (NICE) The National Institute for Health and Clinical Excellence provides independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.

Serious Incidents (SIs): Something out of the ordinary or unexpected. It is an incident – or a series of incidents – that, if left unattended, may pose a risk to service users or the health and safety of staff, visitors and others.

Structured Judgement Mortality Review: The SJR methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.