Torbay and South Devon
NHS Foundation Trust

Council of Governors Meeting

Public

Date: Wednesday 7 May 2025

Time: 2.00 pm – 4.00 pm

Venue: via Microsoft Teams

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Council of Governors

07/05/2025 14:00 - 16:00

Agenda Topic			Presenter	Time	Page
Cover Sheet					1
1.	Opening matters		Chair	14:00-14:10	
	1.1	Chairman's welcome and apologies for absence:	Chair	14:10-14:15	
	1.2	Declarations of interest	Chair		
2.	Business from previous Council of Governors' meeting		Chair	14:15-14:20	4
	2.1	Minutes of Council of Governors' meeting held on 5 February	Chair		4
	2.2	Matters arising not covered elsewhere on the agenda	Chair		
3.	Business Reports				12
	3.1	Chairmans Report (verbal)		14:20-14:30	
	3.2	Lead Governor Update (verbal)	Lead Governor	14:30-14:35	
	3.3	Chief Executive's Report	CEO	14:35-14:45	12
	3.4	Membership Committee Chair's Report	MC Chair	14:45-14:50	17
	3.5	Governor Observer Exception Reports (verbal)	GO Governors	14:50-14:55	
4.	Governance		DCG	14:55-15:00	19
	4.1	Report of the Director of Corporate Governance and Trust Secretary	DCG	15:00-15:15	19
5.	Update on Quality Account				52
	5.1	Draft Quality Account 2024/25 and 2025/26 Priorities	Maria Patterson	15:15-15:25	52
6.	PLACE Feedback				

	6.1	PLACE Report (to follow)	Tony Hopkins	15:25-15:35	
7.	Governor Engagement				122
	7.1	NED Briefing	NEDS	15:35-15:50	
	7.2	Governor Communications Log	Chair	15:50-15:55	122
8.	Information Items		DCG		123
	8.1	Governor Calendar and Information items			123
9.	Closing Matters			15:55-16:00	
	9.1	Any Other Business	Chair		
	9.2	Close of meeting			

Date of next meeting: 2pm Wednesday 6 August 2025 (via microsoft teams)

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MINUTES OF THE PUBLIC COG MEETING
HELD ON 5 FEBRUARY 2025 AT 2 PM
IN THE BOARDROOM AND VIA MS TEAMS

	Governors:							
*	Sal Aziz	(SA)	*	Karen Barry	(KB)	*	Joanna Bowtell	(JB)
*	Val Browning	(VB)		Dave Cawley	(DC)	*	Loveday Densham	(LD)
*	Eileen Engelmann	(EE)		Matthew Giles	(MG)	*	Annie Hall	(AH)
	James Hartley	(JH)	*	John Kiddey	(JK)		Clare McAdam	(CM)
*	Hilary Milner	(HM)		John Nutley	(JN)	*	Yvonne Paulucy	(YP)
	Ron Peart	(RP)	*	Andrew Postlethwaite	(AP)	*	Alison Ramon	(AR)
	John Shribman	JS		John Smith	(JSm)	*	Andrew Stilliard	(AS)
*	Lee Thomas	(LT)		Hayley Tranter	(HT)	*	Vincent Williams	(VW)
*	Louise Winfield	(LW)		Radia Woodbridge	(RW)	*	Ged Yardy	(GY)
*	Matthew Arthur	(MA)						

* denotes member present () denotes attended part of the meeting

Directors Present:		
Chris Balch	Chairman	CB
Mark Greaves	Non-Executive Director	MG
Adel Jones	Chief Strategy and Transformation Officer and Deputy Chief Officer	AJ
Emily Long	Director of Corporate Governance and Trust Secretary	EL
Liz Edwards-Smith	Non-Executive Director	LE
Paul Richards	Non-Executive Director	PR
Chris Saxby	Non-Executive Director	CS
Robin Sutton	Non-Executive Director	RS
Siân Walker-McAllister	Non-Executive Director	SWM
Robert Williams	Non-Executive Director	RW
In attendance:		
Sarah Fox	Corporate Governance Manager	SF
Esther Carter	Minutes	EC

1.	**OPENING MATTERS**
1.1	**Chairman's welcome and apologies:** Apologies were received from the following Executive Directors and Non-Executive Directors: Bill Shields – Interim Chief Executive Officer Mark Brice – Chief Finance Officer Arun Chandran – Chief Operating Officer Kate Lissett – Chief Medical Officer Nicola McMinn – Chief Nursing Officer Martin Beaman – Non Executive Director Governor apologies were received from John Nutley.

	The Chair confirmed this was the last meeting for Annie Hall and John Smith before they reached the end of their tenure as Governors and that the results of the Governor elections were still awaited.
1.2	**Declarations of Interest:** None recorded for this meeting.
2.	**BUSINESS FROM PREVIOUS COUNCIL OF GOVERNORS MEETINGS**
2.1	**Minutes of the meetings held on 6 November 2024 and 26 November 2024.** The Council of Governors approved the minutes of the Public meeting held on 6 November 2024 and the Private meeting held on 26 November 2024 as an accurate record.
2.2	**Matters arising not covered elsewhere on the agenda:** There were none for this meeting.
3.	**BUSINESS REPORTS**
3.1.	**Chairman's Report:** The Chairman verbally reported to the Council of Governors on the following matters: • Vikki Matthews stepped down as NED and Chair of People Committee at the end of January 2025 and Siân Walker-McAllister would now be chairing this Committee. The Board would be thanking Vikki and Liz Davenport at a re-scheduled Board dinner on the 26 February 2025. • New NED Liz Edwards-Smith would be joining the People Committee and taking on Chair of the Charity Committee. Liz would be bringing a wealth of experience in the charity sector to this Committee. • New NED Mark Greaves would be joining the Audit Committee when NED Robin Sutton reaches end of his term. • Assoc NEDs Ashish Ghadiali and David Feindouno would be attending all the Board sub-committees over the next few months to understand the full scope of responsibilities before allocation into an appropriate Committee. The CoG were reminded that these Associate NEDs had a non-voting role on the Board. • Joe Teape the Trust's new CEO starts on 3 March and to ensure a smooth transition, there would be an overlap with Bill Shields remaining as Accountable Officer until 31 March 2025. Bill Shields would then move on to his role as CEO of the Nottingham & Derby ICB. The Chair acknowledged that Bill Shields has had a significant, positive impact and focus to the Trust's financial challenges and changes were underway to review and re-prioritise responsibilities within the Exec Director roles. • The anticipated Trust's non delivery of its Cost Improvement Programme was declared recently to the region and system, resulting in assurance processes being scrutinised to ensure the Trust could deliver going forward. A strengthening of governance processes was underway including greater sub-committee responsibility and report formats were being streamlined to bring further assurance to the Board. • In conjunction with assistance from the national recovery programme, and under external scrutiny of a developmental well-led review, the Trust would be looking to

slim down the frequency of Board and sub-committee meetings. Public Board meetings would be every other month and the frequency of some sub-committees would be reduced to bi-monthly. However, the FPC and Private Board meetings would continue on a monthly basis.

- The outcome of the New Hospital Programme (NHP) for Torbay was recently announced with the Trust's construction project not going ahead until 2033-2035. NHP work on site would now be stood down until 2030/31. This was a huge disappointment and the Trust would be left holding significant estate risks of circa £60M of urgent maintenance works. Difficult decisions would have to be made to prioritise capital spend whilst maintaining clinical services as there would be no additional resources available from the regional estates team.
- There has been funding available of £14.2m for extension and improvement to the emergency department which would be completed in September this year. There had also been significant investment in the Trust's digital infrastructure with EPIC being a significant priority for delivery in the next financial year. Local MP liaison was continuing to ensure the Trust remains attractive to investment.
- NHSE's guidance on forward planning for 2025/26 had been released. The Trust was looking at improving outcomes for Urgent and Emergency care and elective waits. The Chair and Bill Shields would be discussing with the Devon ICB on how the Trust could maintain improvements in productivity whilst achieving financial efficiencies. Under the leadership of Bill Shields, the Trust was more focused and clearer on its priorities and deficits and was working in partnership with other providers to deliver more effective and value for money services.
- As part of the CIP review, the Trust was looking at the cost deficit of delivering adult social care and reviewing CFHD services and community services to ensure resources were being applied effectively.
- The Trust was now first in the country for recruitment into cancer trials and was leading the way in clinical research and development. Three new Consultant Anaesthetists were recently appointed.

MA raised a question regarding whether changes to fragile services would require public consultation. The Chair confirmed there whilst there would be changes to the organisation of clinical team resources within a service, there would be no changes to moving services outside the local area which would require patients having to travel and require public consultation.

JK asked that considering the NHP delay, was the Trust looking at making cuts, to find the finances available to complete some of the maintenance works on site. AJ confirmed that the estates strategy and capital programme were being reviewed and in case the NHP was delayed, the Trust had been working on a contingency plan. The acute medical unit had already been upgraded, two theatres and an endoscopy unit had been built and work to upgrade the ED was currently under construction. The Trust was working with the regional team to look at alternative investment to create an elective care centre.

AJ also confirmed the most important priority was the main tower ward block and the Estates and clinical teams had been identifying the risks and opportunities available for utilising resources more effectively across the estate. A final proposal would be bought to BBF Committee.

3.2	**Lead Governor Report:** The CoG received the verbal report of the Lead Governor. • Membership engagement had been positive resulting in suitable candidates coming forward for the Governor elections, especially for Teignbridge which had multiple vacancies. • It had been felt there needed to be more of a Governor and/or patient voice at the board meetings. Discussions were ongoing to bring forward suggestions for further participation in Board meetings. • There had been questions asked by Committee observers regarding information which should/should not be shared with other Governors outside the Committees. EL confirmed that whilst the Trust would be open and transparent with Governors, this also needed to be balanced with confidentiality to ensure the correct information was cascaded in a responsible and accurate way and at the right time. The Trust needed privacy to work through complex and difficult decisions effectively before communications and would engage with Governors at the appropriate time. It was agreed that Governor observers would discuss with the relevant Committee Chair and then escalate to the Governor Chair if they had any questions about information they could/could not share. • Governors were reminded to send any questions in the first instance to AP who would forward to SF to log and ensure these were answered in a timely manner. SF confirmed that a response was awaited on just one question now.
3.3	**<u>Interim Chief Executive's Report</u>** AJ the Deputy CEO presented the report which had been circulated with the agenda and briefed the Governors on the following points: <u>NOF4 performance</u>: • December showed the Trust did not meet trajectory for ED 4-Hour performance, hitting 65% against a target of 78%. • There was a significant reduction in six and eight hour ambulance handover times. • The Trust did meet the 78-week target of no patient waiting 78 weeks for treatment. The 65 week wait target of zero would be met in March 2025 and an Elective Recovery Group had been set up with support from the National Recovery Group, GIRFT and ICB to ensure effective use of resources to improve local pathways. • Twenty eight day and sixty two day cancer standards were met in January 25 and the Trust continued to focus on maintaining those services. • A same day emergency care unit had been introduced and long stay patients were transferred into more acute medical beds to align with national requirements. <u>Finance</u>: • A forecast out turn of £26.8M was expected which was £15M more than planned. The revised target had been agreed with the system and the Trust was confident this target would be achieved. Weekly Care Group meetings would be held to review the governance arrangement with financial controls. <u>NHP:</u> • AJ thanked the team for working on this and acknowledged the delay was a huge disappointment for staff who had been fully behind the design and development of the Business Case. The Trust was looking at contingency plans for staffing to ensure

	job security and ensure skills and capabilities would be continued to the utilised within the Trust. EPR: • Contract had been signed for EPIC. New positions including Analysts, Project Managers and technical staff had been recruited and staff training was underway. From March 2025, UHP and Torbay staff would come together to ensure effective training and EPR would be implemented in Torbay at the end of March 2026 with UHP go-live at the end of June 2026. There would be a single Senior Responsible Officer reporting into Adel Jones and Sarah Brampton (CFO at UHP). Paul Richards was also Chair of the Devon EPR Board which would bring a great level of leadership. Trust Leadership: • Anne Cholmondeley has started as Interim Chief People Officer until October 2025. • Joe Teape, new CEO starts on 3 March 2025. • Arun Chandran Chief Operating Officer was on a period of leave and operational updates would be given to the Board via Adel Jones. Executive responsibilities would be reviewed to ensure right skills mix across all portfolios. Dartmouth: • Five bids had been received, for the former hospital with one being accepted and the CoG would be informed of the outcome when the formal process has been concluded. The CoG received and noted the Chief Executive Report.
3.4	**Membership Committee Chair's Report:** The Membership Chair presented her verbal report and key highlights received were: • AR thanked JK for chairing the last Membership Committee meeting in her absence and compiling the report for this meeting. • AR thanked fellow Governors, AH, AP, JT, EE and JH for their hard work in engaging with the Teignbridge community to ensure candidates came forward for the Governor elections. • There was a successful Medicine for Members meeting in November 24 with presentation by a Urology Consultant and it was hoped there would be a Cardiology or Renal Consultant talk at the next meeting. It was planned for at least two meetings each year. • The next Annual Members Meeting (AMM)was being planned for September 2025 and work was underway to plan for format for the meeting. • Following the excellent digital demonstrations at the last AMM there had been community engagement with the Trust's digital team to look at the new technology being introduced in the Hospital. This had been a good tangible way of engaging with the community. • The CoG acknowledged the excellent support to Governors from SF in the Governance office in the absence of the Membership Manager.
3.5	**Governor Observer Exception Report:**

	The committee received the Governor Observer Report from the Membership Committee meeting on 23 January 2025.
4.	**GOVERNANCE**
4.1	**Report of the Director of Corporate Governance and Trust Secretary:** The Director of Corporate Governance and Trust Secretary briefed CoG on her report which had been circulated with the agenda. The key highlights received were: • Civica are still working on the results of the Governor elections, and an update would be given as soon as the results were received. • The Trust would be undergoing a developmental Well-Led review which was part of the CQC review framework every 3-5 years. This was a welcomed and positive review following the Trust's recent leadership changes and current operational position. GY confirmed it was a good move to review of frequency of meetings and asked for it be considered that there was more of a patient and Lead Governor voice at Public Board meetings. EL agreed that actively inviting questions from the public prior to the Public Board was good interaction and Governors could also invite questions from their communities to be presented. EL reminded CoG that every Private Board did start with sharing a patient story and that the meeting was a meeting held in public but was not a public meeting, therefore questions would need to be logged in advance of the meetings. Governors were asked to contact EL with any ideas for further public engagement. CB outlined he had been asked to speak to the Governors at RDUH around the introduction of Associate NEDs to share the Trust's experience. At this meeting it was suggested that perhaps Lead Governors from different Trusts meet to discuss their role and gain learning. SF reminded the CoG that expressions of interest for the Lead Governor and Deputy Lead Governor must be sent to the FT office by 9am on Thursday 27 February 2025. In addition, Governor Observer role nominations were due in to the FT office on Thurs 27 February 2025. SF outlined that the Lead Governor and Deputy Lead Governor roles and responsibilities document had been updated and this was contained in the Governance Report. CB noted the upcoming NED appraisals in April 2025 and acknowledged that Governor input was vital to support this process. SF would send out proformas to Governors and this would be followed by a moderating session to work through the comments before passing to the Chair prior to each NEDs appraisal. It was also noted that some Governors had mandatory training outstanding and those who had, would be contacted outside meeting by the CoG Chair.
5	**GOVERNOR ENGAGEMENT**
5.1	**NED Briefing:** CB invited two NEDs to speak to the CoG to outline their work history and experience: <u>Mark Greaves:</u> Joined the Trust as NED on 1 January 2025. Main work history was as a Corporate Finance Partner and was also on the Board of Delt Shared Services which provides IT and back-

	office functions to the public sector. This is owned by NHS Devon and the local Council and has given a unique perspective of NHS financial and operational processes. Robert Williams: Chair of BBF Committee and a year as NED. Management consulting background dealing with organisational change (strategic/new technology) and healthcare systems including EPR implementations in various countries. Previous experience would bring constructive challenge and new ideas to the Board. Regular visits to various clinical departments to get insight and perspective from staff and patients. On the Board of a neurodiversity/learning disability charity in Exeter.
5.2	**Feedback and questions from Members and Governors including Governor Communications Log:** Chair confirmed that questions were being answered in a timelier manner.
6.	**INFORMATION ITEMS**
6.1	**Governor Calendar and Information Items:** SF confirmed the dates would be updated in the Governor handbook and calendar to reflect recent changes in Board meetings and Governor coffee meetings. **Action: SF**
7.	**CLOSING MATTERS**
7.1	**Any Other Business:** GY requested advice in relation to a mental health issue for one of his constituents and who would be the contact in Mental Health services. SWM confirmed the South Hams Council Community Safety Partnership should be contacted and further discussion would be held outside the meeting regarding the correct process for escalation. AR wished it to be acknowledged regarding current pressures on the Trust office to process the new Governor inductions. It was suggested regarding governor 'buddies' to assist new Governors and those wanting to offer their services, to contact SF. EL confirmed that welcome letters would be sent out immediately with invitations to meet with Chair and SF as soon as possible. Chair acknowledged their commitment and said thanks to Annie Hall and John Smith who would be stepping down at the end of February 25 after 9 years as a Governors. Annie would be continuing with the Trust as a volunteer. AS advised that signs for the Dawlish MIU were now up around the town. As this was an MS Teams meeting rather than the usual face to face, the Chair welcomed feedback as to the attend ace and participation in order to consider whether there should be further meetings held via Teams.
7.2	**Dates of 2024 Meetings – 2pm, Wednesday 7 May 2025** To note.
7.3	**Close of meeting** There being no further business, the Chairman declared the meeting closed at 15:35.

Council of Governors
Action Tracker

No	Action	Lead	Due date	Update	Status
Meeting held on 06 November 2024					
1.	**Chairman's Report -** Staff Governor representative be part of the stakeholder group for the Chief Executive interviews.	MG	Nov 25	February Update: Matthew Arthur attended the stakeholder group as a CoG representative.	**Closed**
3.	**Lead Governor Report** – Facilities Manager to provide feedback on PLACE visits and present to CoG.	SF	Feb 25	Facilities Manager to attend a future CoG meeting after analysing the PLACE visit data which is still awaited.	**Open**
5.	**DCG Report** – amend Governor Conduct Committee ToR as detailed in the minutes.	EL	Feb 25	EL covered this item as part of the wider Governance paper presented at this meeting.	**Closed**
6.	**Governor Question Report** – protocol to be developed and reference in Code of Conduct.	EL	Dec 24	February Update: EL covered this item as part of the wider Governance paper presented at this meeting.	**Closed**
Meeting held on 05 February 2025					
7.	**Governor Calendar and Information Items:** Dates would be updated in the Governor handbook and calendar to reflect recent changes in Board meetings and Governor coffee meetings.	SF	Mar 25		**Open**

Actions recorded on this tracker should be grouped by meeting, with progress monitored at each subsequent meeting. Once complete the item should be marked as grey, noted by the Committee as complete and removed from the log before the following that meeting to ensure a proper auditable trail.

Torbay and South Devon NHS Foundation Trust

Council of Governors

Chief Executive's Report

Date of meeting	Date report produced
07.05.2025	16.04.2025

Author(s)		Report approved by	
Name and title:	Jane Harris, Associate Director of Communications and Partnerships	**Name and title:**	Joe Teape, Chief Executive
Phone:		**Date:**	18.04.2025
Email:	Jane.harris18@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

To provide information on key issues to the Council of Governors.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1	Satisfactory	N/A

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Discussion items discussed at Board and Board Sub-Committee level.

Key recommendations and actions requested

The Council of Governors are asked to RECEIVE and NOTE the Chief Executive's report.

The Council of Governors are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This report provides the Council of Governors with information on key corporate matters as well as local, system and national initiatives and developments that contribute to our vision and purpose.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	1
Quality of services provided	2
Sustainable and efficient use of resources	3

Impact on BAF Objectives

BAF Objective	Impact
Quality and Patient Experience: Personalised Care	Yes
People	Yes
Financial Sustainability and Productivity	Yes
Estates	Yes
Operations and Performance Standards	Yes
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	Yes
Sustainability: Green Plan/ Environmental	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	Yes

Risk: Risk ID (as appropriate)

Risk	Risk ID

Please note whether the risk is already included on Datix, whether there is any risk item for escalation or whether/how the intended outcomes of the report mitigate risk

External Standards affected by this report and associated risks

Care Quality Commission, NHS England licence and regulations, national policy and guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance).There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Chief Executive's Report

Introduction and background

The Council of Governors ('COG') meetings are a key part of our governance arrangements. We maintain our usual communication programme with Governors via regular briefings, email, bespoke newsletters and a combination of virtual and face-to-face meetings.

I am also mindful of the important role that Governors provide in actively seeking feedback from members of the public and the support Governors are able to provide to us in communicating key messages.

At the previous COG meeting Governors received a high-level report on: our progress against the exit criteria for National Oversight Framework 4 (NOF4) – financial and performance turnaround including how we are listening to and engaging with our staff; our ongoing work to reduce our waiting lists both locally and system-wide and addressing performance issues in key areas; urgent and emergency care: ambulance handovers, home before lunch and work on the complex care discharge pathway; next steps for the former Dartmouth and Kingswear hospital site and the former Dartmouth clinic, Albany Clinic and land at Brixham Hospital; the new hospital programme and *Building a Brighter Future;* an update on our Electronic Patient Record full business case and implementation plan; Change NHS and national and local engagement on the 10-year health plan; an update on our leadership arrangements and the latest updates from the Integrated Care System for Devon, the Devon joint forward plan and the Peninsula Acute Services Sustainability Programme.

Since the last Council of Governors meeting, Governors have received briefings on cardiology (x2), my introductory welcome message to governors, our response to an FOI request from the Health Service Journal and a leadership update as well as receiving the regular fortnightly Governor newsletters.

While Governors have received operational briefings via the monthly Governor Network meetings, it is my intention at this Council of Governors' meeting to provide, along with my Executive colleagues, an update on the following key areas:

- an overview of my three priorities (our plan for this year, our future plans and our people) followed by more indepth briefing on:
    - our operating plan for 2025/26 and reducing corporate cost (including progress against the exit criteria for National Oversight Framework 4 (NOF4)) including how we are listening to and engaging with our staff
    - our progress in reducing waiting times across urgent and emergency care and planned care
    - an update on estates issues including property disposals
    - an update on our Electronic Patient Record implementation plan
    - an update on what we know about the publication of the 10-year health plan
    - the latest updates from the Integrated Care System for Devon, the Devon joint forward plan and the Peninsula Acute Services Sustainability Programme.

Assurance and Recommendations

1. The Committee are asked to AGREE the recommended assurance rating and TAKE SATISFACTORY ASSURANCE as to those matters reviewed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
1	Satisfactory	N/A

2. For information and noting with satisfactory assurance.

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Report of the Membership Committee Chair to the Council of Governors

Meeting date:	24 APRIL 2025
Report by:	MC CHAIR
This report is for:	Information☒ Decision ☐
Link to the Trust's strategic objectives:	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☐ 4: Well led ☐
Public or Private	Public ☒ or Private ☐

Key issues to highlight to the Council of Governors:

- **Medicine for Members**
- **Annual Members Meeting**
- **Members survey**
- **Membership promotion and engagement**

Key decision(s)/recommendations made by the Committee:

To note the recommendations and actions from the Committee meeting listed below. All Governors are encouraged to support membership activity including attending promotional events and the planning of the Annual Members Meeting and Medicine for Members.

Members Survey- An online survey has been carried out to canvass members' views about why and how they became Trust members. The results (albeit from a relatively small sample) indicated that many people look to the Trust website and Healthy Futures magazine for information. The overwhelming motivation for people becoming members is to be kept informed of significant developments in the Trust. A copy of the survey outcomes is available on request through the Trust office.

Medicine for Members (M4M)– Our second M4M was held on 29th April. Dr Ko Ko, Cardiologist, presented a very interesting talk and Q&A session on heart health. The event was well attended in person and online. Thanks to those governors who supported it. Further M4Ms will be arranged twice yearly with the next planned for November.

Annual Members Meeting (AMM)- The AMM will take place on **Thursday 25th September** in TREC. Details to be finalised. Consideration is being given to organising a presentation on the new electronic patient record system (EPIC) on the day to support the official Trust presentations and attract attendance.

Membership Promotion and Engagement- With limited resources, both time and financial, there is a need to be smart in targeting activities in which to promote engagement.

We have two new committee members who will play a key part. David Thomas can facilitate a link up with Torbay Council to enable us to work in partnership at community events. One of the key takeaways from the survey is the need to encourage more interest from a range of ages and

Torbay and South Devon NHS Foundation Trust

backgrounds and Sharifa Milford Al Hashemy, Interim Joint Head of Inclusion, Diversity ad Equity, has offered to work with us to reach out to groups that are seldom heard.
There is also a need to attract younger people, and we plan to set up a stall at the **Volunteer week event on 2nd, 4th and 5th June.** Many students attend this event, and it would be much appreciated if we could have some offers of help from fellow Governors on these days. Please let the Trust office know if you are available.
Alongside support from Torbay Radio who will help to promote membership on its airwaves and summer roadshows we will also carry on with our town centre stalls across the constituencies. This proved to be very effective in Newton Abbot last year.

Torbay and South Devon NHS Foundation Trust

Council of Governors

Report of the Director of Corporate Governance and Trust Secretary

Date of meeting	Date report produced
7 May 2025	30 April 2025

Author(s)		Report approved by	
Name and title:	Emily Long, Director of Corporate Governance and Trust Secretary	**Name and title:**	Emily Long, Director of Corporate Governance and Trust Secretary
Phone:	07392 316829	**Date:**	30 April 2025
Email:	Emily.long6@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

n/a

Executive summary

The report provides corporate governance updates on matters of relevance to the Council of Governors.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	N/a

Committees that have previously discussed/agreed the report, and outcomes of that discussion

n/a

Key recommendations and actions requested
The Council of Governors are asked to **AGREE** the recommended assurance rating and take **SATISFACTORY** assurance as to those matters reviewed.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?
The report provides assurance to the Council of Governors that the Trust's governance processes ensure the Trust meets its statutory obligations which in turn support the people in its footprint to live well.

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	The report provides information on the work of the Council of Governors in its support of the Triple Aim.
Quality of services provided	
Sustainable and efficient use of resources	

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality and Patient Experience: Personalised Care	All
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	
Sustainability: Green Plan/ Environmental	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	

Risk: Risk ID (as appropriate)	
Risk	**Risk ID**
N/a	

External Standards affected by this report and associated risks
Laws or regulations Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance).There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Report of the Director of Corporate Governance and Trust Secretary

The report provides corporate governance updates on matters of relevance to the Council of Governors.

1. 2025 Elections

The annual elections process for the Council of Governors commenced in November 2024. The contested seats were:

Public Governor	Teignbridge Constituency	(5 seats)
Public Governor	Torbay Constituency	(2 seats)
Public Governor	South Hams	(1 seat)
Public Governor	Rest of the SW Peninsula	(1 seat)

Following the close of elections on 7 February 2025, Civica, the Trust's Returning Officer, confirmed the successful candidates for each Constituency as follows:

Public Governor	Teignbridge Constituency	Geoff King Michael Joyce Alison MacGregor James Osben Eileen Englemann
Public Governor	Torbay Constituency	John Kiddey (plus, one vacant seat)
Public Governor	South Hams	Julie Spinks
Public Governor	Rest of the SW Peninsula	Not filled

In addition, Torbay Council's representative has changed to Councillor David Thomas who replaced Councillor Hayley Tranter in March 2025

Governors who have stood down since the last CoG meeting:

- Hilary Milner appointed governor for Carers stood down from her role on 2 February 2025.
- Matt Giles staff governor for Planned Care stood down 14 March 2025
- Clare McAdam appointed governor for Devon Partnership stood down 24 March 2025. Clare has been replaced by Sarah Adams, who commenced in role on 22 April 2025.

Action required: To receive and note the 2025 election update report.

2. Lead Governor and Deputy Lead Governor

Following a request for expressions of interest for the annual refresh of the Lead Governor (LG) and Deputy Lead Governor (DLG) positions, one nomination was received for LG: Andrew Postlethwaite but this has now been withdrawn. Two expressions of interest were received for the role of DLG: Val Browning and Loveday Densham. CoG will therefore be asked to reconsider nominations for LG, submitting

them no later than 9am on Wednesday 14 May and then vote for their preferred candidate in respect of the LG and DLG positions.

Due to this need to re-run the nomination, it is proposed that incumbents remain in post for May 2025, with new terms commencing as of 1 June 2025. It is proposed that votes be requested and collated by email through the Foundation Trust office.

Action: Governors are asked to consider the proposed process to elect a new GL & DLG.

3. Governor Observers

Following February's Council of Governors meeting expressions of interest were sought from Governors to be Governor Observers for the period of a year with effect from 1 May 2025 on the Board's Sub-Committees.

The following Governor Observers will take up their post in May:

- Audit and Risk Committee — Yvonne Paulucy
- Finance and Performance Committee — Dave Cawley
- People Committee — Alison Ramon
- Quality Assurance Committee — Val Browning
- Building a Brighter Future Committee — Andrew Stilliard
- Charity Committee — Loveday Densham

Action: Governors are asked to note and approve the new nominated Governor Observers for a one-year period with effect from 1 May 2025.

4. Governor Conduct Committee

Following discussion at the November CoG, the Governor Conduct Committee Terms of Reference have been amended and are attached for approval.

Action: CoG to approve amended terms of reference for the Governor Conduct Committee and amended CoG and Board Engagement Policy.

5. Governor Question Protocol

Following discussion at the November CoG a request was made to draft a Governor Question Protocol. This is attached for consideration and approval.

Action: CoG to consider and approve the Governor Question Protocol.

6. Governor Annual Declarations

As agreed at the CoG in November 2024, all Governors were asked to complete and return to the Corporate Governance Manager, an annual declaration form. This ensures that the Trust complies with its Fit and Proper Persons responsibility in respect of Governors. There are a number of Governors who have not yet returned their declarations, despite several reminders, and are asked to do so.

Action: Governors to return completed declarations to the Corporate Governance Manager.

7. Governor Register of Interests

Governors are asked to review the attached Governor Register of Interests and inform the Corporate Governance Manager if there are any amendments that need to be made. The Register is a public document and will be made available on the Trust's website.

Action: To confirm Governor Register of Interests.

8. Governor Reimbursement of Expenses Policy

Governors are asked to review the attached Governor Reimbursements and Expenses Policy which has been updated to ensure it is in line with best practice.

Action: To approve Governor Reimbursements and Expenses Policy.

9. Governor Nomination and Remuneration Committee (GNRC)

Governors are reminded of the membership of the GNRC in line with its Terms of Reference and those governors who are currently members of the Committee:

- Trust Chair (Chris Balch)
- Trust Senior Independent Director (Paul Richards)
- Four Public Governors (Andrew Stilliard (Torbay), Dave Cawley (South Hams))
- Two Staff Governors (Sal Aziz, Radia Woodbridge)
- Lead Governor (Andrew Postlethwaite)

We therefore currently have two public governor vacancies and would ask that Governors contact the Trust office if they would like to join the Committee – ideally the Committee should represent each of the public constituencies.

Action: Governors to inform the Trust office if they would like to join the Governor Nomination and Remuneration Committee.

10. Recording of CoG Priorities and Governor Only Meetings

Governors will be aware that it has been suggested that the CoG Priorities and Governor Only meetings are recorded so that recordings can be made available for Governors who are not able to attend the meetings; however not all Governors are in support of this suggestion. Governors are reminded that these are Governor-led meetings, supported by the Trust Office, and as such it is up to the CoG to make a decision on whether they are recorded or not.

Action: Governors to vote on whether to record CoG Priority and Governor Only meetings.

11. Assurance and Recommendations

The Council of Governors are asked to **AGREE** the recommended assurance rating and take **SATISFACTORY** assurance as to those matters reviewed.

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	N/a

Torbay and South Devon
NHS Foundation Trust

GOVERNOR CONDUCT COMMITTEE

TERMS OF REFERENCE

Version:	**1.0**
Approved by:	**Governor Conduct Committee**
Approved by:	**Council of Governors**
Date approved:	**Xx**
Date issued:	**Xx**
Review date:	**Xx**
Relevant documentation to read in conjunction:	**Trust Constitution** **Council of Governors Standing Orders** **Governor Conduct of Conduct** **Governor Engagement Policy**

GOVERNOR CONDUCT COMMITTEE

TERMS OF REFERENCE

1. Constitution and Authority

1.1. The Committee is constituted as a Standing Committee of the Council of Governors (the "CoG") of Torbay and South Devon NHS Foundation Trust (the "Trust"). Its constitution and terms of reference are subject to amendment by the CoG, to which it remains accountable.

1.2. These terms of reference may only be changed with the approval of the CoG.

1.3. The Committee shall embody the principles of the NHS Constitution, Nolan Principles, and the Trust's values, at all times.

1.4. The Committee shall not have the ability to delegate.

1.5. These Terms of Reference shall be published on the Trust's website.

2. Purpose

2.1. The purpose of the Committee is to support the Council of Governors to ensure that its Governor members promote the values of the Trust; the NHS Constitution; behaviours are in line with the Governor Code of Conduct; comply with the Code of Governance for Provider Trusts, Trust Constitution and Governor fit and proper person requirements; and any other actions/requirements deemed necessary to fulfil the role of the Governor.

2.1.1. Referrals to this Committee shall only be made by the Chair or Trust Secretary in the event that all previous resolution or engagement with the relevant Governor(s) has been exhausted.

2.2. The Committee will promote local level responsibility and accountability.

2.3. This is a Tier 1 Committee in accordance with the Trust's governance framework.

3. Duties

3.1. In pursuance of its purpose, the duties delegated to the Committee are to:

3.1.1. Facilitate the Council of Governors to promote and support the Trust's values by supporting culturally appropriate behaviours and holding their peers to account where a Governor(s) behaviours do not meet culturally appropriate behaviours by reviewing and considering complaints against Governor(s), as referred by the Council of Governors, the Chairman or Trust Secretary which may lead to their removal, in accordance with Annex 4, provision 5:

"5.1 *A Governor may be removed from the Council of Governors by a resolution approved at a meeting of the Council of Governors by not less than three-quarters of the Governor present and voting on the grounds that:*

5.1.1 they have acted in a manner detrimental to the interests of the Trust or otherwise bring the Trust into disrepute; or

5.1.2 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor, for example because:

5.1.2.1 the individual's continuation as a Governor would be likely to prejudice the ability of the Trust to fulfil its principal purpose or discharge its duties and functions;

5.1.2.2 the individual's continuation as a Governor would be likely to prejudice the Trust's work with other persons or body within whom it is engaged or may be engaged in the provision of goods and services;

5.1.2.3 the individual's continuation as a Governor would be likely to adversely affect public confidence in the goods and services provided by the Trust;

5.1.2.4 it would not be in the best interests of the Council of Governors for the individual to continue as a Governor / the individual has caused or is likely to cause prejudice to the proper conduct of the Council of Governors' affairs; or

5.1.2.5 the individual has failed to comply with the values and principles of the NHS, the Trust or this Constitution.

Once this Committee has returned a view and made recommendation to the Council of Governors it must be supported by the Council or Governors; unless a failure in process or conflict of interest can be substantiated. Thereby creating and invoking a procedure for the consideration of such matters, as required by the Constitution, Annex 4, provision 5.2.

For the avoidance of doubt this shall include but not be limited to questions of compliance with the Governor Code of Conduct and completion of the annual training programme, as agreed by the Council of Governors.

3.1.2. Any other relevant matter as may arise from time to time, with regard to Governor conduct.

3.1.3. For the avoidance of doubt, this Committee's remit is to make recommendations in respect of the Governor role only (whether individual(s) are publicly elected, appointed or staff).

4. Powers

4.1. In accordance with the delegated authority outlined above, the Committee is authorised to seek any information it requires from any member of staff, who shall be under a positive obligation to co-operate with any request made by the Committee.

4.2. The Committee may request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary in the best interests of the Trust.

4.3. The Committee derives its power from the Council of Governors and has no powers, other than those specifically delegated in these terms of reference.

5. Membership and Attendance

5.1. The Membership shall be defined by the Council of Governors under direction of the Chair; for avoidance of doubt membership shall always include:

- Lead Governor
- Deputy Lead Governor
- Representatives from each public constituency to which there are elected Governors and one staff Governor
- Chair and/or Senior Independent Director (as appropriate)

5.2. A Governor shall act as Committee Chair. In their absence, one of the other Governors present shall be nominated and appointed as acting Chair for the meeting.

5.3. The following shall be invited to attend all meetings of the Committee:

- Trust Secretary
- Corporate Governance Manager
- HR professional or other adviser from People Services

5.4. Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.5. If any member of the Committee has been disqualified from participating on an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.6. Unless otherwise determined by the Council of Governors, the duration of appointments to this Committee shall be for a continuous term, with annual review; for the avoidance of doubt, no member may continue to attend if they cease to be a governor.

6. Meeting Administration, Record Keeping and Decision-Making

6.1. The Committee shall be supported by a Committee Secretary, or their nominee, who shall be appointed by the Chair.

6.2. The duties of the Committee Secretary shall include, the:

6.2.1. creation and maintenance of a work plan and reporting schedule;

6.2.2. collation of papers and drafting of the agendas;

6.2.3. record of proceedings and decisions taken by the Committee; including decisions taken in writing outside of the meeting; with such record presented at the following meeting for approval; and

6.2.4. where the Committee have met, virtually or otherwise a record of those present and in attendance should be maintained;

6.3. Items for the agenda must be sent to the Committee Secretary a minimum of seven (7) working days prior to the meeting. Urgent items may be raised under any other business.

6.4. A decision is taken in accordance with these Terms of Reference when a quorate majority of the members indicate to each other, by any means, that they share a common view on a matter; with each Member holding one vote.

6.5. In the event of equality of votes (however communicated) in relation to a specific matter the Chair may exercise a casting vote.

7. Quorum

7.1. The quorum necessary for the transaction of business shall be four (4) members; including the Chair, or their nominated deputy. At least three (3) governors need to be in attendance to ensure quoracy.

7.2. A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

8. Frequency of Meetings and Notice

8.1. The Committee shall meet as and when required. Meetings of the Committee shall be called by the Trust Secretary or Trust Chair on behalf of the Council of Governors.

8.2. Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be forwarded to each member of the Committee and any other person required to attend no later than five (5) working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees, as appropriate, at the same time.

9. Conduct of Meetings and Conflicts of Interest

9.1. Except as outlined above, meetings shall be conducted in accordance with the provisions of the Trust Constitution and Council of Governor Standing Orders.

9.2. As per the Trust's Standards of Business Conduct Policy and Conflicts of Interest Policy, any potential, actual or perceived conflict of interest shall be declared and managed through the Trust's declaration procedure; noting the enhanced obligations of Executive Officers in accordance with the Trust's Fit and Proper Persons Regulations SOP.

9.3. At the commencement of any meeting, or should any potential, actual or perceived conflict arise during a meeting, the relevant Committee member must declare this and recuse themselves from any relevant decision; this shall be formally noted in the minutes of the meeting.

10. Review and Monitoring Effectiveness

10.1. As part of the Trust's committee effectiveness review process, the Committee shall review its collective performance annually. The purpose of this review is to be assured that the Committee is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Council of Governors.

10.2. The Committee shall review its Terms of Reference and membership annually.

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NHS
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Council of Governors and Board of Directors Policy of Engagement for Serious Concerns

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Document Information

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Date of Issue:	April 2025~~4~~	Next Review Date:	April 2027
Version:	V3~~2~~.0	Last Review Date:	
Author:	Corporate Governance Manager		
Director Responsible	Director of Corporate Governance and Trust Secretary		
Approval Route: Council of Governors and Board of Directors			
Approved By:		**Date Approved:**	
Council of Governors		February 2023 (V1)	
Board of Directors		February 2023 (V1)	
Council of Governors		May 2025 (V3)	
Board of Directors		XXX	
Links or overlaps with other policies: • NHS England Code of Governance for NHS Provider Trusts • Governor Code of Conduct • NHS England Your Statutory Duties – A Reference Guide for NHS Foundation Trust Governors – updated in 2022 for system working and collaboration • NHS England "Director-governor interaction in NHS foundation trusts – A best practice guide for boards of directors" (joint publication by PA Consulting and Monitor 2012) • Governor Conduct Committee			
We are committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership. We are committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy.			

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Amendment History

Issue	Status	Date	Reason for Change	Authorised
1.0	New Document	Feb 23	New Document	CoG and Board of Directors
2.0	Revisions	Feb 2024	Revisions to align with Constitution/SO's & Trust policy broadly	CoG and Board of Directors
3.0	Revisions	April 2025	Reference to Governor Conduct Committee Terms of Reference	CoG and Board of Directors

1. Introduction

1.1. The relationship between the Council of Governors and the Board of Directors is key to the successful delivery of the Trust's functions. The Council of Governors and Board of Directors are each committed to building and maintaining an open and constructive working relationship.

1.2. The Chair is the prime connection between the Council of Governors and Board of Directors. In addition, the Trust has well established channels for business-as-usual communications and engagement between the two bodies. Informal and frequent communication are an essential feature of a positive and constructive relationship and benefits the Trust and the services it provides.

1.3. In the limited and rare circumstances described below, where Governors have very serious concerns about the functioning of the Trust, they may wish to invoke the formal process set out in this policy.

2. Purpose

2.1. The purpose of this policy is to describe the method by which Governors can engage with the Board of Directors in circumstances when they have serious concerns about:

2.1.1. the performance of the Board of Directors,
2.1.2. compliance with the Trust's NHS Provider Licence; or
2.1.3. other matters related to the overall wellbeing of the Trust and its collaboration with system partners.

2.2. NHS England's Code of Governance for Provider Trusts (updated in 2022) ("**Provider Code of Governance**") recommends that the Council of Governors establishes a policy of engagement to govern such situations. This policy is intended to provide clear guidance for both the Board of Directors and Council of Governors and has been approved by each respectively.

2.3. The policy is not intended to interfere with the usual methods of interaction between the Board of Directors and Council of Governors or the operation of the Trust's Freedom to Speak up: Raising Concerns (Whistleblowing) Policy[1].

3. Definitions and Interpretation

3.1. The capitalised terms and expressions defined in the Constitution apply to this policy.

3.2. The phrase "overall wellbeing of the Trust" is not defined in the Provider Code of Governance. The Trust interprets the phrase to mean the Trust's ability to deliver services in a way that fulfils its purpose, aligns with its values, creating a just and fair culture and crucially ensures compliance with the Trust's NHS Provider Licence.

3.3. The policy should be read in conjunction with the Constitution and other documents relevant to the governance of the Trust, including the Trust's NHS Provider Licence, as well as the Provider Code of Governance.

3.4. If there is any discrepancy between this policy and the National Health Service Act 2006, the Constitution or the Trust's Provider Licence, then those documents shall prevail over this policy. All Governors and Directors have access to these documents and should familiarise themselves with the contents of them.

[1] https://www.torbayandsouthdevon.nhs.uk/uploads/raising-concerns-policy-h30.pdf

3.5. A reference to the Chair shall be read as a reference to the Senior Independent Director where the Chair is unavailable or where it would be inappropriate to engage the Chair due to reasons of conflict.

4. Application of the Policy

4.1. The policy is not intended to cover minor or technical issues which can usually be resolved via the established channels of communication between Governors and the Secretary and Chair.

4.2. The policy seeks to address very serious concerns raised by Governors which cannot be resolved in the normal manner and may be invoked in relation to the following, but non-exhaustive list of situations, outlined below:

4.2.1. breakdown of communications between the Trust and its System stakeholders;
4.2.2. extensive breaches of the Trust's Provider Licence whether alleged or actual;
4.2.3. Board of Director's failure to respond adequately to findings from external regulatory bodies such as CQC or HSE of serious failings;
4.2.4. absence of Board of Directors oversight over significant financial or clinical risks which subsequently materialise;
4.2.5. breakdown of trust between the Trust and its workforce;
4.2.6. major operational oversights leading to loss of continuity of service;
4.2.7. loss of confidence of system leaders in the Board of Directors;
4.2.8. failure to respond to a significant transformational opportunity.

4.3. The policy is not intended for use where Governors have concerns about the performance of the Chair or any single Non-Executive Director. In these situations, Governors are referred to NHS England guidance, including the Provider Code of Governance and the Statutory Guide for Governors[2] and, ultimately, paragraph 27 of the Constitution (appointment and removal of Chair and other Non-Executive Directors).

4.4. Concerns may be raised through the application of this Policy by Governors as a whole acting collectively, by a sub-set of Governors or by Governors individually.

4.5. Where the Council of Governors as a whole is in dispute with the Board of Directors, the procedure in Annex 4 of the Constitution applies.

4.6. For the avoidance of doubt, Directors may not invoke this policy in relation to Governors.

~~4.6.~~4.7. This policy should be read in conjunction with the terms of reference for the Governor Conduct Committee.

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5. Process for Engagement

5.1. Governors should first consult the Trust Secretary who will seek to resolve the concern informally and advise on the appropriateness of raising the matter with the Chair; as outlined in provision 4.1.

5.2. The advice of the Trust Secretary is not binding and the Governors retain the right at all times to raise the matter with the Chair. Where it would be inappropriate to raise the concern with the Trust Secretary or the Chair, the Senior Independent Director should be approached instead.

[2] Governors_guide_August_2013_UPDATED_NOV_13.pdf

5.3. Where the matter has not been resolved informally with the support of the Trust Secretary or where Governors have been advised to raise the concern with the Chair, the Governors may raise the concern with the Chair who will seek to resolve the matter informally. Failing that, Governors should make a request for the matter to be investigated within the terms of this policy.

5.4. The Trust shall, at its discretion, appoint one of the following to investigate the concerns ("**Investigator**"):

5.4.1. the Chair;
5.4.2. the Senior Independent Director;
5.4.3. a Nominated Officer;
5.4.4. the Trust's internal auditor; or
5.4.5. an external investigator such as a professional services firm whose costs will be paid by the Trust provided the matter is not vexatious within the meaning of the Trust's Complaints Policy[3].

5.5. The Investigator is entitled to set the detailed terms of reference but will do so in line with the overall statutory roles of the Council of Governors to:

5.5.1. hold the Non-Executive Directors to account for the performance of the Board of Directors; and
5.5.2. represent the interests of the Trust's Members and the public.

The investigation will therefore focus on the Board of Director's, and particularly the Non-Executive Directors', visibility, oversight and response to the matter raised.

5.6. The Investigator may involve Directors and Officers at their discretion. Directors who are requested to participate in an investigation shall:

5.6.1. co-operate with requests of the Investigator;
5.6.2. attend meetings and produce documents;
5.6.3. answer questions raised by the Governors which form part of the investigation; and
5.6.4. confirm decisions taken by Directors or the Board of Directors (where appropriate).

5.7. Governors who have raised the concern will be invited to submit evidence to the Investigator.

5.8. The Governors and Directors agree to respect the confidentiality of the investigation.

5.9. Whilst the investigation is ongoing, the Council of Governors agrees to refrain from exercising its statutory power to require one or more of the Directors to attend a Council of Governor's meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors performance of their duties (and deciding whether or not to propose a vote on the Trust's or Director's performance) in relation to the matters under investigation.

5.10. The Investigator will review the evidence gathered and will, unless the Investigator is the Chair, report their findings to the Chair. As soon as practicable after the conclusion of the investigation, the Chair will meet with the Governors who raised the concerns to discuss the findings. The meeting has three possible outcomes:

5.10.1. the Governors are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required;

5.10.2. the Governors are satisfied that their concerns will be resolved by actions to be taken in

[3] Complaints Policy

light of the investigation or will be otherwise resolved. The Chair will write a report on the concerns and the actions taken, or to be taken, and present it to the Council of Governors in the closed section of the next Council of Governors meeting;

5.10.3. the matter is not resolved to the satisfaction of the Governors. The Chair will call a closed extraordinary meeting of the Council of Governors as soon as reasonably practicable to consider the matter further. That meeting may resolve to take no further action or, if two thirds of the Governors present agree the motion, the Trust shall refer the matter to NHS England or an independent arbitrator external to the Trust such as the chair of another NHS provider.

6. Distribution

6.1. This policy document will be made available on the Trust's intranet and public website.

6.2. Awareness will be raised through Equality Impact Assessment training, all ratifying committees/groups, policies and procedures training and intranet.

7. Key Contacts

7.1. For further information about this policy, contact foundationtrust.tsdft@nhs.net.

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Appendix 1
Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	**CoG and Board of Directors Engagement Policy**	**Version and Date**	V2.0 April 24
Policy Author	Corporate Governance Manager		

An equality impact assessment (EIA) is a process designed to ensure that a policy, project or scheme does not discriminate or disadvantage people. EIAs also improve and promote equality. Consider the nature and extent of the impact, not the number of people affected.

EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)

Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒

Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☒
Please provide details for each protected group where you have indicated 'Yes'.	

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☒ No☐
Are the services outlined in the policy/procedure fully accessible[6]?	Yes ☒ No☐
Does the policy/procedure encourage individualised and person-centered care?	Yes ☒ No☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☒
If 'Yes', how will you mitigate this risk to ensure fair and equal access?	

EXTERNAL FACTORS

Is the policy/procedure a result of national legislation which cannot be modified in any way?	Yes ☐ No☒

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

To provide the CoG with an engagement policy when working with the Trust/Trust Board of Directors.

Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?

Council of Governors

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**
n/a		

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form	Sarah Fox	**Signature**	*Sarah Fox*
Validated by (line manager)	Emily Long	**Signature**	*Emily Long*

Any issues Please contact Diversity & Inclusion Lead
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travellers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Torbay and South Devon NHS Foundation Trust

Governor Question Protocol

May 2025

Questions to the Trust form a significant means by which Governors can fulfil their principal responsibilities of appointing and holding to account non-executive directors, representing the interests of trust members and approving significant transactions, mergers, acquisitions, separations or dissolutions. The answers provided to questions sit alongside a variety of other sources of information to which Governors have access. These include:

- Annual Members Meeting
- Quarterly Council of Governors meetings
- COG Priority meetings
- Public Board meetings and access to published Board papers
- Monthly Governors' email
- One off Governor visits to Trust facilities
- Governor observer roles on Trust Committees.

These sources enable Governors to input to annual NED appraisals and understand the challenges facing the Trust in terms of quality/safety, performance and financials and to help steer to the strategy and priorities of the Trust.

The process for asking questions, either on an individual basis or through the Council of Governors, is detailed below:

Individual Governor Question

- Individual governor question to be sent to the Lead Governor for review (to identify any themes/duplication of questions) prior to being sent to FT inbox for processing
- Once an individual question has been approved by the Lead Governor, the FT office will acknowledge receipt of the governor question/s
- Governor question to be formally logged and sent to the relevant Executive Director for answering
- Answered question/s will be sent to all governors, logged on the formal question log and added to the next governor monthly email

COG question

- Lead Governor to forward the governor question/s on behalf of COG to the Foundation Trust Office
- FT Office will log COG question and send to relevant Executive Director for answering
- Answered question/s will be sent via email to all governors and logged on the formal question log and added to the next Governor monthly email.

Governors are asked not send questions directly to Trust staff or Executive Directors outside of this process.

All questions will be answered within 20 days, unless there are extenuating circumstances and this will be communicated. If this is the case, the relevant Executive Director will provide information in terms of the reason for the delay.

There may be occasions where an urgent response is required to a question. In this case the Lead Governor or Chair will inform the FT office of the question and ask that a response is provided within 5 working days.

In order to obtain the best response to questions, governors are asked to ensure questions are kept short and are clearly articulated.

If a governor is not happy with the response to a question, the Chair will seek to resolve this issue and feedback to the Council of Governors.

Torbay and South Devon NHS Foundation Trust

REGISTER OF GOVERNORS' INTERESTS AS AT 01 MAY 2025

SOUTH HAMS PUBLIC CONSTITUENCY

Governor name	Declared interests
Val Browning	None
Dave Cawley	Managing Director of Timestep Electronics Ltd Director, Vavasour House (Dartmouth) Management Company Member and ex-Chairman of Dartmouth PPG
Julie Spinks	None

TEIGNBRIDGE PUBLIC CONSTITUENCY

Governor name	Declared interests
Eileen Engelmann	Volunteer for Alzheimer Association Work on a freelance basis for Atlas Remedial and Care as a mentor/coach for people living with dementia and for their carers Volunteer Mealtime Assistant – Newton Abbot Hospital
James Hartley	None
Michael Joyce	Director and Vice Chair – Devon Associate of Local Councils Member – Albany Patients' Group Member – Newton Abbot Locality Patients' Group Councillor – Newton Abbot Town Council
Geoff King	President and Director – Dawlish Celebrates Carnival CIC Chair - Friends of Dawlish
Alison MacGregor	tba
James Osben	Wife is a radiographer at TSDFT
Andrew Postlethwaite	Director – The Forensic Reconstruction Service Expert Witness in the field of Forensic Reconstructions Charted Manager with the Chartered Manager Institute Affiliated to the Chartered Society of Forensic Sciences Guest Lecturer – University of Exeter Member of Teignmouth Hospital Stakeholder Group Member of Mensa Daughter is a member of staff at Royal Devon University Healthcare NHS FT Director - VR Forensics Chair - Channel View PPG

TORBAY PUBLIC CONSTITUENCY

Governor name	Declared interests
Loveday Densham	None
John Kiddey	None
Alison Ramon	Chair Pembroke PPG Member – RDUH FT
Andrew Stilliard	None
Lee Thomas	Director – Torbay Security Ltd Vice Chairman – Torbay Hospital Radio Chairman – Newton Abbot Hospital Radio Trustee – Hospital Broadcasting Association Wife works for the Trust
Vincent Williams	Director – ClubTQ Ltd Director – Gracenote Television Ltd EPR Project Manager – Kettering General Hospital NHS Trust

STAFF CONSTITUENCY

Governor name	Declared interests
Sal Aziz	Administrator - Devon Partnership NHS Trust Bank Director – PatientsCann UK Chair – Medical Cannabis Patients Staff Network Member – Auto Cycle Union Member – British Racing Club
Yvonne Paulucy	None
Radia Woodbridge	None

APPOINTED GOVERNORS

Governor name	Declared interests
Sarah Adams (Devon Partnership Trust)	Deputy Chief Operating Officer, Devon Partnership Trust
Karen Barry (Devon ICB)	Locality Director, Devon ICB Daughter and cousin employed by Trust
Joanne Bowtell (University of Exeter Medical School)	None
John Nutley (Teignbridge Council)	Chair, Ashburton and Buckfastleigh League of Friends Councillor, Teignbridge Council Member of Dartmoor National Park Authority Vice-Chair Exe Estuary Management Partnership Ashburton Town Councillor
Ron Peart (Devon County Council)	tba
David Thomas (Torbay Council)	Owner, Gold Print Member, Torbay Hospital Radio Leader, Torbay Council

Louise Winfield (Plymouth University PSMD)	Daughter-in-law works for the Trust
Ged Yardy (South Hams DC)	Director Galwyn UK Ltd Councillor, South Hams District Council Councillor, Dartmouth Town Council Investor/shareholder – SageTech Medical Limited Member – Devon Health and Wellbeing Board Member – South Hams District Council Audit and Governance Committee Member – Dartmouth Town Council Finance Committee Member – Dartmouth Medical Practice PPG

Torbay and South Devon NHS Foundation Trust

Reimbursement of Expenses for Governors and Members

May 2025~~March 2022~~
Version 6.3~~2~~

Torbay and South Devon NHS Foundation Trust

Document Information

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Date of Issue:	July 2007	**Next Review Date:**	May 2028~~March 2025~~
Version:	6.3~~2~~	**Last Review Date:**	May 2025~~March 2022~~
Author:	Director of Corporate Governance and Trust Secretary		
Director(s) Responsible	Chairman		
Approval / Consultation Route			
Approved By:		**Date Approved:**	
Governance Board		4 July 2007	
Governance Board		21 July 2010	
Council of Governors		28 September 2011	
Board of Directors		5 October 2011	
Council of Governors		14 December 2016	
NED Appointments and Remuneration Committee		March 2019	
Council of Governors		March 2022	
Council of Governors		xx	
Links or overlaps with other policies:			

Amendment History

Date	Reason for Change	Authorised
18 December 2009	Minor changes to ensure consistency of terminology. Section 2.1 referred to Health and Social Care Act 2003 now NHS Act 2006. Section 4.3, added some additional Groups/Committees.	Chairman
12 July 2010	Section 2.1 (updated to reflect new Government white paper) and section 5.2 (quarterly submissions).	Chairman
5 October 2011	Council of Governors (28 Sept) then Board of Directors approved change in mileage rate from 24p to 45p per mile. Revised section 4.3	Chairman
18 March 2019	Reviewed by Company Secretary	Chairman
February 2021	Reviewed by Company Secretary Minor changes/updates following personnel changes and titles of Committees/Groups	Chairman
March 2022	Minor changes/updates following changes in job titles	Chairman

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Torbay and South Devon NHS Foundation Trust

May 2025	Minor Updates	Chairman

NHS
Torbay and South Devon
NHS Foundation Trust

DOCUMENT SUMMARY

This document lays down the guidelines under which Governors may be reimbursed for legitimate expenses, incurred in the course of their official duties, as governors or members of the Torbay and South Devon NHS Foundation Trust.

Torbay and South Devon NHS Foundation Trust

INDEX

Torbay and South Devon NHS Foundation Trust

1. Policy and Audit Declaration

This policy has been drafted in accordance with the principles of significant legislation such as the European Convention on Human Rights (ECHR) 1998 (as amended), Race Relations (Amendment) Act 2000 and the Equality Act 2010. Under the Freedom of Information Act 2000, the document is classified as 'OPEN'.

2. Policy Statement

2.1 The Trust shall provide fair and appropriate reimbursement for the governors and members who participate in events and activities arranged by and for the benefit of the Trust (see introduction to section four).

2.2 This policy applies to all governors (and members under the conditions set out in the introduction of section four) asked to work with Torbay and South Devon NHS Foundation Trust.

2.3 Prospective governors may not make claims under this policy.

3. Introduction

3.1 Torbay and South Devon NHS Foundation Trust (the "Trust") is committed to the involvement of governors and members in all areas of its work whenever decisions are to be made which influence changes to the way the services are provided.

3.2 The post of governor of the Trust is voluntary, and it is a fundamental principle nationally that no governor shall receive any form of salary or remuneration for being a governor.

3.3 The policy of the Trust requires that:

a) All those acting for or on behalf of the Trust look to achieve value for money, noting that all funds apportioned to the Trust are to be applied in the achievement of public benefit for the people of Devon;
b) People contributing their views are not out of pocket for any reason as a result of participation in Trust business and in the fulfilment of their role;
c) Reimbursement practice with partner organisations for joint events is agreed, and to communicate the arrangements with participants.

4. Reimbursement

4.1 Governors participating in Trust events such as Council of Governors meetings, events, Committees or Working Groups, as agreed or invited by the Trust, and whose expenses are not paid by another organisation, shall be entitled to claim expenses.

Torbay and South Devon NHS Foundation Trust

4.2 Members may be entitled to claim if they have been personally requested to participate in an event by telephone call, personal letter, or personal email from a member of the Foundation Trust Office and when agreement has been made in advance for them to do so.

4.3 Expenses will only be reimbursed for the following expenditure:

i. Travel expenses by the cheapest available means to attend Council of Governors meetings, ~~Council of Governor Priorities and Governor Only Board-to-Council~~ meetings, regional / national governor events, members and local constituency meetings arranged by the Trust, and where applicable, meetings of the Membership Committee, Governor ~~NED~~ Nominations and Remuneration Committee and other Board Sub-Committee meetings. Mileage allowances, including allowances for passengers, will be paid at the tax-free limit set for volunteers by HMRC.

Note: In circumstances where public transport would not be appropriate or reasonable, governors / members may claim full reimbursement for the fares incurred where the Trust's prior authorisation has been sought and granted. Copies of r~~R~~eceipts must be attached to claims (screenshots of receipts are acceptable, e.g Ringo parking receipt). Please retain receipts for any expenses beyond mileage as you may be required by the HMRC to present them as part of your self-assessment.~~.~~

ii. Parking and toll charges incurred as a direct result of attending the above meetings;

iii. Public transport to be reimbursed on provision of receipt;

iv. Subsistence allowance where the governor / member is away from their home (for a period of more than five hours during the daytime and necessarily covering the period from midday to 2pm or during the evening from 5:30pm)~~—~~for the purpose of attending one of the above meetings, and where no refreshment is provided at the Trust's expense will be paid in line with Trust subsistence rates. Unless in exceptional circumstances, overnight expenses will not be paid. Periods away from home are calculated from the times of leaving and returning home;

v. Where a governor / member requires alternative transport arrangements, costs will be met, only by prior agreement;

vi. Expenses of a companion required to enable a governor / member to participate. If the attendance (including travel) exceeds five hours, and refreshments are not provided at the venue, expenses for refreshments of up to £5 can be claimed.

4.4 In accordance with NHS accounting rules all expenses (except mileage) should be submitted with receipts, and expenses should be claimed within three months. Further information should be sought from the Foundation

Trust Office. ~~The Foundation Trust Office will issue reminders to all governors who claim expenses~~.

4.5 Claimants should be aware that if they are in receipt of benefits these payments may impact upon their entitlements. This should be clarified with the local benefit agency prior to an expense claim being made.

5. Process for Reimbursement

5.1 Governors remain wholly responsible for the completion and accuracy of their claims. Claim forms are available upon request from the Foundation Trust Office.

5.2 Completed forms should be passed to the Foundation Trust Office or Corporate Governance Manager for authorisation. Claims will only be reimbursed direct to a nominated bank or building society account (the account number and sort code of which is stated on each claim) in accordance with the Trust's accounting timetable.

5.3 In the event that the appropriateness of a reimbursement is queried or disputed by the Foundation Trust Office or Corporate Governance Manager in accordance with this policy, interpretation of this policy shall be referred to the Trust Chairman for final decision.

6. Audit

6.1 Completed forms will be retained for the same period as those submitted by Torbay and South Devon NHS Foundation Trust staff.

7. Contact Details

Corporate Governance Manager/ Foundation Trust Office 01803 655705

8. Review

8.1 A review of this document will be conducted every three years or following a change to associated legislation and/or expenses rates and is the responsibility of the Director of Corporate Governance and Trust Secretary.

Torbay and South Devon NHS Foundation Trust

Council of Governors
(DRAFT)Quality Account 2024/25

Date of meeting	Date report produced
7 May 2025	30 April 2025

Author(s)		Report approved by	
Name and title:	Maria Patterson	**Name and title:**	Nicola McMinn
Phone:		**Date:**	30 April 2025
Email:	Maria.patterson5@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
n/a

Executive summary

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. The quality account also helps us to identify 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 2024/25.

Our performance against the agreed quality priorities for 2024/25 is discussed and the proposed quality priorities for 2025/26 are highlighted. We have developed these in line with the CQC 'we statements' which are designed to put the person at the centre of their care.

This **quality account is shared in draft as work remains ongoing**, the deadline for publication on the Trust website and for submission to the Secretary of State being 30th June 2025.

It is intended that this quality account will be shared to the Council of governors, Healthwatch, The ICB, Torbay and Devon councils to provide comments on the

quality account towards the end of May 2025. Audit 21st May, Final sign off of the Quality account will be undertaken by the Trust Audit Committee on 24th June and Trust Board on the 25th June 2025.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
All	Satisfactory	n/a

Committees that have previously discussed/agreed the report, and outcomes of that discussion

The draft quality account will be discussed at Quality Assurance Committee on the morning of the 7th May 2025; Audit and Risk committee 21st May; Trust Board on 17th June, Audit and Risk Committee 24th June and final sign off by Trust Board on 25th June.

Key recommendations and actions requested

The CoG are asked to AGREE the recommended assurance rating and take SATISFACTORY assurance as to those matters reviewed. The CoG are also asked to AGREE that completion of the Quality Account is underway and will be completed in line with statutory guidelines ready for submission on 30th June 2025.

Governors are invited to provide comment on the draft quality account.

Governors are asked to consider if further actions are recommended.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?

This report highlights the Trust progress against core quality priorities for the population. Quality and safety aspects of our services are also discussed alongside ambitions for improvement. Our progress against clinical audits is also detailed. The quality account supports the organisation to review its performance in providing quality services which support our population to live well.

How does the report support the Triple Aim

Aim	Impact
Population Health and Wellbeing	The quality and safety of our services support population well being
Quality of services provided	The quality account captured our progress against quality priorities and standards and clinical audit.
Sustainable and efficient use of resources	

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality and Patient Experience: Personalised Care	Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Digital and Cyber Resilience	
Building a Brighter Future	
Strategy and Transformation	
Sustainability: Green Plan/ Environmental	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	

Risk: Risk ID (as appropriate)	
Risk	**Risk ID**

External Standards affected by this report and associated risks
The Department of Health and Social Care requires providers to submit their final Quality Account to the Secretary of State by June 30 each year.

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk

	appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance).There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Quality Account 2025/26

Introduction and background

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. The quality account also helps us to identify areas where we want to improve and aids us in embedding a culture of continuous quality improvement across our organisation.

It is a requirement of the Department of Health and Social care that quality accounts are published on the Trust website and forwarded to the Department of Health and social care by 30th June 2025.

The CoG is asked to observe that the quality account is a working document and at the time of submission remains in draft. Work is underway to ensure that all national requirements are included.

It is intended that this quality account will be shared with, Healthwatch, The ICB, Torbay and Devon Councils to provide comments on the quality account towards the end of May 2025. Audit and Risk Committee on 21st May, Final sign off of the Quality account will be undertaken by the Trust Audit Committee on 24th June and Trust Board on the 25th June 2025.

Assurance and Recommendations

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
ALL	satisfactory	N/A

1. The CoG is asked to AGREE satisfactory assurance that the quality account is in progress and will be completed in line with National standards ready for publication by June 30th, 2025.

Photo/ Cover sheet to be completed by comms team

Torbay and South Devon 2024/5 Quality Account

Contents **To be completed with final draft**

Part 1: Our Chief Executive's statement on quality

To be completed

Chief Executive

June 2025

Commented [MP1]: Comms team will support

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 2024/25.

Our quality priority areas for next year, 2025/26, 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 2024/25
Our priorities for 2024/25 were aligned to our four quality and patient safety goals, the Trust continued to focus on embedding improvements made the previous year.

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

Quality goal 2024/25	Quality priority 2024/25
Continuously seek out and reduce harm:	Improve identification and management of sepsis Strengthen the quality of our mental capacity assessments (MCA)
Excellence in outcomes	Reducing falls and harm sustained from falls Reducing emergency and elective care delays
Deliver what matters most to our people	Listening to our people
Reduce Health Inequalities	Seek, identify and address health care inequalities

Continuously seek out and reduce harm:

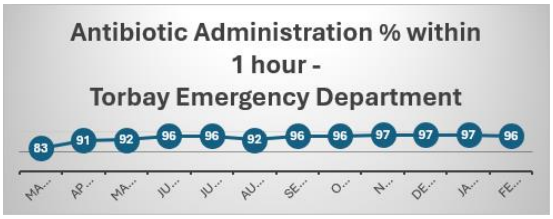
What we did and how we did

We committed to **improving the 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. 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 quality focus is to improve our identification and management of people with sepsis to reduce the number of people in our communities who die from septic shock.

Photo needed	What we did
	✓ Developed a Single Trust Wide Sepsis Policy ✓ Embedded a trust wide training and education programme introduction and roll out ✓ Agreed data collection for ongoing monitoring of compliance ✓ Improvement actions to support recognition and compliance of Sepsis ✓ ✓ 2025-sepsis dashboard for all areas-in development

How we did:
We have seen a sustained improved performance in our emergency department (ED) regarding sepsis 6 compliance to 97%. Antibiotic administration within 60 minutes at 96%, despite ED pressures. Continued focus on waiting room safety and patients in ambulance to ensure location does not impact upon prompt treatment



A Trust wide sepsis Audit is due to commence in April 2025 which will inform further work. We have an ambition to establish a sepsis dashboard for all areas, this is currently in development.

Improving the identification and management of sepsis will remain a quality priority focus in 2025/26 to ensure that practice is embedded.

Continuously seek out and reduce harm:

We committed to **strengthening the quality of our mental capacity act (MCA) assessments** to better support our patients and enhance quality of care.

How we did
We have taken significant steps to improve our mental capacity and deprivation of liberty assessments.

We have:
Combined the MCA form and best interest form to ensure a more holistic assessment is undertaken

The Safeguarding Adult/MCA leads have provided tailored training sessions to ward teams and are supporting visits where Deprivation of Liberty (DoLs) are in place to support MCA reviews and oversee restrictive practices.

Communication to our staff has been key to embed this work. We have established a weekly for staff to call in for advice/guidance and support. Regular updates are provided for staff and shared via ICON bulletin. MCA app/flowcharts and other resources are available as part of our resource pack.

An MCA audit was completed in February 2025. The audit and MCA staff survey highlighted some areas of good practice which could be enhanced with additional training and support for staff in the form of a standard operating procedure for the practical application of the MCA. The audit also evidenced the need for a more standardised way of identifying patients who are subject to a DOLs at a ward level. An action plan has been formulated based on the audit and the staff survey and this will form the focus of this work for the next 12 months. MCA will remain a quality priority for the coming year.

Excellence in outcomes:

Reducing falls and harm sustained from falls

In last year's quality account, the Trust renewed its commitments to reduce the number of patients who fall within our care and the level of harm experienced if patients do fall.

To support this safety priority our leads undertook significant work to publicise falls prevention in the hospital & community via radio, posters 'call don't fall, IT screensavers and social media'.

Over 350 staff trained have been trained in falls prevention.

We have continued to embed the fall safe audit, including visual assessment, lying and standing blood pressure and to audit compliance against this.

We have commenced a trial of providing decaffeinated coffee for patients as routine on wards identified as high-risk wards as caffeine has been shown to be associated with an increase in falls.

We have seen a reduction in patients who fall and sustained a fractured neck of femur, this is evidence of improved safety. This work remains high profile and ongoing and will continue as business as usual.

Reducing elective and emergency care delays

Over the past 12 months we have continued our focus on reducing delay across our emergency care pathway to improve patient safety and quality of care. Our Trust has demonstrated significant and measurable improvements across Urgent and Emergency Care (UEC). Our progress is reflected Nationally as being one of the top 10 most improved Trusts in the country for 3 key measures.

We committed to reducing ambulance handover times and the number of patients who wait longer than 4 hours in our emergency department.
We have seen significant improvements in ambulance handover times and improvements in patients being seen within 4 hours.
We are committed to embedding and sustaining these improvements to enhance safer care for our population. Ensuring patient care is in the right place as soon as possible across our emergency pathways remains a priority for our Trust for the next 12 months.

How we did
To measure improvements, we have compared April 2024 performance to April 2025.
We have seen:

- a reduction in ambulance handover time to 25 minutes from 1 hour 33 minutes
- improvement the % of ambulance handovers completed within 15 minutes from 15.9% to 32.2%
- a significant decrease in the number of ambulance handovers exceeding 3 hours to 2 cases in April 2025, compared to 349 in April 2024
- more patients being treated within our ED in 4 hours

Reducing Elective care delays

To be completed

Commented [MP2]: @WESTACOTT, Derren (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST) @BOYNE, Sharon (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST) how have we done over past 12 months

Delivering what matters most to our people:
How we did: Engaging patients and their families
We committed to strengthening our engagement with patients their families and staff when reviewing safety incidents or responding to complaints.
This work remains ongoing and is a priority for 2025/26 as we continue to embed the patient safety incident response framework (PSIRF) committed to sharing safety investigations reports with patients and families to ensure all concerns are addressed and to confirm accuracy.

Embedding a Just learning culture to better support our staff

We emphasised our commitment to a just learning culture (JLC) ensuring that staff are treated fairly and that a systems approach is taken when conducting safety reviews

How we did

We have made progress in engaging patients, their families and staff in safety investigations, however we recognise that there is more to be done to ensure that patients, families and staff are consistently supported and engaged as partners in safety reviews. This work will be ongoing for the year ahead and will support the Trust to embed PSIRF.

Just learning culture

Progress against this priority has been limited due to the Trusts financial constraints and the Trust focus being on the improvement priorities directly impacting patient safety. Work is underway to start to make small changes in this area via a 'golden thread' approach, weaving a just learning culture into all we do through ongoing policy review and leadership development. There is no dedicated resource or budget assigned to lead this work as a transformational project and therefore, we must accept this will limit the scale and pace of change. Just learning culture is central to our safety strategy and will remain a quality priority for the year agenda.

Reduce Healthcare inequalities: Our remote rural and coastal communities have some of the highest levels of deprivation in the country. We committed to seeking out and reducing health care inequalities across our Devon health and care system. We recognised the adverse impact that COVID-19 had upon 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 asked each of our four care groups to identify their priority for reducing health care inequalities based on their identified and diverse needs.

A workshop was held with our 4 care groups on 1st October 2024 to highlight the impact of healthcare inequalities Following that workshop priority workstreams were identified in the following areas:

For our planned Care appointments, a pilot is in the early stages of testing a healthcare inequality scoring matrix with the aim of supporting prioritisation of patient appointments. This will particularly support people with learning disability, a diagnosis of a serious mental illness those over 65 years of age with caring responsibilities and those living in the core 20 most deprived areas to be prioritised for planned care appointments.

We are working with the paediatric and adult teams to identify children and young people who are on an adult waiting list to prioritise their care, due to the greater impact of waiting for children and young people across their life.

CFHD are developing their health inequalities strategic plan. This includes the development of HI data dashboard, implementing flags on electronic patient record (EPR) for disability status and reasonable adjustments tool. CFHD are working with the ICB and Livewell CIC to pilot a clinical prioritisation tool which includes social determinants of health.
CFHD has also commenced a pilot to enabling people with learning disability to be prioritised for community therapy intervention is successfully underway in our Child Family Health Devon care group.

The progress and effect of these workstreams is being monitored by care groups.

2.2 Priorities for improvement 2025/26

Our quality improvement priorities for 2025/6 remain aligned with our quality goals and with our priorities for patient safety incident investigation. We have identified our improvement priorities for each of our quality goals using 'we statements'.

Quality goal: We will Continuously seek out and reduce harm

Priority one: we will continue our work to promote the **early detection and treatment of sepsis** across our organisation. 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 continue our work to **strengthen 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 implement recommendations made following a Trust wide audit which will be overseen by our mental capacity and safeguarding leads. The outcomes, learning and recommendations will be shared across all our services.

Quality Goal: We will continue to strive for excellence in clinical outcomes:

Priority one: We will continue to work to reduce waits for urgent and emergency care and for patients awaiting planned care or treatment.

We continue our efforts to improve patient safety via reducing ambulance handover delays and will work with system partners to achieve this. 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 continue to strive to reduce long waits for planned care to enhance quality of care and patient safety. Our operational Plan has committed to deliver a 5% improvement in the percentage of patients waiting under 18 weeks for treatment. This will ensure that 66.6% of patient waiting under 18 weeks by March 2026.

Further to this we will reduce the longest waits, so that less than 1% of patients on the waiting list wait over 52 weeks from referral to treatment.

We have committed to treating 75% of people diagnosed with cancer within 62 days by the end of March 2025. We will give 80% of people referred for suspected cancer their diagnosis (or the all-clear) within 28 days by March 2025.

We will continue to monitor patient safety across our urgent and emergency care and elective pathway as a PSIRF priority to ensure we continue to improve.

Priority 2: We will engage and collaborate to ensure that the Trust is prepared to safely **transition to an electronic patient record (EPR)** in April 2026.

The implementation of an Electronic Patient Record in April 2026, is a cornerstone of our clinical quality and safety strategy, enabling safer, more consistent, and data-driven care across the organisation. We will work to ensure that patient safety and quality is integral to our work as we transition to an EPR to ensure that benefits are fully realised. We will ensure that clinical leaders engage with this work to maximise a smooth transition to EPR and realise clinical, safety, productivity and financial benefits.

Quality Goal: Deliver what matters most to our people:
Priority one: We will continue embed the patient safety incident response framework (PSIRF) across our organisation. We recognise that PSIRF requires is a significant cultural shift and that supporting our staff via a just learning culture is key. We will continue our work to build a just learning culture so that our people feel supported and empowered to learn when things go wrong.

We are committed to engaging patients, people who use our services and their families in safety reviews and investigations to ensure that we learn and improve. Our patient safety and engagement teams will work together to develop a strategy to support how we openly engage and collaborate with services user and their families when involved in safety reviews or in response to a complaint.

Quality Goal: Reduce health inequalities:
We are committed to s**eeking out and reducing health care inequalities** across our Devon health and care system while continuously improving the quality of care. Work will continue within our care groups to idnetify and reduce health care inequalities.

Equality quality impact assessment (EQIA)
We recognise that we need to make changes to our services to reduce costs and will work to ensure we consider and seek to minimise changes adversely impacting our population from a quality or equality perspective. We will ensure that decisions in relations to cost improvement programmes are informed by potential impacts on quality (safety, effectiveness and experience) and on health inequalities (access,

experience and outcomes) via a embedding a robust equality impact assessment process.

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 2024/25 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. (**to confirm**)

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

- Tier 1: The Board of Directors, its Committees and the Council of Governors (corporate governance structure and legal structure)
- Tier 2: Executive Governance (the most senior level of operational governance), led by the Chief Executive, we have instituted an Executive Committee, operating within the delegated authority of the Chief Executive.
- Tier 3: Trust senior leadership
- Tier 4: Functional leadership: care groups - 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.

Our services are delivered through our care groups, 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.

In August 2024, the CQC undertook a Mental Health Act 1983 monitoring visit within our Louisa Cary Paediatric Ward.

An action plan has been produced to address areas of improvement identified, with progress being monitored by the Trust's CQC Assurance Group and reports into the Executive Quality Group.

During the visit, no patients raised issues regarding their care, treatment and human rights.

In October 2024, the CQC completed an inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R). This resulted in one improvement action which has since been completed.

Children & Family Health Devon also received a CQC Inspection in November 2024 and is awaiting an inspection report.

Our current CQC ratings are:

Ratings	
Overall trust quality rating	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Outstanding
Are services responsive?	Requires Improvement
Are services well-led?	Requires Improvement

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. 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 2024/25 we recruited 2,048 participants to 72 NIHR CRN portfolio studies, across our clinical specialities.

We are the best performing Trust for the number of NIHR recruiting studies and number of commercial studies compared to similar sized organisations across England (NIHR benchmarking data for 2024/25).
Supporting the life sciences sector is a key objective for the Government. We recruited 155 participants to 18 commercial trials. Our commitment to increasing commercial research activity means that R&D is a vital source of externally generated income for the Trust and provides an important alternative way to fund posts, equipment and training.

Other highlights this year include the pivotal role research is playing in how we improve our services both locally and regionally:

- TSDFT is the South West treating site for the cancer vaccine launchpad which is a way to treat patients on cancer vaccine trials in the South West.
- We are the only site in the South West to offer a personalised vaccine to patients with bowel cancer as part of a trial and successfully the treatment to our first patient participant this year.
- We were the first site in the UK to recruit a participant into the XRAY VISION study comparing treatments for patients with head and neck cancer and REALITY-WW, a real-world haematology study for patients with chronic lymphocytic leukaemia

- We have a growing number of specialities becoming involved in commercial research and this year, the Intensive Care unit team were successfully chosen to open their first commercial study.
- We have been the fastest recruiting site into studies across a number of specialties including orthopaedics and breast care.
- We were the top UK recruiting site for the ACCLAIM study looking at reducing lipoprotein in blood and reducing the incidence of heart attack and stroke.
- We are the only site in the South West taking part in the Chariot MS study exploring disease modifying therapies in slowing the progression of Multiple Sclerosis.
- We have also taken part in research looking at early detection of disease, admission avoidance and using artificial intelligence to help streamline our services.

We continue to build our local academic capability through various training schemes in partnership with higher education institutions, Health Education England, NIHR CRN, and the Torbay Medical Research Fund (TMRF). In 2024/5, the TMRF has again awarded funding for one pre-doc and one doctoral fellowship. TSDFT staff have also successfully applied for one CRN Research Associateship and two CRN-funded Chief Nursing Research Fellowships, joining a growing a growing number of research-active clinical staff. Additionally, a further five of our clinical colleagues have 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, we developed a new strategy for nursing, midwifery and allied health professionals (NMAHPs) which was launched in May 2024 and followed by a further conference in September 2024. We launched a competency framework to support all nursing, midwifery and AHP staff to be confident utilising research and evidence based practice and are working with the University of Plymouth to identify how we can support this further in the coming year.

Operational performance

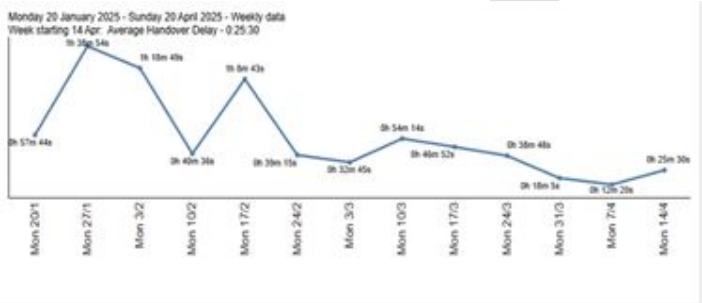
As an organisation we remain in National Oversight Framework 4 (NOF4) for performance and finances along with the other acute providers in Devon and the Devon health and care system as a whole. We have worked hard with commissioners and system partners to meet the improvement targets set out by the national and regional NHS England teams and this remains a core area of focus for us for 2025/26.

Our urgent and emergency care performance

We have implemented a range of improvements that have begun to have a positive impact on waiting times in the Emergence Department and Ambulance handover delays. The focus on Same Day Emergency care and optimising ward stays have been key top these improvements. 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.

Between December and March 2025 performance has improved significantly reflecting the improvements and investments made to improve Emergency patient flow and capacity. Plans for 25/26 are to embed these improvements and achieve the Operational plan standards of 78% of patients seen and discharged from Emergency Department in under 4-hours and sustain an average handover time of less than 45 minutes.



Stroke service performance

Over the past 18 months our Trust has worked to improve outcomes and the experience for patients admitted to our services following a stroke. The Trust was part of the inaugural Thrombolysis in Acute Stroke Collaborative improvement programme run by NHS Elect which commenced in November 2023. In 2023/24 the mean monthly thrombolysis rate was 9.4% and this increase during 24/25 to mean rate of 13.83%. Whilst this has improvement dropped in the first quarter of this year, confidence is high that interventions implemented continue and the right people are receiving thrombolysis. Over the same period the proportion of patients reaching the stroke unit within 4 hours increased from 24.88% to 32.36%, whilst the proportion of patients spending 90% of time on the stroke unit decreased slightly from 69.64% to 67%.

The focus across the Trust on the stroke pathway is much improved and collaborative working is stronger. The stroke improvement plan remains in place and is managed through clinically led Stroke leads meeting and we remain an active participant of the Peninsula Acute Sustainability Programme (PASP).

Our cancer care performance

In 2024/25, Torbay and South Devon received 23,380 Urgent Suspected Cancer (USC) referrals, representing a 2.4% increase compared to last year. This rise equates to approximately 47 additional referrals each month, reflecting the growing demand for timely cancer diagnostics and care.

Despite this sustained increase in referrals, the Trust has continued to improve performance against national Cancer Waiting Time (CWT) standards, ensuring that patients receive faster access to diagnostic and treatment pathways.

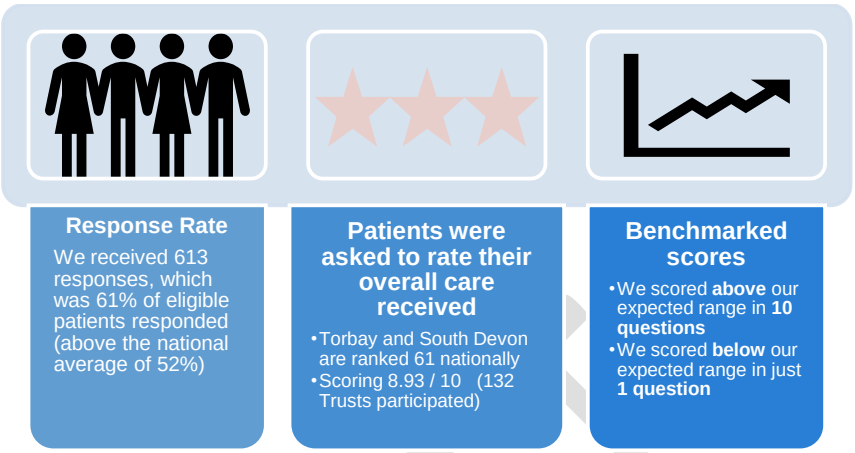
We are pleased to report that the Trust has consistently met or exceeded the key national cancer standards outlined in the 2024/25 NHS Operational Planning Guidance:

- **28-Day Faster Diagnosis Standard (FDS):**
  In March 2025, the Trust achieved 79.4%, with an annual average of 78.9%, exceeding the national target of 77%. This standard ensures that patients receive a definitive diagnosis (either ruling cancer in or out) within 28 days of referral.

- **62-Day Referral to Treatment Standard:**
  In March 2025, performance reached 73.8%, with an annual average of 75.0%, again exceeding the national target of 70%. These standard measures the percentage of patients who start their first definitive treatment for cancer within 62 days of an urgent GP referral.

Looking ahead, the national targets will increase in March 2026 to 80% for the FDS and 75% for the 62-day standard, and the Trust remains focused on continuous improvement to meet these future benchmarks.

National Cancer Patient Experience Survey (NCPES)
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 2023. The results were published in July 2024.



In other achievements:

- August 2024 saw one of our patients become the first person in the South West to receive a cancer vaccine as part of a pioneering trial. The trial looks at creating a personalised vaccine specific to a person's cancer, when markers have shown that there is a risk of the cancer returning.
- The Trust achieved over 80% completeness in cancer staging data submissions to the national Cancer Outcomes and Services Dataset (COSD), which is vital for delivering high-quality, evidence-based cancer services nationally. This recognition from NHS England reflects the dedication of our clinical and administrative teams in improving outcomes through timely and accurate cancer data.
- The Non-Specific Symptoms (NSS) pathway is now live, providing a vital route for patients with concerning but non-specific symptoms to be assessed and diagnosed more quickly, supporting earlier detection of cancer.

Looking forward into 2025/26 there are many more exciting innovations on the horizon:

- In May 2025, we will launch the Lung Cancer Screening programme, which will invite eligible individuals for screening using a dedicated mobile CT scanner, initially based in Sainsbury's Penn Inn. This initiative will detect and diagnose lung cancer at an earlier stage, improving outcomes of our local population.
- The radiotherapy department were awarded £800,000 in capital funding from the NIHR to introduce advanced radiotherapy techniques, including Surface Guided Radiation Therapy (SGRT). This technology, is being commissioned in the summer, uses 3D surface imaging to improve the accuracy, safety, and efficiency of radiotherapy delivery.

Our planned care performance
To be completed (Derren Westacott)

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Our community services performance (Liz Stirling)
To be completed

Children and Family Health Devon

Children and Family Health Devon (CFHD) continues to develop as an integrated service supporting both physical and mental health needs for children, young people, and their families. A key priority has been improving how people experience our services. Our new website is now up and running, offering easier access to information and referrals for families, professionals, and young people.

Some of the CFHD successes and quality improvements over the past year include, but are not limited to:

Parents and young people have a valued voice, through our partnership working provision, which has been very active over the past two years. Young people have developed tools to support others, using videos, letters and personal experiences. Our young people were nominated for a national award for their letter for tomorrow, which discusses the importance of talking about suicide and sharing feelings at a time of greatest need. They came highly commended for their collaborative work, at the Mental Health Awards in October 2024. Parents attend and contribute to senior CFHD meetings, to share their lived experiences that are needed to help shape and improve our services.

The speech and language therapy waiting list pilot, supported by Devon County Council, has been a real success. It's led to a wider rollout of the approach across other parts of the service, and we're already seeing reduced waiting times in several areas as a result.

Our Mental Health Support Team in Schools (MHST) team has made strong progress again this year. The use of Lumi Nova—a digital therapeutic tool for younger children—has been expanded to more schools, with good feedback from both pupils and staff. There are signs that it's helping children feel more confident and better able to manage their worries.

The MHST service were worthy winners at the Mental Health Awards 2024 in the category for 'Most Innovative Mental Health Intervention'. The team provides early help and support to children and young people in schools who may be experiencing emotional distress, with the intention of preventing issues becoming bigger problems that could impact on their long-term mental health. This valuable service provides early interventions that will undoubtedly reduce the number of children and young people's mental health referrals in the future.

The roll-out of the all-age first response service is available through calling 111 and selecting option 2 from the list. This connects a child or young person with a mental heath crisis need to someone who can take their call and offer support.

CFHD has continued to work closely with schools through regular sessions, drop-ins and staff training, helping to build a school environment where mental health is understood and supported. A new pilot project has introduced peer wellbeing ambassadors in some secondary schools, and early signs are that it's encouraging more young people to talk about how they're feeling and seek help when needed.

As of early 2025, MHSTs are supporting around 70% of children in schools across Devon and Torbay, providing early intervention around mental health and emotional wellbeing. Central funding approval has been given to extend this offer further over the next few years, to reach 100% of schools across Devon and Torbay.

CFHD's specialist learning disability team has won the national British Journal of Nursing Silver award for their outstanding innovation in the work they do with young people across Devon who live with a learning disability. The team initiated ground-breaking sibling support groups that were an immediate success for the whole family, as well as the child who receives support from our dedicated specialist learning disability team.

Speech and Language, has started using the Balanced System® framework, which is helping CFHD to provide the right support at the right time. It's a more joined-up approach that brings families, carers and professionals together to support each child's communication needs more effectively.

Meanwhile, Phase 1 of the refurbishment at Evergreen House in Exeter is nearly finished. The site now includes 17 modern, bookable clinical spaces. CFHD has also added a new accessible bathroom, designed to support both personal care and clinical assessments, helping us offer a more respectful and inclusive experience for those who need it most.

Oaklands Court in Tiverton has developed to offer 5 clinical rooms, a conference room and a large meeting room in central Devon to allow equal access to people travelling from across the county to receive specialist community services. The vision to provide integrated health services (both mental and physical health needs addressed together) is becoming a reality with the improved development and use of our estates.

0-19 service

Over the past year, the 0 to 19 Torbay service and Torbay Family Hubs have achieved significant milestones. They secured a new 10-year contract and additional funding for Family Hubs for a further 12 months, ensuring continuity of vital services. Integration of Perinatal and Infant Mental Health (PNIMH) services into the core contract enhanced early intervention and support for families. The service focused on joint commissioning, inclusion, and community engagement, aligning with the Torbay Joint Health and Wellbeing Strategy.

Key achievements from the quarterly reports include increased reach and support, with significant footfall into Family Hubs and enhanced support for underserved communities. The UNICEF Baby Friendly Initiative Gold standard was awarded for infant feeding support . Launched the "One Feed at a Time" campaign to promote breastfeeding. Community engagement was strengthened through events like Ramble Club and Breastfeeding picnics and Building Babies Brains awareness sessions.

The "Family Hubs: Our First 2 Years" report highlights the introduction of 14 new services, 10 launches, 3 campaigns, and 8 events. Recruitment included 15 new staff members and training of 25 Breastfeeding Peer Supporters. Notable achievements include the Unicef BFI Gold Award, positive feedback from

Ofsted/CQC peer review, and increased reach and engagement, with over 36,000 contacts with parents/carers and 31,000 with children.

Perinatal 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)via our maternity and governance and quality group. Metrics are shared via quality and safety assurance groups within the organisation and are visible at Trust board level.

Birth rate

The number of births for 2024/25 was 1672 This is a reduction from 2023/24 when it was 1760 and reduction in birth rate is a national trend.

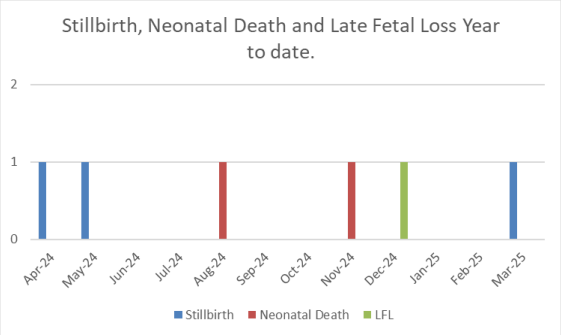
There continues to be an increasing complexity associated with pregnancy and birth due to several factors. These include demographics, health inequalities as well as being related to the standards that underpin safe care. There is also an increased requirement for operative /obstetric intervention during the birth process which impacts on the resources and capacity of the services.

Maternity Safety Support Programme (MSSP)

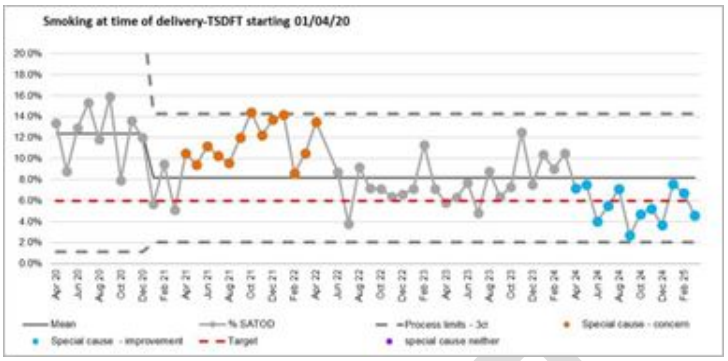
The maternity service was entered onto the MSSP in July 2024. This is a national support programme that is in place to provide intensive support and oversight into maternity services where concerns have been identified. The service was entered due to the Devon system inclusion in the national recovery support process. A national improvement advisor is working with the perinatal team to co-produce a maternity and neonatal improvement plan as well as outlining the exit criteria that will enable progression through the programme.

Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 2024/25. The service recorded three stillbirths, one late fetal loss and two neonatal deaths in 2024/25.



Smoking rates at time of delivery



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Continuing progress has been made against the reduction in smoking at time of delivery. The 24/25 annual rate is 5.5 % which is below the national ambition of 6% for the first time. The team produced a video in which women shared their story around the successes in quitting. We are also participants in the national smoke free pregnancy incentive scheme.

Transitional Care services
To be completed (Corinne Foy)

Our adult social care activity

Adult social care plays a vital role in enabling independence and improving quality of life for residents. As we continue to support individuals to live well within their communities, we recognise that further work is required to ensure we meet demand effectively and provide sustainable, high-quality support across Torbay. Over the past year, we have undertaken significant service improvement work to enhance the support we provide to residents. Our focus has been on promoting independence, managing demand effectively, and ensuring we meet our Care Act duties through preventative and person-centred approaches. Two key areas of improvement have been our reablement pilot and front door improvement work, both of which have delivered positive outcomes for individuals and the wider system.

Reablement Pilot: Promoting Independence
Recognising the importance of supporting individuals to regain and maintain their independence, our delivery partners Channel 3 supported the launch of a reablement pilot in 2024. The aim was to optimise independence for people via a community pathway and those on the waitlist enabling them to regain skills and confidence with daily living activities.
Key achievements of the reablement pilot include:
•Increased independence levels for individuals, with 79% of people achieving full independence following their reablement intervention and not requiring a package of care.

•A proportion of people ended up with a reduced package of care because they had developed the skills for daily activities.
•A reduction in commissioned statutory support packages, as people are better equipped to manage their own health and well-being at home.
•Positive feedback from service users and families, who report improved quality of life and greater confidence in self-care.
•Cost efficiencies within the care system, as more individuals successfully transition to lower levels of support.
Building on this success, we will be integrating reablement principles further across our services to ensure more people benefit from strengths-based approaches that promote self-sufficiency. Learning from the pilot will used in future commissioning activity moving forward.

Front Door Improvement Work: Managing Demand and Promoting Diversion
To enhance how individuals access adult social care support, we have undertaken a 'front door' service improvement activity which aims to improve demand management by promoting diversion to more appropriate services. This work aligns with our Care Act duties, focusing on early intervention, diversion, and appropriate signposting to community-based support.
Key improvements include:
•Strengthened partnerships with community organisations and voluntary sector services, providing alternative support options that prevent escalation of need.
•Enhanced workforce training to embed strengths-based conversations, focusing on what people can do rather than what they cannot.
•Implementation of an enhanced telephony system.

As a result of these improvements, we have seen:
•A reduction in formal care assessments, with more people accessing community-based solutions.
•Greater awareness among residents of preventative support options, helping to build resilience and reduce long-term dependency on statutory services.
•Improved oversight of call quality and demand data which has supported improved decision making, operational planning and management.

Adult social care Panels
Adult social care panels are a decision-making body within adult social care services that consists of senior professionals and key health stakeholders. Panel representatives are responsible for overseeing, reviewing, and making important decisions about the care and support needs of individuals, as well as ensuring that resources are allocated effectively. To improve decision making within panels we have considered practice and processes to improve their effectiveness.
Key improvements include:
•Streamlined processes which have led to enhanced oversight and accountability.
•More effective decision making because of changes to meeting preparation including a standardised format and chair.
• Technology enabled care and Intermediate Care are now consistently represented in all meetings.
•Commissioning representatives attending the Complex Care panel.
• The adult social care team validates care package costs and processes care home placements.

All of which is contributing to improvements in cost control.

Technology Enabled Care (TEC)
Embedding TEC across the service to empower people to fulfil their potential, maximise their independence and remain in a place they call home is a focus for teams. Focus was given to improve practice across teams to drive the opportunities for people to receive TEC as part of packages of care.
Key improvements include:
•Since April 24, 29% new people are now receiving TEC.
•An additional 28 TEC Champions across teams since July 24
•A staff practice survey baseline practitioner's confidence with TEC and initiatives identified to help them improve.
•A TEC decision making tool launched with teams to assist with linking peoples' outcomes and TEC equipment.
Work is also underway to develop a new TEC model to commission Direct Payments
Enabling people to have choice and control over their care is an important feature of Adult Social Care. In June 2024, a review was undertaken on Direct Payments with a series of recommendations which include:
•Improved policy and procedures.
•Streamline processes and resources to support operational teams' practice.
•In depth analysis of the Personal Assistant (PA) market and improve visibility and quality of PA's.
•Exploration of a Direct Payment Officer role to drive practice improvements

Hospital Discharge
Time was spent with teams to understand the issues and impacts for people discharged through Pathway 2. A multi-disciplinary approach was used to review cases and understand through a social work lens if people could have achieved a better outcome. Recommendations are currently under review, but immediate actions were taken to:
•Improve TEC practice by organising training for the team.
•Reinforce Home First principles.
•Address improvements linked to Mental Capacity Assessments

ASC: Looking Ahead
The work undertaken in 2024/25 has demonstrated the impact of proactive, person-centred approaches in adult social care. Moving forward, we will continue to refine our reablement offer, expand our front door improvements, and strengthen our partnerships with health, housing, and community services to create a more sustainable, integrated system of care.
We remain committed to ensuring that all residents receive the right support at the right time, promoting independence, and enhancing quality of life across our communities.

Core indicators
In addition to reporting performance against the statutory indicators for regular assessment a range of further quality indicators are reported to our Board of Directors. The table below summarises the latest monthly performance against the selected key National indicators.

Other national and local indicators	Quality indicator	Target 2024/25	2024/25	2023/24	2022/23	2021/22	2020/21
Did Not Attend (DNA) rate	Effectiveness	5%	4.8%(24/25)	4.8%	5.2%	5.6%	5.1%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	72.%	77.4%	57.5%	54.8%	77.3%
Two-hour urgent community response	Effectiveness	70%	88.6%*	96.8%	80%		
Mixed sex accommodation breaches of standard	Experience	0	163*	42	0	0	0
52-week referral to treatment incomplete pathways year end position	Experience	0	947*	1817	4427	3,199	2,049
Cancelled operations on the day of surgery	Experience	<0.8%	0.8%*	1.3%	1.5%	1.5%	1.5%
Never events	Safety	0	6 total	0	3	0	4
Cancer 28-day Faster Diagnosis	Effectiveness	75%	79.4%*	78.4%	70.7%	67.6%	75.6%
Diagnostic waits greater than six weeks	Effectiveness	15%	31.8%*	21.3%*	31.2%	34.8%	42.1%
Fractured neck of femur – time to theatre	Effectiveness	90%	75%**	76.9%*	57.7%	75.7%	78.8%

* March 2025 positior
** February 2025 posi

Performance plans for 2025/26
We have submitted operational plans that meet the requirements of the Operating Framework for 2025/26. The additional activity will be met through improved productivity across theatres and outpatients and additional funding from commissioners using the Elective Services Recovery Funding (ESRF) for activity delivered above the 2019/20 baseline.

The key operational performance targets are:

- Improve Referral to treatment waiting times with 5% improvement to 66.6% of patients waiting less that 18 weeks from referral to treatment by 2026
- 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) 80% and treatment within 62 days from urgent referral 75%.

SUS and DQIPS
We submitted records during 2024/25 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 charts below:

Admitted Patient Care (APC: Including Day Cases & Inpatients):

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
NHS No Status Indicator	97,099	0	5	100.0%	99.8%	98.3%	99.7%
NHS Number	97,099	104	0	99.9%	99.7%	99.8%	99.7%
Overall	194,198	104	5	99.9%	99.7%	99.1%	99.7%

Outpatient Attendances (OPA):

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
NHS No Status Indicator	558,241	0	0	100.0%	99.8%	98.7%	99.8%
NHS Number	558,241	158	0	100.0%	99.8%	99.9%	99.7%
Overall	1,116,482	158	0	100.0%	99.8%	99.3%	99.8%

The percentage of records in the published data which included the patient's valid general medical practice code was:
- for admitted patient care – 99.9%
- for outpatient care – 100.0%

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 coding performance (Kate Simmons please)
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)
94.35	87.64	96.79	96.06

Clinical audit

The reports of 29 national clinical audits were reviewed by us between 01 April 2024 and 31 March 2025. See Annex 4 for the actions we intend to take to improve the quality of healthcare provided.

The reports of 40 local clinical audits were reviewed by us between 01 April 2024 and 31 March 2025, of which 15 did not require any actions. See Annex 4 for the actions we intend to take to improve the quality of healthcare provided.

Part 3: Our quality indicators

Patient safety

- During 2024/5 we made progress against our patient safety incident response plan (PSIRP)
- Worked to embed our transition from the serious incident framework (SIF) to the patient safety incident response framework (PSIRF) which occurred in February 2024. Our patient safety incident response plan is available on our intranet and externally for members of the public to review
- Worked to complete outstanding serious incident investigation reports, providing closure for patients, families and staff
- Following a number of low harm never events we commenced joint peer review work with University Hospitals, for both hospitals to observe practice and learn from each other and best practice. This worked was highlighted at a regional patient s safety event
- Made progress against local and national PSIRF priorities and ensured that our executive was cited on this position
- 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
- We started the year with two volunteer patient safety partners (PSP) however one PSP has resigned leaving a vacancy. We plan to rectify this in the year ahead with a campaign to recruit. These roles are mandated in the NHS standard contract and 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
- Our Associate Director of patient safety has completed the patient safety specialist training and levels 3&4. We have supported over 40 members of the team to undertake in further training in patient safety reviews and systems thinking.
- We have reinstated human factors training and will commence a train the trainer module in the year ahead.

Learning from National Reports

Following the findings of the Infected Blood Inquiry Report published on 20th May 2024 the Trust has reviewed the 12 recommendations and drafted a report in response to provide significant commentary around each of the Inquiry's recommendations. Compliance with these recommendations will be monitored at the Trust safety and quality assurance group (SQAG).

Our patient safety ambitions for 2024/25

We will continue our work to embed patient safety incident response framework into practice, we have made progress however there is more to be done. 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 a golden thread throughout all we do.

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 clinical effectiveness 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 approaches to patient safety reviews 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
- continue to embed Martha's Rule to ensure patients, families and colleagues have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient. The themes from these contacts will be collated to inform safety improvements where appropriate.
- 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.
- We will continue our work to embed the principles of NATSSIPS2 into our procedures across the trust. This will ensure procedures are carried out in a standardised and systematic way and help cement the safety of these procedures for patients going forward.

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.

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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 non-executive Directors. 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. There has been a steady number of concerns being raised over the last 12 month. There is a process for confidentially logging cases and conversations 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 November 23 and December 2024 there has 176 cases, 35 of which related to bullying and harassment, 17 failure to follow process, fourteen patient safety, nine staff safety, 52 culture of organisation,

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.
- Formal processes not being followed correctly

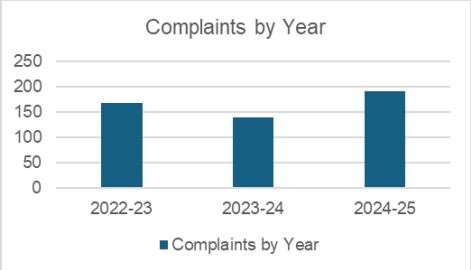
A regular theme was managers lacking interest or capacity in trying to find an early resolution and ignoring the problem rather than addressing it. Lack of resolution often led to formal complaints and grievances which were not always followed or completed in a timely way.

Failure to follow processes related to recruitment, culture of the organisation related to a lack of flexibility and relationships between staff impacting on decision making. Patient safety related predominantly to safe staffing

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. The focus 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 between 01 April 2024 and 31 March 2025 stands at 192 and is a marked increase on the number of complaints received in the previous two years.



Over the course of this year complaint numbers received have been consistently above the lower control limit of 13 complaints per calendar month, and only once dropping below this number, during February 2025, when 12 complaints were received. In 2023-/24, the average number of complaints received per month was 11, in 2024-25 this has increased to an average of 16 per month.

The number of concerns received in the year 2024/25 was 1717, which represents a 9.5% increase on concerns recorded during the previous year (n=1555).

This year saw an improved compliance with the national quality standard of 3-days for complaint acknowledgement, which was 97%. This again represents an improved picture in comparison with the compliance data for the previous year:

- 2023/24 – 88%

Compliance with responding to complaints within the 6-month national quality standard was 97% over the year 2024/25, with 6 complaints breaching this standard in this period:

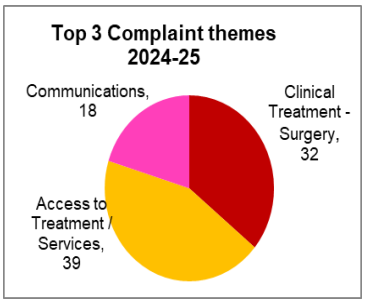
- September 2024 – x1 breach
- November 2024 – x1 breach
- February 2025 x1 breach
- March 2025 x3 breaches*

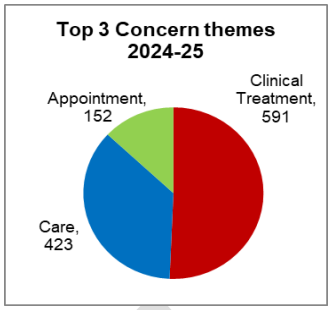
*These either closed during April 2025 or remain open at the time of writing this report.

It has been recognised that these factors have contributed to the 6-month breaches:

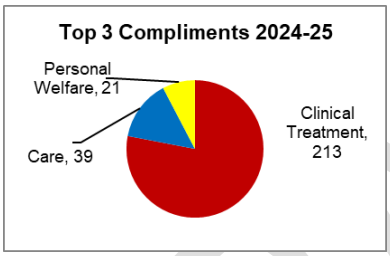
1. Complexity of complaint
2. Number of extensions requested, often reflecting operational pressure
3. Time required for final review and approval, in the presence of factors 1 and 2

The top three complaint themes and top three concern themes can be seen in the charts below.





During the year 2024-25, the Trust formally recorded 332 compliments, which is fewer than the 393 received during 2023-24 and represents a reduction of 15.5%. The top three compliment themes for 2024-25 can be seen in the chart below.



Ongoing actions are being taken by Associate Directors of Nursing and Professional Practice (ADNPPs) and Care Group leadership teams to mitigate complaint and concern themes include:

Planned Care

- Due to a sustained focus, waiting times across planned care have continued to reduce
- Planned care recovery programme and RTT meeting – all long-wait patients are discussed and issues escalated
- Increasing capacity with additional clinics, operating lists and diagnostics
- Reviewing communication & information to patients on waiting lists and on discharge

Maternity

- Personalisation and communication - part of mandatory training in 2025
- Focus on:
  - Listening to women and families
  - Communication; pain management; ward rounds
  - Coproduction:
    - MNVP 15 Steps Action Plan
    - CQC Maternity Survey Action Plan

CFHD

- New triage process introduced
- Integrated mental health assessment clinics commenced

Medicine & Long-Term Conditions

- Review of all complaints and associated action plans during weekly governance meetings
- Your Next Patient initiative being trialled across all wards to support flow and reduce overcrowding in the Emergency Department

Place Based Care

- Review and improve discharge planning communication
- Monitoring and timely management of complaint responses

Cancer and Clinical Services

- Cancer Services Appointment Pathway:
- Increased patient contact for reassurance about appointments and pathways
- Embed new processes for checking patient's appointments are being booked
- Additional support provided for new starters within the booking team
- Replacing a CT scanner in Radiology - close monitoring of waiting lists, experience and patient care

Care Quality Commission (CQC) Survey Programme

The CQC undertakes an NHS patient survey programme, designed to collect feedback on the experiences of people using a range of NHS healthcare services. Our Trust participates in the following surveys as part of the CQC's programme:

- Adult Inpatient
- Urgent and Emergency Care
- Maternity
- Children and Young People (inpatients)

When results are received, these are shared with the appropriate ADNPP, for review, reporting and action plan development. While the action plans are monitored locally, each action plan is added to an overarching CQC Survey Action Plan which is reviewed through the Feedback and Engagement Group meeting.

Friends and Family Test Results (FFT)

Following the improvement work undertaken in 2023-24, a significant increase in FFT returns was observed. However, the service was then significantly challenged by staff absence which resulted in a marked build-up of unprocessed FFT responses. Processing this backlog is now underway but will take some months to complete while concurrently prioritising onward monthly FFT reporting. Until the backlog of returns has been uploaded, the Trust's FFT improvement trajectory remains on hold.

The table below shows the returns that have been processed for the year 2024-25. A review of this data shows that the Trust consistently receives a very high proportion of positive feedback month on month.

Friends and Family 2024-25	Apr-24	May-24	Jun-24	Jul-24	Jan-25	Feb-25	Mar-25
Very Good	321	372	390	322	252	253	281
Good	81	44	56	321	40	24	30
Neither Good nor Poor	4	5	3	5	4	5	3
Poor	0	0	1	2	3	0	1
Very Poor	0	3	4	3	4	4	1
Don't Know	0	1	0	0	1	0	0
Question not answered	87	0	1	0	9	0	7
Total	493	425	455	653	313	286	323

Patient and community engagement (to do comms team)

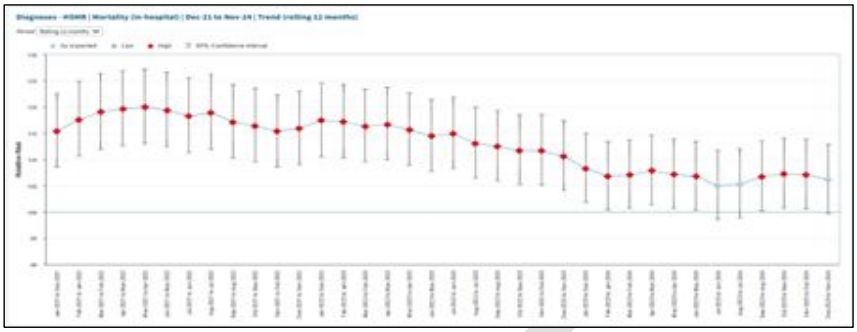
Mortality review processes

We have continued working hard over the last year to improve our Mortality processes and ensure we capture and embed any Learning from deaths.
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.

Historically we were flagging as having an excess of deaths on our HSMR from July 2021. We undertook a programme of work in 2023 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, with high levels of comorbidity and high levels of social deprivation. All these factors can impact on mortality statistics and it is vital that we continue to ensure that these factors are accurately captured going forward.
During 2024/25 the national methodology by which Mortality statistics was calculated was changed (From the Charlson Index to the Elixir/Bottle methodology). This change in methodology resulted in an increase in our HSMR however it remains within the statistically expected range. Work to ensure accuracy of our clinical coding continues during 2024/25 as we adapt to this new methodology.
The current HSMR is 106.1 (99.7-112.9) - 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 0.96.

The trend in HSMR continues to be downwards as demonstrated below.

Figure X: HSMR trend



As part of our redesign of our Mortality processes, we have redesigned our Mortality Surveillance Group. The group oversees trust mortality processes, monitors key Mortality data as well as commissioning focused pieces of work in specific areas. A central aim of the group is to improve clinical engagement-the group receives regular presentations from care groups aimed at identifying common and emerging themes in Mortality and capturing key learning from clinical cases. The group meets quarterly and reports directly to the Patient Safety Group and then to the board. The work of the group is underpinned by a monthly multi-disciplinary Mortality sub-group which ensures progress against workplans and works toward each quarterly Surveillance Group meeting. A Mortality scorecard is also presented to the board of directors bi-monthly by the Chief Medical Officer

We have also introduced the use of Structured Judgment reviews for Mortality cases across the trust. These are triggered by statutory national triggers or by queries raised by the Medical Examiners. This is delivered via an IT platform which ensures consistency and standardisation in the use of these reviews. Records are held centrally by the Patient Safety team allowing the trust to link subsequent investigations and actions associated with these reviews. To date 51 reviews have been carried out using this system since its introduction in July 2024. Going forward this system will provide an important tool in the monitoring of quality of care across the trust. Work continues in the education and use of this tool and in linking review outcomes to subsequent pieces of work. We have also carried out 45 Structured Judgment Reviews looking at specific areas of Mortality (Stroke and Sepsis); this work is overseen and commissioned by the Mortality Surveillance group (See below).

We have continued our work in monitoring mortality associated with long waits in the Emergency Department. Our work in 2022 demonstrated a significant increase in 30 day mortality in patients waiting longer than 8 hours for a bed when compared with 2019 in line with large national research studies in the UK. This increase in Mortality appeared to particularly affect elderly and frail patients. Subsequent work in 2023 has demonstrated an improvement in this mortality. We are currently finalising our review of mortality in this group of patients for 2024 however preliminary data suggest that overall mortality has fallen back to pre-pandemic levels which is encouraging. This work has continued to inform our processes for emergency patients and has the potential to improve care for patients in the future. In addition

we are developing an IT solution whereby monthly mortality reports can be run to deliver near real time monitoring of key mortality metrics.

We are also currently working on some focused specific pieces of work looking at Mortality rates in Sepsis patients, patients suffering from an Acute Kidney Injury, necrotising Fasciitis patients and Stroke patients. These reviews have been triggered via Mortality alerts received from Telstra and will hopefully improve the care of patients in these specific areas

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. Since 9 September 2024, all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners, therefore for the year 2024-25, the figures presented also include deaths in the community.

Year	Total number of deaths reviewed by Medical Examiners – community and acute / community hospital settings (including Rowcroft)	Community (non-hospital setting) deaths reviewed by Medical Examiners (excluding Rowcroft)	Number of acute / community hospital deaths reviewed by Medical Examiners (excluding Rowcroft)	Number of deaths referred to HM Coroner	Number of HM Coroner Inquests	Number of incidents raised following ME scrutiny
2023-24	NA	NA	1395	240	132	32
2024-25	2524	1149	1316	186	60	53

Learning from lives and deaths-people with a learning disability and autistic people (LeDeR)

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 -25

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	4	0	0	4
Hospital	21	15	0	21

The central ICB LeDeR reviewing team has faced a number of staffing challenges during 2024/25 resulting in limited LEDER reviews being considered. The completed SJR reviews have provided interim assurances as no evidence has been found that would indicate deaths of people who have a Learning Disability and/or Autism could have been avoid.

All 25 cases where opinion was given, recorded the individual 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 or 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 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 but have seen a sustained improvement in recent months.

Along with other providers in Devon, we continue to comply with NHS England Tier 1 performance reporting for urgent and emergency care and Tier 2 reporting for planned care; Tier 1 being the highest level of regulatory performance oversight.

The National Oversight Framework Segment 4 exit criteria indicators are shown below:

RAG rated against monthly Operational Plan trajectory	Target March 2025	M Oct	M Nov	M Dec	M Jan	M Feb	M Mar	M Apr	M May	M Jun	M Jul	M Aug	M Sep	M Oct	M Nov	M Dec	Operational Plan trajectory March 2025
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																	
Urgent and Emergency Care																	
Ambulance handovers - time lost over 15 mins - Actual (hours)	1800	3217	3667	2846	3249	2488	2248	1576	3330	4343	3275	3108	2532	1625	1288		1800
Percentage of Ambulance handovers greater than 3 hours	8%	20.0%	24.4%	16.6%	20.2%	14.7%	9.8%	6.7%	21.0%	31.2%	21.3%	18.5%	14.7%	7.6%	3.5%		8%
Total average time in ED (hours/minutes)		06:39	06:33	06:04	06:00	05:43	05:34	05:25	06:20	06:44	06:18	06:17	06:10	05:51	05:26		No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0	836	861	722	800	672	588	525	779	979	854	793	818	677	615		No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	78%	63.2%	61.7%	67.7%	71.6%	70.8%	70.5%	70.7%	65.5%	58.7%	67.3%	65.0%	66.7%	68.8%	70.1%		78%
% patient discharges pre-noon	33%	23.3%	24.0%	22.3%	22.1%	21.3%	19.4%	18.9%	20.8%	21.5%	21.3%	20.4%	19.9%	21.2%	22.6%		33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	4.9%	4.8%	4.8%	5.6%	7.8%	6.3%	6.0%	6.9%	5.9%	9.5%	6.6%	8.3%	9.1%	7.4%		5%
Elective recovery																	
RTT 104 week wait incomplete pathway	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
RTT 78 week wait incomplete pathway	0	125	58	99	70	16	16	11	17	10	6	0	12	14	7		0
RTT 65 week wait incomplete pathway	0	695	470	423	428	382	350	368	285	242	239	229	204	215	141		0
RTT 52 week wait incomplete pathway	0	1985	1817	1796	1661	1615	1703	1761	1651	1524	1288	1265	1262	1299	947		0
Patient waits over 2.5 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Faster Diagnosis Standard - % of GP referred patients diagnosed within 28 days	77.0%	80.9%	78.4%	76.7%	76.7%	80.7%	80.1%	79.4%	81.1%	79.2%	71.5%	82.7%	75.3%	84.5%	79.4%		77.0%
Number of patients waiting longer than 62 days for treatment	138	112	83	104	96	91	87	90	85	78	77	110	95	94	111		138

2024/25 RAG indicator

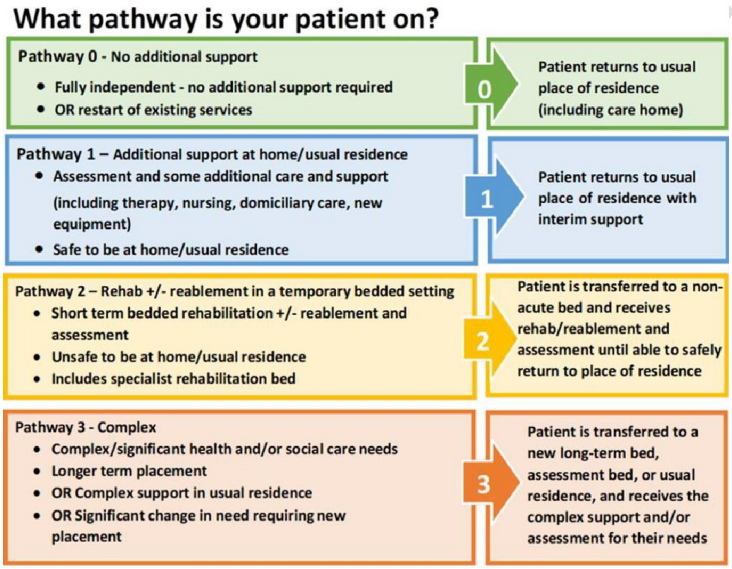
Meeting monthly trajectory

Not meeting monthly trajectory

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 Includes community inpatient wards/assessment areas

0	86.0%	30,494	80.7%	30,773
1	4.9%	1,746	8.3%	3,183
2	8.3%	2,962	9.9%	3,767
3	0.8%	291	1.0%	386

Average length of stay

The average length of stay (LOS) in 2024/25, on a rolling 12-month average, has decreased from 7.1 days in March 2024 to 6.8 days in December 2024. This remains higher than pre-covid levels of around 6 days, however, this is in line with the national average reflective of the national position.

In 2025/26 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.

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

Joe Teape Chief Executive

Date: XX 2025

Commented [PT7]: Joe T or Adel Jones to sign

Annex 2: Quality Account engagement

Commented [PT8]: @PATTERSON, Maria (TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST)

We presented a briefing on the draft quality account to our Council of Governors on XXXX , 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 202/25 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 XXX until XXXX .

- 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
TBC
Lead Governor

Devon Integrated Care Board (ICB)

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:

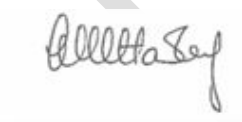
"Torbay Council welcomes TSDFT' S Quality Account and the priorities for improvement have benefitted the residents of Torbay.

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)

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 **2024/5**, **41** 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 **2024/25** follows.

National audits	Eligibility	Participation
BAUS Data & Audit Programme		
A. Penile Fracture Audit	Yes	Yes
B. I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	Not participating
C. Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	Not participating
Breast and Cosmetic Implant Registry	Yes	Yes
British Hernia Society Registry	No	Not applicable
Case Mix Programme (CMP)	Yes	Yes
Cleft Registry and Audit Network Database	No	Not applicable
Emergency Medicine QIPs (RCEM)		
A. Adolescent Mental Health	Yes	Yes
B. Care of Older People	Yes	Yes
C. Time Critical Medications	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	No	Not applicable
B. National Audit of Inpatient Falls	Yes	Yes
C. National Hip Fracture Database	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		
A. National Diabetes Core Audit	No	Not applicable
B. Diabetes Prevention Programme (DPP)	No	Not applicable
C. National Diabetes Footcare Audit	Yes	Yes
D. National Inpatient Diabetes Safety Audit (Harms)	Yes	Yes

E. National Pregnancy in Diabetes (NPID)	Yes	Yes
F. Transition (Adolescents and Young Adults) and Young Type 2 Audit	No	Not applicable
G. Gestational Diabetes Audit	No	Not applicable
National Audit of Cardiac Rehabilitation	Yes	Yes
National Audit of Cardiovascular Disease Prevention (Primary Care)	No	Not applicable
National Audit of Care at the End of Life (NACEL)	Yes	Yes
National Audit of Dementia (NAD)	Yes	Yes
National Bariatric Surgery Registry	No	Not applicable
National Audit of Metastatic Breast Cancer	Yes	Yes
National Audit of Primary Breast Cancer	Yes	Yes
National Bowel Cancer Audit	Yes	Yes
National Kidney Cancer Audit	Yes	Yes
National Lung Cancer Audit	Yes	Yes
National Non-Hodgkin Lymphoma Audit	Yes	Yes
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes
National Ovarian Cancer Audit	Yes	Yes
National Pancreatic Cancer Audit	Yes	Yes
National Prostate Cancer Audit	Yes	Yes
National Cardiac Arrest Audit	Yes	Yes
National Cardiac Audit Programme (NCAP)		
A. National Adult Cardiac Surgery Audit	No	Not applicable
B. National Congenital Heart Disease	No	Not applicable
C. National Heart Failure Audit	Yes	Yes
D. National Audit of Cardiac Rhythm Management	Yes	Yes
E. Myocardial Ischaemia National Audit Project	Yes	Yes
F. National Percutaneous Coronary Intervention	Yes	Yes
G. National Audit of Mitral Valve Leaflet Repairs	No	Not applicable
H. The UK Transcatheter Aortic Valve Implantation Registry	No	Not applicable
I. Left Atrial Appendage Occlusion (LAAO) Registry		
J. Patent Foramen Ovale Closure (PFOC) Registry	No	Not applicable
K. Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	No	Not applicable
	No	Not applicable
National Child Mortality Database (NCMD)	Yes	Yes
National Clinical Audit of Psychosis (NCAP)	No	Not applicable
National Comparative Audit of Blood Transfusion		
A) National Comparative Audit of NICE Quality Standard QS138	Yes	Yes
B) National Comparative Audit of Bedside Transfusion Practice	Yes	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes
National Emergency Laparotomy Audit (NELA)		
A. Laparotomy	Yes	Yes
B. No Laparotomy	Yes	Yes

National Joint Registry	Yes	Yes
National Major Trauma Registry	Yes	Yes
National Maternity and Perinatal Audit	Yes	Yes
National Neonatal Audit Programme (NNAP)	Yes	Yes
National Obesity Audit	Yes	Not participating
National Ophthalmology Database (NOD) A. National Cataract Audit B. Age-related Macular Degeneration Audit	Yes	Yes
National Paediatrics Diabetes Audit (NPDA)	Yes	Yes
National Perinatal Mortality Review Tool	Yes	Yes
National Pulmonary Hypertension Audit	No	Not applicable
National Respiratory Audit Programme a) COPD Secondary Care b) Pulmonary Rehabilitation c) Adult Asthma Secondary Care d) Children and Young Peoples Asthma Secondary Care	 Yes Yes Yes Yes	 Yes Yes Yes Yes
National Vascular Registry	No	Not applicable
Out-of-Hospital Cardiac Arrest Outcomes	No	Not applicable
Paediatric Intensive Care Audit Network	No	Not applicable
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes
Prescribing Observatory for Mental Health UK	No	Not applicable
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): A) Oncology & Reconstruction B) Trauma C) Orthognathic Surgery D) Non-melanoma skin cancers E) Oral and Dentoalveolar Surgery	 Yes Yes Yes Yes Yes	 Yes Yes Yes Yes Yes
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
UK Cystic Fibrosis Registry	No	Not applicable
UK Renal Registry Chronic Kidney Disease Audit	No	Not applicable
UK Renal Registry National Acute Kidney Injury Audit	No	Not applicable

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 (MBRRACE)	Yes	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes	Yes
Mental Health Clinical Outcome Review Programme	No	Not applicable

Reason for non-participation: -

BAUS Data & Audit Programme

A. I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices) – No resources and extremely short staffed.
B. Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA) – No resources and extremely short staffed.

National Obesity Audit – lack of admin capacity.

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 **2024/25**, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit and patient outcome programme incorporating National Confidential enquires	**Cases submitted**	**% cases**
BAUS Data & Audit Programme A. Penile Fracture Audit B. I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices) C. Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)		
Breast and Cosmetic Implant Registry		
Case Mix Programme (CMP)	478	100
Elective Surgery (National PROMS Programme)		
Emergency Medicine QIPs (RCEM) A. Adolescent Mental Health B. Care of Older People C. Time Critical Medications		
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People		
Falls and Fragility Fracture Audit Programme (FFFAP) A. Fracture Liaison Service Database B. National Audit of Inpatient Falls C. National Hip Fracture Database	 12 525	 100 100
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review Programme)		
National Adult Diabetes Audit A. National Diabetes Core Audit B. Diabetes Prevention Programme (DPP) C. National Diabetes Footcare Audit D. National Inpatient Diabetes Safety Audit (Harms) E. National Pregnancy in Diabetes (NPID) F. Transition (Adolescents and Young Adults) and Young Type 2 Audit Gestational Diabetes Audit		

National Audit of Cardiac Rehabilitation		
National Audit of Care at the End of Life (NACEL)		
National Audit of Dementia (NAD)	40	100
National Audit of Metastatic Breast Cancer		
National Audit of Primary Breast Cancer		
National Bowel Cancer Audit	249	100
National Kidney Cancer Audit		
National Lung Cancer Audit	244	100
National Non-Hodgkin Lymphoma Audit	78	100
National Oesophago-Gastric Cancer Audit	139	100
National Ovarian Cancer Audit		
National Pancreatic Cancer Audit	130	100
National Prostate Cancer Audit	346	100
National Cardiac Arrest Audit		
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 I. Left Atrial Appendage Occlusion (LAAO) Registry J. Patent Foramen Ovale Closure (PFOC) Registry K. Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	184	100
National Child Mortality Database (NCMD)		
National Comparative Audit of Blood Transfusion A. National Comparative Audit of NICE Quality Standard QS138 B. National Comparative Audit of Bedside Transfusion Practice		
National Early Inflammatory Arthritis Audit (NEIAA)	32	100
National Emergency Laparotomy Audit (NELA)	101	100
National Joint Registry	543 (424 Hips/ 119 Knees)	100
National Major Trauma Registry		
National Maternity and Perinatal Audit		
National Neonatal Audit Programme (NNAP)	15	100
National Ophthalmology Database (NOD) A. National Cataract Audit B. Age-related Macular Degeneration Audit	1881	100
National Paediatrics Diabetes Audit (NPDA)	161	100
National Perinatal Mortality Review Tool		
National Respiratory Audit Programme A. COPD Secondary Care B. Pulmonary Rehabilitation C. Adult Asthma Secondary Care D. Children and Young Peoples Asthma secondary Care	43	100

Perioperative Quality Improvement Programme (PQIP)		
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): A. Oncology & Reconstruction B. Trauma C. Orthognathic Surgery D. Non-melanoma skin cancers E. Oral and Dentoalveolar Surgery		
Sentinel Stroke National Audit Programme (SSNAP)		
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)		
Society for Acute Medicine Benchmarking Audit (SAMBA)		

Patient Outcome Programme Incorporating National Confidential Enquires	**Cases submitted**	**% Cases**
Medical And Surgical Clinical Outcome Review Programme (NCEPOD) 1. End of Life Study 2. Juvenile Idiopathic Arthritis	 15/7 4/4	 47 100
Maternal and Newborn Infant Clinical Outcome Review Programme (MBBRACE)		

Our response to the findings of clinical audits

We reviewed the reports of **29** national clinical audits in **2024/25** and we intend to take the following actions to improve the quality of healthcare provided:

Ref	**Recommendations / actions**
1101 (Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls	
	Analgesia within 30 minutes - consider PGD (Patient Group Direction) for acute wards. Review PGD timing in community hospitals through AARs (After Action Reviews). Lying & Standing Blood Pressure - Maintain focus through - Quality Boards, Fallsafe Audit, Accreditation Standards, E-learning/ Ward Training - Adequate recording through Vitalpac, monitor use and results. Complete LS/BP video. Update policy. Ward training as requested/ as capacity allows. Post fall training & competencies - Link with Trauma Co-ordinator re policy & post all training. Review post fall policy with clinical support. Consider post fall/ trauma training with competencies and simulation - involve ED Lead and Practice Educator. Promote patient education through leaflets and posters 'call don't fall' - Provide wards with link to patient leaflets. Embed to give out routinely/ ward-based education. Funding required.
1191 (Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls	

Improve vision audit outcomes to 85%+ through Fallsafe audit and staff training. All older people are screened for Delirium upon admission and reviewed - trial on McCallum ward for one month using '4AT' screen on older adults on admission. Dementia lead in (four-month post) Review trial and aim to spread to other wards. Establish training support. Falls lead to support only. NAIF audit increase in January 2025 - Support required to manage and fulfil new fractures on NAIF that are not identified through NHFD.
1192 (Falls and Fragility Fracture Audit Programme FFFAP) National Hip Fracture Database
Lower than national average day one mobilisation figures - local audit to repeat physiotherapy SPRINT audit tool, to identify potential areas for Quality Improvement work.
1210 National Audit of Metastatic Breast Cancer (NAoMe)
Not meeting targets for recording status/ completeness of data - review of COSD (Cancer Outcomes and Services data) completeness on a rolling basis - six monthly suggested. To identify Oncologist to review data. Mortality figures for Trust not available for specific scenarios in report - to interrogate Chemocare and link to Mortality figures. Educate CNS (Clinical Nurse Specialist). Check each patient has the box completed in data fields and go back to clinical team if not complete before data submission.
1211 National Audit of Primary Breast Cancer (NAoPri)
Percentage of patients undergoing TA (Triple Assessment) in one visit - Need more radiology support for TA clinics. We do not have a clear plan of how we will cover gap from advanced practitioner retiring in November 2024 which will exacerbate problem until additional advanced practitioner is fully trained in September 2025. Also, although we might have sufficient radiologist "cover" in breast care, it is not always on the right days/ times as clinic capacity is very limited as we do not have enough space in the breast care unit. All the radiologists cover general radiology and have other roles so no dedicated breast radiologists unlike every other unit in cancer alliance and most units UK wide. We do need to consider locum cover for February 2025 (and have an experienced radiologist who could do this). NACT (Neoadjuvant chemotherapy) rates - To increase rates we will need more oncologists and the capacity to give chemo/ immunotherapy as there are not enough chemo nurses or enough space currently in Torbay. CNS (Clinical Nurse Specialist) contact recording - Educate CNS to fill in separate box on diagnosis/ staging part of Infoflex. Must be ticked. Team to go back to CNS team if no evidence of CNS contact before submitting data as we feel this is 100% in practice. Recording of ER/PR/HER2 status - Ensure recording on COSD (Cancer Outcomes and Services data), check rates. Radiotherapy rates - check more recent year's data to see if has changed - look at how recorded. Mortality rates - we need to be able to generate 1- and 3-year survival rates.

1179 National Lung Cancer Audit
Ongoing nationally poor patient survival/ outcomes (only 33% are stage I-II disease) - Target Lung Health Programme/ Screening to identify early disease and improve survival outcomes and surgical rates.
1217 National Non-Hodgkin Lymphoma Audit (NNHLA)
IT/ data link problems - test new IT/ data process - meeting with local and national dataset teams.
1127 (MINAP) Acute Coronary Syndrome or Acute Myocardial Infarction
Proportion of non-ST-elevation myocardial infarction (NSTEMI) patients undergoing angiograms within 72 hours of admission - Additional interventionalist to enable urgent weekend Percutaneous Coronary Intervention (PCI). Eligible patients receiving pPCi within 60 minutes - Data and process review of pPCI pathway (low percentage of data completion). Low percentage of completed MINAP data - Increase support for data entry to complete MINAP database.
1230 (MINAP) Acute Coronary Syndrome or Acute Myocardial Infarction
DTB (Door to balloon) times below target - Very high percentage of self-presenter (8% nationally vs 25% locally) who have much longer DTB times - training of Emergency Department staff in timely ACS (Acute Coronary Syndrome) management. ACS patients undergoing angiogram within 72 hours below target - Additional weekend lab lists for ACS patients. NSTEMI patients admitted to Cardiac ward within 24 hours - Increase patient flow through Cardiac wards (weekend ward round on Cardiology wards & additional weekend lab lists for ACS patients. Call to Balloon (CTB) - Improve ambulance response times. Case ascertainment low - Increase hours of Cardiology data manager.
1228 Heart Failure Audit
Necessity for audit input personnel - Business case in progress.
1232 (NCMD) National Child Mortality Database Programme - Child Death Review Data Release
Discussion related to organ donation to be embedded into Palliative care pathway - developing new children and young person's advanced care planning Treatment Escalation Plan (TEP) for Palliative Care - managed by Child & Family Health, Devon (CFHD) services. Out of hours end of life care support is not currently a commissioned service - business case to be developed and submitted to Devon Integrated Care Board by CFHD service.
1286 (NCMD) National Child Mortality Database Programme - Child deaths due to Asthma or Anaphylaxis

Current local 'asthma bundle' (pathway) requires updating to align to recommendation 4 - asthma bundle to be updated.
1275 (NCMD) National Child Mortality Database Programme - Learning from Deaths: Children with a learning disability and autistic children aged 4-17 years
New patient electronic record currently in design phase - audit recommendation to be shared with EPR Team for inclusion in building new system.
1241 (NNAP) National Neonatal Audit Programme
Thermoregulation - continue QIP already commenced with audit. Breast Feeding - Work is ongoing around baby friendly initiative, UNICEF - Neonatal BFI accreditation.
1243 (NOD) National Ophthalmology Database Audit (National Cataract Audit)
Insufficient staff for imaging and glaucoma backlog - need additional staff to help with this - Business case approval.
1090 Microbiology cultures and antibiotic sensitivities of Corneal Scrapes
Need to clarify appropriate initial antibiotic choice at regional level - Results being prepared for publication, then to be discussed with all regional corneal consultants to consider if any change in management or new guidelines required.
0931 National Audit of Pathways in Epileptic Seizure Referrals (NAPIER)
Lack of documentation in lifestyle and occupation 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.
1189 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
Managing complete patients under PESP (Paediatric Epilepsy Surgery Programme) - Vagal Nerve Stimulation (VNS) - training and initiation of VNS Clinic. Transition - Ongoing Quality Improvement with ODN (Operational Delivery Network)
1199 National Diabetes Audit Programme - National Diabetes Foot Care Audit (NDFA)
Ulcer Care template - template to be finalised and implemented.
1237 National Emergency Laparotomy Audit (NELA)
Care of the older patient - Investment in frailty services, including geriatrician-led input for emergency laparotomy patients.

Post-operative admission to Critical Care - Increase in critical care capacity (from 10 to 14 operational beds)
1135 National Bowel Cancer Audit (NBOCA)
Clinical Nurse Specialist capacity - new post funded - to be recruited - in hand.
1136 National Oesophago-gastric Cancer (NOGCA)
Limited data - need more comprehensive data outcomes for next meeting. Low endoscopic resection rates for high grade dysplasia - need to enquire if still an issue and if so why. High surveillance rates for high grade dysplasia - need to enquire if still an issue and if so why.
1250 National Respiratory Audit Programme (NRAP) Children & Young Person Asthma Secondary Care
Delay in oral steroid achievement - working with Emergency Department to establish PGD for healthcare professionals to give prompt steroid in select cases. Poor documentation of smoking, technique and PAAP (personal asthma action plan) - Contacted education lead to build into local programme - await response.
1178 NPDA (RCPH National Paediatric Diabetes audit)
Increase the proportion of young people having all their healthcare checks particularly their urine for microalbumin (UMA) - ask young people to anonymously tell us what is deterring them from giving a urine sample - learn from this and implement changes. Increase the proportion of children with an HbA1c less than 58 - by educating and preparing and starting children and young people on hybrid closed-loop (HCL) pumps.

We reviewed the reports of **five** national confidential enquiries in **2024/ 25** and intend to take the following actions to improve the quality of healthcare provided.

1055 (NCEPOD) Endometriosis Study
Be part of a wider MDT meeting reviewing Gynae patients - To join the monthly meeting in Exeter.
1287 Maternal, Newborn and Infant Clinical Outcome Review Programme - The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death (MBRRACE UK)
The Maternity Service is not assured that we have met the standard of this report - We will undertake an audit of this aspect of the mother's care to identify actions or learning.
1170 MBRRACE-UK Perinatal Confidential Enquiry - A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death

Share learning from recommendation regarding the lack of uptake in antenatal screening in Asian women - Antenatal screening midwife to review findings and ensure all midwives are aware of referral if any decline.

No routine audit of black women's risk assessment and undertaking of an oral glucose tolerance test (OGTT) - Audit of OGTT for all Black women - audit to be allocated at the next Maternity Clinical Effectiveness meeting.

ND 1169 MBRRACE-UK Perinatal Confidential Enquiry - A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death

No routine audit of black women's risk assessment and undertaking of an oral glucose tolerance teat (OGTT).

1160 (MBRRACE-UK) - Saving lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21

Update guidance to make certain that Category 4 caesarean section lists are managed separately from more urgent caesarean sections to ensure these operations are not delayed to late in the day.

> Action and agreed suggestions – Add sentence to policy, audit Category 3 Lower section caesarean section to be presented.

Update guidance on the use of coagulation tests in the context of obstetric haemorrhage including the timelines for availability and how to interpret these, noting that women should not be inappropriately denied clotting products based on a single measure of coagulation in the face of ongoing haemorrhage.

> Action and agreed suggestions – Update policy – add sentence to policy and include use of ROTEM (Rotational thromboelastometry)

Review guidance on when to use balloon tamponade to control haemorrhage, how to insert the balloon and inflate it. Resources such as postpartum haemorrhage checklists should include when not to use balloon tamponade and when to abandon it and move on to a different haemostatic technique.

> Action and agreed suggestions – Update policy – add paragraph.

Clarify that review of the care of women who return to theatre may provide important safety learning but should not be perceived as a performance metric after caesarean birth, as re-operation may be the appropriate response to control internal haemorrhage.

> Action and agreed suggestions – Need overarching policy about what should be reported in Datix to include the sentence mentioned.

Update guidance on ECMO (extracorporeal membrane oxygenation) for severe acute respiratory failure in adults to include specific information on referral and admission of pregnant and recently pregnant women with respiratory failure to ECMO services.

> Action and agreed suggestions – Explore with ITU (Intensive Therapy Unit) regarding update to policy.

Ensure that staff working within maternal medicine networks are equipped with the skills to care for the complex and multiple medical, surgical, mental health and social care needs of the current maternity population.

Action and agreed suggestions – update maternal medicine policy to reflect new network & resources.

Ensure that guidance on care for pregnant women with complex social factors is updated to include a role for networked maternal medical care and postnatal follow-up to ensure that it is tailored to women's individual needs and that resources in particular target vulnerable women with medical and mental health co-morbidities and social complexity.

Action and agreed suggestions – No capacity within current workforce to provide postnatal medical clinics. Awaiting funding agreement for new consultant posts. Currently only uncommissioned obstetric debrief clinics – Service pressure on current gynae provision. Midwifery – Birth afterthoughts clinic: currently uncommissioned within current service envelope. Mandatory training includes trauma informed care. Commissioned services: Maternal mental health service, Pelvic Health Clinic.

Develop training resources concerning shared decision making and counselling regarding medication use in pregnancy and breastfeeding, including specific information on the benefits and risks of different medications and non-adherence.

Action and agreed suggestions – Scoping work started by Midwife. Progress on implementation? EPR? Incorporate BRAIN (Benefits, Risks, Alternatives, Intuition, Next steps) acronym into choices/ consent policies or considered overarching consent policy to include BRAIN.

We reviewed the reports of **40** local clinical audits in **2024/ 25** and we intend to take the following actions to improve the quality of healthcare provided (**15** audit projects did not need any actions).

Ref	Recommendations / actions
6661	**Communication alerts and notifications by Radiology - in cases where urgent and unexpected (U code) findings are reported**
	- Presented at the local departmental audit meeting to highlight inconsistencies - Inconsistencies discussed at the meeting to design ways to overcome them - Overall - educate the entire department and have every reporting member sign a form that they understand the protocol
6755	**Non-Sterile Glove Use**
	- Regular ward visits to train staff - Link nurse training on glove use - If Re-Audit improves compliance, roll out across ALL wards - Posters to be displayed throughout ward areas

6766 Chest X-Ray confirmation of nasogastric (NG) tube placement
- Radiographers to be reminded of the need to visualise the NG tube tip and provide a 'line view' - Explore collating suboptimal radiographs into a radiographer review file on PACS - Explore Radiographers being competent to identify wrongly sited tubes and the next steps
6769 Assessing compliance with Bosniak cyst classification
- Email to all Consultants and Registrars as a reminder to correctly classify renal cysts at least Bosniak IIF and above
6778 Appropriateness of referrals for Deep Vein Thrombosis Ultrasound
- Develop a new Standard Operating Procedure to include Wells score, reason for high Wells score and D Dimer if scanning within four hours - failure to include could delay scan - Share findings with MAAT team and wards
6785 Management of dental patients undergoing Intra-oral procedures who are on Anti-Coagulants or Anti-Platelets
- Deliver a teaching presentation to Clinicians - Copies of guidance made accessible in surgeries
6789 Assessment of the success rate of Fine Needle Aspiration (FNA) of the Thyroid
- Consider increasing number of passes made during an FNA or varying types of needle used to optimise capillary effect (25G Orange or 22G Black Spinal needle) - Initiate use of a logbook to improve follow-up - Consider rapid onsite evaluation (ROSE) of aspirate cytology. Involve the cytopathology laboratory technician during the aspiration as their assistance in preparing specimen for slides and instant confirmation on the adequacy of the cellularity of samples obtained can improve positive yield and reduce patient recall rates for repeat FNA - Arrange a training session with the cytopathology laboratory technician for improving skills/ techniques in preparing specimen for slides
6792 High-Resolution Computed Tomography thorax (HRCT) reporting in patients with suspected idiopathic pulmonary fibrosis
- Present at Radiology clinical audit meeting to disseminate findings to local HRCT reporters - Suggest communication with Medica to request that chest radiologists report HRCTs to reduce the number of cases requiring local review and classification - Develop a HRCT report template
6794 Do Primary Angle Closure Suspects (PACS) undergoing Yttrium Aluminium Garnett Peripheral Iridotomy (YAG PI) meet RCOphth PACS Plus Criteria?
- Complete Departmental education regarding new RCOPhth guidance and indications for YAG PI - Email to clinicians with summary of guidance and indications for YAG PI
6796 What percentage of Emergency Department trauma Anterior-Posterior pelvis projections meet established imaging guidelines?
- Training session for all staff on pelvic imaging with a focus on acceptability

6797 Magnetic resonance imaging (MRI) prostate quality performed on mobile scanners
- Use Prostate Imaging Quality (PIQUAL) score for all multiparametric prostate MRI - Encourage radiographers to look at the scans, repeating sequences as required as well as adding notes on CRIS if any difficulties were encountered (e.g. patient in pain/ non-compliant). Identifying suboptimal studies particularly highlight those secondary to non-patient factors. - Disseminate audit findings to external scan providers, asking for improvement plans.
6799 Pain in Children being assessed in the Emergency Department
- Time to 1st dose of Analgesia - Undertake staff education - Pain re-evaluation after 60 min - Update Symphony to include actions taken after the pain score is recorded and next timeline for re-assessment
6800 Injectable Contraceptives - Sayanapress® as an alternative to Depo-Provera
- Consider introducing a specific question in the Injectable Contraceptives template on Lillie. If declined, note reason why
6801 Does Negative Pressure Wound Therapy (NPWT) have a role in Emergency Laparotomy?
- Consider engaging Procurement in ordering NPWT
6802 Quality of SCBU portable chest x-rays (CXR)
- Feedback results to SCBU/ Paediatrics team - Engage with SCBU re holding - Teaching/ Simulation with radiographers to improve quality
6804 Improving Documentation of Intimate Examinations - Digital Rectal Examinations (DRE)
- Present results to a General Surgery & Urology Teaching session - Disseminate results across the whole department via e-mail as a reminder to staff
6806 Isolation Policy
- Supply wards with Isolation poster and then educate staff regarding the appropriate use of the poster information - Ensure continued education given to wards on appropriate use of side rooms - Discuss with Patient Flow and Operational teams
6808 Improving the appropriate use of D-Dimer testing in the Acute Medical Unit (AMU)
- Set up a 'Teaching session' for Junior and Middle Grade doctors regarding these guidelines - Target AMU doctor teaching to further improve documentation - Consideration of adding in a Wells score section to the AMU clerking proforma
6809 Is implementation of the MUST care pathway appropriate after scoring?
- Consider and produce a poster for display to educate prescribers regarding correct Oral Nutritional Supplements (ONS) - Consider and produce a Screen saver to educate prescribers regarding correct ONS - When nursing staff carry out their 'five a day MUST risk assessment audit' to spot check one of the five to check if correctly completed (as they do with other risk assessments). When acute team

Dietetic Support Worker is recruited, they will also run a spot check of how accurately MUST is completed - Matrons to share results of audit with ward managers and teams in huddle meetings to highlight areas needing improvement - Catering Group to check availability of high calorie and high protein items on the menu and nourishing snacks to help encourage increased nutritional intake for all patients with MUST 1+
6811 Diabetic Ketoacidosis (DKA) admissions on a Sodium-glucose co-transporter 2 inhibitor (SGLT-2)
- Generate a document with information for patients regarding "sick day rules" to be followed when prescribed SGLT2i. This will also cover other medication commonly used in patients with diabetes including Ace inhibitors (ACEi), angiotensin receptor blockers (ARBs) and metformin. - Create a cohesive department protocol for follow up of patients post SGLT2i related DKA
6813 Diagnosing Death - Accuracy of Documentation at Torbay Hospital
- Plan, produce and display posters - Plan, propose and produce sticker for the meeting on the 12th of June. SUPERCEDED 11-2-25 - advised that sticker will NOT be produced, G1941 has 'Appendix 6' that, when completed, will be added to patient records (Care & Clinical policy group 3-2-25) - Discuss and investigate with lead Consultant as to whether Registration number is needed - Provide a lecture on death and verification as part of F1 and F2/ Resident doctor teaching programme
6816 Midwifery to Health Visitor Transfer - Birth Trauma and Discharge Notification
- Raise awareness within community maternity staff of the importance of the Maternity Discharge Summary being communicated to Health Visiting team by Day 10, in line with local Maternity and Neonatal system guidance - Present audit results to Maternity Team in addition Safeguarding Children meeting - Learning/ Increase awareness of: - All body maps to contain documentation including whether no marks evident on baby - Any marks noted following completion of the body map to be documented on original body map with a date and time - Blank body maps inserted into Red Books for Health Visitor to confirm any marks at New Birth, 6-8 week contact and 3-to-4-month contact - All maternity and health visiting staff to receive regular Safeguarding supervision and access ad hoc supervision as appropriate - Health Visiting team leaders to access "SystmOne" Maternity EPR for further information, as required. - Maternity and Health Visitors to be reminded of the importance of prompt verbal communication when any marks are identified on a baby
6818 Bone protection in Oncology Patients receiving high dose steroids
- Share results with the wider team to inform those who did not attend the audit meeting/ presentation - Continue promoting best practice when starting steroids
6819 Breast screening prevalent round recall (2022/23 and 2023/24)

- Present at local audit meeting where there are as many screen readers as possible on the call to highlight: try to reduce the number of recalled less well-defined mass and asymmetric density - Email all screen readers confirming presentation of results showing the low positive predictive value for cancer in those categories
6820 Chest Trauma Fragility Fracture Management in General Surgery
- Email osteoporosis referral form for >50-year-olds presenting with rib fragility fracture (fall from standing height or less) - Run a department teaching session and send an email to improve compliance with referring patients with fragility rib fractures for a Dual-energy X-ray absorptiometry (DEXA) scan, to determine if bone-sparing treatment needs to be commenced.

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

- 6752 Assessing the diagnostic efficacy of ultrasound (USS) and computerised tomography (CT) in patients with right iliac fossa (RIF) pain and suspected appendicitis
- 6757 Termination of Pregnancy
- 6773 Timing of surgery following neoadjuvant chemotherapy treatment (NACT) for Breast Cancer
- 6780 Anaesthesia for Major Colorectal Surgery
- 6783 Prophylactic antibiotic prescription in acute pancreatitis and Laparoscopic cholecystectomy after mild gallstone acute pancreatitis
- 6791 Fetal Fibronectin (fFN) sampling in threatened pre-term labour
- 6793 Percutaneous Lung Biopsy
- 6795 Reporting accuracy of chest radiographs in patients subsequently shown to have lung cancer
- 6803 Glaucoma clinic intraocular pressure measurement accuracy using the Reichart Ocular Response Analyser
- 6805 Causes of Gynae Cancer Pathway Breaches following the Coronavirus Pandemic: Follow-up Project
- 6810 Olaparib with bevacizumab for maintenance treatment of advanced high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer (NICE TA-946)
- 6812 Management of individuals disclosing sexual violence in sexual health settings at Devon Sexual Health, Torbay, compared to the BASHH guidelines (2022)
- 6821 Rate of Re-excision of margins with Magseed after breast conserving surgery
- 6822 Urinary retention post autologous fascial sling surgery at Torbay Hospital Compared to national standards and whether spacing of the tape has an impact

6826 Antenatal Safeguarding Co

ID	Date Requested	Governor	Constituency	Summary Description	Executive Lead	Response Date	Summary Response	C-O-G	Date emailed	Status
186	15.11.24	Matt Giles	Staff Governors	The Trust currently operates a cycle to work salary sacrifice team with the purchase limit of £2,000, way adrift of our neighbouring Trust's limit (UHP is £10,000 and RDUH is also around this figure). Previous representations have been made around increasing our limit to match our neighbouring organisations at various meetings, including leaving one of my constituents being accused of her taking a personal issue and turning it into an organisational issue, which I find deeply disappointing. I am now receiving many queries from consultants around this. The cycle to work scheme has many benefits, increasing health and wellbeing through encouraging activity, reducing tax bills, therefore increasing the potential for our consultants to offer increased capacity to the Trust, reducing Trust	Mark Brice	20.02.25	Thank you for your enquiry about the purchase limit for the cycle to work salary sacrifice scheme. We have reviewed the upper limit and increased the value to £5000, we believe this value will enable staff to buy an e-bike. I understand there are specialist bikes at a higher value however on balance we believe that £5000 is proportionate in the circumstances. I have asked Finance to uplift the financial limit. You should therefore be able to place an order shortly.	07.05.25	17.03.25	Responded
192	**18.02.25**	Matt Giles	Staff Governors	This morning whilst sat at my desk next to a window in the tower block, I was visited by 2 contractors looking at the windows. They have been tasked with "making good" the significant number of damaged and defective wooden and plastic windows in the tower block whilst the scaffolding is up. Why, as an organisation, are we spending money on "making good" windows that these contractors advised me need replacing, as opposed to replacing them?	Mark Brice	**03.03.25**	The Tower block was built in 1967 and is in poor condition. Our new hospital plans involve replacement of the ward blocks in the Tower and new ward blocks built, with proposed future demolition of the tower. We had previously hoped our new hospital would be complete before 2030 however recent announcements from Government indicate that Torbay hospital will start its construction projects in wave two, between 2030 and 2035. We are currently exploring alternative routes to funding for replacing the tower ward blocks. With the future plans to replace and demolish the asset we have previously looked at the cost of full window replacement at a cost of circa £750,000 and do not believe this would be a wise spend of money. We have therefore agreed a package of window repairs and refurbishments in situ at a cost of circa £100,000. The work will extend the windows life, enable them to open and close safely and will be cleaned and where timber- painted. This is a solution which improves the environment for staff and patients in the Tower and is commensurate with the anticipated future of the building and the available funding.	**07.05.25**	27.02.25	Responded
193	**19.02.25**	Val Browing	South Hams	1.□ What are the current response times from PALS to Patients and are they informed when a complaint is completed. 2.□ What changes have been made in the last twelve months to improve the PALS service to Patients.	Nicola Mcminn	09.03.25	The Team: The team have benefited from additional substantive resource over the last year. There was a temporary FT B6 post which has now been made substantive. There was also a vacant FT B6 post and this has now been filled. The team are benefitting from having a FT B8a linked to them. While the B8a postholder's role is broader than simply being the senior manager for the Complaints and PALS team, that is an important part of their day-to-day responsibility. The Complaints and PALS team are now at full establishment: •B8a x1 FT Patient Safety Specialist, Feedback and Engagement •B7 x1 FT Complaints and PALS Manager •B5 x 6 (x4 FT; x2 PT) PALS & Complaints Officers •B3 x1 PT Team Administrator •B3 x1 PT Friends & Family Test (FFT) Administrator Risk 3568 – this risk, associated with the impact on their work due to the team being under-	**07.05.25**	20.02.25	Responded
194	**20.02.25**	Matt Giles	Staff Governors	"The need for vacancy controls within the organisation is well recognised. However, when posts are being held up in this process by individuals taking way in excess of a month to approve posts (including the head of education and other executive team members), which is affecting patient care, the value of these controls and impact on safety must be questioned. An example of this being general surgical administrative roles that are both still held in process over 90 days later, with clinics being stood down due to the lack of administrative support. Could I please enquire as to the governance processes of the controls to ensure that vacancies are quickly assessed by those within the process?"	Anne Cholmondeley	09.03.25	Thank you for your email and enquiry. We have robust workforce controls in place due to the Trust's financial position and approvals are reviewed and processed at least weekly. Where it is not possible to decide on an individual role at the first review, this is normally because there is information missing on the initial Trac submission such as the post funding source, risk status or outstanding approver from the care group or finance. When this information is missing the approver, or the recruitment team add a note on the Trac system and contact the care group or finance so the information can be added as soon as possible. If you have any concerns regarding a specific post, please provide us with the title and Trac reference, so the team can review this at the earliest opportunity.	**07.05.25**	20.02.25	Responded
196	**02.03.25**	John Kiddey	Torbay	This message shows due respect and proper consideration of both cultural and faith issues in part of the workforce and is to be warmly welcomed. What assurance have NEDS had from the senior management that ALL faiths among the workforce are given precisely the same degree of understanding and consideration in the way they practice their faith and what evidence have you seen to confirm this?	Chris Balch	03.03.25	My response is as follows: 1.The Trust acknowledges the diverse nature of our workforce and population in terms of ethnicities and faiths. Our chaplaincy service employs four full and part-time chaplains reflecting a range of different branches of the Christian faith. The Torbay Hospital chapel provides a focal point for quiet contemplation and religious services, including the annual Carol Service. There is also multifaith prayer room in addition to our traditional chapel, which is available 24/7, and that a list of faith festivals for the current month covering all main religions is displayed on its noticeboard. 2.The main Christian festivals of Christmas and Easter are a significant focus of attention across the Trust with appropriate decorations and religious services. For example, I and a number of NED's paid pre-Christmas visits to wards and community hospitals to thank our staff for their efforts over the festive season. 3.In addition the Chaplaincy team maintains a list of religious leaders and contacts from a very wide range of faith communities. The chaplaincy service aims to ensure that patients, visitors and staff receive spiritual care that is appropriate for them and does its best to contact the right person	**07.05.25**	01.04.25	Responded
195	**13.03.25**	Matt Giles	Staff Governors	Could Anne please be asked to provide: •Once a job is uploaded to TRAC, what is the specific process that is followed in approving this? •Is there a specified target time for approving posts? Especially clinical roles. •I would really appreciate a step by step process of what individuals and what groups take part (roles acceptable, I don't expect names). •What timeline is allocated to approvers. •What time is allocated to approvers within job plans/roles to enable this. •Is this a linear stream, or are there workarounds to account for individuals being on annual leave, sickness or any other absence.	Anne Cholmondeley	25.03.25	Thank you for your email – we are currently undertaking a review of our workforce controls and approvals process so the answers to your questions are subject to change – • Once a job is uploaded to TRAC, what is the specific process that is followed in approving this? The recruitment team oversee the approvals process and set up the sequence of approvers on Trac at which point the approvers are notified via email that there is a post to review and approve. Typically, the approvals include the budget holder (recruiting manager), finance, associate director, care group director and executive and finally CEO and then the recruitment team release the post for advert. We have already streamlined the approval process for clinical front facing roles and are undertaking a further review. The final exec level approval cannot be completed until the other approvers have completed theirs. • Is there a specified target time for approving posts? Especially clinical roles. There is not a current target time period for approving posts. Approval for front line critical clinical roles has been streamlined now to shorten the approval time with Care Group Directors being the	**07.05.25**	25.03.25	Responded
196	**10.03.25**	John Kiddey	Torbay	When I joined the COG in 2019, we were assured that the use of acronyms and jargon in documents and meetings would be replaced with simple, plain English. This has not happened and acronyms and jargon are in constant use today both at COG and management meetings. I have twice in the past three months had to get clarification of acronyms used at The People Committee. New governors and new employees of the trust are particularly left out when managers continue to use mystifying terms. Such mis-use of language is discriminatory and must surely be a breach of equality rules designed to make sure no-one is excluded. What will NEDS do to improve things?	Chris Balch	17.03.25	I sympathise with your concern about the excessive use of acronyms in NHS documents and the plea for the use of plain English. The NHS is not unique in facing this issue – my professional background in town planning and surveying is similarly littered with acronyms. Indeed it is the hallmark of professions to create their own language which serves to reinforce their identity and preserve their mystic. There is an App called NHS Acronym Buster which I downloaded when I became a NED but I found that it could not keep up with the pace at which new acronyms are being invented! Our new NEDs are also asking for explanations to be provided when they encounter acronyms which they do not understand. More generally we are trying to reduce the length and complexity of reports and seek simpler and more direct use of language. Best practice dictates that when an acronym is first used in a report it is spelt out in full. This is applied in our Board minutes. However I will remind Executive Directors who have oversight of Board and Committee papers of this.	**07.05.25**	17.03.25	Responded
197	**10.03.25**	Andew Stiilard	Torbay	further to the recent response ref Ramadan question can Governors be assured that staff observing the strict fasting regime can be fully able to conduct their duties in an equitable manner to other staff without additional rest periods. If this was not abnormal then it would not be an issue.	Anne Cholmondeley		This March and through to April we have had a number of colleagues fasting from the Abrahamic religions, our Muslim colleagues have been observing Ramadhan whilst our Christian colleagues have been observing Lent, this gives our people an opportunity to understand each other better and the motivation religion and faith has in people practising caring roles in our NHS. For our Muslim colleagues Ramadhan is not only about fasting, it is also about charitable acts, compassion, reflection and supporting the community, all things we hold closely in our NHS values. As of 2020 there are approximately 1.8 billion Muslims across the world, many of whom see fasting during Ramadhan as essential to their faith. There are guidelines within Islam to ensure those who are not able to fast due to their health and wellbeing are exempt from doing so, meaning those who are able to have balanced the need of their work and family life against their religious duties. This will include our staff observing Ramadhan who deliver exceptional care to our patients and community alongside their colleagues. It is important to note that equity recognises that each person has different circumstances and this can mean we need to allocate opportunities and resources differently to ensure everyone has an	**07.05.25**	29.04.25	Responded
196	**24.03.25**	John Kiddey	Torbay	In 2024 Sir Richard Ibbotson confirmed to governors a report in The Daily Mail that TSDF chief executive Liz Davenport was granted a special bonus of £30,000. Until this made public by the media, governors were completely unaware of the bonus or the reasons for it. Sir Richard explained the bonus was paid because Ms Davenport was being paid less than colleagues of similar seniority in trusts of a comparable size. The trust was already in NOF 4 at the time and the board and Non-executive directors were aware of the serious financial problems facing the trust. They also appear to have known about Ms Davenport's plan to retire soon AFTER the Bentley report was produced according to the chairman's comments to governors quoted in the email dated 20th March 2025. The	Chris Balch	01.04.25	Liz received a salary uplift in 2022/3 which was a combination of the national pay rise for 2022/3 and an increase in pension contributions due to length of service. You may be aware that a number of our colleagues also queried this issue, and I detail below the response that was shared via our 'Just Ask' facility: The salaries of our Chief Executive and all other Executive Directors are set by our Nomination and Remuneration Committee. The Committee regularly reviews and aligns with the national NHS salary ranges for an organisation of our size before making recommendations. In the case of our Chief Executive's salary, the Committee makes a recommendation to the Secretary of State for Health and Social Care who, if in agreement with the recommendation, approves it. The increase in Liz's salary between 2021/22 and 2022/23 (as reported on in the Daily Mail and published in our annual report for 2022/23) is due to two main factors – the national pay rise for 2022/3 and an increase in pension contributions due to length of service. The national review body on senior salaries (SSRB) recommended a 3% uplift for very senior managers (VSMs) and Executive Senior Managers (ESMs) for 2022/3 which was approved by the	**07.05.25**	01.04.25	Responded
196	**26.03.25**	Lee Thomas	Torbay	The focus of these questions is on staff who are currently on long-term sick leave (defined as over 28 days), and how this impacts service delivery, costs, and workforce wellbeing. Specifically: 1.How many staff are currently on long-term sick leave? oPlease include a breakdown by staff group and, if possible, by department. 2.What is the average and longest duration of absence among long-term sick staff? oAre there identifiable patterns or common causes (e.g., stress, long COVID, injury)? 3.What cover arrangements are in place for their roles? oAre agency or bank staff being used, and what are the associated costs for cover over the past 12	Anne Cholmondeley	17.04.25	1.How many staff are currently on long-term sick leave? oPlease include a breakdown by staff group and, if possible, by department. 154 individuals on long term sick (over 21 days) Breakdown by staff group Add Prof Scientific and Technic 2 Additional Clinical Services 32 Administrative and Clerical 58 Allied Health Professionals 11 Estates and Ancillary 13 Healthcare Scientists 2 Medical and Dental 6 Nursing and Midwifery Registered 30 There are 110 cost centres across the Trust who have staff on long term sickness 2.What is the average and longest duration of absence among long-term sick staff? oAre there identifiable patterns or common causes (e.g., stress, long COVID, injury)? Average Duration is 91 days	**07.05.25**	17.04.25	Responded
197	**10.04.25**	John Kiddey	Torbay	1.On what date did the board first become aware of the very serious financial situation which was later highlighted in the Bentley report? 2.On what date did NEDS first become aware of the serious financial situation which later resulted in commissioning the Bentley report? 3.On what basis did the board (and NEDS) believe that a report from Ms Bentley was needed? 4.Were concerns raised by NEDS and/ or the board with Ms Davenport about finances before she announced her retirement plans? If so, what were they? If not, why not?	Chris Balch	23.04.25	1.On what date did the board first become aware of the very serious financial situation which was later highlighted in the Bentley report? As a Governor you will be aware that both before and after the Covid-19 pandemic, the Trust has operated a significant financial deficit. At the start of each financial year an operating plan and budget is agreed at both ICB and Trust level. This involves a process of negotiation during which a Cost Improvement Plan (CIP) to deliver a target level of efficiency savings is agreed to reduce the Trust's deficit to an 'acceptable level'. For 2024/25 a CIP target of £40m was identified. This was planned to deliver a significant level of recurrent savings by reducing dependence of agency and bank staff and achieve a reduction in overall headcount. The bulk of savings were projected to be delivered in the second half of the financial year (from October 2024 to March 2025). In May both the FPC and Board noted that the pay run rate, staffing levels and CIP were all adverse to plan. Again in June the FPC noted the low level of recurrent CIP being achieved and escalated the issue to the Board. By September while the Trust was broadly on target to deliver its first half CIP savings this was being achieved through non-recurrent savings e.g. vacancies and balance sheet adjustments. Both the FPC and Board received information which showed that the Trust was struggling to achieve the required level of recurrent CIP and recognised this as a concern..	**07.05.25**	23.04.25	Responded
198	**19.04.25**	John Kiddey	Torbay	1.Were NEDS consulted about the email Joe Teape sent to staff on April 17th BEFORE it was sent? No. 2.If not, why not? It is not common practice for the NEDs to be consulted on 'all staff' communications. These are largely operational in nature and are the responsibility of the Executive working with the Comms team. 3.If they were consulted, did they approve of the wording? Not applicable in view of 1 above. 4.Mr Teape states in the email that NHS England will "consider and take into account all relevant legislation and the supreme court ruling" Are NEDS assured that the trust will comply fully with the amended legislation? The Board will ensure that it complies with legislative requirements, following any guidance provided by NHSE/DHSC on the	Chris Balch	23.04.25	1.Were NEDS consulted about the email Joe Teape sent to staff on April 17th BEFORE it was sent? No. 2.If not, why not? It is not common practice for the NEDs to be consulted on 'all staff' communications. These are largely operational in nature and are the responsibility of the Executive working with the Comms team. 3.If they were consulted, did they approve of the wording? Not applicable in view of 1 above. 4.Mr Teape states in the email that NHS England will "consider and take into account all relevant legislation and the supreme court ruling" Are NEDS assured that the trust will comply fully with the amended legislation? The Board will ensure that it complies with legislative requirements, following any guidance provided by NHSE/DHSC on the implications of the recent Supreme Court decision.	**07.05.25**	23.04.25	Responded

NHS
Torbay and South Devon
NHS Foundation Trust

-Torbay and South Devon NHS Foundation Trust

ALL Governor Meetings 2025

- Public Board – Bimonthly (excluding August and December) starts at 12:30 pm, all meetings are held in the Boardroom, Hengrave House and via MS Teams.
- Council of Governors – Quarterly, starts at 2pm held in the Boardroom and via MS Teams
- Membership Committee – Quarterly, starts at 2pm held Virtually via MS Teams
- CoG Priorities – Bimonthly, starts at 2.30pm, held in the Boardroom, Hengrave House and via MS Teams
- Governor Only – Bimonthly, starts at 2.30pm. Boardroom, but FT Office will look at visiting other Trust sites for these, at request of Governors.
- Governor Coffee Mornings – Monthly, starts at 10.30am, held virtually via MS Teams
- Annual Members - Once a year in September, to present the annual report.
- Governor Nominations and Remuneration Committee – Ad hoc meeting when required.

Public Board meetings - attendance voluntary at Public Session		
Date	**Time**	**Venue**
29 January	11.30 am	Boardroom
26 February	12.30 pm	Boardroom
26 March	12.30 pm	Boardroom
28 May	12.30 pm	Boardroom
30 July	12.30 pm	Boardroom
24 September	12.30 pm	Boardroom
26 November	12.30 pm	Boardroom
Governor Obligations	Governors observe NEDs contributions at Board and hold NEDs individually to account for performance of Board – (Questioning NEDs on the Trust's quality and financial performance)	

Council of Governors Meetings (4 a year)		**Dates**	**Presentation**
Chaired by	Trust Chairperson	January	
Agenda Set by	Lead Governor and Chair	05 February	
Governor attendance	**Statutory Attendance**	March	
Exec & NED attendance	Yes	April	
Trust Office attendance	Yes	07 May	
Time	2pm – 4pm	June	
Venue	Boardroom, Hengrave House, Torbay Hospital	July	
Minutes	Required	06 August	
Description	Formal Statutory Council Meeting	September	
Purpose	Council of Governors are required to meet at least quarterly to ensure Governors can fulfil their statutory duties.	October	
Governor Obligations	Engagement with the Trust	05 November	
Additional Points		December	

Membership Committee Meetings (4 a year)		Dates	Presentation
Chaired by	Membership Committee Chair	23 January	
Agenda Set by	Chair	February	
Governor attendance	**Only Governors who are on the Membership Committee attendance is required**	March	
Exec & NED attendance	No	24 April	
Trust Office attendance	Yes	May	
Time	2pm – 4pm	June	
Venue	Via MS Teams	24 July	
Minutes	Required	August	
Description	Formal Committee Meeting	September	
Purpose	The purpose of the Committee is to support Governors in fulfilling their statutory duty to represent the interests of Foundation Trust Members and the public.	23 October	
Governor Obligations	Review FT membership data to target underrepresented groups	November	
Additional Points	Governors can self-nominate to join Membership committee	December	

CoG Priorities Meetings (6 a year)		Dates	Presentations
Chaired by	Trust Chairperson	21 January	(10-year plan session)
Agenda Set by	Lead Governor and Chair	February	
Governor attendance	**Voluntary Attendance**	18 March **To include a meeting with New CX, Joe Teape, 1.30 - 2.30 in Seminar Room 7, Horizon Centre**	A&E – waiting times
Exec & NED attendance	Voluntary	April	
Trust Office attendance	Yes	20 May	Workforce & Staffing
Time	2.30pm – 4.30pm	June	
Venue	Boardroom, Hengrave House, Torbay Hospital	15 July	EPR & New Hospital
Minutes	Yes, but the format may change to best suit the meeting, which may include PowerPoint slides as a record of the meeting	August	

Description	Formal meetings	16 September	Fragile Services
Purpose	Meetings set aside to allow more complex priority issues to be heard and discussed by the CoG. Enabling the NED/CoG working relationship. Facilitating NEDs or Board Executives to present to the CoG in the form of a 'seminar' on key priority topics or CoG Questions. Allowing the CoG time to ask more detailed questions.	October	
Governor Obligations	Collective working and raise individual and collective questions to ensure views of FT Members and wider Public are received and responded to as required	18 November	Finance and Performance
Additional Points	Priority sessions should where practical be linked to the Priorities set by the CoG and agreed by the Board	December	

Presentations - Priorities 2025	**Date of Meeting: TBC**
A&E	18 March
EPR and NHP	15 July
Workforce & Staffing	20 May
Fragile Services	16 September
Finance & Performance	18 November

Governor Only Meetings (6 a year)		**Dates**	**Presentations**
Chaired by	Lead Governor and deputy Lead Governor	January	
Agenda Set by	Lead Governor	18 February	
Governor attendance	**Voluntary Attendance**	March	
NED attendance	No	15 April	
Trust Office attendance	Only if requested	May	
Time	2:30 pm to 4:30 pm	17 June	
Venue	Boardroom, Hengrave House	July	
Minutes	As required, which may include a bulleted summary of the meeting or no minutes at all under the Chatham House Rule	19 August	
Description	Informal Governor **only** meetings	September	
Purpose	Regular Governor only meetings to ensure Governors can discuss and debate all relevant issues to ensure a level of collective knowledge and responsibility. The agenda may include Governor training as CPD, and reports by Governor Observers, CoG Committees and Constituency leads.	21 October	
Governor Obligations	Enables collective working	November	

Additional Points	Can be held in community settings if requested.	16 December	

Governor Coffee Mornings (12 a year)		**Dates**
Chaired by	Lead Governor	15 January
Agenda Set by	Lead and Deputy Lead Governor	19 February
Governor attendance	**Voluntary Attendance**	19 March
NED attendance	No	16 April
Trust Office attendance	No	21 May
Time	10.30am – 11.30am	18 June
Venue	Remains a Virtual Teams Meeting	16 July
Minutes	No minutes – Chatham House Rule applies	20 August
Description	Informal meeting of Governors **only**	17 September
Purpose	To enable an informal discussion about topical issues. To raise any points to be taken forward by the LG or to be raised more formally as a CoG.	15 October
Governor obligations	To facilitate informal Governor collective working	19 November
Additional Points		17 December

Annual Members' Meeting (1 a year)		**Dates**
Chaired by	Trust Chairperson	January
Agenda Set by	Membership Committee, Lead Governor, and Chair	February
Governor attendance	**Voluntary or as requested to support**	March
NED attendance	Voluntary or as requested to support	April
Trust Office attendance	Yes	May
Time	TBC	June
Venue	TREC Lecture Theatre, next to Horizon Centre, Torbay Hospital	July
Minutes	Required	August
Description	Statutory Annual Members' Meeting to receive annual report, quality report and accounts.	September Date tba
Purpose	To present to members: and the public the annual accounts and report. Including any updates on membership and Governor elections.	October
Governor Obligations	Representing FT Members and Public and Hold NEDS collectively to account for performance of Board	November
Additional Points		December

Chair and Lead Governor Meetings		**Dates**
Chaired by	Trust Chairperson	January
Agenda Set by	Chair and Lead Governor	February
Governor attendance	**Bimonthly Lead Governor and Constituency Leads. Trust CEO may also attend if available.**	March

NED attendance	No	April
Trust Office attendance	No	May
Time	As diary permits – Chair PA arranges meetings	June
Venue	Chair's Office, Hengrave House	July
Minutes	Bulleted highlights produced for CoG	August
Description	Informal meeting	September
Purpose	Regular meetings between the Chair and the LG/CLG. Providing an informal meeting where issues or questions emanating from the Governor meetings can be discussed directly with the Chair.	October
		November
Additional Points		December

Constituency Meetings		**Dates**
Chaired by	Nominated Governor in each constituency	January
Agenda Set by	Constituency Governors	February
Governor attendance	**All Constituency Governors as available**	March
NED attendance	If invited	April
Trust Office attendance	No	May
Time	As diary permits	June
Venue	Local	July
Minutes	As required, which may be bulleted highlights produced for reference	August
Description	Informal meeting	September
Purpose	To enable Governors specific time to focus time on local constituency related issues	October
		November
Additional Points	Normally held quarterly	December

PLEASE NOTE THE DATES BELOW FOR 2025/26 ARE SUBJECT TO CHANGE AND WILL BE UPDATED AS SOON AS POSSIBLE

Governor Observer Reports from the Board Level Sub Committee Meetings		**Dates**	**Committee (Governor Initials)**
Observed by	Nominated Governor for each Committee	January 22 29 29 17	 Audit Committee (AP) Finance and Performance Committee (SA) Quality Assurance Committee (VB) Building a Brighter Future (DC)
Governor attendance	**Nominated Governors as available**	February 26 26 21	 FPC (SA) People Committee (AS) BBF (DC)
Report	Circulated via monthly Newsletter to all Governors	March 25 25	 FPC (SA) QAC (VB)

		6 20	Charitable Funds Committee (AR) BBF (DC)
Description	Observations	April 10 24 22 17	 AC (AP) FPC (SA) PC (AS) BBF(DC)
Purpose	Assessing the NEDs performance	May 22 22 7	 AC (AP) FPC (DC) QAC (VB)
Additional Points	New Governor observers decided to start in May.	June 25 19 24 12 19	 AC FPC PC (JK) CF (LD) BBF
Governor Obligations	Hold NEDs individually to account for performance at each Committee	July 24 24 21	 AC FPC QAC
		August 21 21	 BBF FPC
		September 23 2 15 11	 FPC PC QAC CF
		October 2 23 21 16	 AC FPC PC BBF
		November 25 17	 FPC QAC
		December 18 9 11 18	 FPC PC CF BBF

Governor Nominations and Remuneration Committee (AD HOC)		**Dates**
Chaired by	Trust Chairperson	Held as required
Agenda Set by	Chair	
Governor attendance	**Governor Members Only**	
NED attendance	Senior Independent Director	
Trust Office attendance	Corporate Governance Manager	
Purpose	Involvement input for performance appraisals for Chair and NEDs	

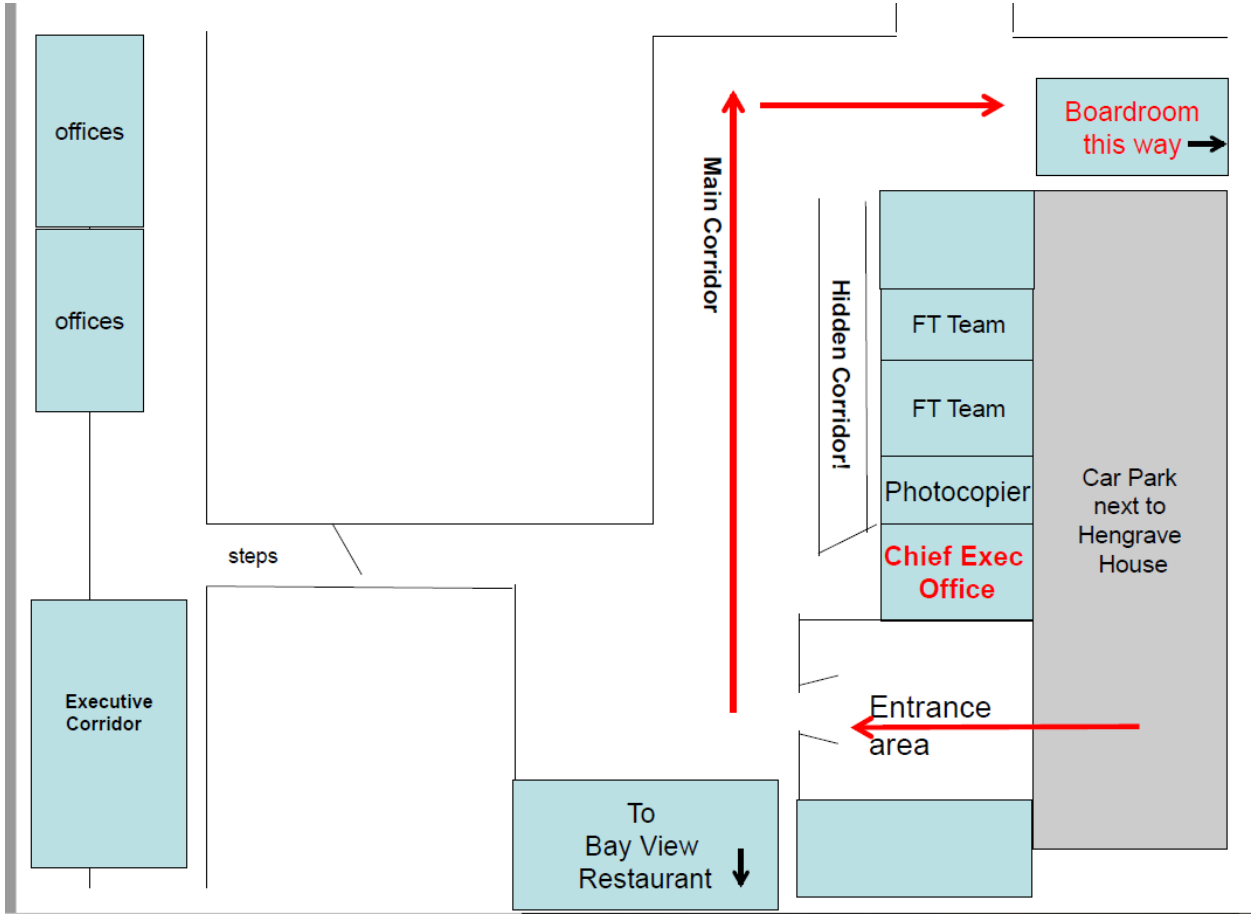
Governor obligations	Hold NEDs individually to account for performance of Board	
Additional Points		

Summary of standing and ongoing Governor Obligations:

- Ask about CQC judgements on the quality of care at the Trust – ad hoc
- Contact Senior Independent Director – if have concerns or if direct contact is inappropriate – ad hoc
- Jointly approve amendments to Trust's constitution – ad hoc
- Approve any "significant transactions" and approve a merger, acquisition, separation or dissolution – ad hoc as required
- Appoint and, if appropriate remove the Chair. Appoint and, if appropriate remove the NEDs – ad hoc, as required
- Appoint and if appropriate remove the Trust's external auditor – ad hoc, as required
- Approve the appointment of the Chief Executive – ad hoc as required
- Decide whether the Trust's non-NHS work would significantly interfere with its purpose – ad hoc as required.
- Have their views taken account of when Trust sets its strategy.
- PLACE Assessments (October 2024) Ensure views of public are added into the annual PLACE Assessments

NHS
Torbay and South Devon
NHS Foundation Trust

MAP TO LOCATE BOARDROOM WITHIN HENGRAVE HOUSE, TORBAY HOSPITAL, TQ2 7AA



Torbay and South Devon NHS Foundation Trust

Building a Brighter Future Committee
Governor Observer Report for meeting dated 19 02 2025

CQC KLOEs – Key Lines of Enquiry
Is it effective? E1: Are people's needs assessed and care and treatment delivered in line with current legislation, standards and evidence-based guidance to achieve effective outcomes? E2: How are people's care and treatment outcomes monitored and how do they compare with other similar services? **Is it responsive?** R1: How do people receive personalised care that is responsive to their needs? R3: Can people access care and treatment in a timely way? **Is it well led?** W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver? W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management? W5: Are there clear and effective processes for managing risks, issues and performance? W6: Is appropriate and accurate information being effectively processed, challenged and acted on?

Governor Observers are asked to consider the following questions:	
Question	**Comment**
Was the meeting well chaired?	Yes
Were members engaged throughout the whole meeting including contributions by NEDs?	Yes
Did the meeting discuss key risks\issues or did you see a risk register?	Yes and yes
If there was an action log, was this discussed and updated?	Yes
Was there anything that concerned you about the governance of the meeting? If yes, please detail.	No
Key issues to be escalated to the CoG which *could* be included as an item for discussion at a future Governor meeting.	Generally as we all know this whole project has been unacceptably delayed by the government.
Key issues to be escalated to the Board.	None

Report completed by: Dave Cawley

Date: 11 03 2025

NOTE: this report is not to be edited or modified without the authors permission.

People Committee
Governor Observer Report for meeting dated 24/02/2025

CQC KLOEs – Key Lines of Enquiry	
Is it safe? S3: Do staff have all the information they need to deliver safe care and treatment to people? S6: Are lessons learned and improvements made when things go wrong? **Is it effective?** E3: How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment? E4: How well do staff, teams and services work together within and across organisations to deliver effective care and treatment? **Is it well led?** W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care? W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver? W3: Is there a culture of high-quality, sustainable care? W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management? W8: Are there robust systems and processes for learning, continuous improvement and innovation?	
Governor Observers are asked to consider the following questions:	
Question	**Comment**
Was the meeting well chaired?	VERY WELL
Were members engaged throughout the whole meeting including contributions by NEDs?	YES
Did the meeting discuss key risks\issues or did you see a risk register?	YES
If there was an action log, was this discussed and updated?	YES
Was there anything that concerned you about the governance of the meeting? If yes, please detail.	NO. MEMBERS WERE CHALLENGED BY THE NEDS WHO ALL OFFERED A FRESH PERSPECTIVE ON WORKFORCE AND NOF 4 ISSUES
Key issues to be escalated to the CoG which could be included as an item for discussion at a future Governor meeting.	THE COG SHOULD BE BRIEFED ON THE VERY LOW STAFF MORALE AND THE REASONS FOR IT. JARGON AND ACRONYMS ARE STILL FAR TOO EVIDENT IN MEETINGS LIKE

	THIS AND THE CHAIR SUPPORTS THE NEED TO USE PLAIN ENGLISH
Key issues to be escalated to the Board.	ISSUE RAISED BY STAFF TO BE ESCALATED TO PRIVATE BOARD

Report completed by: JOHN KIDDEY (PUBLIC GOVERNOR) ……

Date: 24TH FEB 2025 ……