Torbay and South Devon
NHS Foundation Trust

Quality Account 2021/22

Approved by Trust Board on 21st June 2022

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NHS
Torbay and South Devon
NHS Foundation Trust

Quality Account

2021/22

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

ABOUT THIS DOCUMENT

The content of this account and its publication on our website is a regulatory requirement for NHS organisations. However, we want our quality account to be a meaningful and easy-to-use reference point for people wanting to get a sense of the quality of our services.

To this end we have aimed to make this account as clear and user-friendly as possible so that everyone can understand the quality of the services provided last year and see what we will be doing to improve our services in the year ahead.

For NHS services the definition of quality is broadly accepted as having the following dimensions:

- patient safety
- clinical effectiveness
- experience of care

It is through these categories that we define our quality priorities and measure how we are doing in delivering them.

Further information about quality accounts in general can be found at: https://www.nhs.uk/using-the-nhs/about-the-nhs/quality-accounts/about-quality-accounts/

For more information about our services, or to tell us what you think about this report or anything we do please contact us at communications.tsdft@nhs.net.

1 INTRODUCTION AND STATEMENT OF QUALITY

About us

We are here to support the people of Torbay and South Devon to live well. When we formed our integrated care organisation in October 2015 we became the first NHS organisation in England to join-up hospital and community care with social care. We are proud pioneers in integrating health and social care nationally.

Our vision is better health and care for all and we have made significant advances over the years in leading and innovating care across a range of clinical services. As a well-established integrated care organisation, we know the value of working in partnership with others and the positive impact this has for our local population. In progressing our quality agenda, we are committed to placing the needs of our people and community at the heart of our ambitions.

A relentless focus on quality improvement underpinned by people, process and technology is one of our six strategic priorities which will help us achieve our strategic goal of excellent experience of receiving and providing care.

There is no doubt the quality and safety of care has been tested in the last two years. We have seen a dramatic change in the way we understand and respond to quality issues, accelerated by COVID-19. The impact of COVID-19 has not only increased the pressure across all aspects of health and social care, but those who live in our most deprived parts of the community have seen an increasing gap in health inequalities.

What is also clear is that the pandemic has had a significant impact on the quality and safety of healthcare. Our patients are experiencing delays in treatment and accessing services, all of which is having an adverse impact on their experience and clinical outcomes in a way that will requires us to organise and deliver services differently in the future.

Never has our vision for quality and patient safety been more important. Responding to the current challenge will require a step change in how we approach the quality agenda.

Fundamentally, we are committed to reinforcing and enhancing our culture of safety, enabling our people to feel safe and confident to speak up. In responding to the quality and patient safety challenge we are adapting and revitalising our approach to the management of quality. This includes a continued focus on building meaningful partnerships, with our patients, community, our staff and colleagues across the Devon Health and Social Care system.

We have a three-year quality plan which outlines our approach to quality, setting out our ambition for excellence and outstanding care through a set of strategic quality goals and improvement priorities. Drawing on the NHS Patient Safety Strategy 2019 and international best practice, this document sets out our ambitions for the next three years. Key to our success is the requirement to renew and revitalise our approach to quality management and leadership, ensuring that we enable front line clinicians to deliver outstanding care.

Our vision of excellent in quality

We are committed to delivering outstanding care, ensuring excellence in experience and outcomes for our patients and the wider community we serve. While there is no universal definition of 'excellent care', it is important to be clear about what we are aiming to achieve– providing clarity on our purpose enables us to know when we are not delivering against our ambition for patients and staff.

Our vision of excellent care means that we aim to:

- meet the needs of the people we serve, ensuring care is compassionate and person centred and that it is focused on what matters to patients, families and carers
- provide care that is free from harm and the clinical outcomes are comparable with the best in the world
- empower and enable our people to deliver the very best
- establish the infrastructure and foster the culture that empowers and enables our talented people to focus on the things that matter most to them
- work in partnership to continually improve the quality of care and reduce health inequalities with patients our staff and partners across the Devon health and social care system

Our quality goals

Our understanding of quality reflects the description of quality as set out in the '*High Quality for All, NHS Next Stage Review' (2008).* The three components of quality; safety, effectiveness and patient experience are linked. A service cannot be judged to be excellent because it is safe while ignoring its effectiveness or people's experience.

Our quality goals are:

Goal 1	Goal 2	Goal 3	Goal 4
Zero Avoidable Deaths	Continuously seek out and reduce Harm	Excellence in clinical outcomes	Deliver what matters most to our people

Summary of our quality report

In the early days of the pandemic in 2020/21 our quality report said that our focus for 2021/22 would concentrate on recovery of staff alongside restoration and recovery of services. We also said we would learn from innovation in provision of health and care across the country to improve what we do.

I am pleased to report that despite the challenges for our teams and for local people who are all living through the extraordinary circumstances, we have delivered what we said we would.

At the time of writing all of our services are operational again, and our organisation as a whole is well on the way towards a fully recovered position in 2022 where we are ready to “live with COVID-19”.

I commend this quality account to you and confirm that, to the best of my knowledge, the information in the document is accurate.

Liz Davenport

Chief Executive Officer, Torbay and South Devon NHS Foundation Trust

2.1 PRIORITIES FOR IMPROVEMENT

IMPROVEMENT PRIORITIES FOR 2021/22 – HOW DID WE DO?

Priority 1 – Patient safety

Our key priority was to fully restore services suspended due to the pandemic, so that patients would have safe and timely access to services and treatment, preventing harm to them, while balancing the need for our people to rest and recover.

The continuing pressures brought about by the pandemic meant that we were unable to restore all of the services we had suspended. Primary objectives were to improve patient safety, quality and experience metrics with key actions: -

- Re-commence elective/planned care across all specialties
- Assessment areas to function as planned for same day emergency ambulatory care
- Reduce waits in the Emergency Department
- Reduce Length of stay for patients in hospitals across all wards
- A workforce plan to underpin delivery of clinical services and new models
- Support patients to safely remain in their own homes

To date we have been able to restore: -

- The Day Surgery unit to pre-pandemic activity
- The orthopaedic ward to recommence major joint surgery
- Medical Receiving Unit on Level 2 avoiding using an inpatient area for assessment
- Maintain additional 17-beds on McCallum Ward.
- Outpatient moves with re-provision of some services on Crowthorne Ward and Urology services moved to Paignton.
- Work continues to bring all services back on-line optimising ‘attend anywhere’ strategy using virtual clinics;
- Work is underway to re-establish a short stay ward.
- Community therapy services retuning to pre-pandemic levels

Our patient safety focus also included:

- Responding to Care Quality Commission (CQC) recommendations

  Following a CQC inspection in 2020, which identified actions and key areas for quality improvement and patient safety, we have been able to:
  - increase knowledge and awareness of the Mental Capacity Act (MCA) through the provision of MCA training. This supports staff to provide the highest quality of care to their patients whilst maintaining the least-restrictive safe environment for them.
  - quantify what level of resuscitation training staff have undertaken. Clear reports, detailing which staff are trained to levels, 1, 2 and 3, support managers, and our educations leads, to ensure that we always have people trained to the correct level, which in turn provides a skilled workforce to quickly step in to support emergencies in all environments.
  - reduce the number of objects filling our corridors and wards. Through a detailed and ongoing plan of work, we are moving towards a clutter-free environment which reduces trip hazards for staff and patients and reduces the risk of harm resulting from potential falls.

- Delivering the national “Sign up to safety” programme

  Sign up to Safety was a national patient safety campaign which placed patient safety as a top priority in everything we do. Although this programme stopped in 2020, our focus on patient safety continued with the aim of providing harm-free care. We do this by:

  - listening to patients, carers and staff
  - learning from what they say when things go wrong (and when they go well)
  - acting to improve patients’ safety

  The reporting of incidents is recognised as a key measure of a patient safety focussed organisation and that is why we invested to strengthen our central Patient Safety and Quality team, who act as a core resource, supporting staff across the organisation with incident reporting and management. The result was that this year saw a significant increase in the volume of patient safety incidents reported, up by more than 2.5 thousand on the previous year:

  - 2020/2021 – 9,304 patient safety incidents reported
  - 2021/2022 – 11,898 patient safety incidents reported

  We will continue to maintain the high profile for patient safety across all services while we plan and implement our new ‘speak up for patient safety’ campaign in 2022/23.

- Duty of candour and incident investigation

  Through the development of the NHS Patient Safety Strategy, we continue with our commitment to patient safety and quality improvement. While future developments will alter how we approach incident investigations, we are currently guided by the Serious Incident Framework and, for the duty of candour, by the CQC and guidance from professional bodies, e.g. NMC and GMC.

  Where a certain level of harm has occurred to patients in our care, we must inform the patient of this or, if the patient has died or lacks capacity, we must inform their next of kin/family and we actively encourage the patient/family to be involved and tell us what questions they would like to see answered by the investigation. We reported 95 Serious Incidents during 2021/22 for which the formal duty of candour applied and this duty was undertaken for 100% of these incidents.

  Our central Patient Safety and Quality team monitor, coordinate and review all serious incident investigations. The team have continued to improve the style and language of these reports, which are shared with the patient/family involved, to ensure that they are accessible and easily understood. These reports are also shared with our commissioners and the CQC for full transparency.

  While maintaining our responsibility to undertake the duty of candour, forthcoming developments in patient safety will fundamentally alter our approach to incident investigation, and introduce the role of Patient Safety Partners (PSP). Their involvement in safety relates to the role that patients, carers and other lay people can play in supporting and contributing to our governance and management processes for patient safety.

- Pressure ulcer prevention

  Pressure ulcers impact on patients’ emotional and physical health, and on their quality of life so, in line with our quality Goal 2 (Continuously seek out and reduce harm), we are

committed to reducing and avoiding them and for this we rely on the leadership and education provided by our Tissue Viability team.

While there has been an increase in pressure ulcers acquired in our care when compared with the previous year, this is reflected in the figures nationally. However, while our overall numbers of pressure ulcers rose by 14.7%, the number of the most harmful skin damage (categories 3 and 4) reduced by 40%. This has been achieved through the diligent efforts of the Tissue Viability team who have:

- seen a year on year increase for new referrals (12.4% or 134 patients) and a year on year increase in patient contacts (11.6% or 747 contacts)
- provided bespoke pressure ulcer prevention training and support for colleagues
- supported the Orthopaedic surgical team for non-healing surgical wounds
- opened up shadowing opportunities for all nursing students, (previously restricted to 3rd year), thus training and educating our future workforce
- developed a wound care clinic for homeless patients within a local hostel, promoting equitable access to wound care for this disadvantaged group

Working across the whole footprint of the organisation, the Tissue Viability team support community-based staff to provide both preventative education and early intervention skills and so reduce the need for some patients with pressure ulcers to be admitted to hospital. Looking to the future, the team plan to:

- roll-out a new, comprehensive Tissue Viability/Pressure Ulcer Prevention education programme
- undertake a consultation to include Pressure Ulcer Prevention training in the mandatory update programme

- Falls assessment, prevention and treatment

  Falls are one of the frailty syndromes and while many older people are living well, even with long-term health conditions, the older person living with frailty may lack the reserves to cope with minor changes in their physical and/or mental health and wellbeing, and with changes to their environment. This can make it hard for them to cope and be restored to their previous levels of ability. To provide knowledge, skills and awareness of these issues, the Falls Prevention team provide frailty education to all staff and partnership organisations.

  Our Falls Prevention team were integral to the development of the urgent care response pathway, whose focus is to promote the ‘home-first’ approach, which supports people to be cared for in the community when it is safe to do so. This has been achieved through the development of:

  - The Assisted Lift Response Team (ART), which is a falls pick-up service for people across the organisation who have fallen but are not injured
  - A night-time pick-up service (pilot scheme) in Torbay
  - An agreement with South West Ambulance Trust (SWAST) that they can refer into the above two services, thus releasing their ambulance teams to attend very urgent calls involving people who may need admission to hospital

  Patient falls whilst in hospital continue to be a challenge for prevention, but we have invested in 220 new bed/chair alarms, which are being distributed throughout our wards to reduce the risk of falls through early alerting to staff. Across the coming year, we plan to explore and embed some nationally developed resources relating to both falls prevention and appropriate falls management.

We are committed to sharing good practice and promoting patient safety, in line with our quality goal 3 (Excellence in Clinical Outcomes). To that end, our Falls Prevention team will be speaking at the South West Falls Prevention Network about developing an algorithm for Assessing for a Hip Fracture and their Post-Fall Policy.

- Medications safety

  Unsafe medication practices, and medication errors, are a leading cause of avoidable harm in health care across the world. We are fully committed to doing all that we can to avoid and reduce these opportunities for patient harm and this is achieved through a process called medicines optimisation which ensures that:

  - Prescribing decisions are evidence based
  - Medicines are used as safely as possible
  - Patients are involved in the decision-making process
  - Medicines optimisation is part of routine practice

  Our people are committed to patient safety, which is evidenced by their incident reporting. In 2021/22 the majority of medication incidents reported (785 or 99%) were categorised as low-harm, no-harm or near miss.

  Over the past year our Pharmacy Department maintained its service, providing medicines to patients safely and effectively despite the ongoing COVID-19 pandemic and winter pressures. The department has responded rapidly and effectively to ward reconfigurations and service re-design, ensuring the safe supply and use of medicines. We are keeping patients safe by our work throughout the whole medicines optimisation process, some examples of this are:

  - Proactive management of medicines supply shortages so that patient safety is not compromised
  - Educating medical students, foundation doctors and nursing staff to support safe prescribing and administration of medicines
  - Provision of a full delivery service to the wards and departments so that stock and discharge medicines are provided in a timely way and allowing nursing staff to remain on the wards
  - Supporting a foundation doctor buddying scheme with a foundation pharmacist during their induction and as they start working on the wards to promote safe prescribing

  We are delighted that our Medicines Information pharmacist was recognised for her work by being awarded a national excellence award by the UK Medicines Information Group. This service is vitally important in contributing to the safe use of medicines.

  Moving into 2022/23 our Pharmacy Department plan to develop their work with the organisation to address medicines safety and security issues, to improve medicines safety, will continue to deliver their quality improvement projects and will investigate the possibility of a ward based dispensing hub to facilitate safe and timely patient discharge home.

- Pharmacy and Covid-19

  The Pharmacy team continues to support both the trials for the treatment of COVID-19, and the vaccination programme. More recently, our Pharmacy Department has been a fundamental part of the Covid-19 Medicines Delivery Unit, reviewing 1300 patients in the first 4 months. This work has meant that we are one of the highest performing areas in the country for providing this treatment on time.

Priority 2 – Clinical effectiveness

We aimed to work in partnership with our multi-agency colleagues, to strengthen and enhance our approach to caring for children and young people who present with mental health illness, including eating disorders and autism.

What we achieved:

- led the establishment of a south west paediatric mental health network to share best practice
- improving the skills and knowledge of staff when supporting children and young people in mental health crisis through a national training programme, through the We Can Talk training programme we are training up to 100 staff
- identified a consultant paediatrician and senior nurse as mental health leads
- established joint weekly ward rounds on our paediatric wards with our local Child and Adolescent Mental Health Team (CAMHS)
- secured £15k of national monies to improve children and young people's experience especially if they have neurodiversity or experience emotional distress. By providing patients with access to items such as weighted blankets, a 'magic carpet' interactive floor projector, YoTo players and other audio visual, tactile and sensory equipment we can reduce their stress, improve their wellbeing and give them a better experience of being in hospital
- increased nursing capacity to support children and young people with an eating disorder and admission avoidance

Priority 3 – Patient experience

We aimed to enhance the experience of patients through robust listening and feedback opportunities, identifying and embedding improvements in the experience of patients who are discharged from a hospital setting. Further, we wanted to build partnerships with people in the following areas:

- co-creation and development of services with the wider community of people not in our care
- involve people in our care with decisions that will affect them

What we achieved:

- we have redesigned our service for supporting people who use our services to provide feedback through the Friends and Family Test (FFT). Alongside reintroducing our paper survey, we set up a working group to look at a digital option through the adoption of QR code readers. We have piloted this on a number of inpatient wards and will roll out to all inpatient and community services during 2022/23
- we have received the publication of four Care Quality Commission Patient Experience Surveys in 2021 that were undertaken in 2020. Each survey has an improvement plan aligned to findings which is managed through our Integrated Service Units (ISUs)
- virtual consultations have continued to be implemented and replace or complement face to face consultations for a number of services
- we adopted a three-stage approach underpinned by working collaboratively with local stakeholders and our local community who access, use and interface with our services to develop our *Patient /Service User Experience Strategy – What Matters to You Matters* three-year strategy. We tested the outcomes of our initial meeting with over 20 local voluntary groups to build on the themes. the outcome of our engagement with local people together with other data and information the trust holds including themes from complaints and concerns has facilitated the development of the "Patient and Service User experience Strategy – What

Matters to You Matters to Us". This will be a three-year Trust strategy with annual milestones to achieve our priorities as set out below:

- establishing a task and finish group focused on improving the experience of discharge from acute hospital inpatient wards
- During 2021/22 we have implemented FFT with the use of QR code readers across 40 Services and wards and a further 32 yet to be implemented Whilst all FFT was suspended during the COVID 19 pandemic due to infection prevention and control concerns of using a paper-based survey. Implementing the QR code reader has significantly increased the response rate in services where this has been implemented.
- The Four CQC patient experience survey published in 2021 demonstrated areas where the services are providing a positive patient experience and highlighted where we can improve. The trust was not an outlier for any of the surveys. An action for the adult inpatient survey has included reducing noise at night on inpatient wards. As a trust we have sleep packs for patients (eye mask and ear plugs), soft close bins, posters to remind everyone to lower noise levels and lighting levels.
- The Children and young people experience survey highlighted the need for young people to have more play interventions. This resulted in play team programme being reinstated in partnership with infection, prevention and control.
- Virtual consultations with Attend Anywhere and Microsoft Teams has been beneficial to a number of patients across a range of services. Rapid implementation during the covid pandemic took place and this has continued with many more consultations each month.
- Through our engagement work between July 2021 and March 2022 with our local community we have developed a patient and service user experience of Health and Care Services strategy that will underpin a programme of work between 2022-2025 focused on improving the experience of our services.
- A task and finish group focused on patient discharges and improving the patient experience has resulted in a reduction in the number of complaints and concerns over the last six months. The changes implemented have included: timely care plan summary discharge information and carer support identification and enabling support to carers.

IMPROVEMENT PRIORITIES FOR 2022/23 – THE YEAR AHEAD

Quality goal 1 – zero avoidable deaths

We will focus on improving our identification and management of patients with sepsis to reduce the number of people who die from septic shock.

This is a critical area as sepsis accounts for 1 in 5 deaths in the UK with an overall mortality rate in England of 28% in all age groups. NHS hospitals treat around 150,000 cases of severe sepsis each year and many more with uncomplicated sepsis. Mortality from septic shock increases rapidly for each hour that treatment is delayed, and there is opportunity for us to improve in this area.

The key outcome measure that we aim to improve is our “hospital standardised mortality ratio” which compares deaths in our organisation to others across the country. We will also closely monitor our services’ compliance with a national standard called the “sepsis bundle” which will ensure that our processes adhere to best national practice.

Quality goal 2 – continuously seek out and reduce harm

For us this means getting the fundamentals of care right every time. This will include:

- achieving 100% compliance with all risk assessments for patients who are admitted to hospital
- reducing the number of frail patients falling when in hospital(?)
- ensuring all patients are assessed for nutrition and hydration risks within 24 hours of admission to hospital

The “fundamentals of care” are the principles to which all nurses and midwives must aspire in the delivery of care to patients. These principles for the basis of the standards of practice expected of all registrants at the point of entry to the Nursing and Midwifery register and all health care support workers on completion of the Care Certificate. The quality of nursing and midwifery care can be assessed against these minimum standards of practice, and we will measure the following:

- improved compliance with all admissions
- improved risk assessments and care plans
- improved compliance with nutrition and hydration bundle
- improved compliance with falls bundle
- reduction in incidents reported with harm specifically falls and nutrition

Quality goal 3 – excellence in clinical outcomes

We will focus on improving clinical outcomes by better supporting patients whose condition is deteriorating in hospital. This means ensuring all appropriate physiological observations are recorded at their initial assessment to inform a clear plan for further observations throughout their stay. This will be monitored through a physiological “track and trigger” system such as the national early warning score.

We will measure improvements in our processes through:

- compliance with recording vital signs within the specified timescale
- compliance with completion of the early warning score

We expect to see the following outcomes improve as a consequence:

- reduction in unexpected admission to Intensive Care
- reduction in number of cardiac arrest calls when no previous escalation made.

Quality goal 4 – deliver what matters most to people

We will focus on two aspects here:

- improved experience for patients being discharged – this is an area where a number of patients and carers have told us their experience did not feel compassionate or safe. People are also waited too long for treatment or procedures, and we want to act on what we have heard to improve this. Key measures include:
  - improve number of patients with a recorded discharge date
  - reduction in discharge delays
  - reduction in concerns raised by patients
  - increase in patients with positive feedback
  - improve patient survey results
- improved experience for our people so that they feel valued, supported and cared for. This is in response to feedback from our staff survey and other engagement exercises, and we want to make a commitment to improve how our staff feel about working with us and for us. Key measures include:
  - improved staff survey results
  - improved feedback through other staff engagement exercises
  - more positive staff feedback

MONITORING AND REPORTING PROGRESS

The quality of our services is monitored through a rigorous reporting framework that provides structure and a regular timescale to the professional approach and cultural values that are lived in our organisation each day.

Day-to-day quality standards and issues that arise are overseen through the following hierarchy:

- Trust Board, with our Chief Nurse as the accountable individual
- Quality Assurance Committee
- Quality Improvement Group
- Integrated Governance Group for each of our six integrated service units (ISUs)
- Associate Directors of Nursing and Professional Practice have delegated responsibility for quality within ISUs

In support of this annual quality report, quality is a major part of our monthly board report and features in monthly reports for each of the above groups.

2.2 STATEMENTS OF ASSURANCE

These statements follow a prescribed form of words legally required by the Healthcare Act 2009, amended 2011.

OVERVIEW OF SERVICES

During 2021/22 we provided and/or sub-contracted 52 relevant health services. We have reviewed all available data relating to the quality of care in 52 of these services.

The income generated by the relevant health services reviewed in 2021/22 represents 90% of the total income generated from the provision of relevant health services by Torbay and South Devon NHS Foundation Trust for the year.

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

CLINICAL AUDIT PARTICIPATION

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 trust's clinical audit programme. The detail which follows relates to this list.

During 2021/22, 36 national clinical audits and three national confidential enquiries covered relevant health services that we provide.

During this period, we participated in 79% 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 2021/22 follow.

Participation in national clinical audits and confidential enquiries

National audits	Eligibility	Participation
Case Mix Programme (CMP)	Yes	Yes
Child Health Clinical Outcome Review (NCEPOD)	Yes	Yes
Chronic Kidney Disease Registry	No	N/A
Cleft Registry and Audit Network Database	No	N/A
Elective Surgery (National PROMS Programme)	Yes	Yes
Emergency Medicine QIPs (RCEM)	Yes	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	Yes
Inflammatory Bowel Disease (IBD) Audit	Yes	N/P
Learning Disabilities Mortality Review Programme	Yes	Yes
Maternal and Newborn Infant Clinical Outcome Review Programme	Yes	Yes

Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Yes	Yes
Mental Health Clinical Outcome Review Programme	No	N/A
National Adult Diabetes Audit	Yes	Yes
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes
National Audit of Cardiac Rehabilitation	Yes	Yes
National Audit of Cardiovascular Disease Prevention	No	N/A
National Audit of Care at the End of Life (NACEL)	Yes	Yes
National Audit of Dementia	Yes	Yes
National Audit of Pulmonary Hypertension	No	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Cardiac Audit Programme (NCAP)	Yes	Yes
National Child Mortality Database	Yes	Yes
National Clinical Audit of Psychosis	No	N/A
National Comparative Audit of Blood Transfusion Programme	Yes	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes
National Emergency Laparotomy Audit (NELA)	Yes	Yes
National Gastro-intestinal Cancer Programme	Yes	Yes
National Joint Registry	Yes	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes
National Maternity and Perinatal Audit	Yes	Yes
National Neonatal Audit Programme (NNAP)	Yes	Yes
National Paediatric Diabetes Audit (NPDA)	Yes	Yes
National Perinatal Mortality Review Tool	Yes	Yes
National Prostate Cancer Audit (NPCA)	Yes	Yes
National Vascular Registry	Yes	Yes
Neurosurgical National Audit Programme	No	N/A
Out of Hospital Cardiac Arrest Outcomes Registry	No	N/A
Paediatric Intensive Care Audit (PICAnet)	No	N/A
Prescribing Observatory for Mental Health UK	No	N/A
Respiratory Audits – National Outpatient Management of Pulmonary Embolism	No	N/P
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Serious Hazards of Transfusion Scheme (SHOT)	Yes	Yes
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Yes	Yes
The Trauma Audit & Research Network (TARN)	Yes	Yes
UK Cystic Fibrosis Registry	No	N/A
Urology Audits (BAUS)	Yes	Yes

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 (MBBRACE)	Yes	Yes
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Yes	Yes
Mental Health Clinical Outcome Review Programme (NCISH)	No	N/A

Cases submitted to clinical audits and confidential enquiries

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation participated in, and for which data collection was completed during 2021/22, 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
Case Mix Programme (CMP)	N/A	
Elective Surgery (National PROMS Programme)	N/A	
Emergency Medicine QIPs (RCEM)	N/A	
Falls and Fragility Fracture Audit Programme (FFFAP) • National Audit of Inpatient Falls • National Hip Fracture Database	 7 473	 100 100
Learning Disabilities Mortality Review Programme	N/A	
Maternal and Newborn Infant Clinical Outcome Review Programme	N/A	
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	N/A	
National Adult Diabetes Audit • National Diabetes Core Audit • National Pregnancy in Diabetes Audit • National Diabetes in-patient audit – Harms	 155 60 20	 100 100 100
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme • Children & Young People Asthma Clinical & Organisational Audits	 45	 100
National Audit of Breast Cancer in Older Patients (NABCOP)	N/A	
National Audit of Cardiac Rehabilitation	N/A	
National Audit of Care at the End of Life (NACEL)	N/A	
National Audit of Dementia	N/A	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	39	100
National Cardiac Arrest Audit (NCAA)	55	100
National Cardiac Audit Programme (NCAP)	N/A	
National Child Mortality Database	N/A	
National Comparative Audit of Blood Transfusion Programme • 2021 Audit of Patient Blood Management & Nice Guidelines	 53	 100
National Early Inflammatory Arthritis Audit (NEIAA)	N/A	
National Emergency Laparotomy Audit (NELA)	N/A	
National Gastro-intestinal Cancer Programme National Oesophago-gastric Cancer National Bowel Cancer Audit	 121 205	 100 100

National Joint Registry	224	100
National Lung Cancer Audit (NLCA)	205	100
National Maternity and Perinatal Audit	N/A	
National Neonatal Audit Programme (NNAP)	N/A	
National Paediatric Diabetes Audit (NPDA)	155	100
National Perinatal Mortality Review Tool	N/A	
National Prostate Cancer Audit (NPCA)	374	100
National Vascular Registry	N/A	
Sentinel Stroke National Audit Programme (SSNAP)	562	100
Serious Hazards of Transfusion Scheme (SHOT)	N/A	
Society for Acute Medicine Benchmarking Audit (SAMBA)	N/A	
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	N/A	
The Trauma Audit & Research Network (TARN) • Clinical Report Issue 1 - Thoracic & abdominal injuries • Clinical Report Issue 2 - Orthopaedic Injuries • Clinical Report Issue 3 - Head & Spinal Injuries	 462 461 498	 100 100 100
Urology Audits (BAUS)	N/A	

Patient outcome programme incorporating national confidential enquires	Eligibility	Participation
Child Health Clinical Outcome Review Programme (NCEPOD)	N/A	
Maternal and Newborn Infant Clinical Outcome Review Programme (MBBRACE) • MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal deaths for births from Jan - Dec 2019	6	100
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) • Dysphagia in people with Parkinson's Disease • Pulmonary Embolism Study	 3 5	 60 100

OUR RESPONSE TO THE FINDINGS OF CLINICAL AUDITS

We reviewed the reports of 18 national clinical audits in 2021/22 and we intend to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions
0452	(BAUS) Percutaneous Nephrolithotomy (PCNL)
	GIRFT (Getting It Right First Time) - Four such cases were recorded on Hospital Episode Statistics (HES) as being performed in 2019. This small number of cases does not provide the basis for a sustainable, high-quality service. Suggested Action: Discussions need to take place within the urology area network in order to determine how complex stone surgery services should be arranged in the future. Such an arrangement will require PCNL surgery to be centralised on fewer sites.
0754	(Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls
	Bedrails inappropriately used - Bedrail policy review. Competency Framework to be used in all areas. Trial on induction on Ainslie & George Earle ward webpages. Attended Matron's meeting 27/05/2021 to inform of actions and oversight. Patient handling, falls and bedrail assessment - Changes required due to legal challenge. Review and update. Challenges around joint booklet and printing costs. Mandatory/ staff training - Brief mandatory training at induction - 30 minutes falls delivered by manual handling team. Suggest 2- year mandatory for patient facing staff including doctors. Plus, induction for medics. Looking at on line options. Board approval required to mandate this. Written information - To ensure wards give out leaflets and document on patient handling form. In trial on EAU4 difficulties with evidencing leaflets had been issue. Post Fall - seeking agreement set format for post fall assessment for hip fracture through fractured hip group and regional falls network. Regular slot on Doctor's training and set up section on webpage. Process required to audit nice QS86 medic 30-minute response. Data capture on unreported falls - further audit across trust wards.
0927	(Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls
	Improve multi-factorial falls risk assessment (MFFA) compliance in inpatient areas - Fallsafe champions webinar and study day 2022. MDT involvement. Vision project to comply with one MFFA QI project per year - recommence vision project work on Allerton and within JETS team with time provided to staff to undertake this work. Promote analgesia where appropriate being given to the patient within 30 minutes after a provisional diagnosis of Inpatient Femoral Fractures (IFF) following a fall - Involve Lead pharmacist/ Lead Healthcare in the Older Person (HOP) consultant. Inform staff of this recommendation via the FFSG, falls newsletter and webpages, staff training etc? process on. "Senior leaders should include designated time for participation in NAIF and related QI activities in job specifications/plans for falls leads/ practitioners/ coordinators" NAIF 2021 - Request designated time to ensure Quality Improvement work completed.
0881	(Falls and Fragility Fracture Audit Programme FFFAP) National Hip Fracture Database
	Fall in performance of the % of patients mobilised day 1 after hip fracture surgery - Case note review/ root cause analysis of patients who did not mobilise to drive further QI projects.
0839	(National Cardiac Audit Programme) Heart Failure Audit
	Lower than expected rates of referral for Heart Failure nurse follow up - This requires an audit of the cases not referred for follow up. Lower than expected rates of referral to cardiac rehabilitation - This requires discussion with the cardiac rehabilitation team.

0891 (National Cardiac Audit Programme) Heart Failure Audit
Low rate of referral to cardiac rehab - Discuss with Heart Failure Team and Heart Failure Multi-Disciplinary Team (MDT).
0885 (NBACOP) National Audit of Breast Cancer in Older Patients
Fitness assessment for patients form - Exploring where this can be put in our assessment pathway Review of Primary Care Prescription Database (PCPD) and Cancer Outcomes and Services Dataset (COSD) data sets for primary endocrine therapy numbers as the data does not fully align - In the absence of any other (IT) process we have to rely on our MDT to capture this data - look at other ways of capturing recurrence. Chemotherapy admissions - above national average but as small numbers even a single admission could skew data significantly - Chemotherapy admissions to be reviewed by oncology for 2014-18 within 30 days.
0628 (RCEM) Assessing Cognitive Impairment in Older People/ Care in Emergency Departments
Data entry - Symphony input as age group. PADI Form on Symphony. Re-audit.
0634 (RCEM) Care of Children in Emergency Departments
Re-audit in 12 months.
0612 2018 National Comparative Audit of the Management of Maternal Anaemia
Current guideline does not meet national audit/latest British Society of Haematology guideline - Review and updated local guidelines for the detection and management of anaemia in pregnancy Inadequate testing and treatment of women at risk of anaemia/following postpartum haemorrhage (PPH) - Audit the testing and treatment of women at risk of anaemia/following PPH in the puerperium.
0866 National Asthma and COPD Audit Programme (NACAP) - Children & Young People Asthma Clinical & Organisational Audits 2019/20
Improve steroid delivery in Emergency Department and Short Stay Paediatric Unit - Action required - Education of juniors, identify barriers to delivery. Documentation - smoking bundle, personalised asthma action plan - Action required - Educate juniors and nursing staff - local teaching programme. Asthma review within 4 weeks for all admissions - Action required - Consideration of whether job plans need to be changed to allow this.
0889 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
First paediatric assessment - First paediatric assessment proforma. Care planning agreement and content - Review current documents and improve them. Documentation of discussion about SUDEP (Sudden unexpected death of in epilepsy) - Information about SUDEP to be added to the care planning agreement and leaflet to be given to parents at diagnosis of epilepsy either in outpatient clinic or during first epilepsy specialist nurse visit as more appropriate.
0773 National Emergency Laparotomy Audit (NELA)
High risk patients should be admitted to a commissioned ICU bed following an emergency laparotomy - An expansion in commissioned ICU bed capacity into the capacity bed footprint of the recently built ICU (expanding from 10 commissioned beds to 14) is essential in achieving this aim together with a reduction in cancellation of elective surgical cases which require postoperative ICU support (recommendation taken from the ACSA Final Report). This is a priority area for the Trust and Clinical Commissioning Group.

0832 National Gastro-intestinal Cancer Programme - Oesophago-gastric Cancer
Regularly review cases submitted to the National Oesophago-Gastric Cancer Audit, to ensure (a) high case ascertainment, and (b) low levels of missing data on cancer stage, staging investigations and surgical pathology results. Planned action - Our case ascertainment good in the 2020 audit. Ongoing work into improving recording of cancer staging, investigations and path results for audit purposes is being undertaken by our Upper GI cancer waiting times co-ordinator. Review patients who do not have their diagnosis of high-grade dysplasia (HGD) diagnosed by a second pathologist, and examine the reasons for this to ensure that all patients have their diagnosis confirmed by two pathologists - Planned action - Previous audit of 2017-2019 high grade dysplasia cases described in the NOGCA period showed that all our high grade dysplasia patients had their pathology confirmed by a second pathologist. Examine high rates of non-treatment among patients with HGD in a local audit to ensure offers of endoscopic treatment are consistent with British Society of Gastroenterology recommendations. Planned action - Previous audit of 2017-2019 high grade dysplasia cases described in the NOGCA period showed that all our high-grade dysplasia patients were offered endoscopic treatment. Ensure protocols on the referral of patients to local specialist centres for endoscopic treatment will produce annual volumes at these centres that meet recommended caseloads - Planned action - Barretts dysplasia protocol has been agreed as part of upper GI operational policy. Review patients who were diagnosed, after emergency admission to identify opportunities for improving earlier detection. Planned action - Audit of emergency cases performed with results presented to upper GI business meeting March 2021 and actions arising agreed. Ensure all patients with oesophageal cancer being considered for curative treatment have a PET-CT scan. Hospitals with low reported use of PET-CT scans should investigate to determine the causes. Use of PET-CT scans for gastric cancer patients should be reviewed in line with recent evidence. Planned action - Audit of staging investigations already performed for 3-month period June -August 2019: all patients with oesophageal cancer considered for curative treatment offered PET CT. Issue with data submission to the audit identified and MDT co-ordinator now working to update this information. Review waiting times through the oesophago-gastric cancer care pathway and identify ways to reduce the proportion of patients waiting longer than 62 days from referral to treatment. Planned action - Endoscopy and radiology capacity a point of ongoing work for Endoscopy and radiology cancer leads and the trust to enable prompt diagnosis of OG cancer. Work towards consensus-based practice in the use of triplet and doublet palliative chemotherapy regimens. Planned action: Oncology team part of a clinical trial examining the use of chemotherapy in oesophago gastric cancer. To continue to review the use of triplet and doublet regimens as part of their workflow.
0774 National Gastro-intestinal Cancer Programme Bowel Cancer
Clinical Nurse Specialist numbers - Review Staffing. Look at this year's Laparoscopic rates and nodal harvest - review next annual report.
0944 National Maternity and Perinatal Audit - Ethnic and Socio-economic inequalities in NHS Maternity & Perinatal Care for Women and their Babies
Find out what other maternity units in the region are doing to address this report. - Liaise with Local Maternity and Neonatal System (LMNS).
0872 NPDA (RCPH National Paediatric Diabetes audit)
Continue to increase the number of patients with a HbA1c within the nationally recommended target range, improve the mean HbA1c so we are no longer outliers and continue to reduce the number of patients with a hight HbA1c. - Targeted approach to the improvement in patient's glycaemic control. For those near close to target blood glucose levels extra support and education around the principals of dose adjustment through and targeted education package. For those with high HbA1c a focus on ensuring the child and family have the social and psychological support they need and a focus on achievable steps towards a better diabetes self-care routine.
0801 QOMS COVID-19 Oral & Maxillofacial Surgery Trauma Audit (Dental Infection)
Issues with clinic room availability with appropriate air handling - Discuss at Directorate Governance, is on risk register, need to escalate to ISU Management.

We reviewed the reports of four national confidential enquiries in 2021/22 and intend to take the following actions to improve the quality of healthcare provided.

0833 MBRRACE - Perinatal Mortality Review Tool Report
Improve the attendance of external reviewers - The Devon Local Maternity and Neonatal Services are putting in a process for external review attendance at all serious case reviews. Agreement is any cases that are investigated by Healthcare Safety Investigation Branch (HSIB) will not require an external review, any serious incidence that fall out of the HSIB criteria the LMNS will provide an external reviewer. Strong actions targeted at system level changes and audit their implementation and impact: When undertaking Perinatal Mortality Review Tool reviews, the guidance in the review of the standards and include an auditable action for each. Use the Perinatal Mortality Review Tool summary reports to prioritise resources towards key aspects of care - One key priority is a Bereavement Team member. The Maternity service has developed a proposal for a fulltime Bereavement Midwife.
0581 MBRRACE-UK - Lessons learned to inform Maternity Care from the UK & Ireland Confidential Enquiries into Maternal Death & Morbidity 2016-18
We are unable to give ourselves assurance around epilepsy management for women - Epilepsy referral process has been reviewed in line with this new guidance and our existing epilepsy guideline is in the process of being updated. With COVID-19 difficult to assess fully women's response to the routine enquiry question - Undertake a reaudit of the question from the notes.
0932 MBRRACE-UK Perinatal Mortality Surveillance Report - UK Perinatal deaths for births from Jan - Dec 2019
Unable to source a provider to undertake a paediatric pathologist to undertake placental histopathology - Remains on our local risk Register Head of Midwifery now left the Trust need to ensure that the new Head of midwifery keeps the action on the agenda at the Local Maternity and Neonatal System (LMNS). No regional process for external attendance at the Perinatal mortality Reviews (PMRT). - The regional head of midwifery is setting up a regional group of clinical governance coordinators and it is hoped out of this will come a process for attending other units case reviews reciprocally. Uptake of post mortem is low with our families. - Bereavement midwife and Paediatric lead to look at resources available for training and clinicians in discussing consent. Review material for parents to inform them about post-mortem. Review the offer of a partial post-mortem.
0786 MBRRACE-UK Saving Lives, Improving Mother's Care - Rapid Report 2021: Learning from SARS-CoV2 related & associated maternal deaths in the UK
Ensure early senior involvement of the maternal medicine team for any pregnant or postpartum woman admitted with COVID - 19, whatever her gestation and wherever in the hospital she receives care - Action required: To undertake an audit of all known COVID-19 positive women using the UKOSS referral. Referrals to the NHS ECMO service should be made for pregnant women or women post-pregnancy using the same criteria as for other adult: Action required – Audit. Treat pregnant and postpartum women the same as non-pregnant women unless there is a clear reason not to Chest x-ray and chest CT should be performed as per non-pregnant adults. Reasonable effort should be made to protect the fetus as per usual protocols. Action required – Audit. Ensure protocols for assessment of pregnant women with respiratory symptoms include the consideration of SARS-CoV-2 and the different pattern of symptoms in pregnant compared to non-pregnant women - Action required - Include in protocol. The limitations of remote consultation methods should be recognised, including being aware that some women will not have sufficient internet access on their mobile devices or other computer hardware, Face to face treatment may be preferable when the patient has complex clinical needs, you need to examine the patient - Action required – Audit.

We reviewed the reports of 45 local clinical audits in 2021/22 and we intend to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions
6664	Neuromuscular Blockade
	- Multiple shortcuts added to electronic anaesthetic records documentation 'hot list' - Posters placed around the Anaesthetic room/ department in a drive to improve documentation rates
6641	Effectiveness of Sedation
	- Produce/ Design a pre-assessment template to ensure requirements are met - Trial the template and obtain sign off via the Trust Medical Records Committee
6668	Cataract preoperative assessment
	- Reduce the number of face-to-face pre-assessments; include biometry and vital observations on the day of listing. Already done for cataract clinics, but still not for patients listed from other clinics - Vital observations - To identify patients needing a referral to GP. Introduce template letters for patients outside the guidelines - Written patient information - Add this question to pre-assessment and to document the lid hygiene and COVID-19 related advice - Medisoft recording - When vital observations are recorded from previous measurements a comment needs to be made and add that no change in general health has occurred - Patient´s refraction should be added on the telephone consultation (if not previously recorded)
6669	Eyelid skin cancer referral pathway
	- Suspected eyelid cancer referrals to be triaged and seen in 'Lid' clinic within two weeks
6709	Real world outcomes with 'ILUVIEN' implant for Diabetic Macular Oedema
	- As risk of glaucoma remains high, regardless of previous ocular history, ensure patient is fully aware of this before treatment. The discussion must be clearly documented in notes/ consent form prior to treatment
6681	Recording Clinical Evaluations for Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) for Orthopaedic theatres
	- Introduce a mandatory box for fluoroscopy on the Orthopaedic template operation notes
6653	Care of pregnant women carrying Group B Streptococcus (GBS)
	- Set up a Task and Finish group to look at the various pathways for picking up GBS
6676	World Health Organisation (WHO) checklist for emergency caesareans and other obstetric emergency theatre procedures
	- Produce a short version for emergency cases - Provide education to the clinical Team regarding full completion
6667	COVID-19 and Two week wait (2ww) haematuria clinic referrals
	- Re-assess 2ww haematuria clinic NICE criteria following move to Mount Stuart hospital due to the COVID pandemic
6649	Compliance with Special Care Baby Unit (SCBU) holder record keeping logs
	- In regard to changes in patient names, it may be more useful to record the patient's hospital number for direct patient identification, avoiding potential identification errors - If there is no holder, record this on the page at the back of the book - All Radiographers, asked/ reminded to consistently record accurate doses - As an alternative to the current simple chronological listing, the record log will be chronologically ordered by name of holder. Each member of ward staff will have a page in an alphabetised notebook, by surname, upon which the relevant information could be written. The staff member can then simply look at their personal page to see number of x-rays/ exposures they have

6671 Completion of Consent forms for Interventional Radiology (IR) theatres
- All staff asked to scan copy of consent form alongside World Health Organisation (WHO) checklist onto Radiology information system (CRIS) - A slow scanner noted in theatre four, a quicker one is needed to improve compliance
6680 Radiography for knee trauma - compliance with the Ottawa Knee Rule
- Share results with Emergency Department (ED) staff - ED staff to always provide clinical question/ query on request - Raise awareness to ED staff through sharing presentation - Try to examine knee patients with Ottawa Knee Rules in mind. State all parts of the criteria that apply thus allowing for easier diagnostic reporting and then appropriate treatment - Re-introduce ED/ Radiology Multi-Disciplinary Team meetings
6693 The use of Fine Needle Aspiration (FNA) in assessing breast lesions
- To decrease recalls we propose that we do biopsies in the following cases instead of FNA: - U3 lesions - U2 query cysts and cysts that fail to drain completely - U2 fibroadenomas (FA) - Lesion in higher risk patients
6624 Ionising Radiation (Medical Exposure) Regulations IR(ME)R: To optimise computed tomography of kidneys, ureters and bladder (CT KUB) imaging in investigation of renal colic
- Develop a new scan protocol where: - The scan field would start at the superior endplate of T11 or at the superior pole of the highest kidney if it is visible on the scanogram - The scan field would finish at the level of the pubic symphysis - Undertake Radiographer education regarding the new protocol introduction and then undertake further/ additional Radiographer education regarding the protocol
6694 Breast screening - Prevalent round recall
- Try to recall less well-defined mass and asymmetric density on prevalent round as less likely to represent cancer - Write down the feature of the recall abnormality on the screening sheet to facilitate re-audit
6636 Review of adult oncology patients receiving blood transfusions on RGDU/ Turner ward
- Consideration of IV Iron/ Erythropoietin as per European Society for Medical Oncology (ESMO) Guideline - Introduce sticker for prescribing chart - Stop and check poster after each unit of transfusion - Update training by presenting to the Systemic Anti-Cancer Therapy (SACT) group
6670 Management of steroid induced hyperglycaemia
- How to find hyperglycaemia Trust guideline was demonstrated at the audit meeting - Introduce use of steroid sticker on drug charts for early identification - Laminated short guidelines wall poster introduced for Cromie, Midgely and Turner wards - Cromie, Midgley and Turner induction to include a brief guide on the use of steroids - Investigate if IT systems can highlight patients previously/ currently on steroids
6703 Aspirin in Pregnancy
- Disseminate audit findings at Team meetings - Raise awareness of the need to prescribe aspirin to high-risk women and to ensure that this is documented
6658 Prescribing the correct dose of Apixaban in patients with Atrial Fibrillation
- Raise awareness through Medical Unit meeting that calculating Creatinine clearance is important in patients being prescribed Apixaban (Estimated Glomerular Filtration Rate [eGFR] can overestimate kidney function) - Raise awareness through Medical Unit meeting for weighing patients and this being recorded, particularly on drug chart for ease of prescribing

- Produce stickers for Direct oral anticoagulants (DOACs) prescription/ change to DOAC prescribing part of drug chart. To include documentation of weight, age and creatinine - Doctors advised to ensure they include recommendation on Care Plan Summaries (CPS) for dosing - To produce education posters for staff Induction and "Dr Toolbox 'App'" - Remind all staff through Medical Unit meeting and meeting notes that all Doctors ensure they are looking at Pharmacist recommendations for dosing after 'meds reconciliation'
6639 Appropriateness of blood transfusion undertaken in the Medical Receiving Unit (MRU) and surgery
- Staff reminded at Acute Medical Unit (AMU) meeting to think is blood transfusion necessary for this patient? Consider alternatives such as starting iron - Survey junior doctors on AMU to assess transfusion knowledge - Deliver transfusion teaching session - Introduce new transfusion proforma for AMU
6665 Surgical intervention for distal radius fractures (DRF): Are we adhering to standards?
- Devise a pathway for DRFs requiring operative management which ensures targets set by British Orthopaedic Association's Standards for Trauma (BOAST) are met
6673 Intramedullary Nailing (IMN) Femur
- To switch local audit to regional South West Orthopaedic Research Division (SWORD) project to confirm findings - Surgeons encouraged to record whether the lag screw is locked in Static or Dynamic mode (potential of failure) - All surgeons to consider longevity of the surgery in comparison to the rate of infection (i.e. the longer the operation the increased likelihood of infection)
6706 Management of Trauma patients with rib fractures - are they being managed appropriately in our trauma unit?
- Further study required to investigate physiology of patients - Investigate location/ place for a networked rib fixation service at Torbay
6702 Identity (ID)/ Pregnancy check and consent in accordance with Nuclear Medicine Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017
- Consent forms should always be scanned onto Radiology information system (CRIS) and the issue will be communicated back to the Nuclear Medicine team
6705 Inpatient referrals to Rheumatology from acute and general medical wards
- Created a reminder poster for all junior doctors and placed it on notice board in acute and general medical wards across the hospital - Raise awareness of need to fully complete white slip referral forms through Medical Unit meeting - Educating medical junior doctors about importance of clinical information – blood tests and imaging for Rheumatology - White slip Rheumatology referral poster emailed to all medical junior doctors
6675 Repeat General anaesthetic (GA) for tooth decay in Torbay and the use of radiographs for investigation
- X-rays to be taken for all teeth assessed for extraction that have decay - Discussion with Oral and Maxillo Facial Surgery (O&MFS) department to explore potential changes. In particular: - O&MFS letters to state if x-rays were enclosed in referrals - O&MFS to consider x-rays during GA for pre-cooperative children who were unable to cooperate for x-rays awake or pre-operatively to consider sectional orthopantomograms
6643 28-Day Head and Neck Cancer Target
- Introduce and maximise the use of a "One stop" biopsy clinic - Move to a "One week wait" referral to appointment standard - Reminded clinicians when presenting results to clearly state diagnosis and its nature (benign/ malignant) in patient letters

6644 Targets of the “One-Stop” Biopsy Clinic
- Advised all clinicians when presenting results of the two-week wait clinic of the service available and that allocated slots are present - Reminded clinicians when presenting results of the benefit of reduced wait to diagnosis for patient anxiety
6662 Follow up of Preterm Infants born <28 weeks (NG-72)
- Draft new local pathway that will identify children and provide an alert when reviews are due - Develop standardised letter at the point of discharge from Special Care Baby Unit - Develop infographics that will help empower parents - what they should expect and when - Explore opportunity to include infographics in child’s 'Red Book' - Share and liaise with other health professionals - Educational Psychology, Public Health, GPs, etc.
6691 Quality and timeframe for completion of e-discharge summaries on a Paediatric Ward
- Care Plan Summary (CPS) Induction Training for new doctors to include: - Introduction to writing Paediatric CPS - Explain Senior House Officer (SHO) role and responsibility including; - Ensure every patient has a CPS prior to discharge - Complete CPS for the patient you cared for - Hand it over to team members of the following shift if it is not completed or discharge is planned - Seek senior medical advice (Registrar/ Consultant) - For patient with complex medical issues, a senior member of staff (Registrar/ Consultant) to go through CPS contents before giving out to patient - Paste Trust’s already designed poster on mandatory information to go home with CPS and paste it in every cubicle/ corner to increase parent/ carer awareness - Daily; - Regular update and highlight of overdue CPS at every handover meeting. Encourage team to complete CPS at the end of the day - Start preparing CPS on day of admission and update important clinical details daily by person who looked after the child - SHOs who couldn’t complete CPS to handover to colleagues starting the next shift. SHOs who start PM shift to help and resume the task to complete CPS if no clinically urgent matter to attend to - Record number of outstanding/ due CPS on whiteboard including potential to be discharged patients - Design an infographic to remind authors of the mandatory and required information that must be documented on CPS - Standardise ‘To Take Away’ (TTA) medications preparation across all departments: - Sign the signature box on the drug chart for the medication to take home - Record the TTA on the medication section in Infoflex before informing the pharmacist - No paper prescription is needed after signing drug chart and completing medication list - Hand CPS to parents and child to check understanding/ agreement of CPS information and advice given
6674 Use of the Mental Capacity Act (MCA) Assessment and Best Interest Decision Process
- A suite of MCA 2005 seven-minute briefings has been developed which have been disseminated to all staff working within the Trust - Links to the MCA 2005 Icon/ Website page set up as a Trust screen-saver - Prompts added to the “FACE version 3” MCA assessment and recording tool held on the PARIS computer system. The prompts will cover the key learning points from the audit process and will go live on 1st October 2021. Communication in respect of the changes will be made within the Trust Bulletin
6687 Use of Mental Capacity Act (MCA) on the wards in Torbay Hospital
- Disseminate results to Associate Director of Nursing and Professional Practice (ADNPP) group - ADNPPs to formulate a plan for their area to increase standards of MCA practice - Liaise with MCA subgroup re advice for fluctuating capacity

6677 Record keeping within the 0 to 19 service
- Feedback the results to the teams - Arrange training of documentation requirements for teams
6678 Child Protection Medical Service Delivery Standards
- Set up a system of documenting level of experience of trainees at induction; - Need to observe - Competent/ experienced/ confident to perform under direct supervision - Competent/ experienced /confident to perform under telephone supervision - Training for trainees on performing medicals and writing reports - Revise proforma; - Add chaperone details and 'choice of who accompanies child'. Photography issues need to be sorted - Bring all the consent spaces back onto the same page - Education re obtaining social care feedback regarding the final outcome of the Safeguarding process - Education that trainees must ask and Consultants must see children with concerning physical - Education that consultants are expected to discuss child protection medicals and outcomes for learning with juniors routinely, not just the difficult ones
6688 Devon Sexual Health (DSH) - Child Safeguarding audit
- Present Audit findings at staff audit meeting and distribute report to all staff - Compare results with other services across DSH - Review Young Person (YP) assessment proforma and revise using a standardised proforma such as 'Spotting the signs' as advised in new guidance referred to above - Include detail on those who facilitate the YPs access to the service - Disseminate up to date national guidance to the team and consider in new proforma design - Re-Audit British Association for Sexual Health and HIV (BASHH) National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and YP 2021

RESEARCH

The number of patients receiving relevant health services provided or sub-contracted us in 2021/22 that were recruited during that period to participate in research approved by the NHS Ethics / Health Research Authority (HRA) was 2,574.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Through active participation in research our clinical staff stay abreast of the latest possible treatments and leads to improved patient outcomes.

CARE QUALITY COMMISSION (CQC)

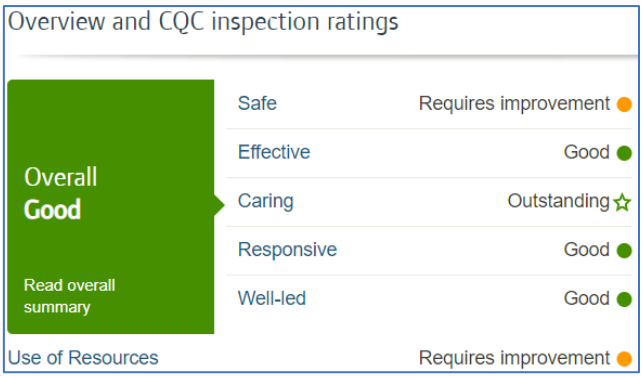
Torbay and South Devon NHS Foundation Trust is required to registered with the CQC and its current registration is to provide the following regulated activities:

- 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.

Torbay and South Devon NHS Foundation Trust has no conditions or restrictions attached to our registration.

During the reporting period 2021/22, the Trust had one CQC inspection in December 2021. In March 2022, the CQC produced the report from this focused unannounced inspection of 3 wards Torbay Hospital - Care Quality Commission (cqc.org.uk). In response, we developed an improvement plan to address the requirement notices and 'should do improvements. Progress towards this improvement plan is very well advanced and monitored through our individual service leadership teams and reported to the Quality Improvement Group and CQC Compliance & Assurance Group. The inspection did not result in any changes to the Trusts CQC ratings.

Our current Trust CQC ratings are shown in the table below.



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.

The Trust during 2021/22 has actively taken part in the CQC's new inspection strategy and engaged in their monthly Direct Monitoring Approach (DMA) where they review a core service. Following these reviews, the Trust has not been required to provide any further information nor undertake any actions. The Trust also meets monthly with the CQC at our Open Enquiries meetings and quarterly, via our engagement meeting as part of standard procedure

Torbay and South Devon NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the 2021/22 reporting period.

DATA QUALITY AND INFORMATION GOVERNANCE

Torbay and South Devon NHS Foundation Trust submitted records during 2021/22 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 was:

- for admitted patient care – 99.9%
- for outpatient care – 100.0%
- for accident and emergency care – 99.5%

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

- for admitted patient care – 98.2%
- for outpatient care – 97.2%
- for accident and emergency care – 97.4%

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. All standards were met in 2021/22.

PAYMENT BY RESULTS CLINICAL CODING AUDIT

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

The key results are:

Primary Diagnosis (% correct)	Secondary Diagnosis (% correct)	Primary Procedure (% correct)	Secondary Procedure (% correct)
86.26	91.4	81.97	94.12

The clinical coding department are formulating an action plan to improve the quality and completeness of clinical coding.

PATIENT MORTALITY

Learning from patient deaths

Mortality is reviewed each month by a multi-disciplinary team at the Mortality Surveillance Group. A mortality scorecard is presented to Board bimonthly by the Medical Director. We use analysis by 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. The HSMR was higher than expected for the summer months May to August 2021 but has reduced for the months September 2021 to January 2022. This is reflected in the rolling 12-month HSMR which is higher than expected at 107.3 but has reduced in the last three months. If mortality from all diagnoses analysed, the HSMR is 100.4 compared to an expected mortality of 100.

The safety team have investigated mortality alerts in acute renal failure and intestinal infection by a review of coding and case note review. Analysis showed no lapses in care. The results have been discussed with our Medical Examiners to ensure scrutiny of Medical Certificates of the Cause of Death occurs to record the underlying main cause of death. Inpatient deaths from alcohol related liver disease have seen a steady rise since August 2021 and will be investigated by the patient safety team.

Analysis of the Standardised Hospital Mortality Index (SHMI) includes deaths occurring in hospital and up to 30 days after discharge. Our SHMI is 1.05 which is as expected.

Medical Examiners now provide scrutiny of all inpatient deaths and we have recently expanded the team in preparation for scrutiny of deaths occurring in the community.

In response to deaths due to suicide in two young people, the paediatric team have undertaken training in suicide prevention to provide the best opportunity to intervene at an early stage.

Mortality figures and reporting

Ref.	Information required	Our response	
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2021/2022, (April 2021 to Mar 2022) of Torbay and South Devon NHS Foundation Trust 1,305 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 293 in the first quarter; • 315 in the second quarter; • 347 in the third quarter; • 350 in the fourth quarter	
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	For the period April 2021 to Mar 2022, 956 case record reviews have been carried out by the Medical Examiners in relation to the above number of the deaths included above. This comprised the following number of case scrutiny which occurred in each quarter of that reporting period: • 209 in the first quarter; • 188 in the second quarter; • 238 in the third quarter; • 321 in the fourth quarter	

27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	During the period April 2021 to March 2022, 7 cases for which the outcome was death were reported on the Strategic Executive Information System (STEIS). All these incidents had reports produced which were communicated to the CCG and discussed at the Trusts' Serious Adverse Event group which meets on a monthly basis.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The themes from learning from death reviews: • focus on communication between clinical teams • Cardiotocograph (CTG) interpretation • Consideration of gastric protection medication • Best interests and mental capacity act (MCA) use • Protocols around nasogastric tube (NGT) in stroke patients
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	Focus on human factors in verbal and written communication between clinical teams. Fetal monitoring in labour (CTG) update mandatory training, production of new training video, update fetal monitoring policy, work with Local Maternity Service to secure placental histopathology. Multi-disciplinary learning around the mental capacity act (MCA), best interests and nasogastric tube placement Hospital grand round learning gastric protection in elderly patients on non-steroidal anti-inflammatory medication
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	The Trust continues to learn from deaths. As a result of actions in 27.5 there is improved understanding of CTG interpretation and establishment of a working group to reduced delay between decision and delivery for urgent caesarean section. MCA training has improved throughout the Trust. Need to ensure treatment decisions made in Treatment Escalation Plans are available to clinical teams managing urgent and emergency care.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	One case record related to death in previous 12 months due to aortic dissection which was not recorded under 27.2 One case record was reviewed related to a death due to liver metastases from an ocular melanoma on follow up not recorded under 27.2
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	During the period April 2021 to March 2022, seven cases for which the outcome was death were reported on the Strategic Executive Information System (STEIS). All these incidents had reports produced which were communicated to Devon Clinical Commissioning Group and discussed at our Serious Adverse Event group which meets on a monthly basis.

2.3 CORE INDICATORS

Performance in 2021/22

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

Other national and local indicators	Quality indicator	Target 2021/22	2021/22	2020/21	2019/20	2018/19
DNA rate	Effectiveness	5%	5.6%	5.1%	5.1%	5.2%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	54.8%	77.3%	90.2%	86.9%
Urgent intermediate care referrals per month (new)	Effectiveness	113	194	212	219	172
Mixed sex accommodation breaches of standard	Experience	0	0	0	0	0
52-week referral to treatment incomplete pathways year end position	Experience	0	3,199	2,049	53	91
Cancelled operations on the day of surgery	Experience	<0.8%	1.5%	1.5%	1.3%	1.3%
Never events	Safety	0	0	4	2	2
Reported incidents – Major and catastrophic	Safety	<72	25	42	10	14
Safeguarding adults - % of high-risk concerns where immediate action was taken to safeguard the individual	Safety	100%	100%	100%	100%	100%

Plans for 2022/23

Looking ahead we are hopeful that we are entering a year with no further significant surges in COVID-19 demand for hospital care. While there will continue to be heightened infection prevention and control measures and social distancing as part of the “new normal” in the way services are delivered we are now planning for a full restoration of service capacity and plans to further increase capacity beyond this, to address the accumulated backlogs in waiting lists. This will require a combination of fully utilising our estate and clinical resources with a mix of investment and transformation building on the new ways of delivering services fast tracked over the last year including remote consultations and patient-initiated care.

It will be a very challenging year but one that will see step changes in the ways many services are delivered. In particular the use of information technology and technology enabled care to make best use of our specialist clinical workforce and facilities.

Over the last year we have worked very closely with our partner organisations and neighbouring providers. This collaborative approach to planning and delivering services will continue and increasingly shape how services are joined up and service capacity is viewed over a network rather than individual organisations.

3 OTHER INFORMATION

OVERVIEW OF SERVICES AND GOVERNANCE

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

- NHS England and Improvement, our regulator
- the Care Quality Commission
- the commissioners via the various health contracts
- the Local Authorities for social care
- our local communities through our members and governors.

Our delivery structure in 2021/22 was based on having two population-based operational "systems" and five integrated service units as follows:

- Torbay system, comprising:
  - Torquay locality
  - Paignton and Brixham locality

- South Devon system comprising:
  - Coastal (Teignmouth and Dawlish)
  - Moor to Sea (Ashburton, Bovey Tracey, Totnes and Dartmouth)
  - Newton Abbot

In addition to the integrated service units there is a central corporate services function and hospital operations team.

The governance process sees the integrated service units hold their teams to account through monthly integrated service unit meetings and then with each integrated service unit reporting performance risk exceptions and recovery plans to the executive team via the monthly integrated governance group. The group then informs the various sub-committees of the Board of Directors of items for escalation.

PERFORMANCE AGAINST QUALITY STANDARDS

Note: This section is an extract from our 2021/22 Annual Report

National and local standards

The purpose of this overview of performance is to provide the reader with sufficient information to understand how the organisation has performed against key regulator standards during the year. In 2021 the standards remain as those described in the 2019/20 Single Oversight Framework.

During the reporting period, performance reports were provided monthly to the Finance, Performance and Digital Committee, and the Board of Directors. These reports covered all the key national and local performance standards to provide assurance to the Board.

2021/22 has seen the continuation of the pressure on the NHS in response to the ongoing COVID-19 pandemic. Operational and performance focus being on the escalation of services required to manage increases in COVID-19 hospitalisations balanced against maintaining urgent care response. This has meant the standing down of non-urgent work and then the reinstatement of services in the period between peaks of COVID-19 hospitalisations. Locally this has required great flexibility from operational teams and estate changes along with continued partnership working and support with neighbouring providers, the independent sector including domiciliary, and care home provision.

In line with the annual plan requirement to set out our performance against indicators described in the Single Oversight Framework (2019/20), our performance against the key indicators used to monitor by NHS Improvement and commissioners is set out as follows:

	Target	Apr-21	Jun-21	Sep-21	Dec-21	Mar-22
NHS I - OPERATIONAL PERFORMANCE						
A&E - patients seen within 4 hours	>95%	84.4%	72.6%	65.1%	62.5%	58.4%
Referral to treatment - % Incomplete pathways less than 18 weeks	>92%	62.7%	64.4%	57.4%	55.6%	52.0%
Cancer - 62-day wait for first treatment - 2-week-wait referral	>85%	71.8%	68.8%	73.3%	61.9%	59.5%
Diagnostic tests longer than the 6 week standard	<1%	36.3%	32.2%	32.6%	37.9%	36.8%
Dementia - Find - monthly report	>90%	96.7%	97.4%	92.7%	87.3%	93.6%

4 Hour Emergency Department ('ED') waiting times

In 2021/22, performance continued to reflect the impact of caring for patients with COVID-19. Delays in ED have been primarily due to pressure on beds for patients requiring ongoing admission for inpatient treatment. The bed pressures experienced are-driven by increased patient length of stay due to complexity of care, infection prevention and control (IPC) measures, and delayed transfers of care once medically fit to leave hospital. Discharge pathway delays continue to be impacted by reduced capacity across the independent sector for nursing, residential home placements, and domiciliary care packages. The high bed occupancy rates then translates to delays at the emergency front door for assessment, transfer to inpatient beds following decision to admit, and increased ambulance handover times.

In January 2022 an additional 26 acute beds were opened to ease high bed occupancy pressures to improve patient flow. In response to the increased number of delayed discharges seen, through continued investment and focus on pathways of care, there has been a reduction in Quarter 4 in the daily number of patients medically fit for discharge occupying a hospital bed. However, ambulance handover delays and maintaining patient flow has continued to be a challenge.

Referral to Treatment (RTT) access times

In 2021/22, the impact of the COVID-19 response has meant a continued stepping down of elective care particularly for the routine and less urgent treatments. The day surgery unit was re-purposed to support emergency care over the winter period with a subsequent loss of elective day-case capacity. As a consequence, waiting times have continued to increase with the number of patients waiting over 52 weeks increasing from 1876 (April 2021) to 2759 (February 2022) and 104 week waits from 6 to 243 by March 2022.

In the outpatient setting, the focus has been on returning to pre-COVID-19 levels of activity and increasing the number of non-face-to-face appointments where possible. Additionally, we have rolled out the Advice and Guidance pathway for initial GP referral response as well Patient Initiated Follow Up (PIFU) whereby patients are discharged rather than be booked for a routine follow up with the ability to request a further review should their condition fall outside of agreed parameters.

Cancer standards

We maintained our commitment to prioritise delivery of cancer treatments. However, increased referral demand coupled with pressures in diagnostics, theatres, beds, and staffing including capacity for 2-week wait clinics over the year has meant that there has been an overall deterioration in performance. We have not met the standards for the 62-day referral to treatment, 28-day faster diagnosis, and two-week urgent referral standards.

Given the competing demand on clinical service capacity and processes to respond to COVID-19 escalation, the actions taken to preserve capacity for cancer pathways has, however, supported performance and mitigated further deterioration and significant impact upon patient care outcomes.

Diagnostics

In 2021/22, demands for diagnostic tests has continued to increase with the delivery of required levels of capacity in CT and MRI dependent upon the insourcing of additional capacity using mobile units. From November 2021 the Nightingale Hospital elective care centre in Exeter has also been used to support additional CT and MRI capacity.

Recruiting to staff vacancies across the major diagnostic modalities had remained a challenge throughout.

Endoscopy services has used weekend insourcing throughout the year to stabilise waiting lists. The management of COVID-19 infection prevention and control constraints for aerosol generating procedures remain a challenge and impacted on efficiency.

Dementia Find

The assessment of patients who were admitted to hospital over the age of 75 for dementia was introduced as part of the updated Single Oversight Framework in October 2017. This standard (90%) was achieved in aggregate for the year, with 94.5% of qualifying patients receiving timely dementia screening on admission to hospital.

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 adopted a process of contacting patients by telephone as well as letter to agree appointment dates and follow-up appointments when initial contact with patients 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 patient's condition change or they fail to engage with offered appointments.

Assurance and performance monitoring

Bi-weekly assurance meetings are held with operational leads, led by the Chief Operating Officer, to review the key NHSEI performance standards and to review operational plans throughout the year.

These meetings are in addition to the monthly ISU, executive-led, Integrated Governance Group (IGG) Meetings where performance is reviewed with system leadership teams following the Integrated Service Units (ISUs) monthly governance process.

This process gives the Executive Team and Trust Board assurance over performance monitoring, escalation of performance risks where additional support is needed, and actions being taken.

ANNEX 1: PARTNER FEEDBACK

Statement from commissioners – NHS Devon Integrated Care Board

NHS Devon Integrated Care Board (ICB) would like to thank Torbay and South Devon Foundation Trust (TSDFT) for the opportunity to comment on the quality account for 2021/22. TSDFT is commissioned by NHS Devon ICB to provide acute health care services from Torbay Hospital, and community health services and adult social care. We seek assurance that care provided is safe and of high quality, that care is effective and that the experience of that care is a positive one.

As Commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the Commissioner over the 2021/22 period.

While managing the ongoing impact of COVID 19 and the challenges presented by the impact on emergency and planned care, Devon health services have worked closely together to share expertise and good practice, as well as providing mutual aid and testing new ways of working.

Despite the pressure on staff and services, this Quality Account has highlighted a number of positive results against key objectives for 2021/22. These include:

1/ Patient Safety TSDFT prioritised restoring key services suspended during the pandemic. To date restoration of the Day Surgery unit, community therapy services and the Medical Receiving Unit all operating at pre-pandemic levels. TSDFT have particularly focused on areas for improvement after incident theming and trending. Focused workstreams on pressure ulcer prevention, falls assessments and medication safety have progressed well and improved both safety and experience for patients.

2/ Clinical Effectiveness The trust aimed to improve services for children and young people who present with mental health illness including eating disorders and autism. The ICB are pleased to note the successful implementation of the south west paediatric mental health network to share best practice and knowledge. Within TSDFT over 100 staff were trained using the national training programme “Time to Talk” which has improved the skills and knowledge of staff in introducing discussions around mental health. To further support this a consultant paediatrician and senior nurse have been identified as named mental health leads.

3/ Patient Experience TSDFT aimed to enhance the experience of patients through robust listening and feedback opportunities, identifying and embedding improvements in the experience of patients who are discharged from a hospital setting. Virtual consultations have continued to be implemented and replace or complement face to face consultations for several services. The development of the “Patient and Service User experience Strategy- What matters to you, matters to us” was developed with over 20 local voluntary groups is commendable and progress will be measures against the annual milestones set out within the strategy.

The ICB also notes and welcomes the 2022/23 priorities outlined by TSDFT in their Quality Account and will look forward to seeing achievements related to reducing harms, excellence in clinical outcomes and zero avoidable deaths. Each of these programmes will continue to evidence and improve quality and safety for the benefit of patients, families, carers and staff building on the lessons learned from 2021/22.

During the reporting period 2021/22, the Trust had one CQC inspection in December 2021. In March 2022, the CQC produced the report from this focused unannounced inspection of 3 wards. An improvement plan to address requirement notices is well advanced with appropriate senior oversight. As a commissioner, we have worked closely with TSDFT during 2021/22 and will continue to do so in respect to all current and future CQC reviews undertaken, in order to receive the necessary assurances that actions have been taken to support continued, high-quality care.

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

ANNEX 2: DIRECTORS' RESPONSIBILITIES STATEMENT

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2021/22 and supporting guidance;
- detailed requirements for quality reports 2021/22;
- relevant stakeholders have been engaged, including:
  - quality account shared with Council of Governors on 07/07/22
  - quality account shared with commissioners on 30/06/22 (feedback in Annex 1)
  - quality account shared with Healthwatch on 30/06/22
  - quality account shared with Overview and Scrutiny Committee on 30/06/22
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2021 to March 2022;
  - papers relating to quality reported to the board over the period April 2021 to March 2022;
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2022;
  - the 2021 National Staff Survey reviewed by the People Committee in April 2022;
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 21/06/22;
  - CQC inspection report dated July 2020;
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board: 21 June 2022

Sir Richard Ibbotson, Chairman

Liz Davenport, Chief Executive