NHS 75

NHS
Torbay and South Devon
NHS Foundation Trust

Our People

Quality Account
2022/23

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

Quality Account 2022/23

Approved by Trust Board on 28 June 2023

Contents

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 a proud integrated health and care organisation of more than eight years' standing. We serve our local people by providing community care, including adult social care and acute care, from Torbay Hospital as well as four community hospitals stretching from Dawlish to Brixham.

Increasingly, we are providing more care as close to home as possible for our people; reducing their need to travel and helping to keep them safe and live well. More and more we are delivering care directly into people's homes either through visits, online or telephone appointments and offering as many appointments as we can at local health and wellbeing centres and community hubs.

Making sure people are safe is at the heart of what we do. This not only includes the people we care for in our hospitals and in our communities but also our dedicated staff.

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 including and listening to our people and communities to improve our understanding of their needs and acting together to deliver better health and care for all.

During the past year we have taken further steps to strengthen our partnerships across the Devon health and care system. Together we have developed a single improvement plan that places quality and patient safety at the heart of how we work, making it the principal driver for change in how we collectively deliver against our identified strategic quality improvements.

Our three-year quality and safety plan 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 and the actions we will take to make our vision a reality.

In this year's Quality Account, we reflect on the strategic changes that are taking place to address the systemic issues and challenges that impact the quality and safety of care as well as share the improvements being made against the clinical improvement priorities agreed against our four quality goals.

Our vision of excellence in quality

We are committed to delivering outstanding care, ensuring excellence in experience and outcomes for our people who use our services and the wider communities 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 both people who use our services and those who work within our services (our dedicated 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 where the clinical outcomes are comparable with the best in the world
- ✓ empower and enable our people to deliver the very best care
- ✓ 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 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.

We held a number of listening and engagement sessions with our people between February and June 2021 to help us identify our key issues and explore the options to address them. Together we co-designed our four quality and safety goals which are aligned to our vision for better health and care for all.

In this year's Quality Account, we will share our progress against the clinical improvement priorities we agreed against the four quality goals, specifically:
- ✓ sepsis
- ✓ deteriorating patient
- ✓ falls
- ✓ nutrition and hydration
- ✓ experience of patients on discharge.

Summary of our quality report

I am pleased to introduce our quality account for 2022/23.

There is no doubt the quality and safety of care has been tested in the last three years. While the COVID-19 pandemic has been declared officially over by the World Health Organisation, people living and working in our local communities continue to be significantly affected by the consequences of the pandemic.

Waiting lists for many services are much longer than any of us would wish and people are experiencing unacceptable delays in treatment and accessing services which is having an adverse impact on their experience and clinical outcomes.

The scale of the challenges we are facing serves to highlight the importance of service transformation and finding new ways to support and treat people who need our care, particularly ways in which wellbeing can be maintained and ill health prevented for both physical and mental health. Our vision is, and remains, better health and care for all.

Never has our commitment to quality and patient safety been more important. We are committed to reinforcing and enhancing our culture of safety, enabling our people to feel safe and confident to speak up. We are embedding a quality improvement approach at every level and this year we have launched our new quality boards which we are rolling out across all services.

Our new compassionate leadership framework will ensure we listen and act upon what people tell us. Being civil and respecting each other are central to creating a just learning culture that will help us deliver all aspects of our work and will help us to make patient safety everyone's business.

The ongoing challenges we are facing and the understandable stresses these are causing again only serve to highlight the importance of focusing on the health and wellbeing of our people so that we can deliver the best care we can.

We have made it a priority to reduce our reliance on agency staff and increase our activity around recruitment as well as developing homegrown talent through our successful apprenticeship programmes.
A further key element to our approach to quality includes a continued focus on building meaningful partnerships, with our patients, community, our staff and colleagues across the health and care system ensuring that we are listening to what matters to our people and reflecting this in our work.

We are committed to putting people at the centre of our thinking and working more closely with colleagues from different organisations. There are examples of how we are doing this throughout our quality account.

As we look to the future it is vital that we strengthen these relationships and develop collaboration across not only clinical but also corporate and operational services.

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

Throughout the year we remained relentlessly focused on addressing the quality and safety challenges that emerged across our services following the pandemic.

We have taken a number of significant steps to ensure that wherever a patient is cared for, acute and/or community services, we collectively work together to deliver the very best care, and achieving the best outcomes and experience and we are very proud of the improvements that have been made across health and social care. Working together we have progressed significant improvement in quality of services and this account brings together some examples of this across our acute, community and adult social care services.

Along with our partner NHS organisations across Devon, we entered into a higher level of regulatory support and monitoring in 2022. This has required us to work together differently to address the more systemic quality and patient safety issues that have emerged in care and treatment across the NHS and in particular the community we serve in Torbay.

We strengthened our partnership across health and social care to ensure we are better placed to address risks of delay in access to treatment.

In 2022/23, we developed a single quality improvement plan across Devon to address issues of quality and safety of care, with specific targets around improvements to reduce/eliminate long waits for planned and emergency care. We are pleased that we have made progress in these areas.

Alongside this Quality Account for Health, we will also be publishing in September our annual account of Quality and Performance for Adult Social Care and the following serves to highlight some of the important quality improvements across key services.

Emergency care

We continued to see significant challenges around delays in our communities accessing and being seen across the emergency pathway and we have implemented a range of improvements that started to have a positive impact over the winter and spring of 2022/23. These included the completion of our long awaited £15.7 Acute Medical Unit (AMU) opened its doors in December 2022.

Our AMU is a flag ship for our building a brighter future programme which aims to make a real difference to how we deliver services to and for our people. In addition, new pathways have been embedded over the last year alongside the development of virtual wards, which provides significant additional activity of 28 beds, which will be further developed in 2023/24 to deliver 77 urgent care beds, providing specialist clinical observation and management in people's own homes.

Cancer care

The delivery of high-quality cancer care has been a key focus of our improvement work and we recognise that there is more we must do. During 2022/23 we were placed into Tier 1 scrutiny for cancer performance. We put a significant focus on improving cancer services and by March 2023 we had:

✓ met the standard for Faster Diagnostics with performance at 77% in March 2023

- ✓ sustained a significant reduction in the number of patients waiting more than 62 days for urgent suspected cancer, meeting the target for reduction
- ✓ delivered all of the Tier 1 performance improvement thresholds resulting in a recommendation that we exit Tier 1 monitoring.

Planned care

We have worked hard to reduce long waiting times for planned outpatients and operations supported by a significant programme of quality improvements. We know that long waits for planned procedures or appointments has a significant impact on people's health and wellbeing and we are committed to continuing to drive this improvement further in 2023/24.

The number of people who are waiting longest for our services is steadily and sustainably reducing including the following achievements by March 2023:
- ✓ no one waiting longer than 104 weeks
- ✓ significant reduction in people waiting for longer than 78 weeks (183 people at year end).

Our focus is the continued reduction in the number of people waiting more than 65 weeks and we are receiving external support to drive improvement aligned with the outpatient and surgical care transformation programme to maintain improvement into 2023/24.

Community Services

Our Community services progressed a range of quality initiatives in 2022/23 some of which included the following:

- ✓ *Lower Limb Therapy Service:* The Trust was recommissioned in 2021 to care for all patients who require compression bandaging across the organisations footprint. The impact has been significant to the population with the healing rate having reduced from 24wks to 5wks to time to heal, this is obviously having a significant impact on individuals and their wellbeing.
- ✓ *Homeless Wound Care Clinic:* A clinic has been set up in Factory Row in Torquay for homeless people to self-present regarding wound care and ongoing wound care needs. This has increased the quality of patients' lives. It has also allowed patients journeys to me more seamless as the Tissue Viability Team will see these individuals on admission and support wards in the management of wound care, and they already have established relationships with clients who feel engaged in their treatment.
- ✓ *Trusted Assessors:* The introduction of two Trusted Assessors has improved patients experience and quality relating to discharge to Care Homes. The Trusted Assessors have built up relationships with the Care Homes which has resulted in Care Homes feeling confident in the assessments provided. It has developed further in that Care Homes at times are using the Trusted Assessors to provide an assessment to prevent any delays in assessment and acceptance. As a result confidence in discharges to Care Homes has improved, patient experience will be better and length of stay has been reduced where they may have previously been delays with Care Homes being able to come in and assess individuals. Given the success this has been funded to continue to 2024.
- ✓ Occupational Therapy In Reach Service*:* this initiative has allowed patients to be reviewed prior to discharge to ensure they are on the correct pathway and will be in receipt of right support on discharge. The impact has been reduced length of stay, reduced deconditioning and better patient outcomes.

- ✓ *0-19 Service:* The 0-19 service has been part of a pilot along with 13 other areas nationally who have introduced Family Hubs. Funding has been sourced nationally through local authority to establish multiagency family hubs. These hubs are designed and are improving outcomes to families through a multiagency response/involvement within a deprived areas.
- ✓ *Drugs and Alcohol Team:* Coproduced multicomplex service working in partnership with Devon Partnership Trust and Jatis to provide services to individuals who are exposed to substance and alcohol misuse and homelessness. This has seen an improvement in service user engagement. There has also been a reduction in deaths since implantation and although it is unclear if this is direct outcome it is felt that there is correlation. It has improved access to a broader range of services which improves better health and wellbeing for the service users.

Adult Social Care

In 2022/23 were further enhanced the integrated to developing and delivering services with Adult Social Care. While the Annual Adult Social Care Account will set our progress and improvements in Adult Social Care across Torbay in 20922/23. Building on the success of the integration and partnership with Torbay Local Authority, since July 2022 we have worked as one health and care system through a strategic approach entitled 'One Devon'. This strategy is focused on enabling partners across health and care to share our valuable resources and knowledge to provide joined-up care for the people who need us with five key areas of focus for improvement that include:

1. mental health
2. healthy ageing
3. good start to life
4. complex needs
5. Digital inclusion.

The following highlights draw attention to not only the increasing demand and level of complex care required within our community, it demonstrated the responsiveness of ASC Services.

- ➢ 8,420 requests for support were received compared to 5,407 in 2020/21
- ➢ 771 people received one-off support compared to 443 in 2020/21
- ➢ 2,226 people received Short Term Reablement services to help them gain independence compared to 1,275 in 2020/21
- ➢ 1,092 people started to receive an ongoing support service including community activities compared to 544 in 2020/21
- ➢ 100% of service users received community based social care services through self-directed support
- ➢ 4,747 carers are on Torbay's carers register - we assessed and reviewed 1,355 carers in 2020/21 and provided 678 carers with Direct Payments
- ➢ 386 people with mental health issues were supported by   compared to 343 in 2020/21
- ➢ 1,775 people received home care support to enable them to stay in their own home compared to 1,729 in 2020/21
- ➢ 949 people were in permanent residential placements during 2021/22 compared to 930 in 2020/21
- ➢ 998 safeguarding concerns were raised. This represents a 9.1% decrease in the 1,098 safeguarding concerns raised in 2010/21

Delivery against our quality and patient safety strategy

During the year we:

- ✓ developed a just culture framework that sets out clearly the intentions that must be in place to ensure we are fostering and promoting a culture of psychological safety for our people
- ✓ launched our just culture survey - the results will enable us to better understand the barriers we face in building culture of psychological safety and how we can work together to address these
- ✓ ensured the voice of people who use our services shaped how we recognise and reward our people through the continued roll out the Daisy and newly launched Primrose award
- ✓ rolled out a revised ward accreditation framework with stretch targets around specific quality improvements
- ✓ rolled out our quality boards – a visual tool within quality improvement methodology that aid services to chart and map quality improvement, providing both focus and a way to recognise achievement.

Clinical quality improvement priorities

Throughout the year we demonstrated improvements in key areas but we recognise that more must be done in 2023/24 to ensure improvements are sustained.

Our improvement goals for 2022/23 were to achieve:
- ✓ 100% compliance with sepsis bundle
- ✓ 100% compliance with all risk assessments for people who are admitted to hospital
- ✓ 100% compliance with nutrition and hydration risks within 24 hours of admission to hospital
- ✓ reducing the number falls resulting in harm when in hospital
- ✓ 100% compliance in vital signs undertaken within the prescribed timescale
- ✓ 100% compliance with early warning score recorded
- ✓ Improved patient experience around discharge.
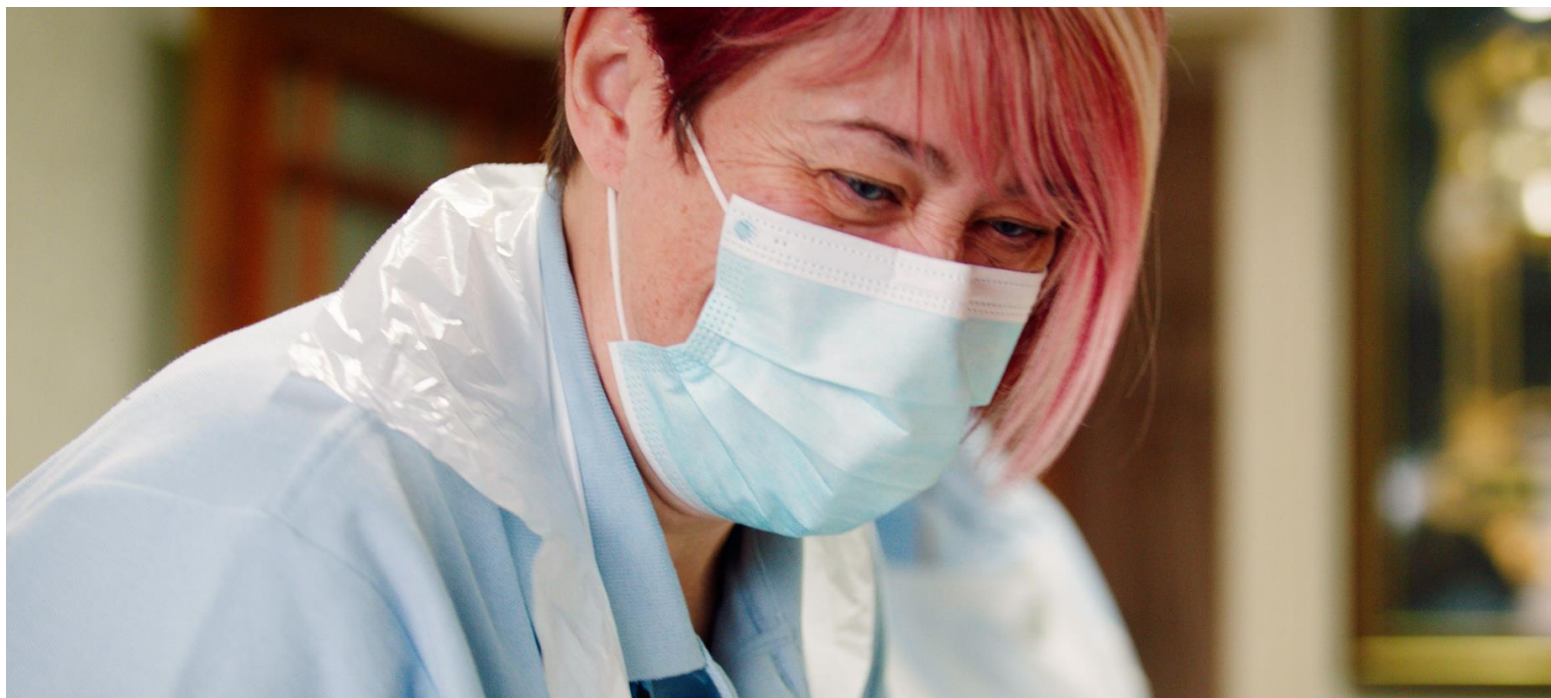
Quality priority one: improve identification and management of sepsis

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

Our aim in 2022/23 was to improve our identification and management of people with sepsis to reduce the number of people who die from septic shock.

Our primary focus has been within our Emergency Department with roll out plan across high risk areas in 2023.

Key interventions delivered include:

✓ we strengthened the clinical leadership for the quality improvement program
✓ we established the overarching Sepsis Improvement Group and established the audit framework.
✓ we introduced a new audit tool
✓ we commissioned new training package for clinical teams.

How did we do?

Against a goal of 100% compliance with the sepsis bundle, we achieved 80% on average in our Emergency Department (ED).

Percentage Compliance for the Sepsis 6 (ED)
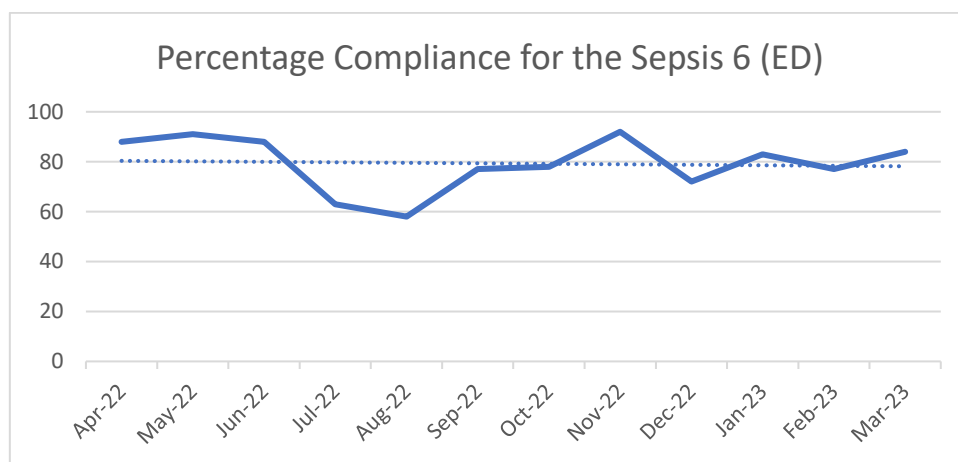
Quality priority two: improve compliance around patient risk assessments

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

In doing so we can safely and appropriately put in place care interventions that are personal and most relevant to a person's need. Our aims in 2022/23 were to:

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

Risk assessments and nutrition and hydration

Key interventions delivered include:

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

How did we do?

We achieved a 98% compliance for nutrition and hydration risk assessments being in March and an average of 96.4% compliance over 2022/23 however there is more we must do to ensure these are undertaken within the four-hour time scale of admission as this level of compliance is lower and while there has been a more sustained improvement in the lastr months of 2022/23 , this still falls below the 100%

Applicable Patients Receiving Nutritional Risk Assessment - Trustwide

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
All Received	95.5%	96.1%	96.4%	96.6%	92.6%	96.6%	98.1%	98.2%	96.3%	97.0%	96.5%	98.0%
Received <24hrs	83.3%	88.1%	92.7%	91.9%	85.4%	88.0%	94.0%	94.3%	90.4%	94.1%	90.2%	90.7%
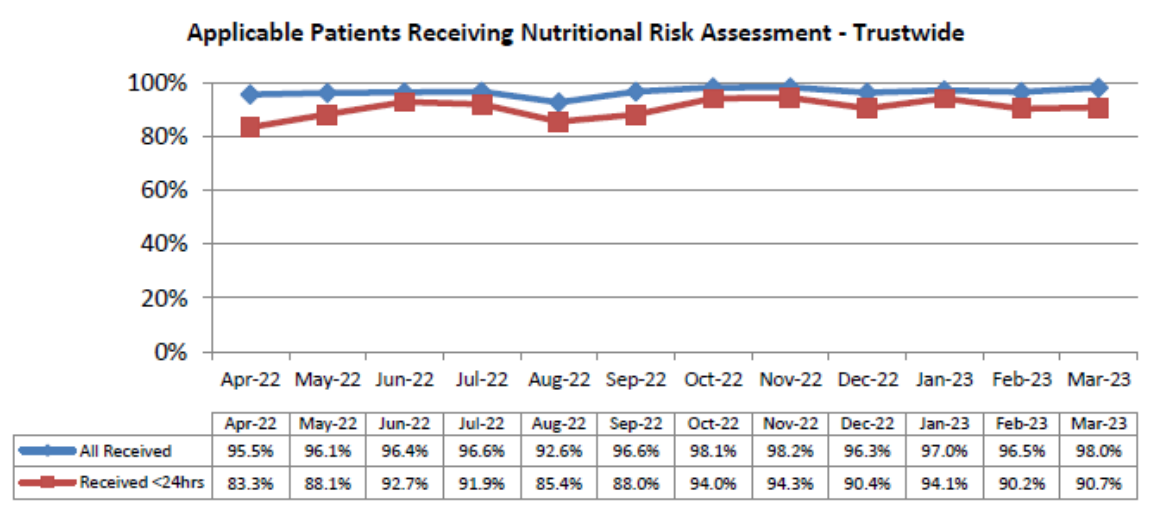
Falls reduction

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

During the year we strengthened the application of the fall safe bundle which sets out a number of critical care interventions that can reduce the risk of people falling, some of which include making sure people have the correct footwear, visual assessments, appropriate lighting and call bells being near to hand. This year we introduced the requirement for people identified as being at risk of falling to have their lying and standing blood pressure recoded.

Key interventions delivered include:

✓ fall safe bundle imbedded including a 'lying and standing blood pressure'
✓ training 'lying and standing blood pressure'
✓ we are now achieving 45% compliance against a national average of 39% for lying and standing blood pressure being recorded
✓ visual assessment tool has been piloted and will roll out and add to fall safe bundle
✓ fall debrief being piloted.

How did we do?

In terms of a reduction in falls, the number of bed-based falls is reducing – we are currently seeing 4.8 falls per 1,000 against 6.1 in the previous year which identifies a 27% reduction in falls.

All Wards - Summary

Bed Based Falls per 1,000 Occupied Bed Days
Rolling 12 Months

Legend: —— TOTAL – – Trend
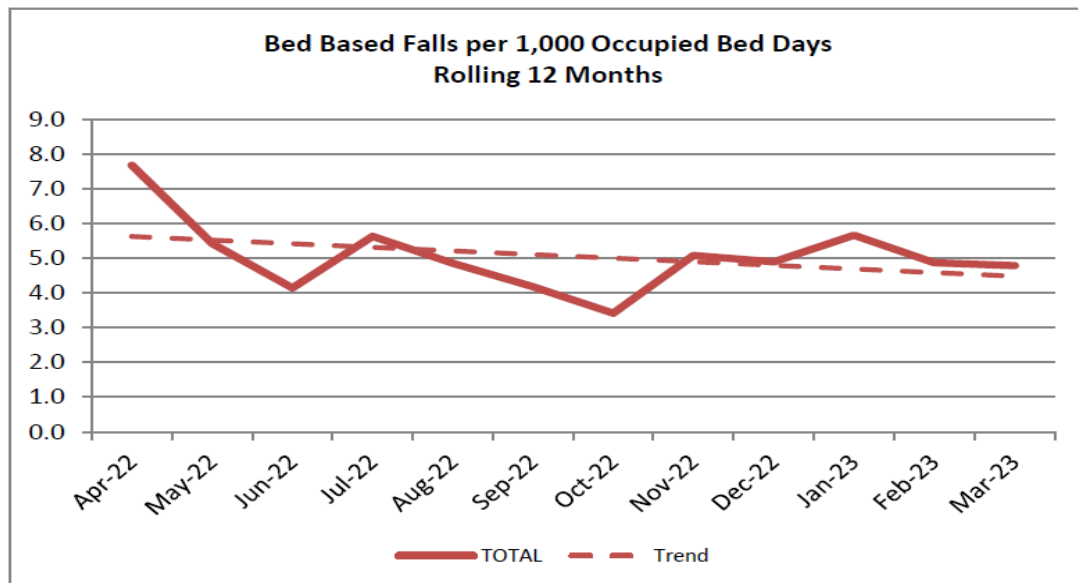
Quality priority three: improved identification of deteriorating patient

We said we would focus on improving clinical outcomes by better supporting people whose condition is deteriorating when they are 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.

Key interventions delivered included:

✓ strengthened and rolled training in NEWs 2, target uplift to 100%
✓ regular monitoring through the deteriorating patient group
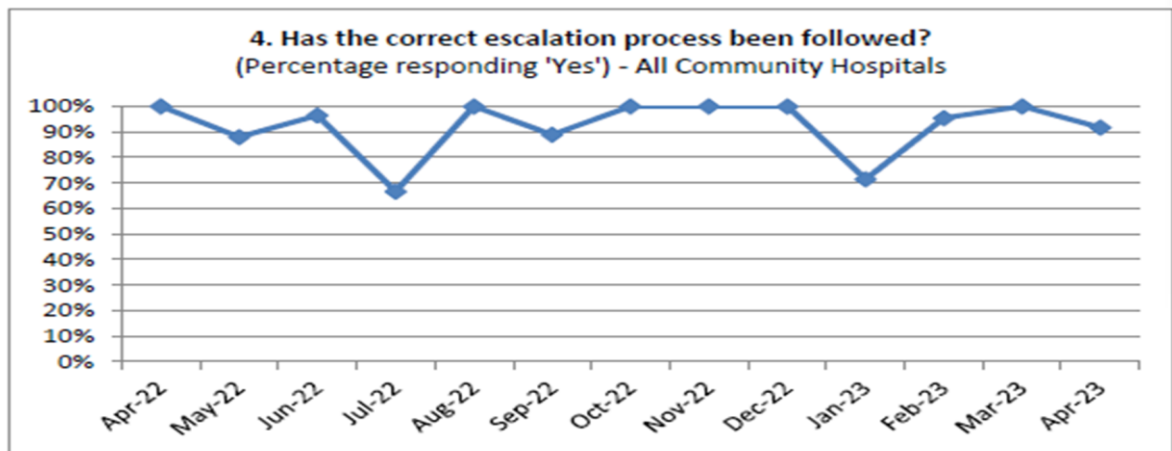✓ targeted support for wards where there is underperformance

How did we do?
Our compliance with recording vital signs within the specified timescale
✓ performance of 98% vs target of 100%.

Completion of the early warning score (a physiological "track and trigger" system)

✓ performance of 100% meets our target.

Audit of escalation shows 100% across surgery in March, however this needs to be consistent and measured across all our inpatient services.

4. Has the correct escalation process been followed?
(Percentage responding 'Yes') - All Community Hospitals

Quality priority four: improved experience for people being discharged

Preparing patients and their families around discharge home is a key priority. Ensuring that patients are involved in decisions about their care and the appropriate arrangements are made to ensure that the transition home is safe, personal and compassionate is crucial to their wellbeing.

Key interventions included:

✓ introduced home for lunch Initiative
✓ enhanced discharge lounge
✓ targeted support for wards where there is underperformance
✓ review of preferred place of discharge
✓ follow-up of patients around person centred care

How did we do?

✓ patient feedback through the NHS patient survey 2023 showed we were performing in the top 20% in the following:
  - involved in decisions about your discharge
  - after leaving hospital did you get enough support
  - were you given enough information
✓ home for lunch: in March 2023 19.3% of people were discharged before 12 noon compared to 67.3% before 5pm
✓ enhanced discharge lounge – promoting a positive step to discharge - the number of people transitioning through our discharge lounge has doubled
✓ deep dive review underway looking at preferred place of discharge, current data shows 74% patients were discharged to their preferred place of care

✓ patient survey – ten randomly selected people who have been discharged each month to be called to collect themes on their experience of discharge due to start in the first quarter of 2023/4.

In 2023/24 our focus will be to deliver sustained improvements across acute and community services with a specific focus on planned and emergency care and delivery against the improvement targets set out by the national and regional team. In doing so we will work with system partners to ensure that we deliver against our commitments to address issues of inequity and inequalities emerging post pandemic. These will include the following improvement priorities:
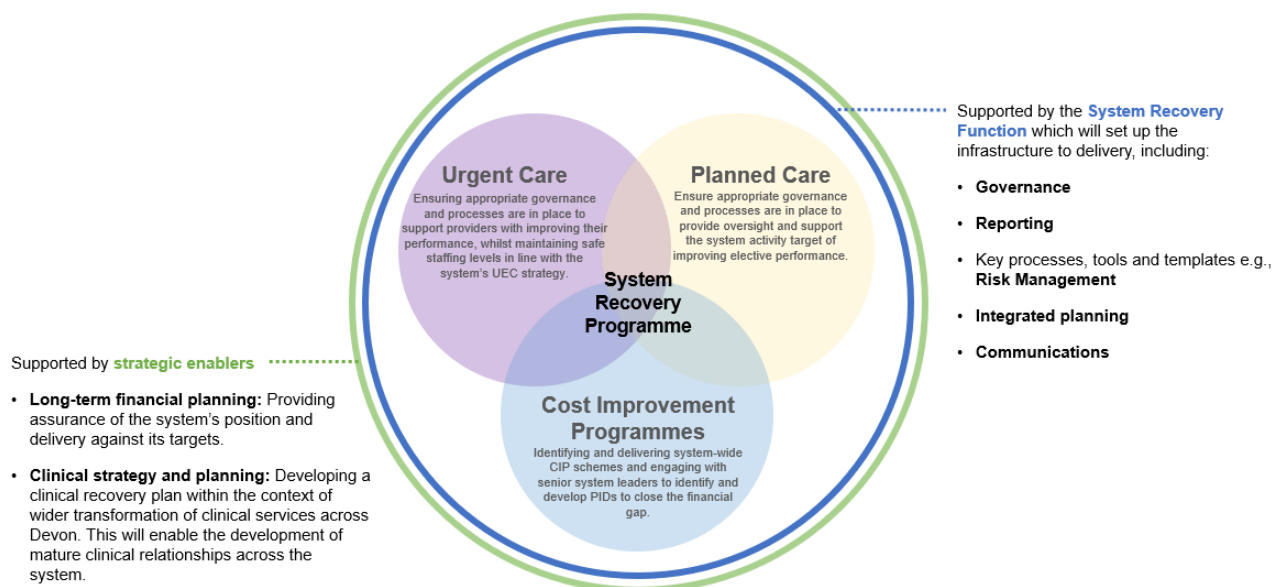
Quality priority one: reduce harm resulting from delays in access to planned and emergency care

Our first priority is to deliver improvements across planned and unplanned services that will reduce harm associated with delays in care. Our ambitions are aligned with those of the wider Devon health and care system, which locally we are calling our regain and renew plan.

This is a new quality priority for 2023/24 to reflect the critical and urgent need to ensure there is consistent quality and equitable access to safe services across Devon. We will be working closely with Devon partners for many aspects of these plans, but the key goals that we have committed to deliver within our own organisation by March 2024 are as follows.

Key measures for unplanned care
✓ reduce ambulance handover delays greater than 15 minutes to 1,110
✓ increase the number of patients seen in ED within four hours to 76%
✓ reduce to zero the number of patients waiting more than 12 hours to be seen in ED
✓ increase pre-midday discharges to 35%
✓ reduce the number of people unnecessarily staying in hospital to 5%.

Key measures for planned care
- ✓ eliminate all waits over 78 weeks
- ✓ reduce waits over 65 weeks to 1,091
- ✓ diagnose 75% of GP-referred patients within 28 days
- ✓ reduce the number of cancer patients waiting over 62 days to 138.

In concert with the above, we will deliver the following improvement measures in collaboration with Devon partners:
- ✓ develop a shared control centre for urgent and emergency care to balance pressure and resources across organisations
- ✓ expand use of virtual wards to manage patient care remotely so that more people can stay at home
- ✓ further develop our frailty and fall services to improve outcomes and experience for people
- ✓ implement a Devon-wide waiting list system that will allow organisations to see people more equitably across different areas
- ✓ develop more advice and guidance services associated with patient-initiated follow-ups
- ✓ improve quality of and access to primary care services.

Quality priority two: achieve sustained improvements against 2022/23 priorities

We recognise that there is more we must do to ensure we sustain current performance and improvement achieved this year around sepsis, deteriorating patient, experience of patient on discharge, falls reduction and risk assessments.

In 2023//24 we will continue our improvement journey against the four quality improvements set out in 2022/23, specifically focusing on:
- ✓ we will roll out the sepsis bundle audit framework across our services and improve compliance within our emergency department, rolling out our new policy in June 2023
- ✓ we will remain focused on the fundamentals of care with a view to improving on the timeless of risk assessments and strengthening the safe bundle to ensure a greater compliance with lying and standing blood pressure
- ✓ we will roll out the early warning score escalation audit across all departments to ensure we are consistently confident that timely and safe escalation takes place when a person's condition deteriorates.

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Quality priority three: enhance the experience of people who use our services with focus on leaving hospital

In 2023/24, we will continue to enhance the experience of people who use our services wherever their care may be delivered across acute and community services. This will involve responding to what patients have told us about their care.

In 2022/23, people told us that their care needs to be more personalised. As part of our wider personalisation agenda across we will take steps to ensure that care plans are personalised. We will work with colleagues across health and social care to

ensure a continued focus on care provider quality and the ability of providers yo deliver continually on person centred care following discharge.

There will be a focused improvement program across our care of the elderly wards and we will make better use of the environment to ensure that we are responding to the needs of our most vulnerable and frail patients through a focused program of work around dementia care. This work will be mapped through a newly established 'care of the elderly, excellence in care group'.

In addition to the priorities set out above, we will continue with our focus on delivery of the national patient safety strategy, ensuring that the role of patient safety leader is rolled out in 2023/24.

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:
- ✓ our Board of Directors, 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 2022/23 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.

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

During 2022/23, **41** national clinical audits and **three** national confidential enquiries covered relevant health services that we provide.

During this period, we participated in **95**% 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 2022/23 follow.

Participation in national clinical audits and confidential enquiries

National audits	Eligibility	Participation
Breast and cosmetic implant registry (BCIR)	Yes	Yes
Case mix programme (CMP)	Yes	Yes
Child health clinical outcome review (NCEPOD)	Yes	Yes
Cleft registry and audit network database	No	N/A
Elective surgery (national PROMS programme)	Yes	Yes
Emergency medicine QIPs (RCEM)	Yes	Yes
Epilepsy 12	Yes	Yes
Falls and fragility fracture audit programme (FFFAP)	Yes	Yes
National gastro-intestinal cancer programme	Yes	Yes
Inflammatory bowel disease (IBD) audit	Yes	N/P
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	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
Muscle invasive bladder cancer audit	Yes	Yes
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 bariatric surgery registry	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 early inflammatory arthritis audit (NEIAA)	Yes	Yes
National emergency laparotomy audit (NELA)	Yes	Yes
National joint registry	Yes	Yes
National lung cancer audit (NLCA)	Yes	Yes
National maternity and perinatal audit	Yes	Yes
National neonatal audit programme (NNAP)	Yes	Yes
National obesity audit	Yes	Yes
National ophthalmology database	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
Renal audits	No	N/A
Respiratory audits	Yes	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
The trauma audit and research network (TARN)	Yes	Yes
UK cystic fibrosis registry	No	N/A
UK Parkinson's audit	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 we participated in, and for which data collection was completed during 2022/23, 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
Breast and cosmetic implant registry	N/A	
Case mix programme (CMP)	N/A	
Elective surgery (national PROMS programme)	N/A	
Emergency medicine QIPs (RCEM)	N/A	
Epilepsy 12 - national clinical audit of seizures and epilepsies for children and young people	N/A	
Falls and fragility fracture audit programme (FFFAP) • national audit of inpatient falls • national hip fracture database	N/A 442	 100
National gastro-intestinal cancer programme • national oesophago-gastric cancer • national bowel cancer audit	 131 196	 100 100
LeDeR – learning from lives and deaths of people with a learning disability and autistic people	N/A	
Maternal and newborn infant clinical outcome review programme	N/A	
National adult diabetes audit • national diabetes core audit • national pregnancy in diabetes audit • national diabetes footcare audit • national diabetes in-patient audit – harms	N/A	
National asthma and chronic obstructive pulmonary disease (COPD) audit programme • pulmonary rehabilitation – organisational and clinical audit	 1	 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 cardiac arrest audit (NCAA)	N/A	
National cardiac audit programme (NCAP) • myocardial ischaemia national audit project • national heart failure audit	 287 397	 100 100
National child mortality database	N/A	
National early inflammatory arthritis audit (NEIAA)	N/A	
National emergency laparotomy audit (NELA)	147	100
National joint registry		100
National lung cancer audit (NLCA)	219	100
National maternity and perinatal audit	N/A	
National neonatal audit programme (NNAP)	N/A	
National ophthalmology database	N/A	
National paediatric diabetes audit (NPDA)	146	100
National perinatal mortality review tool	N/A	
National prostate cancer audit (NPCA)	253	100

National vascular registry	N/A	
Sentinel stroke national audit programme (SSNAP)		100
Serious hazards of transfusion scheme (SHOT)	N/A	
Society for acute medicine benchmarking audit (SAMBA)	N/A	

The trauma audit and research network (TARN)
   1. Clinical Report Issue 1 - Thoracic & abdominal injuries
   2. Clinical Report Issue 2 - Orthopaedic Injuries
   3. Clinical Report Issue 3 - Head & Spinal Injuries
	
	632
	
	476
		
		100
		100
		100

Patient outcome programme incorporating national confidential enquires	Eligibility	Participation
Child health clinical outcome review programme (NCEPOD)	N/A	
Medical and surgical clinical outcome review programme (NCEPOD) 1. NCEPOD epilepsy study	 4	 75

OUR RESPONSE TO THE FINDINGS OF CLINICAL AUDITS

We reviewed the reports of **30** national clinical audits in 2022/2023 and we intend to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions
0975 (falls and fragility fracture audit programme (FFFAP)) - national hip fracture database	
Less than 90% of patients mobilised day one post-operative An audit was completed in January 2023 to identify reasons why patients were unable to mobilise on day postoperatively. Data of ambulance waiting times was not available as this had never before been recorded. An audit was conducted in December 2022 to ascertain current waiting times for ambulances.	
0939 (National cardiac audit programme) (MINAP) acute coronary syndrome or acute myocardial infarction	
Review accuracy of the diagnosis of NSTEMI as there may be imprecision in the differentiation between type one and type two myocardial infarction. In order to ensure the completeness and correctness of our data a review of our raw MINAP data is planned. This action was completed in November 2022 We do not record wire time crossing. For future reference we will therefore record the wire crossing time (WCT), which will improve our figures. We will also look at whole process from arrival at the hospital until wire crossing to enhance our performance. This action was completed in November 2022	
1000 (National cardiac audit programme) (MINAP) acute coronary syndrome or acute myocardial infarction	
Door-to-balloon time above national average. Collect and monitor data of door-to-balloon time and use the data and identify and reduce delays by December 2023. Aldosterone antagonists following STEMI with HFrEF Collect and monitor data of aldosterone antagonists usage following STEMI with HFrEF, to identify reasons and increase usage of MRA (Mineralocorticoid receptor antagonists) from current baseline by December 2023.	
1004 (National cardiac audit programme) heart failure audit	
Collect and monitor data of follow-up arrangements for referrals to cardiology (currently 44.5%)/ specialist heart failure nurse (currently 60.2%) to work towards increasing the referral rate from current baseline by September 2023. Collect and review cardiac rehabilitation (currently 32.1% -) and work towards reducing to national level of 12.1% by September 2023 Recruitment of a further heart failure consultant is underway - we are awaiting outcome of funding for a further heart failure specialist nurse and rehab nurse.	
1003 (National cardiac audit programme) national audit of percutaneous coronary interventions (PCI)	
Non-universal use of intravascular ultrasound (IVUS) for left main stem (LMS) PCI. Conduct an audit on use of IVUS on LMS PCI cases and share results with cardiology by 31 August 2024.	

0989   (NBACOP) National audit of breast cancer in older patients
The reporting of tumour size and Her 2 status is low (and 0% in the over 80 group).
The surgical figure for > 80% for ductal carcinoma in situ (DCIS) is given as 0% cf 60% for the rest of country. To be monitored to determine accuracy.
No use of bisphosphonates in 80+ age group (cf 24% across other units) and 3% in 50-69 year age group compared with 19% across other trusts.
Review of current data as data from NABCOP two years out of date and not in line with current practice. to monitor current practice by 01 February 2023.
Use of Her 2 directed chemotherapy was lower in the 80+ age group compared with national average (26% vs 37%).
DXT in DCIS post-surgery 39% vs 46% nationally in 70+ age group. This has not been achieved duty to the clinical area not having a designated an audit lead
Absence of frailty status and mental capacity score in patients over 70. All patients over 70 diagnosed with breast cancer to be assessed in clinic/ pre-op assessment – standard operating procedure (SOP) in process of being written.

36 (NCMD) National child mortality database programme - suicide in children and young people

Review existing national policies and guidance to improve awareness of the possibility of child suicide. Following possible emergency department presentation/ admission to children's ward review existing paediatric liaison standard operating procedures by December 2022.
Assess the risk of suicide for children and young people experiencing bullying, when and under what circumstances multiagency meetings to be called to discuss individuals – following possible emergency department presentation/ admission to children's ward making a MASH (Multi Agency Safeguarding Team) referral by December 2022.Review local policies on information sharing and escalation to ensure children and young people at risk of suicide can be identified and supported - following possible emergency department presentation/ admission to children's ward review existing paediatric liaison standard operating procedures.
Revised guidance to schools on the use of exclusion risking fracture of relationships with universal services - education's notification to public health nursing.

1005 (NCMD) National child mortality database programme

Non-joint agency response cases, trust to have single point of contact to liaise with bereaved families. To identify clinical professional to act as single point of contact to liaise with bereaved families whilst investigations including internal reviews are carried out and to explain CDOP (child death overview panel) processes by January 2023. This has now been completed
Following CDRMs (child death review meeting) at tertiary hospitals, analysis and actions completed during meeting to be shared for local learning.

On notification of a CDRM date from tertiary hospital child death review coordinator would inform tertiary hospital of professionals involved including social care and request tertiary by January 2023. This has now been completed.
Child death review coordinator to share final paperwork from CDRM for local learning, chase if necessary post meeting by January 2023. This has now been completed.

1007 (NEIAA) National early inflammatory arthritis audit

Insufficient patient recruitment into audit. Implement systems to improve data uploading on the audit webpage by 30 April 2023.

This may require dedicated staff to chase and upload data, including follow-up date for recruited patients. This remains ongoing.

0905 (NNAP) National neonatal audit programme

Improve breastfeeding rates at discharge by 01 December 2022.

This is now complete and latest data demonstrates that there has been an increase noted in breast feeding rates on discharge.

1012 (NNAP) National neonatal audit programme

Optimal cord clamping - re-launch optimal cord clamping through induction of middle grade and paediatric doctors and improve compliance by 01 April 2023.
Simulation of multi-disciplinary team optimal cord care. This plan is now completed.

0941 (NPDA) National paediatrics diabetes audit - spotlight audit report on type 2 diabetes

Review current pathway to ensure all parts of the process contribute towards supporting positive patient outcomes within diabetic and psychology resources currently available by 31 October 2022. This is now completed.

0750 (RCEM) Fractured neck of femur

Implement the Abbey pain tool by conducting presentations, displaying posters to triage to the nursing and medical team by 30 April 2023

Collect and analyse data for Fascia Iliaca block and effectiveness of pain management by 31 January 2023.

Conduct and complete an audit regarding time to x-ray for all ?fractured neck of femur. cases by 30 June 2023.

0751   (RCEM) Pain in children
Complete a local re-audit to monitor current compliance of pain management in children by 30 April 2023. This remains ongoing.
0877   (SAMBA) Society for acute medicine benchmarking audit
SAMBA gives us snapshot data from 24 hours only. We still have no real time data to allow us to benchmark our performance over the other 364 days in the year. We have been asking for this data for at least three years but our systems have not supported its collection. Ongoing meetings between acute medicine team and performance department in order to create a dashboard/ interactive performance report which we can interrogate on a weekly or monthly basis. Once we have better data, we can identify our performance issues more accurately and decide what action is required to improve performance.

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

To increase number of trained staff who are involved in reviewing and investigating blood transfusion related incidents by 31 December 2023.
Review local training to ensure a comprehensive training package to include inclusion of indications for use of emergency Group O red cells current, transfusion essential for paediatric patients and appropriate rates of infusion by December 2023.
Review current staff who authorise paediatric transfusions to ensure they are appropriately trained by December 2023.

1026   (SSNAP) Stroke care - sentinel stroke national audit programme - mimic audit 2021 short   report
0704   (SSNAP) Stroke care - SSNAP - organisational
0948   (SSNAP) Stroke care - SSNAP - post-acute organisational
0729   (SSNAP) Stroke care - sixth SSNAP annual report
0914   (SSNAP) Stroke care - eighth SSNAP annual report
1025   (SSNAP) Stroke care - SSNAP - acute organisational audit

Full/detailed action plan embedded below.

0964   National asthma and COPD audit programme (NACAP) - child and young person asthma organisational audit

Review respiratory nurse specialist requirements and current nursing expertise available within service in the team by 02 August 2023.

0992   National audit of care at the end of life (NACEL)

Quality improvement project initiated to review staff confidence in talking to patients and families about the risks and benefits of food and fluids at the end of life
Complete audit of notes of patients on end of life care plans to identify whether conversations had. Online Torbay junior doctor survey conducted to ascertain their views and concerns in end of life care.

Both completed by October 2022.

0982   National diabetes audit programme - national diabetes foot care audit

Face to face education workshop for primary care staff to be developed by February 2023.
Action is now completed.

0875   National gastro-intestinal cancer programme - bowel cancer

CNS (clinical nurse specialist) business case - submit business case for additional CNS support.
workforce planning.
Meeting with two-week wait numbers, cancer operation numbers, waiting list numbers.

0976   National gastro-intestinal cancer programme – bowel cancer

Workforce - clinical nurse specialist (CNS) current funded workforce is unable to meet the required level of service. To prepare a business case for submission to secure funding to recruit additional CNS by 30 September 2022.

MMR/ MSI sent at diagnosis.
Ensure biopsies are sent and recorded.
Undertake an audit to review compliance of genetic tumour profiling for all patients with stage IV disease by 30 September 2022. Plan is ongoing.

0876 National gastro-intestinal cancer programme - oesophago-gastric cancer
Request for increased resource and support for accurate data submission including prospective clinician validation of the data. Higher than average rate of diagnosis after an emergency admission. Examine performance against an area with similar demographics and consider targeted intervention to reduce rates of emergency admission by 30 November 2022. Lower than average rates of curative treatment offered to patients with stage 0-3 disease. Audit patients with stage 0-3 disease to determine which patients are being offered curative treatment and the drivers for this by 30 November 2023.

0959 NPDA (RCPH national paediatric diabetes audit)
Reduce the number of Children and Young People with HbA1c greater than 80mmol/mol by 25 April 2023. Develop a package of enhanced care and support for those with HbA1c greater than 80mmol/mol by 25 April 2023.

0925 Rapid diagnostic services - bladder pathway
Improvement in two-week wait time to be first seen. Re-audit by 31 December 2022 Improvement in % hitting 28-day target to TURBT (trans urethral resection of bladder tumour) - Re-audit by 31 December 2022.

Action plans provided for context:
- ND1037 - (SHOT) Serious hazards of transfusion: UK national haemovigilance scheme.
- (SSNAP) Stroke care - sentinel stroke national audit programme – ND0948 refers to all of the above stroke action plans.

We reviewed the reports of **three** national confidential enquiries in 2022/2023 and intend to take the following actions to improve the quality of healthcare provided.

0942 (MBRRACE-UK) - Saving lives, improving mothers care - core report: lessons learned to inform maternity care from the UK and Ireland confidential enquiries into maternal deaths and morbidity 2017-19
Complete an audit of previous cancer cases of active and prior cancers of all types to check compliance with OM Care and MDT, including timing of appointments by 30 September 2022. Update pending. Undertake an audit/quality improvement for contraception advice for women of child bearing age with cancer. Review/ create radiology imaging in pregnancy guidance. Review admission under other specialities pathway - to include red flags (not just cancer ones) and signpost RCP 15 document. Red flag symptoms and signs added to junior inductions ready for August 2022 intake. Departmental teaching on red flags - plan session and make part of curriculum for each rotation.

Discuss with medical teaching to see if a session is planned this year for core medical trainees. Update presentation to ensure red flags included.

0611   (NCEPOD) Bowel obstruction study

Timely access to a CEPOD list or have/ produce a dedicated general surgery emergency list by 01 February 2023. This is ongoing.

0608   MBRRACE-UK perinatal confidential enquiry - stillbirths and neonatal deaths in twin pregnancies

Update local guidance on multiple pregnancies to include learning from MBRRACE report by 30 June 2023.

We reviewed the reports of **48** local clinical audits in 2022/23 and we intend to take the following actions to improve the quality of healthcare provided.

Ref   Recommendations / actions
6073   Recording clinical evaluations and patient dose for Ionising radiation (medical exposure) regulations (IR(ME)R) for endoscopy (2021)
Clinical evaluations: decision to use radiology information system (CRIS) or endoscopy management system (EMS) needs to be made.   Staff reminded of the importance of cancelling an episode on CRIS if it has not taken place.   Consultants reminded about recording the screening time, dose, dose type and formal report.
6625   Improving the frequency and accuracy of preoperative radiographic markers (templating) for neck of femur fractures
Poster template for marker placement to be introduced in x-ray rooms.   Reiterate the importance of templating for hemiarthroplasties during meeting   Raise awareness with radiographers to ensure they capture enough of the shaft on the views   Demonstrate to colleagues how to use acetates or 'orthaview' to improve compliance with saving templating through education session
6646 Venous thromboembolism (VTE) assessment and prescription in surgical patients
Present to general surgery morbidity and mortality (M&M) for discussion and reminder of requirements   Discussion at Band 7 nurses meeting to highlight findings and encourage nursing staff to engage with/ remind doctors of requirements on the ward. Ward audits will now include prescriptions as well as assessments.   Presentation at new surgical doctor's induction to highlight results and remind of requirements.   Alteration of the surgical ward round proforma document to include a VTE checkbox.
6656   Tonsillitis pathway
Present results to emergency department and offer/ provide training as necessary.   Distribute new management workflow process around the department.
6657 Fluoroscopy guided musculoskeletal (MSK) intervention consent
The lead MSK consultant to discuss the results with all physicians   The MSK practitioners who scored well below the expected 95% written consent score were given a reminder on ensuring that the consent forms are to be correctly completed in the future.

6660 Time to triage for babies under six months attending emergency department

Promote documentation of gestational age to reception staff via poster
To make a simple additional question on Symphony if any child less than six months books in – ask whether they were premature or in SCBU so that they are then flagged.

6682 Consenting for head and neck skin cancer surgery

Produce a 'bespoke' consent.

6683 Oral and maxillo-facial surgery inpatient record keeping

Implementation of an 'inpatient note keeping/ recording' example in the dental core trainee handbook to understand key areas required for notes to meet standard
Implementation of 'roles' on ward rounds in order to streamline note taking process with greater focus on content.
Clinician stamps for junior colleagues; containing name in capitals, GDC number and designation.

6684 Management of gallbladder polyps

There needs to be discussion across the department regarding;
- confirming a consensus for approach and
- consideration of the creation of a Torbay and South Devon local guideline or distribution of the national ESGAR guideline
This has not successfully produced a consensus so audit mark project as 'not for re-audit'.

6700 Breast pain clinic

Healthcare innovations: to assess, on a regional level, short MDT videos and breast pain leaflets to raise awareness with GPs
Investigate providing GP teaching sessions for breast pain and family history clinics, also promote GP champions in each practice.

6710 Adherence to alcohol withdrawal management plans

Alcohol withdrawal management policy to be re-written

6711 Post natal contraception counselling and prescribing

Commence a quality improvement project to look at increasing contraception counselling, to include a staff survey to assess current staff knowledge
Look to introduce a new patient group direction (PGD) for midwives to be able to prescribe the mini pill.

6712 Effectiveness of referral and referral outcomes to the preterm birth clinic

Introduction of risk assessment for preterm birth (as a proforma to be built into 'SystmOne') for all women at their booking appointment
Review administration process for referrals to preterm birth clinic for appropriate women.

6713 Assessment of care provided to pregnant women with moderate and high risk for growth restriction

Review small gestational age policy to include recommendations from saving babies lives 2, including a revised scanning schedule
Presentation to be shared with all midwives at maternity services meeting
Take to clinical governance meeting
Explore the need for a business case to train sonographers for uterine artery doppler scanning

Consider update to 'SystemOne' re hypertensive disease wording (re decision to restrict the classification looking at previous pre-eclampsia or gestational hypertension with small baby, rather than all with previous hypertensive disorders).

6714 Learning from COVID-related maternal deaths

Agreement that all women who are symptomatic with COVID need to be seen daily by a consultant (not asymptomatic screen positive).
Disseminate requirements for consultant review.
Disseminate results to raise awareness of VTE requirements and oxygen saturation on admission (or diagnosis if detected on screening).

6715 Ankle fracture management using orthopathways (OP) in Newton Abbot Minor Injuries Unit (MIU)

Agreement made to trial OP in Newton Abbot MIU

6717 Management of prosthetic joint infection in knee replacements

Need to standardise local management pathway - staff to contact lead knee consultants for local MDT.
Education of local team members for local management pathway and national guideline.
Complex cases should be discussed in South West Regional Knee MDT - new regional MDT forms needed for communication.
Review complex cases to determine why so many are not being discussed with regional MDT, clarify if they were true complex cases.
Ensure 'low markers' are audited.

6720 Head and neck skin cancer record keeping

Discuss/ Share results with relevant/ involved clinicians.
Design and trial/ pilot a record keeping pro-forma for new skin cancer patients.
Adjust pro-forma post trial/ pilot (interim measure).
Introduce final version of pro-forma.
Complete pro-forma registration/ review with health records committee.

6723 WHO surgical checklist

Assemble a multidisciplinary working group to look at the five parts of the WHO checklist.
Relaunch WHO checklist once reviewed and updated by working group.
Present audit findings to other speciality meetings.

6725 Shoulder x-rays (XR) and follow up within Paignton musculoskeletal (MSK) physiotherapy clinic

MSK team agreed best practice is to continue to insist that the patient is going for an XR, the patient needs to touch base with us post imaging.
Emphasis for physio to insist to patient to book in via booking team with physio post XR.

6729 'Are we meeting national standards for consultant-led care of gynaecology inpatients?'

Move to portal 2 for handover to allow increased functionality.

6733 Venous Thromboembolism (VTE) assessment in trauma admissions

Complete roll out of clinical portal (CP) 2.0 features – VTE risk assessment boxes to appear on

handover sheets.
Education within department highlighting need for VTE assessments and new prompt box on CP handover sheets.
To re-introduce yellow ward sheets.

6736 Anaesthesia record keeping
Introduction of 'red top' inpatient anaesthetic charts to be the standard method of pre-operative assessment in day surgery

6737 Evaluating whether heart failure patients with reduced ejection fraction and iron deficiency are being adequately managed with iron infusions
Produce management of iron deficiency poster for in patient areas

6741 Time to clinical review and treatment of nasal fractures
Look into causes for delayed referral to e-clinic for nasal fracture
Produce, publish and introduce a nasal fracture leaflet for emergency department presentations

6746 Smoking cessation identification and prescribing
Teaching session to be delivered to AMU medical staff regarding Nicotine replacement therapy prescription.
Introduction of in-patient smoking cessation service.
Change medical patient admission documentation to better document smoking status.

6749 Revision Total Hip Replacements including periprosthetic hip fractures (PPF) multidisciplinary team (MDT) discussions
MDT documentation, especially pertaining to PPF needs improving
Develop new database to record MDT discussion/ decisions.

6751 Post-operative venous thromboembolism (VTE) prophylaxis for orthopaedic trauma patients
Introduce new VTE policy for low-molecular-weight heparins while inpatient, followed by oral Rivaroxaban 10mg once a day (OD) on discharge.

6758 Dysphagia care plan compliance
Ward based catering staff to take on role of thickening drinks – thickener tubs can then remain on the drinks trolley not tables and drinks are correct at the point of delivery improving standards.
Dysphagia e-Learning programme undertaken by (average) of 70% of ward staff across in-patients.
Flowchart for appropriate spout usage alongside raising awareness of dangers/ downsides of widespread spout usage.

6761 Assisted vaginal birth – 2020
Feedback re removal of catheters first thing in the morning rather than after 12 hours.
Reminder to document trial without catheter (TWOC) timing, first pass urine and volume passed.

6767 Aspirin prescribing in high risk pregnancy
Women who need to see a specific consultant to be booked for their first trimester screening clinic (FTSC) scan before 13 weeks. This will allow prescription of aspirin at the optimum time

and a separate consultant appointment can be booked if unable to schedule at the same time.

6768 Management of diabetes ketoacidosis (DKA) on Forrest ward

Undertake junior doctor and nurse teaching on Forrest ward regarding fluid prescription and venous blood gas, boehringer mannheim (BM) and ketones as recommended by our guidelines. Diabetes specialist nurses have provided some teaching to emergency department nurses regarding DKA.
To provide teaching to junior doctor teaching on acute medicine.
New proposed ideas about modifying fluid charts for DKA (adding long acting insulin prescription box, adding 10% glucose prescriptions if BM< 14 etc).

6675 Lymphoedema patients having a second appointment within one month of their first assessment

Take to internal MDT to brainstorm ideas to improve this outcome and find a way forward for the service.

6765 CX3 (highly suggestive of lung cancer) chest x-ray (CXR) code compliance

Staff reminded about usage of CX3 code in radiology audit meeting

6721 Intravenous (IV) methylprednisolone for patients with giant cell arteritis (GCA)

Creation of a clear guideline for staff to follow when booking patients in for IV methylprednisolone.
To have a consistent method of informing the GP about the infusions. Introduce a universal form that can be filled in by nursing staff after completion of treatment in both TAIRU and by MAAT.
Liaise with TAIRU and MAAT team about the current process to identify why TAIRU have difficulty fitting in patients for methylprednisolone infusion.
To improve patient sample number for future audits, we will start to record using the biologic tracker on Infoflex.

6726 Venous Thromboembolism (VTE) prophylaxis for Turner Ward

Encourage VTE documentation during board rounds?
Investigate e-Learning module on VTE prophylaxis?
Investigate changes to the prescription chart i.e.
- keeping VTE risk assessment (RA) on the front page(s) may improve VTE RA uptake on the admission as well as recording at 24 hours
- moving the time of administering thromboprophylaxis (Fragmin) to the mid-day can allow nurses discussing with junior doctors if VTE RA is not recorded.

6704 Enteral feeding of infants

Ensure a growth chart is in the notes from admission, and for this to become a part of an 'admission pack'.
Reinforce the weekly routine whereby babies have routine blood tests on a Tuesday and the Wednesday ward round has nutrition emphasis. Babies should be plotted by medical team weekly and discuss any concerns with a dietitian.
A laminated weekly ward round routine to be placed in special care baby unit (SCBU).
Review enteral feeding guideline to make advice on formula and nutritional supplements clear.
Categorise the babies according to traffic light system and collect the data and type of milk according to that.
Reinforce documentation of breastfeeding advice was given, including the babies admitted to SCBU even on intravenous (IV) fluids.

6730 Juvenile idiopathic arthritis (JIA): joint injection to physiotherapy

Commence MDT clinic with paediatric physiotherapy involvement.

6716 Management of progesterone-only-implants within Torbay Devon Sexual Health Service

During meeting all clinicians were advised of the MHRA reporting scheme and how to access it to report deep/ broken implants.

Re-write implant template – currently there are five different templates – aim to reduce template for counselling/ fit/ follow up.

Once the new template has been produced, discuss at contraception meeting.

Documentation of standard fit site – this will be built into new template with space to document if fitted at alternate site with reason why.

Pregnancy testing at baseline – discuss at contraception meeting what we want to aim for since this point is debatable and practice may differ.

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

6666 Assessment of outcomes of meta-tarsal joint (MTPJ) fusions
6672 Review of breast cancer screening assessment against national breast screening standards (NBSS)
6719 Symptomatic breast imaging protocol (2020)
6722 Paediatric coeliac disease service
6724 Induction of labour (IOL): vaginal birth after caesarean (VBAC) and second option
6727 Are plain abdominal x-ray (AXR) clinical details in line with best practice guidelines?
6728 Secondary intraocular lens (IOL) outcomes
6740 Clinical appropriateness for referral to the emergency ENT clinic
6747 Bladder complications following day-case prolapse procedures.

RESEARCH

The number of patients receiving relevant health services provided or sub-contracted us in 2022/23 that were recruited during that period to participate in research approved by the NHS Ethics / Health Research Authority (HRA) was 2,476.

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)

We are required to register with the Care Quality Commission (CQC) to provide care and our current registration is to be able to deliver the following regulated activities:
- ✓ assessment or medical treatment for persons detained under the Mental Health Act 1983
- ✓ diagnostic and screening procedures
- ✓ family planning
- ✓ management of supply of blood and blood derived products
- ✓ maternity and midwifery services
- ✓ personal care
- ✓ surgical procedures
- ✓ termination of pregnancies
- ✓ transport services, triage and medical advice provided remotely
- ✓ treatment of disease, disorder or injury.

We have no conditions or restrictions attached to our registration.

During the reporting period 2022/23, we had no formal CQC inspections but continued to work in partnership with the CQC via our regular planned contact. This scheduled activity includes our monthly CQC meetings with our local inspector and inspection manager as well as the quarterly engagement meetings. These meetings have executive involvement and are a good vehicle for open discussion and sharing between ourselves and the CQC.

We also continued our audit and assurance work to ensure risk assessments were completed for each patient within 24 hours of admission to hospital and in line with our policy.

The audits also reviewed the documentation to ensure detailed, clear and up-to-date nursing records were recorded. as well as patients who required additional support with nutrition and hydration were quickly identified and appropriate actions taken.

We also ensured the results of the audits were reviewed and acted upon appropriately and reported on at an integrated service unit (ISU) level, as well as at the nutritional steering group and by exception to the quality improvement group.

Our current CQC ratings are shown in the table below:

Overview and CQC inspection ratings		
Overall **Good**	Safe	Requires improvement ●
	Effective	Good ●
	Caring	Outstanding ☆
	Responsive	Good ●
Read overall summary	Well-led	Good ●
Use of Resources		Requires improvement ●

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

We have not participated in any special reviews or investigations by the CQC during the 2022/23 reporting period.

DATA QUALITY AND INFORMATION GOVERNANCE

We submitted records during 2022/23 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 ten data security standards. All standards were met in 2022/23.

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)
92.23	70.26	93.67	93.41

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 the Board of Directors 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 is above the expected level of 100 for our population. The rolling 12-month position exceeded the expected range for the 12-months to December 2022 with a relative risk of 111.5 against a 100 benchmark. The rolling 12- month trend shows that the HSMR became statistically higher than expected in July 2021. The last eight data points have remained stable with a slight downward trend. Our HSMR is one of 11 trusts in our peer comparator which are statistically higher than expected out of 20 trusts. The increase in HSMR over the last two years is broadly in line with the trend of increase in HSMR seen by our similar peers.

The factors affecting HSMR have been considered. We have a lower Charlson co-morbidity of 20+ and overall we report a higher percentage of spells in the 'symptoms and signs' chapter (9.0% v 7.5% national). This may impact by reducing the overall expected mortality rate. We have a greater proportion of patients in the higher deprivation quintiles compared to regional peers. Higher deprivation is known to contribute to poorer health outcomes and shorter life expectancy. Our patients are older than the peer average which might result in a greater number of observed deaths.

The higher than expected HSMR is subject to a mortality improvement plan to consider all aspects which impact on HSMR including coding, patient mix and process of care.

The patient safety team has investigated 30 day mortality in patients admitted as an emergency comparing October 2019 figures with those in October 2022. Elderly and frail emergency patients appear particularly sensitive to the adverse effects of waiting for a definitive in-patient bed.

Focused work continues on provision of alternatives to admission by working with frailty teams in the community and acute hospital and the development of virtual wards

Analysis of the standardised hospital mortality index (SHMI) includes deaths occurring in hospital and up to 30 days after discharge. Our SHMI is 1.03 which is as expected.

Medical Examiners now provide scrutiny of all inpatient deaths in the acute and community hospitals and we are rolling out into the community setting in readiness for the commencement of statutory scrutiny in April 2024.

The learning disabilities mortality review (LeDeR) programme requires an independent case review following the deaths of people with learning disabilities. All deaths involving patients with a learning disability are reviewed through the LeDeR process. We have created a new LeDeR process which has established close interaction monthly with the regional LeDeR team. A review of the last two years deaths has been undertaken and is summarised in table 7 on the next page.

Table 7 – summary of LeDer referrals

Year	Review undertaken – o formal diagnosis of LD. Closed with no outcome	Reviews undertaken – closed with outcomes and learning provided	Awaiting LeDeR review outcomes
2021 / 2022	4	5	5
2022 / 2023	4	1	7

Of the reviews resulting in outcomes [all five] in 2022 / 2023no lapses in care were identified therefor no specific action plans relating to clinical improvements, however dissemination of learning did take place with regard to:
- Use of Patient Passport
- Care and Communication
- Liaison with the LD team
- Personalised Care Plans

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 2022/23, 1,456 of our adult patients died in the acute hospital. This includes the Emergency department. This comprised the following number of deaths which occurred in each quarter of that reporting period: • 339 in the first quarter • 308 in the second quarter • 418 in the third quarter • 391 in the fourth quarter.
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	During 2022/23, 1406 case record reviews have been carried out by the Medical Examiners in relation to the number of the deaths included above. This comprised the following number of case scrutiny which occurred in each quarter of that reporting period: • 297 in the first quarter • 300 in the second quarter • 418 in the third quarter • 391 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	During 2022/23, 12 cases for which the outcome was death were reported on the strategic executive information system (STEIS). All these

	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.	incidents had reports produced which were communicated to NHS Devon and discussed at our 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 anticoagulants on care planning summaries to prevent stroke • recognition of deteriorating patient with sepsis • alcohol withdrawal and myocardial infarction • administration of time critical medication to prevent fitting • risks of patients held in ambulances awaiting admission to ED • diagnosis and treatment of meningo-encephalitis in children • recognition and response to post-operative peritonitis • urosepsis in cystectomy patient with solitary kidney and renal stone – delays in non-cancer urology surgery • recognition of the complications of head injury in alcoholic patients • incarcerated hernia in palliative patient • GI bleed led to fall and death in community hospital due to chronic sub dural • understanding of multi-disciplinary nature of child death process.
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 • focus on management of frail and elderly in urgent and emergency care • focus on sepsis and deteriorating patient via appropriate patient safety groups.
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.	• changing focus on patient incident investigation to ensure just culture and thematic review • wider recognition of vulnerability of frail and elderly patients to the effects of prolonged waits 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.	Zero.
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.	Not applicable.
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 2022/23, 12 cases for which the outcome was death were reported on the strategic executive information system (STEIS). All these incidents had reports produced which were communicated to NHS Devon and discussed at our serious adverse event group which meets on a monthly basis.

2.3 CORE INDICATORS
Performance in 2022/23
In addition to reporting performance against the statutory indicators for regulatory assessment a range of further quality indicators are reported to our Board of Directors.

Other national and local indicators	Quality indicator	Target 2022/23	2022/23	2021/22	2020/21	2019/20
DNA rate* HES data	Effectiveness	5%	5.2%	5.6%	5.1%	5.1%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	57.5%	54.8%	77.3%	90.2%
Two-hour urgent community response	Effectiveness	70%	80%			
Mixed sex accommodation breaches of standard	Experience	0	0	0	0	0
52-week referral to treatment incomplete pathways year end position	Experience	0	4427	3,199	2,049	53
Cancelled operations on the day of surgery	Experience	<0.8%	1.5%	1.5%	1.5%	1.3%
Never events	Safety	0	3	0	4	2
Cancer 28-day Faster Diagnosis	Effectiveness	75%	70.7%	67.6%	75.6%	74%
Diagnostic waits greater than six weeks	Effectiveness	25% in 22/23	31.2%	34.8%	42.1%	11.5%

Plans for 2023/24

Looking ahead we have improvement plans to meet the challenges to deliver quality and timely access to our acute and community services. Recovery from the impact of the COVID-19 pandemic continues to see improvements in capacity and activity levels. There remains significant challenges to meet 2023/24 Operating Plan targets to:
- ✓ reduce waiting times for treatment (no patient waiting over 65-weeks)
- ✓ reduce patient delays in the urgent and emergency care setting;
- ✓ reduce long length of stay in acute and community beds;
- ✓ increase the provision of intermediate care to support patient discharge and to help people stay in their homes where appropriate.

In 2023/24, we will continue the work started in 2022/23 to develop one plan that brings together key elements and will focus on:
- ✓ quality and safety for people who use our services and our people
- ✓ cost improvement initiatives – affordability and sustainability
- ✓ innovation and improvement for performance and productivity.

This will require a combination of fully utilising and ensuring efficiency in our estate, engaging with clinicians to improve pathways of care for patients, recruitment to key clinical vacancies, using available investments to ensure our population are receiving better health and care and building on new ways of delivering services including remote consultations and patient-initiated care. We will also work collaboratively with the rest of the integrated care system for Devon to deliver services against a system oversight framework with regular scrutiny and monitoring by NHS England.

3   OTHER INFORMATION

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 2022/23 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 2022/23 we commenced a phased programme of work to proactively reshape our structure in response to societal changes, enhancing what works well and developing improved ways to respond to our challenges.

The first phase, completed in 2022/23, was to remove the two population-based systems and introduce three care pathway groups under which our integrated service units sit:
- ✓ Families and communities, comprising:
  - Torquay locality
  - Moor to Sea locality
- ✓ Medicine and emergency care, comprising:
  - Newton Abbot locality
  - Hospital operations team
- ✓ Planned care, comprising:
  - Paignton and Brixham locality
  - Coastal locality.

Our governance process sees our integrated service units hold their teams to account through monthly integrated service unit meetings. The integrated service units report each month into director led care group integrated governance meetings which provides updates on operational delivery and any risks to the executive team at the trust management group.

Our trust Management group then informs the various sub-committees of our Board of Directors of any items for escalation.

National standards

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

2022/23 has been a challenging year for us with ongoing recovery from the COVID-19 pandemic. Workforce and estates capacity, along with other factors, resulted in a lower level of clinical activity than planned which impacted on elective performance and saw waiting lists climb. Across urgent and emergency care performance, patient flow was the main operational challenge resulting in increased length of stay and frequently having our emergency department and assessment units at full capacity. The four-hour standard and ambulance handover delays did not meet planned levels of performance.

Along with other providers in Devon, we have experienced long patient waits for referral to treatment and cancer care. Since June 2022, we have been required to comply with Tier 1 performance reporting. Tier 1, being the highest level of regulatory performance oversight.

During the reporting period, monthly performance reports were provided to the finance, performance and digital committee and to our Board of Directors. These reports covered all the Tier 1 and other operational plan performance standards.

The key performance indicators for 2022/23 are shown below:

Tier 1 monitored standards

	Target	13 month trend	Apr-22	Jun-22	Sep-22	Dec-22	Mar-23
Tier One oversight performance metrics							
RTT 104 week wait incomplete pathway	0		192	96	50	29	0
RTT 78 week wait incomplete pathway	176		779	713	813	923	183
Number of patients waiting longer than 62 days for treatment	138		245	233	333	253	114
Percentage of patients waiting longer than 62 days for treatment			11.8%	10.2%	13.6%	17.1%	7.0%

4 Hour Emergency Department (ED) waiting times:
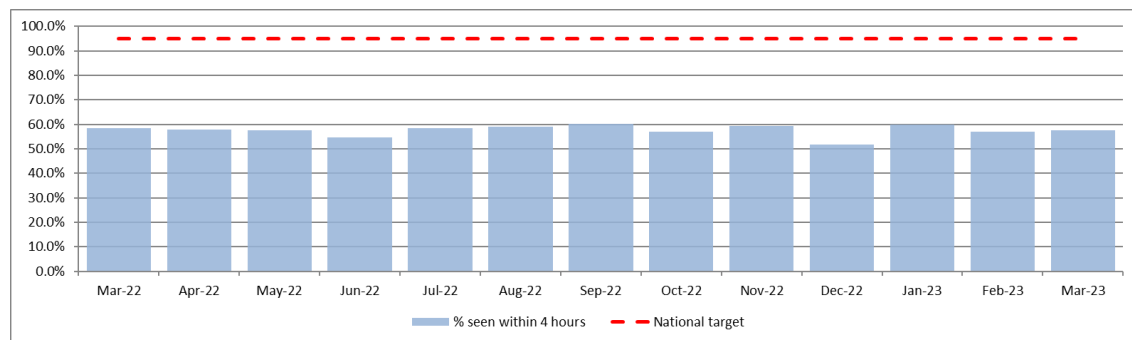
Performance against the four-hour standard in our emergency department in 2022/23 has continued to reflect the challenges of capacity and managing daily patient flow. Long waits have continued to be experienced in the emergency department. Ambulance handover delays have also been high due to the department, at times, reaching capacity.

There has continued to be an impact from managing COVID-19 on hospital capacity and designation of ward beds to meet infection control safeguards. Industrial action from a range of professions during quarter four also affected performance and activity. Working with our colleagues, we developed a robust process to ensure patient safety during periods of industrial action.

Bed capacity has been increased by the opening of the new acute medical unit (AMU) in December 2022 and the discharge lounge has been expanded.

Our improvement actions have focused on increasing the number of daily discharges earlier in the day and at weekends along with reducing the number of patients in hospital with "no criteria to reside". Progress has been seen with improved planning and daily escalation. The number of patients with no criteria to reside has reduced from a daily average of 48 (13%) in December 2022 to 28 (8%) March 2023. Ambulance handover delays have improved in in the last quarter of the year (Q4 month average of 789 over 30-minute delays compared to 1140 in Q3), however, remain a challenge with further improvement required in 2023/24.

Our plan for 2023/24 is to meet the new national 76% operating plan target against the four-hour performance by March 2024. There are a number of further developments supported by the urgent and emergency care transformation programme to increase effective bed capacity for emergency admissions, patient flow, and pathways within the emergency department.

These plans include:
- ✓ the introduction of virtual ward pathways of care to support people to stay at home where we can safely do so, facilitate earlier discharge from hospital and reduce admissions to ensure beds are available for those most in need on hospital care
- ✓ support for the complex discharge process and the capacity of intermediate

and social care to reduce further the number of 'no criteria to reside' to 5%
- ✓ continued focus on timeliness of daily discharges, use of the discharge lounge, and increased number of weekend discharges
- ✓ optimisation of clinical pathways to the new acute medical unit to increase the number of same day emergency care discharges
- ✓ focus on reducing beaches of the four-hour standard for non-admitted pathways of care.
- ✓ streaming patients to alternatives to our emergency department, for example, our urgent treatment centre, minor injury unit, pharmacies and self-care.
- ✓ improving performance at our urgent treatment centre and minor injury unit.

Ambulance handovers:

Percent of ambulance handovers over 15 minutes

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Performance	77%	70%	80%	77%	78%	78%	84%	82%	88%	67%	55%	74%	55%
Target	0	0	0	0	0	0	0	0	0	0	0	0	0
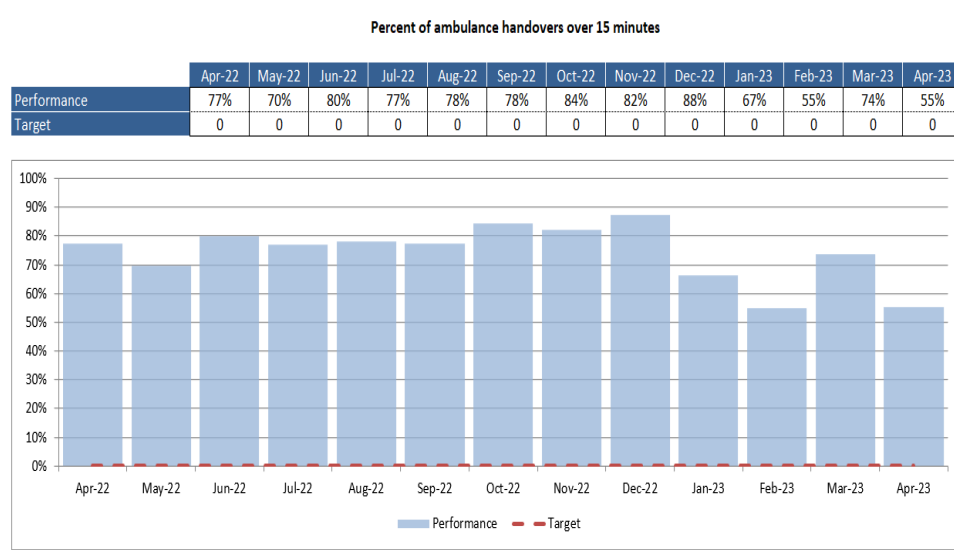
Ambulance Handover delays were challenging for 2022/2023 particularly in the first three quarters of the year with 70-88% of all arrivals in excess of the 15-minute handover standard. In the last quarter of the year, the opening of our new acute medical unit provided support to patient flow in the hospital.

During the same quarter we placed a key focus on committing to improving the two main causes of patient flow imbalance by improving performance in the following ways:
- ✓ increasing the number of patient discharges before noon
- ✓ increasing the number of patient weekend discharges.

As a result of the above we saw a benefit to patient flow within the hospital and emergency department and as result a positive reduction in handover delays to 55% over 15 minutes in April 2023.

The plan for 2023/34 is to continue to build on the improvements above and through the urgent and emergency care board work towards no ambulance delays at the end of March 2024.

Referral to Treatment (RTT) access times:

The number of people waiting for treatment increased during the year with 40,180 patients waiting at the end of March 2023 for first definitive treatment, up from 37,261 in March 2022. The number of people waiting over 104 weeks, however, has been reduced to zero in this time and we achieved our Tier 1 improvement trajectory to reduce the number of people waiting over 78 weeks.
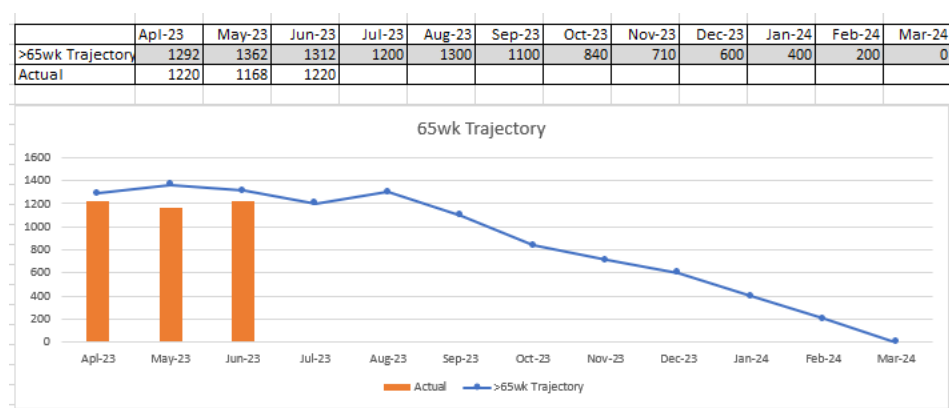
Our day surgery unit supports the delivery of national exemplar performance for day case surgery completion rates and productivity. During COVID-19 escalation our day surgery unit was used as escalation space for emergency admission assessment with a consequential impact on day surgery waiting lists. In April 2022, following the completion of the interim medical assessment areas our day surgery unit was fully restored to elective use. This has enabled teams to increase the number of day case procedures undertaken and start to reduce the number of people waiting for day case procedures.

In 2022/23 we worked closely with system partners to make use of allocated capacity at the former Nightingale Hospital in Exeter recommissioned to provide elective orthopedic short stay procedures and diagnostic hub. In 2023/24 this allocation of capacity will be increased with cataract procedures taking place at the Nightingale.

In the outpatient setting of care, challenges have been seen with increases in waiting times for outpatient appointments and outpatient treatments. Through a focus on outpatient productivity, including pathways to utilise virtual non-face to face appointments and managing follow up pathways to release capacity, performance has started to improve. Work continues to support patient capacity and productivity through the outpatient service transformation programme and insourcing of additional clinical capacity in the most challenged areas.

The plans for 2023/24 are to have no patient waiting over 65 weeks. These plans are reliant on recruitment to vacant posts, sourcing of additional capacity and system mutual aid. We have successfully bid to increase day surgery and endoscopy theatre capacity with two additional day surgery theatres and an additional endoscopy suite scheduled for completion by the end of 2023/24.

Referral to treatment 65 week wait Tier 1 monitoring and trajectory

	Apl-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
>65wk Trajectory	1292	1362	1312	1200	1300	1100	840	710	600	400	200	0
Actual	1220	1168	1220									

65wk Trajectory

Cancer standards:

We maintained our commitment to prioritise delivery of cancer treatments. However, we entered Tier 1 performance monitoring by NHS England due to the increasing number of people waiting beyond 62 days for treatment following urgent referral. Since November 2022 there has been steady improvement with the backlog reduction meeting the threshold for stepping down out of Tier 1. This number reduced from 333 patients in November 2022 (13.6% of total list) to 114 patients (7% of total list) by end of March 2023.

Over the year we have not consistently met the 14-day urgent referral to be seen, nor 28-day from urgent referral to diagnosis standards. There are known challenges and risks. However, close monitoring is in place with action plans reviewed through cancer performance oversight. In March 2023 we achieved 77.4% against the 28-day referral to diagnosis standard (target 75%) and 76% against the 2ww standard (target 93%).

Over 62-day referral to treatment standard: greater than 62-day backlog (open pathways)

62-day urgent referral to treatment cancer standard: Backlog number greater than 62-days
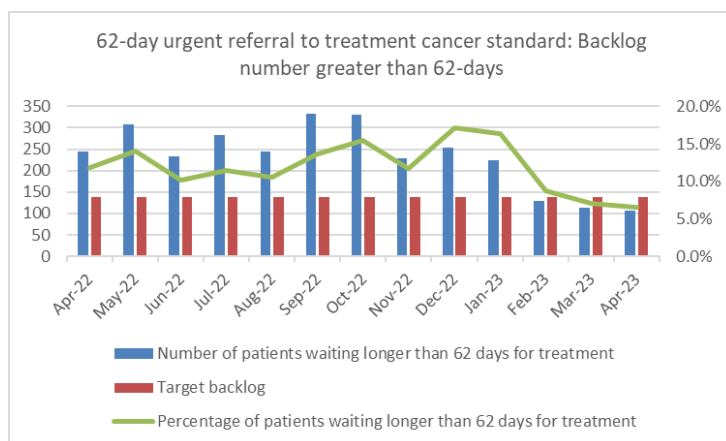
Faster diagnosis 28-days from referral cancer standard
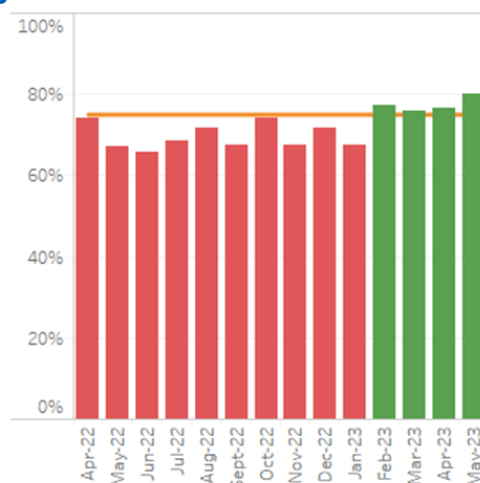
Diagnostics:

Demands for diagnostic tests has continued to increase. The delivery of required levels of capacity in CT and MRI is dependent upon the sourcing of additional capacity using mobile units. We will commission a new Radiotherapy Planning CT scanner at Torbay which will be operational by September 2023 and will strengthen our clinical oncology pathways. People in Torbay and South Devon continue to benefit from additional CT and MRI capacity at the Nightingale Hospital Exeter.

Recruiting to staff vacancies across the major diagnostic specialties remained a challenge throughout the year.

Endoscopy services has used additionally sourced weekend capacity throughout the year to stabilise waiting lists along with additional mobile capacity to support waiting list initiatives in preparation to the estates works to create additional facilities that will impact for a period in 2023/24.

Diagnostic greater than 6-week wait breaches as a percentage of total waits

Equality of service delivery:
We maintain our approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting 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.

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

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

These meetings are in addition to the monthly integrated service unit (ISU),

executive-led, integrated governance group (IGG) meetings where performance is reviewed with system leadership teams following each ISU's monthly governance process.

For 2023/24, monthly urgent care and planned care board meetings have been established to track the delivery of transformation programme and performance against agreed plans.

This process gives the executive team and our Board of Directors assurance in relation to performance monitoring including escalation of performance risks where additional support is needed and actions being taken.

Other areas of performance to note
No criteria to reside

This is the status of a person who (having undergone appropriate treatment and assessment) no longer meets a medical criteria to stay in an acute or community hospital bed. Patients who are identified as having no criteria to reside were previously known as a delayed discharge.

A person occupying a hospital bed with no criteria to reside is potentially occupying a bed space needed for people requiring admission from our emergency department, assessment units or transfer into a community hospital. This has contributed to delays in our emergency department and ambulance handover delays as full capacity is reached.

For these reasons we have implemented an improvement programme supported with funding to remove any process delays in discharge and increase capacity, particularly for the more complex discharges where other care packages or intermediate care support is needed.
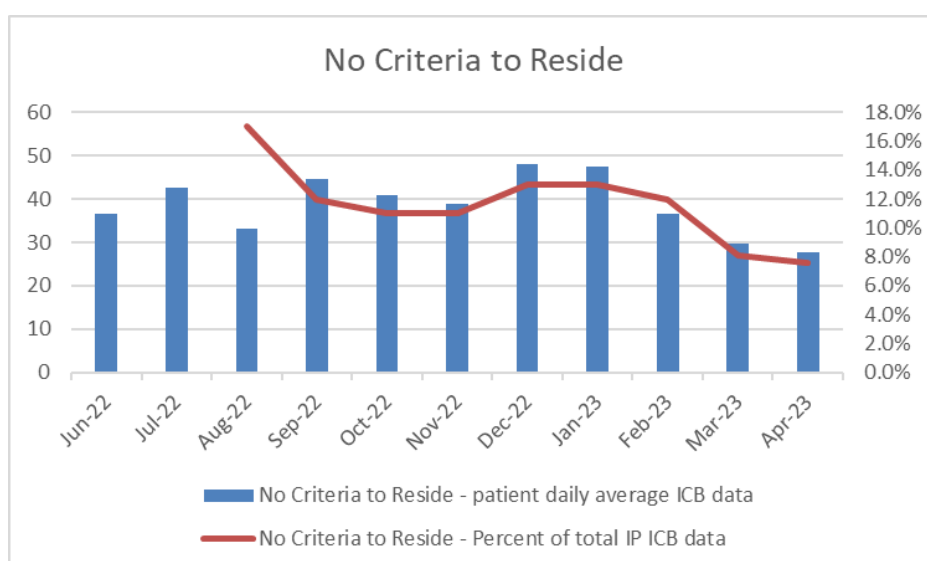
During the year the number of beds occupied in the acute and community hospitals with no criteria to reside has improved from over 13% of beds occupied to 8% in March and 7.5% in April 2023. The recovery target set for improvement for no criteria to reside is 5% for 2023/24.

Complex pathway discharges:

What pathway is your patient on?

Pathway 0 - No additional support
- Fully independent - no additional support required
- OR restart of existing services

0 → Patient returns to usual place of residence (including care home)

Pathway 1 – Additional support at home/usual residence
- Assessment and some additional care and support (including therapy, nursing, domiciliary care, new equipment)
- Safe to be at home/usual residence

1 → Patient returns to usual place of residence with interim support

Pathway 2 – Rehab +/- reablement in a temporary bedded setting
- Short term bedded rehabilitation +/- reablement and assessment
- Unsafe to be at home/usual residence
- Includes specialist rehabilitation bed

2 → Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to safely return to place of residence

Pathway 3 - Complex
- Complex/significant health and/or social care needs
- Longer term placement
- OR Complex support in usual residence
- OR Significant change in need requiring new placement

3 → Patient is transferred to a new long-term bed, assessment bed, or usual residence, and receives the complex support and/or assessment for their needs

The total number of people discharged through pathways one to three has remained fairly consistent throughout most of the year, averaging 251 complex pathway discharges per month. Pathways one to three are considered 'complex' as patients require support to enable a safe discharge.

During December the number of people on pathway two who could be discharged decreased. There was also an increase of COVID-19 cases which led to ward closures and care homes adhering to the guidelines for admission.

Throughout early January, providers began to accept new referrals again, and additional block contracted beds were purchased to support discharge into temporary bedded placement. This resulted in a year high for pathway two discharges and a total of 297 complex pathway discharges for January.

Across the 12 months the following numbers of patients were discharged on each pathway

Pathway	%	Actual
One	56.65	1,704
Two	35.01	1,053
Three	8.34	251

Average length of stay

The average length of stay in 2022/23 has increased however this remains in line with other provider trusts in the south west.

In 2022/23 the average length of stay for patients admitted as an emergency and staying overnight was 7.9 days and this compares to 7.6 days average across other provider trusts in the south west. Infection issues, specifically COVID-19, have contributed to this increase length of stay.

Moving into 2023/24 reducing length of stay remains an ongoing key focus for us to support both elective and non-elective activity and as such has been recognised in improvement plans specifically centered on early morning discharge, discharges before 5pm and at the weekend.

Stroke care

Patients presenting with suspected stroke require rapid assessment diagnostics and dedicated rehabilitation care. The sentinel stroke national audit programme (SSNAP) measures the time critical processes of care provided across acute and community settings.

We did not meet the standards for the percentage of patients admitted to a stroke unit within four-hours of arrival or the percentage of patients spending 90% or more of their hospital stay on a dedicated stroke ward. We have a stroke improvement plan to support patient outcomes and achievement of time critical standards. This plan is managed through the clinically led stroke governance meeting.

Winter planning 2022/23

We improved our operational resilience heading into winter with an understanding that COVID-19 and general winter pressures would be challenging and there would be an ongoing need to clinically risk management patients and importantly support the ongoing work to improve ambulance handovers and response times.

In conjunction with Devon system wide partners we focused on the following key themes of improvement:
- ✓ establishing a winter control room to support daily operational challenges
- ✓ better support for people in the community
- ✓ delivering on our ambitions to maximise bed capacity and support ambulance services

✓ ensure timely discharge and support people to leave hospital when clinically appropriate.

Key areas of support that helped maintain the resilience during the winter period were the continuation of eleven emergency department escalation beds, the expansion of the discharge lounge, opening of the new acute medical unit and maintaining McCullum ward for winter escalation. Community support in the form of additional care home placements and packages of care likewise contributed to resilience.

Maternity performance 2022/23

Maternity assurance metrics are based on recommendations to meet the national priorities to reduce brain injuries occurring during or soon after birth, stillbirths, neonatal and maternal deaths by 50% by 2025.They are also based on the requirements set out in the maternity incentive scheme (MIS) as part of the clinical negligence scheme for the trust (CNST) as well as those recommendations from both Ockenden and East Kent Hospital's reports.

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

Birth rate

The number of births for 2022/23 was 1,847. This is a reduction from 21/22 when it was 2,073. Reduction in birth rate is a national trend.

Perinatal Mortality Rate

The graph below shows the perinatal mortality detail for 2022/23 – there were five deaths.

Torbay's perinatal mortality rate for 2022 is 4.2% which is the same as the national average. A deep dive/thematic review was carried out into all deaths in 2022 and no themes or issues with care were identified
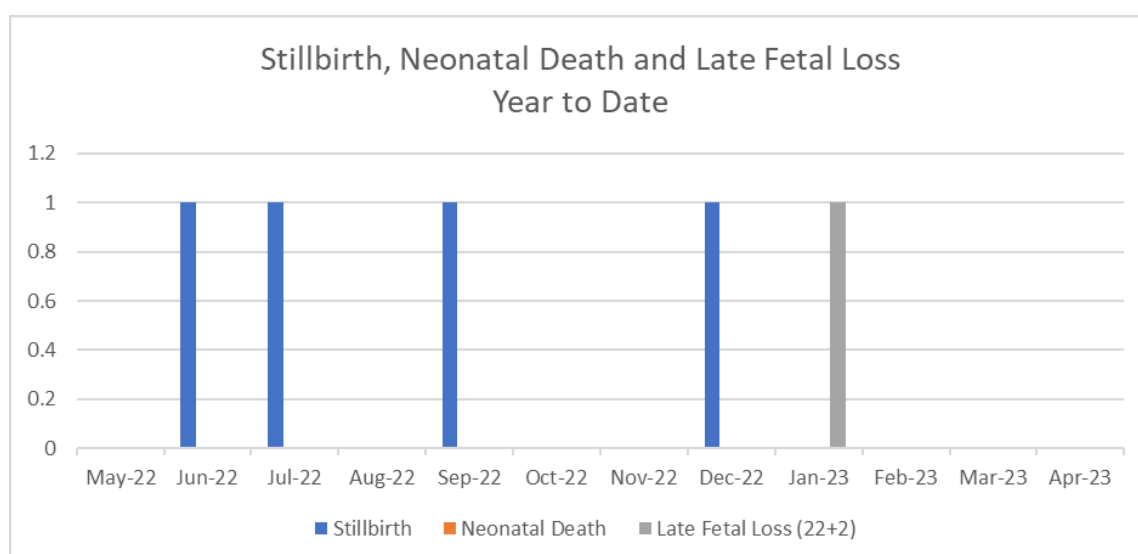
Smoking rates

There has been a marked reduction in the number of women smoking at time of delivery (SATOD). Historically the SATOD data was 13-15%. With the introduction of the smoke-free pregnancy team this rate has dropped to 7.3% for the year 2022/23. This is below the national average of 8.6%.

Identifying fetal growth restriction

Data on our detection of small for gestational age (SGA) babies in quarter four of 2022/23 has evidenced performance above the recommended average. Torbay is one of the top ten trusts in the country for detection of small babies. We have achieved a detection rate of 69.2% which is significantly higher than the national average of 43.6%.

ANNEX 1: PARTNER STATEMENTS

STATEMENTS TO FOLLOW UPON RECEIPT

ANNEX 2: DIRECTORS' RESPONSIBILITIES STATEMENT

Statement to follow upon receipt of Partnership Statements: draft approved by Trust Board on 28 June 2023.

SHOT Key Recommendation	Current activity/evidence	Level of Compliance	Further Actions	Risk associated with non-compliance	Action by: Lead name	Target Date
Staff involved in examining incidents should be fully trained in techniques for effective investigations, including an understanding of human factors methods	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Incidents should be investigated by staff trained in this process and protected time should be allocated for staff to receive training for incident investigation techniques and to carry out comprehensive incident investigations	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Human factors and ergonomics training should be provided to all staff, clinical and laboratory, to ensure a holistic approach to building safe systems and work towards error reduction	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Avoidable transfusion in patients with haematinic deficiency puts them at risk of TACO. Clinical staff should be familiar with full blood count results that suggest deficiencies of iron (microcytosis), or B12 or folate (macrocytosis)	Mandatory Transfusion Training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	Improve compliance: Face to face sessions provided by SSPOT, national E-learning package via eLFH directly accessible via HIVE	unsafe transfusion practice; unnecessary transfusion; potential for overload, morbidity and mortality	Debbie Alford Jess Piper	ongoing
Local transfusion training should include the indications for group O emergency red cells and how to check if group-specific or crossmatched units are available	Included in local face to face training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	inappropriate usage of emergency group O blood (SHOT reportable): delay in transfusion with potential morbidity and mortality	Debbie Alford Jess Piper	tbc
Staff who authorise paediatric transfusion should be trained so that they know how to calculate the correct dose of all components	Mandatory Transfusion Training	Paediatric: Speciality Registrar 53% Consultant 75% Speciality Doctor 50%	Improve compliance: Face to face sessions provided by SSPOT, national E-learning package via eLFH directly accessible via HIVE	unsafe transfusion practice	Debbie Alford Jess Piper	ongoing
Transfusion essentials must be included in the paediatric curriculum and staff should have access to regular and relevant updates.	Mandatory Transfusion Training All nursing staff attend face to face session annually as part of the 'Child Health Mandatory Day'	Nursing Team 99% Speciality Registrar 53% Consultant 75% Speciality Doctor 50%	Improve compliance for medical staff	unsafe transfusion practice	Clinical Lead Paediatrics Debbie Alford Jess Piper	ongoing
Laboratories should have training programmes and regular competency-assessments that ensure staff have the appropriate knowledge and skills commensurate to their role	Mandatory transfusion training via eLFH package, regular competency assessments for all staff	100%	none	unsafe transfusion practice	Steve Mills	ongoing
Paediatric medical and nursing education must include specific transfusion requirements for patients with haemoglobinopathies and processes must be in place to ensure these are communicated effectively to the hospital transfusion laboratories to ensure safe transfusions	none - no regular haemoglobinopathy patients, communication between paediatrics and haematology as required	n/a	n/a	n/a	n/a	n/a
Education for clinical staff should include information on the appropriate rates of transfusion and should consider variations required for individual patient needs. Where an infusion pump is used, procedures must be in place to ensure the correct rate is achieved	all information required within Blood Assist app available on Trust devices, link on ICON and personal devices, recommended to all staff during F2F training,	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	unsafe transfusion practice	Debbie Alford Jess Piper	tbc
Clinical staff involved in frontline care must be trained to recognise major blood loss early and know when to activate/trigger the local major haemorrhage protocol and take prompt and appropriate action	covered in local face to face training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	unsafe transfusion practice	Debbie Alford Jess Piper	tbc

SHOT Key Recommendation	Current activity/evidence	Level of Compliance	Further Actions	Risk associated with non-compliance	Action by: Lead name	Target Date
National Health Service (NHS) Trusts/Health Boards must use intelligence from all patient safety data including national haemovigilance data to inform changes in healthcare systems, policies and practices to imbed the lessons learnt and truly improve patient safety	transfusion safety risks identified particularly relating to the use of clinical IT systems, failure to share learning not only across but within ISUs	poor - however with the implementation of PSIRF this should be addressed	ensure learning from incidents is shared, manage risks appropriately to ensure patient safety	unsafe transfusion practice, morbidity and	Faye Sutton	Sep-23
Effective investigation of all incidents and near miss events, application of effective corrective and preventative actions, and closing the loop by measuring the effectiveness of interventions should be carried out to optimise learning from incidents	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Staff involved in examining incidents should be fully trained in techniques for effective investigations, including an understanding of human factors methods	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Incidents should be investigated by staff trained in this process and protected time should be allocated for staff to receive training for incident investigation techniques and to carry out comprehensive incident investigations	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Human factors and ergonomics training should be provided to all staff, clinical and laboratory, to ensure a holistic approach to building safe systems and work towards error reduction	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
A tried and tested human factors-based framework should be applied to incident investigations. The SHOT HFIT questions may be used in addition, so that answers to the questions can be discovered during the investigation	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
The nine key principles outlined in the white paper on Learning from Adverse Events published by the Chartered Institute of Ergonomics and Human Factors (CIEHF 2020) https://www.ergonomics.org.uk/CIEHFLearningfromAdverseEvents should be applied to investigating transfusion incidents in order to help with understanding a human factors perspective	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Investigations should identify, and include improvement actions, for all the contributory factors involved	action plans following incident investigation	although action plans following serious incidents are in place these are not always actioned in a timely manner, ongoing risks not addressed	ensure action plans are actioned in timely manner, where risks identified ensure mitigations in place to significantly reduce risk	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton	tbc
Near miss incidents should be fully investigated as the learning may prevent serious events in future	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
A thorough post-event investigation should be carried out in all cases with severe complications following transfusion to identify improvements locally with respect to identification and mitigation of risks, patient monitoring and management	DATIX & SABRE workspace, all known cases reported by SSPOT, haemovigilance included in mandatory training little or no training for staff investigating or reviewing incidents	unknown - can only report what is known	ensure Hospital Transfusion Team are informed of any complications of transfusion ensure SSPOT involved in all SABRE/SHOT reportable incident investigations	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton	tbc
Reporters should report all cases of suspected pulmonary complications. Cases should initially be reported using existing SHOT definitions and can be re-categorised by SHOT experts if required	DATIX & SABRE workspace, all known cases reported by SSPOT, haemovigilance included in mandatory training	unknown - can only report what is known	ensure Hospital Transfusion Team are informed of any complications of transfusion	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Ian Currie Deborah Kelly	tbc
The term 'human error' should no longer be used as a conclusion in any incident report and investigators should focus on finding the system and organisational factors that contributed to the incident	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23
Incident investigations must be systematic and thorough, proportionate to the risk and impact, identifying systems-based corrective and preventative actions	little or no training for staff investigating or reviewing incidents; Governance Co-ordinators/Central Safety Team	low - however with the implementation of PSIRF this should be addressed	ensure all staff involved in incident investigation receive appropriate training	Inadequate investigations, failure to identify or action root cause, failure to identify or action process change or compliance	Faye Sutton Jess Piper	Sep-23

SHOT Key Recommendation	Current activity/evidence	Level of Compliance	Further Actions	Risk associated with non-compliance	Action by: Lead name	Target Date
Transfusion information technology (IT) systems reduce the risk of errors at all steps in the transfusion pathway if they are configured and used correctly	Blood Track in place Risks identified relating to IT systems and process particularly Cyberlab including OrderComms and SystmOne in obstetrics	poor	Ensure systems are compliant with the current national legislation, guidelines and recommendations and are regularly validated	significant adverse event	Gary Hotine Peter Sheard Tracy Moss	tbc
IT systems, including LIMS, EPR systems, integration systems (such as NPEx) and electronic blood-tracking systems should be used to their full potential to support safe and appropriate management of anti-D Ig and RAADP. System providers should work with subject matter experts and IT departments within organisations to develop and implement functionality designed to support good practice	SystmOne does not meet the requirements of the BSH guidelines no batch product module in Blood Track	0%	interface with LIMS required to ensure blood group results are not manually inputted into SystmOne requirement for recording of batch of anti-D administered implementation of batch product module within Blood Track	significant adverse event	Gary Hotine Peter Sheard Tracy Moss Alistair Penny (BT only)	tbc
LIMS should be configured to support safe release of all blood components, including ABO/D compatibility, red cell antigen matching, irradiated, CMV-negative and other specific requirements	current LIMS compliant in all but CMV neg for pregnant	high	Ensure CMV negative blood components for pregnant women is part of the specification for new LIMS	potential to issue non CMV neg blood, low risk due to leucodepletion of blood components	Gary Hotine Peter Sheard Alistair Penny	tbc
Collection of blood components must include checks to ensure correct blood components are collected for the right patient. Electronic checking systems and smart refrigerators should be used to support safe practice	Blood Track in place Access to system only given if fully compliant with mandatory training and competency assessments, automatic suspension of account on expiry of mandatory training, ability to suspend accounts manually if concerns about individuals practice	high	Smart refrigerators to be considered when replacements required	low - correct checking as per transfusion policy and training	Alistair Penny Pinder	Julia achieved
Laboratories should have a schedule for regular LIMS upgrades in accordance with manufacturers recommendations and contractual requirements. The operational LIMS should include all available functionality to support safe practice, where deficiencies are noted a roadmap for upgrade and/or development should be in place and regularly reviewed by the laboratory management and the LIMS supplier	Current LIMS is adequate but obsolete	n/a	Procure and implement new LIMS	low - current system adequate	Gary Hotine Peter Sheard	tbc
The LIMS should be used to its full potential to support transfusion safety, transfusion service managers should work with the LIMS supplier to ensure that all functionality is available and operational to support safe laboratory transfusion practice	Current LIMS is adequate but does not have the ability to record sample taker - required under BSH guidelines	good	Procure and implement new LIMS	low - current system adequate	Gary Hotine Peter Sheard	tbc
Interoperability between patient administration systems and LIMS reduces the risk of errors in manual registration of patient information. Transfusion service managers should work with the LIMS supplier and IT departments to explore options for interfacing	LIMS has direct feed from IHCS, however interfacing required to other clinical systems to ensure no manual transcribing of results SystmOne and Symphony in particular	poor	necessary interfaces in place	significant adverse event	Gary Hotine Peter Sheard Tracy Moss	tbc
IT should be used to its full potential to support safe transfusion practice as well as guiding appropriate clinical decision-making relating to transfusion of blood components	Blood Track in place Clinical systems in place that do not meet standards as per BSH guidelines (OrderComms, SystmOne, Symphony)	poor	OrderComms - robust PPID required, mobile devices in all clinical areas to enable safe sampling at the bedside, on demand sample label printing at the bedside using barcode technology SystmOne and Symphony interfaces required Electronic authorisation of blood components with robust rules to ensure appropriate requesting of blood components	significant adverse event	Gary Hotine Peter Sheard Tracy Moss	tbc
Healthcare organisations should ensure that collaborative working is in place between subject matter experts from clinical and laboratory departments together with hospital-based IT departments to ensure systems functionality and interoperability are optimised. The support of IT suppliers should be sought to further enable improvement across the range of transfusion activities	Concerns raised by HTT regarding lack of communication/input when implementing IT systems – resulting in systems not supporting safe transfusion practice Risk register and DATIX provides supporting evidence	0%	ensure HTT involved in IT projects for all clinical systems to ensure safe transfusion practice	significant adverse event	Gary Hotine Peter Sheard Tracy Moss	tbc
Electronic health record providers and hospitals who plan to implement or continue to develop an electronic health record should map the pathway for D-negative women in pregnancy and post-partum and jointly develop intelligent pathways that support decision making	SystmOne does not meet the requirements of the BSH guidelines no input from HTT during project planning and implementation	ensure HTT involved in IT projects for all clinical systems to ensure safe transfusion practice	significant adverse event	Gary Hotine Peter Sheard Tracy Moss	tbc
All blood transfusion IT solutions must ensure appropriate IT interfaces between the laboratory information management system and electronic health record to remove the requirement of healthcare professionals to manually enter a blood group or D-type to reduce the risk of a transcription error that may prevent appropriate management	no interface between LIMS and SystmOne or Symphony	0% 0%	interfaces required	significant adverse event	Gary Hotine Tracy Moss	tbc

SHOT Key Recommendation	Current activity/evidence	Level of Compliance	Further Actions	Risk associated with non-compliance	Action by: Lead name	Target Date
LIMS should be configured to support safe release of all blood components, including ABO/D compatibility, red cell antigen matching, irradiated, CMV-negative and other specific requirements	current LIMS compliant in all but CMV neg for pregnant	high	Ensure CMV negative blood components for pregnant women is part of the specification for new LIMS	potential to issue non CMV neg blood, low risk due to leucodepletion of blood components	Gary Hotine Peter Sheard Alistair Penny	tbc
Transfusion laboratory staff should use the laboratory exit check when issuing blood components to reduce component labelling errors	Blood Track requires label verification prior to issue of blood components	100%				achieved
Laboratories should have training programmes and regular competency-assessments that ensure staff have the appropriate knowledge and skills commensurate to their role	Mandatory transfusion training via eLFH package, regular competency assessments for all staff	n/a 100%	none	n/a unsafe transfusion practice	Alistair Penny Steve Mills	ongoing
Laboratories should have a schedule for regular LIMS upgrades in accordance with manufacturers recommendations and contractual requirements. The operational LIMS should include all available functionality to support safe practice, where deficiencies are noted a roadmap for upgrade and/or development should be in place and regularly reviewed by the laboratory management and the LIMS supplier	Current LIMS is adequate but obsolete	n/a	Procure and implement new LIMS	low - current system adequate	Gary Hotine Peter Sheard	tbc
The LIMS should be used to its full potential to support transfusion safety, transfusion service managers should work with the LIMS supplier to ensure that all functionality is available and operational to support safe laboratory transfusion practice	Current LIMS is adequate but does not have the ability to record sample taker - required under BSH guidelines	good	Procure and implement new LIMS	low - current system adequate	Gary Hotine Peter Sheard	tbc
Interoperability between patient administration systems and LIMS reduces the risk of errors in manual registration of patient information. Transfusion service managers should work with the LIMS supplier and IT departments to explore options for interfacing	LIMS has direct feed from IHCS, however interfacing required to other clinical systems to ensure no manual transcribing of results SystmOne and Symphony in particular	poor	necessary interfaces in place	significant adverse event	Gary Hotine Peter Sheard Tracy Moss	tbc
Laboratories should have capacity plans in place that include all aspects of transfusion practice. These should be reviewed regularly and have appropriate escalation processes when safe staffing levels are not met	Business continuity plan in place, required as part of UKAS accreditation	100%	n/a	n/a	Alistair Penny	achieved
All haemoglobinopathy patients should have an extended phenotype and receive extended Rh- and K-matched units	policy in place	100%	n/a	n/a	Alistair Penny	achieved
All UK hospitals should check that they have signed up to share results access in Sp-ICE	access in place	100%	n/a	n/a	Alistair Penny	achieved

SHOT Key Recommendation	Current activity/evidence	Level of Compliance	Further Actions	Risk associated with non-compliance	Action by: Lead name	Target Date
Workforce planning, safe staffing, and a well-resourced healthcare system Healthcare leaders must ensure that systems are designed to support safe transfusion practice and allocate adequate resources in clinical and laboratory areas to support the following: • Safe staffing levels • Staff training in technical and non-technical skills • Appropriate equipment, including IT systems	DATIX - incidents related to lack of suitably trained staff in clinical area low compliance with mandatory transfusion education and competency assessment, IT systems not supportive of safe transfusion practice	poor	increase complaisance with mandatory training IT solutions required to counter the risks raised relating to Cyberlab, OrderComms, SystmOne and Symphony	significant adverse event	Debbie Alford Jess Piper Gary Hotine Peter Sheard Tracy Moss	tbc
All blood transfusion IT solutions must ensure appropriate IT interfaces between the laboratory information management system and electronic health record to remove the requirement of healthcare professionals to manually enter a blood group or D-type to reduce the risk of a transcription error that may prevent appropriate management	no interface between LIMS and SystmOne or Symphony	0%	interfaces required	significant adverse event	Gary Hotine Tracy Moss	tbc
Avoidable transfusion in patients with haematinic deficiency puts them at risk of TACO. Clinical staff should be familiar with full blood count results that suggest deficiencies of iron (microcytosis), or B12 or folate (macrocytosis)	Mandatory Transfusion Training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	Improve compliance: Face to face sessions provided by SSPOT, national E-learning package via eLFH directly accessible via HIVE	unsafe transfusion practice; unnecessary transfusion; potential for overload, morbidity and mortality	Debbie Alford Jess Piper	ongoing
Local transfusion training should include the indications for group O emergency red cells and how to check if group-specific or crossmatched units are available	Included in local face to face training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	inappropriate usage of emergency group O blood (SHOT reportable); delay in transfusion with potential morbidity and mortality	Debbie Alford Jess Piper	tbc
Staff who authorise paediatric transfusion should be trained so that they know how to calculate the correct dose of all components	Mandatory Transfusion Training	Paediatric: Speciality Registrar 53% Consultant 75% Speciality Doctor 50%	Improve compliance: Face to face sessions provided by SSPOT, national E-learning package via eLFH directly accessible via HIVE	unsafe transfusion practice	Debbie Alford Jess Piper	ongoing

Recommendation	Current Position	Compliance	Action	Risk	Lead	Status
Transfusion essentials must be included in the paediatric curriculum and staff should have access to regular and relevant updates.	Mandatory Transfusion Training All nursing staff attend face to face session annually as part of the 'Child Health Mandatory Day'	Nursing Team 99% Speciality Registrar 53% Consultant 75% Speciality Doctor 50%	Improve compliance for medical staff	unsafe transfusion practice	Clinical Lead Paediatrics Debbie Alford Jess Piper	ongoing
Education for clinical staff should include information on the appropriate rates of transfusion and should consider variations required for individual patient needs. Where an infusion pump is used, procedures must be in place to ensure the correct rate is achieved	all information required within Blood Assist app available on Trust devices, link on ICON and personal devices, recommended to all staff during F2F training,	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	unsafe transfusion practice	Debbie Alford Jess Piper	tbc
Clinical staff involved in frontline care must be trained to recognise major blood loss early and know when to activate/trigger the local major haemorrhage protocol and take prompt and appropriate action	covered in local face to face training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	unsafe transfusion practice	Debbie Alford Jess Piper	tbc
Collection of blood components must include checks to ensure correct blood components are collected for the right patient. Electronic checking systems and smart refrigerators should be used to support safe practice	Blood Track in place Access to system only given if fully compliant with mandatory training and competency assessments, automatic suspension of account on expiry of mandatory training, ability to suspend accounts manually if concerns about individuals practice	high	Smart refrigerators to be considered when replacements required	low - correct checking as per transfusion policy and training	Alistair Penny Julia Pinder	achieved
Accurate patient identification is fundamental for patient safety and patient identification errors must be avoided during blood sampling. This practice must be reinforced with all staff by mandatory transfusion training and be audited regularly	covered in mandatory transfusion training DATIX raised on non-compliance	training compliance -75% approximately 5% of all blood samples received rejected participation in national comparative audit (Oct 22)	Improve compliance: Face to face sessions provided by SSPOT, national E-learning package via eLFH directly accessible via HIVE	unsafe transfusion practice	Debbie Alford Jess Piper	ongoing
Blood sample tubes must be labelled next to the patient and systems should be in place to facilitate this	OrderComms does not facilitate this in its current form	poor	OrderComm process to comply with BSH guidelines, including mobile devices to enable PPID at the bedside and on demand label printing using barcode technology again at the bedside	significant adverse event	Gary Hotine Tracy Moss Clinical Systems Administration Team	tbc

Recommendation	Current status	Compliance	Action	Risk	Lead	Status
Samples must be labelled accurately at the patient side using positive patient identification	OrderComms does not facilitate this in its current form	poor	OrderComm process to comply with BSH guidelines, including mobile devices to enable PPID at the bedside and on demand label printing using barcode technology again at the bedside	significant adverse event	Gary Hotine Tracy Moss Clinical Systems Administration Team	tbc
Hospital transfusion policies should include guidance for safe labelling of transfusion samples	policy in place		n/a	n/a	Julia Pinder	achieved
		100%				
A checklist should be incorporated into blood component collection procedures to avoid any critical check being missed	covered in mandatory transfusion education policy in place Blood Track in place Access to system only given if fully compliant with mandatory training and competency assessments, automatic suspension of account on expiry of mandatory training, ability to suspend accounts manually if concerns about individuals practice	100%	n/a	n/a	Julia Pinder	achieved
A formal pre-transfusion risk assessment for TACO should be undertaken whenever possible for all patients receiving blood transfusion (especially if older than 50 years or weighing less than 50kg) and appropriate mitigating actions taken	covered in mandatory transfusion education Blood Assist app available audit	unknown	redesign of blood authorisation booklet to include TACO risk assessment audit of compliance electronic blood authorisation (refer to IT)	significant adverse event	Julia Pinder	tbc
Use weight-adjusted red cell dosing to guide the appropriate number of units required, for all nonbleeding adult patients, ideally using tools which also highlight inappropriate transfusion	covered in mandatory transfusion education Blood Assist app available audit blood authorisation booklet includes low body weight formula	unknown	audit of compliance electronic blood authorisation (refer to IT)	significant adverse event	Julia Pinder	tbc
Febrile, Allergic and Hypotensive Reactions Give appropriate targeted treatment and if needed, use preventative cover for future transfusion	covered in mandatory transfusion education transfusion policy in place Blood Assist app available audit blood authorisation booklet includes guidance	unknown - dependent on clinical teams actions	n/a	n/a	n/a	n/a
Patients who develop respiratory distress during or up to 24 hours following transfusion, where transfusion is suspected to be the cause, must be reported to SHOT with as much detail (clinical and laboratory aspects) as possible	covered in mandatory transfusion education	unknown - there has not been a case reported to HTT for several years	n/a	n/a	n/a	n/a

Recommendation	Current status	Compliance	Action required	Risk	Lead	Status
A structured review and incident investigation should be undertaken for every case of TACO to optimise organisational and individual patient-safety measures	DATIX	unknown - there has not been a case reported to HTT for several years	n/a	n/a	n/a	n/a
Patients must be informed about the risks of transfusion reactions including delayed reactions and know when and how to seek medical help. These discussions should be part of consent pre-transfusion	covered in mandatory transfusion education transfusion policy in place Blood Assist app available audit blood authorisation booklet includes consent form	unknown - dependent on clinical teams actions	audit of compliance	significant adverse event	Julia Pinder	tbc
Haematology teams must be informed when sickle cell patients are admitted to secondary care	unable to find policy	unknown - dependent on clinical teams actions	policy in place	significant adverse event	Patrick Roberts	tbc
IT systems, including LIMS, EPR systems, integration systems (such as NPEx) and electronic blood-tracking systems should be used to their full potential to support safe and appropriate management of anti-D Ig and RAADP. System providers should work with subject matter experts and IT departments within organisations to develop and implement functionality designed to support good practice	SystmOne does not meet the requirements of the BSH guidelines no batch product module in Blood Track	0%	interface with LIMS required to ensure blood group results are not manually inputted into SystmOne requirement for recording of batch of anti-D administered implementation of batch product module within Blood Track	significant adverse event	Gary Hotine tbc Peter Sheard Tracy Moss Alistair Penny (BT only)	
IT should be used to its full potential to support safe transfusion practice as well as guiding appropriate clinical decision-making relating to transfusion of blood components	Blood Track in place Clinical systems in place that do not meet standards as per BSH guidelines (OrderComms, SystmOne, Symphony)	poor	OrderComms - robust PPID required, mobile devices in all clinical areas to enable safe sampling at the bedside, on demand sample label printing at the bedside using barcode technology SystmOne and Symphony interfaces required Electronic authorisation of blood components with robust rules to ensure appropriate requesting of blood components	significant adverse event	Gary Hotine tbc Peter Sheard Tracy Moss	
It is essential that safety critical steps should be protected from distraction (e.g. by implementing a physical cue such as a tabard or armband	none	unknown	ensure safety critical steps are protected from distraction	significant adverse event	Deborah Kelly	tbc
Redeployment/surge nursing to areas where transfusion is required should be accompanied by training and competency assessment	DATIX - incidents relating to no trained staff in clinical area	poor	ensure all surge/escalation wards are safely staffed and enough staff available who are trained to carry out transfusions	significant adverse event	Deborah Kelly	tbc
Positive patient identification must be carried out before administering any blood component	Blood Track in place	100%	n/a	n/a	Julia Pinder	achieved

SHOT Key Recommendation	Current activity/evidence	Level of Compliance	Further Actions	Risk associated with non-compliance	Action by: Lead name	Target Date
Local transfusion training should include the indications for group O emergency red cells and how to check if group-specific or crossmatched units are available	Included in local face to face training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	inappropriate usage of emergency group O blood (SHOT reportable); delay in transfusion with potential morbidity and mortality	Debbie Alford Jess Piper	tbc
Clinical staff involved in frontline care must be trained to recognise major blood loss early and know when to activate/trigger the local major haemorrhage protocol and take prompt and appropriate action	covered in local face to face training	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	unsafe transfusion practice	Debbie Alford Jess Piper	tbc
policies and procedures to cover: a. Rapid release of blood components and products for major haemorrhage, AIHA and reversal of anticoagulants. b. Compliance with SHOT1, NICE4 and BSH7 recommendations. c. Agreed criteria where rapid release of PCC is acceptable without the initial approval of a haematologist. d. Concessionary, rapid release of the best matched red blood cells for patients with red cell antibodies. e. Criteria and pathways for laboratory escalation to a haematologist where transfusion is urgent, and the presence of antibodies might delay release of red blood cells. f. Treatment of patients who refuse transfusion of blood components and/or products.	a-e. Trust wide Major Haemorrhage policy & Laboratory policies in place however dependent on correct activation of major haemorrhage protocol and communication from the clinical area. f. 'No Blood' policy in place All reinforced by mandatory transfusion education	All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44%	ensure local transfusion training on induction for all staff involved in the transfusion process	unsafe transfusion practice	Debbie Alford Jess Piper	tbc

training programmes to include: a. Recognition of bleeding, importance of communication, processes for activation of major haemorrhage protocols and rapid access to blood components and products in clinical staff training programmes. b. Major haemorrhage drills, simulations and debriefs into regular staff training activities, including clinical and laboratory teams. c. Concessionary, rapid release of the best matched red blood cells for patients with red cell antibodies. d. A process for recording participation and identifying dates for re-training. e. Treatment of patients who refuse transfusion of blood components and/or products.	a. Major Haemorrhage activation and blood component availability covered in mandatory transfusion education b. blood transfusion laboratory and obstetrics conduct regular simulations, ED have just started but no Trustwide simulations c. Laboratory policies in place d. HIVE records e. 'No Blood' policy in place	a + d. All Staff -75% Moor to Sea 64% Torquay 85% Coastal 77% Paignton and Brixham 77% Newton Abbot 75% Trustwide Support 79% Consultant 75% Foundation 1 95% Foundation 2 79% Speciality Doctor 44% Speciality Registrar 44% b. varied c + e. 100%	a. ensure local transfusion training on induction for all staff involved in the transfusion process b. implement standard MH simultation drills for all clinical teams	unsafe transfusion practice	a. Debbie Alford Jess Piper b. Trust Simulation lead	tbc
investigate all transfusion delays to identify system factors for improvement.	DATIX, SABRE/SHOT reports	100%	ensure learning from incidents is adopted across the organsiation - included in PSIRF	significant adverse incident	Faye Sutton	

Sep-23

Stroke Improvement Plan - April 2021

Outcome	Owner	Action	By whom	Progress
Assurance that scope of concerns and issues requiring improvement is understood through deep dive into current quality and safety metrics	Rhoda Allison & Lesley Wade	Review incidents, complaints and concerns over past 2 years and identify trends	Rhoda Allison	Completed (see attached). No identified trend in complaints or concerns but increase in moderate harm incidents in last quarter [Word icon] M:\ACUTE\ HOP_stroke\Stroke\ Incidents and
		Conduct a review of moderate harm incidents in last quarter (Jan- March 2021)	Andy Mortimore	Completed - 6 incidents identified- One related to security (patient not on supportive obs-Andy to check a one point in stay this occurred): One related to medicines (primary card record error): One PU not hospital acquired: One related to IPC; C-diffs were all different types- One PU still to look at; and NE April: 0 moderate harms or above; May: 1 moderate harm (security incident- ? no harm); June: 1 severe (fall causing fractured pubic rami).
		Identify medical resource to complete systematic judgement review of mortality cases (2017-2019)	Lesley Wade	Completed - Current mortality data is 2017-2019: 10 SJR's were completed last year. A further 10 are required. Dr Shash Rajan is allocating them across HOP/Stroke to be completed within 4 weeks & summary produced. List being provided to Dr Shash Rajan 15/07/2021 who will pass on. New data was reviewed and showed that we were not an outlier - therefore action was no longer required.
		Hold forum with medical registrars re their feedback on quality and safety in stroke	John France/Chris Cawston	Completed - 13/05/21 All registrars e-mailed: e-mail feedback received & date being sought for a meeting. 17/02/2022 - Email has been sent out and responses recieved from two registrars. No official forum. No concerns have been raised. Action closed
		Complete a datix on recent patient with high BP who was not managed and investigate	Andy Mortimore	Completed - investigation showed thaere was one BP reading outside of agreed parameters which was not escalated
		Complete joint investigation of recent incident with ED	Rhoda Allison, John France, ED	[Word icons] C:\Users\ALLIR99\ Documents\ incidents\Meeting C:\Users\ALLIR99\ Documents\ incidents\Meeting
		Complete investigation into never event	Andy Mortimore	Completed - The NEVER event has been completed and reports have been sent off. The event which was on George Earl and involved the NG Tube, will be presented at Quality Assurance Committee including slides produced by Rhoda Allison. There have been themes in respect of documentation and also some issues with the policy. Therefore, suggestions of amendments are placement of the tube. Presentations being made to various committees and more feedback once the outcomes have been agreed
		Conduct AAR on last 1 infected cannula	Nicola Hughes-Jones	Completed - No infected cannula
		Complete AAR for recent C Diff	Nicola Hughes-Jones	Completed - with IPC: all different c diff- no lapses in care
		Review readmission rates & benchmark with other Trusts	Lesley Wade	Completed
		Live patient experience surveys to be carried out monthly	Andy Mortimore	Complete/Ongoing- feedback is positive. data stored in GE shared drive and displayed on ward 'How are we doing'board 16/12/21 Marina is being trained to deliver this on a monthly basis from January 2022. 17/02/2022 - Ashley, James, Lesley and Rhoda to provide two hours per month to deliever this action - ongoing. Action closed.

Outcome	Owner	Action	By whom	Progress
Robust hyper-acute stroke pathway inc. scanning, thromboolysis, access to stroke unit & access to specialist staff	John France	Development of single document: Clinical guidance re: Acute pathway (in line with policies) plus recording of patient information	Tanzil Al-Imran/John France	Has been developed - needs sign off. John France and Helen Harris have seen proforma - yet to be implemented - 16/12/2021 18/02/2022 - To be sent out to HOP Stroke consultants for discussion at next business meeting.
		All Acute Stroke pathway related guidance & information available on single ICON page	Amanda Goodwin/Caroline Smith/Ashley Armitage	Completed - Information now available on ICON
		Ensuring early identification & management of suspected stroke in ED Fast swabbing in ED	Rajesh Ramakrishna	Completed - 08/06/21 Raj contacted by Rhoda Allison & he has confirmed this is not done & he is away until end of June. RA has asked if anyone else can complete // Action taken out 17/02/2022 - Joann Hall has taken action through the SSANP meeting to request swabs are completed on ambulance to support fast swabbing.
		Ensure radiology aware that Stroke alerts require prioritisation for CT	John France	Completed - Agreed with Tim Simpson that Stroke alerts get priority for urgent CT. Second priority only to CT Trauma scans. Will be monitored for progress by Stroke Co-ordinators & via SSNAP DIY
		Robust management of beds via Control to maintain ring-fencing for acute stroke admissionsRobust management of beds via Control	Andy Mortimore/Lesley Wade	Completed - Control Room form changed to reflect broader situation in acute stroke re: beds & outliers. Member of stroke team of operational team feeds back at 10:00 Control. Still struggling due to pressures re: general medical demand & flow, but process in place
		Training & competencies in swallow screening	Cate Hayman	Linda Gibson starting in the new year - to work with Cate Hayman on this 06/12/2021 17/02/22 - Updated Swallow Screen training to be uploaded to the HIVE. Nursing staff to be advised once training is live. Rhoda and Liz to take to ADNPP's and Matrons for sign off. If not approved, an alternative will be provided.
		Identify which RNs and HCAs will provide hyperacute care post thrombolysis or for haemorrhagic stroke	Nicola Hughes-Jones	Completed - There is a list of HCA that may be used for post thrombolysis care immediately- these staff have been identified to receive training first
		Arrange Practice Educator hours to support training to hyperacute staff in neuro obs and when to escalate	Andy Mortimore	Completed - Jo Wheaton to provide 18 hours per week for May. ISU agreed to extend for 3 months.
		Write competencies for: Band 2, Band 3, Band 4, Band 5	Jean Buxton	Completed.
		Issue competencies to all band 2, 3,4 and 5 staff and invite self assessment	Nicola Hughes-Jones	Completed.
		Ensure that HCAs providing post thrombolysis care immediately have these acute competencies signed off (inc manual BP)	Nicola Hughes-Jones/ Jo Wheaton	Completed - 6th July - All have had training & 19 HCA's have had competencies signed-off. 100% of the staff had education in the competency for lysis. Not all staff have been signed off. All areas have a formal sign off in respect of competency - Complete
		Ensure that all remaining staff have acute competencies signed off (inc manual BP)	Jean Buxton/Jo Wheaton	Completed - Therapy competency being updated and using the stroke specific education framework. Laura Shenton to speak to Jean Buxton in respect of whether the current competencies have used the Stroke Specific Education Framework
		Provide training on hyperacute management of haemorrhagic stroke to nursing staff	Jean Buxton/Andy Mortimore	17/02/2022 - Andy to clarify with Jean that blood pressure training has been completed. Evidence to be sent to James for saving in evidence folder. ISO care evidence to be sent as well.
		Conduct snap-shot audit of BP Management on ward	Nicola Hughes-Jones/Andy Mortimore	Completed - 14/5/21 and 17/5/21 snap-shot audit Feedback given to RN in relation to BP management. Evidence of appropriate escalation. Completed

Outcome	Owner	Action	By whom	Progress
Robust, resilient & skilled nursing workforce	Andy Mortimore	Complete nursing workforce plan	Andy Mortimore	Completed - 13/05/21 Laura Millgate & andy Mortimore meeting 20th May
		Standardisation of skills & competencies for band 6 and band 7 nurses	Andy Mortimore	Completed - Linda to work with Jean and Andy to review whether this needs work.
		To share comptencies with Templar team	Andy Mortimore	Completed - Linda to pick this up with Jean and Andy.
		Development plan for Band 6 staff	Rhoda Allison	Completed - In place & being led by Mike Bilham. First session took place April- unclear who attended. Request update from MB after 3 months
		Band 7 to be supervisory for 6 months to stabilise the service- needs ECF for backfill	Andy Mortimore	Completed
		Sharon Boyne (ADNPP Coastal) to work with matron & nursing team to identify how RCN Leadership course could be utilised	Andy Mortimore	Completed - July: starting roll out of observations of care training Obs of care session delivered to staff by SB. Further sessions would be helpful. 17/02/2022 - Lucy Waring linking to Trust's Pathway to Excellence programme. Observation of care session delivered to staff by SB, further sessions would be helpful.

Outcome	Owner	Action	By whom	Progress
Robust Medical cover for Acute Stroke pathway	Lesley Wade	Identify what is required for Geriatrician team to meet SSNAP definition of "appropriately trained physician"	John France	Completed - 26/05/21 John France to contact RCHT where Geriatricians provide TIA clinics & support stroke. Complete - Chris Cawston (06/01/2022).
		Clarify when Dr Bhaskaran will be returning	Lesley Wade	Completed - 27th April 2022 - Confirmed with John France (4/1/22)
		Enhance stroke skills in HOP team	John France	Completed - Dr Cawston to do NIHSS accreditation. Consultants to attend thrombolysis training in August. Complete - Chris Cawston (06/01/2022)
		Secure locum for stroke	Lesley Wade	Completed - Currently reviewing CV's of 2 locums & trying to book. 15/07/2021 Stroke locum appointed and will start 19/07/2021

Outcome	Owner	Action	By whom	Progress
Improvements in oral care delivered to patients on GE	Andy Mortimore	Conduct baseline audit of provision of mouthcare and state of oral hygiene	Jo Brudenell	Completed – identified potential improvement in assessment of oral hygiene, provision of care and outcomes in oral hygiene
		Ensure resources are available (posters) to prompt staff on oral care	Andy Mortimore	Completed
		Education session with regional team and SLT on oral care	Andy Mortimore	Completed- 19 staff attended
		Launch oral care assessment tool	Jo Brudenell	Completed
		SLT staff providing further education sessions	Jo Brudenell	Completed - re audit to be provided to show sustained education (06/01/2022)
		Finalise the SOP for delivering oral care	Andy Mortimore	Due shortly - JH emailed AM for SOP 06/01/2022 SOP is written with NHSE/MCM for comment and requires sign off.
		Reaudit standard of oral care on GE	Lucy Waring/Andy Mortimore	Completed - Due by month end July 2021 Andy to send over results for evidence of reaudit 06/01/2022). Lucy Waring to do further reaudit mid 2022.
		Obtain small supply of 360 tooth brushes to trial	Jo Brudenell	Completed - RA confirmed we can remove.
		Enable procurement of non foaming toothpaste	Jo Brudenell	Completed - RA confirmed we can remove.

Outcome	Owner	Action	By whom	Progress
Ensure robust Management & Governance structure for the stroke service	Lesley Wade	Review form and function of SSNAP meetings including TOR with roles & responsibilities	Lesley Wade/Julie Clark	Completed - 26/05/21Meetings held with Julie Clark & Mandy Goodwin. TOR to be updated & MT site to be created plus clear set of folders in GE drive. Completed
		Invite ED & Radiology representation to monthly SSNAP meeting	James Hobbs/Ashley Armitage	Completed - Both ED & Radiology have agreed to attend. To be invited to June 9th meeting by MG/JC. Completed and will attend the meeting on 21/07/2021. However, Radiology representatives unable to attend on a Wednesday so will need to re-arrange day of meeting should they need to be present.
		TOR for Stroke Management meetings	Lesley Wade	Completed
		Update acute stroke policies	John France/Caroline Smith	Completed - 13/05/21 Nursing policies updated. Three policies CL014, G1739, G1416, due for update by 29th June 2021. Will be reviewed by that date. 06/01/2022 - All up to date (06/01/2022)

Outcome	Owner	Action	By whom	Progress
Availability of accurate data to inform improvement	Lesley Wade	Robust data re: los & readmission for stroke patients	tbc	Completed
		Use of DIY tool to monitor performance	Bev Coomes	Completed - 08/06/21 Julie to speak with Bev to ensure this is done fortnightly.
		Analysis of 4-hr stroke breaches from previous two weeks	Lyndsey Harper	Completed - 08/06/21 Toni Boarer to work with Julie Clark & nurses to get consistent & in-depth analysis. Data now available for each meeting. Two week breach analysis is distributed by LH.
		Dashboard for use in SSNAP meetings (monthly)	James Hobbs	Completed - 08/06/21Graphs/charts available but need refreshing & sharing for regular use

Outcome	Owner	Action	By whom	Progress
Consistent & accurate recording of SSNAP data	Lesley Wade	Review role for inputting/administration of SSNAP	Andy Mortimore	Outstanding - Part of workforce review work. - Pause and review after the winter 17/02/2022 - James Hobbs to arrange meeting with Jean, Andy, Lesley, John, Ashley and Lyndsey to discuss how to recruit admin.
		Training for all staff recording SSNAP to ensure consistent & accurate recording & a clear understanding	Andy Mortimore/Lesley Wade	Completed
		Ensure National changes to SSNAP reporting are reflected in electronic SSNAP	Lesley Wade	Completed - 08/06/2021 Project form completed for IT to try to get work prioritised.

Outcome	Owner	Action	By whom	Progress
Equitable access to specialist rehabilitation	Laura Shenton	Review of SALT capacity & skill-mix to include ability to provide daily input as per SSNAP requirements	Cate Hayman/Jo Brudenell	Completed - 17/02/2022 recruitment to vacant posts remains an ongoing problem.
		Work with ISDN on approach for improved training for staff on psychological support for stroke survivors	Isobel Ewart	Completed - 17/02/2022 - Action to be removed and to be reviewed with the network.
Y:\STROKE IMPROVEMENT PLAN May 2021\		Audit of staffing levels in Stroke Rehab team; to complete benchmarking against other services	Laura Shenton	Completed - National stroke organisational audit completed- awaiting results 17/02/2022 - Action to be removed and to be reviewed with the network.
		Work with ISDN on approach to six-month reviews (potential to commission via Stroke Association)	Laura Shenton	Completed - Telephone pilot was conducted using post stroke checklist- this identified a numb er of unmet needs which were signposted on. The model did not meet SSNAP requirements of 6 month reviews. ISDN working up a project re a networked approach 17/02/2022 - Action to be removed and to be reviewed with the network.