Torbay and South Devon
NHS Foundation Trust

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

Quality Accounts 2024/25

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Part 1: Our Chief Executive's statement on quality

I am proud to introduce our quality account for 2024/25, my first as your Chief Executive. Since joining Torbay and South Devon NHS Foundation Trust, I have seen firsthand your unwavering commitment to ensure our patients receive high quality, safe care.

Despite working in an extremely demanding climate, against a backdrop of increasing demand for care and support and significant financial challenges, our people continue to go above and beyond every day to deliver safe, compassionate care.

I'm proud of our people and all they do, but morale in some areas is very low. We cannot support our patients if our people do not feel safe and supported, and during the past year we have worked hard to create a compassionate and inclusive culture and workplace where they feel safe to speak up if they see or hear something which may cause harm to others. Our new Patient Safety Incident Support Framework (PSIRF) is a key enabler of this work and one which our people and teams have worked hard to embed.

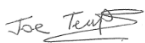
We continue to work with our partners across the NHS, local authorities, Healthwatch, and the voluntary sector to deliver a truly integrated health and care system, where people can access the services and support, they need, in the right place and at the right time.

We are making some improvements in key areas: our waiting times for diagnostics, planned care and cancer treatment times are getting better, but we are still not meeting national targets. Demand for our urgent and emergency care services also remain high and this is putting pressure on our frontline teams and the ambulance service.

Our new plan for better care will help us deliver our promise to support people to have the best start in life, to take control of their health, and to age well. It builds upon our strengths to increase quality, performance and value for money, and at its core is our commitment to quality and safety. Clinical engagement is embedded across all of our programmes of work to provide safe and quality care that fosters and embeds a learning and improvement culture because these are the things that are important to us.

This year's Quality Account highlights areas where our people should feel proud of and also where we need to keep up momentum and remain focused on. I want to thank all of our people for their commitment to providing high quality care. It is thanks to your dedication and passion that we have seen improvements during the past year and I hope that we continue to deliver our brighter future for people in Torbay and South Devon.

Best wishes



Joe Teape
Chief Executive

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

What is a quality account?

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

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

This information has been used to report on our progress against the priority areas we identified for improvement in 2024/25.

Our quality priority areas for next year, 2025/26, are also included. We have developed these in line with the CQC ‘we statements’ which are designed to put the person at the centre of their care.

2.1 Priorities for improvement 2024/25

Our priorities for 2024/25 were aligned to our four quality and patient safety goals, and we continued to focus on embedding improvements made the previous year.

Figure 1: Quality Goals 2024-25

For each quality goal we identified one or more priorities for focused quality improvement. These are:

Table 1: Quality goals and priorities 2024/5

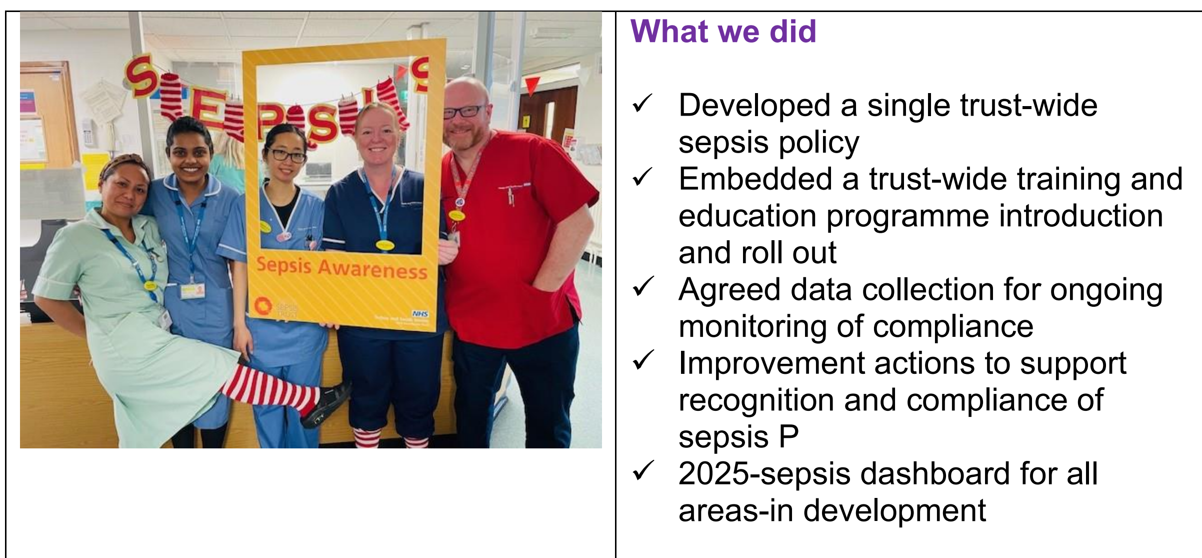
Quality goal 2024/25	**Quality priority 2024/25**
Continuously seek out and reduce harm:	Improve identification and management of sepsis Strengthen the quality of our mental capacity assessments (MCA)
Excellence in outcomes	Reducing falls and harm sustained from falls Reducing emergency and elective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

Continuously seek out and reduce harm:

What we did and how we did

We committed to **improving the identification and management of sepsis**. Sepsis is a rare but serious complication of an infection. Without quick treatment, sepsis can lead to multiple organ failure and death. When a person presents with symptoms that may be related to sepsis, it is crucial that key clinical interventions are initiated swiftly, in line with the national standards which as described as the sepsis bundle.

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

	**What we did** ✓ Developed a single trust-wide sepsis policy ✓ Embedded a trust-wide training and education programme introduction and roll out ✓ Agreed data collection for ongoing monitoring of compliance ✓ Improvement actions to support recognition and compliance of sepsis P ✓ 2025-sepsis dashboard for all areas-in development

How we did:

We have seen a sustained improved performance in our emergency department (ED) in relation to sepsis six compliance which achieved 97%. Antibiotic administration has been consistently achieved within 60 minutes at 96% in line with national guidance; this despite ED pressures. Our team remains focused on the safety of our patients who are in the waiting room or in an ambulance to ensure that location does not delay upon prompt treatment.

Figure 2: compliance with sepsis 6 bundle

Figure 3: antibiotic administration within 1 hour

Improving the identification and management of sepsis will **remain a quality priority for 2025/26** to ensure that practice is embedded. A trust-wide sepsis audit began in April 2025, and the results will inform ongoing improvement work. We have an ambition to establish a sepsis dashboard for all areas; this is in development, the impact of this work will be captured in next year's quality account.

Continuously seek out and reduce harm:
We committed to **strengthening the quality of our mental capacity act (MCA) assessments** to better support our patients and enhance quality of care.

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

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

Our Safeguarding Adult/MCA leads have provided tailored training sessions to ward teams and attend and support areas where Deprivation of Liberty (DOLs) are in place to enhance the quality of MCA reviews and oversee restrictive practices.

How we did:
Communication with our staff has been critical to embedding this improvement work. Our MCA leads have established a weekly virtual meeting which staff can call into for advice/guidance and support. Regular updates are provided for our staff and shared via ICON bulletin. An MCA app and flowcharts have been developed, alongside other resources which are available as part of our resource pack.

MCA staff survey highlighted areas of good practice which could be further enhanced with additional training and support for staff. Regular local audits are undertaken by the safeguarding team to monitor standards regarding MCA compliance. In addition, during 2024/25 Audit Southwest (ASW) completed 2 independent audits for DOLs and advocacy. The ASW audit found limited assurance.

An action plan has been formulated based on the audit and staff survey findings; this will form the focus of this work for the next 12 months. **MCA will remain a quality priority for the coming year.** Our MCA leads are developing a standard operating procedure to support the practical application of the MCA.

Excellence in outcomes:

Reducing falls and harm sustained from falls

In last year's Quality Account, we renewed our commitments to reduce the number of patients who fall within our care and the level of harm experienced if patients do fall.

What we did

To support this safety priority our leads undertook significant work to publicise falls prevention in the hospital and community though radio messaging, posters which used the call don't fall campaign message, screensavers and social media.

More than 350 of our clinical staff have been trained in falls prevention.

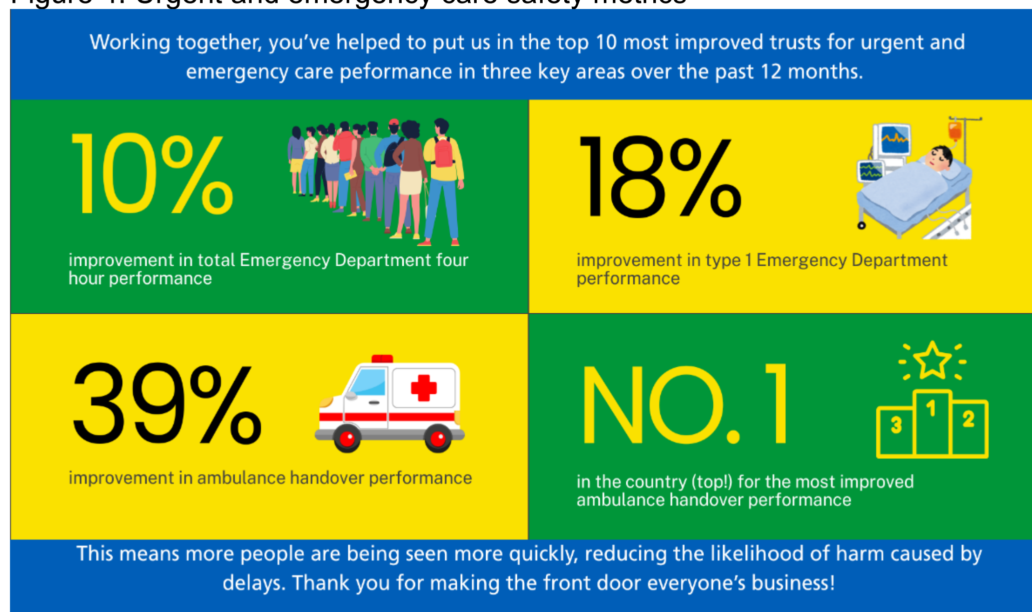
Our teams continue to embed the fall safe audit, including visual assessment, lying and standing blood pressure and to audit compliance against this for all clinical areas.

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

How we did:

As a result of this improvement work, we have seen a reduction in patients who fall, and a reduction in harm from falls (fractured neck of femur) which demonstrates the impact of this improvement work on quality and safety for our patients. Our work to reduce falls will continue being led by our falls leads, it will remain high profile and ongoing and will be stood down as a quality priority for the coming year.

Reducing elective and emergency care delays
During the past 12 months we have continued our focus on reducing delay across our urgent and emergency care (UEC) pathway to improve patient safety and quality of care. Our teams have worked to achieve significant and measurable improvements across UEC during the past 12 months. Our improvement has been highlighted nationally, and we are one of the top 10 most improved trusts in the country for three key measures.

Figure 4: Urgent and emergency care safety metrics


We committed to reducing ambulance handover times and the number of patients who wait more than four hours in our emergency department. We have seen significant improvements in patients being seen within four hours.

We are committed to embedding and sustaining these improvements to provide safe care for our population. Ensuring patient care is in the right place as soon as possible across our emergency pathways remains a priority for our organisation for the next 12 months.

How we did

To measure improvements, we have compared April 2024 performance to April 2025.

We have seen:

- a reduction in ambulance handover time to 25 minutes from one hour 33 minutes, this means our patients are assessed by our teams more rapidly
- improvement in the percentage of ambulance handovers completed within 15 minutes from 15.9% to 32.2%. This means ambulances are released swiftly to respond to those in need
- more patients being treated within our ED in four hours, which enhances quality of care

Reducing elective care delays

Our teams have worked hard to reduce the amount of time our patients are waiting to access elective treatment. We have made significant progress in meeting national targets for waiting times which is seen in the table below. We continue to strive to do better. We are using our operating theatres more efficiently and our teamwork has improved. This will support improved outcomes for our population.

Table 2: Elective care, patients waiting by number of weeks

	April 2024	April 2025
78 weeks	99	4
65 weeks	423	145
52 weeks	1796	950

We have met the national waiting time targets for patients with suspected cancer and those who require onward treatment including:

- 28-day Faster Diagnosis Standard: 80.2% (target was 77%)
- 62-day treatment standard: 75.6% (target was 70%)

We have experienced some delays in radiotherapy treatment due to challenges in recruitment to key posts which are being experienced across the region. We continue to monitor this position and are seeking to recruit to these posts.

Delivering what matters most to our people:

How we did: Engaging patients and their families

We committed to strengthening our engagement with patients their families and staff when reviewing safety incidents or responding to complaints.

This work remains ongoing and is a priority for 2025/26 as we continue to embed the patient safety incident response framework (PSIRF) committed to sharing safety investigations reports with patients and families to ensure all concerns are addressed and to confirm accuracy.

We will continue our priority to reduce elective and emergency care delays during the next 12 months due to the significant impact improvements will have for our population

Embedding a just learning culture to better support our people
We emphasised our commitment to support and grow a just learning culture (JLC) to ensure our people feel safe and supported to speak up if they see or hear something which may cause harm or are involved in an incident which may need to be investigated. We have promised to ensure people are treated fairly and a systems approach is taken when incidents occur and require a safety review or investigation.

How we did
We have made progress in engaging patients, their families and our people in safety investigations, however we recognise that there is more to be done to ensure that everyone is consistently supported and engaged as partners in safety reviews.

Progress against this priority has been restricted due to our financial position; there is no dedicated resource or budget assigned to lead this work as a transformational project and the scale and pace of change has been limited. Our focus has been on embedding priorities that directly impact patient safety.

Work is underway to start to make small changes in this area via a 'golden thread' approach, weaving a just learning culture into all we do through ongoing policy review and leadership development. We recognise the importance that an open and just culture has upon staff feeling safe to speak out, our freedom to speak up guardian (FTSUG) is invited to attend our safety insight meeting to share any themes and trends which may impact patient safety. Our patient safety team is committed to leading by example to compassionately and fairly engage our people when Safety incidents occur.

Just learning culture is central to our safety strategy and will remain a quality priority for the next 12 months.

Reduce healthcare inequalities: Our remote rural and coastal communities have some of the highest levels of deprivation in the country. We committed to seeking out and reducing healthcare inequalities across our Devon health and care system. We recognised the adverse impact that COVID-19 had upon all aspects of health and social care but those who live in our most deprived communities have seen an increasing gap in health inequalities. We asked each of our four care groups to identify their priority for reducing health care inequalities based on their identified and diverse needs.

We held a workshop with our four care groups on 01 October 2024 to highlight the impact of healthcare inequalities Following that workshop priority workstreams were identified in the following areas:

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

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

Children and Family Health Devon (CFHD) is developing its health inequalities strategic plan. This includes the development of a health inequalities data dashboard, implementing flags on an electronic patient record (EPR) for disability status and reasonable adjustments tool. CFHD is working with the ICB and Livewell CIC to pilot a clinical prioritisation tool which includes social determinants of health. CFHD has also started a pilot to help people with learning disability to be prioritised for community therapy intervention.

The progress and effect of these workstreams is being monitored by care groups and will remain a quality priority to embed these projects and wider work during the next 12 months.

2.2 Priorities for improvement 2025/26

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

Figure 5: Quality goals 2024/25

Quality goal: We will continuously seek out and reduce harm

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

Priority two: We will continue our work to **strengthen the quality of our mental capacity act assessments**. Our clinical teams will ensure documentation is fully completed and contains all relevant details. Our MCA leads will lead the implementation of recommendations made following a trust-wide audit which will be overseen by our mental capacity and safeguarding leads. The outcomes, learning and recommendations will be shared across all our services.

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

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

We continue our efforts to improve the quality of care for our patients by working with our system partners to reduce ambulance handover delays. We are committed to increasing the number of patients who are seen and have a decision made about their onward care or discharge within four hours of attending our emergency department to 78%. Our ambition is to reduce to zero the number of people waiting more than 12 hours to be seen in our emergency department.

We will remain focused on reducing long waits for planned care to enhance outcomes for our population. Our operational plan has made a commitment to achieving a 5% improvement in the percentage of patients waiting fewer than 18 weeks for treatment. We will reduce the longest waits for treatment, so fewer than 1% of patients are waiting more than 52 weeks from referral to treatment.

We have made a commitment to treating 75% of people with a cancer diagnosis within 62 days by the end of March 2025. We will give 80% of people referred for suspected cancer their diagnosis (or the all-clear) within 28 days by March 2026. Achieving these performance metrics will improve quality of care, patient safety and outcomes for our patients.

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

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

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

Quality Goal: Deliver what matters most to our people:

Priority one: We will continue embed PSIRF across our organisation. We recognise that PSIRF requires is a significant cultural shift and that supporting our people by creating a just learning culture is key. Our patient safety and people teams will work

together to continue our work to build a just learning culture. We will work with our FTSUG to ensure that our organisational culture is aligned with a just learning culture. Our leaders will role model these values.

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

Quality goal: Reduce health inequalities:
We are committed to **seeking out and reducing health care inequalities** across our Devon health and care system while continuously improving the quality of care. Work will continue within our care groups to identify and reduce health care inequalities to improve the health and wellbeing of our population. We have agreed to adopt the One Devon South Local Care Partnership's strategy to tackle health inequalities, and we will communicate this strategy widely within our organisation.

Reducing health care inequalities will remain a priority focus for the year ahead and next year's Quality Account will update on our progress against this ambition.

Embedding equality impact assessment (EQIA) in service change
We need to make changes to our services to improve quality and ensure we are spending the money which is available to us. We will ensure we minimise any planned changes which may adversely impact our population from a quality or equality perspective. We will ensure that decisions in relations to cost improvement programmes are informed by potential impacts on quality (safety, effectiveness and experience) and on health inequalities (access, experience and outcomes) via embedding a robust EQIA process. We will ensure that a diverse panel approach is in place to review any service change which may impact patients or our people and consider any impact. This will be a priority for the year ahead.

2.3 Statements from our Board

Review and list of services provided by us
We are an integrated care organisation. We continue to work with and be accountable to:

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

A full list of our services is available on our website.

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

- Tier 1: The Board of Directors, its committees and the Council of Governors (corporate governance structure and legal structure)
- Tier 2: Executive governance (the most senior level of operational governance), led by our Chief Executive, we have instituted an executive committee which operates within the delegated authority of the Chief Executive.
- Tier 3: Trust senior leadership
- Tier 4: Functional leadership: care groups - reporting to tier 3.
- Tier 5: Any group or meeting reporting into tier 4.

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

Our services are delivered through our care groups; these care groups are:

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

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

Our executive committee reviews all information escalated to it as well as its own standard form reporting, agreeing the matters to be reported to the Board and Board-sub-committees, whose members have agreed work plans aligned to the business assurance framework, risk map and strategic priorities for the year.

Care Quality Commission (CQC)
We are required to register with the Care Quality Commission (CQC) to provide care, and our 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.

The CQC rated our inpatient and community children's services as good. You can read more about its findings at [CQC inspection reports published for children's services - Torbay and South Devon NHS Foundation Trust]

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

An action plan has been produced to address areas of improvement identified, with progress being monitored by our CQC assurance group and reports into the executive quality group.

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

Children and Family Health Devon also received a CQC Inspection in November 2024.

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

Our CQC ratings are:

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

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

Research and innovation

There is strong evidence showing a clear link between being a research active organisation and improved patient outcomes. Through active participation in research our clinical staff stay abreast of the latest possible treatments, we expand the opportunities available to develop our colleagues and we empower and engage the people we care for. Our mission is to embed clinical research as part of core business.

Our primary research business involves recruiting into national and international multi centre commercial and non-commercial studies as part of the National Institute for Health and Care Research Clinical Research Network (NIHR CRN) portfolio. In 2024/25 we recruited 2,048 participants to 72 NIHR CRN portfolio studies, across our clinical specialities.

We are the best performing trust in the country for the number of NIHR recruiting studies and number of commercial studies compared to similar sized organisations across England (NIHR benchmarking data for 2024/25).

Supporting the life sciences sector is a key objective for the government. We recruited 155 participants to 18 commercial trials. Our commitment to increasing commercial research activity means that research is a vital source of externally generated income for our organisation and provides an important alternative way to fund staff, equipment and training.

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

- We are the only NHS trust in the South West which is taking part in a ground-breaking cancer vaccine launchpad which is a way to treat patients on cancer vaccine trials. You can read more online: Torbay and South Devon NHS to host pioneering therapeutic cancer vaccine research trial - Torbay and South Devon NHS Foundation Trust
- We are the only site in the South West to offer a personalised vaccine to patients with bowel cancer as part of a trial and successfully the treatment to our first patient participant this year.

- We were the first site in the UK to recruit a participant to the XRAY VISION study comparing treatments for patients with head and neck cancer and REALITY-WW, a real-world haematology study for patients with chronic lymphocytic leukaemia
- We have a growing number of specialities becoming involved in commercial research and this year; the intensive care unit team was chosen to open its first commercial study.
- We have been the fastest recruiting site into studies across a number of specialties including orthopaedics and breast care.
- We were the top UK recruiting site for the ACCLAIM study looking at reducing lipoprotein in blood and reducing the incidence of heart attack and stroke.
- We are the only site in the Southwest taking part in the Chariot MS study exploring disease modifying therapies in slowing the progression of Multiple Sclerosis.
- We have taken part in research looking at early detection of disease, admission avoidance and using artificial intelligence to help streamline our services.

We continue to build our local academic capability through various training schemes in partnership with higher education institutions, Health Education England, NIHR CRN, and the Torbay Medical Research Fund (TMRF). In 2024/5, the TMRF was again awarded funding for one pre-doc and one doctoral fellowship.
Our people have successfully applied for one CRN Research Associateship and two CRN-funded Chief Nursing Research Fellowships, joining a growing a growing number of research-active clinical staff. Additionally, a further five of our clinical colleagues have completed the NIHR Associate Principal Investigator training programme; gaining invaluable learning and the practical skills associated with leading clinical research delivery.

In response to England's Chief Nursing Officer's nursing research strategy and allied health professionals national research strategy, we developed a new strategy for nursing, midwifery and allied health professionals (NMAHPs) which was launched in May 2024 and followed by a further conference in September 2024. We launched a competency framework to support all nursing, midwifery and AHP staff to be confident utilising research and evidence-based practice and are working with the University of Plymouth to identify how we can support this further in the coming year.

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

Our urgent and emergency care performance
We have implemented a range of improvements that have begun to have a positive impact on waiting times in the emergency department and ambulance handover delays. The focus on same day emergency care and optimising ward stays have been key top these improvements. We reopened our minor injuries units in Totnes

and Dawlish, which closed at the start of the pandemic, and now use a bookable appointments approach.

From December 2024 to March 2025 performance has improved significantly reflecting the improvements and investments made to improve emergency patient flow and capacity. Plans for 25/26 are to embed these improvements and achieve the operational plan standards of 78% of patients seen and discharged from the emergency department in under four ours and sustain an average handover time of less than 45 minutes. These areas are discussed in the quality priority section also.

Stroke service performance
During the past 18 months we have worked to improve outcomes and the experience for patients admitted to our services following a stroke. We were part of the inaugural Thrombolysis in Acute Stroke Collaborative improvement programme run by NHS Elect which began in November 2023. In 2023/24 the mean monthly thrombolysis (a procedure used to break down a blood clot) rate was 9.4% and this increased during 24/25 to 13.83%. While this improvement dropped in the first quarter of this year, we continue our work to ensure the right people are receiving thrombolysis and to increase the number of patients who receive thrombolysis. During the same period the proportion of patients reaching the stroke unit within four hours increased from 24.88% to 32.36%, while the proportion of patients spending 90% of time on the stroke unit decreased slightly from 69.64% to 67%.

Our stroke improvement plan remains in place and is managed through clinically led stroke leads meeting, and we remain an active participant of the Peninsula Acute Sustainability Programme (PASP) and collaboration has improved across the South West region.

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

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

We have consistently met or exceeded the key national cancer standards outlined in the 2024/25 NHS Operational Planning Guidance:

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

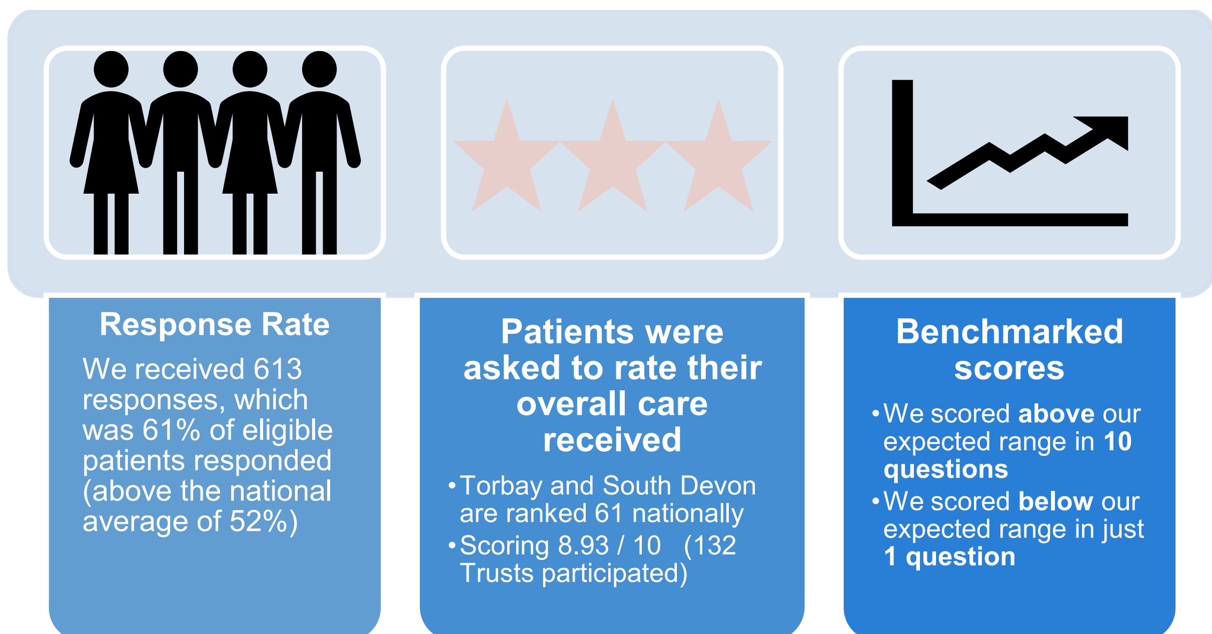
- **62-day referral to treatment standard:**
  In March 2025, performance reached 73.8%, with an annual average of 75.0%, again exceeding the national target of 70%. These standard measures

the percentage of patients who start their first definitive treatment for cancer within 62 days of an urgent GP referral.

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

National Cancer Patient Experience Survey (NCPES)
The annual national patient experience survey is commissioned and run by NHS England. It surveys all adult patients with a confirmed primary diagnosis of cancer who received cancer-related treatment in the months of April, May and June 2023. The results were published in July 2024. Our service was once again rated highly: [Local cancer services rated highly - Torbay and South Devon NHS Foundation Trust]

Figure 6: National cancer patient experiences survey results



In other achievements:

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

There are many more exciting innovations planned during 2025/25n the horizon:

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

Our planned care performance

As detailed in the quality priorities section, we remain committed to reducing waits for elective care to improve people's outcomes. We have made significant progress in meeting national targets for waiting times, In February 2024 we opened our new £15million day surgery and eye surgery theatre which is helping us to see, diagnose and treat people quicker, and improve their experience of receiving care. More than 2,500 people who needed a low-complexity cataract procedure have been treated at Torbay Hospital's new state-of-the art operating theatre thanks to the investment. As well as working in the new larger modern operating theatres, our ophthalmology team has recruited new clinical staff to manage the increased numbers of people who have been referred for treatment. As a result, people needing low-complexity cataract procedures are now waiting on average, fewer than 10 weeks to be treated since their referral.

We continue to strive to do better. For the year ahead we have plans to co-locate surgical admissions with theatres to help us to work smarter, as these areas are located a few floors from each other currently. We will continue to focus on reducing waits in oral maxillofacial surgery and ophthalmology services by increasing capacity.

Our community services

We have continued to collaborate with primary care and other system partners to ensure people in Devon are able to access community services in a timely way, in the right setting. We also provide opportunities to involve them in co-creating and designing changes to services to ensure they continue to meet people's needs and that they have a good experience of care.

We know that people come to harm the longer they stay in a bed, due to muscle waste and we continue to do all we can to support people to leave hospital when they no longer need acute care. Intermediate care beds continue to support more patients returning home. Our urgent community response services are exceeding performance targets with the volume growing.

There is continued focus with system partners to encourage the use of our community service pathway, and the teams are making positive use of irtual wards to minimise the risk of admission to hospital. Our community waiting lists continue to

improve through a focus on quality assessment, prevention, and promoting patient independence. We have focused on encouraging teams to use Attend Anywhere consultations where possible in community therapies and this is having a positive impact in reducing waiting times.

Community hospitals have been working closely with our discharge hub to ensure patients with a prolonged length of stay have a weekly review to make sure they receive the right care, in the right place, at the right time. There is further progress to be made in reducing how long patients remain in hospital, we are supporting twice weekly reviews of all our inpatients which has helped to focus attention on the Home First principle.

Community services: Quality and safety

Community hospitals and community nursing teams have undertaken a full review of staffing levels using NHS England's Safer Staffing tool to ensure the appropriate level of staffing is available to deliver high quality and safe care, using quality and safety metrics that are continually monitored monthly.Work is also underway on demand and capacity modelling across services and with partners to optimise the community models.

Community services: Innovation and independence

Technology-enabled care is being expanded to promote independence, and a new deconditioning training programme has already reached 40% of staff in six weeks with numbers growing. This is acute and community focused and promotes the values of retaining independence and preventing deconditioning. There is a frailty clinical reference group that is examining redesign of service and includes the interface between all community teams, and collaboration with NHS Devon and South Western Ambulance Service NHS Foundation Trust to promote better patient outcomes, minimising the need for urgent and emergency care admission.

Children and Family Health Devon

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

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

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

The speech and language therapy service has started using the Balanced System® framework to provide the right support at the right time. Our waiting list pilot, supported by Devon County Council, has received promising feedback from parents and carers.

The new joined-up approach brings families, carers and professionals together to support each child's communication needs more effectively. People who have been waiting the longest time to see a specialist therapist have been contacted and offered a drop-in appointment. offered a drop-in appointment. It's led to a wider rollout of the approach across other parts of the service, and we're already seeing reduced waiting times in several areas as a result.

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

The MHST support programme is being rolled out to all schools and colleges across Devon within the next four years as part of the government's plans to prioritise mental health prevention and early intervention in education, ensuring that every student has accessible mental health support.

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

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

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

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

Meanwhile, phase 1 of the refurbishment at Evergreen House in Exeter is nearly finished. The site now includes 17 modern, bookable clinical spaces. An accessible

new bathroom has also been installed to support both personal care and clinical assessments, helping us offer a more respectful and inclusive experience for those who need it most.

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

0-19 service

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

Key achievements from the quarterly reports include increased reach and support, with significant footfall into family hubs and enhanced support for underserved communities. The UNICEF Baby Friendly Initiative (BFI) gold standard was awarded for infant feeding support, and we launched the One Feed at a Time campaign to promote breastfeeding. Community engagement was strengthened through events like Ramble Club and breastfeeding picnics and Building Babies Brains awareness sessions.

The Family Hubs: Our first two years report highlights the introduction of 14 new services, 10 launches, three campaigns, and eight events. Recruitment included 15 new staff members and training of 25 breastfeeding peer supporters. The service received positive feedback from the Ofsted/CQC peer review, and increased reach and engagement, with more than 36,000 contacts with parents/carers and 31,000 with children.

Perinatal performance

Maternity assurance metrics are based on the required reporting as set out by NHS England Perinatal Quality Surveillance Model (2020) and Three- year Delivery Plan (2023). They are also based on the requirements set out in the maternity incentive scheme (MIS) as part of the clinical negligence scheme for trusts (CNST) via our maternity and governance and quality group. Metrics are shared via quality and safety assurance groups within the organisation and are reported to our board.

Birth rate

The number of births for 2024/25 was 1672, a reduction from 1760 in 2023/24 and following national trends.

There continues to be an increasing complexity associated with pregnancy and birth due to several factors. These include demographics, health inequalities as well as

being related to the standards that underpin safe care. There is also an increased requirement for operative /obstetric intervention during the birth process which impacts on the resources and capacity of the services.

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

Perinatal mortality rate
The graph below shows the perinatal mortality detail for 2024/25. The service recorded three stillbirths, one late fetal loss and two neonatal deaths in 2024/25. There is no universally accepted definition of “avoidable’ mortality. Perinatal mortality trends are reviewed in detail at the mortality surveillance group and individual cases are also reviewed by the child death overview panel (CDOP) to provide additional scrutiny. We review our data for patterns /themes with a focus on:

- learning and improvement
- Identify risk factors
- Consideration of the local context
- Application of the perinatal mortality review tool (PMRT).

We use a nationally mandated reporting framework called the perinatal quality surveillance model. This enables demonstration against the aim of achieving the national target to reduce brain injury and stillbirth, neonatal and maternal deaths by 50% by 2025. The most recent national data does show a reduction in both stillbirth and neonatal death however the gap continues to grow between the most deprived and the least deprived populations.

We work as one system and our work is aligned to the Devon Local Maternity and Neonatal System (LMNS) and we comply with reporting to NHS England.

Figure 7: stillbirth, neonatal and late fetal loss data

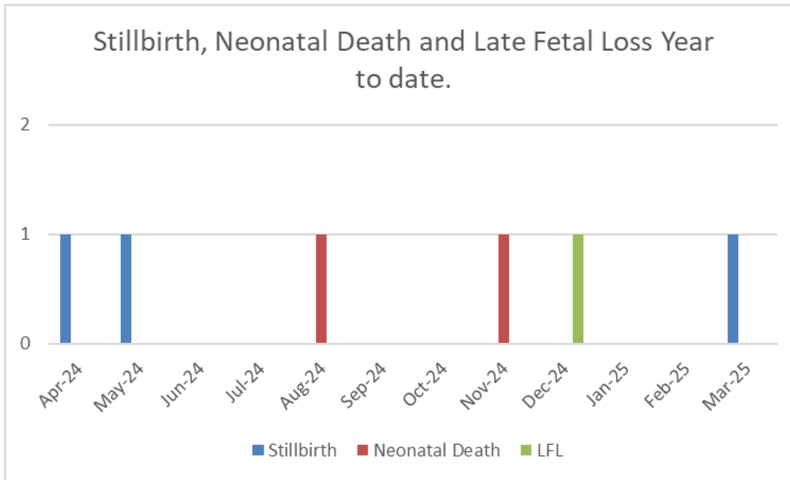
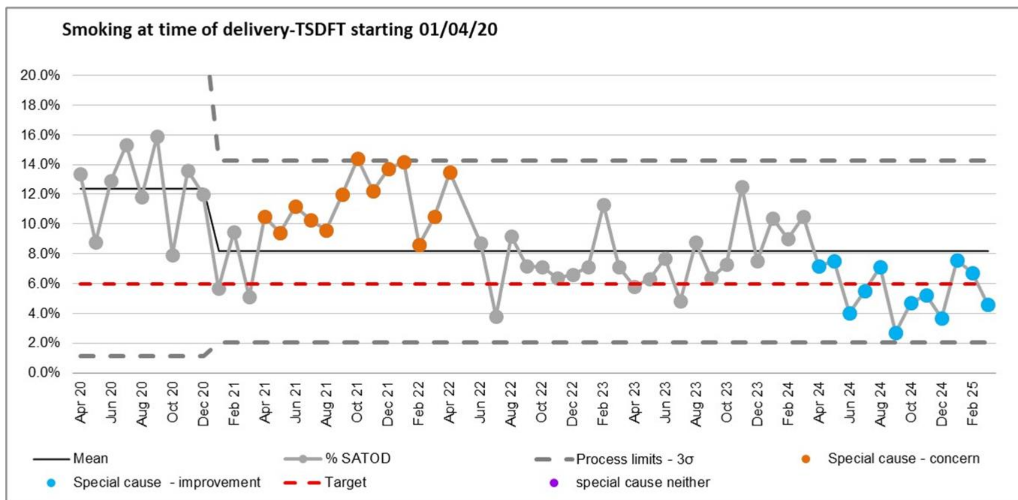


Figure 8: Smoking rates at time of delivery



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Our award-winning smoking cessation team continues to support people to quit smoking and vaping during pregnancy, and during 2024/25, 5.5% of people had stopped smoking at the time of delivery – below the national ambition target of 6%, which is a fantastic achievement for our team. For context in 2017/18 the rate of smoking at time of delivery was around 15%.

The team produced a video in which women shared their story around the successes in quitting. We are also participants in the national smoke free pregnancy incentive scheme.

In November 2023, the Care Quality Commission (CQC) carried out a short-notice inspection of maternity services at Torbay Hospital as part of its National Maternity Inspection Programme. The inspection looked only at the safe and well-led key questions.

Inspectors rated our clinical services in maternity as good and noted that our midwives provide safe, compassionate care to women and families. Following the inspection, we produced an action plan and have now completed most of the actions.

Neonatal Transitional Care services Our Neonatal Transitional Care (NTC) unit opened in December 2023 and includes four cots. This was a result of significant work at pace and collaborative working between neonatal and maternity teams to bring this to fruition. NTC is defined as a service, rather than location and at Torbay is delivered primarily in a bay on the Special Care Baby Unit (SCBU) footprint but is also supported on the post-natal ward; care is provided by neonatal nurses, nursery nurses, midwives and maternity support workers with collaborative working resulting in both positive outcomes for mothers and babies.

Provision of NTC aligns to the British Association of Perinatal Medicine (BAPM) framework and is, in essence about keeping mothers and babies together. The philosophy of care supports resident post-natal mothers to be primary care givers for their babies with care requirements above normal newborn care, but who do not require admission to a neonatal unit. This not only supports the nurturing of close and loving relationships but also facilitates the delivery of family centred care through active involvement and consideration of fathers/partners and extended family.

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

Reablement pilot: Promoting independence
Recognising the importance of supporting people to regain and maintain their independence, our delivery partners Channel 3 supported the launch of a reablement pilot in 2024. The aim was to optimise independence for people via a community pathway and those on the waitlist enabling them to regain skills and confidence with daily living activities.

Key achievements of the reablement pilot include:

- Increased independence levels for people, with 79% of people achieving full independence following their reablement intervention and not requiring a package of care.
- A proportion of people ended up with a reduced package of care because they had developed the skills for daily activities.
- A reduction in commissioned statutory support packages, as people are better equipped to manage their own health and well-being at home.
- Positive feedback from people who use our services and their families, who report improved quality of life and greater confidence in self-care.
- Cost efficiencies within the care system, as more individuals successfully transition to lower levels of support.
- Building on this success, we will be integrating reablement principles further across our services to ensure more people benefit from strengths-based

approaches that promote self-sufficiency. Learning from the pilot will used in future commissioning activity.

Front door improvement work: managing demand and promoting diversion
To enhance how people access adult social care support, we have undertaken a 'front door' service improvement activity which aims to improve demand management by promoting diversion to more appropriate services. This work aligns with our Care Act duties, focusing on early intervention, diversion, and appropriate signposting to community-based support.

Key improvements include:

- Strengthened partnerships with community organisations and voluntary sector services, providing alternative support options that prevent escalation of need.
- Enhanced workforce training to embed strengths-based conversations, focusing on what people can do rather than what they cannot.
- Implementation of an enhanced telephony system.

As a result of these improvements, we have seen:

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

Adult social care panels
Adult social care panels are a decision-making body within adult social care services that consists of senior professionals and key health stakeholders. Panel representatives are responsible for overseeing, reviewing, and making important decisions about the care and support needs of individuals, as well as ensuring that resources are allocated effectively. To improve decision making within panels we have considered practice and processes to improve their effectiveness.

Key improvements include:

- Streamlined processes which have led to enhanced oversight and accountability.
- More effective decision making because of changes to meeting preparation including a standardised format and chair.
- Technology enabled care and intermediate care are now consistently represented in all meetings.
- Commissioning representatives attending the complex care panel.
- The adult social care team validates care package costs and processes care home placements.

All of which is contributing to improvements in cost control.

Technology Enabled Care (TEC)
Embedding TEC across the service to empower people to fulfil their potential, maximise their independence and remain in a place they call home is a focus for

teams. Focus was given to improve practice across teams to drive the opportunities for people to receive TEC as part of packages of care.

Key improvements include:

- •Since April 24, 29% new people are now receiving TEC.
- •An additional 28 TEC champions across teams since July 2024
- •A staff practice survey baseline practitioner's confidence with TEC and initiatives identified to help them improve.
- •A TEC decision making tool launched with teams to assist with linking peoples' outcomes and TEC equipment.
- Work is also underway to develop a new TEC model to commission direct payments
- Enabling people to have choice and control over their care is an important feature of adult social care. In June 2024, a review was undertaken on direct payments with a series of recommendations which include:
    - •Improved policy and procedures.
    - •Streamline processes and resources to support operational teams' practice.
    - •In depth analysis of the Personal Assistant (PA) market and improve visibility and quality of PAs.
    - •Exploration of a direct payment officer role to drive practice improvements.

Hospital discharge
Time was spent with teams to understand the issues and impacts for people discharged through pathway 2. A multi-disciplinary approach was used to review cases and understand through a social work lens if people could have achieved a better outcome. Recommendations are under review, but immediate actions were taken to:
Improve TEC practice by organising training for the team.

- Reinforce Home First principles.
- Address improvements linked to mental capacity assessments

Adult social care
The work undertaken in 2024/25 has demonstrated the impact of proactive, person-centred approaches in adult social care. We will continue to refine our reablement offer, expand our front door improvements, and strengthen our partnerships with health, housing, and community services to create a more sustainable, integrated system of care.

We remain committed to ensuring that all residents receive the right support at the right time, promoting independence, and enhancing quality of life across our communities.

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

Directors. The table below summarises the latest monthly performance against the selected key national indicators.

Table 2.

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

* March 2025 position
** February 2025 position

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

The key operational performance targets are:

- Improve referral to treatment waiting times with 5% improvement to 66.6% of patients waiting less than 18 weeks from referral to treatment by 2026
- Reduce patient delays in the urgent and emergency care setting to achieve 78% of people seen within four hours

- Improve diagnostic waits so 95% of people wait less than six weeks by March 2025
- Meet the cancer standards for faster diagnosis (28 days) 80% and treatment within 62 days from urgent referral 75%.

Secondary uses service and data driven quality improvement (DQIP)
We submitted records during 2024/25 to the secondary uses service (SUS) to include in the hospital episode statistics (HES). These are included in the latest published data.

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

Table 3: Admitted Patient Care (APC: Including Day Cases & Inpatients):

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

Outpatient Attendances (OPA):

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

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

- for admitted patient care – 99.9%
- for outpatient care – 100.0%

The data security and protection toolkit is an online self-assessment tool that allows organisations to measure their performance against the national data guardian's 10 data security standards. All standards were met in 2024/25.

Clinical coding performance
An annual data security protection toolkit audit of clinical coding has been completed. The audit was completed by an NHS Digital-approved auditor. Data security and protection toolkit (DSPT) audit results are:

Table 4: Data security and protection toolkit (DSPT) audit results

Primary Diagnosis (% correct)	Secondary Diagnosis (% correct)	Primary Procedure (% correct)	Secondary Procedure (% correct)
94.35	87.64	96.79	96.06

Clinical audit

We reviewed the reports of 29 national clinical audits from 01 April 2024 to 31 March 2025. Please see Annex 4 for the actions we intend to take to improve the quality of healthcare provided.

We reviewed the reports of 40 local clinical audits from 01 April 2024 to 31 March 2025 and 15 did not require any actions. Please see Annex 4 for the actions we intend to take to improve the quality of healthcare provided.

Part 3: Our quality indicators

Patient safety

During 2024/25 we:

- made progress against our patient safety incident response plan (PSIRP)
- worked to complete outstanding serious incident investigation reports, providing closure for patients, families and staff
- undertook joint peer review work with University Hospitals Plymouth NHS Trust, following an increase in low harm never events. This was an opportunity for both hospitals to observe practice, challenge and learn from each other. This work was highlighted at a regional patient safety event as positive for safety improvement
- made progress against local and national PSIRF priorities and ensured that our executive team was kept updated continued to focus on our ambition to roll out and embed a just learning culture, this work will continue to be prioritised in the coming year supported by our peoples and patient safety teams
- recruited two volunteer patient safety partners (PSP). One PSP has since resigned leaving a vacancy which we plan to recruit to. These roles are mandated in the NHS standard contract and to support us to ensure that the voices of patients are central to patient safety reviews and investigations
- reviewed our governance structure to ensure clearer channels of communication and oversight regarding patient safety and quality improvement
- reinstated human factors training and will commence a train the trainer module in the year ahead.
- continued to strengthen and embed a safety skillset and knowledge within our teams. Our Associate Director of Patient Safety has completed the patient safety specialist training, levels 3 and 4 which means we are compliant with this National ambition. We have supported more than 40 members of the team to complete training in patient safety reviews and systems thinking.

Our patient safety ambitions for 2024/25

We will continue our work to embed the patient safety incident response framework within our organisation; we have made significant progress however there is more to be done. We will continue our work to ensure a positive safety culture which is aligned to the just learning culture workstream.

We will prioritise the National Safety Standards for Invasive Procedures (NatSSIPs) 2 which were released in 2023. These national standards cover all invasive procedures, including those performed outside of the operating department. This approach aligns with the aims of the Patient Safety Strategy (2019) and the PSIRF. We have established a task and finish group to lead embed NatSSIPs 2 and to develop both a detailed work plan and measurable outcomes. This work will be overseen by the clinical effectiveness group.

We will:

- continue to embed our transition to PSIRF with a focus on systemic and human factors to capture impactful learning

- strengthen the links between quality improvement and patient safety to ensure that system improvement is generated and sustained following safety recommendations
- strengthen our commitment to ensure that we prioritise compassionate engagement, involvement and support for those affected by patient safety incidents (both patients and staff) throughout any patient safety review or investigation
- continue to provide training to all colleagues on approaches to patient safety reviews to support our safety culture
- professionalise safety investigations via developing expert patient safety incident investigators to lead patient safety incident investigations (PSII). We will continue to review this resource to ensure we have the appropriate level of safety investor resource in line with PSIRF guidance
- encourage staff to capture examples of good care and to share via our safety and quality systems
- share learning from safety reviews, investigations and examples of good practice to promote learning and a positive patient safety culture
- ensure that feedback from complaints is captured as valuable insight to inform a proactive safety culture and our patient safety incident response plan
- continue to embed Martha's Rule (Call for Concern) to ensure patients, families and colleagues have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient. The themes from these contacts will be collated to inform safety improvements where appropriate.
- engage with our information team to support our electronic patient record project (EPR) to ensure that patient safety is central to decision making.
- we will continue to remain responsive to any national reports, guidance or enquiry.

Learning from national reports
Following the findings of the Infected Blood Inquiry Report published on 20 May 2024 we have reviewed the 12 recommendations and drafted a report in response to provide significant commentary around each of the inquiry's recommendations. Compliance with these recommendations will be monitored by our safety and quality assurance group (SQAG).

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

Guardians act in a genuinely independent and impartial capacity to support staff who raise any concerns. The FTSUG reports directly to for our Chief Nurse for speaking up and has regular access to the Chief Executive, Chair and non-executive Directors. The FTSUG reports directly to the Board of Directors formally twice a year.

The guardian also works alongside the senior leadership team, employee relations team and local trade unions to support our work to become an open and transparent place to work, where our people feel safe and are actively encouraged to speak up. The FTSUG completes and submits regular data reports to the national FTSUP's office on a quarterly basis.

We have one full time FTSUG There has been a steady number of concerns being raised during the past 12 months. There is a process for confidentially logging cases and people can also speak anonymously through an electronic communication platform. The FTSUG reports to our board every six months with numbers of cases and themes. From November 2023 to December 2024 there were 176 cases, 35 related to bullying and harassment, 17 a failure to follow process, 14 patient safety; nine staff safety and 52 about the organisation's culture.

Themes from the conversations included:

- poor professional behaviours
- breakdown in working relationships
- bullying and harassment including sexual harassment.
- formal processes not being followed correctly.

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

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

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

The Freedom to Speak Up role must be proactive in raising awareness but reactive to colleagues coming forward to speak up. Greater visibility within all sites and major departments is needed to share information about the service and how the guardian can be accessed. The focus is to continue to support staff to speak up and we will continue to promote the freedom to speak up guardian role to support this important agenda.

Patient experience

The number of complaints received from 01 April 2024 to 31 March 2025 was 192 and is a marked increase on the number of complaints received in the previous two years.

Table 5: Complaint received

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

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

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

- 2023/24 – 88%

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

- September 2024: one breach
- November 2024: one breach
- February 2025: one breach
- March 2025: three breaches*

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

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

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

The top three complaint themes and top three concern themes are:

Figure 9:

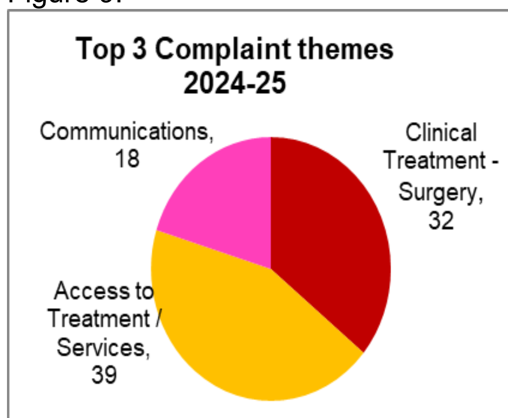
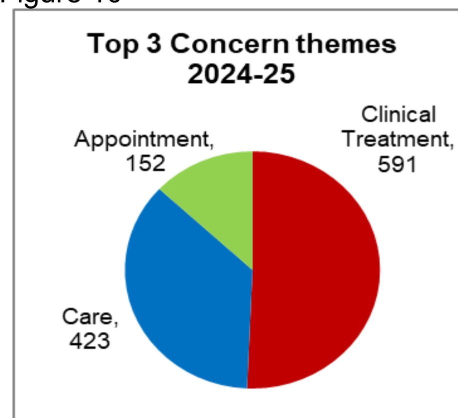
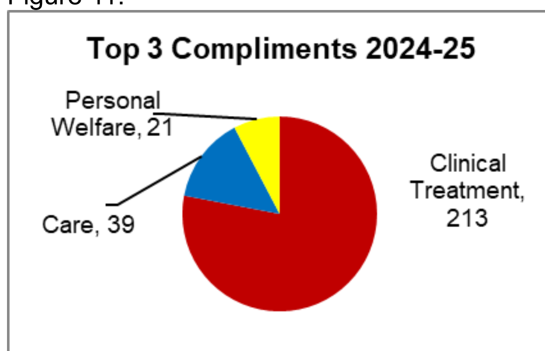


Figure 10



During 2024/25, we formally recorded 332 compliments, which is fewer than the 393 received during 2023/24 and represents a reduction of 15.5%. The top three compliment themes for 2024/25 are:

Figure 11:



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

Planned care

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

Maternity

- Personalisation and communication - part of mandatory training in 2025
- Focus on:
    - Listening to women and families
    - Communication; pain management; ward rounds
    - Coproduction:
        - MNVP 15 seps action plan

        - CQC maternity survey action plan

CFHD

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

Medicine and long-term conditions

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

Place based care

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

Cancer and clinical services

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

Care Quality Commission (CQC) survey programme

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

- Adult inpatient
- Urgent and emergency care
- Maternity
- Children and young people (inpatients)

Results are shared with the appropriate Associate Director of Nursing and Professional Practice for review, reporting and action plan development. While the action plans are monitored locally, each action plan is added to an overarching CQC survey action plan which is reviewed through the Feedback and Engagement Group meeting.

Friends and Family Test Results (FFT)

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

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

Table 6: Friends and family test data

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

Patient and community engagement

Through the national Change NHS campaign which launched in October 2024, more than a quarter of a million contributions have been received from people across England to develop the new 10 Year Health Plan.

We supported the Devon-wide NHS 10 year plan engagement programme to support the development of the national plan while informing local priorities and pieces of work.

From November 2024 to 28 February 2025 people were invited to share their experiences, views and ideas for improving the NHS. The support received from the people and communities in Devon was fantastic and more than 3,400 pieces of individual feedback was received. Nationally 500 workshops were completed and 10% of these were completed in Devon.

NHS Devon is coordinating the responses and will share with partners and the public ahead for the government’s publication of the 10 Year Plan, anticipated to be summer 2025.

Mortality review processes

We have worked hard to improve our mortality processes and ensure we capture and embed any learning from deaths.

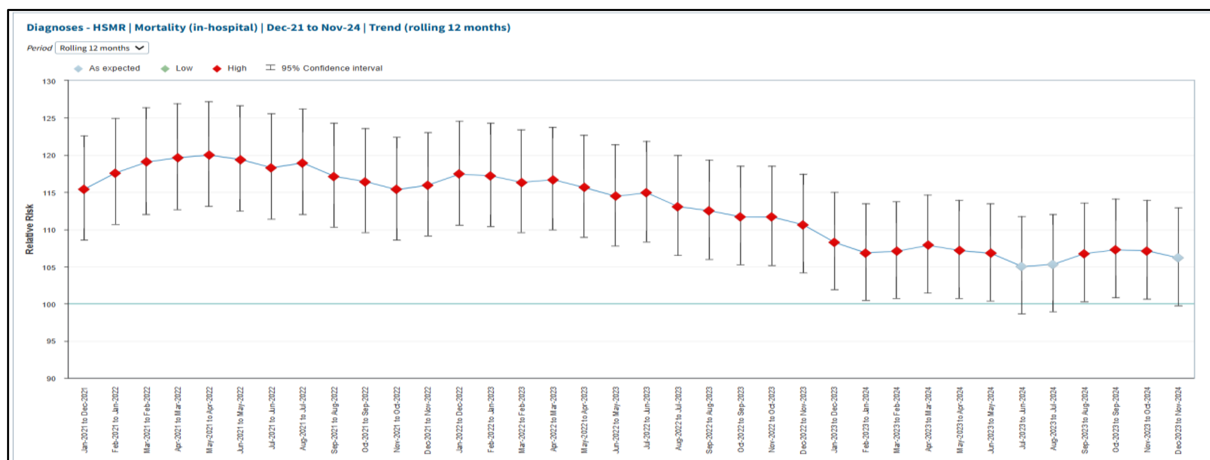
We use analysis by Telstra (Dr Foster) to process hospital episode statistics (HES) data directly from NHS Digital to inform the monthly mortality review. The Hospital Standardised Mortality ratio (HSMR) is measured from the mortality arising from a standardised ‘basket’ of 56 diagnoses and includes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

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

During 2024/25 the national methodology by which mortality statistics was calculated changed (from the Charlson Index to the Elixir/Bottle methodology). This change in methodology led to an increase in our HSMR however it remains within the statistically expected range. Work to ensure accuracy of our clinical coding continues during 2024/25 as we adapt to this new methodology.
The current HSMR is 106.1 (99.7-112.9) - this is within the statistically expected range of mortality compared to hospital trusts nationally. Our current SHMI (Summary Hospital Level Mortality Indicator) is similarly within the expected range at 0.96.

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

Figure 10 : HSMR trend



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

We have introduced the use of electronic structured judgment reviews for mortality cases. These are triggered by statutory national triggers or by queries raised by the

medical examiners. This is delivered via an IT platform which ensures consistency and standardisation in the use of these reviews. Records are held centrally by the patient safety team allowing us to link subsequent investigations and actions associated with these reviews. This system will provide an important tool in the monitoring of quality of care across the trust. Work continues in the education and use of this tool and in linking review outcomes to subsequent pieces of work. We have also carried out 45 structured judgment reviews looking at specific areas of mortality (stroke and sepsis); this work is overseen and commissioned by the mortality surveillance group (see below).

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

We are developing an IT solution to run monthly mortality reports to deliver near real time monitoring of key mortality metrics.

We are working on some focused specific pieces of work looking at mortality rates in sepsis patients, patients suffering from an acute Kidney injury, necrotising fasciitis patients and stroke patients. These reviews have been triggered by mortality alerts received from Telstra and will hopefully improve the care of patients in these specific areas

The medical examiner (ME) service
Medical examiners continue to provide scrutiny of inpatient deaths in the acute and community hospitals. If any concerns are raised or potential leaning is identified the medical examiners refer this to us by raising an incident which is investigated in line with our policy. Since 09 September 2024, all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners, therefore for the year 2024/25, the figures presented also include deaths in the community.

Table 7: Medical examiner data

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

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

Table 8: Summary of LeDer referrals 2023/24 -25

Location of death	Number of deaths meeting LeDeR criteria	Structured judgement review (SJR) undertaken	LeDeR reviews undertaken – closed with outcomes and learning provided	Awaiting LeDeR review outcomes
Community	4	0	0	4
Hospital	21	15	0	21

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

All 25 cases where opinion was given, recorded the individual as receiving either adequate, good or excellent care with good family or carer involvement, speciality input from the learning disability team and appropriate escalation of treatments or the involvement of palliative care.

National standards

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

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

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

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

Figure 11: RAG rated metrics against operational plan trajectory

RAG rated against monthly Operational Plan trajectory	Target March 2025	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Operational Plan trajectory March 2025
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1803	3217	3667	2846	3249	2488	2248	1576	3330	4343	3275	3108	2532	1625	1268	1803
Percentage of Ambulance handovers greater than 3 hours	8%	20.0%	24.4%	16.6%	20.2%	14.7%	9.8%	6.7%	21.0%	31.2%	22.3%	18.5%	14.7%	7.6%	3.5%	8%
Total average time in ED (hours/minutes)		06:39	06:33	06:04	06:00	05:43	05:34	05:25	06:20	06:44	06:18	06:17	06:20	05:53	05:26	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds	0	836	861	722	800	672	588	525	779	979	854	793	818	677	615	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	78%	63.2%	65.7%	67.7%	71.6%	70.8%	70.3%	70.7%	65.5%	68.7%	67.3%	65.0%	66.7%	68.8%	70.1%	78%
% patient discharges pre-noon	33%	23.3%	24.0%	22.3%	22.1%	21.3%	19.4%	18.9%	20.8%	21.5%	22.3%	20.4%	19.9%	21.2%	22.6%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	4.9%	4.8%	4.9%	5.6%	7.8%	6.5%	6.0%	6.9%	5.9%	9.5%	6.6%	8.3%	9.1%	7.4%	5%
Elective recovery																
RTT 104 week wait incomplete pathway	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT 78 week wait incomplete pathway	0	125	58	99	70	16	16	11	17	10	6	0	12	14	7	0
RTT 65 week wait incomplete pathway	0	695	470	423	416	382	353	368	285	242	239	229	204	215	141	0
RTT 52 week wait incomplete pathway	0	1985	1817	1796	1661	1615	1703	1761	1651	1524	1288	1265	1262	1299	947	0
Patient waits over 2.5 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Faster Diagnosis Standard - % of GP referred patients diagnosed within 28 days	77.0%	80.9%	78.4%	76.7%	76.7%	80.7%	80.1%	79.4%	81.1%	79.2%	71.5%	82.7%	75.3%	84.5%	79.4%	77.0%
Number of patients waiting longer than 62 days for treatment	138	112	83	104	96	91	87	90	85	78	77	110	95	94	111	138

2024/25 RAG indicator

Meeting monthly trajectory

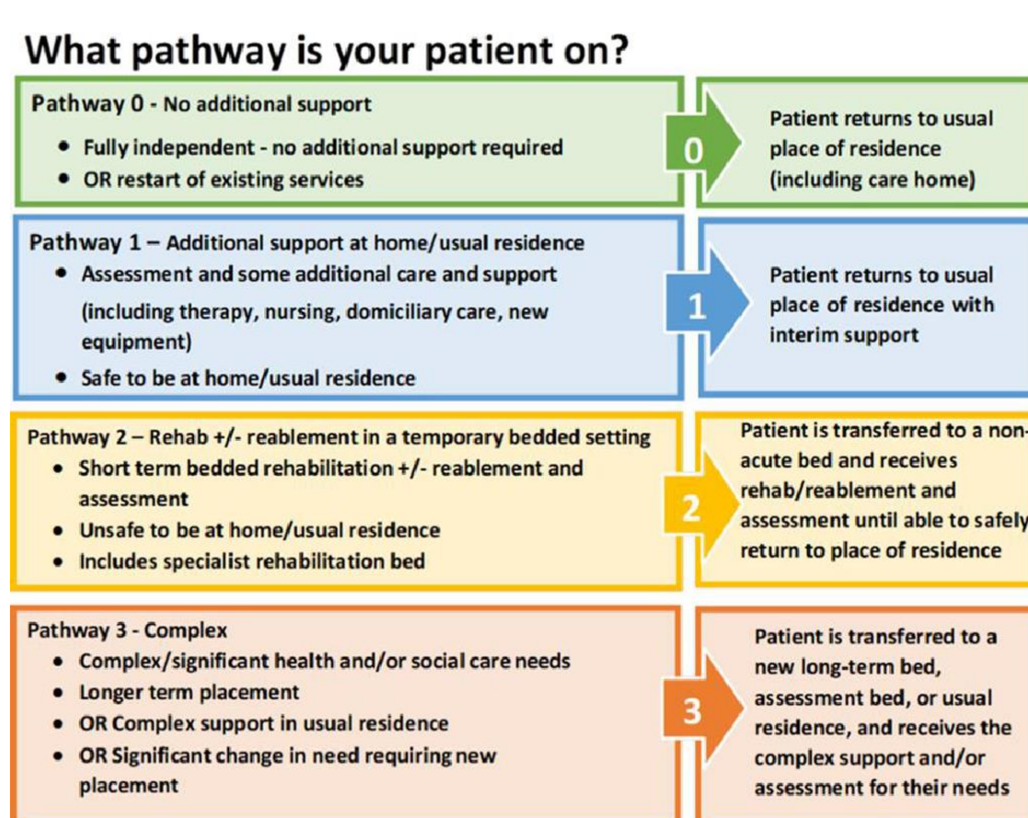
Not meeting monthly trajectory

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

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

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

Figure 12: discharge pathways



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

Table 9: percentage of patients discharged on each discharge pathway

Pathway	% District General Hospital (DGH)	Actual DGH	% Integrated Care Organisation (ICO)	Actual ICO Includes community inpatient wards/assessment areas
0	86.0%	30,494	80.7%	30,773
1	4.9%	1,746	8.3%	3,183
2	8.3%	2,962	9.9%	3,767
3	0.8%	291	1.0%	386

Average length of stay

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

In 2025/26 reducing length of stay remains an ongoing key focus to support both elective and non-elective activity and as such has been recognised in improvement plans to target the longest stay patients with more frequent review and specifically centred on early morning discharge, discharges before 5pm, and at the weekend.

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

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

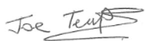
The Department of Health and Social Care has issued guidance on the form and content of annual quality accounts (which incorporate the above legal requirements).

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

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

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

By order of the Board



Joe Teape Chief Executive

Date: 25.06.2025

Annex 2: Quality Account engagement

We presented a briefing on the draft quality account to our Council of Governors on 07 May 2025, providing an update on our progress against our four quality goals, sharing and discussing our revised quality goals and priorities, highlighting key priorities for our patient safety incident investigation for 2025/26.

The draft Quality Account was circulated to the organisations listed below for review and comment from 26 May to 16 June 2025.

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

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

Annex 3: Statements from stakeholders and partners

Council of Governors

On behalf of patients, governors appreciate the Trust focus on patient safety as paramount and fact that a priority for the next year is to reduce waits for emergency care and for patients or treatment to maximise quality. All plans to improve services for the future are welcome.

Challenges have continued this year regarding finance/funding, waiting times, staffing and maintenance issues resulting in the organisation remaining in NOF4 status.

2025 saw the signing of the contract for the implementation of the One Devon Electronic Patient Record (EPR), Epic, which will be shared with Royal Devon University Healthcare NHS Foundation Trust, and University Hospitals Plymouth NHS Trust. This will help transform services. It is hoped that implementation will happen by spring 2026.

Funding of £14.2 million has been secured for a new ED expansion. The build has already commenced and is progressing well. This will enable the Trust to provide a better service to patients and a better environment for staff who provide those services. The waiting times have improved in ED due to new efficiency measures being put in place.

Acting Lead Governor
Val Browning
22 May 2025

NHS Devon Integrated Care Board (ICB)

Torbay and South Devon NHS Foundation Trust Quality Account 2024/2025: NHS Devon Integrated Care Board commentary

NHS Devon Integrated Care Board (ICB) would like to thank the Torbay and South Devon NHS Foundation Trust for the opportunity to comment on the Quality Account for 2024/25. The Trust is commissioned by NHS Devon ICB to provide integrated care with an acute and community hospitals as well as multi-disciplinary health and social care teams within the community across Torbay and South Devon. We seek assurance that care provided is safe and of high quality, ensuring that care is effective and that the experience of care is positive.

As commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the Commissioner over the 2024/25 period.

Despite ongoing pressure on staff and services this Quality Account has highlighted progress against the priorities for 2024/25 and as aligned to the four quality and patient safety goals of the Trust. Consolidating and building on the progress of the previous year the goals included continuously seeking to reduce harm, excellence in clinical outcomes, delivering what matters most to our people and reducing health inequalities.

The 2024/25 priorities:
1/ Improve Identification and Management of Sepsis Through the development of policy, training and education, monitoring of compliance and improvement actions to support the identification of sepsis the Trust has demonstrated a sustained improvement. The Emergency Department achieved a 97% compliance with the 'sepsis 6' care bundle and with the administration of antibiotics within one hour (96%). Furthermore, to ensure the safety of all patients the team considered and assessed patients at risk while waiting, for example in the waiting room or in ambulances. In progress is a sepsis dashboard and this work will continue as a priority for 2025/26.

2/ Strengthen the Quality of Mental Capacity Assessments The combination of the Mental Capacity Assessment and the Best Interest Form has enabled a comprehensive approach to patient assessments. The Trust Leads support staff with both training and in clinical areas where Deprivation of Liberty safeguards are in place, ensuring the quality of patient assessments and oversight of practice. The development of a standard operating procedure will further support the clinical teams. This work will remain a priority for 2025/26.

3/ Reducing Falls and Harm Sustained from Falls The delivery of both falls prevention training and an awareness campaign in conjunction with embedding compliance through the fall safe audit of key interventions, such as visual assessments and lying and standing blood pressure measurement, has achieved overall reductions in patient falls. Additionally, the reduction of patient falls with harm from a fractured neck of femur is an example of the importance and impact of this

work. The Falls Leads will now continue to develop and promote this high-profile work across the Trust.

4/ Reducing Emergency and Elective Care Delays Significant Urgent and Emergency Care improvements are evidenced with the Trust noted as the most improved for ambulance handover performance nationally, with a 39% improvement in performance metrics. The Type 1 Emergency Department performance has improved by 18% and the Four-Hour performance by 10%. Turning to Elective Care the Trust have worked to achieve progress towards the National targets for waiting times and the reduction in the numbers of patients waiting evidence this. The recruitment to Radiotherapy posts remains a concern and impacts care delivery which the Trust are working to address. The 28-day Faster Diagnosis Cancer Standard target (77%) has been exceeded at 80.2% and the 62-day Treatment Standard (70%) has seen a 75.6% performance. These achievements impact positively on the delivery of care for patients with suspected cancer and people requiring onward treatment. The Trust is committed to the safe care of the population and over the coming year Emergency and Elective care pathways and performance remain a priority.

5/ Listening to Our People Improved engagement with patients, families, carers and staff in relation to both complaints and patient safety incidents has been prioritised with opportunities to progress still further. Staff are engaged with consistently and fairly in processes through the development of a just learning culture underpinned through policy and leadership. These programmes of work both continue to be a priority for 2025/2026 as the Patient Safety Incident Response Framework is further embedded.

6/ Seek, Identify and Address Healthcare Inequalities Engaging with the four care groups the Trust have identified priority workstreams to address the impact of healthcare inequalities. These include testing a healthcare inequality scoring matrix in planned care, addressing the impacts to children and young people on adult waiting lists and developing a strategic plan for Children and Family Health Devon. Embedding projects over 2025/2026 this work will continue to be a quality priority.

The ICB notes and welcomes the 2025/26 priorities outlined by the Torbay and South Devon NHS Foundation Trust in their Quality Account and will look forward to seeing achievements related to:
1/ Promoting the Early Detection and Treatment of Sepsis
2/ Strengthening the Quality of Mental Capacity Act Assessments
3/ Reducing Waits for Urgent and Emergency Care and for Patients Awaiting Planned Care or Treatment
4/ Engaging and Collaborating to Safely Transition to an Electronic Patient Record in April 2026
5/ Embedding the Patient Safety Incident Response Framework
6/ Reducing Healthcare Inequalities
7/ Equality Impact Assessment Process Embedded in Service Change

Each of these programmes will continue to evidence and improve quality and safety for the benefit of patients, families, carers and staff building on the lessons learned and improvements achieved from 2024/25.

Care Quality Commission (CQC) involvement:
As a commissioner, we have worked closely with the Torbay and South Devon NHS Foundation Trust during 2024/25 and will continue to do so in respect of CQC reviews undertaken, to receive the necessary assurances that actions have been taken to support continued, high-quality care. The Trust's CQC Assurance Group reporting into the Executive Quality Group monitors action plans through to completion, with the oversight of the ICB.

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

Devon County Council

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST QUALITY ACCOUNT 2024/25

Devon County Council's Health and Adult Care Scrutiny Committee (hereafter referred to as the Scrutiny Committee) has been invited to comment on the Torbay and South Devon NHS Foundation Trust Quality Account for the year 2024/25. All references in this commentary relate to the reporting period 01 April 2024 to the 31 March 2025 and refer specifically to the Trust's relationship with the Scrutiny Committee.

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

Members appreciate the positive work that has been carried out by the Trust in reference to the 2024/25 priorities including improving the identification and management of sepsis and recognise the importance of this remaining a quality priority for 2025/26. Members also commend the improvement work that has led to a reduction in patients who fall along with a reduction in harm for those experiencing a fall.

Members welcome the focus in 2024/25 on reducing waits for planned care and addressing the elective care backlog both in terms of reducing patient harm and improving outcomes and recognise the need for this to continue, along with the steps to improve quality and safety for patients in emergency care. Members welcome the progress on cancer performance but recognise any delays in radiotherapy treatment need to be urgently addressed.

Members welcome the priorities for improvement in 2025/26 including the need to do better in terms of engaging patients and families in safety reviews and investigations.

The Scrutiny Committee commend the continued focus on patient flow and ambulance delays. Members note the improvements the Trust has made reducing ambulance delays and the length of time patients are waiting within the Emergency Department but this work needs to remain a high priority.

Members remain concerned by the 2023 CQC rating the Trust received from its well-led inspection, with its overall rating changing from Good to Requires Improvement.

Members appreciate the continued challenges the Trust faces with significant pressure across urgent, emergency and elective care. Members expect the Trust to ensure patients and staff receive the best support possible. The Scrutiny Committee fully supports the Trust priorities for 2025/26 in their entirety, and the necessary focus being given to these priorities. Members welcome the prospect of a continued positive

working relationship with the Trust, and ongoing monitoring of progress against these priorities through the Quality Account Standing Overview Group of the Health and Adult Care Scrutiny Committee.

TORBAY COUNCIL

Torbay Council confirmed receipt of the Torbay and South Devon Quality Account, which has been circulated to the Torbay Council Sub-Board members for their informal feedback. The Council have confirmed that they will provide informal feedback to us and that they intend to publish the final Quality Account for information on the public agenda for a future meeting. Torbay and South Devon NHSFT and Torbay Council continue to collaborate regularly in line with our day-to-day arrangements.

healthwatch
in Devon, Plymouth and Torbay

Healthwatch Plymouth, Devon and Torbay 2024/25

Quality Account for Torbay and South Devon NHS Trust
Healthwatch in Devon, Plymouth and Torbay welcome the opportunity to review and comment on the 2024/25 Quality Account from Torbay and South Devon NHS Trust.

As the local independent healthcare consumer champion, we commend the Trust's ongoing efforts to improve patient experience and appreciate the transparency in reporting both achievements and areas requiring further work.

From a patient experience and satisfaction perspective it is pleasing to read about a reduction in complaints and improved discharge process with initiatives such as Home for Lunch and the enhanced discharge lounge. Innovations such as the Homeless Wound Care Clinic and Trusted Assessors exemplify efforts to reach marginalised groups and are welcomed, as is the introduction of forums like the Youth Forum and Parent and Carer Forum to involve a diverse range of voices in service development.

The Trust should also be commended for highlighting areas for improvement, and we would encourage a particular focus on improving areas such as complaint response timeliness, staff communication training, mixed-sex accommodation breaches and Digital Inclusion. While website accessibility is a positive step, more support is needed for those with low digital literacy or no internet access to ensure equitable engagement.

With regards to the complaints process, recent Healthwatch England research warns that people have low confidence in the NHS complaints system and struggle to navigate it, which prevents them from acting when they have a poor experience. Royal Devon University NHS Foundation Trust have used this research to develop the 'You said, we did' pages on their website, improving how patients see the changes made as a result of them either providing feedback or raising a complaint. We would suggest Torbay and South Devon NHS Foundation Trust refer to this research to consider their own potential improvements to their complaints process.

To further develop the transparency of the Trust's progress and responsiveness, we would recommend expanding the use of real-time tools and "You Said, We Did" reporting to visibly demonstrate responsiveness to patient voice. Regularly updating the public on progress stemming from patient feedback, especially for areas noted in the Quality Account, would be extremely beneficial for the Trust and all of its patients. More detailed reporting on engagement reach across deprived and remote communities would also support transparency and improvement.

We appreciate the Trust's openness and commitment to improvement in this year's Quality Account. Healthwatch looks forward to continuing our collaboration to ensure that all patients, carers, and communities are heard and served effectively.

Many Thanks

Pat Harris
Strategic lead Healthwatch in Devon Plymouth and Torbay

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

During **2024/25**, **41** national clinical audits and three national confidential enquiries covered relevant health services that we provide.

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

The national clinical audits and national confidential enquiries that we were **eligible to participate** in during **2024/25** follows.

National audits	Eligibility	Participation
BAUS data and audit programme A. Penile Fracture Audit B. I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices) C. Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	 Yes Yes Yes	 Yes Not participating Not participating
Breast and Cosmetic Implant Registry	Yes	Yes
British Hernia Society Registry	No	Not applicable
Case Mix Programme (CMP)	Yes	Yes
Cleft Registry and Audit Network Database	No	Not applicable
Emergency Medicine QIPs (RCEM) A. Adolescent Mental Health B. Care of Older People C. Time Critical Medications	 Yes Yes Yes	 Yes Yes Yes
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes
Falls and Fragility Fracture Audit Programme (FFFAP) A. Fracture Liaison Service Database B. National Audit of Inpatient Falls C. National Hip Fracture Database	 No Yes Yes	 Not applicable Yes Yes
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review Programme)	Yes	Yes
National Adult Diabetes Audit A. National Diabetes Core Audit B. Diabetes Prevention Programme (DPP) C. National Diabetes Footcare Audit D. National Inpatient Diabetes Safety Audit (Harms) E. National Pregnancy in Diabetes (NPID) F. Transition (Adolescents and Young Adults) and Young Type 2 Audit G. Gestational Diabetes Audit	 No No Yes Yes Yes No No	 Not applicable Not applicable Yes Yes Yes Not applicable Not applicable

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

B. Age-related Macular Degeneration Audit		
National Paediatrics Diabetes Audit (NPDA)	Yes	Yes
National Perinatal Mortality Review Tool	Yes	Yes
National Pulmonary Hypertension Audit	No	Not applicable
National Respiratory Audit Programme a) COPD Secondary Care b) Pulmonary Rehabilitation c) Adult Asthma Secondary Care d) Children and Young Peoples Asthma Secondary Care	 Yes Yes Yes Yes	 Yes Yes Yes Yes
National Vascular Registry	No	Not applicable
Out-of-Hospital Cardiac Arrest Outcomes	No	Not applicable
Paediatric Intensive Care Audit Network	No	Not applicable
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes
Prescribing Observatory for Mental Health UK	No	Not applicable
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): A) Oncology and Reconstruction B) Trauma C) Orthognathic Surgery D) Non-melanoma skin cancers E) Oral and Dentoalveolar Surgery	 Yes Yes Yes Yes Yes	 Yes Yes Yes Yes Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)	Yes	Yes
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes
UK Cystic Fibrosis Registry	No	Not applicable
UK Renal Registry Chronic Kidney Disease Audit	No	Not applicable
UK Renal Registry National Acute Kidney Injury Audit	No	Not applicable

Patient outcome programme incorporating national confidential enquires	**Eligibility**	**Participation**
Child Health Clinical Outcome Review Programme (NCEPOD)	Yes	Yes
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	Yes	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes	Yes
Mental Health Clinical Outcome Review Programme	No	Not applicable

Reason for non-participation:

BAUS Data and Audit Programme

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

National Obesity Audit – lack of admin capacity.

Cases submitted to clinical audits and confidential enquiries

The national clinical audits and national confidential enquiries that we **participated** in, and for which data collection was completed during **2024/25**, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit and patient outcome programme incorporating National Confidential enquires	Cases submitted	% cases
BAUS Data and Audit Programme A. Penile Fracture Audit B. I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices) C. Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)		
Breast and Cosmetic Implant Registry		
Case Mix Programme (CMP)	478	100
Elective Surgery (National PROMS Programme)		
Emergency Medicine QIPs (RCEM) A. Adolescent Mental Health B. Care of Older People C. Time Critical Medications		
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People		
Falls and Fragility Fracture Audit Programme (FFFAP) A. Fracture Liaison Service Database B. National Audit of Inpatient Falls C. National Hip Fracture Database	 12 525	 100 100
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review Programme)		
National Adult Diabetes Audit A. National Diabetes Core Audit B. Diabetes Prevention Programme (DPP) C. National Diabetes Footcare Audit D. National Inpatient Diabetes Safety Audit (Harms) E. National Pregnancy in Diabetes (NPID) F. Transition (Adolescents and Young Adults) and Young Type 2 Audit Gestational Diabetes Audit		
National Audit of Cardiac Rehabilitation		
National Audit of Care at the End of Life (NACEL)		
National Audit of Dementia (NAD)	40	100
National Audit of Metastatic Breast Cancer		
National Audit of Primary Breast Cancer		
National Bowel Cancer Audit	249	100
National Kidney Cancer Audit		
National Lung Cancer Audit	244	100
National Non-Hodgkin Lymphoma Audit	78	100
National Oesophago-Gastric Cancer Audit	139	100

National Ovarian Cancer Audit		
National Pancreatic Cancer Audit	130	100
National Prostate Cancer Audit	346	100
National Cardiac Arrest Audit		
National Cardiac Audit Programme (NCAP) A. National Adult Cardiac Surgery Audit B. National Congenital Heart Disease C. National Heart Failure Audit D. National Audit of Cardiac Rhythm Management E. Myocardial Ischaemia National Audit Project F. National Percutaneous Coronary Intervention G. National Audit of Mitral Valve Leaflet Repairs H. The UK Transcatheter Aortic Valve Implantation Registry I. Left Atrial Appendage Occlusion (LAAO) Registry J. Patent Foramen Ovale Closure (PFOC) Registry K. Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	184	100
National Child Mortality Database (NCMD)		
National Comparative Audit of Blood Transfusion A. National Comparative Audit of NICE Quality Standard QS138 B. National Comparative Audit of Bedside Transfusion Practice		
National Early Inflammatory Arthritis Audit (NEIAA)	32	100
National Emergency Laparotomy Audit (NELA)	101	100
National Joint Registry	543 (424 Hips/ 119 Knees)	100
National Major Trauma Registry		
National Maternity and Perinatal Audit		
National Neonatal Audit Programme (NNAP)	15	100
National Ophthalmology Database (NOD) A. National Cataract Audit B. Age-related Macular Degeneration Audit	1881	100
National Paediatrics Diabetes Audit (NPDA)	161	100
National Perinatal Mortality Review Tool		
National Respiratory Audit Programme A. COPD Secondary Care B. Pulmonary Rehabilitation C. Adult Asthma Secondary Care D. Children and Young Peoples Asthma secondary Care	43	100
Perioperative Quality Improvement Programme (PQIP)		
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): A. Oncology and Reconstruction B. Trauma C. Orthognathic Surgery D. Non-melanoma skin cancers E. Oral and Dentoalveolar Surgery		
Sentinel Stroke National Audit Programme (SSNAP)		
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)		
Society for Acute Medicine Benchmarking Audit (SAMBA)		

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

Our response to the findings of clinical audits

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

Ref Recommendations / actions
1101 (Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls
Analgesia within 30 minutes - consider PGD (Patient Group Direction) for acute wards. Review PGD timing in community hospitals through AARs (After Action Reviews). Lying and Standing Blood Pressure - Maintain focus through Quality Boards, Fallsafe Audit, Accreditation Standards, E-learning/ Ward Training - Adequate recording through Vitalpac, monitor use and results. Complete LS/BP video. Update policy. Ward training as requested/ as capacity allows. Post fall training and competencies - Link with Trauma Co-ordinator re policy and post all training. Review post fall policy with clinical support. Consider post fall/ trauma training with competencies and simulation - involve ED Lead and Practice Educator. Promote patient education through leaflets and posters 'call don't fall' - Provide wards with link to patient leaflets. Embed to give out routinely/ ward-based education. Funding required.
1191 (Falls and Fragility Fracture Audit Programme FFFAP) National Audit of Inpatient Falls
Improve vision audit outcomes to 85%+ through Fallsafe audit and staff training. All older people are screened for Delirium upon admission and reviewed - trial on McCallum ward for one month using '4AT' screen on older adults on admission. Dementia lead in (four-month post) Review trial and aim to spread to other wards. Establish training support. Falls lead to support only. NAIF audit increase in January 2025 - Support required to manage and fulfil new fractures on NAIF that are not identified through NHFD.
1192 (Falls and Fragility Fracture Audit Programme FFFAP) National Hip Fracture Database
Lower than national average day one mobilisation figures - local audit to repeat physiotherapy SPRINT audit tool, to identify potential areas for Quality Improvement work.
1210 National Audit of Metastatic Breast Cancer (NAoMe)
Not meeting targets for recording status/ completeness of data - review of COSD (Cancer Outcomes and Services data) completeness on a rolling basis - six monthly suggested. To identify Oncologist to review data. Mortality figures for Trust not available for specific scenarios in report - to interrogate Chemocare and link to Mortality figures. Educate CNS (Clinical Nurse Specialist). Check each patient has the box completed in data fields and go back to clinical team if not complete before data submission.
1211 National Audit of Primary Breast Cancer (NAoPri)
Percentage of patients undergoing TA (Triple Assessment) in one visit - Need more radiology support for TA clinics. We do not have a clear plan of how we will cover gap from advanced practitioner retiring in November 2024 which will exacerbate problem until

additional advanced practitioner is fully trained in September 2025. Also, although we might have sufficient radiologist "cover" in breast care, it is not always on the right days/ times as clinic capacity is very limited as we do not have enough space in the breast care unit. All the radiologists cover general radiology and have other roles so no dedicated breast radiologists unlike every other unit in cancer alliance and most units UK wide. We do need to consider locum cover for February 2025 (and have an experienced radiologist who could do this).
NACT (Neoadjuvant chemotherapy) rates - To increase rates we will need more oncologists and the capacity to give chemo/ immunotherapy as there are not enough chemo nurses or enough space currently in Torbay.
CNS (Clinical Nurse Specialist) contact recording - Educate CNS to fill in separate box on diagnosis/ staging part of Infoflex. Must be ticked. Team to go back to CNS team if no evidence of CNS contact before submitting data as we feel this is 100% in practice.
Recording of ER/PR/HER2 status - Ensure recording on COSD (Cancer Outcomes and Services data), check rates.
Radiotherapy rates - check more recent year's data to see if has changed - look at how recorded.
Mortality rates - we need to be able to generate one and three year survival rates.

1179 National Lung Cancer Audit

Ongoing nationally poor patient survival/ outcomes (only 33% are stage I-II disease) - Target Lung Health Programme/ Screening to identify early disease and improve survival outcomes and surgical rates.

1217 National Non-Hodgkin Lymphoma Audit (NNHLA)

IT/ data link problems - test new IT/ data process - meeting with local and national dataset teams.

1127 (MINAP) Acute Coronary Syndrome or Acute Myocardial Infarction

Proportion of non-ST-elevation myocardial infarction (NSTEMI) patients undergoing angiograms within 72 hours of admission - Additional interventionalist to enable urgent weekend Percutaneous Coronary Intervention (PCI).
Eligible patients receiving pPCi within 60 minutes - Data and process review of pPCI pathway (low percentage of data completion).
Low percentage of completed MINAP data - Increase support for data entry to complete MINAP database.

1230 (MINAP) Acute Coronary Syndrome or Acute Myocardial Infarction

DTB (Door to balloon) times below target - Very high percentage of self-presenter (8% nationally vs 25% locally) who have much longer DTB times - training of Emergency Department staff in timely ACS (Acute Coronary Syndrome) management.
ACS patients undergoing angiogram within 72 hours below target - Additional weekend lab lists for ACS patients.
NSTEMI patients admitted to Cardiac ward within 24 hours - Increase patient flow through Cardiac wards (weekend ward round on Cardiology wards & additional weekend lab lists for ACS patients.
Call to Balloon (CTB) - Improve ambulance response times.
Case ascertainment low - Increase hours of Cardiology data manager.

1228 Heart Failure Audit

Necessity for audit input personnel - Business case in progress.

1232 (NCMD) National Child Mortality Database Programme - Child Death Review Data Release

Discussion related to organ donation to be embedded into Palliative care pathway - developing new children and young person's advanced care planning Treatment Escalation Plan (TEP) for Palliative Care - managed by Children and Family Health, Devon (CFHD) services.

Out of hours end of life care support is not currently a commissioned service - business case to be developed and submitted to Devon Integrated Care Board by CFHD service.
1286 (NCMD) National Child Mortality Database Programme - Child deaths due to Asthma or Anaphylaxis
Current local 'asthma bundle' (pathway) requires updating to align to recommendation 4 - asthma bundle to be updated.
1275 (NCMD) National Child Mortality Database Programme - Learning from Deaths: Children with a learning disability and autistic children aged 4-17 years
New patient electronic record currently in design phase - audit recommendation to be shared with EPR Team for inclusion in building new system.
1241 (NNAP) National Neonatal Audit Programme
Thermoregulation - continue QIP already commenced with audit. Breast Feeding - Work is ongoing around baby friendly initiative, UNICEF - Neonatal BFI accreditation.
1243 (NOD) National Ophthalmology Database Audit (National Cataract Audit)
Insufficient staff for imaging and glaucoma backlog - need additional staff to help with this - Business case approval.
1090 Microbiology cultures and antibiotic sensitivities of Corneal Scrapes
Need to clarify appropriate initial antibiotic choice at regional level - Results being prepared for publication, then to be discussed with all regional corneal consultants to consider if any change in management or new guidelines required.
0931 National Audit of Pathways in Epileptic Seizure Referrals (NAPIER)
Lack of documentation in lifestyle and occupation advice - Information leaflets arranged, discussion in Neurology Clinical Governance meeting. No standardised proforma for first seizure referral for the ward patients - First Fit Guidance on Microguide App. Not seeking witness account in all available cases - discussion in Neurology Clinical Governance meeting. No advice to video future events - discussion in Neurology Clinical Governance Meeting.
1189 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)
Managing complete patients under PESP (Paediatric Epilepsy Surgery Programme) - Vagal Nerve Stimulation (VNS) - training and initiation of VNS Clinic. Transition - Ongoing Quality Improvement with ODN (Operational Delivery Network)
1199 National Diabetes Audit Programme - National Diabetes Foot Care Audit (NDFA)
Ulcer Care template - template to be finalised and implemented.
1237 National Emergency Laparotomy Audit (NELA)
Care of the older patient - Investment in frailty services, including geriatrician-led input for emergency laparotomy patients. Post-operative admission to Critical Care - Increase in critical care capacity (from 10 to 14 operational beds)
1135 National Bowel Cancer Audit (NBOCA)
Clinical Nurse Specialist capacity - new post funded - to be recruited - in hand.
1136 National Oesophago-gastric Cancer (NOGCA)
Limited data - need more comprehensive data outcomes for next meeting. Low endoscopic resection rates for high grade dysplasia - need to enquire if still an issue and if so why. High surveillance rates for high grade dysplasia - need to enquire if still an issue and if so why.
1250 National Respiratory Audit Programme (NRAP) Children & Young Person Asthma Secondary Care

Delay in oral steroid achievement - working with Emergency Department to establish PGD for healthcare professionals to give prompt steroid in select cases. Poor documentation of smoking, technique and PAAP (personal asthma action plan) - Contacted education lead to build into local programme - await response.
1178 NPDA (RCPH National Paediatric Diabetes audit)
Increase the proportion of young people having all their healthcare checks particularly their urine for microalbumin (UMA) - ask young people to anonymously tell us what is deterring them from giving a urine sample - learn from this and implement changes. Increase the proportion of children with an HbA1c less than 58 - by educating and preparing and starting children and young people on hybrid closed-loop (HCL) pumps.

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

1055 (NCEPOD) Endometriosis Study
Be part of a wider MDT meeting reviewing Gynae patients - To join the monthly meeting in Exeter.
1287 Maternal, Newborn and Infant Clinical Outcome Review Programme - The care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death (MBRRACE UK)
The Maternity Service is not assured that we have met the standard of this report - We will undertake an audit of this aspect of the mother's care to identify actions or learning.
1170 MBRRACE-UK Perinatal Confidential Enquiry - A comparison of the care of Asian and White women who have experienced a stillbirth or neonatal death
Share learning from recommendation regarding the lack of uptake in antenatal screening in Asian women - Antenatal screening midwife to review findings and ensure all midwives are aware of referral if any decline. No routine audit of black women's risk assessment and undertaking of an oral glucose tolerance test (OGTT) - Audit of OGTT for all Black women - audit to be allocated at the next Maternity Clinical Effectiveness meeting.
ND 1169 MBRRACE-UK Perinatal Confidential Enquiry - A comparison of the care of Black and White women who have experienced a stillbirth or neonatal death
No routine audit of black women's risk assessment and undertaking of an oral glucose tolerance teat (OGTT).
1160 (MBRRACE-UK) - Saving lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21
Update guidance to make certain that Category 4 caesarean section lists are managed separately from more urgent caesarean sections to ensure these operations are not delayed to late in the day. Action and agreed suggestions – Add sentence to policy, audit Category 3 Lower section caesarean section to be presented. Update guidance on the use of coagulation tests in the context of obstetric haemorrhage including the timelines for availability and how to interpret these, noting that women should not be inappropriately denied clotting products based on a single measure of coagulation in the face of ongoing haemorrhage. Action and agreed suggestions – Update policy – add sentence to policy and include use of ROTEM (Rotational thromboelastometry) Review guidance on when to use balloon tamponade to control haemorrhage, how to insert the balloon and inflate it. Resources such as postpartum haemorrhage checklists should include when not to use balloon tamponade and when to abandon it and move on to a different haemostatic technique. Action and agreed suggestions – Update policy – add paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

6766 Chest X-Ray confirmation of nasogastric (NG) tube placement

- Radiographers to be reminded of the need to visualise the NG tube tip and provide a 'line view'
- Explore collating suboptimal radiographs into a radiographer review file on PACS
- Explore Radiographers being competent to identify wrongly sited tubes and the next steps

6769 Assessing compliance with Bosniak cyst classification

- Email to all Consultants and Registrars as a reminder to correctly classify renal cysts at least Bosniak IIF and above

6778 Appropriateness of referrals for Deep Vein Thrombosis Ultrasound

- Develop a new Standard Operating Procedure to include Wells score, reason for high Wells score and D Dimer if scanning within four hours - failure to include could delay scan
- Share findings with MAAT team and wards

6785 Management of dental patients undergoing Intra-oral procedures who are on Anti-Coagulants or Anti-Platelets

- Deliver a teaching presentation to Clinicians
- Copies of guidance made accessible in surgeries

6789 Assessment of the success rate of Fine Needle Aspiration (FNA) of the Thyroid

- Consider increasing number of passes made during an FNA or varying types of needle used to optimise capillary effect (25G Orange or 22G Black Spinal needle)
- Initiate use of a logbook to improve follow-up
- Consider rapid onsite evaluation (ROSE) of aspirate cytology. Involve the cytopathology laboratory technician during the aspiration as their assistance in preparing specimen for slides and instant confirmation on the adequacy of the cellularity of samples obtained can improve positive yield and reduce patient recall rates for repeat FNA
- Arrange a training session with the cytopathology laboratory technician for improving skills/ techniques in preparing specimen for slides

6792 High-Resolution Computed Tomography thorax (HRCT) reporting in patients with suspected idiopathic pulmonary fibrosis

- Present at Radiology clinical audit meeting to disseminate findings to local HRCT reporters
- Suggest communication with Medica to request that chest radiologists report HRCTs to reduce the number of cases requiring local review and classification
- Develop a HRCT report template

6794 Do Primary Angle Closure Suspects (PACS) undergoing Yttrium Aluminium Garnett Peripheral Iridotomy (YAG PI) meet RCOphth PACS Plus Criteria?

- Complete Departmental education regarding new RCOPhth guidance and indications for YAG PI
- Email to clinicians with summary of guidance and indications for YAG PI

6796 What percentage of Emergency Department trauma Anterior-Posterior pelvis projections meet established imaging guidelines?

- Training session for all staff on pelvic imaging with a focus on acceptability

6797 Magnetic resonance imaging (MRI) prostate quality performed on mobile scanners

- Use Prostate Imaging Quality (PIQUAL) score for all multiparametric prostate MRI
- Encourage radiographers to look at the scans, repeating sequences as required as well as

adding notes on CRIS if any difficulties were encountered (e.g. patient in pain/ non-compliant). Identifying suboptimal studies particularly highlight those secondary to non-patient factors.
- Disseminate audit findings to external scan providers, asking for improvement plans.

6799 Pain in Children being assessed in the Emergency Department

- Time to 1st dose of Analgesia - Undertake staff education
- Pain re-evaluation after 60 min - Update Symphony to include actions taken after the pain score is recorded and next timeline for re-assessment

6800 Injectable Contraceptives - Sayanapress® as an alternative to Depo-Provera

- Consider introducing a specific question in the Injectable Contraceptives template on Lillie. If declined, note reason why

6801 Does Negative Pressure Wound Therapy (NPWT) have a role in Emergency Laparotomy?

- Consider engaging Procurement in ordering NPWT

6802 Quality of SCBU portable chest x-rays (CXR)

- Feedback results to SCBU/ Paediatrics team
- Engage with SCBU re holding
- Teaching/ Simulation with radiographers to improve quality

6804 Improving Documentation of Intimate Examinations - Digital Rectal Examinations (DRE)

- Present results to a General Surgery & Urology Teaching session
- Disseminate results across the whole department via e-mail as a reminder to staff

6806 Isolation Policy

- Supply wards with Isolation poster and then educate staff regarding the appropriate use of the poster information
- Ensure continued education given to wards on appropriate use of side rooms - Discuss with Patient Flow and Operational teams

6808 Improving the appropriate use of D-Dimer testing in the Acute Medical Unit (AMU)

- Set up a 'Teaching session' for Junior and Middle Grade doctors regarding these guidelines
- Target AMU doctor teaching to further improve documentation
- Consideration of adding in a Wells score section to the AMU clerking proforma

6809 Is implementation of the MUST care pathway appropriate after scoring?

- Consider and produce a poster for display to educate prescribers regarding correct Oral Nutritional Supplements (ONS)
- Consider and produce a Screen saver to educate prescribers regarding correct ONS
- When nursing staff carry out their 'five a day MUST risk assessment audit' to spot check one of the five to check if correctly completed (as they do with other risk assessments). When acute team Dietetic Support Worker is recruited, they will also run a spot check of how accurately MUST is completed
- Matrons to share results of audit with ward managers and teams in huddle meetings to highlight areas needing improvement
- Catering Group to check availability of high calorie and high protein items on the menu and nourishing snacks to help encourage increased nutritional intake for all patients with MUST

1+

6811 Diabetic Ketoacidosis (DKA) admissions on a Sodium-glucose co-transporter 2 inhibitor (SGLT-2)

- Generate a document with information for patients regarding "sick day rules" to be followed when prescribed SGLT2i. This will also cover other medication commonly used in patients with diabetes including Ace inhibitors (ACEi), angiotensin receptor blockers (ARBs) and metformin.
- Create a cohesive department protocol for follow up of patients post SGLT2i related DKA

6813 Diagnosing Death - Accuracy of Documentation at Torbay Hospital

- Plan, produce and display posters
- Plan, propose and produce sticker for the meeting on the 12th of June. SUPERCEDED 11-2-25 - advised that sticker will NOT be produced, G1941 has 'Appendix 6' that, when completed, will be added to patient records (Care & Clinical policy group 3-2-25)
- Discuss and investigate with lead Consultant as to whether Registration number is needed
- Provide a lecture on death and verification as part of F1 and F2/ Resident doctor teaching programme

6816 Midwifery to Health Visitor Transfer - Birth Trauma and Discharge Notification

- Raise awareness within community maternity staff of the importance of the Maternity Discharge Summary being communicated to Health Visiting team by Day 10, in line with local Maternity and Neonatal system guidance
- Present audit results to Maternity Team in addition Safeguarding Children meeting
- Learning/ Increase awareness of:
  - All body maps to contain documentation including whether no marks evident on baby
  - Any marks noted following completion of the body map to be documented on original body map with a date and time
  - Blank body maps inserted into Red Books for Health Visitor to confirm any marks at New Birth, 6-8 week contact and 3-to-4-month contact
- All maternity and health visiting staff to receive regular Safeguarding supervision and access ad hoc supervision as appropriate
- Health Visiting team leaders to access "SystmOne" Maternity EPR for further information, as required.
- Maternity and Health Visitors to be reminded of the importance of prompt verbal communication when any marks are identified on a baby

6818 Bone protection in Oncology Patients receiving high dose steroids

- Share results with the wider team to inform those who did not attend the audit meeting/ presentation
- Continue promoting best practice when starting steroids

6819 Breast screening prevalent round recall (2022/23 and 2023/24)

- Present at local audit meeting where there are as many screen readers as possible on the call to highlight: try to reduce the number of recalled less well-defined mass and asymmetric density
- Email all screen readers confirming presentation of results showing the low positive predictive value for cancer in those categories

6820 Chest Trauma Fragility Fracture Management in General Surgery

- Email osteoporosis referral form for >50-year-olds presenting with rib fragility fracture (fall from standing height or less)

- Run a department teaching session and send an email to improve compliance with referring patients with fragility rib fractures for a Dual-energy X-ray absorptiometry (DEXA) scan, to determine if bone-sparing treatment needs to be commenced.

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

- 6752 Assessing the diagnostic efficacy of ultrasound (USS) and computerised tomography (CT) in patients with right iliac fossa (RIF) pain and suspected appendicitis
- 6757 Termination of Pregnancy
- 6773 Timing of surgery following neoadjuvant chemotherapy treatment (NACT) for Breast Cancer
- 6780 Anaesthesia for Major Colorectal Surgery
- 6783 Prophylactic antibiotic prescription in acute pancreatitis and Laparoscopic cholecystectomy after mild gallstone acute pancreatitis
- 6791 Fetal Fibronectin (fFN) sampling in threatened pre-term labour
- 6793 Percutaneous Lung Biopsy
- 6795 Reporting accuracy of chest radiographs in patients subsequently shown to have lung cancer
- 6803 Glaucoma clinic intraocular pressure measurement accuracy using the Reichart Ocular Response Analyser
- 6805 Causes of Gynae Cancer Pathway Breaches following the Coronavirus Pandemic: Follow-up Project
- 6810 Olaparib with bevacizumab for maintenance treatment of advanced high-grade epithelial ovarian, fallopian tube or primary peritoneal cancer (NICE TA-946)
- 6812 Management of individuals disclosing sexual violence in sexual health settings at Devon Sexual Health, Torbay, compared to the BASHH guidelines (2022)
- 6821 Rate of Re-excision of margins with Magseed after breast conserving surgery
- 6822 Urinary retention post autologous fascial sling surgery at Torbay Hospital Compared to national standards and whether spacing of the tape has an impact
- 6826 Antenatal Safeguarding Communication

Mortality and learning from deaths

Mortality figures and reporting

Ref	Information required	Our response
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2024/25, 2,754 of our patients died in the **acute and community hospitals, this includes the Emergency department**. this also includes patients who died in the community setting [patients own home and Rowcroft] This comprised the following number of deaths which occurred in each quarter of that reporting period: • 425 in the first quarter • 557 in the second quarter • 885 in the third quarter • 887 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 2024/25, 2,658 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: • 405 in the first quarter ➢ 279 hospital and community hospital ➢ 126 own home and Rowcroft • 539 in the second quarter ➢ 323 hospital and community hospital ➢ 216 own home and Rowcroft • 848 in the third quarter ➢ 350 hospital and community hospital ➢ 498 own home and Rowcroft • 866 in the fourth quarter. ➢ 365 hospital and community hospital ➢ 501 own home and Rowcroft
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation	During 2024/25 five cases for which the outcome was death were reported on the strategic executive information system (STEIS). All these incidents had reports produced which were

	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.	communicated to NHS Devon and discussed at our serious adverse event group which meets on a monthly basis.

Mandatory indicators

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

	Prescribed information	Comment
12	(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and	The SHMI value November 2024 - October 2024 is 0.96 (rounded) and statistically 'as expected' (↑)
	(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	The overall % palliative care spells within the HSMR basket for the financial year 24/25 is 6.41%
18	The Trust's reported outcome measures scores for: Groin hernia surgery	National data no longer collected via patient reported outcome measures (PROMS)-therefore no national comparison available.
	varicose vein surgery	This surgery is not routinely undertaken at the Trust
	hip replacement surgery	No national data available
	knee replacement surgery	No national data available
19	The percentage of patients aged: (i) 0 to 14 and (ii) 15 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	No national data available
20	The trust's responsiveness to the personal needs of its patients during the reporting period.	Data from the CQC inpatient survey published in August 2023 scored the trust in the following categories: • care and treatment scored 8.3/10 which is about the same as national average. • Respect and dignity 9.3/10 about the same as the national average • Overall experience 8.3/10 about the same as national average For maternity services:

		• Labour and birth scored as 8/10-much about the same as other Trusts • Staff caring for you scored 8.4/10 about the same as the national average For Urgent and emergency Care • Care and treatment scored 7.5/10 about the same as other trusts • Overall experience 8.8/10 about the same as other trusts • Respect and dignity 9.3 out of 10 about the same as other trusts
21	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	The percentage of staff who would recommend the Trust if a friend or relative needed treatment for 2024 was 60.40%
21.1	Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2) Please note: there is a not a statutory requirement to include this indicator in the quality accounts reporting but provider organisations should consider doing so.	Full results available online
23	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	94.5% April 2024-March 2025 local data

24	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	43.5 per 100,00 bed days local data
25	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	12,145 patient safety incidents reported between 01/04/2024 and 31/03/2025. 1,149 near miss incidents [9.4%] 6,569 no harm incidents [54%] 3,712 low harm incidents [30.6%] 666 moderate harm incidents [5.5%] 31 severe harm incidents [0.26%] 18 death incidents [0.15%]

Glossary

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

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

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

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

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

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

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

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

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

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

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

HIVE: The Trusts e -learning platform

Microguide: The local medical guidance app for clinicians

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

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

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

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

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

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

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