Torbay and South Devon
NHS Foundation Trust

Quality Account 2019/20

About this document

What is the Quality Account and why is it important to you?

Torbay and South Devon NHS Foundation Trust is committed to improving the quality of the services we provide to our patients, their families, and carers.

Our 2019/20 Quality Account is an annual report which shows:

- How we have performed over the last year against the quality improvement priorities which we laid out in our 2018/19 Quality Account.
- The quality of the NHS services provided and the development of our care model.
- How we are implementing the care model.
- How we have engaged staff, patients, commissioners, governors, Healthwatch and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year.
- Statements about quality provided by our commissioners, governors, OSCs, Healthwatch and Trust directors.
- Our quality improvement priorities for the coming year (2020/21).

If you would like to know more about the quality of services that are delivered at the Trust, further information is available on our website www.torbayandsouthdevon.nhs.uk

Do you need the document in a different format?

This document is also available in large print, audio, braille, and other languages on request. Please contact the equality and diversity team on 01803 656680.

Getting involved

We would like to hear your views on our Quality Account. If you are interested in commenting or seeing how you can get involved in providing input into the Trust's future quality improvement priorities, please contact tsdft.qualityimprovement@nhs.net or telephone 01803 655690.

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Part 1: Introduction and statement of quality from the Chief Executive

This year has ended like no other with the onset of a pandemic that has affected people right across the world. Whilst there have sadly been many people unwell and nationally we have seen a number of tragic deaths we have been planning for a terrible event like this for many years. With any such planning you can never be sure of exactly what will happen but our preparedness has enables us to continue to provide good care and also keep our staff and patients safe.

But to do this we have had to focus most of our efforts on this work so for the first time our annual account has been deferred at the request of the Government. We are, however now in a position to publish our document.

We want to share with you our achievements and challenges which relate to our three improvement priorities linked to our strategic objective to deliver Safe, high quality care and best experience:

- I am pleased to report that we have successfully implemented integrated clinical systems into both our Coastal and Newton Abbot localities meaning our staff are now able to access a full patient record with ease.

- Despite some significant challenges we have made some progress with electronic prescribing and will review our next steps as the pressures from the pandemic slow.

- Importantly we have successfully achieved our third priority to improve the experience of the hugely important carers. We have listened to carers to find out what is important to them and worked with many carers to launch a carers awareness campaign to ensure people are properly recognised for this important role

Our achievements are already making a real difference and in the coming year we intend to build on these successes and as move towards a new normal we can pick up on the challenges and the priorities for the year ahead. You can read about each of these priorities, the difference our actions are already making and our priorities for the coming year in the body of the document.

Our staff have worked with huge commitment throughout the year to ensure the care we provide is of the highest quality. This has not faltered even with the pressures they have seen during the pandemic. We remain committed to delivering high quality care and continue to see our staff and community continuing to be innovative, caring and compassionate during these unprecedented times. I commend this Quality Account to you and confirm that, to the best of my knowledge, the information in the document is accurate.

Liz Davenport, Chief Executive

Part 2: Priorities for improvement

Looking back: 2019/20

In our 2018/19 Quality Account we reported that we would focus on three priority areas for quality improvement in the period 2019/20. These were all locally agreed priorities developed in conjunction with key stakeholders at our annual Quality Accounts Stakeholder meeting. The meeting included Healthwatch, Trust governors, commissioners, and local councillors as well as our health and care teams. The priorities were then endorsed by the Trust board prior to publication.

Patient safety

Priority 1: To change our inpatient prescribing for people in hospital inpatient beds across the ICO to our commissioned electronic prescribing and medicines administration (EPMA) programme by 31 December 2019. This will be for adults in all specialties with exceptions such as chemotherapy and intra-operation medications.

In quarter 1 and quarter 2 we agreed to:

- Embed EPMA across our medical and assessment wards
- Roll out EPMA into our surgical inpatient wards and to our community hospitals
- Set up systems and measures to monitor impact of the new EPMA system

In quarter 3 and 4:

- Roll out EPMA to parts of our outpatient services
- Ensure that EPMA is fully embedded into all inpatient wards across the ICO.
- Report and publish measures as well as impact both through the Quality Account and through Trust newsletters and Trust communications.

In the spring and summer of 2019, the EPMA system was started to be rolled out and the Trust begun to see the safety benefits with fewer missed doses and improved clarity of prescriptions. However, with the rollout it soon became clear that there were two issues.

These were namely:

- whilst the EPMA system did not link with the hospital record until a patient was admitted onto a ward, maintaining a paper process at the same time was more onerous than previously thought.

- the IT kit supporting the EPMA system was not fit for purpose,

In autumn 2019 the project was paused and work commenced to work on the IT kit and to see how to connect EPMA from the very start of a patient's journey through the Emergency Department. This work has been complex and has taken the rest of the year to progress. Also, a revised business case was started and paused in preparations for COVID-19.

2020/21 Plans

With the coronavirus pandemic the project has been paused until the Trust is in a position to restart this work safely, having reviewed and updated the final business case with recommendations to continue with the system or to offer an alternative strategy. This work will progress through existing Trust governance processes with recommendations to the Board.

Clinical Effectiveness

Priority 2: To implement the roll out of a community IT integrated clinical system to Coastal, and Newton Abbot localities.

In 2019/20 we agreed:

- To migrate patient records into a new IT system into the two localities
- To train clinical staff to use the system
- To go live in both localities by the end of March 2020

In June 2019 the training team trained the Community Nursing and Community Matrons team in Coastal (Teignmouth and Dawlish). The nursing team at the same time cleansed their caseload of patients and migrated active patients on to SystmOne.

In July 2019 SystmOne went live in Community Nursing and Community Matrons in the Coastal locality. This moved staff from using paper and two IT systems to just one IT system with the ability to see GP information for the first time, where appropriate.

The team are now able to access the full patient record. They are able to see information in their office and in a patient's home via a laptop. Where mobile network coverage is unavailable they are able to use a mobile working solution, which enables them to see an 'offline record'

The following comments have been received from the nursing team both positive and negative which we are reviewing to continue to improve the system. These include:

'SystmOne has made my life so much easier by having instant, up to date notes about a patient.'

'The care plan aspect needs some more development to simplify things.'

'Once you get your head around it, it's a really good system.'

'It is so time consuming as there are so many elements to complete, particularly if there are multiple wounds.'

In September 2019 the implementation team began training the Newton Abbot Community Nursing team and the system went live at the end of autumn 2019.

The following comments from the team and from the local GP practices have been received:

'During the weekend we have so much more information as we can see all teams notes from different localities.'

'It saves me time, improves communication and I feel that I am fully informed before going to see a patient.'

'Seeing your notes helped me to understand a patient and their ability with daily living tasks. I have now changed my approach with this patient enabled by your notes.'

Comment from a GP.

For the Intermediate Care teams, SystmOne has enabled them to be able to have access to a patient record regardless of where the staff member is normally based. Previously, if the patient was not known to them, they did not have the full information of the patient and their health concerns.

The Community Nursing team in Newton Abbot have really embraced this new way of working as they moved from being completely paper based to recording their assessments on an IT system. The project team have overdelivered in their requirements and for the community the IT project has been a resounding success.

Plans for 20/21

Moving forward for 2020/2021 the plan is still to implement SystmOne in the community teams in Torbay (Torquay/Paignton and Brixham) for Intermediate Care and Therapies, Community Nursing and Community Pharmacists. This will involve moving health staff from their current electronic recording system, Paris, to SystmOne so that the whole of Torbay and South Devon community are using one IT system. This will provide a more integrated way of working within the community enabling more effective and efficient working practices and aiding communication. With the coronavirus pandemic the Trust is expecting a delay of currently about 3 months with COVID and subject to further local review before the project is restarted.

Patient experience

Priority 3: To improve the Carers' experience for themselves and their families receiving care across the urgent and emergency care pathway

In 19/20, we agreed to:

- Undertake a range of survey work to gain feedback, identify issues and priorities for carers and their families using Urgent and Emergent Care Services within the Trust.
- Liaise with staff to identify their priorities and any 'quick wins'
- Undertake a feasibility study for having additional volunteers / carers' supporters across the urgent and emergency care pathway particularly to address issues already raised such as Carers having to leave people unsupported while they park their car
- Identify means of improving communication / signage / publicity as required
- Use the existing Carers' Supporters in other wards to identify issues for Carers who have been admitted via urgent and emergency care
- Ensure agreed systems for identifying and recording carers are robustly in place, and identify any gaps and embed existing support to carers e.g. Orange Lanyard and Hospital Passport
- Begin a programme of Carer Awareness training across the pathway

We agreed to continue the work throughout the year, sharing successes and learning with the Carers and the clinical teams. At the end of quarter 4 we agreed to remeasure the Carers' experience of accessing and using urgent and emergency care.

What we did

In order to improve the experience of Carers and their families across the urgent and emergency care pathway it was important for Carers Services to raise awareness in the Emergency Department (ED) at Torbay Hospital and the South Western Ambulance Service Trust (SWAST). Firstly, a campaign of awareness-raising began, which involved Carers Services making themselves available to deliver brief Carer Awareness training when staff were available during their shifts. Sixty-five front line ED staff and thirty-five front line members of SWAST staff received this training.

Pictured: Sue Bracknell and Carole Brierley (Family Carer Supporters)

Conversations that took place during Carer Awareness training presented an opportunity to make staff aware of the services available to Carers and also to ask staff for suggestions about how Carer experience within their area of work could be improved. As a result of these conversations Carers Services identified the following:

- Staff across the ED and SWAST can identify Carers using Carer Recognition Tools and refer using the contact number on the Tool when new Carers were identified.

- A box holding all the necessary information, temporary Carers cards, orange lanyards etc. should be held in a prominent position in ED (actioned).

- An opportunity for ambulance crews to have a conversation with Carers about their situation and to hand them a pack of information (actioned - developed and distributed to SWAST by Carers Services).

- Staff in ED needed to be clear how to record Carers correctly (actioned - posters were placed in staff areas to describe the correct process).

Carers Services embedded a member of staff in the ED for a few hours on most days to identify and support Carers and to ask them a questionnaire about their experience of ED. The key findings from the original questionnaire taken at the time they were in ED were as follows:

- Of those questioned, 29% had already been identified as a Carer by Ambulance staff, 24% by ED staff, 13% were self-identified. This left 38% who had not been identified prior to meeting the Carers worker.

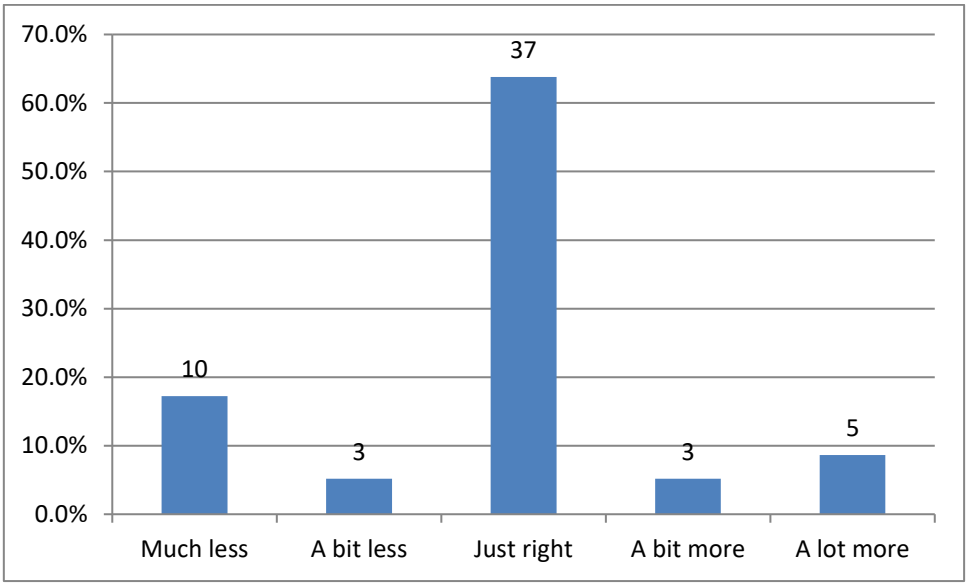
- 73% of those questioned felt their knowledge and skills as a Carer had been ‘completely’ valued that day. 6% answered ‘not at all’ in reply to this question.

- 30% said they would like to change something about their experience in ED that day, with lack of refreshments (see below), long waits and not being kept informed as the most common things raised. 70% did not want to change anything about their visit to ED.

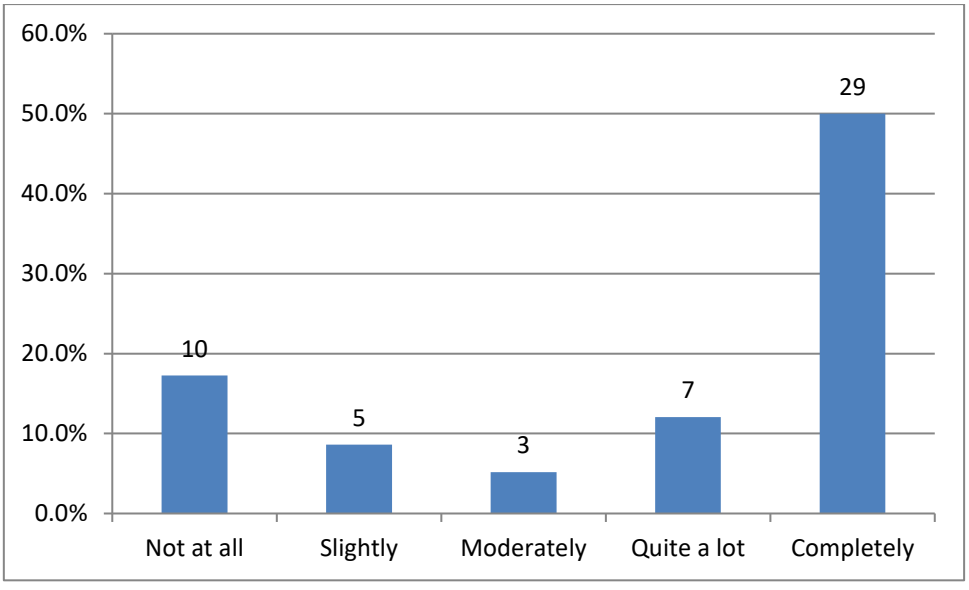
- Conversations with Carers highlighted concerns they had about the service, and some said they had difficulty accessing drinks and food (if they were there for a considerable time). This was addressed with ED management and improved access was provided.

Carers were asked to take part in a follow-up questionnaire six weeks after they completed the original questionnaire (with many patients having an inpatient stay). The information below covers the key points raised:

- The wards were aware of Carers in 53% of cases when they transferred from ED.
- 49% of Carers rated the discharge home for the person they care for as ten out of ten. 6% of carers rated it zero out of ten.
- When asked if they were treated as an equal partner in the patient's care, 48% of Carers replied 'completely' and 24% replied 'not at all'.
- Carers were asked if they were involved as much as they wanted to be in the patient's care. The responses were as follows:



- Carers were asked if they felt their views (as a Carer) were respected by hospital staff. Responses as below:



- Carers were asked if concerns about discharge had been adequately resolved before the patient left. 51% scored this 10/10, but 16% of Carers scored it 0/10.

- Carers were asked to rate if they felt adequately supported when the patient came home (with 0 being not at all supported and 10 being very well supported), and 45% scored 10 (very well supported), but 20% scored 0 (not at all supported).

Family Carer Supporters were well- regarded by the teams based in ED and by Carers who received their support. The following quotes refer to the value of the service:

> "Made you aware you are still a human… Nice to have someone there. Nice to be considered" - a Carer who completed the questionnaire
>
> "We have really enjoyed having the Carer support in ED and they have proved to be invaluable with information and signposting which has been fantastic" – Sue Bramwell, Emergency Department Matron

Posters and a leaflet were developed and distributed in prominent locations to help Carers to self-identify and to understand what they should experience as a Carer for someone in Torbay Hospital. A service to Carers for people with learning disabilities or dementia to sit with the people they care for in ED while the Carer parks their car has been piloted.

Next steps:

Prior to the pandemic Carers Services were seeking additional funding to extend this piece of work for 12 months, to include:

- Providing a member of staff covering ED, EAU3 and AMU each day

- Further Carer Awareness to staff across the Urgent and Emergency Care path and continuation of the service to sit with patients while their Carer parks the car.

- Considering telephone contact to carers post discharge to check the carer is receiving sufficient support and to link them and their families to the voluntrary sector for ongoing community based support, where appropriate.

With the pandemic the Carers Service have actively been supporting carers and their families during these difficult times. Areas of focus include much more phone contact time with carers providing support, guidance and reassurance, PPE requirements and emergency mental health issues.

Priorities for improvement

Looking forward: 2020/21

The Trust identified three improvement priorities for the year. These were developed through discussions with health and care teams and our Trust Executive. We continued to hold the annual Quality Account stakeholders meeting to discuss and agree the priority areas for the year as the feedback year on year of this event is positive. These priorities were signed off by our Board and then paused as the Trust stepped up its emergency planning in preparation for COVID-19. The priorities agreed are:

Patient Safety

Priority 1- To improve early recognition and management of deteriorating patients in care/ nursing homes using the RESTORE2 framework.

Optimising the quality of care for people living in care homes is pivotal to people living the best possible life. It is recognised that people who live in care homes are frequently frail and often have complex health needs. Being able to respond promptly to a deterioration in physical health for an individual has benefits to the person and the health and care system. Adopting a recognised validated tool to support early recognition across care homes and optimise communication of changes to a health care professional in a timely fashion supports providing the right care, right time, right place ethos of the Trust and the health and care system.

It is therefore vital that our care home teams recognise when a resident is becoming unwell and have the necessary skills and tools that allow them to act appropriately and seek support and early intervention in order to:

- Reduce the likelihood of further deterioration;
- Increase the residents' chances of recovery;
- Avoid a hospital admission, which can be detrimental to the health and wellbeing of care home residents, where not appropriate.

RESTORE2 is a physical deterioration and escalation tool for residential and nursing homes. It is designed to support homes and health professionals to:

- Recognise when a resident may be deteriorating or at risk of physical deterioration;
- Act appropriately according to the resident's care plan to protect and manage the resident;
- Obtain a complete set of physical observations to inform escalation and conversations with health professionals;
- Speak with the most appropriate health professional in a timely way to get the right support
- Provide a concise escalation history to health professionals to support their professional decision making

The initial aim of this project was to implement the RESTORE2 deterioration tool into 30% of care homes across Torbay and South Devon by April 2021. With the impact of the pandemic affecting

progress, the ICO will review the timeline and adapt the project with COVID19, ensuring residents are fully supported and cared for.

We will report our progress against our objectives on a quarterly basis to the Quality Improvement group. This meeting will provide a highlight report to the Board.

The project is being clinically led by the System Director of Nursing and Professional Practice (Torbay). Board level support will be provided by the Chief Nurse. Due to pandemic work, the first report will be due at the end of quarter two.

Clinical effectiveness

Priority 2: To replace the Trust's IT data network to reduce likelihood of system failures. To deliver improvements in speed, bandwidth and resilience to provide a platform for IT transformation.

The Trust's IT network is 14 years old and has provided a very stable and reliable platform on which to build the Trust's growing digital platforms. However, the network is suffering an increasing number of failures and is reaching the limits of its capacity.

The Health Informatics Service has proposed a replacement of the entire network; this includes the Local Area Network (LAN), Wireless Network (Controllers and Access Points) and the Trust managed Wide Area Network (WAN) and a proportion of building cabling and network cabinets.

The anticipated replacement cost is estimated to be £2.3M and due to its value, a robust procurement process, possibly OJEU, will be necessary. Overall design, procurement and implementation is anticipated to last at least 18 months and expenditure will be phased across the implementation period. Whilst there is an expected delay as Trust manages COVID-19 patients, the network replacement programme will continue as soon as practicable.

The work will be led by the IM &T specialist project manager alongside the network manager. Progress against agreed objectives will be reported via a monthly highlight report to the IM&T Group. This is then available to the Finance, Performance and Digital Committee and reported onwards to the Trust Board. At Executive level this work is supported by the Health Informatics Service Director.

Patient experience

Priority 3 & 4: End of life

Two end of life projects were chosen as part of the 20/21 improvement priorities. These were:

- Introduce a patient feedback tool (FAMCARE) for family and loved ones about their experience of the end of life care their relative received by the ICO.

- To scope out, test and trial the introduction of bereavement bags which have already been successfully implemented in a neighbouring Trust. The purpose is to ensure good care and dignity to the family at the end of their loved one's lives.

With COVID-19, our focus on end of life care is crucial, and as such, we will adapt these two projects accordingly.

For bereavement bags, this simple project is designed to enhance dignity at the end of life and its basic aim is to ensure the last collection of the loved ones documents and personal items are presented in a caring and professional manor.

The initiative is to use bereavement belonging bags to collate all small personal items and relevant documents and for this to be handed over on the ward. The process has been tested in neighbouring trusts, with positive feedback and will be rolling out the same process.

The process will involve testing in quarter one, in one location, and spreading to 3 by quarter end. Within 6 months of start 9 areas will be fully compliant and by the end of quarter 3 all areas will be included in the process. Monthly surveys will also be undertaken at the half way stage to see what impact the bereavement belonging bags have had

For both projects, the improvements will be monitored and measured by the project teams with quarterly reports to the Quality Improvement group and then to Board.

The feedback tool work will be led by the Lead Cancer Nurse and Matron of Cancer Services. The bereavement bags will be led by the Patient Safety and Experience Lead. The first progress report will be provided at the end of quarter 2, subject to COVID-19demand on the service.

National improvement initiatives

Currently the Trust is involved in a number of national improvement initiatives including:

Seven-day services

Torbay hospital continues to work on developing seven-day services. There are 10 clinical standards which are used to measure progress in this area. Our report to our Trust Board in February notes the following from the June 2019 audit:

Seven-day service standards		Self-assessment
Standard 2	Emergency admissions seen by a suitable consultant within 14 hours of admission	
Standard 5	Seven day a week access to diagnostic services such as CT, endoscopy etc.	
Standard 6	Seven day a week access to consultant directed interventions e.g. interventional radiology and endoscopy	
Standard 8	High dependency patients seen twice daily and other patients once daily by a suitable consultant	

Standard 1	Patients should be involved in shared decision making	Currently we do not have robust measurement systems to measure all these standards see commentary below
Standard 3	An integrated management plan established within 24hrs of admission to hospital	
Standard 4	Enhanced handover of clinical care between clinical teams	
Standard 7	Seven day a week availability of liaison mental health services	
Standard 9	Readily available support services e.g. pharmacy, community care services	
Standard 10	Regular review of outcome in terms of patient experience, safety, and clinical outcome	

Standard 1. Although shared decision making is implicit for patient and clinician interaction, it is rarely explicitly recorded in the notes. Treatment escalation plans are an exception to this. The use of printed patient information sheets is rarely recoded for emergency patients.

Standard 3 Work is required to identify the members of the multidisciplinary team needed to provide a holistic assessment of emergency patients within 24hrs of admission as an emergency patient. This is addressed a work group which seeks to embed the SAFER principles onto all wards.

Standard 4. Handover is led by competent senior decision makers in the major acute specialities daily. Work is required to provide assurance that the handover process is accurately documented.

Standard 7. Liaison psychiatry is available for both adults and children. The Liaison Psychiatry service has focused on their hour response times to ED. The latest flash report shows that despite staff shortages the hour target to ED was achieved in just below 80% (Oct 2019). The team continues to comply with the 24-hour target to the hospital wards achieving 88% within 24 hours. The Psychiatric Liaison team has worked with ED to reduce attendance in an identified cohort of patients who attend ED frequently with mental health problems.

Standard 9. The development of community support services is a major component of the emergency offer. This includes development of integrated care and work with care providers and community hospitals. Recent developments include the discharge hub which is expanding to work 7 days a week over the winter and work to strengthen community care. The Home First workgroup has projects with named leads and support for i) Development of the Frailty Service ii) Admission avoidance iii) enhanced intermediate care iv) transport v) community support on discharge.

Standard 10. Outcomes of emergency patients are monitored by a weekly multi-disciplinary team and two weekly strategic meetings.

In 2020/21 our aim is to work on improving seven-day services in part as a response to the pandemic which will require timely, accessible services 7 days a week.

Rotas and gaps

In July 2019 an agreement was reached between NHS Employers, the BMA and Department of Health on the amendments to the 2016 terms and conditions for doctors in training. The agreement covers the period from 1 April 2019 to 31 March 2023.

The new terms were introduced in August 2019 with a phased implementation to include changes to new limits of working hours and safeguards on rest. These amendments have necessitated the review of all trainee rotas across the Trust to include changes to ensure compliance with reduced working hours and rest periods.

Rota reviews have been carried out by Practice Managers working alongside Medical HR on every Junior Doctor rota as a requirement of the Junior Doctor Contract implementation timescales. The rota updates have provided further challenge to the operational teams in covering doctors' duties. The majority of rotas are now compliant with the new limits on working hours and additional rest periods. Several rotas have needed additional agreement to secure the necessity for 1:2 weekend working and these are being reviewed and will increase to 1:3 where additional staffing allows.

The impact of the latest review has included the need for additional Trust doctors to cover training gaps and in some cases the review of Speciality Doctor and Consultant working arrangements.

New ways of working are also being explored to include:

- Working with departments to secure funding for the current cohort of Physician Associates and re-modelling the last cohort of Physician Associates to ensure they are being placed in areas which have vacancies/gaps.

- Review of Hospital at Night (H@N), specifically focussing on the issues with the shared H@N rota for Junior doctors. With a plan to propose options for different working patterns/models, based on quality, workforce and economic considerations.

Sign up to safety

Tissue viability and pressure ulcer prevention:

The Tissue Viability is a service works across both primary and secondary care, accepting referrals from all healthcare providers within these areas. The service takes responsibility for pressure ulcer prevention, education, monitoring, complex wound care, equipment provision (including overseeing rental activity) and providing assurances to all ISU management teams.

2019/20 Pressure Ulcer Incidences:

- There has been a 6% reduction in reported Category, (Cat.), 2/3/4 pressure ulcers when compared to same period 2018/2019. This equates to 117 less pressure ulcers reported.

- The reduction is also reflected in a 6.5% reduction in pressure ulcers acquired in our care when compared to 2018/2019. This equates to 69 less pressure ulcers acquired in our care.

- Of the 233 reported Cat.3/4 pressure ulcers acquired in our care for the period 2019-2020, 5 were declared to STEIS as being due to lapses in care by Trust staff.

- Of these 5 pressure ulcers, 2 were on a specialist ward and related to a specific medical condition. This has been investigated and work is ongoing to develop a comprehensive

guidance plan for patients admitted with this medical condition in order to reduce the risk of pressure damage occurring for future patients. Bespoke pressure ulcer prevention training is in place for this team.

Four of the five Integrated Service Units have had no pressure ulcers where there has been an established lapse in care for 12 months, which is a testament to the education and support supplied by the tissue viability team and the hard work of the staff within these services. Ongoing support, alongside an education programme is being given to the remaining Integrated Service Unit by the tissue viability team.

Falls assessment prevention and treatment:

The focus for the Trust is to continue to reduce the harm caused by falls as well as minimising the falls risk. 2019/20 has seen an increase in falls from the previous year of 84, with a reduction over the Winter period. This is encouraging as the Falls team ran a winter falls prevention campaign.

The Falls team and Falls Group have worked to create a new falls handling and bed rails form for wards which is easier to complete.

The Supportive Observations policy has been amended and there have been brief changes to the post fall guide to ensure no further escalation of injury. The Clinical Site Managers have also agreed to manage inpatient, post falls, for any potential spine injury.

Six specialist Raizer chairs have been purchased. Falls training has continued throughout the year alongside taking the lying and standing Blood pressure. Training is now available in eLearning.

Medications Safety

The Trust has been actively encouraging the reporting of medication incidents, as nationally this type of incident has typically been under reported. All medication errors are automatically sent to the Clinical Governance Pharmacist for review and action. Pharmacy has been particularly focusing on high risk medications and missed doses with the wards and departments. Through regular monthly audits and interventions, missed doses are showing a decrease. During 2019/20 We have had no serious incidents with high risk medications.

During 19/20 Pharmacy have also sent out over 15 alerts to support the safe use of medicines where there have been safety issues and supply problems. We have maintained our weekly huddle to review concerns with the supply of medicines, to monitor our usage and to put actions in place to best mitigate any impact on our services.

Also, during the year:

- Six Supporting Medicines Safety newsletters were published during 19/20 covering a range of topics including advice on controlled drug record keeping, the risk of omitting

immunosuppressants and advice on preparing for a CQC visit with regards to medicines.

- With regards to insulin safety, a trial of a pocket information card for junior doctors and nursing staff, along with targeted education for all staff prescribing, administering & monitoring insulin has been created. This trial will be continued and extended in the coming year.

- Insulin Hypoboxes were added as an item on our stock lists to ensure they are part of the pharmacy top-up. A contents list is being attached to the hypo boxes to facilitate the refilling of the boxes after use.

- We have worked to raise the profile of incidents in theatres & PACU (PACU in full required) with the diabetes team on the use of VRIII charts. The diabetes team provided education sessions. A further action plan was developed with one of the anaesthetists and these have been well received.

- Controlled drugs (CDs) audits have been undertaken and resulted in an eLearning package being developed.

- The use of CD bottle adapters has been implemented, with the aim of reducing wastage when drawing up liquid controlled drugs. A small trial showed a reduction in the discrepancies between the recorded and actual quantities of liquid controlled drugs and although incident numbers are small there has been a reduction in reported liquid discrepancies.

- A policy on the administration of medicines has been developed to clarify who within the Trust can administer medication, under what authority they can administer e.g. via a prescription, their accountability & competence to do so.

- Numerous patient group directions have been developed and implemented to enable nurse led clinics / care to provide the best care to patients in a timely and effective way without compromise to patient safety.

Duty of candour and Incident Investigation: These key facets remain as central tenants to the trust's response to serious clinical incidents.

Every serious adverse event is reported through the trust's clinical governance reporting structures, as set out in our adverse event management process, and, through this, we can identify incidents that trigger the Duty of Candour procedure and investigation response

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity of the event as well as the potential for learning. Recommendations are made as part of the adverse event review and local management teams develop action and improvement plans to meet these recommendations

Duty of candour also ensures we ask what the families want to be investigated and how they would like to receive feedback on the incident

To ensure compliance the incident report includes a section on how duty of candour was completed, when, and by whom. This is both monitored internally, by the Serious Adverse Events group as well as externally by the local CCG.

Speaking Up

We recognise that in order for staff to deliver high quality care they must have a safe and supportive working environment. Staff must feel able to raise concerns in the knowledge that they will be listened to, that actions will be taken and that they will be thanked for living the values of the NHS.

In 2019/20, as a Trust, we have agreed to focus on:

- Development and launch of a speaking up vision which will be embedded in the Trust People Strategy
- Publicising the learning from speaking up cases across the Trust
- Development of management training in responding to concerns
- Ensuring the Trust annual report includes a summary about speaking up
- Focus attention on minority groups and overcoming barriers to speaking up
- Review of the Trust bullying and harassment policy and practices.

In 2019/20 the speaking up vision is being embedded into the Trust's people strategy with an increasing awareness of the routes available to all staff in how they can feel safe and confident in speaking up. There are higher numbers of staff speaking up via the Freedom to Speak Up Guardians with concerns including patient safety, quality of care and cultures of bullying and harassment. Staff can speak up to through their line management chain, contact the guardian generic email, contact information-guardian names, mobile numbers and personal email addresses are on a specific speaking up intranet page, and there are local speaking up champions in various departments that staff can approach. There are also anonymous green boxes that can be used to make guardians aware of issues.

Many of the cases are highly confidential and so it has proved difficult to widely share learning, however there has been significant work on introducing a new bullying and harassment policy and support network this year. Positive outcomes and support spread via personal staff experience have brought about increased confidence in the speaking up process.

Management training is being provided by Health Education England disseminated through the National Guardian Office due to be launched summer 2020. Raising awareness through Trust and local Induction as well as preceptorship groups has increased the focus on minority groups but there is still further work to do. A summary of speaking up is now included in the Trust's annual report.

In 2020/21, as a Trust we have agreed to focus on:

- Embedding the anti-bullying network and use of policy to aid resolution across the organisation.
- Increasing the network of Freedom to Speak Up Champions to provide local support to staff.
- Roll out national training in raising and responding to concerns.
- Working with stakeholders to identify how to improve safety culture.
- Identify hotspots to provide early intervention and support in speaking up.

Statements of assurance from the Board

Review of services

During 2019/20 Torbay and South Devon NHS Foundation Trust provided and/or sub-contracted 52 relevant health services.

Torbay and South Devon NHS Foundation Trust has reviewed all the data available to them on the quality of care in 52 of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 89% (as of the end of February 2020) of the total income generated from the provision of relevant health services by Torbay and South Devon NHS Foundation Trust for 2019/20.

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

Participation in clinical 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 Trust's clinical audit programme. The detail which follows relates to this list.

During 2019/20, 41 national clinical audits and 3 national confidential enquiries covered relevant health services that Torbay and South Devon NHS Foundation Trust provides.

During that period Torbay and South Devon NHS Foundation Trust participated in 95% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation Trust was eligible to participate in during 2019/20 are as follows:

National audits	Eligibility	Participation
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	Yes	Yes
BAUS Urology Audit – Cystectomy	No	N/A
BAUS Urology Audit - Female Stress Urinary Incontinence	No	N/A
BAUS Urology Audit – Nephrectomy	Yes	Yes
BAUS Urology Audit - Percutaneous Nephrolithotomy	Yes	Yes
BAUS Urology Audit Radical Prostatectomy	No	N/A
Care of Children in Emergency Departments	Yes	Yes
Case Mix Programme (CMP)	Yes	Yes
Elective Surgery - National PROMs Programme	Yes	Yes
Endocrine and Thyroid National Audit	Yes	Yes
Falls and Fragility Fractures Audit programme	Yes	Yes
Head and Neck Audit	Yes	Yes
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Yes	N/P

Major Trauma Audit	Yes	Yes
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes
Mental Health - Care in Emergency Departments	Yes	Yes
Mental Health Care Pathway - CYP Urgent & Emergency Mental Health Care and Intensive Community Support	No	N/A
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes
National Audit of Breast Cancer in Older People	Yes	Yes
National Audit of Cardiac Rehabilitation	Yes	Yes
National Audit of Care at the End of Life	Yes	Yes
National Audit of Dementia (Care in general hospitals)	Yes	Yes
National Audit of Pulmonary Hypertension	No	N/A
National Audit of Seizure Management in Hospitals	Yes	Yes
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes
National Bariatric Surgery Registry (NBSR)	No	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Cardiac Audit Programme (NCAP)	Yes	Yes
National Clinical Audit of Anxiety and Depression	No	N/A
National Clinical Audit of Psychosis	No	N/A
National Diabetes Audit – Adults	Yes	Yes
National Early Inflammatory Arthritis Audit	Yes	Yes
National Emergency Laparotomy Audit (NELA)	Yes	Yes
National Gastro-intestinal Cancer Programme	Yes	Yes
National Joint Registry	Yes	Yes
National Lung Cancer Audit	Yes	Yes
National Maternity and Perinatal Audit	Yes	Yes
National Neonatal Audit Programme - Neonatal Intensive and special care	Yes	Yes
National Ophthalmology Audit	Yes	Yes
National Paediatric Diabetes Audit	Yes	Yes
National Prostate Cancer Audit	Yes	Yes
National Smoking Cessation Audit	Yes	N/P
National Vascular Registry	Yes	Yes
Neurosurgical National Audit Programme	No	N/A
Paediatric Intensive Care Audit Network	No	N/A
Perioperative Quality Improvement Programme	Yes	Yes
Prescribing Observatory for Mental Health (POMH-UK)	No	N/A
Sentinel Stroke National Audit programme	Yes	Yes
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Yes
Society for Acute Medicine's Benchmarking Audit	Yes	Yes
Surgical Site Infection Surveillance Service	Yes	Yes
UK Cystic Fibrosis Registry	No	N/A
UK Parkinson’s Audit	Yes	Yes

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

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation participated in, and for which data collection was completed during 2019/20, 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
Assessing Cognitive Impairment in Older People / Care in Emergency Departments	129	100
BAUS Urology Audit – Nephrectomy		
BAUS Urology Audit - Percutaneous Nephrolithotomy		
Care of Children in Emergency Departments	129	100
Case Mix Programme (CMP)	747	100
Elective Surgery - National PROMs Programme		
Endocrine and Thyroid National Audit		
Falls and Fragility Fractures Audit programme	410	100
Head and Neck Audit	Tbc	Tbc
Major Trauma Audit	Tbc	Tbc
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Tbc	Tbc
Mental Health - Care in Emergency Departments	Tbc	Tbc
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Adult Asthma Adult Asthma & COPD Organisational Audit	 98 1	 100 100
National Audit of Breast Cancer in Older People	931	100
National Audit of Cardiac Rehabilitation		
National Audit of Care at the End of Life	72	100
National Audit of Dementia (Care in general hospitals)	Tbc	Tbc
National Audit of Seizure Management in Hospitals	Tbc	Tbc
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Tbc	Tbc
National Cardiac Arrest Audit (NCAA)	81	100
National Cardiac Audit Programme (NCAP)		
National Diabetes Audit – Adults Inpatient Audit – Hospital Characteristics Foot Care Audit Pregnancy in Audit	 1 145 45	 100 100 100
National Early Inflammatory Arthritis Audit	Tbc	Tbc
National Emergency Laparotomy Audit (NELA)	Tbc	Tbc
National Gastro-intestinal Cancer Programme Oesophago-Cancer Audit Bowel Cancer	 128 223	 100 100

National Joint Registry	672	100
National Lung Cancer Audit Clinical Audit Organisational Report Molecular Testing in Advanced Lung Cancer	 228 1 25	 100 100 100
National Maternity and Perinatal Audit Organisational	 1	 100
National Neonatal Audit Programme - Neonatal Intensive and special care	TBC	TBC
National Ophthalmology Audit	1413	100
National Paediatric Diabetes Audit	150	100
National Prostate Cancer Audit	267	100
National Vascular Registry	143	100
Perioperative Quality Improvement Programme	TBC	TBC
Sentinel Stroke National Audit programme Clinical Audit Report Organisational Report	 615 1	 100 100
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	TBC	
Society for Acute Medicine's Benchmarking Audit	TBC	TBC
Surgical Site Infection Surveillance Service	TBC	TBC
UK Parkinson's Audit	TBC	TBC
	TBC	

Patient outcome programme incorporating national confidential enquires	Cases submitted	% cases
Child Health Clinical Outcome Review Programme (NCEPOD)	TBC	TBC
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBBRACE)	TBC	TBC
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) Bowel Obstruction Study Long Term Ventilation Study	 3 2	 60 40

The reports of 65 national clinical audits were reviewed by the provider in 2019/20 and Torbay and South NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions
0596	**(BTS) Non-Invasive Ventilation (NIV) - Adults**
	• Re-audit of outcomes of each patient whose data was submitted into the audit to improve the accuracy of the data. - Ongoing by Respiratory Consultant and Registrar. All deaths of patients treated with NIV are reviewed in the departmental Morbidity & Mortality meetings. Improved selection of appropriate patients for NIV. New NIV pathway proforma developed by Respiratory team. In use on Midgley and ED since May 2019. Effect of proforma needs to be audited.

- Improvement of Chronic obstructive pulmonary disease (COPD) discharge bundle to highlight patients at high risk of developing hypercapnic respiratory failure. Review of COPD discharge bundle. Review of hospital and community COPD services. Increased recruitment to Torbay Hospital Outreach Respiratory Team (THORT).
- Development of Respiratory Highcare setting with increased nurse staffing levels and consultant cover. - Ongoing, we remain the only hospital in the south west region without a respiratory high care environment.

0709 (Falls and Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database

- Mental Health score on admission - education/ reminders to staff.
- Physiotherapy assess day after surgery - Education/ Liaison.
- Nutritional health scores - Support/ reminders
- Pressure score documentation - support/ reminders
- Increased nail use - re-audit
- National initiative for inpatient falls monitoring - submit prospective falls data
- Nail/ Hemi-arthroplasty/ Total Hip Replacement documentation - Edit operation notes/ liaise with Operations Manager.

0512 (ICNARC): Adult Critical Care (Case Mix Programme)

- Use our clinical information system to provide more detailed information with respect to unit acquired blood stream infections.

0571 (NAIC) National Audit of Intermediate Care (IC) 2018

- Increase referrals - Raise awareness of IC by organising videos and meeting members of staff in the hospital.
- Increase IC in people's homes rather than placement - To focus on trying to keep people in their own home for IC rather that in a placement. To work with the homes who provide IC placement to ensure standards of care are of a good standard. Update the contracts we have with the homes to establish expectations.
- Goal setting with the patient - All the teams are focusing on writing goals with the patient and to ensure these goals are written in a collaborative manner and documented appropriately. These goals will be audited in six months' time.
- The proportion of the workforce that are nurses in the IC teams in comparison to the rest of the country is half the amount - other disciplines in the teams to increase their skill set: Paramedics to be competent at intravenous administration and 'SWICS' to be competent at administering Fragmin. All localities to work closer with community matrons to ensure patients can receive the right care. Non-registered staff are able to administer subcutaneous Fragmin. The two paramedics in the IC teams will be competent in administering Intravenous drugs.
- Patients are seen by community teams as well as IC teams which makes our data analysis more complex to interpret. Safeguarding and Mental Capacity Act Lead to work with the IC leads to better understand how data is recorded and work with Information Department to see if there are more accurate ways of collecting data.

0636 (NEIAA) National Early Inflammatory Arthritis Audit

- Delay in receiving GP referral - Review of referral process, including evaluating causes for possible delays
- Lack of medical staff capacity - We now have a locum consultant for three months, who is helping out with clearing the backlog of pending urgent/ EIA patients. Also, all consultants are currently in post now. This has improved our waiting times significantly, as of 13/2/20, only eight patients out of several patients referred for EIA clinic are waiting to be seen within three weeks. Most patients now have an appointment within three weeks as per National recommendation.
- Scope to better triage patients to EIA clinics - We plan to implement a standard EIA referral template; which community practitioners can use while referring patient for EIA clinic. This

will be set up via DRSS service. This will help medical staff acquire rightful and adequate clinical information, which will help to select patients rightfully for EIA clinic. In the long run this will reduce the burden on EIA clinic due to filtering out non-EIA patients.

0664 (NNAP) National Neonatal Audit Programme

- Antenatal steroids at 86% vs national at 91% - Obstetrics and Gynaecology (O&G) and Midwifery team to review all notes of mothers who delivered babies between 23- and 33-weeks gestation for any missed opportunities or the mother came and delivered straightaway with no window to administer.
- Antenatal magnesium sulphate at 50% vs national at 72% - O&G and Midwifery team to review all notes of mother who delivers a baby below 30 weeks gestational age for any missed opportunities or the mother came and delivered straight away with no window to administer
- Parental consultation within 24 hours of admission at 80% vs national at 96% - This has been a persistent problem and a large number of strategies have been put in place to improve it including responding to CQC – strategies available on request from the Quality and Compliance Manager.
- Keeping mothers and babies together (term babies) – our unit at 3.6 days was above national average at 3 days - This problem has been addressed and is reflected in the 'ATAIN' (computer system) figures of current quarter at 4.1% term admission in comparison to all Southwest units at 4.7% and a proper transition care model is being addressed.
- Keeping mothers and babies together (late pre-term babies) – our unit was 7.8 days and was above national average at 6 days - This issue is being addressed through a transition care model and also through conversion of John MacPherson's Bay 4 to Nursery 3 where there are pull-down beds for mums/ dads to stay with babies overnight – minimising separation times.
- Mother's milk at time of discharge for babies born at less than 33 weeks – we have no record in 2018 - This has been identified as an educational issue for the junior doctors completing 'Badger' (computer system) discharge summaries and this is something which is addressed at their induction – possibly only data entry issue.
- We have achieved UNICEF Breast Feeding Initiative Stage 2 which shows that we are adhering to breast feeding opportunities and support given to mother.
- Neonatal nurse staffing numerically staffed according to national guidelines – our unit is at 63.2% vs national average of 63.9% - We are almost at par and our staffing issues have been addressed through recruitment and further QI training of appropriate staff members.

0518 (RCEM) Feverish Children (Care in Emergency Departments)

- Re-audit observations within 15 mins to identify area of weakness.
- Senior review - Investigate current pathway and advertise change.
- Sepsis tool - Ensure being used/ try to prove that note bias, otherwise change required.

0602 (RCEM) Venous thromboembolism (VTE) Risk in Lower Limb Immobilisation

- VTE assessment re-audit required.

0615 (TARN) Clinical Report Issue 3 November 2018 - Head & Spinal Injuries

- Review times to operation for trauma patients - review causes and present to Trauma Review Group

0612 2018 National Comparative Audit of the Management of Maternal Anaemia

- Source a new maternal anaemia patient leaflet - completed.
- A local audit should be undertaken in 12 months.

0623 Each Baby Counts

- Breakthrough pain with a previously working epidural in a woman with a history of uterine surgery should trigger an obstetric review for scar rupture - This is not in our local policy. It needs to be added to the policy and also added to our PRactical Obstetric Multi-Professional Training (PROMPT) - Add to elective Caesarean and Epidural Policy.
- Where it is recognised that a guideline was not followed, a reason for 'why this happened' should be identified and documented. The use of debrief as a tool will aid these insights - Debrief after

theatre lists is Trust policy. More difficult after emergency cases as there is not a defined end to the "list". Team members involved with continuing other emergencies. Over-runs of elective lists make debrief challenging. Additional elective lists should reduce over-runs and improve learning from debrief - Reiterate the importance of introductions: carry forward work on theatre cap challenge. Lanyards now in use for midwife in charge. Improve handover process for the Delivery Suite. Continue to pursue additional elective lists.

0587 Lung Cancer (National Lung Cancer audit)

- Inadequate Lung Cancer Nurse Specialist (LCNS) support for population of patients - Business case to support the appointment of an additional LCNS. Although a Band 4 Support Worker has been appointed and a Navigator role is being set up this does not replace the need for additional LCNS time.
- Ensure all appropriate patients (good performance status) have an attempt at pathological diagnosis considered. 1) Multi-Disciplinary Team (MDT) discussion. Close liaison with Interventional Radiologists. 2) Audit to explore reasons/ trends for not confirming a pathological diagnosis.
- Invest in data collection clerks and MDT co-ordinators to ensure good quality data. Continue with clinical validation.
- Maintain our current timely access to chemotherapy. 1) Ongoing support and investment in the chemotherapy day unit may be required in order to provide this. 2) Audit to explore reasons/ trends for not offering chemotherapy to good performance status patients with non-small-cell lung cancer and patients with small cell lung cancer.

0548 National Asthma and Chronic obstructive pulmonary disease (COPD) Audit Programme - Outcomes of patients included in the 2017 COPD Clinical Audit

- Production of a Non-Invasive Ventilation (NIV) use proforma for all cases - ongoing audit of trial of the proforma.
- Continuous monitoring equipment purchased for the ward from charitable funds - Equipment currently on order awaiting delivery.
- A need for higher care environment on Midgely ward for use of NIV and continuous monitoring of patients - Board level agreement for removal of some beds on Midgely to create the required higher care environment.

0645 National Asthma and Chronic obstructive pulmonary disease Audit Programme/ Adult

- Length of stay is likely to fall to National median if the Torbay Hospital Outreach Respiratory Team (THORT) is not supported - they also complete discharge bundles which includes smoking advice/ prescribing - Reinforcement of the THORT/ Early Supported Discharge team.
- Implementation of Non-Invasive Ventilation (NIV) proforma for patient care - proforma currently in trial stages on Midgely and Emergency Department.

0569 National Audit of Care at the End of Life (NACEL)

- (Acute) Undertake further national care of the dying audit in 2019
- (Acute) Late recognition of dying patient at 45 hrs - local audit to look at care during period leading up to formal identification of dying
- (Acute) Lack of Trust guideline to promote dignity - Develop guideline to promote dignity.
- (Acute) Poor documentation of discussion of side effects of medication and pro's and cons of artificial nutrition and hydration with patient, spiritual care of patient and family, care after death - 1) Amend End of Life Care (EOLC) plan to provide obvious prompts to discussion (next print run). 2) Include importance of discussions in end of life education delivered to Trust staff 3) Carry out monthly audits of completion of end of life care plans and feedback gaps to ward terms in real time
- (Acute) Lack of availability of comfort packs for relatives - Source funding to provide comfort packs
- (Acute) Poor documentation of preferred place of care at end of life - Add section on preferred place of care at end of life to EOLC care plan.

- (Acute) Need to elicit views of carers on experience of end of life care - Carer survey forms part of 2019 end of life audit, continue to discuss at Trust EOLC meeting to explore options
- (Acute) Work towards seven day working for Hospital Palliative Care Nursing Team - Business case to expand numbers within the team
- (Acute) Incomplete availability of data on delivery of EOLC education to Trust staff - Develop HIVE (Training records/ system) to provide data.
- (Acute) Gaps in availability of education on EOLC for staff - Recruit to unfilled posts in education team.
- (Community) Prescribing and administration issues around EOLC medications - Present audit results at Quality Improvement Group (completed) Feedback audit results to doctors and nurses working in community hospitals
- (Community) Further national end of life audit in 2019 - undertake further national care of dying audit in 2019.
- (Community) Lack of Trust guideline to promote dignity - Develop guideline to promote dignity.

0575 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)

- Agree a referral pathway with Bristol Children's neurology services.
- Review Transition pathway to adult services and modify as needed.
- Look at current Service Contactiblity provision and identify what is going well and what needs changing.

0654 National Cardiac Arrest Audit (ICNARC)

- Ongoing audit of destination following successful cardiac arrest outcome (ROSC >20 mins - Why do so few go to ICU?

0509 National Cardiac Audit Programme National Audit of Cardiac Rhythm Management Devices & Ablation 2016-17

- The predominant relevant finding from this audit is that our rates of data completeness and particularly for NHS number and post code are inadequate. This needs to be proactively addressed and the methods to do so will be discussed at a departmental meeting.

0655 National Cardiac Audit Programme (NCAP)

- Cardiac rehabilitation for heart failure patients - Increased investment in the Cardiac Rehabilitation team with additional appointments

0625 National Delirium Awareness Day Audit

- Update old paper screening tool to include 4AT test, potentially other ways to record e.g. Nerve Centre.
- Delirium guideline is due for renewal.
- Update patient/ relative leaflet to include latest recommendations.

0656 National Diabetes Audit Programme Foot Care Audit

- Development of an 'EMIS' (computer system) template in Primary Care to help with diabetic foot screening which will incorporate an electronic referral to improve referrals
- Continue to offer a diabetic foot screening workshop to those practices where Root Cause Analysis of a major amputation has identified any issues with either screening or following referral pathways.
- To identify from the audit data all those patients in whom there was more than three days between first presentation and being seen in Podiatry. To use this information to find out if there was a delay in referral from the practice and offer a diabetes foot screening workshop to these practices.
- A formal one-day foot screening workshop to be arranged that is open to all Primary Care staff, ward staff, community and care home nursing teams
- Audit data submission. A change in policy means that only two people from each organisation are able to submit data. Agreed to be one admin and one clinical person.
- Explore weekend cover for diabetic foot problems and submit an options appraisal/ business case due to likely cost of weekend working cost pressure.

0583	**National Diabetes Audit Programme - National Pregnancy in Diabetes Audit 2018**
	• Capacity - Develop new role of Diabetes Practitioner to manage low risk Gestational diabetes mellitus independently of Absolute neutrophil count thus increasing capacity for more complex patients. • Managing complexity - Educational events with Midwives to discuss implementation of protocols and facilitate communication between specialties
0584	**National Emergency Laparotomy Audit - Fourth Patient Report (NELA)**
	• Clinical pathways and Clinical Care - We have proposed a pathway framework which contains many of the standards of care that have been previously been agreed in addition to some newly introduced. This is currently in consultation stage. • Develop and agree pathways to promptly identify deteriorating patients and subsequent referral to senior decision makers pre/ post operatively. Collaborate with leads for deteriorating patient and New Early Warning System workstreams. • Ensure a Trust-wide approach to sepsis and ensure delivery of antibiotics within 60 minutes. • Develop and agree Multi-Disciplinary Team pathways for management of sepsis/ peritonitis for patients admitted under non-surgical specialities. • The surgical consultants agreed to accept direct referrals from non-surgical specialities to avoid delays in review that have been implicated in previous mortality reviews - for inclusion in pathway framework. • Develop policies to define timeline to surgery and pathways to facilitate arrival of patients in theatre within appropriate timeframes. This will form a component of the proposed pathway framework.
0714	**National Gastro-Intestinal Cancer Programme**
	• Loop ileostomy closure - Compile list of patients with loop ileostomy and run chart of waiting times.
0505	**National Head and Neck Cancer Surveillance Audit 2018**
	• Local data only reviewed, teams will review national recommendations when published to see if any local actions are required
0733	**National Lung Cancer Audit - Spotlight Report on Molecular Testing in Advanced Lung Cancer**
	• Number of patients requiring a second biopsy - consider on-going audit of patients requiring a second biopsy in order to ensure most appropriate initial diagnostic test has been requested. • High proportion of patients undergoing bronchoscopy - consider the development of an on-site endobronchial ultrasound service. • Review pathway for molecular testing - Reflex testing to be adopted by Pathology laboratory. To discuss at Lung Cancer Multi-Disciplinary Team business meeting.
0730	**National Lung Cancer Audit Organisational Audit**
	• Respiratory Physician dedicated PAs - Job planning and service provision review. • Lung Cancer Nurse Specialist Provision - At least one Whole Time Equivalent additional post required. • Smoking cessation - Policy, provision and training required. • Pulmonary rehabilitation - dedicated service for lung cancer patients.
0662	**National Vascular Registry (NVR - Comprising Carotid Intervention and AAA)**
	• Vascular units should ensure that all data on lower limb revascularisation and major amputation procedures are being uploaded to the NVR, including the provision of administrative support to allow this: - Action - Plan with Royal Devon and Exeter hospital (RD&E) to support admin to upload RD&E data only. No Plan for Torbay angioplasty data agreed. Needs Radiology discussions with Medical Director and funds identified. • Vascular units should review their pathways of care for patients with critical limb ischaemia (CLI), using the Vascular Society of Great Britain and Ireland (VSGBI) Quality Improvement

Frameworks (QIF) for peripheral arterial disease and amputation. Action: - Data/ 'Getting It Right First Time' – Large numbers with poor outcomes.

- Work in progress to develop rapid access and urgent ambulatory pathways. Needs to be matched with diagnostics within RD&E. Major limitation with access to inpatient theatres and no hybrid theatre in vascular hub.
- Vascular units should aim for patients admitted as emergency with CLI to have their lower limb bypass or endovascular revascularisation procedure within five days. Action: - See above concerns
  - Theatre capacity
  - Hybrid capacity and access
  - Interventional Radiology (IR) capacity at 'Hub'
- No emergency admissions of such to Torbay – Vascular network policy.
- Vascular units should review local care pathways and patient outcomes for lower limb amputation using recommendations in the VSGBI QIF. Specifically:
  - patients undergoing major amputation should be admitted in a timely fashion to a recognised arterial centre with agreed protocols and timeframes for transfer from spoke sites and non- vascular units.
  - below knee amputation (BKA) should be undertaken whenever appropriate. Vascular units should aim to have an above knee (AKA) to BKA ratio below one. Action: Poor process data for Torbay and RD&E within report.
- In Patient theatre limitation within vascular Hub.
- Clinical pathway established for transfer of emergencies and diabetic foot problems.
- AKA:BKA ratio < 0.5 in both units.
- Vascular units should examine how to improve their performance against the shared NCEPOD and VSGBI QIF recommendations for amputation. Action: To be confirmed
- NHS Trusts at which patients are not having their carotid endarterectomy within 14 days of experiencing symptoms should review the referral pathways within their networks and implement improvements to reduce waiting times. Action: - Moderate performance but both Trusts better than National performance.
- Limitation is related to lack of IP theatre lists in Hub.
- For non-complex aneurysms, vascular units should ensure the time patients take from referral for vascular assessment to elective Abdominal aortic aneurysm (AAA) repair is less than eight weeks for both screen and non-screen detected patients. Action: Area of concern. Concerns expressed by National AAA screening programme. Multiple delays in pathway. Lack of inpatient theatre capacity. Lack of hybrid theatre and IR capacity within Hub.
- Vascular units should evaluate how access to endovascular repair can be improved for emergency repair of ruptured aneurysms. This may require review of anaesthetic as well as surgical aspects of the care pathway. Action: - Concern: Low numbers of emergency or urgent Endovascular aneurysm repairs performed. No hybrid theatre in Vascular Hub 2/3rd of vascular hubs have hybrid theatres. IR suite in RD&E remote from theatres.

0592 NPDA (RCPH National Paediatric Diabetes Audit)

- To improve the median HbA1c of our patients and increase the proportion with HbA1c within the target range - We are currently engaged in the national collaborative Quality Improvement program. We have on-going projects looking at further unifying the message we give to our patients and families and in educating and empower patients to spot patterns in blood glucose and adjust insulin regimes.
- To help empower children and families to make changes to their insulin regimes and diabetes self-care routines based on sound knowledge - To support us in educating children and families to become experts in their diabetes we have built up a library of educational resources and motivational tools.
- To increase the number of children receiving the appropriate care processes and to have a structured evidenced based approach to acting on the results and charting children's health - We have developed new screening and management and are starting to capture results in a more meaningful way to be able to chart children's health in relation to early signs of diabetes

complications over the years they are in care.

The reports of 33 local clinical audits were reviewed by the provider in 2019/20and Torbay and South Devon NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions
6608	**Tracheostomy Theatre Safety Project**
	• A number of educational processes will be set up for staff to attend/ take part: Lunchtime "drop in" session in theatres with one of the Head & Neck specialist nurses - Staff to practice suctioning via an Endotracheal Tube in theatre during a General Anaesthetic case - E-learning module(s) available on tracheostomy.org - "Trach" study day (probably a half-day)
6583	**Emergency Readmission following Laparoscopic Hysterectomy**
	• Share findings with all consultants performing this surgery
6553	**Safeguarding referrals for children undergoing multiple dental extractions under general anaesthetic (GA)**
	• Share findings with the Day Surgery Unit Paediatric Sister • Produce new policy for management of children having dental extractions under GA
6588	**Assessing the appropriateness of Urgent Referral Service referrals**
	• Provide feedback regarding electronic referral service results to Emergency Department (ED) to improve service • Provide teaching to ED staff to ensure relevant information included in referral/ any questions can be addressed
6574	**Preoperative urine testing pathway for primary arthroplasty surgery**
	• Highlight results at Trauma and Orthopaedic audit meeting • Raise awareness of poor rate of instruction recorded in operation notes • Remind all staff Asymptomatic Bacteriuria patients require antibiotics if catheterised • Discuss process for making notes on the drug charts with Outreach Team • Investigate evidence that this guideline improves patient care. International consensus has suggested no clinical need for testing these patients
6536	**Amblyopia treatment options**
	• Clinical discussion re hours of patching recommended/ prescribed completed at presentation. • Current two guidelines updated, circulated and merged into one cohesive document • Staff instructed after discussions at presentation to document offer of both treatments in notes; if not then clinical reason for choice must be recorded • Change atropine occlusion to weekend rather than current Monday, Wednesday and Friday • Staff to check near vision in all atropine patients and, if unable to, switch to 'month on/ month off' • Update patient leaflets to account for all changes
6604	**Ambulatory/ Outpatient Pulmonary Embolism (PE) management**
	• Trial a PE pro-forma and to email out to juniors and seniors regarding this • Investigate Radiology quick scan option which would shorten the length of stay for those unsuitable • Liaise with Respiratory Medicine and Haematology regarding best follow up for patients with confirmed PE
6601	**Management of Sepsis in Emergency Department**
	• More time taken in 'Resus' to ensure Intra Venous (IV) fluids are given • A change to IV behaviours is required in A&E staff
6605	**Investigation of suspected Cauda Equina Syndrome (CES)**
	• Clinicians should make sure patient is Magnetic resonance imaging (MRI) safe before considering requesting MRI. • Currently we still have consultant to consultant referrals for out of hour MRI - Radiology Clinical • Aiming to put potential/ possible CES patients through "next" slot on scanner. This is next after patient arrives at the MRI department, if no higher priority emergencies, not next after discussion with Radiologist • The Radiologist must receive a request card from clinician before patient can be scanned to avoid delays

6607	**Assessment of the burden of outlying Orthopaedic patients**
• Results to be shared at Directorate meeting and efforts made to improve placement of orthopaedic patients • Share data with Trust board to consider reassigning Warrington ward back to Orthopaedics	
6602	**Chest pain pathway**
• Ensure all patients with low "HEART" score (0-3) and negative Troponin should be discharged to GP through new pathway • Consider initiating primary prevention medication only if angina diagnosis is the most likely through new pathway • All patients with Intermediate HEART score (4-5) and negative Troponin for primary prevention and Outpatient Cardiology referral • All high-risk patients should be admitted and have Cardiology review	
6576	**Podiatrist corticosteroid injection therapy**
• Treatment outcomes to be recorded; pre and post injection pain score using validated visual analogue scale score and Manchester Oxford foot questionnaire to measure treatment outcome	
6500	**Improving Multiple Sclerosis (MS) Magnetic Resonance Imaging (MRI)**
• Negotiate use of same scanner for all MS patients • Roll out new MRI Protocol and Clinical Guideline • Survey patients to ensure they are happy with new imaging practice • Trial new MRI sequences • Develop new MRI request form with tick boxes to identify correct protocol	
6582	**Interventional Radiology World Health Organisation (WHO) Safety Checklist**
• Scan completed forms onto Computerised Radiology Information System for each patient • The scanner in theatres is not working, report fault to IT or request a new one.	
6594	**Staff safety and usage of personal Thermoluminescent Dosimeters (TLDs) in Radiology and Diagnostic Imaging**
• Staff to be emailed when TLD is about to expire so new ones can be obtained • All staff notified through a team meeting that temporary TLDs can be worn if staff members forget • Education of staff as part of Clinical Governance and Audit meeting	
6603	**Computerised Tomography (CT) abdo-pelvis (AP) and kidney, ureter and bladder (KUB) radiation dose and records**
• Staff encouraged to routinely collect patient weight or patient AP diameter from scout image to help inform future dose reduction efforts • To investigate further Radiation Dose Monitoring software: - National Institute for Health and Care Excellence Medtech Innovation Briefing 127 identified potential cost savings by avoiding manual or semiautomatic data collection - General Electric Healthcare have 'Dose Watch' software, between £10,000 to £20,000 a year	
6584	**Infectious Diseases in Pregnancy Screening**
• Take audit results to Team Leaders meeting • New generic email set up for the Screening team • For patients with a suspected diagnosis of hepatitis B, a referral is to be made to the Gastroenterology team prior to formal confirmation from Bristol	
6568	**Paediatric Head Injury (post injury observations) (CG-176)**
• Share results with Emergency Department (ED) colleagues • Further training required to increase awareness of guidance recommendations among medical and nursing staff • Explore development of head injury observational pro-forma in conjunction with ED colleagues – incorporating a section to document acceptable variations	
6606	**Diagnosis and Initial Management of Juvenile Idiopathic Arthritis (JIA)**
• Develop a specific JIA referral guideline/ tool for GPs, Emergency Department and community Physiotherapists	
6569	**Autism in Children and Young People: Recognition, referral, diagnosis and management (CG-128/ 170)**

• Emphasise/ train Community Paediatric colleagues to use Wood's light during physical examination • Explore possible change in working patterns to improve waiting times • Offer post diagnostic telephone follow up at six weeks	
Audits completed and reviewed NOT requiring a plan or specific actions due to good results or compliance	
6590	On-site Cytotechnician evaluation of Fine Needle Aspiration adequacy in a Neck Lump clinic
6598	Post-tonsillectomy bleeds
6599	Post-operative management of children undergoing adenotonsillectomy for Obstructive Sleep Apnoea (OSA)
6596	Botox for the management of urinary incontinence in women (CG-171)
6551	Orthodontic Breakages
6589	Macular Hole surgery at Torbay Hospital
6612	Surveillance of women at higher risk of breast cancer
6586	Use of low dose diuretic in patients with moderate to severe Hyponatraemia secondary to syndrome of inappropriate antidiuretic hormone secretion (SIADH)
6544	Barriers to implementing the NICE Guidelines for Jaundice in newborn babies under 28 days (CG-98) - National Study
6545	Outcome of Waterbirth Babies - Reasons for SCBU Admissions
6578	Neonatal Lumbar Puncture in Sepsis
6566	Accuracy of grading for knee osteoarthrosis (OA)
6567	Positron Emission Tomography (PET)/ Computerised Tomography (CT) correlation with histology in lung cancer staging

The reports of 3 national confidential enquiries were reviewed by the provider in 2019/20 and Torbay and South Devon NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

0724	**MBRRACE - Perinatal Mortality Surveillance Report 2019**
• In order to achieve the various UK Governments' ambitions renewed efforts need to be focused on implementing existing national initiatives to reduce stillbirths and continue the slow but steady decline in neonatal mortality rates observed since 2013. Particular emphasis should be placed on reducing preterm birth - The Trust is working towards the Saving Babies Lives Care Bundle Version 2. A business case is needed as the guidance involved extra scanning and consultant obstetrician resource as a minimum. This is an ongoing action that is being monitored through the Maternity Clinical Governance Group. • Trusts and Health Boards should work to implement fully the National Bereavement Care Pathway to ensure that all patients are offered high quality, individualised bereavement care after the loss of their baby - Not in place. Take to the Maternity Clinical Governance Group. • Placental histology should be undertaken for all stillbirths and if possible all anticipated neonatal deaths, preferably by a perinatal pathologist - Service not commissioned locally. Investigate if this service can be commissioned and where and what cost to the organisation.	
0520	**(NCEPOD) Peri-Operative Management of Surgical Patients with Diabetes Study**
• List order prioritisation - Discussion with theatre booking staff, reminder to anaesthetic staff at Clinical Effectiveness meeting. Snap-shot audit to check in three months. • Length of peri-op starvation - Snap-shot audit of starvation times for inpatients. • Improved peri-op monitoring of Capillary Blood Glucose - Education to anaesthetic staff at Clinical Effectiveness meeting.	
0619	**(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 2014-16**
• Women with a high Body Mass Index should be given information about the symptoms of Venous thromboembolism (VTE) - Unsure of what information the Royal College of Obstetricians and Gynaecologists provides - Review of information.	

- Women with complex and multiple problems need senior review prior to discharge timing of follow up appointments, arranged with the appropriate services before the women are discharged - To include guidance in local policy - Update Medical disorders in Pregnancy.
- If a cancer diagnosis is suspected, investigations should proceed in the same manner and on the same timescale as for a non-pregnant woman a discussion of potential risks and benefits with the women - To include guidance in local policy - Update Medical disorders in Pregnancy.
- Pregnant or postpartum women who are diagnosed with cancer should have the possibility of an underlying familial syndrome considered. To include guidance in local policy - Update Medical disorders in Pregnancy.
- Thrombosis, particularly migratory or in an unusual location, should be fully investigated as it may be a presenting sign of cancer in pregnancy or postpartum - To be included in existing local policy - Update VTE policy.
- Repeated presentation with pain and/ or pain requiring opiates should be considered a 'red flag' and warrant a thorough assessment of the woman to establish the cause - New guidance needs to be developed - Produce new guidance.

Research

The number of patients receiving relevant health services provided or sub-contracted by Torbay and South Devon NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 1,329.

Participation in clinical research demonstrates Torbay and South Devon NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Torbay and South Devon NHS Foundation Trust was involved in conducting 178 clinical research studies during 2019/20 in 35 specialities.

During 2019/20 80 clinical staff participated in approved research at Torbay and South Devon NHS Foundation Trust.

In the past year more than 21 publications have resulted from our involvement with the National Institute Health Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates Torbay and South Devon NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques. Here are just a few examples of how our participating in research improves patient care.

Summary of the Impacts and Outcomes from studies Torbay Hospital has led or participated in.

Clinical Specialty	Study details
Cancer (bladder)	Patient-reported Quality of Life Outcomes in Patients Treated for Muscle-invasive Bladder Cancer with Radiotherapy ± Chemotherapy in the BC2001 Phase III Randomised Controlled Trial

	BC2001, the largest randomised trial of bladder-sparing treatment for muscle-invasive bladder cancer, demonstrated improvement of local control and bladder cancer-specific survival from the addition of concomitant 5-fluorouracil and mitomycin C to radiotherapy. The study also assessed the impact of treatment on the health-related quality of life (HRQoL) of BC2001 participants and showed that Quality of life of bladder cancer patients treated with radiotherapy±chemotherapy deteriorates during treatment, but improves to at least pre-treatment levels within 6 months. Addition of chemotherapy to radiotherapy does not affect patient-reported quality of life.
Cancer (breast)	Synchronous Versus Sequential Chemo-Radiotherapy in Patients with Early Stage Breast Cancer (SECRAB): A Randomised, Phase III, Trial The optimal sequence of adjuvant chemotherapy and radiotherapy for breast cancer is unknown. SECRAB. was a prospective, open-label, multi-centre, phase III trial looking to assess whether local control can be improved without increased toxicity by comparing synchronous to sequential chemo-radiotherapy, conducted in 48 UK centres. The study results show that synchronous chemo-radiotherapy significantly improved local recurrence rates. This was delivered with an acceptable increase in acute toxicity. The greatest benefit of synchronous chemo-radiation was in patients treated with anthracycline-CMF.
Cancer (Colorectal)	3-month versus 6-month adjuvant chemotherapy for patients with high-risk stage II and III colorectal cancer: 3-year follow-up of the SCOT non-inferiority RCT Patients diagnosed with bowel cancer are likely to have surgery to remove the tumour. Patients diagnosed with a more advanced stage of the disease are then likely to be offered what is known as adjuvant chemotherapy. The study assessed the efficacy of 3-month versus 6-month adjuvant chemotherapy for colorectal cancer and to compare the toxicity, health-related quality of life and cost-effectiveness of the durations. Overall, the study showed that 3-month adjuvant chemotherapy for patients with bowel cancer is as effective as 6-month adjuvant chemotherapy and causes fewer side effects.
Cancer (Malignant Haematology)	Characteristics Associated with Significantly Worse Quality of Life in Mycosis fungoides/Sézary Syndrome from the Prospective Cutaneous Lymphoma International Prognostic Index (PROCLIPI) Study

	Mycosis fungoides (MF) and Sézary Syndrome (SS) are the most common cutaneous T-cell lymphomas. MF/SS is accompanied by considerable morbidity from pain, itching and disfigurement. The study aimed to identify factors associated with poorer health-related quality of life (HRQoL) in patients newly diagnosed with MF/SS. Conclusions: This is the first prospective study to investigate HRQoL in newly diagnosed patients with MF/SS. The results show that HRQoL is worse in women and in those with alopecia and confluent erythema. MF/SS diagnosis has a multidimensional impact on patient HRQoL, including a large burden of cutaneous symptoms, as well as a negative impact on emotional well-being. The results show that a comprehensive validated cutaneous T-cell lymphoma-specific questionnaire is urgently needed to more accurately assess disease-specific HRQoL in these patients.
Cancer (Malignant Haematology)	The UK NCRI Study of Chlorambucil, Mitoxantrone and Dexamethasone (CMD) Versus Fludarabine, Mitoxantrone and Dexamethasone (FMD) for Untreated Advanced Stage Follicular Lymphoma: Molecular Response Strongly Predicts Prolonged Overall Survival This trial was the first to prospectively assess molecular response and the impact on outcomes for 400 patients. Long-term follow-up data shows that no cases of progression occurred in minimal residual disease (MRD) negative patients after six years of follow-up. Although there was no difference in outcomes between arms, this is the first prospective study to report MRD negativity resulting in significantly improved Overall survival (OS).
Cancer (Malignant Haematology)	Prophylactic levofloxacin to prevent infections in newly diagnosed symptomatic myeloma: the TEAMM RCT Myeloma is a type of cancer that develops from cells in the bone marrow, called plasma cells, which are part of the immune system. Because myeloma affects the immune system, people who have it are at greater risk of picking up infections. This risk is higher at the start of antimyeloma therapy when the myeloma is active. The study assessed the risks, benefits and cost-effectiveness of prophylactic levofloxacin in newly diagnosed symptomatic myeloma patients. The results showed that during the 12 weeks from new diagnosis, the addition of prophylactic levofloxacin to active myeloma treatment significantly reduced febrile episodes and deaths without increasing healthcare associated infections or carriage.

Cancer (prostate)	Addition of Docetaxel to Hormonal Therapy in Low- And High-Burden Metastatic Hormone Sensitive Prostate Cancer: Long-Term Survival Results from the STAMPEDE Trial The STAMPEDE trial has previously reported that the use of upfront docetaxel improved overall survival (OS) for metastatic hormone naïve prostate cancer patients starting long-term androgen deprivation therapy. The clinically significant benefit in survival for upfront docetaxel persists at longer follow-up, with no evidence that benefit differed by metastatic burden. The research advocates that upfront docetaxel is considered for metastatic hormone naïve prostate cancer patients regardless of metastatic burden.
Dermatology	Comparing alternating pressure mattresses (APM) and high-specification foam mattresses (HSFMs), to prevent pressure ulcers (Pus) in high-risk patients: the PRESSURE 2 RCT Special mattresses are used to help prevent PUs. This study compared alternating pressure mattresses (APMs) with high-specification foam mattresses to see which is better at preventing PUs. In this trial of > 2000 patients, the rate of development of new pressure ulcers did not differ according to mattress type.
Gynaecology	Surgical interventions for uterine prolapse and for vault prolapse: the two VUE Randomised Controlled Trials (RCTs) About 1 in 10 women has pelvic organ prolapse (POP) surgery, and around three of these women require a further operation. The aim of this study was to identify the most appropriate surgery for two different types of POP found in women: (1) when the uterus itself has come down – the Uterine trial comparing surgical uterine preservation with vaginal hysterectomy – and (2) when a previous hysterectomy has resulted in the top of the vagina coming down – the Vault trial comparing abdominal procedures with vaginal procedures. The study considered clinical effectiveness, adverse events, quality of life and cost-effectiveness. There results show there was no difference in symptoms or quality of life between uterine preservation versus vaginal hysterectomy for uterine prolapse or between abdominal versus vaginal approaches for vault prolapse. Women in both trials will be followed up for at least 6 years to determine longer-term costs and consequences.
Health Services Research	Capturing the Role of Context in Complex System Change: An Application of the Canadian Context and Capabilities for Integrating Care (CCIC) Framework to an Integrated Care Organisation in the UK Purpose: This study applied the Canadian Context and Capabilities for Integrating Care (CCIC) Framework to investigate factors influencing the implementation and outcomes of a complex integrated care change programme in Torbay and South Devon (TSD) and, more specifically, in one of five sub-localities, Coastal. If integrated care approaches are to

	be properly adapted to local contexts, a better understanding is required of key determinants of implementation and how these might be appropriately supported. Conclusions: The CCIC Framework provided a useful tool capturing key elements of complex system change with key domains being transferable across settings, while also finding local variation in the UK. This would encourage its wider application so that further comparisons can be made of the ways in which different contextual and implementation properties impact upon delivery and outcomes.
Orthopaedics	Midterm Outcomes of a Synthetic Cartilage Implant for the First Metatarsophalangeal Joint in Advanced Hallux Rigidus A prospective, randomized, noninferiority clinical trial of synthetic cartilage implant hemiarthroplasty for hallux rigidus (big toe arthritis) demonstrated functional outcomes and safety equivalent to first metatarsophalangeal (MTP) joint arthrodesis at 24 months. The clinical and safety outcomes for synthetic cartilage implant hemiarthroplasty observed at 2 years were maintained at 5.8 years. The implant remains a viable treatment option to decrease pain, improve function, and maintain motion for advanced hallux rigidus.
Physiotherapy	Exercise or manual physiotherapy compared with a single session of physiotherapy for osteoporotic vertebral fracture: three-arm PROVE RCT Osteoporosis is a condition in which bones lose their strength and are more likely to break. It affects around 3 million people in the UK. Fractures of the spine are very common in people with osteoporosis. The objective was to investigate the clinical effectiveness and cost-effectiveness of two different physiotherapy programmes for people with OVF compared with a single physiotherapy session. This is the largest RCT to date assessing physiotherapy in participants with OVFs. At 1 year, neither treatment intervention conferred more benefit than a single 1-hour physiotherapy advice session on quality of life or muscle endurance.
Rheumatology	Group cognitive behavioural programme to reduce the impact of rheumatoid arthritis fatigue: the RAFT RCT with economic and qualitative evaluations Rheumatoid arthritis (RA) is a lifelong inflammatory condition affecting multiple joints, with fatigue as a major consequence. The study found that the RAFT programme improves RA fatigue impact beyond usual care alone; at 6 months and this was sustained for 2 years with high patient satisfaction, enhanced team skills and no harms and is a potentially low-cost intervention that can be delivered by rheumatology nurses and OTs rather than a psychologist.

Stroke	Tranexamic acid to improve functional status in adults with spontaneous intracerebral haemorrhage: the TICH-2 RCT 7 patients recruited @ Torbay Stroke caused by bleeding in the brain [i.e. an intracerebral haemorrhage (ICH)] is a medical emergency. Around one-third of such strokes are complicated by continuing bleeding, which usually occurs within the first few hours after trauma and childbirth, and is associated with death or severe disability. Tranexamic acid is a drug that is seen to reduce death from bleeding after trauma and childbirth. Conclusion Treatment with tranexamic acid did not result in a significant improvement in recovery at 90 days (i.e. functional status), despite small reductions in the number of early deaths, amount of brain bleeding and the number of complications.
Stroke	Dopamine Augmented Rehabilitation in Stroke (DARS): a multicentre double-blind, randomised controlled trial of co-careldopa compared with placebo, in addition to routine NHS occupational and physical therapy, delivered early after stroke on functional recovery The results show that Co-careldopa in addition to routine NHS occupational and physical therapy is not clinically effective or cost-effective in improving walking, physical functioning, mood or cognition following stroke.
Surgery	Robotic-assisted surgery compared with laparoscopic resection surgery for rectal cancer: the ROLARR RCT This was a multicentre, randomised trial comparing robotic with laparoscopic rectal resection in patients with rectal adenocarcinoma. The study concluded that robotic surgery does not reduce the need to perform open surgery in a small number of patients with rectal cancer. Robotic surgery is more expensive than laparoscopic surgery, with no obvious benefits for patients in the short or long term.
Surgery	Eicosapentaenoic acid (EPA) and/or aspirin for preventing colorectal adenomas during colonoscopic surveillance in the NHS Bowel Cancer Screening Programme: the seAFOod RCT 15 patients recruited @Torbay. Bowel cancer kills > 15,000 people every year in England and Wales. Most bowel cancers develop from a polyp, also known as an adenoma. Polyps are found and removed at colonoscopy, but colonoscopy does not prevent further polyps. Use of drugs or dietary supplements (called

	chemoprevention) may be able to reduce polyp growth and the possibility of developing bowel cancer. The Systematic Evaluation of Aspirin and Fish Oil (seAFOod) trial tested the effects of naturally occurring omega-3 eicosapentaenoic acid (EPA) (a dose roughly equivalent to two oily fish portions every day) and aspirin on bowel polyp growth. Patients took EPA on its own, aspirin on its own, EPA and aspirin together or placebo (dummy) medication. The results showed that there was no reduction in the number of patients who had at least one adenoma at check-up in either EPA or aspirin users. However, EPA and aspirin were found to reduce the number of certain types of adenoma in different parts of the bowel by 10–20%. Both EPA treatment and aspirin treatment were safe for patients, with no increased bleeding risk, but EPA caused 10% more symptoms of mild stomach upset, including diarrhoea. It is concluded that both EPA and aspirin have chemoprevention benefits, which are limited to certain bowel polyp types. The results also suggest that aspirin (possibly with EPA) could be used to help prevent bowel cancers that occur despite colonoscopy.
Urology	Clinical and Patient-reported Outcome Measures in Men Referred for Consideration of Surgery to Treat Lower Urinary Tract Symptoms: Baseline Results and Diagnostic Findings of the Urodynamics for Prostate Surgery Trial; Randomised Evaluation of Assessment Methods (UPSTREAM) Clinical evaluation of male lower urinary tract symptoms (MLUTS) in secondary care uses a range of assessments. It is unknown how MLUTS evaluation influences outcome of therapy recommendations and choice, notably urodynamics (UDS; filling cystometry and pressure flow studies). This study is a randomised controlled trial evaluating whether symptoms are noninferior and surgery rates are lower if UDS is included. The initial findings show that men being considered for surgery have additional clinical features that may affect treatment decision making and outcomes, notably storage LUTS and impaired sexual function.

CQUIN

A proportion of Torbay and South Devon NHS Foundation Trust income in 2019/20 was conditional on achieving specialist quality and improvement and innovation goals agreed between Commissioners other than South Devon and Torbay CCG and any person or body they entered into a contract, agreement, or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed specialist goals for 2019/20 and for the following 12-month period are available electronically at: http://www.torbayandsouthdevon.nhs.uk

In 2019/20 the potential value of the CQUIN payment was £2,637,000 and income subsequently received was £2,637,000 (tbc). In 2018/19 the potential value of the CQUIN payment for the Trust was £4,793,000 and the income subsequently received was £4,793,000. In 2020/21/20 the planned value of the CQUIN payment is £2,550,000.

(N.B. The CQUIN value of the contract in 19/20 has reduced from 2.5% to 1.25% of applicable contract value)

Care Quality Commission

Torbay and South Devon NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures.
- Family planning
- Management of supply of blood and blood derived products.
- Maternity and midwifery services.
- Personal care.
- Surgical procedures.
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely.
- Treatment of disease, disorder or injury.

Torbay and South Devon NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Torbay and South Devon NHS Foundation Trust during 2019/20.

Torbay and South Devon NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

During the period April 2019 to March 2020, TSDFT received no unannounced CQC inspections, one announced CQC inspection, and one announced NHSI Use of Resources assessment, as detailed below.

The Trust received an announced CQC inspection in March 2020 of the following areas:

- Children and young people services

- Community health inpatient services
- Maternity
- Medical care
- Surgery
- Urgent and Emergency services

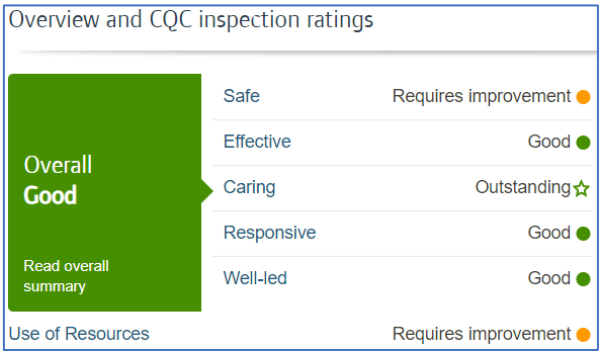
These inspections were part of the CQC's routine inspection programme. Three additional core service inspections, planned for the same inspection, were cancelled shortly before the visit due to the national COVID-19 pandemic: Community end of life; Community health services for adults, and Diagnostic imaging. The announced trust-wide well-led inspection planned for the end of March/beginning of April 2020, was also cancelled by the CQC due to COVID-19.

The final CQC inspection report for TSDFT with the findings from the inspection of the six core services was published in July 2020 (https://api.cqc.org.uk/public/v1/reports/c1101016-4312-4e83-a15f-1176d9143c08) . Requirement notices and 'should do' action plans are monitored through TSDFT's individual service leadership teams and reported to the Trust's CQC and Compliance Assurance Group.

NHS Improvement conducted an announced Use of Resources assessment with an onsite one-day visit in February 2020. The final report for the announced 2020 inspection was published in July 2020 (https://www.cqc.org.uk/sites/default/files/new_reports/uor-AAAK0284.pdf).

Other than for the Use of Resources, the Trust's overall ratings from the CQC have not changed during 2019/2020, as the CQC do not change overall ratings when the trust-wide well-led inspection has not been conducted.

The Trust's current ratings (following publication of the final reports in July 2020) are shown in the table below.



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

Data quality

High quality data is important to our organisation for many reasons including our ability to improve our services and to understand how efficient our services are.

Within the Trust data quality is managed primarily by the Health Informatics Service and the Information team working together to ensure there are appropriate governance processes in place to manage and improve data quality.

NHS number and general practitioner registration code

Torbay and South Devon NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

The percentage of records in the published data, as of February 2020:

which included the patient's valid NHS number was:

- 99.8% for admitted patient care.
- 99.9% for outpatient care.
- 99.0% for accident and emergency care.

and those which included the patient's valid General Medical Practice Code was:

- 96.3% for admitted patient care.
- 95.5% for outpatient care.
- 96.3% for accident and emergency care

Information governance

Torbay and South Devon NHS Foundation Trust Information Governance Assessment report is no longer available and the system has been replaced by the "Data Security & Protection Toolkit (DSP Toolkit)".

Torbay and South Devon NHS Foundation Trust's toolkit publication for 2019/20 was standards met.

This is, in part due to the prioritisation of COVID-19 prevention and detection work. NHS Digital have extended the deadline with the requirement that all Trusts will develop an agreed action-plan to capture the required evidence, where necessary.

Clinical coding

Torbay and South Devon NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

Data quality improvements

- Embedding the new information governance toolkit.
  Demonstration of this can be seen in the availability and quality of evidence on NHS dashboards which are monitored monthly.

- Maintaining or improving the Trust national SUS data quality position.
  There has been a slight decrease in the Trust national SUS data quality position due to a shift of focus to the rapid response of urgent care to the pandemic.

- Obtaining a realistic overview of the Trust's data quality and related risks to information reporting.
  Following the establishment of the Information Assurance Group data quality issues are being captured and tracked, with routes to solutions discussed.

- Acting on the recommendations of three data quality audits undertaken by the external auditor in spring 2018 as part of the Trust's annual quality account.

  An external assessment of the Health Informatics Service has highlighted a capacity lacking issue in data quality, which has now been approved by the Board.

In 20201/21 the Trust will take the following actions to improve data quality:

- Implement the recommendations from the external review, assigning a dedicated data quality workforce.

- Review national SUS coding, to maintain acceptable quality levels.

- Mitigate the changes and anomalies to data capture, necessitated due to pandemic prevention and detection.

- Improve the density of coding relating to palliative care by implementing additional data feeds from our local hospices.

- Increase coding provision to support the recording of mortality, to align with the summary Hospital-level Mortality Indicator.

Mandated quality indicators

As part of the annual report the Trust is required to report against several mandatory quality indicators. These are described below.

Domain1:

Learning from patient deaths

27.1	During 2019/20, (April 2019 to Mar 2020) of Torbay and South Devon NHS Foundation Trust 1231 patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 292 in the first quarter; 283 in the second quarter; 323 in the third quarter; 333 in the fourth quarter
27.2	For the period April 2019 to Mar 2020 206 case record reviews have been carried out in relation to the above number of the deaths included above. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 54 in the first quarter; 52 in the second quarter; 56 in the third quarter; 44 in the fourth quarter
27.3	1 death representing <1% of the patient deaths reviewed via Structured Judgement Framework(SJF) review during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 for the first quarter; 0 for the second quarter; 0 for the third quarter; 1 for the fourth quarter. These numbers have been estimated using the Structured judgement framework based on the Royal College of Physicians guidance.
27.4	Based on the reviews undertaken being alert to communication issues and process issues is key to ensuring good and timely care. If an intervention is in place using medical devices these need to be observed at regular intervals
27.5	The Trust has been working on the implementation of the new Medical Examiners and 5 have been recruited but due to Covid where unable to start the medical Examiner process in March 2020. This new role and the new Director of Patient Safety will continue the mortality review process so that all deaths will have scrutiny by quarter 4 of 2020/21
27.6	The learning for the Trust has been that the vast majority of deaths have been dignified and expected. From learning from deaths, the one area which has a consistent profile is communication, whether this be with the families or interprofessional and this will be a continuous area of learning and sharing. The Trust has created a training video which explores communication in all settings and is being used to good effect, particularly with the junior doctors. The video highlights the need to escalate issues upwards to ensure good timely decision making. The following have been present on reviews and are observations rather than material issues: timely use of TEP forms, using Learning Disability nurses to help early in children's care, use of hospital passports, availability of femoral artery lines. These have been shared intra-departmentally or via the 5 point safety brief
27.7	64 case record reviews and investigations were completed after January 2019 (check) which related to deaths which took place before the start of the reporting period.
27.8	0% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structure Judgement framework.
27.9	<1% of the patient deaths during 2018/19 (check) are judged to be more likely than not to have been due to problems in the care provided to the patient.

Preventing people from dying prematurely

	July 18 – June 19	July 17- June 18	July 16 – June 17	July 15 – June 16
SHMI	0.9473	0.9159	0.8530	0.8440
National High – Low	1.19 – 0.69	1.26 - 0.69	1.22 – 0.73	1.17 - 0.69
Band *(Band 2 = as expected Band 3 = lower than expected)*	2	2	3	3
Observed deaths	1,685	1,780	1,808	1,798
Expected deaths	1,780	1,943	2,119	2,130
Spells	46,085	46.557	49,473	47,927

Source of information: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/shmi-data

The summary hospital-level mortality Indicator, or SHMI, is a measure of the number of patients that have died in hospital or within 30 days of being discharged from hospital. SHMI takes into account several factors including a patient's condition.

The SHMI score is measured against the NHS average which is 1.0. A score below 1.0 denotes a lower than average mortality rate and indicates good, safe care. The SHMI data is published in arrears.

The highest Trust score is 1.19 and the lowest Trust score is 0.69. There is no national average. The Trust is performing better that the national benchmark.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Compliance with data standards for this indicator.

Torbay and South Devon NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services by:

- Maintaining systems and process for mortality data review through the Quality Assurance Group and reported performance to the Trust Board.

Palliative care coding (contextual indicator for SHMI)

	July 18 – June 19	July 17- June 18	July 16 – June 17	July 15 – June 16
Palliative care coding % deaths	25	25.3	22.8	22.1
England average	36	32.9	31.2	29.1
High	59	58.7	58.6	54.8
Low	15	13.4	11.2	0.6

Source of information: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi/current/palliative-care-coding

The highest Trust score is 59% and the lowest Trust score is 15%. The national average is 36%.

The number of deaths recorded as coded to palliative care within the Trust has remained within normal range and is below the national average

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Compliance with data standards for this indicator.
- Peer review of coding principles and practices including capture of palliative coding.

Torbay and South Devon NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services by:

- Maintaining systems and process for mortality data review through the Quality Assurance Group and reported performance to the Trust Board.

Helping people to recover from episodes of ill health or injury

Hip replacement	Apr 18 - Mar 19	Apr 17 – Mar 18	April 16 – Mar 17
Adjusted Health gain score	0.451	0.504	0.482
National average	0.457	0.458	0.44
Highest Trust performance			0.54
Lowest Trust performance			0.30
Knee replacement			
Adjusted Health gain score	0.331	0.349	0.353
National average	0.337	0.337	0.32
Highest Trust performance			0.403
Lowest Trust performance			0.245
Groin hernia surgery			

Adjusted Health gain score	Low numbers data not published	Low numbers data not published	Low numbers data not published
National average	n/a	n/a	n/a
Highest Trust performance	n/a	n/a	n/a
Lowest Trust performance	n/a	n/a	n/a
Varicose vein surgery			
Adjusted Health gain score	Low numbers data not published	Low numbers data not published	Low numbers data not published
National average	n/a	n/a	n/a
Highest Trust performance	n/a	n/a	n/a
Lowest Trust performance	n/a	n/a	n/a

Source of information: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

The Patient Reported Outcome Measures (PROMs) data is published nationally in arrears.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- The process for collecting the PROMS data has been reviewed and validated
- The compliance reports supplied by our PROMS contractor are regularly reviewed

Torbay and South Devon NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by:

- Clinical services maintain strong peer review of profession practice and monitor patient outcomes in conjunction with established revalidation and education and training programmes.

Patients readmitted to a hospital within 30 days of being discharged

	April 18-March 19	April 17 – March 18	April 16 – March 17
0-15 years old			
% readmissions	13.5	12.5	12.5
National Average	12.5	11.9	11.6
=>16 years old			
% readmissions	15.2	14.5	13.6
National Average	14.6	14.1	13.6

Source of information: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/compendium-of-population-health-indicators/compendium-hospital-care/current/emergency-readmissions-to-hospital-within-30-days-of-discharge/emergency-readmissions-to-hospital-within-30-days-of-discharge

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- The benchmarking data is taken from HES using national datasets

Torbay and South Devon Foundation Trust has taken the following actions to reduce this rate, and so improve the quality of its services through:

- Regular monitoring and feedback to clinical and operational teams.

Domain 4:

Ensuring people have a positive experience of care

Overall patient experience – inpatient survey

Between August 2018 and June 2019 a questionnaire was sent to 1250 inpatients at each Trust Responses were received from 611 patients at Torbay and South Devon NHS Foundation Trust.

The survey was published 2020 and overall performance is shown below.

Patient survey	2019	2018	2017	2016
Overall view of inpatient services **(for feeling that overall, they have a good experience)**	8.3/10	8.4/10	8.4/10	8.3/10

Source of information: CQC

There is no worst or best performing Trust or a national average.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Information is reported nationally and to the Trust Board.

Torbay and South Devon Foundation Trust has taken the following actions to increase this rate, and so improve the quality of its services by:

- Learning from feedback received and making changes
- Continuing to use real time feedback to augment the national inpatient survey.

Staff survey: staff recommendation of the Trust as a place to work

Staff survey	2019	2018	2017
Torbay and South Devon NHS Foundation Trust	65.2%	67.3%	65.2%
National average score for combined acute and community Trusts	64%		

Source of information: http://www.nhsstaffsurveys.com

In 2019 the national average score was 64%. The best performing Trust achieved 81% with the lowest performing Trust achieving 44.2%

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Nationally published data set commissioned by NHS England

Torbay and South Devon NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Using the staff survey results to inform the development of an annual action plan

Staff survey: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Staff survey	2019	2018	2017
Torbay and South Devon NHS Foundation Trust	18.1%	23%	23%
National average score for combined acute and community Trusts	18.0%	25%	24%

Source of information: http://www.nhsstaffsurveys.com

In 2019 the national average score for combined acute and community Trusts was 18.0%. The best performing Trust achieved 11.7% and the worst performing Trust achieved 24.9%.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Nationally published data set commissioned by NHS England

Torbay and South Devon NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, through addressing areas requiring improvement:

- Using the staff survey results to inform the development of an annual action plan

Domain 5: Patient Safety

Patients admitted to hospital who were risk assessed for venous thromboembolism

	Q3 2019/20	Q3 2018/19	Q3 2017/18
% VTE assessed UNIFY return	92.58%	92.23%	91.37%
National standard	95.00%	95.00%	95.00%
Highest performing	100.00%	100.00%	100.00%
Lowest performing	71.59%	54.86%	76.08%

Source of information: https://improvement.nhs.uk/resources/vte/

Quarter 4 data has not been published as VTE data collection and publication is currently suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic.

The highest performing Trust is 100% and the lowest performing Trust is 71.59%. The national standard is 95%. The Trust is performing 92.58% against the national standard of 95%.

Torbay and South Devon NHS Foundation considers that this data is as described for the following reasons:

- VTE compliance data is reviewed as part of the Trusts internal governance processes.

Torbay and South Devon NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services by

- Performance by ward area is shared with ward managers and reviewed through the wards SAFER group.

Rate of C. difficile infection

C.difficile rate per 100,000 bed days – 2yrs and over	April 18-Mar 19	April 17-March 18	April 16 – March 17	April 15 – March 16
Torbay & South Devon NHS Foundation Trust	11.6	18.5	19.6	22.4
Nationally set target for the trust	13.8	13.8	14.2	14.5
Best performing	0	0	0	0
Worst performing	79.7	90.4	82.6	67.2

The latest national data was published in July 2019.

In the financial year 2018/2019 the C. difficile rate per 100,000 bed days is 11.6 (hospital onset status)

The best performing trust was 0 and the worst performing trust rate 79.7 per 100,000 bed days. The national average is 11.7 per 100,000 bed days. The data is published in arrears.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Adherence to all infection control and prevention policies and standards and continued proactive engagement between all clinical areas and the infection control team.

Torbay and South Devon NHS Foundation Trust has taken the following actions to reduce this rate, and so improve the quality of its services by:

- Adherence to all infection control and prevention policies and standards and continued proactive engagement between all clinical areas and the infection control team.

Number of patients' safety incidents recorded

	April 2019 – Mar 2020	April 18 – Mar 2019	April 17 – March 18	April 16 – March 17
Number of incidents reported	7633	7255	6525	7056

Source of information: Trusts Risk Management System Datix

The numbers of incidents reported over the last 12 months, as highlighted in the table above, are within the expected range for the Trust and incidents have been reported from all areas of the organisation.

There is no highest or lowest score or national average for incident reporting. The Trust remains within the top 25% of Trusts for healthy reporting, as recorded by the National Reporting and Learning System (NRLS). Trusts are encouraged to record incidents, and this is a marker of a good learning organisation.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- Accurate data recording.

- Monthly review of the data via the Quality Improvement Group. All incidents are reviewed centrally and within the Integrated Service Delivery Units. The data is available on a monthly basis visa the Quality Improvement Group dashboard and on the individual area Datix dashboards made available to managers.

Torbay and South Devon NHS Foundation Trust has taken the following actions to improve this number of reported incidents, and so the quality of its services through:

- A programme of incident awareness and training at Clinical Induction, bespoke area training and via updates and prompts through the 5 Point Safety Brief.
- The numbers of incidents are monitored every month for trends and changes.

Number and % of patient safety incidents that have resulted in severe harm or death

	2019/20	2018/19	2017/18
Number of incidents reported	7633	7255	6897

	2019/20	2018/19	2017/18
Number of incidents severe harm or death	13	11	23
Number of incidents of moderate harm	366	486	460
% of all severe or death incidents	<0.1%	<0.1%	<0.1%

Source of information: Trusts Risk Management System – Datix

The number of incidents of severe harm or death is 13, and 366 for moderate incidents for the period from April 2019 to March 2020.

Torbay and South Devon NHS Foundation Trust considers that this data is as described for the following reasons:

- The information is taken from the monthly reported incident data, from datix, and as recorded on the QIG dashboard

Torbay and South Devon NHS Foundation Trust has taken the following actions to reduce this number, and so the quality of its services by:

- The Trust actively shares learning from serious events at an Integrated service unit level as well as from a Trust -wide perspective via the Serious Adverse Events (SAE) group.
- The Trust utilises SAE Alerts as well as the monthly 5-point safety to help spread safety messages from incidents that have occurred within the Trust.

Part 3: Our performance in 2019/20

Overview of the quality of care based on Trust performance

Torbay and South Devon NHS Foundation Trust an integrated care organisation. It continues to work with and be accountable to:

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

Operational delivery

The Trusts delivery structure is based on having two population based operational delivery systems and 5 locality integrated service units as follows.

Torbay System delivery system comprising of:

- Torquay Locality
- Paignton and Brixham locality
-

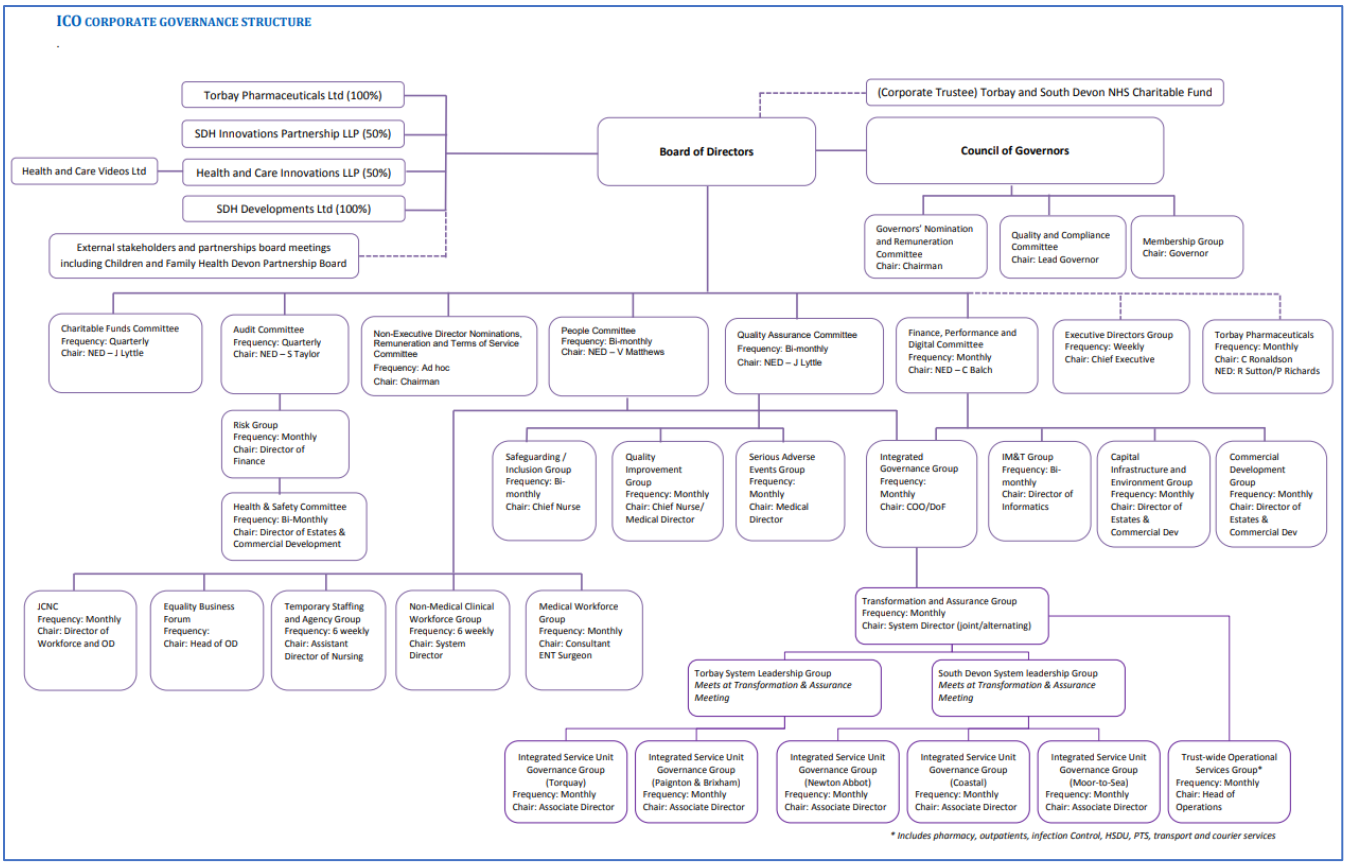
South Devon delivery system comprising of:

- Coastal (Teignmouth and Dawlish)
- Moor to Sea (Ashburton, Bovey Tracey, Totnes and Dartmouth)
- Newton Abbot

In addition to the Integrated Service Units (ISUs) there is a central corporate services function and hospital operations team.

In 2019/20 this was the first year of operating under the new system with changes in the organisation governance to reflect this. The new ISUs report up via the monthly Assurance and Transformation Group Meeting to an Integrated Governance Group and then on upwards to the Board. During COVID-19 a new silver and gold command structure has been implemented in addition to ensure prompt decision making, timely action with a focus on keeping patients safe and stepping up and stepping down services in a managed way. Gold Command is run by a Trust Executive with tactical support from Silver, a senior leader in the organisation. As of the end of the financial year the gold/silver command structure continues for the foreseeable future.

In addition, from the 1st April 2019 and working with partners of Devon Partnership Trust / Livewell SW and Royal Devon and Exeter Foundation Trust, the Trust started in its role of lead provider for the provision of Children's services across Devon formerly operation under "Virgin Care"



Performance in 2019/20

In 2019/20, the Foundation Trust did not deliver the level of performance expected against the all of the key NHSI performance standards. However good progress has been made in delivery additional capacity and service changes as part of the agreed recovery plan for 19/20.

The onset of COVID-19 has had an impact on the final end of year reported performance. The challenge into 2020/21 will be to respond to the changing needs of the COVID-19 escalation and maintain critical services for the most clinically urgent patient's whist supporting longer term recovery plans for the patient's requiring more routine and less time-critical interventions.

A summary of the key clinical access performance standards used by regulators to assess our performance is set out below.

Indicator/Target	Quality Indicator	Target/ Standard	19/20	18/19	17/18
Maximum time of 18 weeks from point of referral to treatment (RTT) - incomplete pathways	Experience	92%	76.2%	81.0%	81.6%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge Ⓐ	Experience	95%	86.1%	81%	89.7%
Maximum 6 week wait for diagnostic procedure	Effectiveness	<1%	11.3%	10.1%	4.2%
Cancer 62 day wait for first treatment from urgent GP referral for suspected cancer Ⓐ	Effectiveness	85%	74.3%	73.7%	83.1%
Cancer 62 day wait for first treatment from NHS cancer screening service referral	Effectiveness	1.00	0.94	0.92	0.93

With regards to:

Referral to treatment standard: In 2019/20 plans to increase capacity in critical areas have been progressed. This culminated with increased substantive workforce in many of the key areas including urology and general surgery with the longest RTT waits.

In November 2019 the refurbishment of two clean air operating theatres was completed, and this led to an increased level of activity and steady reduction in our number of longest waiting patient's over 52 weeks. This together with additional sessions supported from "SW region winter monies" demonstrated progress to eliminate 52 week waits with 43 achieved by end of February with a forecast of achieving 19 by the end of March. Over the course of the year the total number of patients waiting for treatment remained in line with our agreed plan. The long waits recovery plans also supported additional capacity and improved ways of working that delivered a reduction in diagnostic waiting times and additional outpatient activity in critical areas.

With the Escalation of COVID-19and standing down on non-urgent elective activity in March this was not achieved, and the impacts on access times continue to be seen. Recovery will be a key challenge as we continue the Covid-19 Journey. With the changes and investments made in 2019_20 we are however better equipped to respond to these challenges.

Cancer standards: The Foundation Trust maintained its commitment to prioritise delivery of cancer standards with several significant investments to increase capacity across clinical teams and diagnostics capacity approved during 2019/20. Throughout the disruption from theatres the Foundation Trust made a commitment to protect theatre lists for cancer and urgent patients; this has been maintained.

As a result of these investments, performance has remained consistent throughout the year with an overall increase in the number of patients treated on cancer pathways of 7%. This is set against the 10% overall increase in urgent two-week wait referrals for suspected cancer compared to 2018/19.

The active tracking lists have remained static with a significant reduction in patients waiting over 104 days.

In the year we have seen continued innovation and pathways improvement with the introduction of straight to test pathways in Prostate, Bladder, Lung, LGI and UGI suspected cancer pathways. Alliance investment and subsequent skill mixing to appoint CWT Navigator roles has enabled the Trust to achieve and maintain the 28-day faster diagnosis standard. Early implementation of this standard and capturing the activity resulted in the Trust being selected to participate in the national 28-day Faster Diagnosis Standard (FDS) pilot.

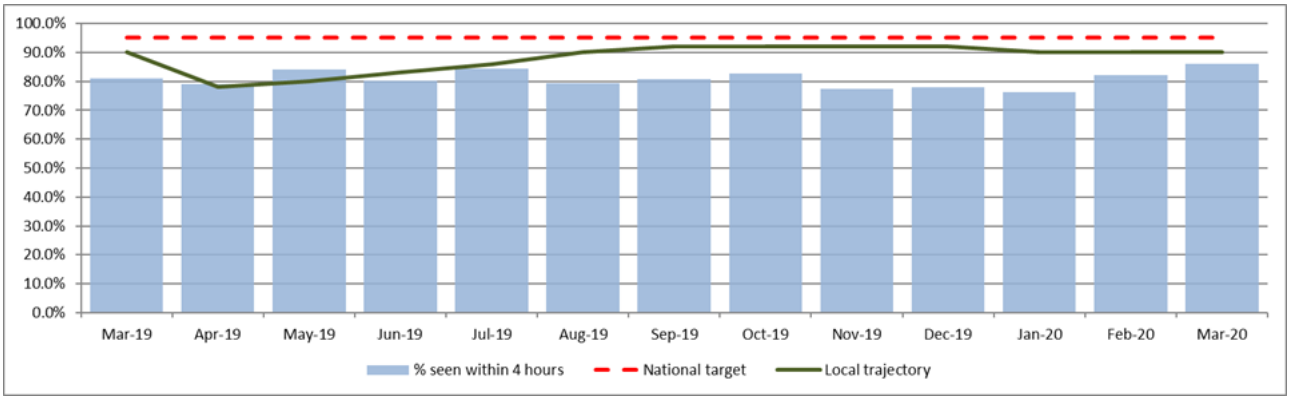
Maintaining timely access to diagnostic's and improving clinical infrastructure remain a challenge

Diagnostics: In 2019/209, the Foundation Trust has been reliant on additional insourcing to meet the increasing demand for diagnostics tests across CT, MRI and endoscopy. This capacity has been supported with continued investments whilst planning has continued to establish both in house and STP solutions to the diagnostic challenge.
Against the National standard of 1% of diagnostic waits over 6 weeks and local improvement trajectory to achieve 4% by end of March the trust recorded a gradual deterioration in performance

to 15% in September, a recovery of performance to 7% by the end of February and good assurance of delivering 4% by end of March. As already noted the Covid-19 escalation and standing down of routine work had an immediate impact meaning the end of year target not achieved. The Trust continued to priorities the most urgent tests and recovery will one of many challenges to be faced with the ongoing COVID-19-19 journey.

A&E wait time standards:

Managing the length of time patients spend in the Emergency Department has remained a challenge throughout 2019/20. Delays accessing an inpatient bed for these patients requiring admission being the greatest cause of extended stays within the department. The monthly performance is set out below.



This shows an improving trajectory to end of March 2020. It is noted however that with the onset of COVID-19 that the normal systems and processes for managing patients through the emergency pathways has changed greatly as well as a lowering of overall demand impacting on the March performance.

Trust has been successful in a bid for capital funding of >13m. This is in recognition of the challenges of space within the Emergency Department to deliver effective front door emergency care and the development of appropriate facilities for direct admission from GP referral and same day emergency care. A project team has been established to work out estate options with a preferred option to be agreed in 2020-21.

Whilst the capital estate solution will take some time to come into place the focus has remained on whole system pathway service improvement to improve the flow of patients, manage demand and ensure safe care.

Local priorities

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

Other National and local priorities	Quality indicator	Target 2019/20	2019/20	2018/19	2017/18
DNA rate	Effectiveness	5%	TBC	5.2%	5.48%
Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	90.2%	86.9%	80.5%
Timeliness of social care assessment	Effectiveness	>70%	70.7%	78.6%	78.5%
Urgent intermediate care referrals per month (new)	Effectiveness	113	219	172	161
Mixed sex accommodation breaches of standard	Experience	0	0	0	0
52-week referral to treatment incomplete pathways year end position	Experience	10	53	91	33
Delayed transfer of care (bed days lost)	Experience	4548	4693	5847	5311
Cancelled operations on the day of surgery	Experience	<0.8%	1.3%	1.3%	1.3%
No of children with child protection plan	Safety	None set	191	146	160
Never events	Safety	0	2	2	1
Reported incidents – Major and catastrophic	Safety	<60	10	14	23
Safeguarding adults - % of high-risk concerns where immediate action was taken to safeguard the individual	Safety	100%	100%	100%	100%

Plans for 20/21:

As we look ahead to the next 12 months there are clearly new risks being identified with COVID-19 that will impact on activity and performance.

Having completed the escalation planning and seen out the first wave of COVID-19 hospitalisations (March and April) the Trust remains committed to maintaining the same levels of COVID-19 response as needed and indicated by NHS planners. The response has required reconfiguration of services and has as a result reduced our capacity to maintain or reintroduce business as normal routine elective services. Future delivery of these services will now have to work within criteria set out to comply with COVID-19 policies and constraints of workforce, facilities, PPE and managing patient risks.

It is likely that due to the changes and constraints to business as usual that elective activity will remain below historical levels and result in patient access times for routine treatments remaining high or increasing over the short to medium term.

To offset the loss of elective capacity the trust will be adopting new ways of working and clinical pathways. This is a great opportunity in many ways to positively embrace change and will include virtual consultations for outpatient appointments, that are already being favoured by many patients, flexible use of day case and inpatients theatres with transition to outpatient treatments where possible along with relocation of services including to community hospitals and primary care settings.

This will certainly be a very different year in terms of normal hospital activity and performance. It is likely that we will see significant change in the way services are delivered with system wide and local configuration of services to manage both the Covid-19 resilience and clinical care for routine elective services.

Annex 1 – Engagement in developing the Quality Account

Prior to the publication of the 2019/20 Quality Account we have shared this document with:

- Our Trust governors, commissioners, and Board
- Healthwatch.
- Torbay Council Health Scrutiny Board.
- Devon County Council's Health and Wellbeing Scrutiny Committee.
- Trust staff.
- Carers Group.

As in previous years, we continue to hold an annual Quality Account engagement event inviting key stakeholders to come together and recommend the priority areas to be included in this year's Quality Account.

The feedback from the event continues to be positive with stakeholders feeling engaged in the development of the Quality Account and receiving feedback from the work undertaken in the previous year.

In 2020/21 we will continue to share our progress against our Trust improvement priorities and continue to work closely with the users of our services to improve the overall quality of care offered.

Statements from Commissioners, Governors, OSCs and Healthwatch

Statement from Torbay Council's Health Overview & Scrutiny Board on Torbay and South Devon NHS Foundation Trust Trust's Quality Account 2019/20

Members of Torbay Council's Overview and Scrutiny Board have considered the draft Quality Account 2019/2020 for Torbay and South Devon NHS Foundation Trust. The Members were not able to consider the draft Quality Account within a formal setting prior to the deadline for submission of response due to moving the Overview and Scrutiny Board to facilitate a Board meeting between colleagues at the ICO and CCG on the health and social care sector's response and continuing efforts around Covid-19.

In relation to the 6 week minimum for diagnostic procedure, Board notes that the national standard was for a 1% diagnostic wait of 6 weeks with the Trust's local improvement trajectory aiming to achieve 4% by the end of March. Whilst recognising that an achievement of 4% was lower than the 15% diagnostic wait experienced in September it was still higher than the national standard of 1%. Over the coming year, and taking account the impact of the Covid-19, the Board will be seeking assurances from the Trust about its actions to reduce the wait to 1%.

Moving forward, it is felt that future Quality Accounts should provide greater narrative as to why areas were scored "red" and what was being done to improve the situation.

Whilst recognising that the Covid-19 Pandemic had resulted in a pretty fluid situation towards the end of the period covered by the Quality Account 2019/2020, the aspirations around patient safety and improved IT are considered to be 'steady'. Again the Board will hope to hear over the coming year how these have been met and how more stretching aspirations can be included in future Accounts.

The Board commends Torbay and South Devon NHS Foundation Trust for its openness and transparency of its operations. As has been shown over previous years and as demonstrated during the response to the ongoing Covid-19 pandemic, the Trust and its partner organisations are working for the benefit of the whole Torbay community.

Statement from NHS Devon Clinical Commissioning Group on Torbay and South Devon NHS Foundation Trust Quality Account 2019/20

NHS Devon Clinical Commissioning Group (CCG) is the lead commissioner for Torbay and South Devon NHS Foundation Trust (TSDFT) and is pleased to provide commentary on TSDFT's Quality Account for 2019/20.

NHS Devon CCG's role is to quality assure services it commissions, delivered by TSDFT, by attending organisational meetings and boards, and by reviewing performance and quality data, including investigation reports. This continuous process has enabled confirmation that the information presented in this Quality Account appears to be an accurate and fair interpretation regarding the services provided.

TSDFT's Quality Account validates the organisation's commitment to quality in patient care. The account details achievements and improvement that reflects the positive patient experience. TSDFT describe areas that require further improvement. For example, further efforts to drive Electronic Prescribing Medicines Administration, (EPMA) which did not meet the proposed roll out due to inadequate IT support systems.

TSDFT's position as lead provider for Children and Family Health Devon is an excellent opportunity for continued system working across Devon in the coming year, working in partnership with other local NHS organisations to provide quality care for all ages.

NHS Devon CCG commends the work undertaken within Coastal and Newton Abbot localities to aid communication between professions across health and social care and improve access to timely patient information. This is an example of positive integrated working across the system and we look forward to seeing this rolled-out in other areas of the organisation.

It is pleasing to see the engagement with patients and carers and the use of patient experience, feedback and questionnaires. We will be looking forward to seeing this data used to guide, drive and monitor improvement and experience across acute and community settings for patients and carers of all ages.

NHS Devon CCG recognises the quality of work implemented through the TSDFT three priorities. The implementation of RESTORE2 for early recognition of deterioration of patients in care homes is fully supported, and we acknowledge the preliminary work so far reported through the Quality Improvement Group ensuring continued engagement with the care sector. The Trusts participation in the Sign up to Safety campaign and in particular the reduction in pressure ulcer incidence achieved is also notable.

We recognise the scope of replacing the Trusts IT data network. The reduction in potential risk of system failures will provide assurance that the Trust is operating safely and allow for further IT improvements going forward.

NHS Devon CCG is encouraged to see the use of patient experience and feedback for families and carers within end of life care. Alongside this the introduction of

bereavement bags demonstrates empathy, compassion and recognises the importance of dignity at end of life.

Looking ahead, we are pleased to support the three quality improvement priorities TSDFT has developed, recognising their value in relation to the shared priorities across the STP towards the Devon Integrated Care System (ICS).

NHS Devon CCG acknowledges the increased demand on TSDFT during the COVID 19 pandemic and commends the response of all staff across the organisation.

NHS Devon CCG commend this Quality Account and TSDFT for its continued focus on quality of care, patient safety and a positive patient experience.

Statement from Devon County Council's Health and Adult Care Scrutiny Committee on Torbay and South Devon NHS Foundation Trust Quality Account 2019/20

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Torbay and South Devon NHS Foundation Trust Quality Account for the year 2019/20. All references in this commentary relate to the reporting period of the 1st of April 2019 to the 31st of March 2020 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2019-20 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge.

In terms of the priorities for 2019-20 Members appreciate the work undertaken by the Trust in promoting Patient Safety, particularly through changing the inpatient prescribing system for people in hospital inpatient beds. The Committee recognises that time is needed to make all the changes required, however.

The Committee appreciates the Trust's work on clinical effectiveness, particularly through the use of the SystmOne IT system for Community Nursing and Community Matrons in the Coastal locality.

Members also particularly applaud the Trust's work to improve carers' experience for themselves and their families receiving care across the urgent and emergency care pathway.

The Committee fully supports the Trust's Quality Priorities for Improvement 2020/21 and expects that the Trust will continue to safeguard patients and provide the very best quality care the Trust can.

Members appreciate the Trust's focus to improve early recognition and management of deteriorating patients in care/nursing homes, particularly considering Devon citizens' older average age. The Committee also supports the Trust's continuing attention to end of life care. The goal of replacing the Trust's IT data network is also greatly supported by members.

The Committee is very grateful for the Trust's continuing hard work in the face of the COVID-19 Pandemic.

Members anticipate that regular information on the progress of the Trust's 2020/21 goals will be shared by the Trust.

The Committee welcomes a continued positive working relationship with the Trust in 2020/21 and beyond to ensure the best possible outcomes for Devon residents.

Statement from Healthwatch (Torbay) on Torbay and South Devon NHS Foundation Trust Quality Account 2019/20

Healthwatch Torbay is the independent local champion for people who use health and social care services within the localities of Brixham, Paignton and Torquay. We act as a critical friend to the Trust and in this role we are pleased to report that Healthwatch has continued to be made welcome. Our participation has included evaluation of patient information leaflets; patient interviews to gain insight to inform change in practice; membership of operational level boards and regular report back contact with the Chief Executive and governors. In this way we ensure the voice of local people is listened to and acted on.

Again, this year, Healthwatch was invited to participate in the discussion to prioritise areas for improvement. We are pleased to support the chosen areas, past and present as they will ensure a process of continuous improvement in key areas relevant to local people.

> Carers are especially valued in Torbay and we are fortunate in having extensive carer awareness underpinned by innovative ways of working as shown by the success of the priority for last year.
>
> Patients are constantly telling us how frustrated they are when they realise that information about them has not been transferred to their GP. We are all anxious to see the full roll-out of SystmOne across the whole community in the wake of the Coastal and Newton Abbot success.

Priorities for this year will be challenging in the aftermath of the pandemic. Healthwatch Torbay will be part of a wider whole Devon Healthwatch from 2020, this will ensure that we will then give user feedback in an integrated way, from both South Devon and Torbay. Our own work to date on the impact of the pandemic on services has shown that there is still a great deal to come that will require new ways of working. Although the new priorities were selected earlier in the year, they nevertheless still have relevance in looking forward.

> The quality of care in care homes is very important to local people as a safety net for when care at home is no longer an option. Although Restore2 will not have a lot of meaning to care home residents as a term its impact on personal resilience will.
>
> We are all aware of the value of a solid IT infrastructure. The provision of care during the pandemic has already shown that a hybrid system (face to face plus virtual) can improve the speed of response and a reduction in travel. Let's hope that this proposed improvement is totally successful.
>
> The third priority to focus on End of Life is, as the report states "crucial". Even small things such as bringing the person's belongings together in a dignified way will make a difference. It is good to see a priority which is simple and will be valued by all.

Overall the report demonstrates a Trust which is actively seeking out to contribute to and to implement innovation from the wider knowledge-base of care. As

Healthwatch Torbay we are confident that the Voice of local people is listened to. We are also confident that the Trust will act on any challenges we present.

Overall, we consider that the Quality Account presents a realistic overview of the Trust's performance and identifies appropriate internal controls and assurances.

Statement from Trust Governors on Torbay and South Devon NHS Foundation Trust Quality Account 2019/20

The Governors' quality statement shows that the Trust has continued its commitment in developing and implementing its strategy for health and social care. The year has been the most challenging yet, further compounded by the COVID-19 pandemic, for which the Trust has shown an unprecedented commitment to patient care.
With an equally challenging financial budget the Trust has maintained the provision of safe, high-quality and best experience care, both within the acute hospital and the surrounding community.

The Governor observer role has continued to provide the Council of Governors with the engagement of the safety and quality agenda along with the provision of assurance on the performance of the Trust against the National Key Performance Indicators

Coupled with this, the Quality and Compliance committee members have continued to provide the Council of Governors with evidence that the Trust, through its statutory committees' reviews and reports, have complied with the CQC Key Lines of Enquiry.

The Governor observer role has also provided the opportunity for governors to review the performance of the Chairman and Non-Executive Directors in a timely manner.

It has been notable that there has been a welcome increase in communication between the Trust and the Council of Governors with the provision of a Governors' fortnightly e-Newsletter, edited and forwarded by the newly-appointed Membership Manager, Sally-Ann Reay. This has covered important key dates and news, Governor observer reports, as well as messages from the Chairman, reminders of Trust emails sent and notices of forthcoming meetings.

Another new development was the provision of monthly Network Meetings, often at different community hospitals. These have incorporated informal presentations to the Council of Governors from different stakeholders and Trust Staff members, as well as relevant information from Board meetings and questions from Governors.

The Quality Account had listed four priority areas for quality improvement in 2019/20, all of which had shown considerable progress, which are ongoing. In particular, the start-up use of the IT SystmOne for Community Nursing and Healthcare in the Coastal and Newton Abbot localities very quickly showed the clinical effectiveness of this system. Being very much appreciated by all healthcare personnel who have used it to advance consistent community patient care, it will be rolled out to other localities in the near future.

Governor representatives participated in the Quality Account Stakeholders meeting for this year and the audit chosen for 2020/21 would be the provision of 'bereavement bags' for near relatives. This was considered an important

improvement to ensure that the collection of loved one's effects were presented in a professional, caring and dignified manner.

The governors are again able to confirm that they continue to receive assurance of the Trust's commitment to, the provision of safe high-quality responsive health and social care. We recognise and support the key challenges facing the Trust in delivering new models of care within a very tight financial framework and look forward to continuing to be active participants working together in the future.

Annex 2

Statement of Directors' responsibilities in respect of the Accounts

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance; Detailed requirements for quality reports 2019/20:

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period April 2019 to September 2020

    - papers relating to quality reported to the board over the period April 2019 to September 2020

    - feedback from commissioners dated 07/07/2020

    - feedback from governors dated 10/07/2020

    - feedback from the local Healthwatch organisations dated 21/06/20

      feedback from Overview and Scrutiny Committee dated 02/07/2020 and 09/07/2020

    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/08/2020

    - the 2019 national staff survey 28/02/2020

    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 31/03/2020

    - CQC inspection report dated 02/07/2020 and Trust CQC improvement plan submitted on the 31/07/20 to address requirement notices and 30/09/20 for the CQC Should Do Improvements.

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board (*Signature to be added post Board approval)*

- Date: 25 November 2020

- Chairman:

- Date: 25 November 2020

- Chief Execuitve: