TORBAY COUNCIL

Wednesday, 19 October 2022

ADULT SOCIAL CARE AND HEALTH OVERVIEW AND SCRUTINY SUB-BOARD

A meeting of **Adult Social Care and Health Overview and Scrutiny Sub-Board** will be held on

Thursday, 27 October 2022

commencing at **2.00 pm**

The meeting will be held in the Churston Room - Town Hall

Members of the Board

Councillor Johns (Chairwoman)

Councillor Douglas-Dunbar
Councillor Foster
Councillor Loxton
Councillor O'Dwyer

Together Torbay will thrive

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Governance Support, Town Hall, Castle Circus, Torquay, TQ1 3DR

Email: governance.support@torbay.gov.uk - www.torbay.gov.uk

ADULT SOCIAL CARE AND HEALTH OVERVIEW AND SCRUTINY SUB-BOARD
AGENDA

1. Apologies

2. Minutes (Pages 4 - 6)

To confirm as a correct record the minutes of the meeting of the Adult Social Care and Health Overview and Scrutiny Sub-Board held on 23 June 2022.

3. Declarations of Interest

a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

4. Urgent Items

To consider any other items that the Chairwoman decides are urgent.

5. Wait Times for Adult Social Care Assessments and Care (Pages 7 - 15)

To receive an update on the length of time people are waiting to receive care assessments for adult social care and the action being taken to address this.

(Note: Jo Williams – Director of Adults and Community Services and Shelly Machin – System Director will be present for this item.)

6. **Suicide Prevention in Torbay** (Pages 16 - 22)

To receive an update on suicide prevention in Torbay.

(Note: Rachel Bell – Public Health Specialist and Lincoln Sargeant – Director of Public Health will be in attendance for this item.)

7. **GP Strategy for Devon** (Pages 23 - 59)

To consider the GP Strategy for Devon and how this impacts on Torbay residents.

(Note: Jo Turl, NHS Devon's Director of Commissioning Primary, Community and Mental Health Care will be present for this item.)

8. **Torbay and South Devon NHS Foundation Trust Quality Account 2021/22** (Pages 60 - 98)

To review the Quality Account for 2021/22 and provide feedback to the Trust.

(Note: Deborah Kelly – Chief Nurse will be present for this item).

9. **Adult Social Care and Health Overview and Scrutiny Sub-Board Action Tracker** (Pages 99 - 100)

To receive an update on the implementation of the actions of the Sub-Board and consider any further actions required (as set out in the submitted action tracker).

Meeting Attendance

Please note that whilst the Council is no longer implementing Covid-19 secure arrangements attendees are encouraged to sit with space in between other people. Windows will be kept open to ensure good ventilation and therefore attendees are recommended to wear suitable clothing.

If you have symptoms, including runny nose, sore throat, fever, new continuous cough and loss of taste and smell please do not come to the meeting

Minutes of the Adult Social Care and Health Overview and Scrutiny Sub-Board

23 June 2022

-: Present :-

Councillor Johns (Chairwoman)

Councillors Douglas-Dunbar, Loxton and O'Dwyer

Non-Voting Co-opted Member
Pat Harris, Healthwatch

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1. Apologies

An apology for absence was received from Councillor Barnby.

2. Torbay and South Devon NHS Foundation Trust Torbay Hospital Care Quality Commission Inspection Report

The Chief Nurse for the Torbay and South Devon NHS Foundation Trust, Deborah Kelly, presented the response from Torbay and South Devon NHS Foundation Trust, Torbay Hospital, to the Care Quality Commission (CQC) Inspection Report. Miss Kelly drew members attention to the CQC Improvement Actions required from the Trust and detailed those actions which had already taken place.

Miss Kelly responded to questions in relation to the following:

- Who was responsible for ensuring that patients had the correct levels of nutrition and hydration and how was this recorded.
- What was the expectation of the levels of reporting to be achieved.
- How long would it take for the Trust to achieve the improvements required by the CQC.
- What measures were being taken to support nurses in their work and to provide additional training.
- Had the provision of nutrition and hydration improved since the CQC inspection.
- How would future enquiries from the CQC be shared with the Board.
- How did the Trust measure its performance to ensure it was meeting the levels required by the CQC in the future.
- How was the discharge of patients into the community monitored.
- What information was provided to patients and would details of access to primary care be included.
- How would Healthwatch Torbay be promoted.

Resolved (unanimously):

1. that the Torbay and South Devon NHS Foundation Trust continue to monitor the discharge improvement programme and report back to the Board at a future meeting; and

2. that the Trust be recommended that statistics concerning issues raised by the CQC be included in the dashboard of compliments and complaints.

3. Adults Social Care Governance Changes

The Director of Adult Social Services, Joanna Williams, provided an update on the Adults Social Care Governance Changes and the appointment of the Adults Social Care Continuous Improvement Board. Members noted the Vision for Adult Social Care in Torbay and the projects and key priorities contained in the report.

Members asked and received responses to the following questions:

- What improvements were expected through the Mental Health Residential Review project for the under 65's.
- What measures would be put in place for those patients that had difficulty in living outside residential care.
- How did the Mental Capacity Act affect the work of Adult Social Services.
- How would the Adult Social Care Continuous Improvement Board be constituted.
- What factors were causing the increase in suicide rates in the Bay.
- Was there work to be done on mapping what the voluntary sector was doing for mental health.
- How would the performance of the Adult Social Care Continuous Improvement Board be monitored.
- How would children going on to young adulthood be supported.

Resolved (unanimously):

1. that the Board noted that the current Adults Improvement Board would be revised and replaced with a newly appointed Adults Social Care Continuous Improvement Board, with an independent Chair, to provide the principal mechanism by which Torbay Council oversees the delivery of Adult Social Care, jointly with Torbay and South Devon NHS Foundation Trust. The Head of Governance Support be delegated authority to prepare the terms of reference and membership for the revised Board in consultation with the Cabinet Lead for Adult Social Care, the Director of Adult Social Services and the Chairwoman of the Adult Social Care and Health Overview and Scrutiny Sub-Board; and

2. that the overall governance structure for Adult Social Care (as set out in the submitted report), including the relationship with the newly appointed Adult Social Care and Health Overview and Scrutiny Sub Board, be noted.

4. Terms of Reference and Membership of the Adult Social Care and Health Overview and Scrutiny Sub-Board

Members noted the Terms of Reference and Membership of the Adult Social Care and Health Overview and Scrutiny Sub-Board. It was agreed that additional speakers to provide expert advice and support, would be invited to future meetings as required.

5. Adult Social Care and Health Overview and Scrutiny Sub-Board Work Programme

The Board noted the contents of the Adult Social Care and Health Overview and Scrutiny Sub-Board Work Programme for 2022/23.

Resolved (unanimously):

That, subject to the review of the Torbay and South Devon NHS Foundation Trust Draft Quality Account in July and the change to the date of the Torbay and South Devon NHS Foundation Trust Draft Quality Account to 2021/22, the Initial Adult Social Care and Health Overview and Scrutiny Sub-Board Work Programme for 2022/2023 as presented, be approved, and be kept under regular review by the Chairwoman of the Adult Social Care and Health Overview and Scrutiny Sub-Board and the Democratic Services Team Leader.

Chairwoman

Torbay and South Devon NHS Foundation Trust

Waiting lists and outstanding support package reviews within Torbay Adult Social Care Baywide Report

for

Torbay Council Oversight & Scrutiny Committee

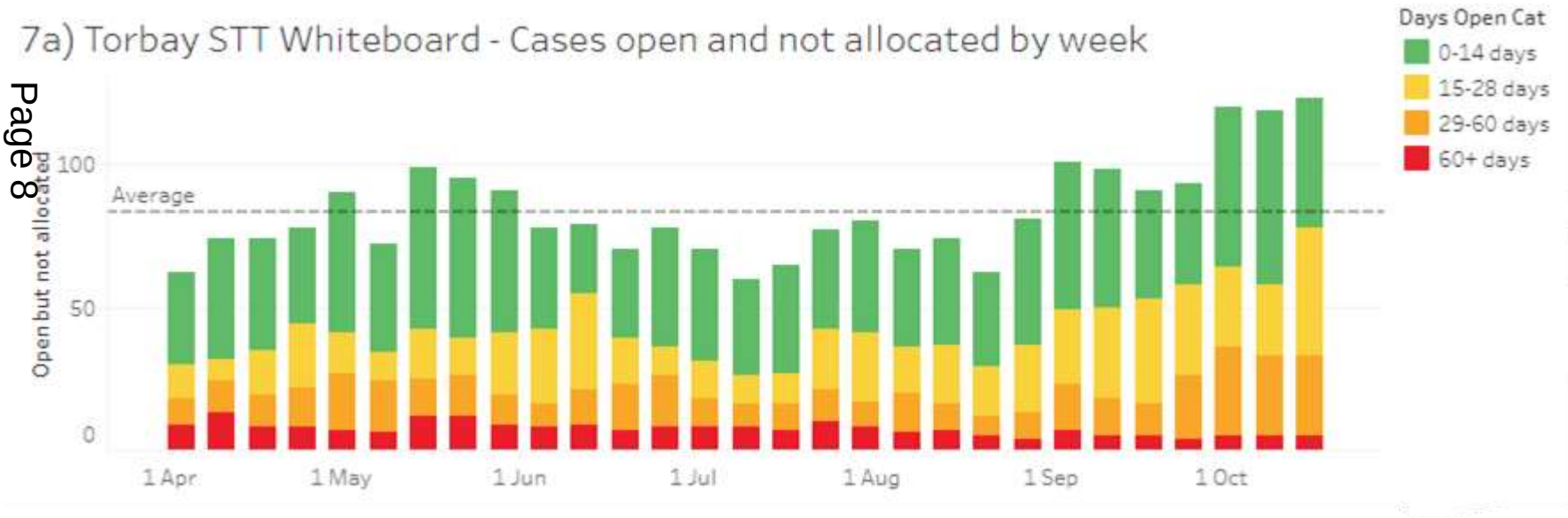
Committee date: 27 October 2022

Report authored by Samantha French, Adult Social Care Community Services Manager, Baywide Torbay, on 13 October 2022

This report is written so as to provide a situational overview of waiting lists in Front End (Triage) and Complex Care Team (CCT) within the Adult Social Care (ASC) Bay Wide Teams and also the overall picture of overdue reviews. Waiting list information is held centrally using digital White Boards and the data for to Overdue Reviews is extracted from PARIS.

Triage waiting list

The Torbay STT Whiteboard graph below indicates the weekly waiting list levels for the Front-End Services within ASC from October 2021 to October 2022. It is a waiting list detailing S.9 assessments combining Discharge to Assess (D2A), individuals dropping below financial threshold, referrals from other agencies and routes.



The graph shows a steady increase in the waiting list over the last 12 months due to a range of contributory factors including (but not excluded to):

- Increase in overall number of referrals to the Front-End Service compared to 12 months previously for D2A and other S.9 assessments,
- Increase in the staff absence including sickness, particularly COVID, and vacancies,

- Operational pressure within other ASC Team leading to pressure in the Triage team, for example deficit of staffing in HSCC and CCT team. The front-end service has also encompassed the Single Point of Contact (SPOC) service within the interim structure

Management of the Triage Waiting List including the management of risk

Risk and client safety is managed daily by triaging of all the work that comes through the Front-End service, including the waiting list. Triaging activities are completed by band 7 Social Workers (of which there are WTE 4.5) and this is overseen by the Front-End Services Lead. The Front-End team operate RAG (Red, Amber, Green) ratings and a "target action date" system. RAG ratings are defined as:

Duty (completion same day): Typical work in this category includes safeguarding, welfare concerns, urgent carer breakdown, individuals without support, Discharge to assess (social care involvement / contact but visit carried out by Therapy), care handbacks (from agencies)

Red (within 7 days urgent for next allocation - the upcoming Friday (case allocation day): Typical work in this category includes carer breakdown (non-urgent), individuals with care and support in place but change in need, D2A reviews (urgent visit carried out but follow up required)

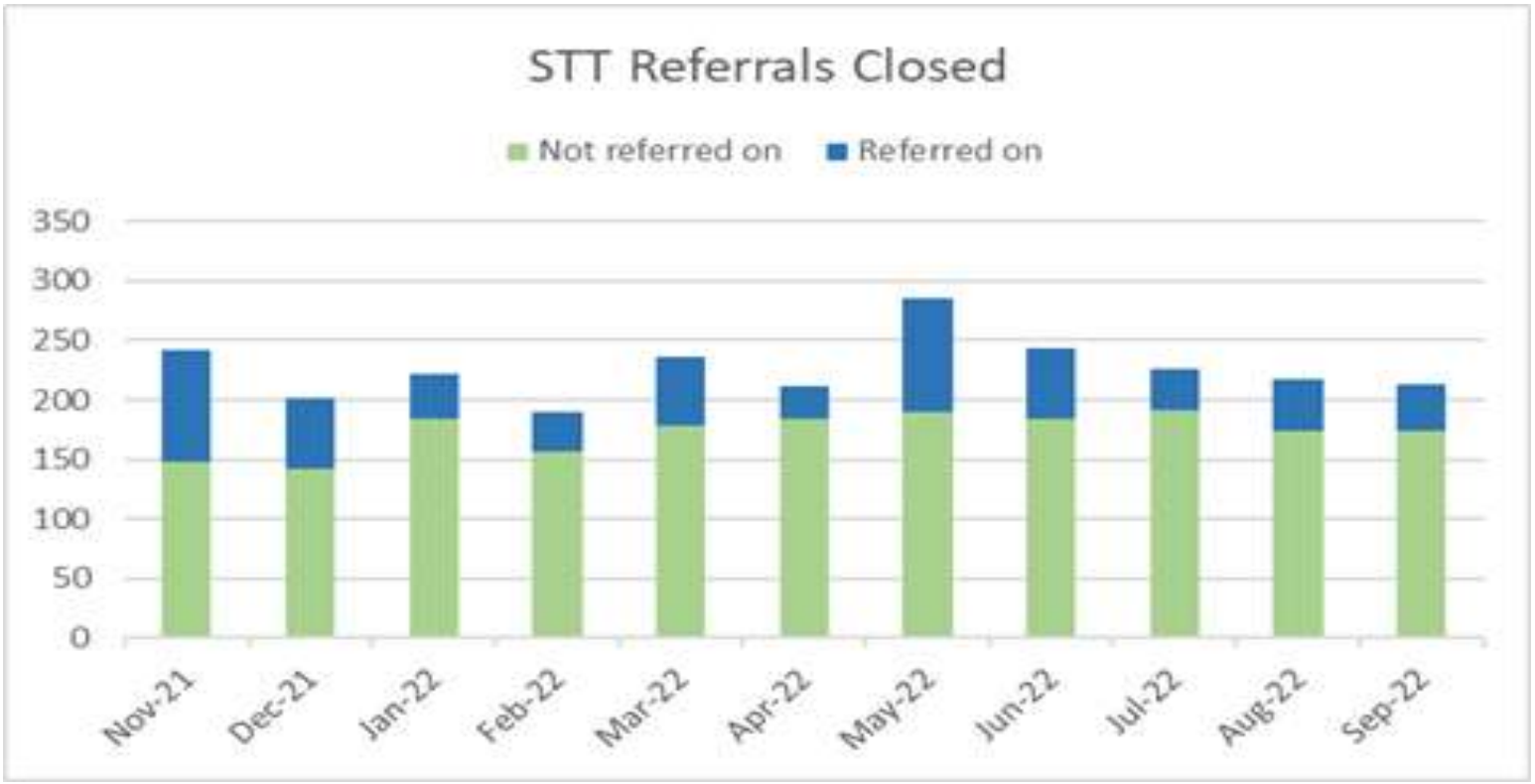
Amber (within 14 days): Typical work in this category includes respite requests, individuals spending down (reaching the social care financial threshold) within 28 days, D2A residential reviews (IHF funding in place and in a place of safety)

Green (a future appointment): POC and residential care reviews (work completed but review required), future dated individual spend down

With the exception of duty allocations, "target action date" ensure that clients waiting will be moved to the designated allocation day. Urgent cases would not be accounted for within the waiting list stats as they are allocated the same day or up to 72 hours (not allocated to the waiting list). The waiting list stats are captured on a weekly basis, thus not fully capturing the daily throughput of work.

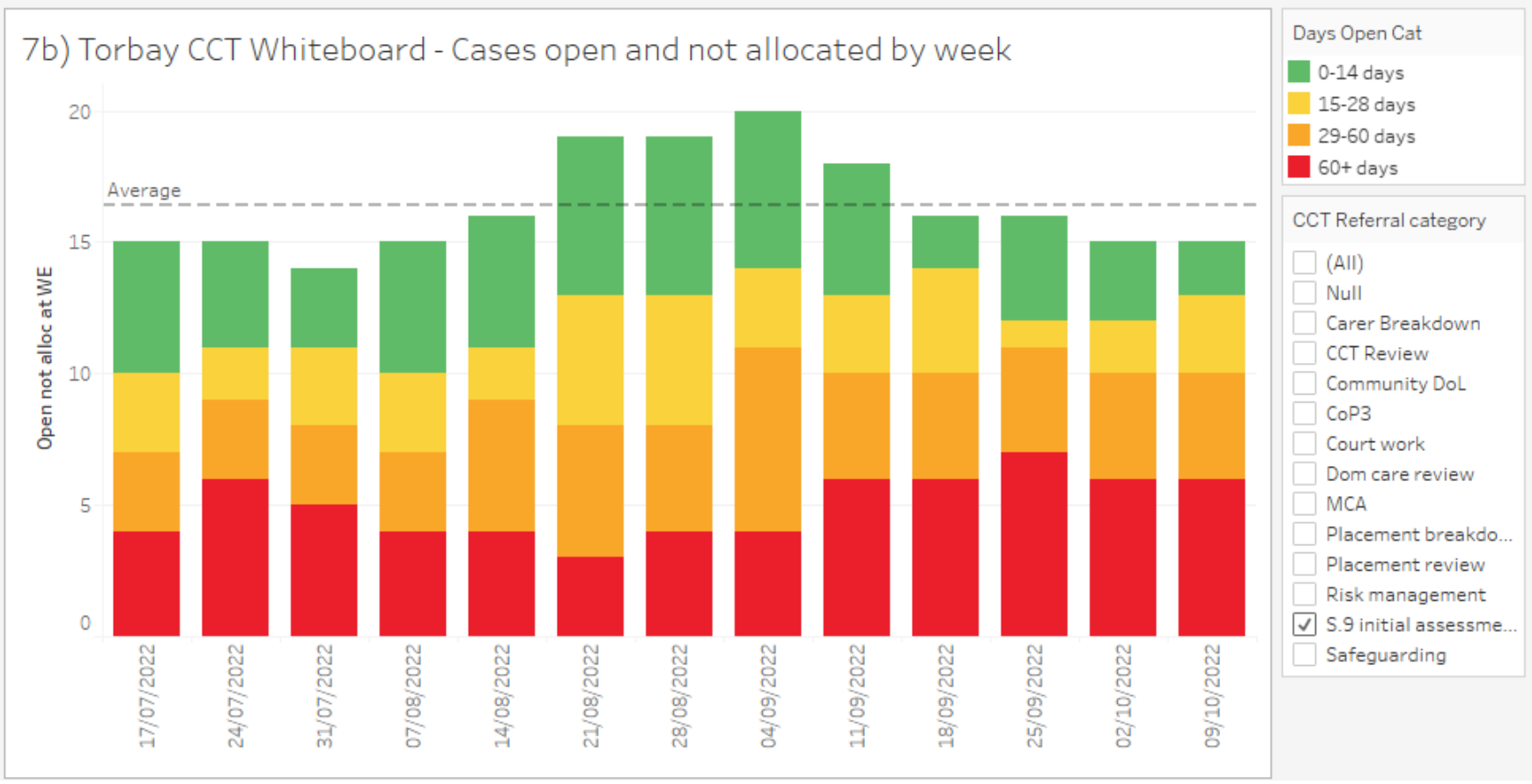
Allocations and closures within the Front End by month

The work within the FE service is captured within closures, with additional data collection as to the pathway of cases (allocated, referred on and to where etc). This is shown in the "SST Referrals closed" graph.



CCT Waiting list

The Torbay CCT Whiteboard graph shows the weekly waiting list for the Complex Care Team from July 2022 to October 2022. The data is only displayed from July 2022 because the filter for S.9 assessments was introduced from that date to support improvements in data capture and evidence-based decision-making.



The graph indicates a steady increase in the overall waiting list for CCT in respect of S.9 assessments, hitting a peak over the summer period where there was an increase is staff absence, mostly attributable to increased annual leave. The waiting lists for CCT have steadily increased over the last 12 months, following a similar trajectory of the Front-End Service.

Similarly, to the Front-End Services, this is due to a range of issues, including (but not exclusive to) the following factors:

- An increase in staff vacancies, support to other teams including rotational activities,
- Staff sickness and increased annual leave,
- Difficulties associated with social worker recruitment resulting in extended deficit of staff, and
- Increases (at times) with processes such as Providers of Concern and Whole Service Safeguarding to which CCT staff are deployed on an urgent basis

Management of the TCCT List including the management of risk

The waiting list in CCT is monitored on a daily basis by CCT Lead Leanne Bruce and Claire Lloyd CCTeam2 Lead. This ensures priority allocations to be highlighted and allocated in a timely manner. Ongoing is targeted work undertaken by a Senior Social Work Practitioner within the CCT service who will contact clients and/or their representative(s) to ensure their safety. The monitoring information is updated on the CCT digital whiteboard. There are strong links between the FE and CCT services and flow of information, especially to alerting any change in information regarding client circumstances who are awaiting input from CCT. Additionally, CCT have recently also started to operate duty system to improve current processes. The CCT duty worker covers workloads for absent (due to leave or sickness) and respond to urgent matters on the CCT waiting list. Cases are triaged as follows:

Urgent – allocated the same day or within 24 hours: Typical work in this category includes safeguarding, duty work due (individuals with a sudden change in need, carer / care arrangement breakdown), cases that require urgent risk assessment / support

Cases to be allocated during planned weekly allocation: Typical work in this category includes new S.9 assessments, non-urgent change in need, complex BI process, risk enablement / risk assessment, Community DoLS, MCA's, court directed work

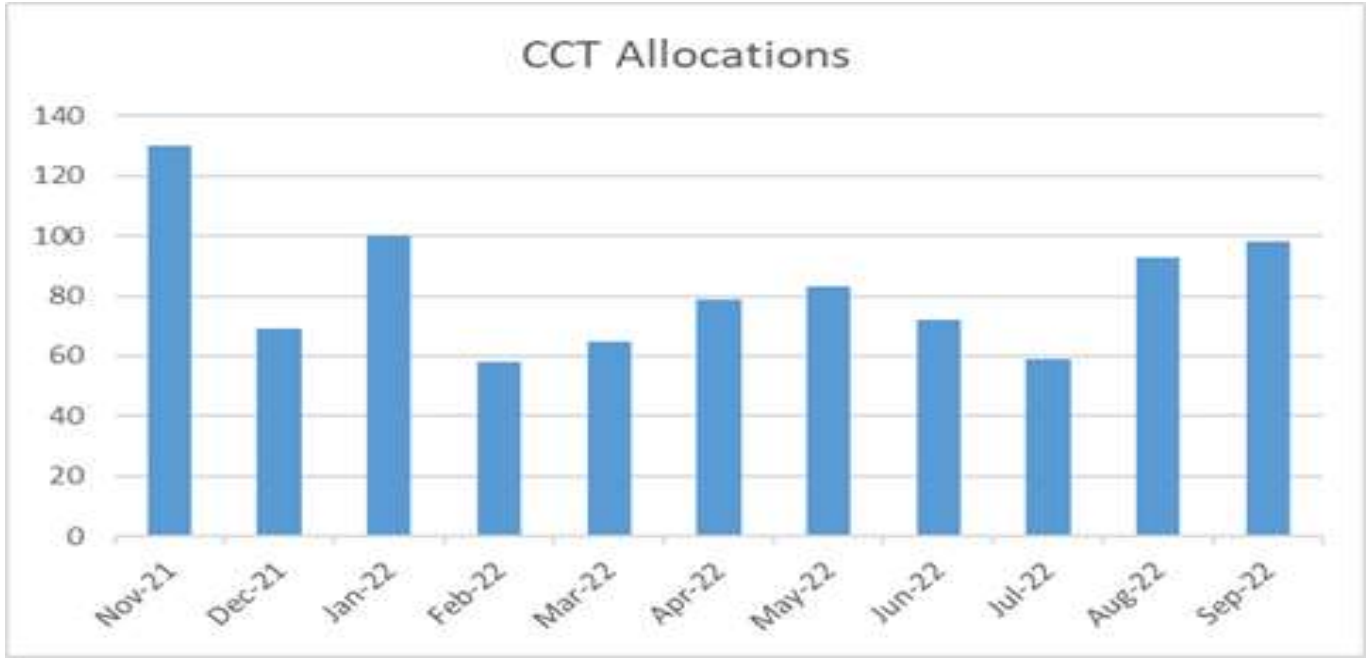
Future appointments: Typical work in this category includes overdue reviews, planned reviews (not overdue -care in place but review within 28 days), Planned move of car setting

Similarly, to the FE service urgent cases would not be accounted for within the waiting list stats as they are allocated within up to 72 hours (with safeguarding allocated the same day), whereas the waiting list stats are captured on a weekly basis, thus not fully capturing the daily throughput of work.

Allocations within CCT

The work within the CCT service is captured within the graph CCT Allocations.

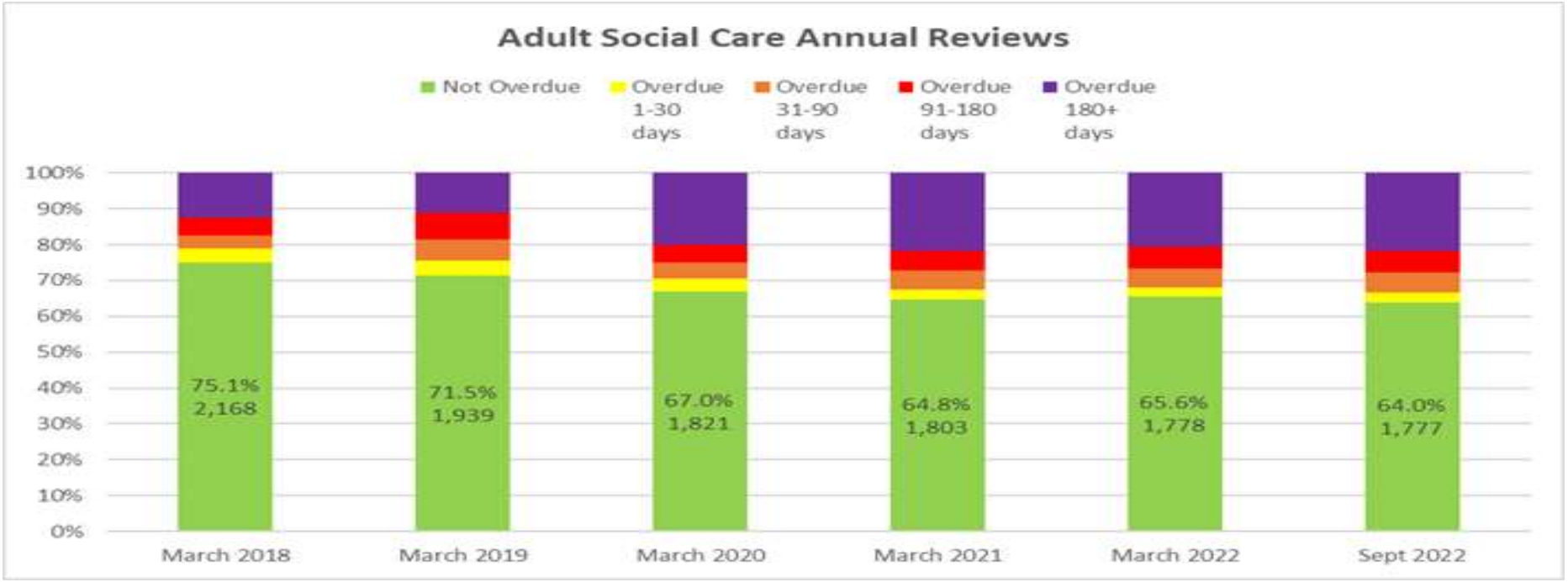
There is a surge of allocations in January 2022 which is following a cessation of non-urgent work to support Christmas Leave. There is another dip in the summer months due to staff deficits followed by a steady increase throughout the end of August / beginning of September due to increase in overall staffing (new staff joining and less annual leave being taken).



Reviews in Adult Social Care

The graph, Adult Social Care Annual Reviews, shows the overall number of reviews within adult social care including ASC and Community Mental Health Team. The overall compliance in terms of reviews needs to be improved and there is a targeted work plan underway to improve the current position:

- Over 400 reviews identified with the enabling market sector. This work is being undertaken by the R and I team, supported by the IPMO,
- Identification of categories of overdue reviews, i.e. reviewable equipment (sensory, OT, pendant alarms), residential and domiciliary care to support a targeted approach by relevant MDT Leads,
- Targeted identification of cases where there is evidence of a Social Care review within the last 12 months (data errors)
- Demonstration through our data recording of any between full review 'touch points' for all individuals with overdue reviews, and
- Senior Leadership Team agreement to the ringfencing of review-only work to be undertaken by the Review & Insights Team. The Review and Insight Team now have the dedication of one single Lead Social Worker who is responsible for overseeing all allocation and authorisations of this teams work


Adult Social Care Annual Reviews
Not Overdue
Overdue 1-30 days
Overdue 31-90 days
Overdue 91-180 days
Overdue 180+ days
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
75.1% 2,168
71.5% 1,939
67.0% 1,821
64.8% 1,803
65.6% 1,778
64.0% 1,777
March 2018
March 2019
March 2020
March 2021
March 2022
Sept 2022

TORBAY COUNCIL

Meeting: Adult Social Care and Public Health Overview and Scrutiny Sub-Board

Date: 27/10/22

Wards affected: All

Report Title: Suicide Prevention in Torbay

When does the decision need to be implemented? For information – no decision required

Cabinet Member Contact Details: Cllr Jackie Stockman, Cabinet Member for Adults and Public Health, 01803 851255, jackie.stockman@torbay.gov.uk

Director/Divisional Director Contact Details: Dr Lincoln Sargeant, Director of Public Health, 07425 634685, lincoln.sargeant@torbay.gov.uk

1. Purpose of Report

1.1 This report will update on local suicide prevention activity in Torbay as outlined in the Torbay Suicide and Self-harm Prevention Action Plan 2022/23 (Appendix 1) and provide information on how the council is working with partners to reduce the high number of suicides in Torbay. The Torbay Suicide and Self-harm Prevention Action Plan is owned and monitored via the Torbay Mental Health and Suicide Prevention Alliance (statutory and CVSE membership), with a multi-agency sub-group formed to identify priorities for the year and to co-produce and monitor interventions in line with priorities. The annual plan is endorsed by the Torbay Health and Wellbeing Board.

1.2 There is no acceptable number of suicides in Torbay – the aim should be an aspiration of zero suicides, but plans must be realistic to the context within which they sit. Last year's plan (2021-22), aimed for no increase in Torbay's suicide rate from 19.0 per 100,000 over the course of the year. We are pleased to report that this was achieved with our current rate of 18.8 per 100,000. However, we are not complacent, as our rate is still significantly higher than most areas in the country and this is combined with an economic position that currently challenges the most vulnerable individuals in our society. Evidence suggests that suicide rates are likely to increase in most countries post pandemic and during times of financial crisis.

1.3 In this year's plan (2022/23), new priorities include:

i) Supporting research and data collection;

ii) Tackling basic needs first;

iii) Tailoring approaches to improve mental health in children and young people; and

iv) Providing Devon-wide online mental health and wellbeing support for adults.

1.4 Torbay Council specific recommendations are outlined in Section 3.

2. Reason for Proposal and its benefits

2.1 To update on local suicide prevention activity in Torbay as outlined in the Torbay Suicide and Self-harm Prevention Action Plan 2022/23 and provide information on how the council is working to reduce the high number of suicides in Torbay.

The priorities within this plan are intended to help residents thrive and – particularly this year – help tackle poverty, deprivation and vulnerability given our national economic climate.

2.2 The recommendations contain tangible activities where the council can further contribute to suicide prevention activity, acknowledging that a large amount of suicide prevention takes place in functions which reduce suicide related risk factors, (such as housing, financial and social support).

3. Recommendation(s) / Proposed Decision

1. Continue to support the multi-agency priorities and actions outlined in the Torbay Suicide and Self-harm Prevention Plan 2022/23 and the Torbay Joint Health and Wellbeing Strategy 2022-26, including:

- Promoting information and awareness around suicide through all statutory, community and voluntary partnerships in the Bay
- Promoting suicide awareness and free suicide training with local employers and businesses to support creation of suicide safe environments. This will support actions identified in the Cost of Living Summit 5 October 2022
- Referral and signposting pathways to appropriate support and services, based on level of need

2. Enable Torbay Council staff and providers who interact with vulnerable residents to identify and act on potential indicators of poor mental wellbeing or suicide risk, and also to maintain their own wellbeing. This is primarily through:

- Promoting a range of suicide prevention training to all employees (universal and targeted offer based on roles and functions)
- Partnerships with and signposting to partners providing relevant support e.g., Samaritans, TALKWORKS, QWELL, Devon Wellbeing Hub and the Torbay Community Helpline

3. Focus on specific actions to improve children's emotional health and wellbeing through new multi-agency forums leading implementation of children's services priorities (SEND action plan, early help, family hubs)

Appendices

Appendix 1: Torbay Suicide and Self-harm Prevention Plan 2022/23

Background Documents

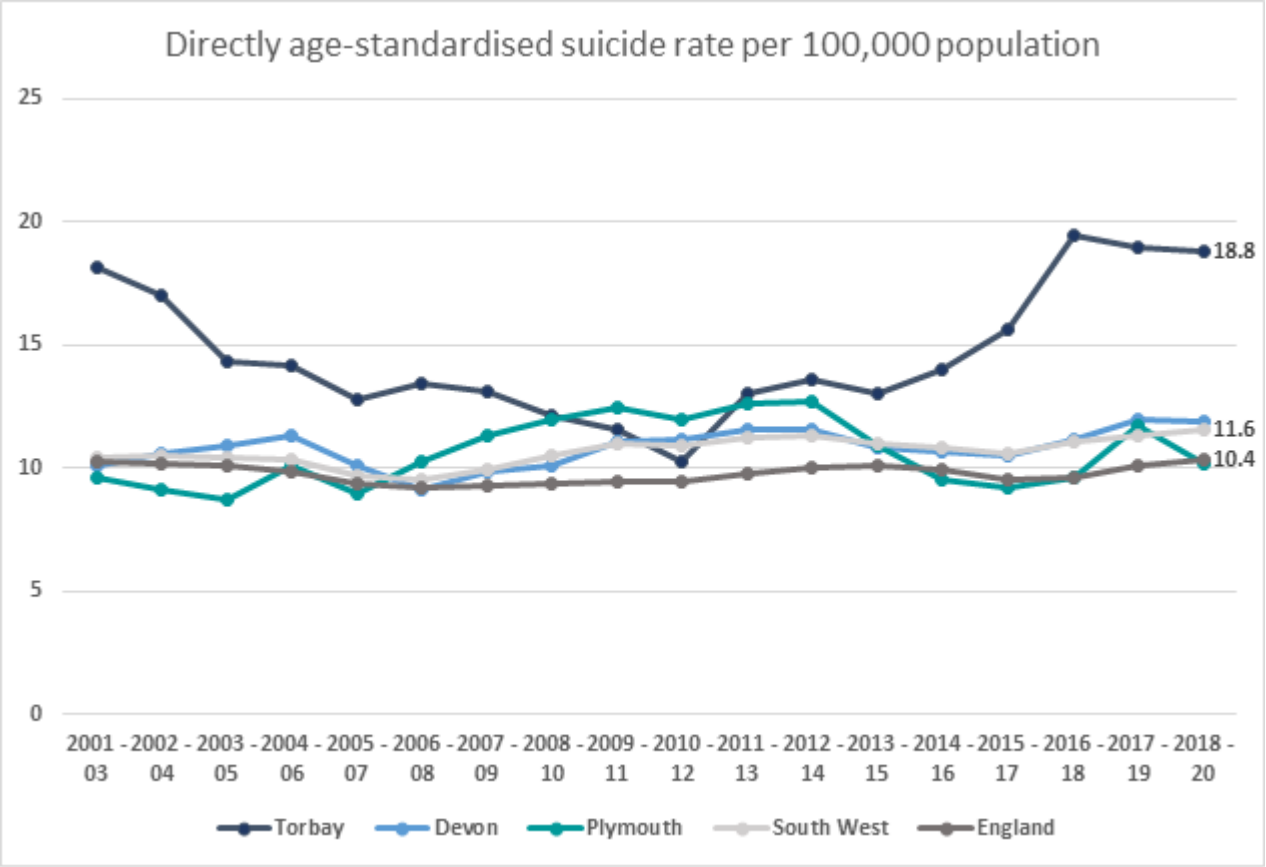
National suicide prevention strategy

House of Commons Health Committee suicide prevention report

Supporting Information

1. Introduction

1.1 Suicide is a major public health issue: it is the leading cause of death in men under 50 years, young people and new mothers. Torbay's suicide rate, in general, increased year on year 2010 – 2020 (see Figure below) and is one of the highest suicide rates amongst local authorities in England. Local Authorities are recommended to coordinate and implement work on suicide prevention under their local public health and health improvement responsibilities. The main thrust of this is through the development and delivery of a local multi-agency suicide prevention plan. The Torbay Suicide and Self-harm Prevention Plan has been endorsed by the Health and Wellbeing Board and demonstrates our multi-agency approach to tackling suicide in 2022-23 (Appendix 1).



Source: OHID Public Health Outcomes Framework

1.2 As well as seeing a stabilisation in suicide rate during the 2021/22 action plan, additional achievements are outlined in the infographic over the page.

1.3 The Torbay priorities for action this year include:

1.3.1 Reduce social isolation and loneliness

1.3.2 Promote a 'culture of curiosity' both publicly and professionally – identifying and responding to unusual behaviours, disengagement, or 'did not attend (DNAs)'

1.3.3 Address system gaps for people with severe mental illness (in partnership with the Community Mental Health Framework redesign)

1.3.4 Support research and data collection – e.g., suicide and self-harm research with people with lived experience

1.3.5 Tackle basic needs first – e.g., working with partners in food banks, children's centres, housing and DWP

1.3.6 Tailor approaches to improving mental health for children and young people – building on the school based self-harm programmes and health needs assessment

What did we achieve last financial year			
Saw **no increase** in the suicide rate from the previous year		Saw **no inpatient suicides** in Devon and Torbay mental health settings	
Created a **resilient** and more sustainable **mental health offer within the Torbay Community Helpline**		**Trained 4 local trainers** to deliver online and face-to-face **Community Suicide Awareness and Emotional Resilience training**	
Supported 139 people with their mental health via the Torbay Community Helpline over a 7-month period. **13 callers had suicidal thoughts or intent.**		Saw **reductions in self-harming thoughts, frequency and intensity and improved happiness** in the majority of young people who engaged with the **school based self-harm prevention pilot.**	
Awarded £50,000 to 20 local CVSE groups for creative suicide prevention activity		**Commissioned qualitative research into self-harm** in Torbay from local academics **with lived experience.**	

1.4 The Dev

1.4.1 Devon-v

1.4.2 Devon-v

1.4.3 Devon & Torbay – Embedding National Confidential Inquiry for Suicide Harms (NCISH) ’10 ways to improve patient safety’ in acute and community mental health provision

1.4.4 New Devon-wide online mental health and wellbeing support for adults – QWELL [Qwell - Mental Health & Wellbeing Online Service - Wellbeing Info]

1.5 For every life lost to suicide, the estimated total cost to the economy is around £1.67 million. For every person who ends their life by suicide, a minimum of six people will suffer a severe impact on their lives due to this bereavement. This means that in 2021, the potential cost to the local economy of suicide was around £35 million and severely impacted upon 126 Torbay residents. Suicide and mental ill health also disproportionately

affect those living in poverty, in deprivation and those who are vulnerable and/or have a learning disability.

2. Options under consideration

2.1 Recommendations are for consideration. No decision is required.

3. Financial Opportunities and Implications

3.1 National suicide prevention funding has been allocated to all local authorities in Devon 2020 - 2023 and supports implementation of some of the priorities outlined within the action plan.

4. Legal Implications

4.1 None identified.

5. Engagement and Consultation

5.1 Multi-agency members of the Suicide Prevention Plan Sub-Group (of the Torbay Mental Health and Suicide Prevention Alliance) have been involved in the development of this plan. It is a living document steered by group members and will account for emerging issues and new membership as appropriate. This plan has been endorsed by the Torbay Health and Wellbeing Board and will be made publicly available on the Torbay Council website.

6. Purchasing or Hiring of Goods and/or Services

6.1 Not applicable.

7. Tackling Climate Change

7.1 No relevant issues identified.

8. Associated Risks

8.1 Risks from non-implementation are loss of opportunity to work across partnerships to reduce rates of suicide, self-harm and mental distress in the population.

9. Equality Impacts - Identify the potential positive and negative impacts on specific groups

9.1 Not required for this report.

10. Cumulative Council Impact

10.1 Activities within the Torbay Suicide and Self-harm Prevention Plan and specific recommendations may reduce suicide, self-harm and mental distress for employees and residents.

11. Cumulative Community Impacts

11.1 Activities within the Torbay Suicide and Self-harm Prevention Plan and specific recommendations may reduce suicide, self-harm and mental distress for the community.

NHS Devon

General Practice Strategy

Covering note for the Overview and Scrutiny Committee – October 2022

Members will recall briefings to previous Overview and Scrutiny Committee meetings regarding the development of a new General Practice Strategy, which will set the vision for General Practice in Devon for the next 10 years.

This Strategy will replace the previous iteration, published in 2019, much of which has now been achieved, but which requires substantial revision to incorporate learning from the pandemic and to reflect the increased pressure on the system.

Consideration has also been given to the national picture, considering the findings from the national Fuller Stocktake review, which looked at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care.

In terms of the process involved in developing the Strategy over the course of the last few months, care has been taken to ensure wide engagement with key partners and stakeholders.

29 reference-style group meetings have taken place with GPs, practice managers, other health professionals (for example within secondary care and mental health services), system partners, patients and Healthwatch.

Surveys were also widely circulated – two different surveys tailored to those working within the healthcare system and those the healthcare system is here to care for.

A number of emergent themes arose from the engagement, for instance, differentially investing to tackle health inequalities, consistency of access and support to users when accessing technology, a strong focus on the prevention agenda and supporting practices with a Greener NHS plan.

The new Strategy has therefore been developed taking into account the output from the engagement. A further opportunity is now being given to all parties who contributed (both in terms of healthcare partners and patients) to review the draft Strategy document and provide further comments.

So far, the early feedback has been extremely positive; the Strategy is viewed as addressing issues that are difficult for Primary Care with an overall positive message.

A sample of comments received from GPs, practice managers, stakeholders and Healthwatch includes:

> *"Good to have the phrase 'needs versus wants' – it is so important to have those discussions"*
>
> *"An accessible document – easy to read"*
>
> *"The document describes what Primary Care wants to be and can do"*
>
> *"The differential funding and deprivation section of the strategy is a progressive move. Traditional measures of deprivation tend to under-estimate coastal towns as it is usually taken as an average"*
>
> *"The engagement with practices can be heard in the document"*
>
> *"The Strategy is well written, supportive and flexible. It says we need to change and move forward but affords opportunity to deliver services to meet local population need. Really like the sharing of stories, it makes the document real"*
>
> *"It is of high quality, and I'm pleased to see the inclusion of patient participation groups within the priorities"*
>
> *"The document demonstrates that you listened to the panel"*

The document is acknowledged as presenting challenges; however, feedback so far suggests that it is considered both practical and actionable.

Once finalised and approved, operational plans will be developed in conjunction with the Local Medical Committee (LMC) and Collaborative Boards.

The draft Strategy is therefore presented today to members of the Overview and Scrutiny Committee for consideration and to seek feedback.

Following conclusion of the second round of engagement, the full complement of feedback will be worked through and, where necessary, reflected in the final Strategy document.

The final Strategy document will be presented formally to NHS Devon's Primary Care Commissioning Committee for approval at the end of September 2022.

NHS Devon

NHS Devon Strategy for Primary Care (General Practice)

DRAFT

2022-2027

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Contents

1. Foreword

This strategy sets out our ambitions for General Practice in Devon, and how practices will work together as Primary Care Networks (PCNs) and as part of wider Neighbourhood teams over the next 5 years. Partnership working is key to the delivery of this strategy and is founded in the PCN model.

We are proud of the excellent general practice we offer in Devon, with nearly all of our practices being rated as 'Outstanding' or 'Good' and achieving consistently high satisfaction rates in the annual GP Patient Survey.

Devon has been a national exemplar, leading the way in developing digital solutions for GP practices, with other systems learning from us to make improvements to digital access in general practice.

The outbreak of the COVID-19 pandemic presented general practice with unprecedented challenges, which compounded the existing threats to the stability of primary care across the country. A forced transformation took place, resulting in general practice and our patients having to adjust to significant changes in the way that health services were accessed and delivered. Being ahead of the game with digital innovation meant that we were well-placed to shift to new, safe ways of working in the very early stages of the pandemic, when our priority was to limit exposure to both patients and staff. We will now need to learn to live with further waves of Covid infection, using this insight to shape how we can do things differently

Within the wider system we are undergoing a major restructure with the establishment of the Integrated Care Board (ICB) from July 2022, a Devon-wide approach to the delivery of health and social care, meaning health and care providers will work much more closely together, in a partnership known as One Devon.

We look forward to increased collaboration with our partners across Devon and further scope for innovation, joined-up care, helping us to achieve a collective aim - to improve outcomes for our population. General practice has a pivotal role within the new system and the success of our plans is reliant on general practice services that are fit for the future.

Now is the time to describe our strategic priorities and we revisited our 2019 general practice strategy to take stock of the successes and achievements so far and to establish a framework that sets our priorities for the future, describing how we will achieve them.

Our strategy will enable the transformation of General Practice, ensuring we have an offer that is stable, resilient, and sustainable into the future.

This document focuses on the future delivery of general practice, but primary care includes pharmacists, dentists, optometrists, allied health professionals and the voluntary sector. As the ICS evolves and commissioning responsibilities move to the ICB, we will include all areas of primary care in our collective aims.

Dr Nigel Acheson
Chief Medical Officer
Integrated care system for Devon (ICSD)

2. Executive Summary

In developing this 5-year strategy, we heard from people across General Practice in Devon. Their dedication and passion about wanting to provide the best care possible to their patients was clear.

Patients told us how much they value General Practice, how they want services to be accessible, and that sometimes they don't find it easy to access care in the way they would like. Patients saw the value of care being delivered differently and that continuity of care is far more important for some than others. It is clear that there is a difference between what some patients need and what some want, and that how care is delivered is just as important as by whom. Patients reported that digital access is often welcomed as a helpful route to care but for others it is seen as a barrier, making access to General Practice harder.

General Practice in Devon is mainly rated Good or Outstanding by the CQC, but we know from the reported pressures that practices are struggling.

For both patients and staff, change can be difficult and significant changes are required in the way that services are delivered, and by which clinician/professional.
As part of the development of this strategy, we have reviewed national documentation, key research, primary care models and existing strategies in place nationally. We have also conducted extensive engagement with healthcare professionals, Devon system partners, patients and other key stakeholders, to ensure this strategy reflects the opportunities available to best meet the challenges faced by General Practice and the wider system over the next 5 years.

A number of demographic and environmental factors set out in this Strategy make transformation an absolute necessity. A rising population, weighted to an older demographic, areas of high deprivation, significant workforce challenges, limited capital investment opportunities and a wide range of unsuitable estate make working more effectively across health care teams and doing things differently essential.

Honesty with patients and the wider population is required, as is the ambition to describe how these changes will lead to better care for the patients who need it most, and in better health outcomes for those in society whose needs are not always identified and met.

Care in General Practice is provided by a rich variety of clinical and non-clinical staff and patients reported they want to see the right person. We need to shift perception that the right person is always a GP and show how much value every member of the team brings to their care in General Practice.

2.1 Strategic Principles

Our key set of General Practice Strategy principles, underpinned by the national and local research, come with clear financial commitments and priorities. They are:

- General Practice is a speciality which has a key role in prevention, the identification and management of long-term conditions, and the treatment of certain urgent

care issues. Each of these specialisms may require a different delivery model

- Good access to good quality General Practice services for all patients will be based on what is clinically appropriate. This includes the type of professional that a patient sees and the method of delivery of care
- To ensure General Practice remains sustainable it needs to work as part of broader neighbourhood teams, utilising population health management
- Investment will be focused at Primary Care Network level and distributed differentially to ensure we address health inequalities and areas of deprivation
- Evidence and data will be required to adapt and improve services for patients
- Devon geography means that one size does not fit all but a scaled up general practice is likely to be more sustainable

For General Practice to be sustainable it will be delivered differently with more at-scale working at PCN or locality level. We already know that this works from examples in larger practices and where PCNs deliver services, such as extended access at scale. How this happens will vary and range from smaller practices working collectively, supra-practices or vertically integrated provision.

Honest and open discussions with patients about why their services are changing will be embedded throughout General Practice and in the wider system.

2.1.1 Investment

We will differentially invest, to focus resources where change is needed most, in our most deprived populations and where life expectancy and outcomes are lowest. This will in turn support the wider health and care system to manage demand.

2.1.2 Models of care

We will work with General Practice to support working to a model of care which differentiates prevention, long-term condition management and on the day care. We will support the development of specifications, outcomes and SLAs which will support PCNs to work together to deliver services at scale.

Our key drivers to enable change and support access for patients across the county are **workforce, modern infrastructure for estates and digital** and **population health management** (**PHM**).

2.1.3 Workforce

We will invest as an ICS in delivering the right workforce for Devon both to retain the workforce we have, and, in the people, we will need in the future to meet our rising and ageing population. We will work with providers to develop service level agreements and job descriptions which support integrated working and give staff the right level of clinical and professional support. We will also build on the success of the Digital Locum Pool to support practices which have short-term capacity challenges.

2.1.4 Estate

We will utilise our estate in the best way possible and for General Practice this means more at scale working across their PCNs and as wider neighbourhood teams. We will actively prioritise investing in the co-location of services and at scale provision. Where available, ICS capital investment will be open to General Practice and targeted towards our more deprived areas, and where it will have the biggest benefit to patients.

2.1.5 Digital

The Digital Front Door will continue to be the route into care, but we will ensure this does not disadvantage those who do not have access to modern technology by agreeing standards with General Practice for support to people who need it.

2.1.6 Population Health Management

PHM will ensure we use evidence base to target investment and resources where they are needed most and will ensure our neighbourhood teams are able to shape services in the best possible way for their patients. We will fund dedicated business intelligence and change management support in order to drive this forward.

The next five years will be difficult but by setting out our commissioning intentions now we will be able to focus resources where they are needed most and support General Practice in Devon to continue to deliver care to their patients in a way that existing staff are able to and will attract the staff we need for the future.

3. Shaping the Strategy

3.1 What we have already achieved

Devon has achieved great successes through collaboration and General Practice working collectively as PCNs and Localities. Much of this achieved a global pandemic and significant changes in how care is provided across a large geographical area.

3.1.1 Access

- All practices deliver online services with more than 500,000 online consultations taken place in 2021/22.
- Huge increase in remote working capability deployed to help GPs and practice staff work flexibly, nimbly, from anywhere.
- Extended Access (evening and weekend appointments) commissioned and provided across Devon.
- Extended Access repurposed temporarily to support the COVID-19 vaccination programme which saw PCNs deliver the majority of Devon jabs.

3.1.2 Workforce

- 335 WTE recruited to additional roles and reimbursement scheme (ARRS) with all PCNs successfully recruiting new and additional staff.
- Digital locum service created that allows clinicians from anywhere in the country to work safely as part Devon GP practice teams
- Primary Care Workforce Bank, originally set up to support COVID-19 vaccinations, now providing another option for GP practices seeking additional staff
- Investment into Practice Manager training
- General Practice Nurse strategy in place and shaping training and development
- Recruitment successes through use of funded (BMJ) advertising for all practices.
- Investment in meetings to ensure GP clinical voice is part of General Practice workplans, including LCP-level funding

3.1.3 Modern Infrastructure

- New practice buildings in Crediton, with others such as Dartmouth and Brixham in progress
- Huge increase in remote working capability deployed to help GPs and practice staff work flexibly and from anywhere
- New online consultation software provider procurement complete, giving practices a choice of system for the first time

3.2 Research

The NHS Long Term Plan (2019) described the approach to delivering strategic and GP contract objectives.

The key changes pertinent to this strategy are described as:

- Local NHS organisations increasingly focused on population health and local partnerships with local authority-funded services through new Integrated Care Services
- Boosting 'out of hospital' care, dissolving the historic divide between primary and community health services and health inequalities
- Patients will get more control over their own health and more personalised care when needed
- Digitally enabled primary and outpatient care across the NHS
- Redesign of the NHS to reduce pressure on emergency hospital services

The COVID-19 pandemic accelerated some changes, such as digital enablement and accessing care differently, whilst hindering development of others, such as prevention and reducing inequalities.

Recent reports such as the Kings Fund (2020) and the Policy Exchange (2022), reinforce the need for us to plan for the next 10 years. Recurrent themes include workforce challenges, continuity of care, on the day access, quality of service, working at scale and digital access.

The Fuller Stocktake (2022) with its framework for increased integration suggested the following priorities for General Practice:

- PCNs need to evolve into integrated neighbourhood teams with shared ownership for the health and wellbeing of their populations by investing time and space to solve problems collaboratively
- Services for urgent, same day care should be streamlined; using data and digital technology to ensure the right person provides the right care
- Continuity of care where it's needed for patients should be more proactive and accessible
- Being more proactive in reducing ill health, creating healthier communities by working across the voluntary sector and local authorities

These national findings mirror the Devon engagement conducted for this Strategy, most notably the clear separation between on the day care and long-term condition management.

3.3 Devon engagement

Engagement with local patients, partners and healthcare professionals took part in focus groups and surveys were sent to patients and staff across Devon.

3.2.1 System partners and healthcare professionals said:

- The strategy must describe what General Practice does and should be communicated with the population effectively
- There needs to be access to data and business intelligence
- Prevention should be a priority with strong links to community. It should help provide good access and support continuity of care
- The strategy should seek to address health inequalities
- We need to promote the Additional Roles and Reimbursement Scheme (ARRS)
- The strategy should be more of a guide and enabler, allowing more local delivery plans and models
- We need to support the mixed economy of rural and urban in Devon
- We need to address issues where estates (buildings) may be a barrier to change
- We need to support practices with the Greener NHS plan

3.2.2 While patients and public said:

- Mixed experiences of using general practice services – some very positive experiences during the pandemic
- GP services can be difficult to access and there are barriers to accessing care, impacting on the level of care and support they received
- Feedback emphasised the value of face-to-face appointments, continuity of care and having a good relationship with the GP and wider practice staff
- Technology was useful for busy people, routine appointments, specific care and accessing a broad range of services
- Some participants were less positive about the use of technology, reporting long waiting times for responses, lack of access to technology and lack of skills
- There should be consistency of access and experience
- Support for users when accessing technology to ensure it meets the needs of those with differing skills or access
- We should manage patient expectations with clear communications, signpost well, support access and build trust with patients
- We should explore how positive aspects of living and working in Devon can be emphasised through the strategy to support recruitment
- Self-care can be a vibrant part of general practice. The strategy could set out how these aspects can be delivered alongside more traditional forms of health and care
- We need to incorporate patient participation within the strategy and redefine the roles of patient participation groups (PPGs) following the pandemic

The findings of this engagement and the feedback collated has been key to the development of this Strategy.

3.3 Current Access

The role of General Practice is to detect, treat, and safely manage the ongoing health of their patients, in both the short- and long-term, according to patient need. Appropriate access must be in place to enable this to happen.

In 2021/22, General Practice in Devon delivered:

- 8.1 million appointments, of which 4.8 million were face-to-face
- Over 43,000 home visits were conducted
- Over 2.7 million on-line and telephone consultations
- And exceeded the number of appointments delivered when compared to the previous 3 years, and when compared with the national average
- Above the regional and national average for both on the day and face to face appointments, and online consultations.

All Devon practices offer online services and there has been a huge increase in remote working with resources deployed to help GPs and practice staff work more flexibly. Devon has been testing a digital locum service that allows clinicians from anywhere in the country to work remotely to provide greater access than our existing workforce could accommodate. Digital locums help manage triage and online consultations, ensuring there is enhanced capacity on-site for local GPs to see people face-to-face. Evening and Saturday appointments are also available through Extended Access in all practices.

More than 500k people in Devon are now registered on the NHS App (NHS Digital 2022), providing access to General Practice.

Procurement has recently been completed for new online consultation software for Devon practices, giving them a choice of system for the first time. This choice will enable PCNs to have the flexibility to care for patients in a way that meets their needs.

Rapid changes had to be made at the start of the COVID-19 pandemic. To limit exposure to both patients and staff, access changed radically with the digital front door becoming the first point of access. Some patients like a digital approach but it has led others to see General Practice as ‘closed’ or hard to access and this needs to be resolved.

Our patient survey showed mixed responses, from real benefits such as prescriptions, to on-line services not being intuitive or easy to use. Patients were also concerned about digital inequity with some being excluded from accessing care.

We have invested in additional capacity to meet some of the most immediate issues and pressures commonly experienced over winter through the National Winter Access Fund. This investment created over 130,000 appointments and we further invested into additional capacity through local funding with the Devon Spring Access Fund, providing short-term, immediate benefits to patients and the wider Devon health system. But these are short-term measures and do not provide a viable solution to the long-term challenges we face.

Why and how patients access care was a key theme; whether for long term conditions, accessing one-off care or supporting the identification of illness. This diversity of need must be reflected when changing access to care, to best reflect what is clinically appropriate and on a needs-based approach.

The pandemic has also resulted in a backlog of work where patients often actively avoided using health services, which was further compounded by reduced staffing due to COVID-19 illness.

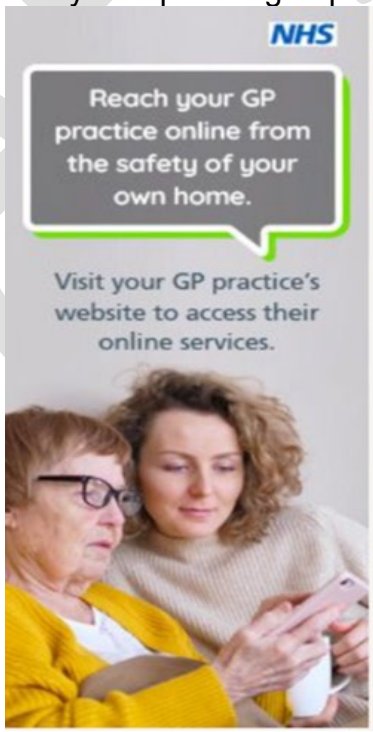
Our patient survey question on access (including getting through on the telephone) reported 34.5% having 'bad' access. 13.6% reported 'good' access (including on the telephone). This shows a significant variation in patient experience and probably expectation. What is reasonable will vary but telephone access remains a crucial point of contact for all patients. Many practices already ask patients to call for non-urgent matters such as test results outside of peak times and this should be respected by patients. A reasonable average waiting time for a call to be answered we consider as no longer than 5 minutes.

The latest Ipsos patient survey reports 80% of patients in Devon are satisfied with the appointment offered, higher than the National average of 72%. Experience of making an appointment is lower; 65% rated as Good in Devon though higher than the national average of 56% (Ipsos, 2022).

One of the biggest challenges we face is addressing the difference between what patients want, feel they need, and what their actual clinically assessed requirements are.

Patient overall experience described as 'Good' in Devon has dropped from 86% in 2020 to 80% in 2022. Although still higher than the national figure of 72%, whether it is the waiting time for an appointment, ease of getting through on the phone or who delivers care and from where, we must tackle patients perceiving barriers to accessing care in an increasingly busy system. And in a way that is realistic, sustainable, and safe. This will ensure patients know the right care is delivered in the right way by the right person.

Significant change requires a national change in policy, but we should press on in Devon with addressing this challenge locally with patient groups.



4. The Case for Change

Devon has excellent General Practice, with most practices consistently achieving 'Good' or 'Outstanding' ratings from the Care Quality Commission (CQC). But there is still variation in terms of access and quality of care according to where people live, and we need to address this.

Demand on services was already extremely high before the COVID-19 pandemic and this will increase not just because of the pandemic backlog, but because of an ageing and growing population.

4.1 Future planning

The population of Devon is set to grow by 17,308 (14%) by 2043, with low growth in under 65s (0.4% for 0-15 years and 5% for 16-64 years), but considerable growth in the older population (40% for 65-84 years and 92% increase in people aged 85 and over). With a higher-than-average age profile and associated long term conditions, continuing to deliver services in the same way will not be sustainable.

AREA	AGE GROUP	2022	2027	2032	2037	2043
Plymouth	All ages	264,780	267,235	269,810	271,129	273,161
Torbay	All ages	139,170	143,021	146,411	149,479	153,086
Devon	All ages	826,095	860,677	889,291	912,665	938,240
Devon ICS	**All ages**	**1,232,066**	**1,272,960**	**1,307,543**	**1,335,309**	**1,366,530**
Cumulative growth (from 2022)	**All ages**	**3.0%**	**6.4%**	**9.3%**	**11.6%**	**14.2%**

Figure 1 ONS Devon projections 2022-2043

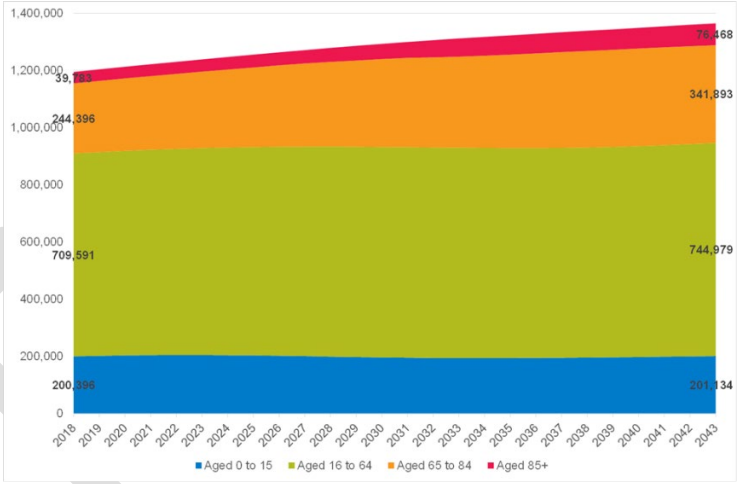


Figure 2 Population Change in Devon 2018-2043 (ICSD)

The ICS has been placed in the most challenged category nationally owing to longstanding financial and performance challenges. We must make improvements and General Practice has an integral role in our plans to deliver care differently and make best use of all available funding, by making smarter choices in how and where we target investment.

Pressure with General Practice has been reported on a weekly basis through the Devon LMC General Practice Activity Report. Localities are consistently reporting unsustainable demand, staffing issues and unrealistic patient expectations.

4.1.2 Workforce

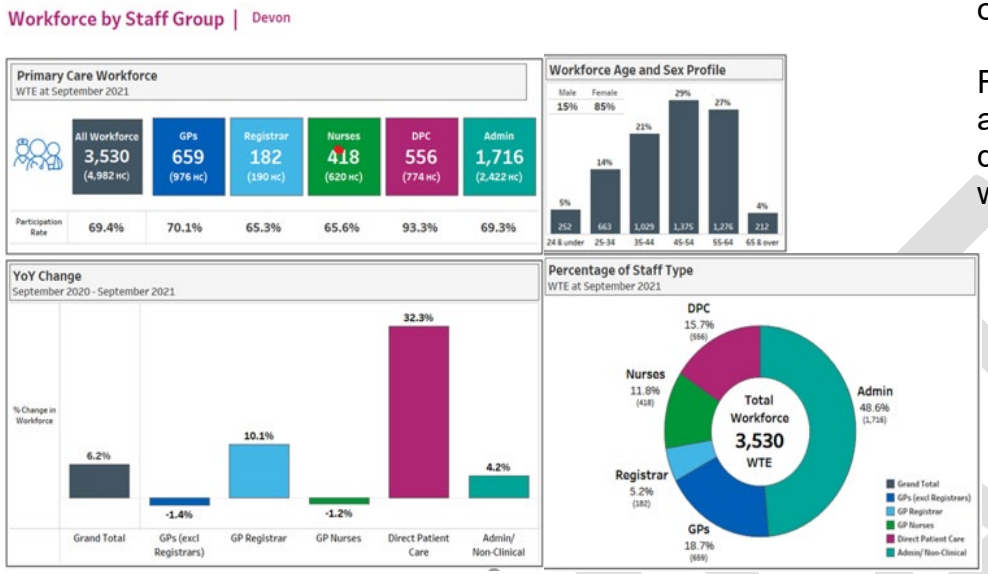


Figure 3 - Primary Care Workforce in Devon (Health Education England) 2021

There are 121 GP practices in Devon, providing care to our 1.2 million patients. Within these practices there are 3,530 total staff (WTE). Between March 2020 and March 2021, there was an increase of 0.8% of GP Nurses, 4.6% of admin/non-clinical staff and 8.9% in Direct Patient Care staff. However, there was also a 0.2% fall in the number of GPs. Workforce planning will need to consider the broad range of roles and the number of practices and PCNs in our large geographical area.

We know there are increasing staffing issues linked to staff burnout, high vacancy rates, and low retention. We will also lose a significant number of professionals in the next ten years because of the age profile of our workforce, which is more pronounced than many other parts of England. Currently, 19% of GPs are over the age of 55 and across other staff roles in General Practice 30% of staff are over 55.

Forecasts show the current workforce will need to grow over and above 2022 numbers by 906 in order to meet growth demand by 2030. On current service delivery models this would include 203 GPs, 107 nurses and 440 administrators.

The working patterns of clinicians are changing; the intensity of clinical sessions, choice of non-clinical and specialist roles and national policies influencing retirement age make recruitment and retention investment ever more pressing.

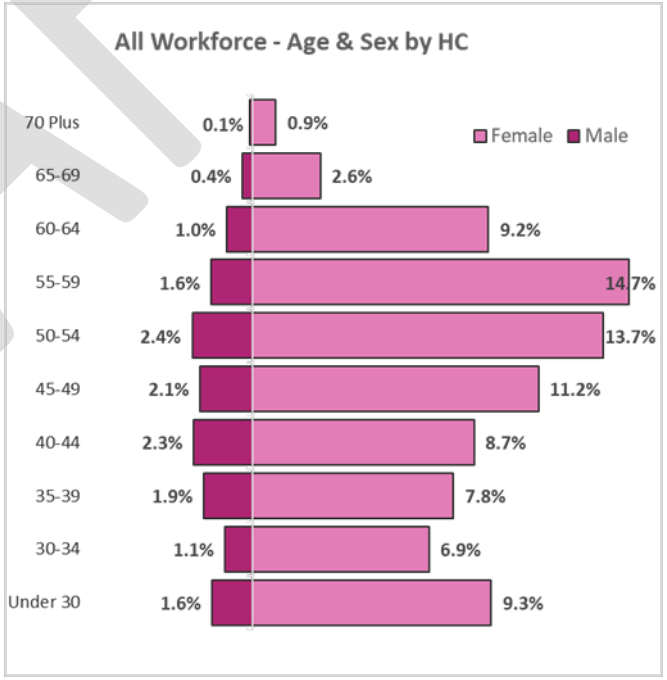


Figure 4 Workforce by age and gender in Devon (HEE, 2021)

GPs make up less than 20% of the overall workforce so we need to consider all areas of workforce and how to recruit and retain the best. In 2021/22 PCNs received £12.5m new investment into Additional Roles; 429 professionals in PCNs who are able to support patients across a wide range of health conditions and needs. But we were unable to utilise all available funding as recruiting the right people is challenging within the landscape of still newly evolving PCNs.

It is recognised that staff will often move between primary care and secondary care. General Practice therefore cannot operate in isolation and must work as part of the ICS in workforce planning. To ensure we invest where most needed, it is crucial that practices and PCNs submit accurate staff detail into the National Workforce Reporting Service (NWRS) as this data will inform where and how funding is allocated.

As an ICS it is unaffordable to continue to develop as we are, as to match expected increased annual demand growth of 2.9% by 2030 the ICS would need to find over 24,000 WTE staff across all providers.

In order to maintain the current workforce position over the next 3-5 years, the ICS will need to make best use of all available staff through different ways of working, embedding digital innovation and maximising the skill mix of staff across all provider organisations, including General Practice.

Engagement for this Strategy demonstrated the clear link between where and how services are delivered should help support General Practice to successfully attract and retain the workforce it needs. Both in terms of attractive roles and reducing the risk of burn out trying to deliver all things to all patients. Other linking factors were co-location of services, working in a medium to large practice, and working as PCNs.

This is reflected in the way services are already being shaped, either through designing Health and Wellbeing Centres, or delivering services such as Extended Access at scale across PCNs.

With the growing complexity of PCNs, Collaborative Boards and LCPs, commissioners must not lose sight of grassroots GPs and wider practice and PCN staff. There is an unprecedented opportunity for genuine co-design between commissioners and General Practice Leaders.

It essential that our future planning provides a pipeline of the trained staff required and we will need a robust and responsive training hub that provides appropriate, accredited training, supports retention and the development of all staff groups, aligning to ICS priorities.

4.1.3 Digital

Has the technology used by General Practice teams improved your ability to access General Practice services?

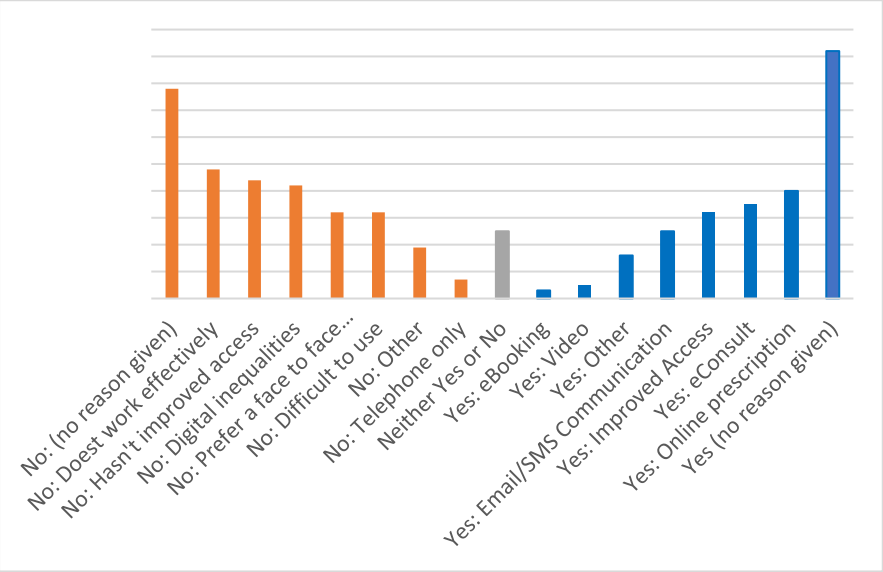


Figure 5. Has technology improved access to General Practice (Devon Patient Survey, 2022)

Digital advances are continually creating possibilities for new ways of enabling people to stay well, prevent ill-health, and provide care. The ability to share information across all our services will improve quality and in particular the safety of services and transform the ways we work.

The use of digital solutions and data will drive collaborative system working, connecting health and care providers, improve outcomes, and put the patient at the heart of their own care.

4.1.4 Estates

Although familiar to patients the traditional converted house has become more difficult to staff effectively, be an effective way to deliver 21st care and be affordable and sustainable in the upkeep of aging buildings. This is further compounded by the rapidly changing health system requiring greater integration of services and buildings only 20 years old becoming outdated and in need of investment.

Without enough space, correctly configured PCNs are limited in how they can expand their services, makes recruitment more difficult and can often hinder practices attracting new partners as many do not wish to take on building ownership.

How we use buildings is key to improving access to care, driving prevention and wellbeing. Creating safe, accessible, and modern facilities that are capable of housing more staff and adapting to new models of care need to be fit for the future. We recognise that the capital investment required to develop every building in Devon is unachievable and so difficult choices will need to be made.

4.2 Model of Care

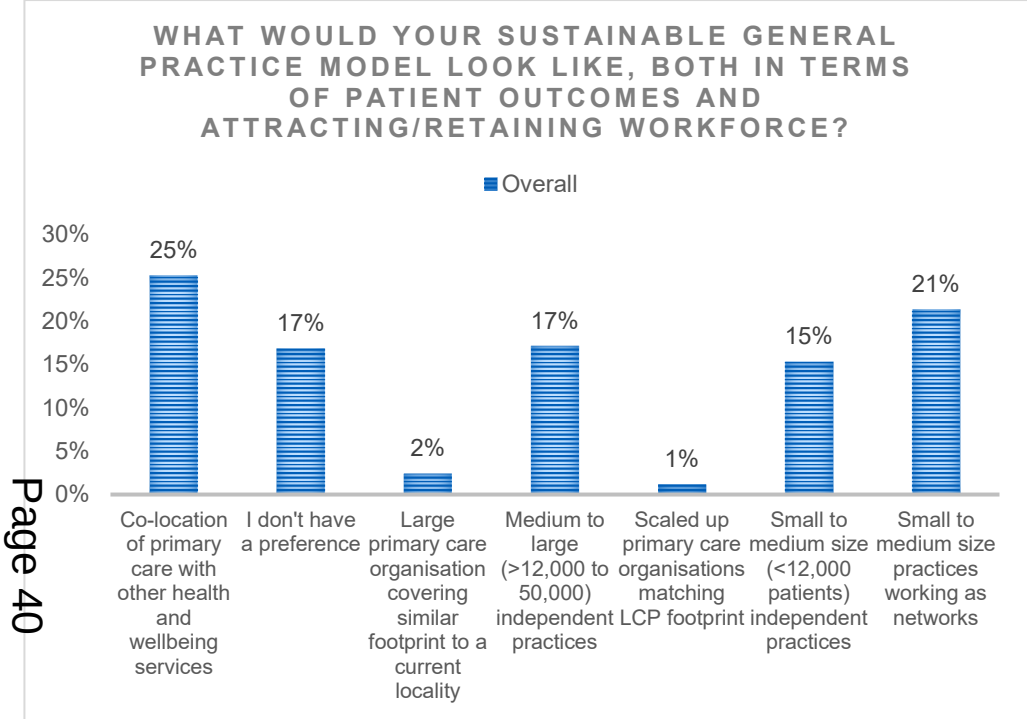


Figure 6. What healthcare staff and GPs told us. Devon Strategy Survey (2022)

Evening and Saturday access is already in place and from October 2022 will form part of the National requirements for PCNs. 'Good' access includes a mixture of online, telephone and face-to-face consultations as this means the needs of patients can be met effectively. Working at scale across PCNs allows for a more diverse range of clinical staff available to see patients and help meet clinical need, sometimes at locations away from the patient's practice.

4.2.1 Continuity of Care

General Practice plays an essential role in detection and management of Long-Term conditions (LTCs) with continuity of care and face-to-face consultations reported as a key priority by both health professionals (71%) and patients (76%) living with complex LTCs.

The number of research articles and case studies showing its link to reduction in mortality are significant and show why this this needs to be a key focus when shaping future service delivery models. How PCNs develop services will need to accommodate a rising, aging population and the associated increased need for continuity, balancing against those patients requiring less continuity but still requiring access to care.

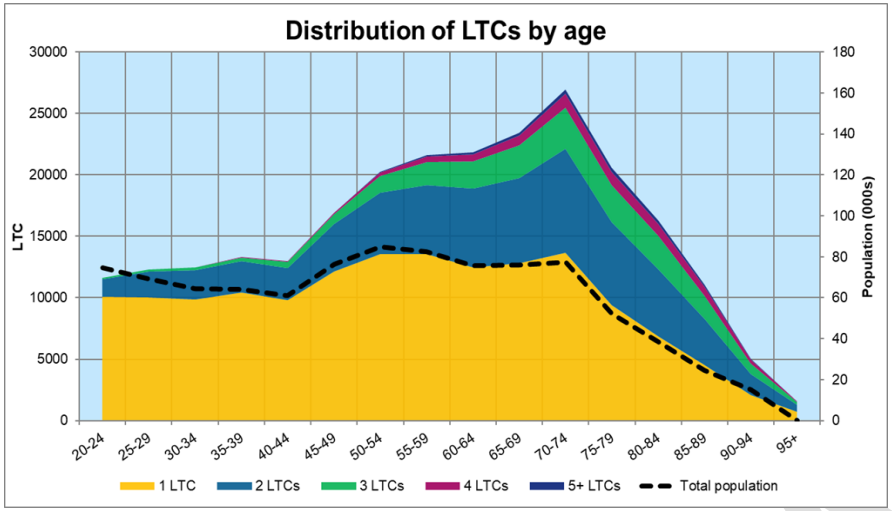


Figure 7. Distribution of Long-Term Conditions by age

With the expected continued growth of an older population, and a forecast of 2.3% annual growth in General Practice contact, effective and accessible continuity of care will be an even greater part of any change and, coupled with workforce challenges, reinforces the need for PCNs to work differently.

4.2.2 On the day care

Timely access when patients need it most was reported as a key priority for both health professionals and patients. In contrast to LTCs any patients with generally good health and digitally aware, reported that continuity was less of a priority, and were happy to adapt to digital access or a remote, online locum.

The evidence both locally and nationally is that we need to facilitate, and support scaled-up, on the day access for General Practice. This in turn will support practices to deliver continuity of care where it's needed most. This may look different for patients as the change from practice to PCN delivery means visiting different locations according to need. But this is already happening in extended access, demonstrating patients are willing to travel if it makes sense, something our patient survey showed.

4.2.3 Preventative care

General Practice plays a key role in the prevention of future illness through the delivery of national screening programmes, proactive interventions identifying new symptoms early so investigations and referrals happen in a timely manner, reducing patients at risk from developing long-term conditions.

Our practices and patients reported there was scope for development of online platforms as a tool for providing healthcare information, advice, and signposting. Patients reported that social media platforms should also be developed for this purpose.

4.2.4 Deprivation

We know there are significant health inequalities in Devon that must be addressed. With an increase in poor mental health and wellbeing, even greater pressure is evident across the whole health and care system.

General Practice already works with partner organisations including the voluntary sector and the addition of roles like Social Prescribers has further improved actively connecting patients to preventative and supportive care. This needs to be expanded, particularly where there are existing inequalities.

Our plan to invest differently into where services are needed most will be guided by deprivation and the known health inequalities that follow.

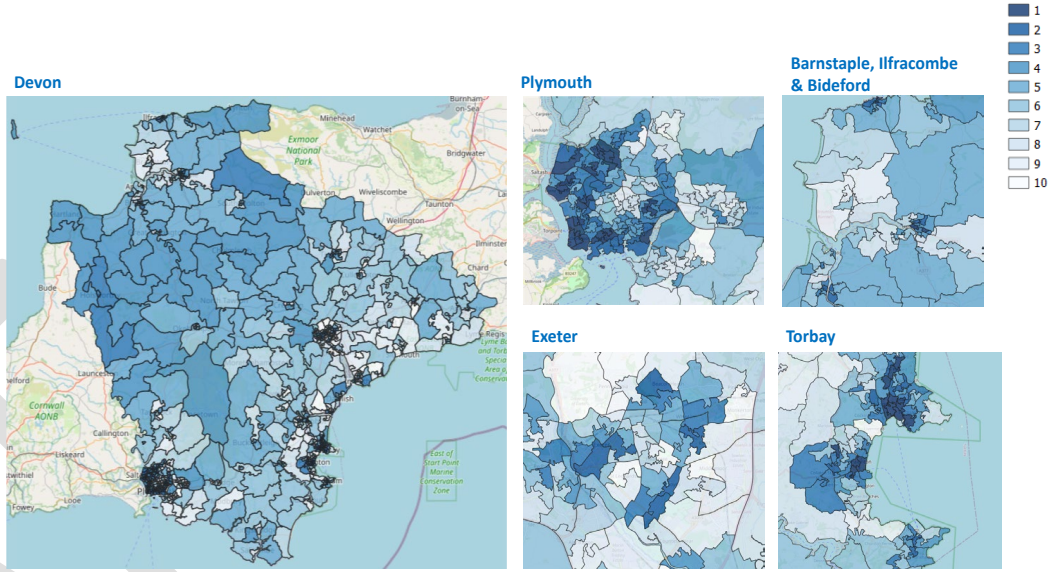


Figure 8: Devon Population Deprivation Decile Distribution

5. What will be Different

5.1 Different for patients

5.1.1 Access

PCNs already work differently, and this will expand, with where and how patients are seen, led by clinically appropriate timelines
and whether patients need urgent, pressing, routine, preventative care and whether continuity of care is crucial.

The ICS will lead and support open conversations with patients on why things need to change and what is reasonable to expect. This will vary across our population both in terms of clinical need, deprivation and geographical location; what works in a city may not work for a rural community, but the reasons for working differently set out in our case for change will be universal.

Patients will also see an increase in signposting to self-care, or other areas of Primary Care as an alternative to General Practice.

5.1.2 Communications and engagement activity

To support General Practice, we will launch a new public communications plan so patients understand why and how General Practice will change in the future. It will include what patients can expect, how to access services, what expectations there are on them, and to raise the profile of the wider clinical roles in PCNs.

5.1.3 Making digital inclusive

We need to collectively support patients with digital access, training, access to tools and skills. Some practices already have great examples/case studies of in-house training they offer to patients in using online consultations and we need to further develop skills and knowledge across Devon.

Specific support has been trialled to develop patient's skills in using online GP consultations, including online learning and face-to-face support using an iPad in a waiting room. Digital 'trainers' will help local people with their digital queries via online 'virtual drop-in sessions, social media or even 1-to-1 advice and guidance either over the phone, via email or webchat. We will learn from these projects and support PCNs to ensure this type of support is available where it is needed.

5.1.4 Patient Participation Groups (PPGs)

PPGs can and should be hugely important in improving the wellbeing of our communities. Working with Healthwatch Devon, Plymouth and Torbay to support PPGs is an effective partnership in helping community groups develop a stronger voice in shaping local health and social care services.

Support such as the Healthwatch Assist Network is already available with support for promotion, resources, running surveys, and events.

PCNs, in conjunction with their member practices, will need to develop their member practices' PPGs further to:

- Strengthen and improve their PPGs with clear roles and responsibilities for members
- Introduce more innovative ways of working across their PCNs
- Provide training and support for people to be informed and active members, supporting self-care, empowering local long term condition support groups
- Support patients in how use of social media, apps and digital platforms

5.1.5 Equality, diversity and inclusion

Primary care services share the system vision for equality, diversity and inclusion.

"Everything we do will be inclusive of our people and communities across Devon. We will prioritise co-production, actively involving local diverse communities and listening to the voices of our population. Our senior leaders will champion diversity and build trusted relationships." (NHS Devon People and Communities Strategy (2022))

As the front door to healthcare, General Practice should be welcoming and accessible to all. Examples of our priorities include (but are not limited to)

- Ensuring availability of translation services
- Providing awareness training to staff e.g. – cultural awareness training and Pride in Practice.
- Being fully inclusive of all its staff, patients, and communities

5.2 Different For General Practice

5.2.1 Neighbourhood teams

PCNs are already working with their Local Care Partnerships (LCPs) and this work will expand. Working collectively to meet patient needs will mean more collaborative working and moving away from the traditional model of delivering everything General Practice does for their own registered patients from their own premises. We have already seen this works well for the highly successful COVID-19 vaccination programme, demonstrating how much General Practice can do when it works together both with each other and with other parts of the Devon health system.

5.2.2 Provider model

We have practices ranging from 2,500 to over 40,000 registered patients with GP partners predominantly holding the responsibility for delivering General Practice. There is no desire to move away from GP partnerships, but we must recognise the challenges faced in the traditional model and how this will become increasingly hard to sustain. This is further compounded by the changing role of General Practice and the multi-disciplinary teams providing a range of care, including PCN staff.

This does provide opportunities for GPs to share practice responsibility with their wider clinical and non-clinical team and this is already happening on a small scale.

There is no one size fits all and not one model that can, or should, be replicated across urban and rural practices. We will actively support practices through contractual mergers, closer partnership working or integrating with other providers in Devon. We will support and actively encourage changes that add real value to the care offered to patients and the ongoing resilience of General Practice across Devon.

5.2.3 Integrated estates

Building ownership must not be a block in developing health services in Devon. We must use all means available to us to allow General Practice to work in different settings and in different ways to make best use of all health estate we have across Devon.

We must use our estate across the whole health system as efficiently as possible and make sure investment is targeted wisely.

Whether rural or urban we will actively support General Practice to use their own estate differently across PCNs and to share estate with other local providers to offer the best and most sustainable care to their patients.

5.2.4 Greener NHS

As part of this strategy, the Greener NHS agenda will be a key area in how we can support general practice to improve the environmental impact of our services. We have to achieve an 80% reduction in our 1990 baseline carbon-footprint by 2030.

5.2.5 Workforce

The ICS workforce strategy is due to be completed by Autumn 2022. As part of the work to inform the strategy, detailed

analysis of current workforce and the workforce required to meet future demand will be shared with PCNs.

The ICS is developing a workforce planning tool, which will be available for all organisations within Devon to use in planning future workforce requirements and addressing any gaps. We will ensure General Practice is an equal partner within the ICS, planning and recruiting collectively both for clinical and non-clinical roles.

5.2.6 Primary Care Leadership

The four Collaborative Boards represent General Practice in the North, South, East, and West, comprised primarily of GPs and Practice Managers. Their operational role increased under the urgent need to work differently under the COVID-19 Pandemic and now is the time to take stock and review the way ahead. We recognise the challenge of being both a leader in the ICS and being personally invested in individual practices and how these priorities can sometimes come into conflict. Change must be safe, supportive and in the context of building sustainable General Practice for the future and we will need to further develop provider collaboratives.

5.2.7 Deprivation

Using good and consistent data through the One Devon dataset will ensure we effectively target investment into all areas of deprivation across the County.

5.2.8 Quality Dashboard

Led by the Quality team, the quality dashboard will support investment decision with input from provider collaboratives to ensure support and focus is on the right place for the right reasons.

5.3 Different for systems

5.3.1 Integrated Care Systems (ICS)

The ICS function is to enable partner organisations to work together through the established Primary Care Networks and Local Care Partnerships and around the provider collaboratives for specialised services that already exist.

The key aims of ICSs are to:

1. Integrate care
2. Improve health outcomes
3. Tackle inequalities
4. Enhance productivity
5. Support social and economic development of communities

A large proportion of daily patient contacts is within General Practice; in May 2022:

- 26k patients attended an emergency department in Devon
- 620k appointments were delivered in General Practice in Devon

It is essential that General Practice is given the right support to enable there to be collective stewardship of our system to deliver the best value for all available funding.

5.3.2 Local Care Partnerships

Working collaboratively can be challenging but it when underpinned by good and honest relationships good decisions are made. LCP's want a happy and healthy workforce, vibrantly supporting and enabling every person to improve health and wellbeing outcomes and reduce health and wellbeing inequalities and do so by working across the health and wellbeing system. Often a cause for strained relationships, LCPs will work to reduce the unwanted overspill into each other services.

LCPs will be the route to enact the changes set out in this Strategy.

5.3.3 System flow

As practices continue to step beyond the traditional patient list and work at scale, managing patient flow at scale, this will enable a more robust General Practice which can meet the needs of patients and avoid unnecessary escalation within NHS services.

5.3.4 Investment

Organisations have previously been driven by an activity-based model of commissioning rather than value, contributing to distorted priorities and making it more difficult to invest in preventative approaches. National funding makes stepping away from activity-based prioritisation difficult so where we commission locally, it will be outcome-based and at scale to support better access to the right service for patients.

5.3.5 PHM

PHM data will identify specific clinical needs that could be met more effectively, including service redesign at neighbourhood or place level. It will help tackle health inequalities by delivering targeted MDT interventions that lead to health improvements and better outcomes for patients, including children and young people and those with mental health issues.

A PHM approach will also result in the development of more sustainable, increasingly integrated services that make better, more effective use of our physical and financial resources. Differential investment will be aligned to demonstrable patient need and include supporting health prevention and closer working with the voluntary sector. It can also help inform future workforce requirements; patient needs will be different across LCPs and require variation in staffing models across PCNs.

Primary Care Networks delivering vaccinations
North Devon

Three Primary Care Networks in North Devon worked in partnership to deliver the first phases of the covid vaccination programme. They identified Barnstaple Leisure Centre as a central venue large enough to hold clinics safely. Clinics were held throughout the week and weekends, staffed with a mix of admin, clinical pharmacists, pharmacy technicians, nurses and doctors from all the practices, on a rota basis.

A lead manager for the programme coordinated vaccine delivery and a site manager was in the clinic at all times to oversee and trouble shoot. A bank of enthusiastic volunteers helped at every clinic supporting and directing patients.

6. Implementing the Strategy

To enable continued delivery of safe, quality care in sustainable ways we will provide support across 4 key areas:

- Workforce
- Modern Infrastructure: Estates
- Modern Infrastructure; Digital Devon
- PHM

And with targeted investment to ensure General Practice can engage and thrive in the Integrated System for Devon

6.1 Workforce

Without the right workforce, trained and well supported, General Practice will not be able to deliver the right care in the right way. We will work towards a more resilient, stable and competent integrated multi-disciplinary workforce and, to reduce barriers to employment options, encourage parity of contractual terms for all staff.

We are committed to working with General Practice to tackle the workforce challenges that we collectively face. We do not underestimate the challenge of retaining good staff who continually face pressure at work; nearly 50% of staff are non-clinical and the first person a patient speaks to. We will foster a better employment culture through wellbeing support and continued investment into our health and wellbeing offer available to all staff working in General Practice.

- Place-level funding to target care in the areas of greatest need
- Service Level Agreements to support joint or rotational roles across services
- PHM data will be used to help shape the right workforce for PCNs
- Working with the Training Hub, we will create whole career pathways across General Practice roles with the right accredited training
- We will support PCNs recruit from outside of the county by funding finders fees charged by agencies across the of roles available to General Practice. To ensure this is a sustainable approach we will prioritise PCNs with the greatest health challenges and where recruitment has been a historically challenging
- We will build resilience in place-based teams by making use of alternative employment models such as community trusts, supra PCNs or third sector
- We will continue to invest in the future workforce of Devon by supporting accredited training. PCNs will need to work with us to ensure trainee posts are supported both in time to study and a practice to work in

- We will continue to support practices and PCNs to secure International Medical Graduates for Devon

- We will support at scale recruitment and development of retention initiatives and attend recruitment fayres outside of Devon

- We will invest to minimise the risk of GP burn-out by working closely with the LMC and appraisers to ensure the right level of support is available when its needed.

- We will expand the workforce bank offer to include more roles, including funded training for those able to commit to bank hours and who will support PCNs with the greatest need

- The ICS will use a workforce planning tool for use in planning future workforce requirements and addressing gaps, ensuring General Practice is an integral part of Devon-wide workforce planning

- We will support PCNs to retain good staff by supporting PCNs to develop shared processes and procedures, essential for working at scale, and create opportunities to develop ARRS roles into portfolio careers

6.1.2 Leadership

- We will commission an independent assessment of the overall value of how we currently engage, and plan, and we will work together to deliver good value for money planning and leadership

- We will work with Collaborative Boards to establish a suitably representative and empowered Provider Collaborative with a wide range of clinical and professional roles represented in discussions.
- We will continue to invest in PMs wishing to move into system roles

- We will equip people with effective leadership skills and will support the development of Clinical Directors and other PCN leaders, with particular emphasis on nurturing those who have not yet felt able to step forward, and those from under-represented groups, such as pharmacists

Paramedics undertaking home visits
St Thomas Medical Group, Exeter

The St Thomas Medical Group (and Exeter West Primary Care Network) employs four paramedics, along with GPs and Advanced Nurse Practitioner's (ANP), for a home visiting service. The team visit people who are housebound and need acute care home, as well as Quality and Outcomes Frameworks (QOF) activity. The service frees up GP time and patient feedback is extremely positive. When fewer home visits are needed, the paramedics focus on acute care and manage urgent illness for the wider PCN.

6.2 Modern Infrastructure: Estates

The best use of buildings is key to enable the delivery of 21st Century services, together with the changing working patterns and skill mix of staff. A One Public Estate approach with integration of community assets and existing buildings is required.

To support both urgent on the day, and continuity of care for patients who need it, PCNs should deliver services across their combined sites. Patients must be part of the change from the beginning and any proposed changes in how a registered patient population will access care will require good patient engagement.

Investment for new estate will be primarily targeted to where there is greatest need in health inequalities and where there are opportunities to bring services together. This will allow financial scope to maximise opportunities where they arise and where they align to the ICS priorities. The ICS capital funding will prioritise health and wellbeing hubs with PCNs at the heart of developing the right hub for the registered population.

Working at greater scale can be done in different ways; from one practice as a PCN to multiple PCNs. We will support models that encourages integration and the best use of both staff, buildings and accessibility for patient.

- We are supporting PCNs to review and assess their current estates with outcomes integrated into Locality Plans.
- We will facilitate innovative ways of collaborative working to maximise the use of our buildings, share facilities and expand services.
- We will support PCNs in their engagement to ensure the challenges we face are transparent and on why sustainable and safe General Practice will be delivered differently. Service change will be underpinned by a patient able to see the right person and the right time for the right reason.
- We will support PCNs to deliver services at scale. An example would be on the day care as a 'hub' model at one site for all patients.
- In line with the NHS Plan and the Investment Plan and Toolkit, we will continue to invest into the Section 106 team and work with local authority partners to access the Infrastructure Levy as part of new building developments to ensure continued investment into General Practice.
- Prioritisation will be based on supporting delivery of integrated services at scale and will be by exception only at practice-level where geography makes investment essential.
- We will ensure there is full utilisation of Minor Improvement Grant, investment shaped on the outcomes of the Devon Toolkit.

6.3 Modern Infrastructure: Digital Devon

We will take a 'digital first' approach, whereas many interactions as possible with health and care will begin or be done digitally.

There is a new national commitment to make the NHS App the front door to NHS Services and we will encourage and support practices and patients to use it. Over 40% of the population of Devon already use it now, the national target is to have 75% of the population using it by 2024.

The NHS App already allows people to order repeat prescriptions and access their healthcare record and we are linking our new online consultation systems to it, so people can consult online with their practice. In future it will be expanded to allow people to manage appointments across the NHS, allow GP practices to send messages to their patients and allow patients to report some information back.

We will work with practices to improve the ways people can book appointments online, via the NHS App or other means. This will take on the learning from the development of a new generation of online booking systems developed for Covid vaccinations.

We know that some areas of Devon face challenges with broadband connectivity and mobile phone signal. This is improving and we are working with partners to help with that where we can. As faster connections become available, we will use them to connect our GP practices. We will also use new technologies such as 5G, initially for backup services. We will work closely as part of the One Devon Partnership to identify areas where there are the biggest gaps and signpost people to other local suitable alternatives for accessing the internet to use health tools e.g. local libraries

- We will help people and clinicians find and use trusted apps through our online Health App finder, ORCHA

- We will maximise the use of social media platforms to share healthcare information to as wide an audience as possible. We will work with GP Practices to help them make sure their websites are consistent, simple, informative, up to date and secure and that they are offering patients the services they need online

The Devon and Cornwall Care Record (DCCR) will ensure safe and secure access to patient medical records for the right people across NHS services throughout the peninsula, as patients access services across county borders. As our hospitals digitise more of their services and connect to the DCCR the scope quality of that record will improve. The record held and managed by a person's GP will still be the heart of their electronic health and care record.

- We will continue to provide technology to GP practice staff to allow them to work securely as flexibly as

possible. This will include expanding the use of new solutions such as ‘GP in the Cloud’

- We will support practices in the adoption and utilisation of technologies, so they are able to fully exploit their potential, while at the same time ensuring a levelling up of best practice happens across Devon.

- The Primary Care Digital Programme Board will continue to provide a route for innovation and development, ensuring reducing health inequity is an embedded part of the decision-making process

- We will take a problem-based approach to innovation, using technology to help improve primary care. By understanding the particular challenges and use cases, we will explore at scale the best options to address these challenges. Our team will support the adoption and adaption of these technologies into practices, while looking to ensure the best value. The innovation programme will be overseen by the digital board but will be based on real time evaluation and feedback from frontline primary care teams

- We will help staff collaborate through systems like Office 365 and the shared Devon GP Intranet

- We will support PCNs and wider geographies to consolidate onto the same GP Clinical system

- We will continue to give practices choice over the technology they use where we can

- We will continue to maximise the benefits of the Devon-developed digital locum platform

- We will primarily use national frameworks and catalogues as the preferred way to purchase new technology

- To avoid digital exclusion, we will ensure that there are always alternatives available to patients for accessing their GP practice, when internet or mobile phones aren’t available

Developing hubs for patient care
Beacon Medical Group, Ivybridge and Plympton

Beacon Medical Group in Ivybridge introduced the use of total triage for same day, urgent care demand. This is accessed through online consultations, telephone or walk-ins.

Patients are reviewed by members of the Urgent Care Team, comprising of a GP, paramedic, nurse practitioner, clinical pharmacist, physiotherapist and a minor illness nurse, and then directed to the most appropriate clinician for their needs at the appropriate location.

Multi-disciplinary working has fostered a great team ethos, with all clinicians providing expertise and knowledge as part of their speciality, managing 200-300 patients per day.

The increased focus from the wider team on urgent care issues is releasing more capacity and enabling GPs to spend time managing more complex and long-term conditions.

Using digital tools to improve access to urgent care
Buckland Surgery, Newton Abbot

Buckland Surgery utilised funding from the Winter Access Fund implement a new digital triage system. The practice triaged all patients through their online consultation software, increasing their capacity to manage the demand and ensure people got the most appropriate care for their needs.

An increase of receptionists to answer the initial phone calls, and an increase in same-day urgent appointments and additional locum GP sessions also helped improve access.

The practice provided training for patients using online forms, improving their ability to access care this way, leading to a significant improvement in their clinical triage with patients receptive in accessing the practice digitally.

The practice can now better manage people's needs leading to a reduction in waiting times for urgent appointments, an improvement in patient experience, a reduction in complaints, and improved levels of staff sickness and morale.

6.4 Population Health Management (PHM)

The impact of the COVID-19 pandemic slowed our collective pace in the delivery of effective PHM so we will drive momentum as part of system wide reinvigoration. We can then understand and target underserved patient groups including children and young people and adults and children with mental health issues.

- The ICS will ensure any outstanding concerns regarding data governance and financial liability for data controllers are addressed
- ICS partners will work together to deliver in accordance with the NHS LTP and local policies
- PHM will identify gaps in care and the populations who will benefit most from a different approach to care
- Success will be measured by a decline in health inequalities
- Alignment to demonstrable patient need, PHM will help inform differential investment
- We will continually measure success and monitor outcomes to ensure investment is being made at the right time in the right place
- All practices signed up to the One Devon Data Set
- All PCNs achieving the requirements of the tackling health inequalities spec in the PCN DES
- All PCNs achieving step 3 on the PHM domain on the Maturity Matrix
- PHM fully embedded into PCNs, using data, working collaboratively with system partners, including the voluntary sector, at neighbourhood level. Develop new interventions to reduce inequity and improve patient heath and outcomes suitable and appropriate for the registered population.

Plant-based NHS lifestyle intervention
Coastal Primary Care Network, Dawlish and Teignmouth

The Coastal Primary Care Network is delivering one of the first plant-based lifestyle courses on the NHS. The intervention programme (Whole Life) is a 7-week online course for patients with the aim of supporting patients to live long and healthy lives through plant-based eating and daily activity.

The course supports people to change their eating habits and lifestyle and has seen improvements in blood pressure, weight and cholesterol in just 28 days.
www.wholelifeplantbased.com

6.5 Investment

Funding for Primary Medical Care (for delegated Primary Care commissioned services) is determined at ICB level through the use of a nationally calculated funding formula. This funding formula sets a needs-based target allocation for each ICB and where current funding levels differ from this target level a 'distance from target' value exists. NHS England then apply a pace of change adjustment to bring systems towards their target allocation over time, this adjustment is known as convergence.

For Primary Medical Care, the opening Devon ICB position for 2022/23 is that we receive less than our target allocation (based on population) by £8.1m (4%). In 2022 we received an additional £1.6m to being closing the gap by an initial 20% to £6.5m.

Although not yet confirmed we can reasonably assume that national allocations will continue at the same rate of change that will close the distance from target by 20% each year until the ICB is 2.5% away from target when is likely to be determined that we are close enough to target and no further adjustments will be made.

6.5.1 Funding principles

- Health inequalities will only reduce if we proactively support our services by investing equitably so we will differentially invest where there is greatest need
- We will use data such as deprivation scores to underpin any changes in how we will invest in General Practice.
- Workforce investment, training and development will be prioritised according to where recruitment and retention of staff is most challenging.
- The PCN estates toolkit will inform premises investment and, when available capital is made available, how the ICB will prioritise projects
- Working at scale across PCNs and with other health providers will be prioritised and ICS capital investment programmes will include supporting PCNs to work at scale.
- We will ensure rurality is part of differential investment especially as working at scale will be more challenging where PCNs operate across a large geographical area.
- We have committed to review Local Enhanced Services at LCP level to ensure what is commissioned meets the needs of our varied population and will be based on PHM identified needs.

7. Concluding remarks

"If General Practice fails, the whole NHS fails" - Roland and Everington

This Strategy reaffirms our priorities and ambitions as we embrace a major transition into an integrated system landscape. We are confident that we can effectively tackle the major barriers to progress and achieve our individual and collective ICS ambitions through collaboration and innovation.

Primary Care is the bedrock of healthcare provision in the NHS and General Practice has been described as the "jewel in the crown" of the NHS. Yet, perversely, it has locally been underfunded and criticised in comparison to other care providers. To some extent this reflects a failure to effectively showcase the activities and achievements of General Practice in a robust way, it is a fundamental flaw that the success of General Practice is not measured by its own achievements, but by the demand experienced in other parts of the health system.

Achieving our priorities in workforce, alongside our pivotal role within the ICS, will seek to repair this. General Practice has continued to function amidst unprecedented challenges including unmanageable demand, underinvestment, health inequalities and a workforce crisis, all of which were compounded by the pandemic. The remarkable adaptability of General Practice, exemplified by the pandemic, is a mammoth achievement and yet, at the time of writing, the national press coverage of General Practice reflects an underachieving service. In effect, General Practice has been 'busy surviving' a range of challenges for some years, preventing any time to stop, reflect and transform; we consider that now is the optimal time for a change in how we invest and work at scale.

The engagement work undertaken as part of this Strategy development showed that neither our General Practice community, nor our patients could give a unified response as to what it is that General Practice should look like or how it should be transformed. This demonstrates the range within General Practice as specialism and why this Strategy has identified key areas to address patient access and quality care.

As we enter this new phase, it is crucial to resolve this 'identity crisis' and be able to clearly define, in a united voice, what can reasonably be expected, as well as set out our expectations of our patients and system partners, underpinned by comprehensive literature reviews and national reports.

If we are to achieve General Practice that is sustainable and fit for the future, it will, alongside the whole health system, require a paradigm shift, for the benefit of its constituents, system partners and crucially, for our population. We look forward to working closely with our PCNs in the continued delivery of good General Practice and creating a sustainable model of care for the next 10 years.

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Glossary

AHP	Allied Health Professional
ARRS	Additional Roles and Reimbursement Scheme
BI	Business Intelligence
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CHC	Continuing Health Care
CPD	Continuous Professional Development
CQC	Care Quality Commission
DES	Directed Enhanced Service
DCCR	Devon and Cornwall Care Record
EA	Extended Access
ED	Emergency Department
EHR	Electronic Health Record
ETTF	Estates and Technology Transformation Fund
FTE	Full-Time Equivalent
GP	General Practitioner
HEE	Health Education England
HOPE	Helping individuals Overcome Problems Effectively
ICB	Integrated Care Board
ICS	Integrated Care System
LCP	Local Care Partnership
LES	Locally Enhanced Service
LHCRE	Local integrated Health and Care Record
LDC	Local Dental Committee
LMC	Local Medical Committee
LOC	Local Optical Committee
LPC	Local Pharmaceutical Committee
LTC	Long Term Condition
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
MECC	Making Every Contact Count
MIG	Medical Interoperability Gateway
MIG	Minor Improvement Grant
NWRS	National Workforce Reporting Service
NHSE	National Health Service England
PCN	Primary Care Network
PHM	Population Health Management
PM	Practice Manager
PMS	Primary Medical Services
PN	Practice Nurse
POD	Prescription Ordering Direct
PPG	Patient Participation Group
QEIA	Quality and Equality Impact Assessment
QOF	Quality and Outcomes Framework
SCR	Summary Care Record
SCR-AI	Summary Care Record – Additional Information
SLA	Service Level Agreement
STOMP	Stopping Over Medication of People
STP	Sustainability and Transformation Partnership
VTS	Vocational Training Scheme
WTE	Whole Time Equivalent

Appendix 1: List of Figures

NHS
Torbay and South Devon
NHS Foundation Trust

Quality Account

2021/22

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

Torbay and South Devon
NHS Foundation Trust

Quality Account 2021/22

Draft for Partner Review (Approved by Board on 29 June 2022)

Contents

Note that this draft document is complete with the following exception:

- Annex 1 / Annex 2 tbc following review by relevant system partners

ABOUT THIS DOCUMENT

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

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

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

- patient safety
- clinical effectiveness
- experience of care

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

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

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

1 INTRODUCTION AND STATEMENT OF QUALITY

About us

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

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

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

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

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

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

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

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

Our vision of excellent in quality

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

Our vision of excellent care means that we aim to:

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

Our quality goals

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

Our quality goals are:

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

Summary of our quality report

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

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

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

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

Liz Davenport

Chief Executive Officer, Torbay and South Devon NHS Foundation Trust

2.1 PRIORITIES FOR IMPROVEMENT

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

Priority 1 – Patient safety

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

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

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

To date we have been able to restore: -

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

Our patient safety focus also included:

- Responding to Care Quality Commission (CQC) recommendations

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

- Delivering the national “Sign up to safety” programme

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

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

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

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

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

- Duty of candour and incident investigation

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

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

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

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

- Pressure ulcer prevention

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

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

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

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

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

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

- Falls assessment, prevention and treatment

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

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

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

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

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

- Medications safety

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

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

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

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

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

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

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

- Pharmacy and Covid-19

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

Priority 2 – Clinical effectiveness

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

What we achieved:

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

Priority 3 – Patient experience

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

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

What we achieved:

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

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

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

IMPROVEMENT PRIORITIES FOR 2022/23 – THE YEAR AHEAD

Quality goal 1 – zero avoidable deaths

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

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

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

Quality goal 2 – continuously seek out and reduce harm

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

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

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

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

Quality goal 3 – excellence in clinical outcomes

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

We will measure improvements in our processes through:

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

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

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

Quality goal 4 – deliver what matters most to people

We will focus on two aspects here:

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

MONITORING AND REPORTING PROGRESS

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

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

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

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

2.2 STATEMENTS OF ASSURANCE

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

OVERVIEW OF SERVICES

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

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

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

CLINICAL AUDIT PARTICIPATION

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

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

During this period, we participated in 79% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2021/22 follow.

Participation in national clinical audits and confidential enquiries

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

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

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

Cases submitted to clinical audits and confidential enquiries

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation participated in, and for which data collection was completed during 2021/22, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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

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

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

OUR RESPONSE TO THE FINDINGS OF CLINICAL AUDITS

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

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

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

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

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

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

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

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

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

- Produce stickers for Direct oral anticoagulants (DOACs) prescription/ change to DOAC prescribing part of drug chart. To include documentation of weight, age and creatinine

- Doctors advised to ensure they include recommendation on Care Plan Summaries (CPS) for dosing

- To produce education posters for staff Induction and "Dr Toolbox 'App'"

- Remind all staff through Medical Unit meeting and meeting notes that all Doctors ensure they are looking at Pharmacist recommendations for dosing after 'meds reconciliation'

6639 Appropriateness of blood transfusion undertaken in the Medical Receiving Unit (MRU) and surgery

- Staff reminded at Acute Medical Unit (AMU) meeting to think is blood transfusion necessary for this patient? Consider alternatives such as starting iron

- Survey junior doctors on AMU to assess transfusion knowledge

- Deliver transfusion teaching session

- Introduce new transfusion proforma for AMU

6665 Surgical intervention for distal radius fractures (DRF): Are we adhering to standards?

- Devise a pathway for DRFs requiring operative management which ensures targets set by British Orthopaedic Association's Standards for Trauma (BOAST) are met

6673 Intramedullary Nailing (IMN) Femur

- To switch local audit to regional South West Orthopaedic Research Division (SWORD) project to confirm findings

- Surgeons encouraged to record whether the lag screw is locked in Static or Dynamic mode (potential of failure)

- All surgeons to consider longevity of the surgery in comparison to the rate of infection (i.e. the longer the operation the increased likelihood of infection)

6706 Management of Trauma patients with rib fractures - are they being managed appropriately in our trauma unit?

- Further study required to investigate physiology of patients

- Investigate location/ place for a networked rib fixation service at Torbay

6702 Identity (ID)/ Pregnancy check and consent in accordance with Nuclear Medicine Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017

- Consent forms should always be scanned onto Radiology information system (CRIS) and the issue will be communicated back to the Nuclear Medicine team

6705 Inpatient referrals to Rheumatology from acute and general medical wards

- Created a reminder poster for all junior doctors and placed it on notice board in acute and general medical wards across the hospital

- Raise awareness of need to fully complete white slip referral forms through Medical Unit meeting

- Educating medical junior doctors about importance of clinical information – blood tests and imaging for Rheumatology

- White slip Rheumatology referral poster emailed to all medical junior doctors

6675 Repeat General anaesthetic (GA) for tooth decay in Torbay and the use of radiographs for investigation

- X-rays to be taken for all teeth assessed for extraction that have decay

- Discussion with Oral and Maxillo Facial Surgery (O&MFS) department to explore potential changes. In particular:

- O&MFS letters to state if x-rays were enclosed in referrals

- O&MFS to consider x-rays during GA for pre-cooperative children who were unable to cooperate for x-rays awake or pre-operatively to consider sectional orthopantomograms

6643 28-Day Head and Neck Cancer Target

- Introduce and maximise the use of a "One stop" biopsy clinic

- Move to a "One week wait" referral to appointment standard

- Reminded clinicians when presenting results to clearly state diagnosis and its nature (benign/ malignant) in patient letters

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

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

RESEARCH

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

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

CARE QUALITY COMMISSION (CQC)

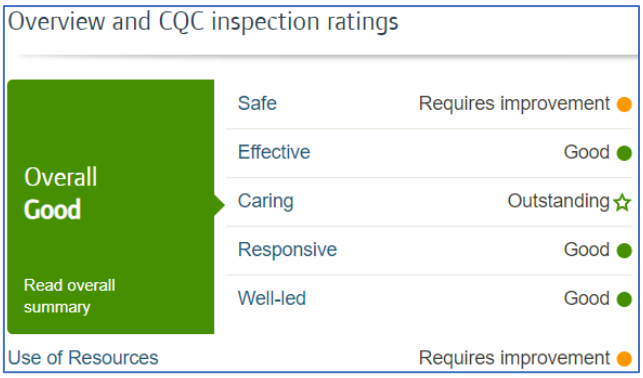
Torbay and South Devon NHS Foundation Trust is required to registered with the CQC and its current registration is to provide the following regulated activities:

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

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

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

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



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

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

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

DATA QUALITY AND INFORMATION GOVERNANCE

Torbay and South Devon NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

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

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

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

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

PAYMENT BY RESULTS CLINICAL CODING AUDIT

We have not been in receipt of a payment by results clinical coding audit by the Audit Commission. Instead, an annual data security protection toolkit audit of clinical coding has been completed. The audit was completed by an NHS Digital approved auditor

The key results are:

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

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

PATIENT MORTALITY

Learning from patient deaths

Mortality is reviewed each month by a multi-disciplinary team at the Mortality Surveillance Group. A mortality scorecard is presented to Board bimonthly by the Medical Director. We use analysis by Dr Foster to process hospital episode statistics (HES) data directly from NHS Digital to inform the monthly mortality review. The Hospital Standardised Mortality Ratio (HSMR) is measured from the mortality arising from a standardised 'basket' of 56 diagnoses. The HSMR was higher than expected for the summer months May to August 2021 but has reduced for the months September 2021 to January 2022. This is reflected in the rolling 12-month HSMR which is higher than expected at 107.3 but has reduced in the last three months. If mortality from all diagnoses analysed, the HSMR is 100.4 compared to an expected mortality of 100.

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

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

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

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

Mortality figures and reporting

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

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

2.3 CORE INDICATORS

Performance in 2021/22

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

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

Plans for 2022/23

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

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

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

3 OTHER INFORMATION

OVERVIEW OF SERVICES AND GOVERNANCE

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

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

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

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

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

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

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

PERFORMANCE AGAINST QUALITY STANDARDS

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

National and local standards

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

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

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

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

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

4 Hour Emergency Department ('ED') waiting times

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

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

Referral to Treatment (RTT) access times

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

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

Cancer standards

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

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

Diagnostics

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

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

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

Dementia Find

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

Equality of service delivery

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

Assurance and performance monitoring

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

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

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

ANNEX 1: PARTNER STATEMENTS

Statement from Council of Governors

[Tbc following Board approval]

Statement from commissioners

[Tbc following Board approval]

Statement from Healthwatch

[Tbc following Board approval]

Statement from OSC

[Tbc following Board approval]

ANNEX 2: DIRECTORS' RESPONSIBILITIES STATEMENT

[Tbc following feedback from partners in Annex 1]

Adult Social Care and Health Overview and Scrutiny Sub-Board Action Tracker

Date of meeting	Minute No.	Action	Comments
23/6/22	2	1. that the Torbay and South Devon NHS Foundation Trust continue to monitor the discharge improvement programme and report back to the Board at a future meeting; and 2. that the Trust be recommended that statistics concerning issues raised by the CQC be included in the dashboard of compliments and complaints.	Complete
23/6/22	3	1. that the Board noted that the current Adults Improvement Board would be revised and replaced with a newly appointed Adults Social Care Continuous Improvement Board, with an independent Chair, to provide the principal mechanism by which Torbay Council oversees the delivery of Adult Social Care, jointly with Torbay and South Devon NHS Foundation Trust. The Head of Governance Support be delegated authority to prepare the terms of reference and membership for the revised Board in consultation with the Cabinet Lead for Adult Social Care, the Director of Adult Social Services and the Chairwoman of the Adult Social Care and Health Overview and Scrutiny Sub-Board; and 2. that the overall governance structure for Adult Social Care (as set out in the submitted report), including the relationship with the newly appointed Adult Social	Complete

Date of meeting	Minute No.	Action	Comments
		Care and Health Overview and Scrutiny Sub Board, be noted.	
23/6/22	5	That, subject to the review of the Torbay and South Devon NHS Foundation Trust Draft Quality Account in July and the change to the date of the Torbay and South Devon NHS Foundation Trust Draft Quality Account to 2021/22, the Initial Adult Social Care and Health Overview and Scrutiny Sub-Board Work Programme for 2022/2023 as presented, be approved, and be kept under regular review by the Chairwoman of the Adult Social Care and Health Overview and Scrutiny Sub-Board and the Democratic Services Team Leader	Complete Work Programme updated.