Torbay and South Devon NHS Foundation Trust Quality Account 2025/26

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Part 1: Our Chief Executive's statement on quality

Chief Executive's Foreword

I am pleased to introduce our Quality Account for 2025/26, which reflects the care we provide, the progress we have made during the past year, and the areas where we know we must continue to improve.

Our Quality Account sets out, in an open and transparent way, how we are working to deliver safe, effective and compassionate care for the people of Torbay and South Devon. It is intended to provide a balanced account of where we have made progress, where care has improved, and where performance, experience and outcomes are not yet where we want them to be.

It has been another demanding year for our organisation and for the wider NHS. Demand for services remains high, our workforce has faced sustained pressure, and financial constraints continue to challenge how we deliver care. Despite this, I continue to be humbled by the dedication, professionalism and compassion shown by our people every day. Their commitment to patients, families and each other is what underpins everything we achieve.

Patient safety remains our highest priority. During the past year we have continued to strengthen how we learn from incidents through the embedding of the Patient Safety Incident Response Framework (PSIRF), supporting a more open, fair and learning-focused culture. We have seen tangible improvement in areas such as the identification and treatment of sepsis and we have continued to focus on reducing avoidable harm, while recognising there is more to do to secure sustained improvement across all services.

We have made important progress during the year, including sustained improvement in ambulance handover times and emergency department performance, reductions in some of our longest waits for planned care, and continued progress in embedding our electronic patient record. However, we must be equally clear about the areas where we are not yet delivering the standard of care our communities should expect. Despite improvement in flow, corridor care remains an unacceptable feature of periods of pressure and continues to impact on patient experience, dignity and safety. We also know that performance and outcomes remain challenged in a number of key areas, including stroke, cancer diagnosis and treatment pathways, diagnostics and some specialty services such as cardiology. These pressures are not experienced equally, and health inequalities continue to affect access, experience and outcomes for some of the people and communities we serve. Alongside the ongoing impact of winter and system pressure, this is why we have refreshed our strategy for 2026/27 and focused our five signature moves on the areas where we most need to improve quality, equity and resilience.

This year also marked a significant milestone with the introduction of our new electronic patient record, Epic. This is a major change for our organisation and an important foundation for providing safer, more joined-up and more personalised care. We are committed to ensuring that patient safety, quality and staff support remain central as we continue to embed this system and realise its benefits for patients and colleagues.

Delivering what matters most to our people is essential to delivering high-quality care. We continue to work to create a compassionate, inclusive and just culture where staff feel supported and able to speak up, and we remain committed to reducing health inequalities by making our services fair, accessible and responsive to the needs of our diverse communities.

This Quality Account highlights both what we are proud of and where we must remain focused. I would like to thank our people, volunteers, partners, patients and communities for their continued support and for working with us to improve care. Together, we remain committed to learning, improving and delivering the safest and best possible care for the people we serve.

Best wishes

Joe Teape

Chief Executive

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

What is a quality account?

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

Each year we collect information about the quality of the services we provide within three areas defined by the Department of Health and Social Care: patient safety; clinical effectiveness; and patient experience.

This information has been used to report on our progress against the priority areas we identified for improvement in 2025/26.

Our quality priority areas for next year, 2026/27, are also included. We have developed these in line with the CQC ‘we statements’, which are designed to put the person at the centre of their care.

2.1 Priorities for improvement 2025/26

Our quality improvement priorities for 2025/26 remained aligned with our quality goals and with our priorities for patient safety incident investigation. We have identified our improvement priorities for each of our quality goals using we statements.

Our quality goals

2.2 Quality priorities for improvement 2025/26

Figure 1: Quality priorities 2025/26

Quality Priorities 2025/26
Improve identification and management of sepsis
Strengthen the quality of our mental capacity assessments (MCA)
Safe Transition to EPR
Reducing elective and emergency care delays
Listening to our People
Reducing health inequalities
Embedding Equality Impact Assessment (EQIA)

Quality goal: We will continuously seek out and reduce harm

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

Our quality focus remains to improve our identification and management of people with sepsis to reduce the number of people in our communities who die from septic shock. We reiterated our commitment to promoting the early detection and treatment of sepsis and rolled out a sepsis audit across our organisation.

What we did and how we did

What we did

- ✓ Developed a single trust-wide sepsis policy
- ✓ Launched a trust-wide training and education programme introduction
- ✓ Agreed data collection for ongoing monitoring of compliance
- ✓ Improvement actions to support recognition and compliance of sepsis
- ✓ 2025 sepsis dashboard for all areas-in development

How we did:

We met every target we set out as part of our sepsis awareness and improvement programme. The final being the successful launch of our sepsis monitoring dashboard. Since its launch in September 2025, we have seen a sustained performance compliance for the Sepsis 6 across our acute and community in-patient areas for both adults and children. This is the first time we have been able to reliably report Sepsis 6 compliance across our organisation at both a patient and unit level. Since rolling out our sepsis policy and associated e-learning training we have seen this assurance maintained with our adult areas averaging 97% and our paediatric areas averaging 95% compliance. This is despite the continual operational demands and increasing attendance and acuity across our organisation.

Our ambition is to achieve more than 85% compliance with sepsis awareness training consistently. We are 73.8% compliant, but training was temporarily paused to support the implementation of our new electronic patient record, Epic and a full change over in our medical rotations. We will continue to support people to complete their training and achieve our compliance target once Epic is in place.

Figure 2: Compliance with Sepsis 6 bundle across all adult inpatient areas. (September 2025 – April 2026)

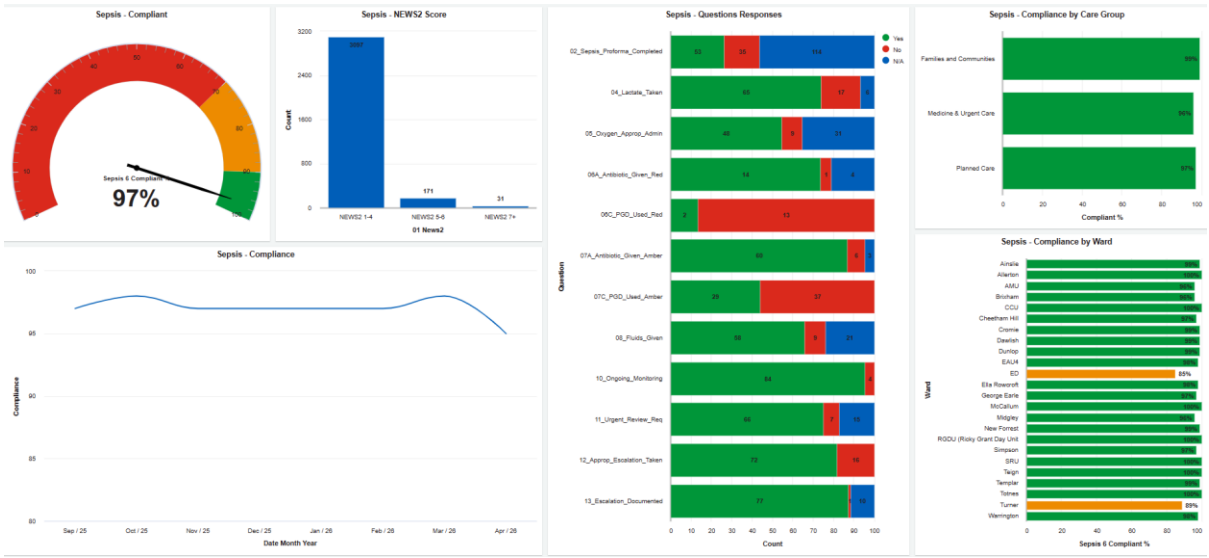
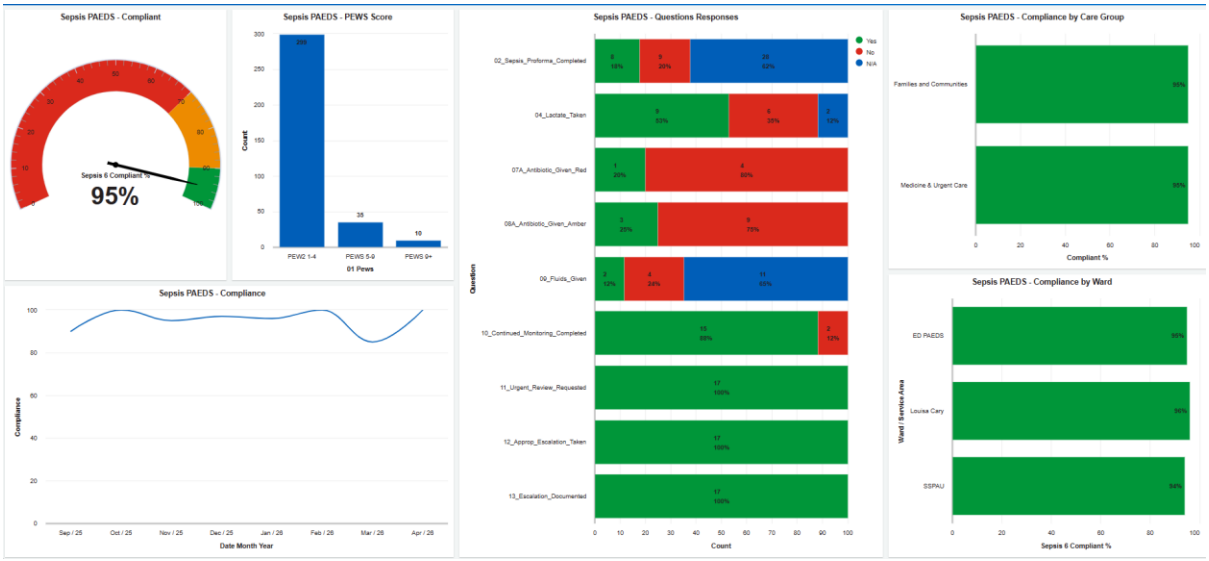


Figure 3: Compliance with Sepsis 6 bundle across all paediatric inpatient areas. (September 2025 – April 2026)



Priority two: Strengthen the quality of our mental capacity act assessments

We renewed our commitment to strengthening the quality of our Mental Capacity Act (MCA) assessments to better support our patients and enhance the quality of care.

How we did

We have taken significant steps to improve our mental capacity and Deprivation of Liberty Safeguards (DoLS) assessments.

We have strengthened our Mental Capacity Act (MCA) processes by combining the MCA assessment and Best Interest documentation into a single, integrated form, enabling a more holistic, person-centred assessment and clearer decision-making.

Our safeguarding adult and MCA leads have delivered tailored training to ward teams and provide direct support to clinical areas where DoLS are in place. This has enhanced the quality and consistency of MCA assessments, improved the standard of reviews, and strengthened oversight of restrictive practices.

We provide regular updates to our staff through ICONews and have developed a range of accessible resources, including an MCA app and practical flowcharts, which are available as part of our MCA resource pack. A programme of MCA audits has been scheduled during the next 12 months to systematically identify areas of strong practice and those requiring targeted support and improvement. These audits form a key component of our continuous quality assurance and improvement framework.

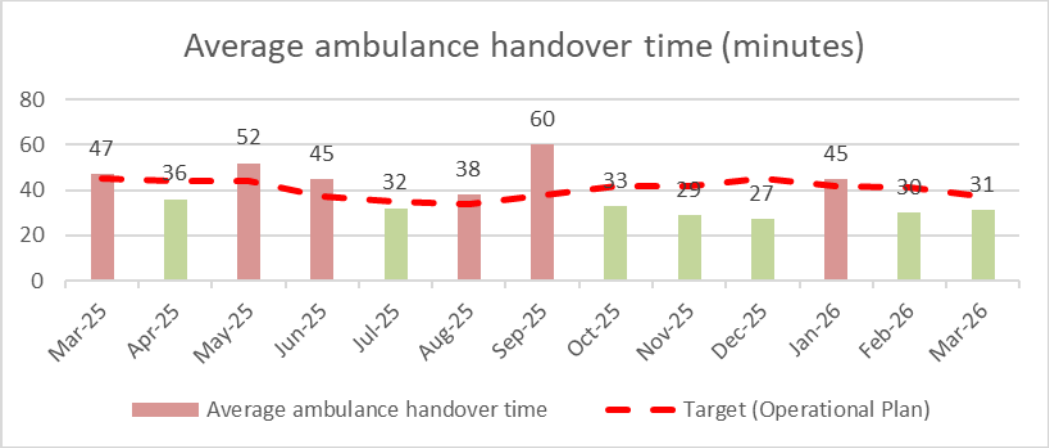
Strengthening compliance with the MCA will remain a focus for our clinical team. Our clinical teams will continue to be supported by our MCA leads to ensure decision-making is lawful, consistent and truly person-centred across all services.

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

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

Working with our system partners we continued to improve the quality and safety of care for patients across Devon to reduce ambulance handover delays. Devon's health and care system has seen a sustained improvement in reducing ambulance handover delays, which has resulted in a reduction in associated patient harm. Please see figure 4 below.

Figure 4: Average ambulance handover delays



We recognise that, in responding to system pressures and admitting people from ambulances to enable ambulances to get back on the road quickly, there has been an increase in the number of patients cared for in corridor areas. This is not the type of care we want to provide and can negatively impact patient experience, dignity and safety. Reducing corridor care will be a key quality priority for the coming year, with focused actions to improve patient flow and capacity across the system.

We have remained strongly focused on reducing long waits for planned care to improve outcomes for our population. During the past 12 months, we have reduced the number of patients waiting for elective treatment, and the table below demonstrates this sustained improvement. We recognise that any delay to planned care can have a significant impact on patients and their quality of life, and we continue to prioritise further improvement.

We have faced challenges in the delivery of elective orthopaedic care due to sustained levels of emergency admissions. In response, we have developed and implemented mitigation plans to address these pressures, including the recruitment of additional orthopaedic consultants and targeted actions to protect elective capacity. These measures are intended to support continued progress in reducing waiting times and improving access to timely treatment for our patients.

Table 5: No of patients awaiting elective treatment 2025-2026

	March 2025	March 2026
78 weeks	7	7
65 weeks	141	47
52 weeks	931	600

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

We launched our new One Devon electronic patient record, Epic, on 03 April 2026. Epic is a major enabler for service transformation, supporting the standardisation of clinical best practice and the delivery of safer, higher-quality care. It will be a cornerstone of our clinical quality and safety strategy, enabling more consistent, data-driven decision-making and improved continuity of care across the organisation.

Patient safety and quality have been central to our approach throughout the transition to Epic and we ensured that risks were identified and mitigated, and clinical engagement and leadership were embedded at every stage of the programme. Clinical leaders have been actively involved to support a safe and effective transition and maximised the clinical, safety, productivity and financial benefits of the system.

As part of the development of the business case, we undertook extensive staff engagement and delivered comprehensive training. Colleagues highlighted the significant challenges associated with operating multiple clinical systems and paper records, particularly for patients receiving care from more than one provider across Devon. The programme was informed by robust international evidence demonstrating that electronic patient records can improve patient safety, care quality and health outcomes.

The implementation of Epic is expected to deliver a range of benefits for patients and staff, including:

- An improved patient experience, with patients needing to tell their story only once, rather than repeating information at multiple points in their care journey
- Enhanced patient safety and outcomes through more accurate, timely information sharing and improved clinical decision-making, releasing more time for direct care
- Improved patient access to test results, appointment details and other information related to their hospital care through a single, secure platform
- Better access to information for staff, supporting more effective and informed clinical decisions
- Strengthened ability for teams to monitor patient outcomes and identify opportunities for continuous improvement
- Seamless sharing of patient information across acute and community services throughout Devon, supporting integrated care delivery.

We will continue to monitor the impact of Epic on patient outcomes, staff experience and quality of care as the system is embedded across our organisation and further integrated with the wider Devon health and care system.

Quality goal: Deliver what matters most to our people:

Priority one: We have committed to embedding PSIRF across our organisation, with a clear focus on supporting our people and fostering a just, learning culture where our people feel safe and confident to speak up if they see or experience incidents of harm. This commitment reflects our belief that learning from harm is most effective when it is compassionate, fair and focused on improvement rather than blame.

Our patient safety and people teams have worked together to progress this work, which is a key priority in Our Plan for Better Care and our wider commitment to delivering high-quality, compassionate care. This collaborative approach reflects a shared understanding that patient safety, staff wellbeing and organisational learning are intrinsically linked and must be addressed together to achieve meaningful and lasting improvement.

We are developing a robust, organisation-wide Restorative Just and Learning Culture (RJLC) programme, underpinned by a clear policy and governance framework. This will ensure a consistent, fair and transparent approach to learning from harm, incidents and concerns. The programme is designed to embed restorative and just principles across our safety and people processes, supporting a shift away from fear and blame towards openness, learning and accountability.

A core element of this work is the structured development of our leaders. Through a phased and planned approach, leaders will be equipped with the knowledge, skills and confidence to apply restorative practice in the design, implementation and evaluation of the RJLC programme. This includes supporting staff following patient safety incidents, undertaking fair and compassionate reviews, and creating psychologically safe environments in which concerns can be raised and learning is actively encouraged.

Quality goal: Reduce health inequalities:

We are committed to seeking out and reducing health care inequalities across our health and care system while continuously improving the quality of care. Work has continued within our care groups to identify and reduce health care inequalities to improve the health and wellbeing of our population. We have agreed to adopt the One Devon South Local Care Partnership's strategy to tackle health inequalities, and we will communicate this strategy widely within our organisation. Reducing health inequalities remains a core commitment, in line with the NHS values.

Embedding equality impact assessment (EQIA) in service change

EQIAs are a critical mechanism for supporting the delivery of high-quality, safe and equitable care. We are committed to ensuring all proposed service, pathway and policy changes are underpinned by a robust EQIA to ensure decisions actively consider their potential impact on different population groups. This approach supports the reduction of harm, improves health outcomes and helps address health inequalities.

During the past 12 months, we have reviewed and strengthened our EQIA process and embedded it as a core requirement within all change and transformation activity. This includes ensuring decisions about cost improvement programmes are explicitly

informed by their potential impact on quality covering safety, effectiveness and experience and on health inequalities, including access, experience and outcomes.

To support consistent and effective application, we have introduced a multidisciplinary panel approach to review EQIA submissions for any service change that may impact patients or staff. The panel considers identified risks and inequalities, and where a potential adverse impact is identified, teams are required to reconsider and revise their proposals to ensure appropriate mitigation is in place.

This approach is now firmly embedded within our change processes and provides assurance that equality considerations are central to decision-making. All of our cost improvement programmes having undergone an EQIA , ensuring that financial sustainability is achieved without compromising quality or equity of care.

Quality priorities 2026/27

During the past few years, we have made significant progress in improving, integrating and strengthening our services and partnerships, but we know there is still more to do. We have engaged staff, patients, carers and residents to help shape our future direction and refresh our strategy so that it reflects the evolving needs of our communities, our workforce and the wider health and care system. This work builds on the foundations of our integrated care model and aligns with the ambitions of the NHS 10-Year Health Plan.

Why we have refreshed our strategy for 2026/27

During the past year, we have continued to make progress in several important areas, including improved ambulance handover times, better emergency department performance, reductions in some of our longest waits for planned care and the introduction of Epic as a major enabler for safer, more joined-up care. However, we know that progress has not been consistent across all services or for all the people and communities we serve, and there remain significant areas where quality, access, experience and outcomes must improve.

Demand for urgent and emergency care continues to place sustained pressure on our services and, despite improvements in flow, corridor care remains an unacceptable feature of periods of operational pressure. We also know that performance remains challenged across several key pathways and specialties, including stroke, cancer diagnosis and treatment, diagnostics and cardiology. These issues affect timeliness of care, patient experience and, in some cases, clinical outcomes. Alongside this, winter pressure continues to test the resilience of our services and reinforces the need to build a more sustainable year-round model of care rather than relying on seasonal responses alone.

We also recognise that these pressures are not experienced equally. Health inequalities continue to shape how people access services, how quickly they receive care, and the outcomes they experience. If we are to improve quality in a meaningful and lasting way, we must address both overall performance and unwarranted variation across different communities and groups.

This is why we have refreshed our strategy for 2026/27. Our five signature moves are not separate ambitions; they are our response to the quality, equity and operational challenges we face. They set out how we will strengthen neighbourhood care, modernise acute and specialist services, improve coordination across pathways, use digital technology more effectively and support our people to deliver safe, compassionate and sustainable care. Our quality priorities for 2026/27 have therefore been developed to align with these strategic moves and focus improvement where it is most needed.

Our strategy for 2026–2031 details our five signature moves:

- **living well in our neighbourhoods:** working with communities to make care easy to reach and part of everyday life
- **reimagining acute and specialist care:** modernising hospital services and strengthening their links with community care, focusing specialist care where we can deliver the highest quality and safest care sustainably

- **joined-up care, every step of the way:** supporting people through every stage of their care, so transitions feel smooth and people get the right support throughout
- **smart use of technology for better care:** using digital tools and fresh thinking to make care more personal, connected and easier to access
- **caring, skilled people ready for tomorrow:** growing a compassionate, adaptable team and a positive culture, so colleagues feel valued and ready to meet changing needs.

These five signature moves provide the strategic framework for how we will respond to the quality, equity and operational challenges described above. They translate our refreshed strategy into practical priorities for improvement, ensuring that our focus for 2026/27 is not only on sustaining progress but on addressing the areas where performance, experience and outcomes remain most challenged. Our quality priorities for the coming year have therefore been selected to align with these strategic moves and target improvement where it will have the greatest impact for patients, communities and our people.

Our quality priorities for 2026/27 have been selected to address the areas where quality, access, experience and outcomes remain most challenged, and to deliver the greatest improvement through our five signature moves.

Collectively, these priorities are intended to improve the conditions for safer patient flow, stronger clinical pathways and timelier, coordinated care in areas where performance remains challenged, including stroke, cancer and diagnostics.

Quality priority 1

Ending corridor care by improving patient flow, discharge and neighbourhood-based support

Why this is a priority

People tell us they want care that is timely, coordinated and delivered as close to home as possible. However, pressure across urgent and emergency care, delays in discharge and limited flow through hospital pathways can result in avoidable waits, poorer experience and increased risk of harm. Corridor care remains unacceptable and does not reflect the standard of care we want to provide. Strengthening patient flow, reducing unnecessary admissions and improving access to neighbourhood-based support are therefore central to improving safety, dignity, continuity of care and year-round system resilience.

What we will do

- Improve internal patient flow through consistent use of clinical criteria, earlier senior review, proactive discharge planning and stronger daily flow management
- Reduce avoidable admissions by strengthening rapid community and neighbourhood responses for people with frailty, long-term conditions and urgent care needs
- Work with community services, primary care, social care and voluntary sector partners to improve timely discharge and reduce delays in transfers of care
- Use data and real-time operational insight to anticipate pressure, manage capacity safely and target action where corridor care risk is highest

- Ensure staff are supported to escalate concerns and maintain patient safety, privacy and dignity during periods of operational pressure

What success will look like

- A sustained reduction in corridor care and improved patient dignity and safety during periods of pressure
- Fewer avoidable admissions and readmissions, with more people supported safely at home
- Improved patient experience of access, flow, discharge and coordination of care
- Better continuity of support for people with frailty and long-term conditions, helping them remain independent for longer

How we will measure improvement

- Reduction in the number of patients receiving care in temporary escalation spaces
- Reduction in emergency admissions for agreed conditions
- Reduction in average length of stay for people aged 65 and over
- Improved patient-reported experience of flow, discharge and coordination of care
- Increased use of neighbourhood care services to support admission avoidance and timely discharge

Strategic alignment
Living well in our neighbourhoods; joined-up care, every step of the way; reimagining acute and specialist care

Quality priority 2

Strengthening engagement with our communities and workforce through listening, learning and a just culture

Why this is a priority

A compassionate, skilled workforce and meaningful involvement of patients, families and communities are essential to safe, high-quality care. If we are to improve quality in a lasting way, people must feel confident that concerns, feedback and incidents are listened to, responded to well and used to improve services. Strengthening a just culture and improving how we hear and act on what staff and patients tell us are therefore central to safer care, better experience and continuous improvement.

What we will do

- Create a just, learning culture where staff feel safe to report concerns, incidents and near misses and are supported to learn and improve
- Strengthen how learning from incidents, complaints, claims and feedback is captured, triangulated and shared across the organisation
- Strengthen patient, family and staff involvement in safety reviews, service redesign and quality improvement
- Improve staff confidence to speak up and strengthen visible, compassionate leadership in teams and services

- Make PALS, complaints and other feedback routes more accessible, responsive and easier to navigate
- Improve the timeliness, quality and consistency of complaint responses and the communication that supports them

What success will look like

- Staff feel supported, valued and confident to speak up and contribute to improvement
- Patients, families and communities feel listened to and involved in improving care
- Learning from incidents, complaints and feedback leads to measurable improvements in safety, quality and experience

How we will measure improvement

- Improved staff survey results relating to speaking up, culture, leadership and learning
- Improved quality of incident reporting, with clearer evidence of learning and action
- Improved patient experience measures relating to feeling listened to, involved and treated with compassion
- Improved timeliness and quality of complaint responses
- Evidence that learning from feedback leads to measurable improvements in quality and safety

Strategic alignment

Caring, skilled people ready for tomorrow
Joined-up care, every step of the way

Quality priority 3

Using digital technology and neighbourhood-based care to improve continuity, safety, equitable access and people's ability to live well at home

Why this is a priority

People increasingly need care that is coordinated across services, supported by timely access to accurate information and designed to help them remain well at home for as long as possible. Digital technology and neighbourhood-based models of care are key enablers of safer, more joined-up care, better patient and staff experience, and reduced reliance on avoidable hospital admission. If used well, they can improve continuity, support proactive care for people with complex needs, and help reduce unwarranted variation in access, quality and outcomes, including in pathways where performance remains challenged.

What we will do

- Embed Epic in a way that strengthens patient safety, clinical decision-making, information sharing and quality improvement across services
- Support neighbourhood and community teams to use shared digital records and data to proactively coordinate care for people with complex needs
- Improve the quality, accessibility and sharing of clinical information to support safer transitions between hospital, community and primary care services

- Use digital tools, analytics and population insight to identify unwarranted variation, improve equitable access and target improvement in neighbourhood-based care and key clinical pathways
- Provide staff with the training and support needed to use digital systems confidently, consistently and safely to improve care

What success will look like

- Improved continuity, safety and coordination during transitions between services
- More people supported to remain well and independent at home, with fewer avoidable hospital admissions
- Improved patient and staff experience of information sharing, communication and coordination across care pathways
- Better use of data and digital capability to reduce unwarranted variation, improve equitable access and strengthen quality across neighbourhood and clinical care pathways

How we will measure improvement

- Improved continuity and safer transitions between services
- Reduced delays, duplication and errors related to information sharing
- Improved staff confidence in accessing accurate, timely patient information
- Improved patient experience of coordination and communication across services
- Demonstrable improvement in agreed indicators for equitable access, information sharing, pathway coordination and quality outcomes, supported by digital tools and neighbourhood models of care

Strategic alignment
Living well in our neighbourhoods
Smart use of technology for better care
Joined-up care, every step of the way

2.3 Statements from our Board

Review and list of services provided by us

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

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

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

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

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

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

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

- Families and communities which includes adult social care
- Medicine and urgent care
- Planned care and surgery
- Children and Family Health Devon

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

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

Care Quality Commission (CQC)

We are registered with the CQC to provide care, and our registration is to be able to deliver the following regulated activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- family planning
- management of supply of blood and blood derived products
- maternity and midwifery services
- personal care
- surgical procedures
- termination of pregnancies
- transport services, triage and medical advice provided remotely
- treatment of disease, disorder or injury.

We have no conditions or restrictions attached to our registration.

Patient transport services were assessed by the CQC in July 2025 and received an overall rating of Good. During the assessment the CQC observed patient care and spoke with people using the service. People said they were well-supported, cared for and treated with dignity and respect. The inspection report can be found here.

Torbay Council's Local Authority Assessment of Adult Social Care was undertaken by the CQC in September 2025 and received an overall rating of Good. The report highlighted strong performance in co-production, integration, and person-centred care. A copy of the report can be found here

Our CQC ratings are:

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

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

Research and innovation

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

Our primary research business involves recruiting into national and international multi centre commercial and non-commercial studies as part of the National Institute for Health and Care Research Delivery Network (NIHR RDN) portfolio. In 2025/26 we recruited 1,439 participants to 67 NIHR RDN portfolio studies, across our clinical specialities.

We had the highest number of NIHR recruiting studies and we are the second highest recruiting Trust to commercial studies compared to similar sized organisations across England (NIHR benchmarking data for 2025/26).

Supporting the life sciences sector is a key objective for the government. We recruited 55 participants to 21 commercial trials. Our commitment to increasing commercial research activity means that research is a vital source of externally generated income for our organisation and provides an important alternative way to fund staff, equipment, and training.

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

- We were the first site in the UK to open and the first in Europe to recruit a patient to the COPERNICUS trial (a multi-centre international clinical trial in non-small cell lung cancer (NSCLC)
- We were the first site in the UK to recruit to the MEVPRO-3 prostate cancer trial
- We were the first site in the UK to open the Rosetta breast cancer study which focuses on triple negative breast cancer
- Top recruiter for the personalised onco-gene directed NSCLC lung cancer trials SOHO-02, Krascendo and Codebreak 202
- Torbay was one of the best recruiters to cancer vaccine studies in the UK with a large proportion of cancer vaccine studies open across four subspecialties. Specifically, we are the one of the highest recruiters to the personalised bladder cancer vaccine trials V940-005 and V940-011
- We are the only NHS recruiting Trust in the South West which is taking part in a ground-breaking cancer vaccine launchpad which is a way to treat patients on cancer vaccine trials
- We have been invited to become one of only seven Preferred Partner providers in the UK by the pharmaceutical company Novo Nordisk chosen from 350 sites it works with.

- We have increased the number of specialties getting involved in research, including opening our first commercial studies in podiatry, respiratory and intensive care
- We have been the fastest recruiting site into studies across several specialties including orthopaedics and breast care
- We have been the highest recruiting sites in the UK in various months for studies in stroke care (EASE), ophthalmology (DAME), hepatology (CIRRHOCARE), and physiotherapy (REACH)
- We have taken part in research supporting the government's three shifts for healthcare:
    - From hospital to community (CIRRHOCARE using wearables for home monitoring in patients with decompensated cirrhosis)
    - From analogue to digital: the ASSIST MS trial uses artificial intelligence to enhance MRI scans to guide treatment in patients with Multiple Sclerosis (MS)
    - From sickness to prevention (PANACEA trial) using a breath test to detect upper GI cancer.

- We have streamlined our study set up processes to support the government's 150-day study set up metric, give clear oversight of our research infrastructure capacity and ensure that studies open in a timely way, improving our relationships with study sponsors and increasing our reputation and profile as a reliable and high performing clinical trials delivery site.

We continue to build our local academic capability through various training schemes in partnership with higher education institutions, Health Education England (HEE), NIHR RDN, and the local charity the Torbay Medical Research Fund (TMRF).

In 2025, the first fellow on the TMRF-funded doctoral programme completed their PhD. We have made a successful bid to the TMRF for further pre-doctoral and doctoral fellowships to continue to offer opportunities for academic development to our people. We successfully applied for one RDN Research Associateship and two RDN-funded Chief Nursing Research Fellowships, joining a growing number of research-active clinical staff. Additionally, a further 13 of our clinical colleagues have completed the NIHR Associate Principal Investigator training programme; gaining invaluable learning and the practical skills associated with leading clinical research delivery.

We held our third Nursing, Midwifery and Allied Health Professional Research conference showcasing the work being undertaken by our research delivery team as well as people across our organisation involved as users of research, active in research and research leaders.

We successfully secured £88,000 of NIHR funding for our pharmacy unit. A large proportion of this funding went towards purchasing a new isolator key to meeting the demands of a recent pharmacy audit. This will ensure we have a sufficient back up in case our main isolator goes down, providing crucial resilience for our aseptic unit.

We invested more than £15,000 into renovating a room on our icky Grant cancer day unit to support the administration of research Systemic Anti-Cancer Therapy (SACT). This room is used to treat trial and non-trial patients. The renovation including increasing the capacity from one treatment chair to two.

Operational performance

As an organisation we are no longer in special measures and are in segment 3 for performance and finance. We have collaborated with commissioners and system partners to meet the improvement targets set out by the national and regional NHS England teams and this remains a core area of focus for us for 2025/26.

Our urgent and emergency care performance

During 2025–26, we delivered a sustained programme of urgent and emergency care (UEC) recovery and improvement, aligned to national priorities and system expectations. This has been driven through our UEC recovery programme, supported by the improvement and innovation (I&I) team, and reinforced through participation in the NHS England four-hour breach sprint to March 2026.

Key improvements have focused on patient flow, with opening of the non-admitted pathway zone of our emergency department (ED), building on and supporting wider ambulatory pathways, strengthened demand and capacity management, and a sustained emphasis on reducing length of stay and exit block. These actions were a core component of our 2024/25 and 2025/26 winter plans and contributed to improved emergency department waiting times and ambulance handover performance during periods of extreme pressure. Getting It Right First Time (GIRFT)_has gone so far as acknowledging our improved handover times via the Timely Handover Process, by creating a case study applauding the improvement by more than 60% in handover times but also the collaborative work throughout the organisation via the Your Next Patient flow initiative.

Access to urgent care has been further improved through the commitment to community urgent care services via Newton Abbot's urgent treatment centre and Totnes' minor injuries unit, which uses a bookable appointment model, reducing avoidable emergency department attendances while supporting local access.

Alongside operational recovery, significant progress has been made during 2025/26 on the £14.2million redevelopment of our ED, which is due to be completed in spring 2026, and a the approval of a supporting clinical workforce business case to offer further clinical skill and resilience out of hours. This work integrates clinical redesign, demand and capacity modelling being driven by a new ED six-month stabilisation plan to ensure that immediate recovery actions are aligned with longer□term capital investment to support safer, more dignified and sustainable emergency care.

Stroke service performance

We were identified as an outlier for 30-day mortality following stroke, as measured by the Sentinel Stroke National Audit Programme (SSNAP), for the reporting period 2021/23. In response, we undertook a series of structured judgement reviews, which identified key contributory factors, including delays in patients reaching the stroke unit, with mean times outside the national average, and delays in being reviewed by a stroke consultant, which were also outside national targets.

Although improvements were demonstrated, we were notified that we remained an outlier for the subsequent reporting period 2023/24. In May, we were visited by Dr David Hargroves, National Clinical Director for Stroke, who subsequently wrote to us in September outlining key recommendations for improvement. A number of these

recommendations aligned with work already underway regionally through the Peninsula Acute Sustainability Programme (PASP). The recommendations acknowledged improvements in thrombolysis rates, a key intervention associated with improved stroke mortality, during and following the most recent mortality reporting period, while also identifying further changes required to strengthen the overall pathway.

Work to refresh and strengthen the stroke improvement plan began immediately and remains ongoing. A whole-pathway mapping session was held with key stakeholders from across the stroke pathway, followed by further focused sessions to explore specific areas in greater detail. As a result, changes are being implemented to the stroke standard operating procedure, including the ring-fencing of beds for stroke patients. We also began using a new thrombolysis drug in line with national guidance, and further work is underway to reduce time spent in ED to maximise opportunities for patients to access thrombectomy where clinically appropriate.

At indicator level, SSNAP comprises 40 indicators across seven domains, and we are now seeing sustained improvement in many measures, with performance in line with, and in some cases exceeding, the national average. While these improvements take time to translate into overall domain scores, the most recent published SSNAP results (October–December 2025) demonstrate improvement at domain level for both George Earl and Templer stroke teams, although overall ratings remain at E and D respectively. We remain committed to continued improvement in stroke care, with a clear focus on reducing unwarranted variation and improving outcomes for patients.

Our cancer care performance

In 2025/26, we received 25,145 Urgent Suspected Cancer (USC) referrals, representing a 10% increase compared to last year (an extra 190 referrals a month), with nearly all suspected cancer tumour types contributing to this rise.

A number of factors challenged our cancer waiting times performance in 2025/26, namely industrial action and referral increases. Here is how we performed against the key national cancer standards:

28-day Faster Diagnosis Standard (FDS): This standard expects that patients receive a definitive diagnosis (either diagnosis or ruling out of cancer) within 28 days of referral. Although we ended the year ahead of the national target of 75% and achieved the FDS seven out of 12 months, the annual average was 72%. There are a few complex diagnostic pathways, which have a significant impact on the overall performance, for example urology and colorectal, which remain our focus areas both locally and regionally in 2026/27.

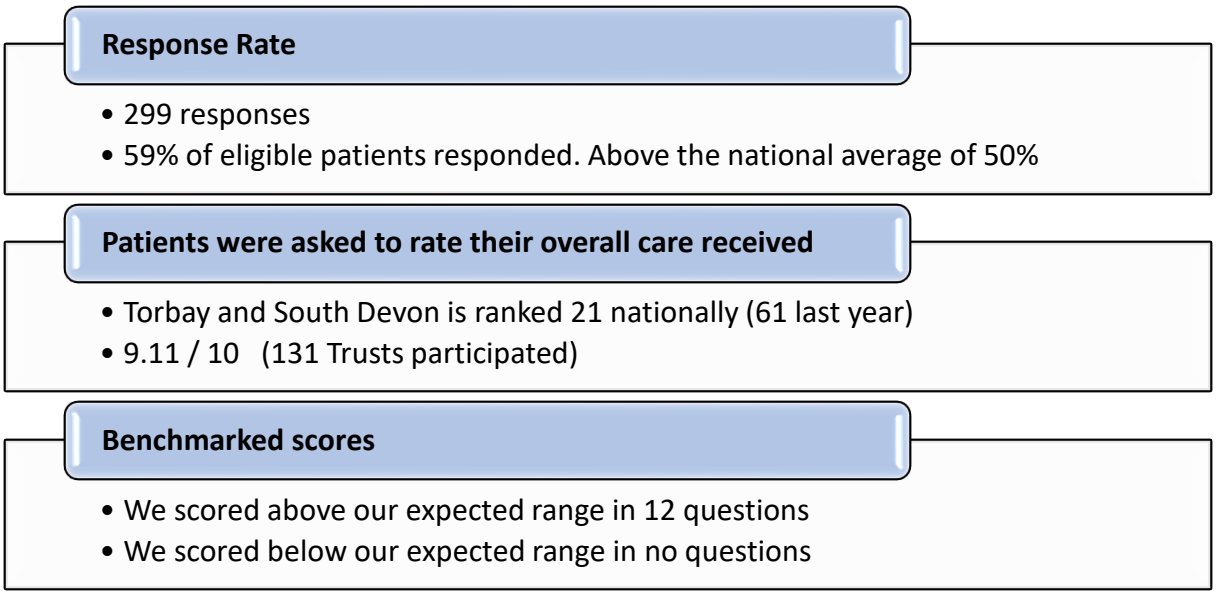
62-day referral to treatment standard: This standard measures the percentage of patients who start their first definitive treatment for cancer within 62 days of an urgent GP referral. In March 2026, the national target of increased from 70% to 75%. We treated 2,162 patients for cancer, with 68% of them having treatment within 62 days.

National Cancer Patient Experience Survey (NCPES)

The annual national patient experience survey is commissioned and run by NHS England. It surveys all adult patients with a confirmed primary diagnosis of cancer who received cancer-related treatment in the months of April, May and June 2024. The results were published in July 2025.

We were ranked 21 out of 131 organisations when our patients were asked to rate their overall care received.

Figure 6: National cancer patient experiences survey results:



Our planned care performance

As set out in our quality priorities, we remain firmly committed to reducing waiting times for elective care and improving outcomes for the people we serve. During the past year, we have continued to make steady and meaningful progress despite significant operational pressures.

All specialties have achieved further reductions in elective waiting times, reflecting the sustained efforts of our clinical and operational teams to optimise capacity, streamline care pathways and prioritise people who have waited longest. This improvement has been delivered alongside continued high demand for planned care services.

Building on the progress made in previous years, we have begun refurbishment works on two operating theatres and the construction of a new operating theatre following approved capital investment. These developments are progressing well and once completed in mid-2026/27, will provide additional surgical capacity, supporting further reductions in waiting times and improved resilience across our elective programme.

Our ophthalmology service continues to strengthen our diagnostic and treatment capability. Approval has been secured for a new ophthalmology imaging hub, with a 30-week build programme now underway. This development will significantly increase imaging capacity, enabling faster diagnosis and supporting earlier treatment for people referred to the service.

We have also secured approval for a new oral and maxillofacial surgery, restorative dental and orthodontic suite. This investment will provide modern, fit-for-purpose clinical facilities to support these high-demand services and is scheduled for completion in 2026/27, representing a major step in ensuring the long-term sustainability of specialist dental and maxillofacial care.

We will continue to focus on reducing elective waiting times as these capital developments are delivered and additional capacity becomes available. We remain committed to providing timely, high-quality elective care and to ensuring that people in our communities receive the treatment they need as quickly and safely as possible.

Community services

We have made significant progress in strengthening community services to support people to remain at home and avoid avoidable hospital admission, with a particular focus on people living with frailty.

A more integrated model of care has been developed across community services, acute care and wider system partners, enabling earlier identification of need and a more proactive, coordinated response. Central to this has been the expansion of services delivering care closer to home, including virtual wards and enhanced community response services. These models enable more people to receive timely assessment, treatment and monitoring in their own homes, reducing the need for hospital admission.

While supporting timely discharge from hospital remains important, our focus has shifted towards admission avoidance. Where hospital care is required, pathways have been strengthened to ensure people return home as soon as they are clinically able. Discharge to Assess and intermediate care services continue to play a key role in supporting recovery and rehabilitation in a home or community setting.

Urgent community response services remain central to this approach, providing rapid assessment and intervention for people at risk of deterioration. Closer working between urgent response teams, virtual wards and community services has improved coordination, consistency and continuity of care.

Access to community services has also improved through changes in how care is delivered. Increased use of digital consultations and more flexible assessment models have supported reduced waiting times and improved patient experience, alongside a continued focus on prevention and supporting independence.

There has been a renewed focus on ensuring community hospital beds are used appropriately for those with the greatest need. Strengthened multidisciplinary review processes and closer alignment with discharge and community teams have improved patient flow and reinforced delivery of care in the most appropriate setting.

Community services: quality and safety

As the complexity of care delivered in community settings has increased, we have placed a strong emphasis on ensuring services remain safe, responsive and sustainable.

Workforce models have been reviewed and strengthened, with safer staffing approaches now embedded across community hospitals and community nursing teams to better reflect patient acuity and care needs. Enhanced use of data and

quality metrics has supported improved real-time oversight, enabling earlier identification and management of risk.

Demand and capacity modelling has continued to develop, providing a clearer understanding of system pressures and supporting more effective planning across community services. This is particularly important as more care is delivered outside of hospital environments, including virtual wards and home-based pathways.

Community services: innovation and supporting independence

A key area of development has been the transformation of services for people living with frailty. A dedicated frailty hub, called The Harbour, was established at Newton Abbot Community Hospital, providing a coordinated approach to assessment, urgent care and ongoing management. This model is supported by closer working between community teams, primary care and system partners, enabling more timely and consistent care.

The frailty virtual ward has also expanded, offering an effective alternative to hospital admission through multidisciplinary assessment, monitoring and treatment delivered in people's homes. This has strengthened the overall frailty pathway, with an increased emphasis on early intervention, proactive care planning and maintaining independence.

Partnership working has been integral to this progress, including collaboration with NHS Devon and South Western Ambulance Service NHS Foundation Trust to reduce avoidable conveyance to hospital and improve patient outcomes.

The use of technology-enabled care continues to grow, supporting more personalised and flexible approaches to care delivery. This includes wider use of remote monitoring and digital consultations, alongside preparation for the introduction of a new electronic patient record.

Preventing deconditioning and supporting independence has remained a key priority. Training programmes are now embedded across community services to ensure staff are equipped to support people to maintain mobility and function during periods of illness and recovery.

0-19 service

Torbay's 0–19 service had another successful year. Family Hubs were rebranded as Best Start in Life, and Torbay secured grant funding for a further three years. While all local authorities now receive Best Start in Life funding, Torbay's role as a trailblazer site has enabled the area to secure additional funding for Best Start Healthy Babies. This will support the continued delivery of the infant feeding and perinatal infant mental health workstreams.

During the year, Torbay's public health nursing service hosted a visit from the Mission Delivery Unit which reports back to Downing Street. The service was recognised as an example of good practice, and the purpose of the visit was to gain insight into the quality of our 2.5-year health and development review. As part of the visit, we showcased the newly refurbished St Edmund's Best Start Family Hub.

A key achievement for the 0–19 service has been the integration of colleagues from Action for Children with public health nursing on to Epic. During the past year, significant work has been undertaken to develop and configure the system to meet

the needs of both services. A series of engagement and training sessions has also been delivered to support people through the transition.

The introduction of the sign-in app across Best Start Family Hubs has streamlined processes and enabled faster check-in for families, while providing staff with real-time data. Since its implementation, this has resulted in a 164% increase in the unique reach of parents and carers, and a 150% increase in the reach of babies and children.

Perinatal services

Our maternity assurance arrangements remain aligned with national expectations, including the NHS England Perinatal Quality Oversight Model (2025) and the Three-Year Delivery Plan for Maternity and Neonatal Services (2023). These frameworks provide a strong foundation for the systematic monitoring of safety, quality and outcomes across maternity and neonatal services.

Following the CQC's inspection in 2023, a number of areas for improvement were identified, particularly in relation to safety and leadership. The inspection highlighted the need for strengthened oversight and more rapid progress in addressing known risks, while also recognising the commitment of our staff and several areas of good practice. These included effective safeguarding arrangements and targeted action to reduce health inequalities.

In response, we have strengthened our improvement planning and enhanced clinical leadership in maternity services. Actions have been accelerated in key areas, including triage, risk management and workforce sustainability, to support safer care and more effective oversight.

Our assurance framework also incorporates the standards set out in the Maternity Incentive Scheme (MIS) within the Clinical Negligence Scheme for Trusts (CNST). Oversight of MIS requirements is provided through the Maternity Governance and Quality Group, which ensures that learning from incidents, audits and reviews is systematically considered and translated into improvement actions. As a result of this work, the maternity team successfully delivered all Year 7 MIS safety actions, securing the associated financial incentive for our organisation.

Key performance indicators and quality metrics are routinely reviewed through our quality and safety assurance groups and reported formally to the Board. This approach provides transparent organisational oversight, supports timely escalation of risk and ensures continued focus on improving safety, leadership and quality within maternity services

Birth rate

During 2025/26, there were 1,725 births within the service, compared with 1,672 births in 2024/25, representing a modest increase in activity.

Alongside overall birth numbers, the service continues to experience increasing complexity across pregnancy and birth care, including a high level of safeguarding activity within the community. This reflects changes in population demographics, widening health inequalities and rising clinical acuity. We are caring for a growing

number of women with multiple long-term health conditions, as well as those with complex social circumstances and diverse needs, resulting in an increased requirement for enhanced surveillance and multidisciplinary support throughout the antenatal, intrapartum and postnatal period.

Demand for obstetric intervention has also increased, placing additional pressure on workforce capacity and service infrastructure. These factors continue to inform our workforce planning, service redesign and quality improvement priorities to ensure that care remains safe, responsive and equitable for women and their families.

Maternity and Neonatal Improvement Programme

The maternity service entered the Maternity Safety Support Programme (MSSP) in July 2024 following Devon's inclusion in the national recovery support process. During the past year, we have worked closely with our national improvement adviser through the Maternity and Neonatal Improvement Programme (MNIP) to strengthen safety, governance, and leadership across maternity and neonatal services.

We have continued to receive enhanced and targeted support in 2025/26 from NHS England as part of the MatNeo improvement support team (formally the maternity safety support programme) This has enabled intensive focus on areas of improvement particularly to support a strengthening of culture and governance.

A comprehensive improvement plan has been developed jointly, setting out actions, milestones, and expected outcomes in response to concerns identified by the CQC and national bodies.

Governance and reporting arrangements have also been strengthened, including clearer escalation pathways and improved alignment with Trust-wide quality and safety structures. This external support has provided constructive challenge and expertise, helping us to accelerate improvement and embed safer systems for the future.

Perinatal mortality rate

The graph below sets out perinatal mortality data for 2025/26. During this period, the service recorded five stillbirths, two late fetal losses and five neonatal deaths.

While there is no single nationally agreed definition of avoidable perinatal mortality, every case is reviewed with rigour, openness and sensitivity. Trends in perinatal mortality are reviewed in detail through our mortality surveillance group, and all individual cases are subject to further independent scrutiny via the Child Death Overview Panel (CDOP). This robust, two-stage review process supports:

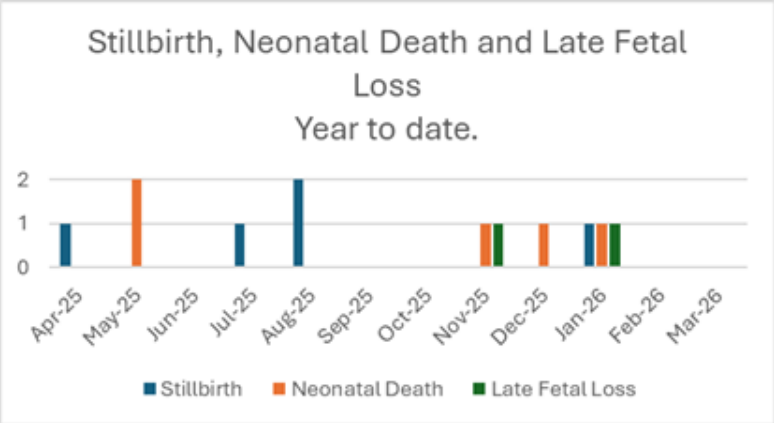
- shared learning and continuous improvement
- identification of contributory and modifiable risk factors
- consideration of local and system context
- consistent, high-quality case review through the use of the Perinatal Mortality Review Tool (PMRT)

In addition, targeted oversight of perinatal deaths from 2025/26 has been provided by colleagues from the national perinatal improvement team, offering external assurance and expert challenge.

We continue to operate within the nationally mandated Perinatal Quality Oversight model, which provides a structured approach to monitoring safety, identifying emerging risk and supporting sustained improvement in maternity and neonatal outcomes.

This work is delivered as part of a whole-system approach through the Devon Local Maternity and Neonatal System (LMNS). We remain fully compliant with NHS England reporting requirements and actively contribute to system-wide learning and improvement, supporting safe, equitable and responsive maternity and neonatal care across Devon.

Figure 7, stillbirth, neonatal and late fetal loss data



Adult social care

During 2025/26, adult social care played a vital role in supporting people to live safely, independently and well, despite sustained demand, workforce challenges and ongoing financial pressures. Services supported more than 2,800 residents with increasingly complex needs, alongside a growing population of unpaid carers, which increased by 6.9% to 5,764 people.

A continued focus on prevention and early intervention delivered measurable benefits for people and the wider system. Safeguarding concerns reduced by 12.4% and satisfaction with services remained high, with 88% overall satisfaction and 98% positive feedback from Easy Read surveys. The reablement pilot demonstrated particularly strong outcomes, with 79% of participants regaining full independence and requiring no ongoing package of care.

Improvements at the point of access to services, strengthened hospital discharge pathways, closer partnership working with the voluntary sector and the expanding use of technology-enabled care have all supported more timely and appropriate interventions. These approaches have helped to prevent unnecessary escalation to long-term statutory support, improved flow across health and care pathways, and delivered better outcomes for people. In March 2026 our board formally gave notice on the current Section 75 agreement with Torbay Council to provide adult social care services for Torbay residents due to rising gap between the cost of delivering adult social care and the funding available each year.

There are no immediate changes to anyone's care and services will continue as they do now. We will continue to work with Torbay Council and NHS Devon to carefully transition services and our people to the council by April 2027. We remain committed to integrated working and will continue to embed strengths based, person-centred care across our services, while working closely with our partners, including the voluntary sector.

Core indicators

In addition to reporting performance against the statutory indicators for regular assessment, a range of further quality indicators are reported to our Board of Directors. The table below summarises the latest monthly performance against the selected key national indicators.

Table 2. Core Indicators

Other national and local indicators	Quality indicator	Target 2025/26	2025/ 26	2024/ 25	2023/ 24	2022/ 23	2021/ 22
Did Not Attend (DNA) rate (Year To Date)	Effectiveness	3.5%	5.1%	4.9%	5.0%	5.1%	5.4%
Stroke care: 90% of time spent on stroke ward (YTD)	Effectiveness	80%	76.2%	71.9%	70%	57.1%	54.8%
Two-hour urgent community Response (YTD)	Effectiveness	80%	90.4%	88.6%	95.5%	78.9%	xxx
Mixed sex accommodation breaches of standard (YTD)	Experience	0	2138	1688	42	0	0
52-week referral to treatment incomplete pathways year end position (March snapshot)	Experience	0	607	947	1817	4427	3,199
Cancelled operations on the day of surgery (YTD)	Experience	<0.8%	0.9%	1.1%	1.3%	1.7%	1.5%
Never events (YTD)	Safety	0	2	6	0	3	0
Cancer 28-day Faster Diagnosis (YTD)	Effectiveness	75%	72.0%	78.8%	77.9%	72.1%	67.1%
Diagnostic waits greater than six weeks (March snapshot)	Effectiveness	5%	37.0%	31.8%	21.3%	31.2%	36.8%
Fractured neck of femur – time to theatre (YTD)	Effectiveness	90%	60.5%	71.%	57.1%	54.5%	78.8%

Performance plans for 2026/27

We have submitted operational plans that meet the requirements of the operating framework for 2026/27. The additional activity will be met through improved productivity across theatres and outpatients and additional funding from commissioners using the Elective Services Recovery Funding (ESRF) for activity delivered above the 2019/20 baseline.

The key 2026/27 operational performance targets are:

- improve referral to treatment waiting times with 7% improvement to 73.8% of patients waiting less than 18 weeks from referral to treatment by March 2027;
- reduce patient delays in the urgent and emergency care setting to achieve 82% of people seen within four hours by March 2027;
- improve diagnostic waits so 85% of people wait less than six weeks by March 2027
- meet the cancer standards for faster diagnosis (28 days) 80% and treatment within 62 days from urgent referral 80% by March 2027.

- Secondary uses service and **data driven quality improvement (DQIP)**

We submitted records during 2025/26 to the secondary uses service (SUS) to include in the hospital episode statistics (HES). These are included in the latest published data.

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

NHS number status - APC: including day cases and inpatients

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
NHS No Status Indicator	102,586	0	5	100.0%	99.8%	98.2%	99.7%
NHS Number	102,586	102	0	99.9%	99.7%	99.8%	99.7%

- NHS Number Status – OPA: Outpatient Attendances:

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
NHS No Status Indicator	498,222	0	0	100.0%	99.9%	98.5%	99.8%
NHS Number	498,222	87	0	100.0%	99.8%	99.9%	99.8%

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

- Registered GP practice – APC including day cases and inpatients

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Registered GP Practice	102,586	0	41	100.0%	99.9%	100.0%	99.8%

- Registered GP practice – OPA: outpatient attendances

Data Item	Provider Total	Provider Missing	Provider Invalid	Provider % Valid	ICB* % Valid	Region* % Valid	National % Valid
Registered GP Practice	498,222	0	198	100.0%	99.7%	99.4%	99.6%

The data security and protection (DSPT) toolkit is an online self-assessment tool that allows organisations to measure their performance against the national data guardian's 10 data security standards. We met all standards during 2024/25. Our 2025/26 DSPT is due for completion 30 June 2026, we are on track to submit with Standards Met.

Clinical coding performance

An annual data security protection toolkit audit of clinical coding has been completed. The audit was completed by an NHS Digital-approved auditor.

Data security and protection toolkit (DSPT) audit results are:

Table 3: Data security and protection toolkit (DSPT) audit results

Primary diagnosis (% correct)	Secondary diagnosis (% correct)	Primary procedure (% correct)	Secondary procedure (% correct)
98.62	87.46	97.45	94.35

Clinical audit

We reviewed the reports of 29 national clinical audits from 01 April 2025 to 31 March 2026. Please see Annex 4 for the actions we intend to take to improve the quality of healthcare provided.

We reviewed the reports of 40 local clinical audits from 01 April 2025 to 31 March 2026 and 15 did not require any actions. Please see Annex 4 for the actions we intend to take to improve the quality of healthcare provided.

Children and Family Health Devon (CFHD)

Quality achievements during 2025/26

During 2025 / 2026, the CFHD key quality priorities were to improve patient experiences of our services, strengthen provision of evidence-based interventions and embrace innovation / Quality improvement. CFHD services continued to deliver safe and effective care throughout the year, despite significant pressure from rising demand, particularly for mental health, neurodiversity, and SEND-related services. Clinical quality, safeguarding, and risk are monitored closely through the Quality Committee, with issues reviewed every month and actions tracked through formal governance processes. Learning from incidents, complaints and feedback is routinely shared with teams to improve services and reduce future risk.

The achievements include

- Our CYP Participation group producing a film featured in BBC Spotlight and BBC website on 'Devon's young people leading the way on children's mental health.'
- Embracing innovation through the pilot of AI tool in clinical practice. This demonstrated reduction in administration burden on clinicians (releasing clinical time) and wider trust wide implementation of Ambient Voice technology is now being considered.

- Implementing evidence-based intervention: Dialetical Behaviour Therapy project was rolled out to provide evidence-based treatment for CYP with self-harming, impulsive risk taking and emotionally unstable personality traits.
- Improving patient experience by significantly reducing waiting list for mental health assessments, from over 70 weeks to less than 18 weeks.
- Increasing our participation in research activities.

Research, audit and service evaluation

CFHD has strengthened its approach to learning and improvement through a wide range of research, audits and service evaluations. These projects focus on developing better treatments, understanding outcomes for children and young people, and improving how services are delivered.

Areas of work include:

- Strengthening support for children with cerebral palsy
- Improving mental health interventions
- Reviewing national clinical standards for children with complex needs.

This work helps ensure care is based on evidence, continually reviewed, and shaped by learning to improve outcomes for children, young people and families across Devon

Figure 1 – Examples of ongoing research, audit and service evaluation work across CFHD

Improving access and waiting times

- Many CFHD services are meeting expected waiting times, including community nursing, physiotherapy, children's wellbeing support, urgent care, and services for children in care.
- Performance in the **Mood, Emotions and Relationships (MERs)** pathway improved significantly during the year, with children and young people increasingly being offered assessment appointments within the 18-week standard. Refer to Figure 2

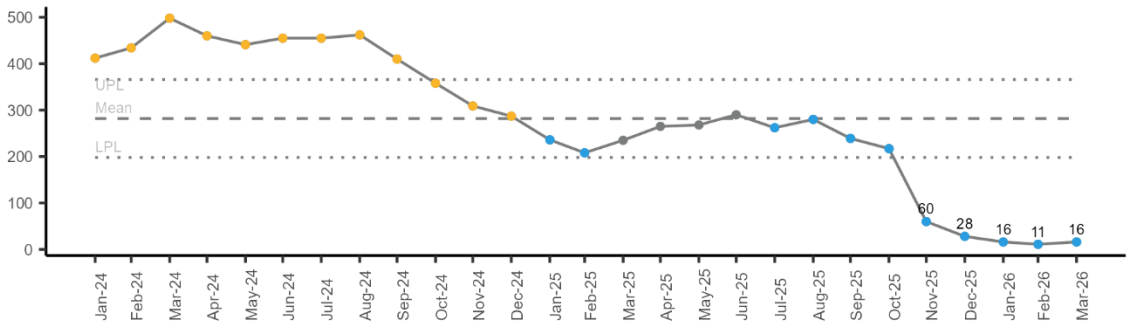


Figure 2 – MERs numbers of CYP waiting over 18 weeks for initial assessment.

Learning disability and neurodiversity services

- CFHD continued to develop specialist learning disability services, including early intervention, sleep support, positive behaviour support, and psychological wellbeing for children and young people with learning disabilities.
- New roles, training, and specialist pathways were introduced to strengthen support for families and improve earlier intervention.
- Significant work took place to reduce long waits for autism assessments through joint working with NHS partners, local authorities, and NHS-approved independent providers. This helped more children to be seen sooner while ensuring diagnoses are recognised for education, SEND and EHCP support in Devon.

Children's mental health support

- Mental health services focused on strengthening early assessment, improving triage, and increasing access to evidence-based interventions such as DBT, EMDR and family-based approaches.
- Cross-pathway working and multi-disciplinary team (MDT) discussions were expanded to ensure children receive the right support without unnecessary duplication or delay.
- Learning from complaints highlighted the importance of clear communication, continuity of care and ensuring families understand what support is being offered and why. This learning has led to changes in assessment, referral, and discharge processes.

Safeguarding and keeping children safe

- Safeguarding remains a core priority for CFHD. Dedicated safeguarding leads and reporting processes ensure concerns are identified, responded to, and shared appropriately with partner agencies.

Listening to children, young people and families

- We undertook a successful pilot of early resolution to complaints, and this is now fully embedded. This aims to ensure quicker contact and communication to service users once complaints are received and reaching an agreement to resolve concerns quickly.
- Our participation group contributed to the production of a communication passport, for use by children & young people in accessing health care.
- The use of 'Praise champion' was piloted in the Exeter Mental health team, to capture complements & excellence in the workplace.
- Families and young people provided valuable feedback through compliments, Friends and Family questionnaires and complaints. Across the year, **compliments consistently outweighed complaints**, with themes including compassion, professionalism, advocacy, and positive impact. Refer to Figure 3

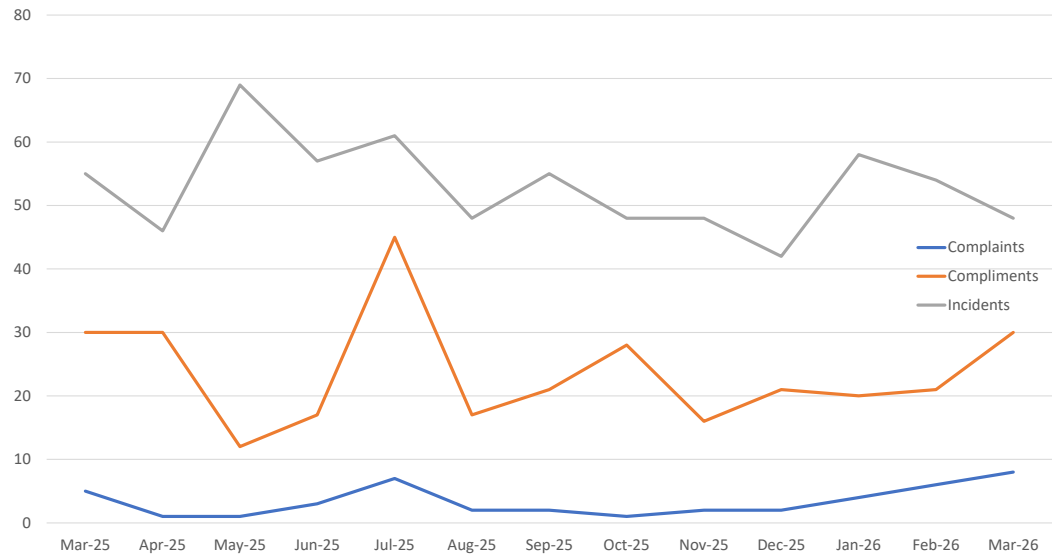


Figure 3 – CFHD Trend analysis of complaints, compliments, and incidents

Looking ahead

CFHD enters 2026/27 with a clear focus on:

- Reducing waiting times where families feel the greatest pressure
- Strengthening early intervention and prevention
- Improving on digital offer to patients
- Improving the use of Routine Outcome Measures in clinical practice
- Improving SEND and neurodiversity pathways with partners
- Ongoing quality improvement / evidence-based practice
- Continued learning through research/audit

Overall, CFHD services during 2025/26 continued to provide safe, compassionate, and improving care for children, young people and families, while openly recognising challenges and learning from experience.

Part 3: Our quality indicators

Patient safety

We participated in an audit undertaken by Audit Southwest to seek external assurance on our PSIRF maturity in autumn 2025. The findings indicated we had made reasonable progress in implementing the PSIRF, although full maturity has not yet been achieved. There is a strong organisational understanding of PSIRF principles however, evidence gaps limited performance in some assessment areas. Notable good practice was identified in our incident response methodology, particularly the use of the systems engineering initiative for patient safety (SEIPS) and human factors analysis, which has been proposed for inclusion in the ASW good practice guide.

During 2025/26 we sought to align patient safety activity and improvement to the following PSIRF domains:

1. Compassionate engagement and involvement

We recruited two volunteer patient safety partners, in line with NHS Standard Contract requirements, to ensure that the voices of patients and families are central to patient safety reviews and investigations

We strengthened our commitment to compassionate engagement, involvement and support for patients, families and staff affected by patient safety incidents throughout reviews and investigations

We continued to embed Martha's Rule (Call for Concern), providing patients, families and staff with 24/7 access to rapid critical care outreach review when concerns are raised, with learning from contacts used to inform safety improvement

We ensured feedback and learning from complaints is captured as valuable insight to inform a proactive safety culture and our Patient Safety Incident Response Plan (PSIRP).

We encouraged staff to share examples of good care, supporting recognition, learning and a positive patient safety culture

2. System-based approaches to learning

We continued to embed our transition to PSIRF with a strong focus on systems thinking and human factors, enabling more meaningful learning from safety incidents

We reinstated human factors training and developed plans to commence a train-the-trainer programme to build sustainable internal capability

We strengthened and embedded safety science and systems skills across teams, increasing organisational knowledge and capability

We encouraged the capture and sharing of learning from safety reviews, investigations and examples of good practice to drive system-wide improvement

We strengthened links between patient safety and quality improvement, ensuring learning from safety incidents results in sustained system change

3. Considered and proportionate responses to patient safety incidents

We made progress against our PSIRP and local and national PSIRF priorities

We revised local PSIRF priorities to include a targeted focus on escalation of care factors within maternity services, reflecting our local safety profile

We restructured the patient safety team to establish two dedicated patient safety incident investigator roles, improving proportionate and high-quality investigation capacity

We continued to professionalise safety investigations through the development of expert Patient Safety Incident Investigators (PSIIs), with ongoing review of resource levels to ensure alignment with PSIRF guidance

4. Supportive oversight, governance and improvement

We reviewed and strengthened our patient safety governance structure, ensuring clearer oversight, accountability and communication routes for safety and quality improvement

We continued to provide training for colleagues on patient safety review methodologies to support a just, learning culture

We worked closely with our information and One Devon Epic teams to ensure patient safety remained central to EPR design and decision-making, supporting safer systems and workflows

We committed to remaining responsive to national reports, guidance and inquiries, ensuring learning is integrated into local practice and improvement plans

We strengthened oversight of inquests and learning from deaths with enhanced collaboration between patient safety, inquest team and the coroner via monthly Inquest review meetings.

Our patient safety ambitions for 2026/27

During the coming year, we will build on the progress made in embedding the PSIRF to further strengthen our patient safety systems and culture. Our focus will be on maturing our PSIRF implementation, embedding proportionate, system-based responses to patient safety incidents and ensuring that learning consistently leads to sustained improvement. We will continue to strengthen compassionate engagement with patients, families and staff affected by incidents, supported by the active involvement of patient safety partners and the continued embedding of Martha's Rule/Call for Concern.

We will further professionalise patient safety investigations through the ongoing development of expert investigators, expand human factors capability through train the trainer programmes, and continue to build safety science and systems thinking expertise across the organisation. Stronger integration between patient safety and quality improvement will remain a priority, ensuring that insights from incidents, complaints and examples of good practice directly inform service improvement.

Governance and oversight arrangements will continue to be refined to support timely escalation, transparency and organisational learning, including learning from deaths.

National Safety Standards for Invasive Procedures **compliance**
Following Epic's launch, we will look to strengthen compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) to reduce avoidable harm, improve consistency and ensure invasive procedures are delivered safely across all services.

Freedom to Speak Up (FTSU)

FTSU is a core component of our approach to creating a safe, inclusive and learning culture, and is recognised nationally as essential to both workforce wellbeing and patient safety. In line with the recommendations of Sir Robert Francis following the Mid-Staffordshire NHS Foundation Trust Public Inquiry, all NHS organisations are required to have effective arrangements in place to support staff to raise concerns without fear of detriment.

In October 2025, our substantive Freedom to Speak Up Guardian left and interim arrangements are in place, led by the People Promise Manager with support from the Wellbeing Facilitator. These arrangements have ensured continuity of access for staff and maintained alignment with national FTSU principles, while recognising the limitations of an interim model.

Freedom to Speak Up Guardians operate independently of management structures and act impartially to support staff to speak up. Our FTSU function retains direct access to the Chief Executive and the Board level Freedom to Speak Up Non-executive Director. Formal FTSU reports are presented to our board twice a year, providing oversight of case volumes, themes and emerging risks. Learning from FTSU is also being aligned with the work of the Patient Safety Incident Review Group (PSIRG) and the Cultural Insights Review Group (CIRG) to strengthen organisational learning and assurance.

The FTSU function works closely with senior leaders, employee relations, and patient safety teams to support an open and transparent culture in which our people feel safe and encouraged to raise concerns. We continue to submit national FTSU data returns in line with guidance and participates in national benchmarking and assurance processes.

FTSU activity and themes

From November 2023 to December 2024, 176 concerns were raised, with primary themes including organisational culture, bullying and harassment, failure to follow processes, patient safety and staff safety.

From October 2025 to March 2026, 66 concerns were raised. These reflected persistent challenges across several areas, including inappropriate behaviours, limited psychological safety, and inconsistent leadership responses. Concerns were particularly complex where issues related to senior leaders or patient safety.

While interim FTSU arrangements maintained access for staff, this period highlighted risks relating to capacity, independence and sustainability, given the seriousness and volume of concerns being raised. National guidance emphasises the importance of well-resourced, visible- and independent FTSU arrangements, and we recognise the need to strengthen its model to meet these expectations consistently.

Analysis of concerns raised through FTSU identified recurring themes, including:

- Poor professional behaviours including bullying, harassment and, in some cases, sexual harassment
- Breakdowns in working relationships, often associated with hierarchical cultures and inconsistent leadership
- Failure to follow processes, including recruitment, acting-up arrangements and employee relations procedures
- Patient safety concerns linked to workforce pressures, lack of escalation and perceived futility in reporting
- Limited psychological safety, with staff expressing fear of speaking up, particularly where concerns involved senior leaders

A recurring issue was delayed or ineffective early resolution, with some managers lacking the capacity or confidence to address concerns promptly. In several cases, unresolved issues escalated into formal employee relations processes, which were not always progressed in a timely or consistent way.

Many colleagues contacted the FTSU Guardian in confidence seeking support to make sense of difficult experiences and concerns affecting their wellbeing and ability to provide safe care. This reinforces the vital role of FTSU not only as a reporting mechanism, but as a crucial source of cultural intelligence to inform organisational learning and improvement.

FTSU alignment with patient safety and learning

FTSU is increasingly recognised as a critical enabler of the PSIRF, providing valuable insight into emerging risks and organisational culture. Intelligence from our FTSU process informs the work of our PSIRG and the CIRG enabling triangulation of staff concerns with incident data, complaints, and staff survey findings. This integrated approach strengthens our understanding of risk and supports more effective, system-based learning and improvement.

Recent analysis has identified an increase in FTSU concerns directly related to patient safety. This reinforces the importance of clear escalation routes, effective governance oversight and timely action in response to staff concerns. We recognise that where our people feel psychologically safe to speak up, patient safety risks are more likely to be identified early, reducing the likelihood of avoidable harm.

Looking ahead

We recognise the FTSU function must be both proactive and responsive. While people can raise concerns confidently or anonymously through electronic reporting platforms, further work is required to increase the visibility, accessibility and consistent presence of the service across all sites and directorates to rebuild confidence and awareness.

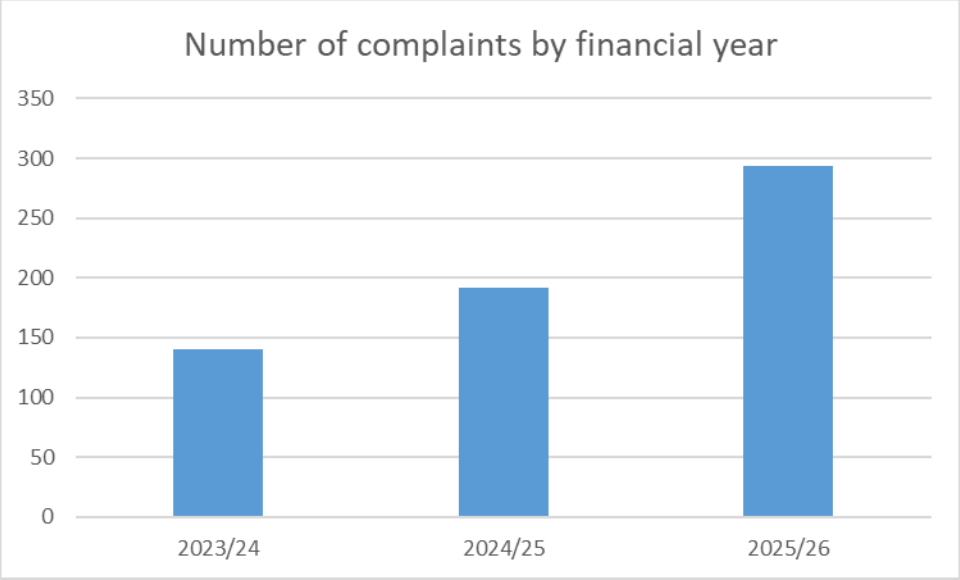
In response to the themes identified, we are developing a more structured and proactive approach to FTSU. This includes closer alignment with PSIRG and CIRG, enhanced Board-level reporting, and targeted cultural interventions in areas of higher risk. Strengthening the FTSU function is a key component- of our wider cultural improvement and patient safety strategy.

By investing in robust, independent and well-aligned FTSU arrangements, we aim to create a psychologically safe environment where people's voices are heard, concerns are acted upon, and learning is translated into safer, higher quality care for patients.

Patient experience

The number of complaints received from 01 April 2025 to 31 March 2026 was 294 and is a marked increase on the number of complaints received in the previous two years.

Table 4: Complaint received



In 2024/25, the average number of complaints received per month was 12; in 2025/26 this increased to an average of 25 per month. This is consistent with local and national trends.

The number of concerns received during 2025/26 was 1515, which represents a 11.8% decrease in concerns recorded during the previous year (n=1717).

During 2025/26, we were unable to meet the national quality standard of three days for complaint acknowledgement due to a number of vacancies within the team. Our compliance is recorded as 28.9%. Recruiting issues have now been resolved and the team is now working at its original capacity.

Compliance with responding to complaints within the six-month national quality standard was 92.3%% over the year 2025/26, with 14 complaints breaching this standard in this period.

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

1. Complexity of complaint
2. Number of extensions requested, often reflecting operational pressure

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

Figure 9: Top 3 complaint themes 2025/26

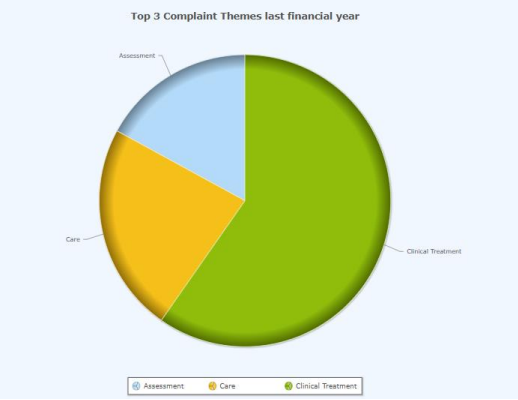
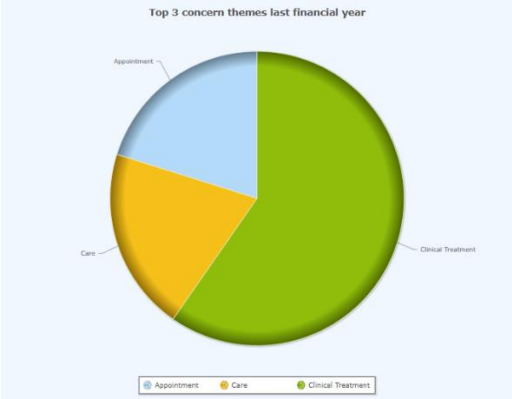


Figure 10 Top 3 concern themes 2025/26



During 2025/26, we formally recorded 289 compliments, which is a 12% decrease compared to 2024/25.

We acknowledge that demonstrating that we are learning from complaints is sub-optimal and our focus for 2026/27 is how to share learning across all of our services.

Patient and community engagement

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

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

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

NHS Devon shared the responses partners and the public ahead of the government's publication of the 10 Year Plan last summer.

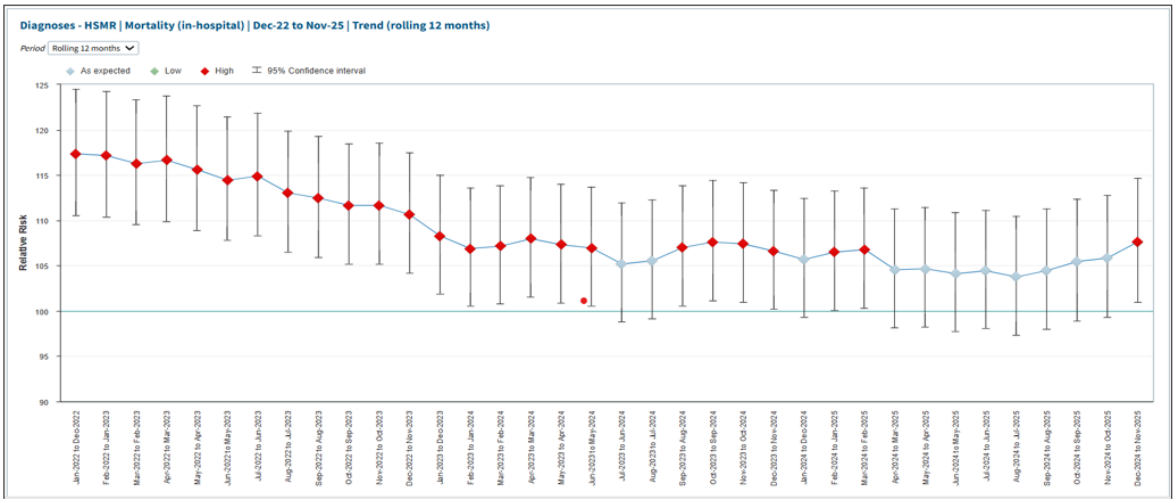
Mortality review processes

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

Work to ensure the accuracy of our clinical coding has continued during 2025/26 as we adapt to the new Elixhauser Bottle methodology. There have been significant challenges with coding resource over the last year which has impacted on our coding statistics however these are in the process of being resolved with further coder recruitment ongoing.

Our current overall HSMR is 107.6 (101-114.6) - this is higher than is statistically expected. Our non-elective HSMR is 107.8 also statistically higher than expected. Our elective HSMR is 106.8-this is within the expected range. Our current SHMI (Summary Hospital Level Mortality Indicator) is similarly within the expected range at 96.44.

The trend in HSMR has been for a fall in mortality over the last three years as is demonstrated below:



Analysis suggests that the recent increase in our HSMR statistics is likely a result of the effect of uncoded mortality data as a result of coding resource issues. As our coding resource challenges resolve it is anticipated that this will improve and our HSMR figure will fall back to within the expected range in line with previous trends. Alongside the improvement in our coding resource we will continue to closely monitor the statistics and will commission more in-depth work to analyse any specific areas of increasing mortality to ensure there are no emerging process issues behind any increase in mortality.

As part of our redesign of mortality processes, in 2025 we redesigned our mortality surveillance group which oversees our mortality processes, monitors key mortality data and commissions focused pieces of work in specific areas. A key aim is to identify any emerging mortality trends and to investigate any areas of concern.

The group has received over the last year Clinical Mortality reviews from General Surgery, Anaesthetics, Drug and Alcohol services, Care of the Elderly and Emergency Medicine. These are important in highlighting any trends in Mortality in specific areas and are a useful forum for clinical teams to raise any issues of emerging concern.

The group receives also specific mortality alerts via Telstra (Dr Foster). These are reviewed and where necessary further work is commissioned to analyse any increase in Mortality. Commissioned detailed work over the last year includes analyses of mortality in Stroke, Sepsis, Necrotising Fasciitis and Renal Medicine patients. Significant process changes and improvements in care have been made as a result of these reviews over the last year.

The work of the group is underpinned by a monthly multi-disciplinary mortality sub-group which ensures progress against workplans and works toward each quarterly surveillance group meeting. A mortality scorecard is also presented to the board of directors bi-monthly by the Chief Medical Officer.

The recent advent of our new trust EPR system (EPIC) is a major step forward for the trust. It is hoped that the new system will simplify and improve our coding processes and it has the potential to significantly improve our monitoring of Mortality data. Alongside the new EPR in time we are hoping to develop the facility to generate near real time monitoring of key mortality metrics. This will allow us to rapidly respond to any emerging areas of concern rapidly and take action where needed.

In 2025 we introduced an IT module which streamlined, simplified and improved the completion of Structured Judgement reviews as well as facilitating better central oversight of the reviews. We have continued to improve and refine this process over the last year. In total there have been 56 Structured Judgement Reviews carried out in 2025. Work continues in the education and use of this tool and in linking review outcomes to subsequent Patient Safety Investigations where required.

We have continued to monitor mortality associated with long waits in the emergency department. Our work in 2022 demonstrated a significant increase in 30-day mortality in patients waiting longer than eight hours for a bed when compared with 2019 in line with large national research studies in the UK. Subsequent work from 2022-2024 has demonstrated a significant improvement in this mortality with overall mortality now back to pre-pandemic levels, however we do still appear to have a higher rate of mortality in frail elderly patients. We are finalising our review of mortality in this group of patients for 2025 however preliminary data suggest that overall mortality has fallen back to pre-pandemic levels which is encouraging. This work has continued to drive improvements in patient flow for our non-elective patients.

We are in the final stages of development of our new Learning from Deaths Policy which will underpin our Mortality processes and ensure that we are identifying and disseminating any learning across the trust whenever possible. The policy should be published within the next few months.

The Medical examiner (ME) service

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

Table 7: Medical examiner data

Year	Total number of deaths reviewed by medical examiners – community and acute / community hospital settings (including Rowcroft)	Community (non-hospital setting) deaths reviewed by medical examiners (excluding Rowcroft)	Number of acute / community hospital deaths reviewed by medical examiners (excluding Rowcroft)	Number of deaths referred to HM Coroner	Number of HM Coroner Inquests	Number of incidents raised following medical examiner scrutiny
2023-24	NA	NA	1395	240	132	32
2024-25	2524	1149	1316	186	60	53
2025-26	4114	1931	1381	341	109	19

Learning from lives and deaths-people with a learning disability and autistic people (LeDeR)

The Learning Disabilities Mortality Review (LeDeR) programme is a national, mandated process requiring independent case reviews following the deaths of people with learning disabilities and autistic people. All deaths involving people with a learning disability are reviewed through the LeDeR process, enabling system-wide learning to improve care, reduce health inequalities and prevent avoidable deaths.

In 2023, a revised LeDeR process was implemented, strengthening monthly engagement with the regional LeDeR team. Due to the complexity and length of LeDeR reviews, Structured Judgement Reviews (SJR) continue to be undertaken for all patients with a learning disability and/or autism who die in hospital, enabling earlier identification of learning and assurance.

Table 8: Summary of All LeDeR referrals across the ICB 2025/26

Location of death	Number of deaths meeting LeDeR criteria	Structured Judgement Review (SJR) undertaken	LeDeR reviews completed (with outcomes and learning)	Awaiting LeDeR review outcomes
Community	4	0	0	4
Hospital	21	15	0	21

During 2024/25, the central ICB LeDeR reviewing team experienced staffing challenges which impacted the timeliness and number of completed reviews. However, there has been significant improvement during 2025/26, with 84% of LeDeR reviews now completed within six months compared to only 5% at the same point in the previous year. This improvement reflects substantial team effort and increased reviewer capacity, including the use of trained bank staff. Devon is now performing within the top 10 nationally for LeDeR review completion. The planned merger with Cornwall as part of ICB clustering arrangements may impact future performance, as Devon provides support to improve capacity across the wider system.

Completed Structured Judgement Reviews continue to provide interim assurance. Across cases reviewed, there has been no evidence identified to suggest that deaths of people with a learning disability and/or autism were avoidable. All cases where an opinion was recorded described care as adequate, good or excellent, with strong evidence of family or carer involvement, specialist input from learning disability teams, and appropriate escalation of treatment, including palliative care where required.

Learning, themes and system insights

Key themes identified from reviews include:

- Delayed discharges linked to lack of suitable placements
- Lack of clarity in care pathways across services
- Epilepsy management, including care planning and risk management
- Gaps between acute learning disability teams and community learning disability services

Alongside these findings, there were also positive examples of joined-up, person-centred practice across health and care systems, demonstrating effective multidisciplinary working and coordination.

Discussions at governance forums highlighted potential inequality gaps, particularly the under-representation of people from ethnic minority groups in LeDeR referrals. In response, work is underway to strengthen engagement with community groups, police and prison services, Disability Together partnerships, and to increase parental and family involvement, to improve awareness and representation within the programme.

Current position – 2025/26 referrals

A review of current year referrals indicates ongoing reporting and engagement with the LeDeR process, with multiple cases referred and progressing through review. No referrals have met criteria for Safeguarding Adults Reviews (TDSAP) to date.

Emerging case insights broadly reflect known themes, including complex co-morbidities (e.g. respiratory disease, epilepsy, frailty), and instances where admissions were clinically appropriate with escalation of care provided, but patients did not respond to treatment. During 2025/26 TSDFT have identified 18 deaths which have all been referred to LEDER. At this point none have been identified as requiring a focus review which is indicative that no immediate concerns have been noted.

Summary

Significant progress has been made during 2025/26, particularly in improving timeliness of LeDeR reviews and national benchmarking. While challenges remain, particularly in relation to system capacity, pathway clarity and reducing inequalities, there is clear evidence of strengthened governance, improved performance and a growing focus on embedding learning into practice across the system.

National standards

This performance overview provides information about how we have performed against agreed operational planning objectives during the year (local snapshot data).

We have seen a sustained improvement in planned care waiting times for our longest wait patients. Across urgent and emergency care performance, patient flow and bed capacity remained the main operational challenge and frequently having our emergency department and assessment units at full capacity. The four-hour standard and ambulance handover delays did not meet planned levels of performance but have seen a sustained improvement in recent months. In November 2025 we introduced the Timely Handover Protocol setting a 45-minute maximum ambulance handover, which has resulted in a significant improvement in handover times, achieving an average of 30 minutes. The improvement has shifted pressures into the department creating additional patient flow challenges. Significant estate changes in the ED will increase the majors and minors capacity.

Figure 11: RAG rated metrics against operational plan trajectory

INTEGRATED PERFORMANCE DASHBOARD OF KEY PERFORMANCE METRICS — Torbay and South Devon NHS Foundation Trust

RAG rated against monthly Operational Plan trajectory	Target March 2026	13 month trend	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Operational Plan trajectory Mar 2026
Oversight Framework																
Urgent and Emergency Care																
Ambulance handovers - time lost over 15 mins - Actual (hours)	1981		1268	839	1530	1159	725	943	1823	810	624	559	1283	621	755	1980
Average handover time (mins)	45 mins		47	36	52	45	32	38	60	33	29	27	45	30	31	37
Total average time in ED (hours/minutes)			05:26	04:58	05:40	05:11	04:50	04:50	05:40	05:33	05:23	05:20	06:30	06:10	06:06	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0		615	415	688	494	457	426	655	585	549	520	918	740	734	No trajectory
Percentage of patients waiting over 12 hours in ED	6.1%		9.1%	5.7%	9.5%	7.1%	6.1%	5.8%	9.3%	8.1%	7.7%	7.4%	13.3%	11.5%	10.1%	6.1%
UEC 4-hour target (RAG against local trajectory to national target)	78%		70.1%	72.8%	70.1%	72.6%	73.5%	74.1%	68.4%	68.0%	68.3%	70.8%	67.9%	66.4%	66.6%	78.0%
% patient discharges pre-noon	33%		22.6%	22.4%	22.3%	24.1%	27.8%	23.4%	21.4%	20.1%	19.5%	19.2%	17.8%	17.1%	17.1%	33%
Elective recovery																
RTT 78 week wait incomplete pathway	0		7	4	8	8	9	16	13	16	9	9	13	8	7	0
RTT 65 week wait incomplete pathway	0		141	145	126	95	97	105	110	109	84	94	83	76	47	0
RTT 52 week wait incomplete pathway	268		931	914	805	740	615	618	615	647	607	663	604	607	600	268
RTT % Incomplete pathways <18 wks	66.8%		63.3%	61.8%	64.2%	66.2%	68.4%	68.8%	68.9%	68.0%	67.7%	66.3%	67.0%	66.8%	66.4%	66.8%
RTT Wait for first appointment <18 weeks	70.3%		70.4%	70.1%	71.7%	73.8%	74.1%	73.7%	73.0%	72.2%	71.8%	70.0%	70.4%	70.0%	69.9%	70.3%
Cancer: Faster Diagnosis Standard patients diagnosed within 28 days	80%		79.2%	75.1%	70.5%	75.1%	69.8%	60.8%	68.0%	75.1%	76.3%	78.7%	60.6%	79.7%	75.8%	80.5%
Cancer: 62-day wait for treatment (24/25 target 70%) (25/26 target 75%)	75%		74.3%	68.0%	70.2%	67.7%	62.8%	69.1%	64.0%	72.4%	73.5%	80.3%	75.2%	67.1%	66.2%	75.1%
Cancer: No of patients waiting >62 days to start treatment	138		111	133	225	223	220	257	176	132	91	119	159	177	177	138
Cancer: % of patients > 62 days to start treatment	tbc		6.0%	6.7%	7.9%	7.9%	7.0%	8.9%	7.9%	6.5%	4.5%	5.9%	7.6%	8.1%	7.2%	tbc

RAG indicator
Meeting monthly trajectory
Not meeting monthly trajectory

Our Health Equity Enabling Group (HEEG) was set up in January 2026 to provide strategic leadership and practical support to embed health equity consistently across our services. Membership comprises of colleagues from across clinical, operational, corporate and improvement functions, enabling a coordinated, whole organisation approach to reducing health inequalities. A key mechanism for delivering this work is the health inequalities dashboard which was developed to support the delivery of ourCore20PLUS5 commitments and South Local Care Partnership (LCP) health equity priorities.

The dashboard provides a single, integrated view of health inequalities across access, experience and outcomes, with a clear focus on areas where we can can take direct action to reduce unwarranted variation. By presenting timely, comparable and clinically relevant equity data, the dashboard enables HEEG members to rapidly identify where inequities exist, understand which population groups are most affected, and agree priority areas for improvement. This supports a consistent, equity□based approach to decision□making, service improvement and assurance, and enables routine, transparent reporting to our Board, committees and system partners.

Structured around six core thematic areas, the dashboard offers executive□level assurance on CORE20 and PLUS group reach, waiting list equity, adult and children's clinical priority pathways, ageing and frailty, high□intensity service use, carers, inclusion health, and the foundations of high□quality equity data. Consistent comparisons between equity cohorts and our organisation's averages, alongside the visibility of unknown categories, support targeted improvement action while strengthening data quality, including delivery of reasonable adjustments and compliance with the Accessible Information Standard.

The dashboard enables the HEEG to move beyond the identification of inequalities to clear, prioritised and measurable action. It supports the targeting of improvement activity and service redesign where inequalities are greatest or widening, and where our services are best placed to intervene, including waiting list equity initiatives, personalised care approaches and pathway improvements. Progress can be monitored over time, providing assurance on whether actions taken are leading to measurable reductions in inequality and embedding health equity within routine operational decisions, service planning and quality improvement activity.

Through the HEEG, the dashboard supports NHS England's health inequalities assurance requirements and oversight of delivery against the South LCP Health Equity Plan. It aligns equity improvement with our key priorities including waiting list equity, virtual wards, integrated urgent and emergency care, personalised support for carers, children and young people's specialist nurse models, and healthy ageing and frailty programmes. Workforce and anchor institution measures are included as contextual enablers, supporting a sustainable and embedded approach to tackling health inequalities across both clinical and organisational practice.

Equality of service delivery

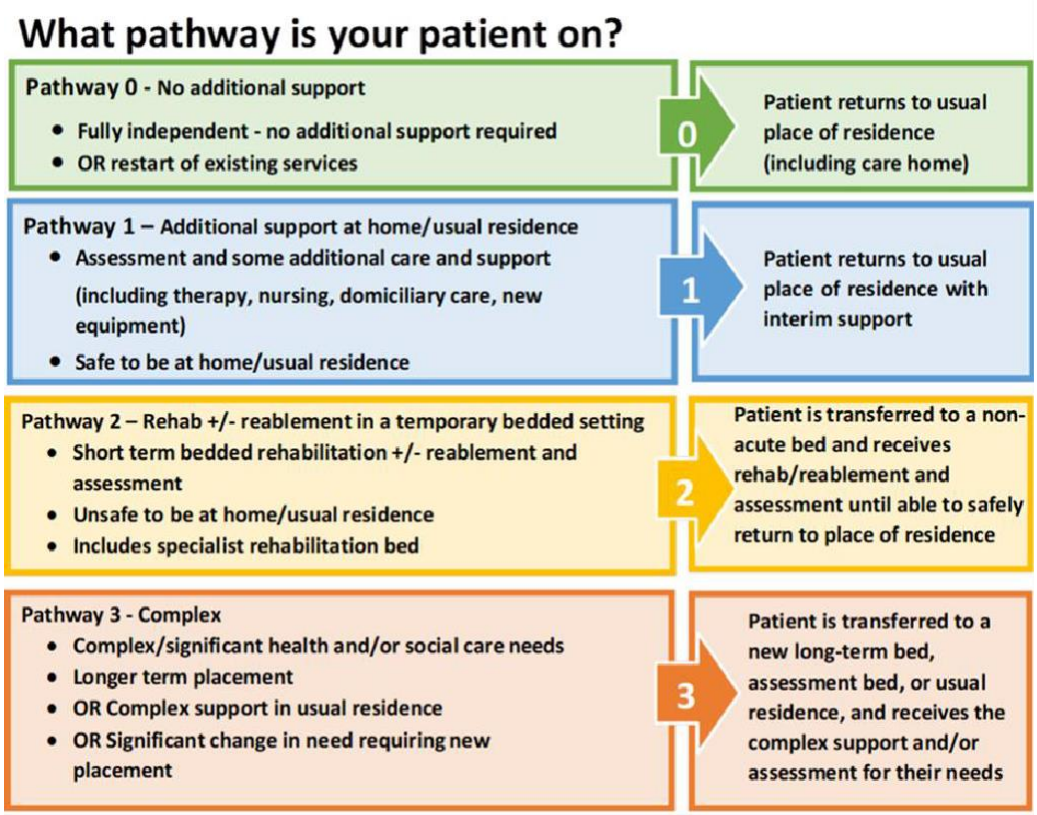
We maintain our approach to equality of service delivery by adhering to strict chronological booking processes in accordance with clinical prioritisation. We have a process of contacting people by telephone, as well as letter, to agree appointment dates and follow-up appointments when initial contact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

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

Complex pathway discharges

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

Figure 12: discharge pathways



Across the 12 months the following numbers of patients were discharged on pathways one to three.

Table 9: Percentage of patients discharged on each discharge pathway

Pathway 2025/26	% District General Hospital (DGH)	Actual DGH	% community hospitals	Actual community
0	76%	15997	9%	234
1	9%	1888	57%	1490
2	13%	2824	30%	791
3	2%	424	4%	105

(Data source E1004 Tableau Report)

Average length of stay (LOS)

The average length of stay, excluding zero-day LOS in 2025/26, on a rolling 12-month average, has improved from 7.0 days in March 2024 to 6.8 days in January 2026; this is in line with the national average (data source Dr Foster).

In 2026/27 reducing length of stay remains an ongoing key focus to support both elective and non-elective activity and as such has been recognised in improvement plans to target the longest stay patients with more frequent review and specifically centred on early morning discharge, discharges before 5pm, and at the weekend.

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

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

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

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

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

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

By order of the Board

Joe Teape Chief Executive

Date: 25 June 2026

Annex 2: Quality Account engagement

We presented a briefing on the draft quality account to our Council of Governors on 13th May 2026, providing an update on our progress against our four quality goals, sharing and discussing our revised quality goals and priorities, highlighting key priorities for our patient safety incident investigation for 2025/26.

The draft Quality Account was circulated to the organisations listed below for review and comment from 29 May to 16 June 2026.

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

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

Annex 3: Statements from stakeholders and partners

Council of Governors

Council of Governors on behalf of patients and governors appreciate the Trust focus on patient safety as paramount and the fact that the priority for this year has been to reduce waits for emergency care and subsequent treatment to maximise quality. We were delighted to see the formal announcement that our elective surgical hub at Torbay Hospital has achieved national GIRFT accreditation – a real recognition of sustained hard work and high standards across the whole planned surgery pathway.

Challenges have continued this year regarding finance/funding, waiting times, staffing and maintenance issues however owing to the hard work of the staff we have now come out of NOF 4 which is a great achievement. Last year saw the signing of the contract for the implementation of the One Devon Electronic Patient Record (EPR), EPIC, which will be shared with Royal Devon University Healthcare NHS Foundation Trust and University Hospitals Plymouth NHS Trust. This has now been up and running at Torbay since beginning of April and is helping to transform clinical services.

Funding of £14.2 million was secured for a new ED expansion. The build has now reached a stage whereby the new building can be utilised by patients and staff and the excellent new design has been much appreciated by staff and patients as it enables the Trust to provide a better service for patients and a better environment for staff who provide these services.

NHS Devon Integrated Care Board (ICB)

Torbay and South Devon NHS Foundation Trust Quality Account 2025/2026: NHS Devon Integrated Care Board commentary

NHS Devon Integrated Care Board (ICB) would like to thank the Torbay and South Devon NHS Foundation NHS Foundation Trust for the opportunity to comment on the Quality Account for 2025/26. The Trust is commissioned by NHS Devon ICB to provide a range of secondary and integrated community services across Devon**.** We seek assurance that care provided is safe and of high quality, ensuring that care is effective and that the experience of care is positive.

As Commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the Commissioner over the 2025/26 period.

This Quality Account has highlighted progress against the priorities for 2025/26 which include:

1/ Improving the identification and management of Sepsis. The Trust has demonstrated sustained improvement in the delivery of the Sepsis Six bundle, increasing from 89% in March 2024 to consistently achieving 97% by February 2025. Despite ongoing pressures within the Emergency Department, antibiotic administration has remained compliant with national guidance, consistently exceeding 95%. This achievement reflects a comprehensive and systematic approach to improving sepsis awareness and early recognition. Key initiatives have included the development and implementation of a Trust-wide sepsis policy, delivery of standardised training programmes, and the effective use of data to monitor and drive compliance. This priority will continue into 2025/26, with plans for a Trust-wide audit and the development of a sepsis dashboard to further support performance monitoring and improvement.

2/ Strengthen the quality of our mental capacity assessments (MCA). The Trust has undertaken a range of initiatives to enhance the quality of care for patients undergoing Mental Capacity Assessments and Deprivation of Liberty Safeguards (DoLS) assessments. These improvements have been supported through the delivery of tailored training programmes, enhancements to documentation standards, and the introduction of weekly virtual advice sessions to provide ongoing support to staff. This priority will continue into 2026/27, and the ICB looks forward to further improvements being delivered through the implementation of the Audit Southwest action plan.

3/ Reducing falls and harm sustained from falls. The ICB welcomes the positive reduction in falls resulting in harm across the Trust and recognises the significant achievement of training over 350 staff in falls prevention. The continued use of the Falls Safe Audit is acknowledged as an example of good practice across clinical areas. Initiatives to raise awareness, including campaigns such as “Call Don’t Fall”, delivered through hospital radio, social media, and visual materials, demonstrate a

proactive and forward-thinking approach. The ICB recognises and commends these efforts to drive improvement and enhance patient safety.

4/ Reducing elective and emergency care delays. The ICB is reassured by the Trust's continued improvement in urgent and emergency care performance metrics and commends the organisation for being recognised among the top 10 most improved trusts across three key measures. This achievement reflects a sustained and focused effort to address performance challenges and enhance service delivery within a highly pressured environment. In addition, the ICB acknowledges the Trust's outstanding progress in ambulance handover performance, with the organisation achieving the top national position for improvement in this area. This is particularly noteworthy given the ongoing system pressures and demonstrates strong operational leadership, effective partnership working, and a commitment to patient flow and safety. The ICB further recognises the sustained focus, dedication, and organisational commitment to improving the quality and timeliness of care within urgent and emergency services. These efforts highlight a clear strategic priority to enhance patient experience and outcomes, supported by continuous monitoring and quality improvement initiatives. The continuation of this priority into 2026/27 is welcomed by the ICB, and there is an expectation that the Trust will build on this positive trajectory to deliver further measurable improvements across urgent and emergency care pathways.

The Trust has made significant progress in reducing waiting times for patients accessing elective treatment. Targeted initiatives to optimise the use of theatre capacity and workforce resources have contributed to a reduction in the number of patients experiencing prolonged waits and delays in care. The ICB recognises these achievements and the continued focus on improving elective performance. However, it also acknowledges the ongoing challenges associated with delivering radiotherapy services, particularly in relation to the recruitment and retention of specialist staff.

The continuation of this priority into 2026/27 is welcomed by the ICB, and there is an expectation that the Trust will build on this positive trajectory to deliver further measurable improvements across urgent and emergency care and elective pathways.

5/ Listening to our people. The Trust has demonstrated a strong commitment to enhancing meaningful engagement with patients and families involved in safety investigations and patient experience processes. This work has been supported by the development and implementation of the Patient Safety Incident Response Framework (PSIRF), which was successfully rolled out during this period. Embedding a Just Culture remains a key priority within PSIRF, and the adoption of a "golden thread" approach provides a robust and consistent mechanism to support Trust-wide implementation and improvement. The ICB acknowledges the absence of dedicated financial resources in this area and recognises the significant progress achieved to date through effective leadership, prioritisation, and innovative approaches.

6/ Seek, identify and address health care inequalities. The Trust recognises the demographic challenges within the TSDFT footprint, including areas of deprivation, poorer health outcomes, and the impact of rurality on access to services. The widening gap in health inequalities is being actively addressed through the work of the four care groups, which are tailoring their priorities and interventions to meet the diverse and complex needs of the populations they serve. Several bespoke pilot initiatives are currently underway, and the ICB welcomes the development of a healthcare inequalities scoring matrix aimed at supporting the prioritisation of patient appointments. This approach is designed to ensure that individuals with the greatest need are identified and supported, including patients with a learning disability, those diagnosed with a serious mental illness, individuals aged over 65 with caring responsibilities, and those residing within the Core20 most deprived areas.

The ICB recognises and commends the Trust's proactive approach to identifying and directly targeting patients with associated risk factors, ensuring a more equitable and needs-based approach to the delivery of planned care services. The ICB is pleased to see this priority continue into 2026/27.

The ICB also notes and welcomes the 2026/27 Trust Priorities outlined by the trust in their Quality Account, and will look forward to seeing achievements related to:

1/ Early detection and treatment of sepsis

2/ Strengthening the quality of mental capacity act assessments.

3/ Continue to work to reduce waits for urgent and emergency care and for patients awaiting planned care or treatment.

4/ Safe transition to an electronic patient record (EPR) in April 2026.

5/ To embed PSIRF across the organisation

6/ To seek out and reduce health care inequalities

Each of these programmes will continue to evidence and improve quality and safety for the benefit of patients, families, carers, and staff building on the lessons learned from 2025/26.

Care Quality Commission (CQC) involvement:

As a commissioner, we have worked closely with the Torbay and South Devon NHS Foundation Trust during 2025/26 and will continue to do so in respect of CQC reviews undertaken, to receive the necessary assurances that actions have been taken to support continued, high-quality care. The Trust's External Review Oversight Group monitors action plans through to completion, with the oversight of the ICB. There have been two inspections to note in 2025/2026; Patient Transport Services and Community Health Service for Children Young People and Families both of which achieved a "Good" status with all domains for each report achieving "Good".

The ICB also note the positive work in maternity services where the Trust entered a 6 month period of targeted Maternity & Neonatal Support under the Neonatal Improvement Support Team, with evidence of milestones progress being made.

On review of this Quality Account, the Trust's commitment to the continuous improvement of care quality is clearly evident. The ICB looks forward to working in partnership with the Trust over the coming year to build on this progress and further enhance the quality and effectiveness of healthcare services provided to the population of Devon.

Health and Adult Care Scrutiny Committee

COMMENTARY ON THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST QUALITY ACCOUNT 2025/26

Devon County Council's Health and Adult Care Scrutiny Committee (hereafter referred to as the Committee) has been invited to comment on the Torbay and South Devon NHS Foundation Trust Quality Account for the year 2025/26. All references in this commentary relate to the reporting period 1 April 2025 to the 31 March 2026 and refer specifically to the Trust's relationship with the Committee.

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

Members appreciate the positive work that has been carried out by the Trust in reference to the 2025/26 priorities including meeting every target it set as part of a sepsis awareness and improvement programme.

Members also commend the improvement work that the Trust has undertaken working with system partners across Devon to reduce ambulance handover delays and the resultant reduction in associated patient harm.

Members welcome the focus in 2025/26 on reducing long waits for planned care. The Committee recognises the improvements in the number of patients waiting for elective treatment but note that any delay to planned care can have a significant impact on patients and their quality of life and urge the Trust to continue to prioritise further improvements.

Members raised concerns about inadequate communication with patients on waiting lists, particularly the lack of clarity around expected waiting times. It is essential that the Trust utilises the opportunities that bringing in Epic, the new electronic health record system, offers enabling secure, real-time access to patient information across settings, improving decision-making, efficiency, and patient safety.

Members welcome the priorities for improvement in 2026/27 including *Ending corridor care by improving patient flow and safety in acute and community services and strengthen neighbourhood care*. Members felt corridor care was both unsafe and compromised patients' dignity.

The Committee welcome the Trust strengthening community engagement and appointing local executive leads but citied cardiology as an area where earlier

involvement engaging the local population would have been beneficial. The Trust needs to also ensure it works closely with local Members.

The Scrutiny Committee commend the focus on creating a culture where staff and service users feel safe to report concerns and incidents with the quality priority *Improving engagement with our communities and workforce through listening, learning and a just culture, to support continuous improvement in quality and safety*.

Members remain concerned by the 2023 CQC rating the Trust received from its well-led inspection, with its overall rating changing from Good to Requires Improvement. The Committee hopes that the improvement journey of the Trust as highlighted in this Quality Account will in due course reflect in an improved CQC rating.

Members appreciate the continued challenges the Trust faces with significant pressure across urgent, emergency and elective care. Members expect the Trust to ensure patients and staff receive the best support possible. The Scrutiny Committee fully supports the Trust priorities for 2026/27 in their entirety, and the necessary focus being given to these priorities. Members welcome the prospect of a continued positive working relationship with the Trust, and ongoing monitoring of progress against these priorities through the Quality Account Standing Overview Group of the Health and Adult Care Scrutiny Committee.

TORBAY COUNCIL

Feedback from Torbay Council will be added following review of the Quality Account at Overview and Scrutiny Committee being held on 16 July 2026.

Statement from Healthwatch for TSDFT Quality Account 2026

Healthwatch in Devon, Plymouth and Torbay welcome the opportunity to comment on Torbay and South Devon NHS Foundation Trust's Quality Account for 2025/26.

We recognise the continued pressures facing the Trust and wider health and care system, including high demand, urgent and emergency care pressures, waiting times, workforce challenges and financial constraints. As an integrated care organisation serving communities with significant health inequalities, an older population and areas of deprivation, it remains essential that patient, carer and community feedback continues to shape service improvement, quality assurance and decision-making.

We welcome the Trust's continued focus on improving patient safety, including sepsis recognition, mental capacity assessments, Patient Safety Incident Response Framework development and the embedding of a just, learning culture. It is positive to see reported progress in sepsis monitoring and compliance, and we support the continued focus on Mental Capacity Act practice, particularly where this supports more person-centred care and better involvement of families and carers.

We also welcome the Trust's focus on reducing emergency and elective care delays. Improvements in ambulance handover times and planned care waits are important for patient safety and experience. However, we note the Trust's recognition that pressures have contributed to some patients being cared for in corridor areas. We therefore welcome the 2026/27 priority to end corridor care by improving patient flow, strengthening neighbourhood care and supporting timely discharge. Patient dignity, safety and experience should remain central to this work.

A key area of Healthwatch activity during the last year has been our insight report into Reasonable Adjustments in Torbay. This highlighted that, while hospital passports, digital flags and liaison roles are in place, their impact can be limited by inconsistent use, low awareness and wider system barriers. People with learning disabilities, neurodivergence, mental health conditions, sensory needs and complex needs told us that small, personalised adjustments – such as quiet spaces, flexible communication, clearer information and carer involvement – can make a significant difference. We welcome the Trust's response to this work, including its commitment to using Epic to improve visibility of reasonable adjustment needs, review passport options with local groups and continue strengthening staff awareness and training.

We note the introduction of Epic as a major opportunity to support safer, more joined-up care across acute, community and neighbourhood services. However, digital change must be implemented in a way that remains accessible to people who are digitally excluded or who need human support. Our wider Healthwatch work on digital healthcare access continues to highlight the importance of clear

communication, non-digital alternatives and support for people who lack confidence, access or private space to use digital services.

We welcome the Trust's continued commitment to community services, neighbourhood-based care, prevention and support for people to live well at home.

We note the Trust's reference to formally giving notice on the current Section 75 agreement with Torbay Council for the provision of adult social care services. We welcome the reassurance that there will be no immediate changes to people's care and that services will continue as they do now during the transition period. Given the importance of continuity, clarity and joined-up support for people using health and social care services, Healthwatch will continue to monitor patient, carer and community experience carefully as future arrangements are developed with Torbay Council and NHS Devon.

Healthwatch values its ongoing relationship with Torbay and South Devon NHS Foundation Trust and looks forward to continuing to act as a constructive critical friend, ensuring patient and carer voice remains central to quality improvement, service change and assurance.

Annex 4: National clinical audits (and number of local audits)

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

During 2025/26, 39 national clinical audits and three national confidential enquiries covered relevant health services that we provide.

During this period, we participated in 95% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which we were eligible to participate in.

The national clinical audits and national confidential enquiries that we were eligible to participate in during 2025/26 follows.

National audits	Eligibility	Participation
BAUS data and audit programme		
A. British audit of the investigation and referral of Women with recurrent urinary tract infection using recent guidance (BOOMERANG)	Yes	Not participating
B. Evaluating the management pathway for suspected testicular cancer referrals (EMPAST)	Yes	Yes
Breast Spine Registry	No	Not applicable
Breast and Cosmetic Implant Registry	Yes	Yes
Case Mix Programme (CMP)	Yes	Yes
Cleft Registry and Audit Network Database	No	Not applicable
Emergency Medicine QIPs (RCEM)		
A. Adolescent Mental Health	Yes	Not participating
B. Care of Older People	Yes	Not participating
C. Mental Health Self Harm	Yes	Not participating
D. Time Critical Medications	Yes	Not participating
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)		
A. Fracture Liaison Service Database	No	Not applicable
B. National Audit of Inpatient Falls	Yes	Yes
C. National Hip Fracture Database	Yes	Yes
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)	Yes	Yes
National Adult Diabetes Audit		
A. National Diabetes Core Audit	No	Not applicable
B. Diabetes Prevention Programme (DPP)	No	Not applicable
C. National Diabetes Footcare Audit		

D. National Inpatient Diabetes Safety Audit (Harms) E. National Pregnancy in Diabetes (NPID) F. Transition (Adolescents and Young Adults) and Young Type 2 Audit G. Gestational Diabetes Audit	Yes Yes Yes No No	Yes Yes Yes Not applicable Not applicable
National Audit of Cardiac Rehabilitation	Yes	Yes
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)	No	Not applicable
National Audit of Care at the End of Life (NACEL)	Yes	Yes
National Audit of Dementia (NAD)	Yes	Yes
National Audit of Eating Disorders (NAED)	No	Not applicable
National Bariatric Surgery Registry	No	Not applicable
National Audit of Metastatic Breast Cancer (NAoME)	Yes	Yes
National Audit of Primary Breast Cancer (NAoPri)	Yes	Yes
National Bowel Cancer Audit (NBOCA)	Yes	Yes
National Kidney Cancer Audit (NKCA)	Yes	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes
National Non-Hodgkin Lymphoma Audit (NNHLA)	Yes	Yes
National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Yes
National Ovarian Cancer Audit (NOCA)	Yes	Yes
National Pancreatic Cancer Audit (NPaCA)	Yes	Yes
National Prostate Cancer Audit (NPCA)	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Cardiac Audit Programme (NCAP) A. National Adult Cardiac Surgery Audit (NACSA) B. National Congenital Heart Disease (NCHDA) C. National Heart Failure Audit (NHFA) D. National Audit of Cardiac Rhythm Management (NACRM) E. Myocardial Ischaemia National Audit Project (MINAP) F. National Percutaneous Coronary Intervention (NAPCI) G. The UK Transcatheter Aortic Valve Implantation Registry (TAVI) H. Left Atrial Appendage Occlusion (LAAO) Registry I. Patent Foramen Ovale Closure (PFOC) Registry J. Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	 No No Yes Yes Yes Yes No No No No No	 Not applicable Not applicable Yes Yes Yes Yes Not applicable Not applicable Not applicable Not applicable Not applicable
National Child Mortality Database (NCMD)	Yes	Yes
National Clinical Audit of Psychosis (NCAP)	No	Not applicable

National Comparative Audit of Blood Transfusion - 2025 Major Haemorrhage Audit	Yes	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes
National Emergency Laparotomy Audit (NELA) A. Laparotomy B. No Laparotomy	 Yes Yes	 Yes Yes
National Joint Registry	Yes	Yes
National Major Trauma Registry	Yes	Yes
National Maternity and Perinatal Audit (NMPA)	Yes	Yes
National Neonatal Audit Programme (NNAP)	Yes	Yes
National Obesity Audit	Yes	Not participating
National Ophthalmology Database (NOD) A. National Cataract Audit B. Age-related Macular Degeneration Audit	Yes	Yes
National Paediatrics Diabetes Audit (NPDA)	Yes	Yes
National Perinatal Mortality Review Tool	Yes	Yes
National Pulmonary Hypertension Audit	No	Not applicable
National Respiratory Audit Programme a) COPD Secondary Care b) Pulmonary Rehabilitation c) Adult Asthma Secondary Care d) Children and Young Peoples Asthma Secondary Care	 Yes Yes Yes Yes	 Not participating Not participating Not participating Yes
National Vascular Registry	No	Not applicable
Out-of-Hospital Cardiac Arrest Outcomes	No	Not applicable
Paediatric Intensive Care Audit Network	No	Not applicable
Perioperative Quality Improvement Programme (PQIP)	No	Not participating
Prescribing Observatory for Mental Health UK	No	Not applicable
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)	Yes	Yes
UK Cystic Fibrosis Registry	No	Not applicable
UK Interstitial Lung Disease (ILD) Registry	No	Not applicable
UK Parkinsons Audit	Yes	Yes
UK Renal Registry Chronic Kidney Disease Audit	No	Not applicable
UK Renal Registry National Acute Kidney Injury Audit	No	Not applicable

Patient outcome programme incorporating national confidential enquires	Eligibility	Participation
Child Health Clinical Outcome Review Programme (NCEPOD)	Yes	Yes

Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	Yes	Yes
Medical and Surgical Clinical Outcome Review Programme	Yes	Yes
Mental Health Clinical Outcome Review Programme	No	Not applicable

Reason for non-participation: -

BAUS Data and Audit Programme

A. British audit of investigation and referral of women with recurrent urinary tract infection using recent guidance (BOOMERANG) –we will not be participating due to staffing issues.

National Obesity Audit – lack of administrative capacity.

RCEM – Adolescent Mental Health, Care of Older People, Mental Health Self Harm and Time Critical Medication – we did not approve funding for these audits due to financial constraints.

Perioperative Quality Improvement Programme (PQIP) - Unable to participate due to logistical/staffing reasons.

National Respiratory Audit Programme – Adult Asthma Secondary Care/COPD/Pulmonary Rehabilitation – we did not participate due to lack of administrative capacity.

Cases submitted to clinical audits and confidential enquiries

The national clinical audits and national confidential enquiries that we participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit and patient outcome programme incorporating National Confidential enquires	Cases submitted	% cases
BAUS Data and Audit Programme – Evaluating management pathway for suspected testicular cancer referrals (EMPAST)		
Breast and Cosmetic Implant Registry		
Case Mix Programme (CMP)	457	100
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	23	100
Falls and Fragility Fracture Audit Programme (FFFAP) B. National Audit of Inpatient Falls C. National Hip Fracture Database	 11 498	 100 100
LeDeR – Learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disabilities Mortality Review Programme)		

National Adult Diabetes Audit A. National Diabetes Footcare Audit B. National Inpatient Diabetes Safety Audit (Harms) C. National Pregnancy in Diabetes (NPID)		
National Audit of Cardiac Rehabilitation		
National Audit of Care at the End of Life (NACEL)	60	100
National Audit of Dementia (NAD)		
National Audit of Metastatic Breast Cancer	67	100
National Audit of Primary Breast Cancer	736	100
National Bowel Cancer Audit	235	100
National Kidney Cancer Audit	152	100
National Lung Cancer Audit	241	100
National Non-Hodgkin Lymphoma Audit	91	100
National Oesophago-Gastric Cancer Audit	133	100
National Ovarian Cancer Audit	37	100
National Pancreatic Cancer Audit	128	100
National Prostate Cancer Audit		
National Cardiac Arrest Audit		
National Cardiac Audit Program (NCAP) A. National Heart Failure Audit B. National Audit of Cardiac Rhythm Management C. Myocardial Ischaemia National Audit Project D. National Percutaneous Coronary Intervention		
National Child Mortality Database (NCMD)		
National Comparative Audit of Blood Transfusion A. National Comparative Audit of NICE Quality Standard QS138 B. National Comparative Audit of Bedside Transfusion Practice		
National Early Inflammatory Arthritis Audit (NEIAA)	64	100
National Emergency Laparotomy Audit (NELA)	159	100
National Joint Registry	393 (222 Hips/ 171 Knees)	100
National Major Trauma Registry		
National Maternity and Perinatal Audit		
National Neonatal Audit Programme (NNAP)		
National Ophthalmology Database (NOD) A. National Cataract Audit B. Age-related Macular Degeneration Audit		
National Paediatrics Diabetes Audit (NPDA)	158	100
National Perinatal Mortality Review Tool		
National Respiratory Audit Programme A. Children and Young Peoples Asthma secondary Care	48	100
Sentinel Stroke National Audit Programme (SSNAP)	602	100

Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)		
UK Parkinson's Audit	20	100

Patient Outcome Programme Incorporating National Confidential Enquires	Cases submitted	% Cases
Medical And Surgical Clinical Outcome Review Programme (NCEPOD) 1. Acute Limb Ischemia 2. Blood Sodium	1 2/6	100 33
Maternal and Newborn Infant Clinical Outcome Review Program (MBRRACE)		

Our response to the findings of clinical audits

We reviewed the reports of 20 national clinical audits in 2025/26 and we intend to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions
1208 National audit of dementia round 6	
	1. Identification of patients with dementia at the time of admission should be incorporated into development of electronic patient record (EPR) so patients can be easily informed. 2. Improving screening for delirium in patients with dementia (and other at risk groups) - staff education, embedding pathways within new EPR to prompt and facilitate this. Incorporate screening into risk assessment documentation. 3. Use of structured pain assessments for inpatients with dementia – staff education. Introduction of laminated structured pain assessments to observation trolleys. Incorporating visual pain scale into Vitalpacs and EPR if this is possible. 4. Completion of personal information document – staff education.
1282 National Paediatrics Diabetes audit (NPDA)	
40% of parents are reducing working hours or giving up work after their child is diagnosed with diabetes – Ensure we are discussing this with families and sign posting them to support.	
1299 National Lung Cancer audit (NATCAN)	
Ensure services maximise the update of lung cancer screening for people aged 55 to 74 who are at high risk of lung cancer –	1. Explore with managers and senior leadership team regards funding for screening programme. 2. Explore avenues of funding to establish EBUS (Endobronchial Ultrasound) as a diagnostic test at Torbay Hospital.

Ensure providers have sufficient thoracic surgery capacity to accommodate the larger number of people with non-small cell lung cancer (NSCLC) who are candidates for curative surgery.

1. Continue to keep surgical resection as a focus in our MDT (Multidisciplinary Team) discussion – with screening we are already seeing an increase in lung cancer resection – this will not be reflected in our data until 2025/26.
2. New surgical colleagues are now present in Torbay all of Tuesday and are also engaging in joint clinics with the Oncology team. This has led to a smoother pathway for patients and shorted wait times. This service is impacted by staffing challenges. Derriford Thoracic Unit is currently in the process of putting together a business case for extra surgical colleagues.
3. Surgical capacity to be increased by increasing the number of theatre lists at Derriford Hospital.

Identify opportunities for increasing the proportion of people with NSCLC stage 3B-4 (PS 0-1) to have Systemic Anti-Cancer Therapy (SACT) as per NICE guidance, such as help people maintain their fitness for SACT throughout the care pathway.

1) Maintain current practice – encouraging individual patients to consider SACT and time biopsy.
2) Trust-wide – look at pre-hab to help maintain patient fitness.

Ensure NHS hospitals have the necessary resources and capacity to meet the timelines for patients to start primary treatment -

1. Aim to address diagnostic pathway delays but establishing EBUS (Endobronchial Ultrasound) at Torbay (currently and historically has been our biggest delay to the path Trust senior leadership team to urgently look at MDT room space for us to carry out our MDTs without undue time pressure.
2. Efficient MDTs with just one discussion per patient – to help encourage timely investigations and ordering of said investigations at first consult.
3. Ensure oncology teams are well supported with staff recruitment needs (screening has led to a definite increase in workload for the thoracic oncologists)
4. Continue to maintain local radiotherapy services

Ensure NHS hospitals have the necessary resources and capacity so that biomarker test results are delivered within 14 days of the test being performed, as defined in the National Optimal Lung Cancer pathway -

1. Biomarker testing is well established at Torbay and has been for more than12 months. There is a separate genomics navigator, and we have incorporated these results into patient pathway/MDT.

1311 National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)

1. SUDEP (Sudden Unexpected Death in Epilepsy) information provision – Documentation of SUDEP discussion for all patients.
2. ECGs (electrocardiogram) performed and documented 34% - ECGs performed, reviewed and documented for all patients presenting with seizure or sudden collapse.
3. Delay between EEG (electroencephalogram) referral and report (not clearly reflected in audit data but a known issue for our service) - Ongoing discussion with operations managers with EEG provision and costings.

1313 National Audit of Inpatient Falls (FFFAP)

1. L/S (Lying/standing) blood pressure measurements to aim for 60% for inpatient – Currently around 80% based on Fallsafe audit with 200 patients a month. The introduction of Epic will increase compliance regarding the number of patients having lying and standing blood pressure undertaken within 4 hours of admission as a mandatory field.
2. 4AT delirium for inpatients aged 65 years on admission aim for 65% on Epic - IT systems not in place currently. From April we should be able to obtain this information on admission under the dr's assessment. Repeating screening will be more challenging as can be added to nursing assessment under search but not a mandatory field. Will look to see if we can request this user change.
3. Expedite analgesia provision (national average 1:19 minutes) - Staff awareness of quicker analgesia provision post fall through, falls newsletter, post fall training and use of SBAR (Situation, Background, Assessment, Recommendation). Monitor results through NAIF (National Audit of Inpatient Falls) audit. Already added to hot debrief. Epic and NAIF will provide evidence. NAIF will add in section to acknowledge patient may 'informed decline' so results will be more accurate.
4. Falls leads attendance at AAR (After Action Review) aim for 80% - First AAR results for 2025 at 62%. Now two falls leads, aim for higher attendance.
5. NAIF audit – moderate and above – Look at new data and share at PSIRF (Patient Safety Incident Response meeting). Learn from AAR action plans and provide an overarching trust action plan with themes from moderate and above falls.
6. Quality improvement – Toilet Runway project to understand safe and effective use of ward toilets, day and night – Look into the feasibility of this project with a small working group. Obtain toilet and night falls data.

1314 National Hip Fracture Database (NHFD)
1. Increase performance in KP10 by 5% - Empty NOF (neck of femur) bed x 2 available on Ainslie. 2. Increase performance in KP12 by 5% - Achieve x 2 daily trauma lists Monday-to Friday. 3. Increase performance in KP14 by 5% - Quality improvement projects in peri-operative fluid management and analgesia protocol to limit inability to mobilise day 1 post operatively due to poor pain management or postural hypotension.
1327 National Audit of Care at the End of Life (NACEL)
1. Attending to dying persons emotional needs – particularly in community hospitals 2. Feedback to community hospitals matrons to ensure this information is cascaded to all staff. Discuss with palliative care education team to ensure this is highlighted in any teaching sessions which include care for the dying person. 3. Send email summary of NACEL audit to all Torbay/community teams
1333 National Bowel Cancer Audit Report (NATCAN)
1. Laparoscopic surgery rates – Identify which surgeons not starting cases laparoscopically. 2. Unplanned return to hospital – Identify a resident doctor to audit hospital returns to discover why this is happening.
1334 National Kidney Cancer Audit (NKCA)
1. Renal Cancer Clinical Support Nurse (CNS) - identified as essential role by Cancer Network but no funding available. 2. Improve MDT data capture 3. Recruitment of Oncologists and Urologists – Consultant posts are being advertised to recruit into vacant posts in Oncology and Urology.
1351 National Child Mortality Database Programme (NCMD) – Infants, children and young people with life limiting conditions
1. Recommendation 2 – All bereaved families allocated a key worker, most likely to be someone working in area or department in which child died. This is in progress and service development is now included in a new policy which is awaiting ratification. 2. Recommendation 3 – appropriate staff to access training in parallel planning and documenting advance care planning. Professional bodies to develop training and all appropriate staff in provider agencies to attend. Update October 2025, training in progress of development and delivery by professional bodies. Update December 2025, training sessions to be delivered but need to check all systems can access ETEP. (Treatment Escalation Plan).

3. Recommendation 4 – Advanced care planning documents easily visible and accessible – For all children who have Advance Care plans in place to have this information visible and accessible in all Trust records systems to support scheduled/unscheduled care attendances. Children's TEP has been delayed as some changes were required for modified choices to be displayed in EPIC, requiring a software update, so implementation pushed back few months. Training videos are being created, awaiting go live date. Update December 2025 – ETEP is now live, training sessions to be scheduled.

1355 National Emergency Laparotomy Audit (NELA)

1. Specialist care for older patients and those living with frailty – Investment in Frailty services, including Geriatrician-led input for emergency laparotomy patients.
2. Critical Care bed capacity – increase in critical care capacity (from 10 to 14 operational beds).
3. Risk-adjusted 30-day mortality – MDT review of mortality cases.

1358 National Maternity and Perinatal Audit (NMPA)

1. Audit findings recognised some areas for improvement – bring findings re: cord gases and vaginal deliveries to the next meeting.
2. Joint piece of work with obstetrics and paediatrics looking at cold babies at the time of LSCS (Lower Segment Caesarean Section).

1367 National Respiratory Audit Programme (NRAP) Children and Young Peoples Asthma Secondary Care

1. Slow steroid delivery – implementation of PGD (Patient Group Direction).
2. Documentation of smoking status, technique and PAAP (Personalised Asthma Action Plan) - complete new asthma guideline. Six monthly grand round to remind residents.
3. Lack of dedicated respiratory nurse – explore funding options.

1373 Sentinel Stroke National Audit Programme (SSNAP)

1. Improve rate of patients being scanned within 20 minutes of clock start – Produce breach analysis of 20-40 minutes breaches for review.
2. Improve rate of patients being give CTA (Computed Tomography Angiography) on first imaging visit – Discuss at Neuroradiology MDT-
   a) Book patients at the same time
   b) Perform without additional conversation with radiology.
3. Reduce variability at the front door for all patients arriving with a query stroke diagnosis
   a) Define expectation re: patients that should go direct to CT comms/pathway drawn and communicated.
   b) Review PASP NOSIP (National Optimal Stroke Imaging Pathway) vs. TSDFT SOP (standard operating procedure) for imaging.
   c) Review workforce model for specialist stroke nursing: Extend until midnight and additionally in the morning for extra resilience.

d) Review pre-alert SOP/phone guidance and 24 hour guidance.

4. Improve rate of patients being assessed by stroke skilled clinician within one hour of clock start – Scope ability to implement pre-hospital video triage.
5. Support and enable swift transfer of patients to the stroke unit post CT – implement ED clerking proforma.
6. Improve rate of patients arriving onto the stroke unit within four hours – target above national average and aim 60% -
   a) Direct to George Earle pathway – 8am-3pm unclerked.
   b) Clerking proforma as above.
   c) Explore prioritisation of patients out of hours (OOH) for clerking – education and discussion with medical registrars.
   d) Identify how EPIC will support this function out of hours.
   e) Ensure data input accurate – transfer time from ED +10 minutes.
   f) Review number and location of HASU beds; consider hyper-acute bay or increasing number of beds.
   g) Explore protocolised use of night diaries to support improved discharge planning.
7. Improve rate of patients seen by a consultant within 14 hours – Clerking proforma to support time spoken to a consultant.
8. Improve rate of patients seen by a stroke skilled nurse within four hours – Ward nurses to clearly document when the patient is greeted on the ward.
9. Improve rate of patients who were given a formal swallow assessment within 24 hours of clock start – Aim for SALT (Speech and Language Therapy) on ward each morning Monday – Friday.
10. Governance -
    a) Refresh and relaunch stroke governance/leads meeting.
    b) Regular performance report.
11. Access to analytics support for stroke performance – weekly metrics/run charts
    a) Sessions from MT/MB
    b) Production of weekly run charts
    c) Tableau
12. Roll out use of Tenecteplase (TNK) to replace Alteplase by November 2025 – Protocol written by L, hyperacute stroke book updated by H.
13. Out of hours support for reperfusion decision making- regional rota – Meeting to progress joining West of England rota no longer happen see update.
14. Out of hours support for reperfusion decision making – local solution – Identify options for local solution to this problem.
15. Mapping event to understand challenges, obstacles and opportunities – Agenda and invites – agree and source data.
16. Thrombolysis and thrombectomy –
    a) DIDO (Door-in to Door-out) process mapping review. Switch to TNK – see above.
    b) CTP (Computed Tomography Perfusion) for late window thrombolysis
17. Speech and Language Therapy -
    a) Data input for SALT to be improved.
    b) Identify a method of consistency of data input

c) Workforce planning – calculate SALT workforce requirement for Monday-Friday morning cover on wards.

18. Workforce – rehabilitation pathway – Review and quantify therapy to Neuro Rehabilitation outliers (i.e. time not given to stroke).

1340 National Cardiac Arrest Audit

Issues affecting cardiac call bleeps – upgrade to CritCo system.

1377 UK Parkinson's Disease

1. Improve documentation of key audit markers within clinic letters – to be implemented immediately following MDT discussion, with ongoing monitoring over the next three to six months.
2. Continue targeted discussions around LPA (last power of attorney), ACP (advance care planning) and EOL (end of life) considerations for patients with more advanced Parkinson's disease or increasing care needs – standardisation using EPIC (templates/ Smartphrases) to be incorporated alongside the EPIC rollout.
3. Review and incorporate elements of Southwest Parkinson's bone health algorithm to support fracture risk assessment where appropriate – initial steps already in practice within the nurse team; further alignment to reviewed and embedded over next three to six months.
4. With the upcoming EPIC electronic patient record implementation, utilise team templates and Smartphrase functionally to standardise documentation of audit markers across consultant and nurse clinics – Advance care planning/ EOL & LPA discussions – ongoing, with reinforcement in appropriate patient groups during routine reviews over the next 3 months.

1411 National Paediatric Diabetes Audit (NPDA)

Increase in obesity levels amongst CYP (Children, Young People) in our service – We are focusing our annual review on lifestyle discussions and advice. Offering dietetic home visits, giving activity and exercise advice and reviewing BMI annually in our meetings.

We reviewed the reports of three national confidential enquiries in 2025/26 and intend to take the following actions to improve the quality of healthcare provided.

1390 MBRRACE Maternal, Newborn and Infant Clinical Outcome Review Programme – Hypertensive disorders, cardiac disease, mental health-related causes, homicide and accidents 2021-23 and morbidity findings for women living in the most deprived areas
1. NO FIGO passport – to be considered following enrolment of EPIC.
1164 Rehabilitation following Critical Illness Study (NCEPOD)
1. Educational package – to be written and delivered to all ICU (Intensive care unit) staff 2. Access to SLT – Speech and Language Therapy access for Intensive Care Unit patients, with role embedded in weekly ICU MDT. SLT access to ward patients. 1. ICU Rehab Nurse role band 6 – skilled support to support step down to ward for patient, family and ward staff. 2. Additional Physio/Fitness Instructor band 5 – embedded within ICU Rehab team. 3. Occupational Therapy support band 5 – ICU experience and embedded within ICU Rehab team. 4. Psychological support for relatives – additional funding for Rehab Psychologist.
1245 MBRRACE – Perinatal Mortality Review Tool Report (PRMT)
Attendance of a neonatal nurse at PMRTs for NND (Neonatal death) – need to include the invitation, speak to a matron for Child Health to identify a member of the nursing team to attend.

We reviewed the reports of 55 registered local clinical audits in 2025/ 26. We intend to take the following actions to improve the quality of healthcare provided in 23 of these (two audit projects were withdrawn; nine did not require any actions and 21 are still ongoing).

Ref Recommendations / actions
6863 Adherance to BTS guidelines in repeating chest radiographs in patients with Community acquired pneumonia
-The short code used by radiologists for follow-up chest X-rays in the imaging report has been changed to suggest that the clinical team make the decision about whether a repeat is warranted or not, as they have the necessary information regarding risk factors.
6869 Audit of Management of Nasal Fractures
- Nasal Fracture Management poster - to display and share with relevant staff to reinforce appropriate referral criteria.

- Contact the clinic bookers to clarify the clinic booking processes for these patients
6872 Indications for plain abdominal films from the ED.
- Raise clinician awareness of iRefer indications and preference for erect chest X-ray when perforation suspected. - Share findings with MAAT team and wards
6877 Missed appointments in orthodontic clinic (DNA; did not attend)
- Design feedback questionnaire to establish possible reasons for missing appointments
6843 Assessment and Management of First Time Lateral Patellar Dislocation (FTLPD)
- Updating the online management pathway for FTLPD to reflect the new guidance - Encourage self-referral to physiotherapy at the time of presentation, included as part of the online pathway, rather than at first clinic follow-up. - A printable leaflet for patients with general information, self-directed exercises, and the physiotherapy self-referral information. - Dissemination of the new guidance and above changes to relevant heads of our ED, minor injuries units and urgent treatment centres.
6843 Does appropriate implementation of the MUST care pathway improve with increased dietetic ward presence?
- Further MUST training for bank and temporary staff Train the new roles of support workers in carrying out the assessment
6836 Electronic record keeping - Nutrition and Dietetics Clinic and medical notes
- Review and amend how we document consent - Ensure type of diabetes i9s recorded and not assume patient has Type 1. - Teaching/ simulation with radiographers to improve quality
6849 Assessing the need for inpatient management of TLS in high risk CLL patients starting Venetoclax
-All patients with CLL should be stratified into risk categories. Younger patients with no significant comorbid conditions could be managed in the outpatient setting with close monitoring.
6857 Communication and information provision for children and young people surgical patients and parents
-Introduce standardised discharge leaflets across all surgical specialties -Staff refresher training on safety-netting language and importance of written plus verbal communication