Torbay and South Devon
NHS Foundation Trust

Quality account 2020/21

About this document

What is the quality account and why is it important to you?

We are committed to improving the quality of the services we provide to our patients, their families, and carers.

Our 2020/21 quality account is an annual report which shows:

- how we have performed over the last year against the quality improvement priorities which we laid out in our 2019/20 quality account
- the quality of the NHS services provided and the development of our care model
- how we are implementing the care model
- how we have engaged staff, patients, commissioners, governors, Healthwatch and local Overview and Scrutiny Committees (OSCs) in deciding our priorities for the year
- statements about quality provided by our commissioners, governors, OSCs, Healthwatch and our directors
- our quality improvement priorities for the coming year (2021/22).

If you would like to know more about the quality of services we deliver, further information is available on our website www.torbayandsouthdevon.nhs.uk

Do you need the document in a different format?

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

Getting involved

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

Contents

Page

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

The past year has been unlike any other in the history of the NHS. As 2020/21 progressed, the full extent and devastating impact of the global pandemic on our community, our patients, families and our staff unfolded. In response we adapted and reshaped our services and care models across acute and community services so that we were well placed to keep our patients, the public and staff safe. Our guiding principle throughout this period has been to respond to the needs of our community in the safest and most compassionate way as possible, ensuring that they continued to access and receive the highest quality of care.

Sadly, like many organisations across health and social care, we have had to report patient deaths and staff illnesses resulting from the pandemic. In addition, thousands of patients have been affected by the delays in access to treatment and care. I know this has taken a huge emotional toll on everyone, especially when it has been difficult to support loved ones in our usual way.

The legacy of the last 12 months will be felt for generations and as we recover from the devastating impact of the pandemic, we will draw lessons from the tremendous courage and resilience of patients and our staff during this period. I am deeply thankful to everyone who has worked tirelessly to provide safe, high quality care in these difficult times. The kindness and compassion of all our staff reminds me of why I feel so privileged to lead this organisation and work in the NHS.

Our vision for health and care in Torbay and South Devon remains resolute, we are committed to delivering the highest quality of service, ensuring our community is supported and empowered to be as well, and as independent as possible, able to manage our own health and wellbeing, in their own homes. Over the past 12 months, we have built greater alliances and strengthened partnerships across health and social care and our achievements would not have been possible without the support of our people, the public and our partners.

In 2020/21, we achieved a pivotal milestone in our ambition for long term sustainable progress against the long-term plan. We have been successful in securing funding as part of the Government's hospital development program. This not only allows us to reshape and reconfigure our hospital and health care infrastructure, it enables us to build on our integrated approach to service delivery. This is a pivotal step, it signals a renewed focus and energy to build future models of care, continuing to innovate integrated pathways of health and social care, locally and regionally. We will build on the strengths our past innovations of greater integration of services so that our patients are enabled to navigate and access care in a way that supports them to remain as well as possible.

In 2020, we initiated a strategic program of work that will underpin and set out our ambitions for future models of care delivery entitled *'Building a Brighter Future'.* This 10-year program of work heralds a new way of working with patients, our staff and community. 'Building a Brighter Future' will set out our own long-term plan for health and social care in Torbay and South Devon, harnessing the partnerships and alliances we have established across the region.

We recognise that in shaping our future, we must do this together, we are committed to renewing and revitalising our approach to partnering with patients and the public, establishing a new way of working together to shape services and care for the future. Working together, we will design new

models of care, strengthen existing ones, ensuring that technological and digital capability together with the latest advancements in health and social care sit at the heart of our shared ambitions and plans. We look forward to the continued planning and delivery of our health infrastructure plan, which will result in a step change in the quality of our digital services offered as well as new infrastructure and buildings to support the delivery of our services.

While establishing a platform for sustained long term progress, we have retained a very clear focus on our current quality improvement journey. In responding to the findings of the Care Quality Commission (CQC) and through the focus and delivery of the adult social care improvement plan, we have continued to improve the quality and safety of care, key highlights this year include:

Improvements

Practice and care

- there has been a 10.1% reduction in all reported category 2/3/4 pressure ulcers when compared to the year 2019/2020. This equates to 89 less pressure ulcers reported
- we have rolled out the maternity early warning score framework, achieving 100% compliance in practice
- we have established our maternity improvement collaborative to progress the findings from the Ockenden report
- we have worked closely with our care home colleagues in Torbay and South Devon to implement the enhanced health in care homes framework having implemented it in 85% care homes against a target of 30%.

Pathways

- we have strengthened and enhanced our emergency care pathway through the creation of the surgical receiving unit and medical receiving unit, enabling patients to be directly referred from primary care, bypassing the emergency department front door, ensuring more timely assessment and treatment.

Infrastructure

- we have completed a detailed design for the new network and the associated equipment we have purchased which is held in secure storage ready for delivery
- work has progressed to update our Wi-Fi controller infrastructure which will enable the rollout of new state-of-the-art wireless transmitters across the hospital and community sites. This will commence from mid-March 2021
- we have developed our digital strategy and the plan to install and embed our new digital infrastructure will be in place by autumn 2021
- we began refurbishment of some key inpatient areas with a specific focus on care of the elderly and starting to create dementia friendly environments.

There is no doubt that COVID-19 has presented unprecedented challenges. At the time of writing, the cases in hospital and presentations in the community is in decline and the national vaccination programme is now well underway, therefore, we should all begin to feel more positive. Through the tremendous work of primary and social care over 72% of our 18+ population have been vaccinated with at least one dose and 40.7% have received a full course as of early May.

With the steady unlocking of society, further waves of COVID-19 are likely in late 2021/22. We will continue to maintain robust infection control precautions and adapt our services to ensure we are delivering timely urgent and emergency care. In doing so we will continue to strengthen and enhance our emergency care pathways and ensure our cancer standards are met.

With the support of Mount Stuart hospital, as well as our own theatre teams, we have been able to continue elective procedures and day surgery. Our focus for 2021/22 will be to ensure we are restoring services to pre-pandemic levels, specifically in relation to planned activity.

In 2021/22 our plans will focus heavily on recovery of staff and restoration and recovery of services, increasing the number of people able to have surgery and reducing the waiting list times, which have risen as a result of the pandemic. We will also build on our learning from 2020 and some of our innovations, as a result of the pandemic. These include:

- establishing a new COVID-19 testing facility at Newton Abbot racecourse with 7117 COVID-19 swabs and tests undertaken between 01 February and 11 May alone
- establishing the COVID-19 vaccination centre at the hospital, delivering vaccinations to over 90% of our staff to date
- working in partnership across the Devon system to establish the Nightingale hospital, which has been a great example of developing cross organisational services for the people of Devon
- setting up a care hotel, a step-down facility for patients
- increasing access to the Think 111 service, where people are now able to receive more advice and able to ring to get a time to go to an urgent treatment centre or to the emergency department for urgent care
- increasing the number of consultants led of virtual outpatient appointments with 21,722 video consultations and 64,425 telephone consultations in 20/21, instead of people driving to appointments and waiting unnecessarily.

We will continue to report on our quality priorities and I am pleased, that despite the pandemic, we have been able to make progress on the four areas we committed to in 2020/21.

Finally, this will be the last year of our report in this form as the national requirements have changed. In 2021/22 we will continue to report on our quality priorities via the Board of Directors and provide a quality summary in the performance section of the annual report. I commend this quality account to you and confirm that, to the best of my knowledge, the information in the document is accurate.

Liz Davenport, Chief Executive

Part 2: Priorities for improvement

Looking back: 2020/21

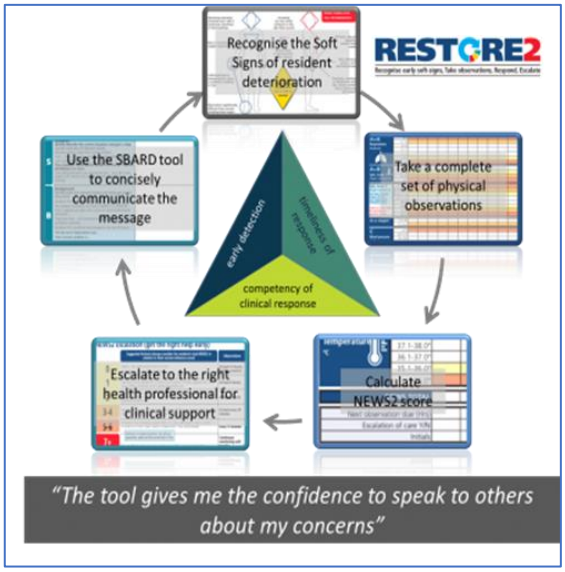
In our 2019/20 quality account we reported that we would focus on four priority areas for quality improvement in the period 2020/21. These were all locally agreed priorities developed in conjunction with key stakeholders at our annual quality accounts stakeholder meeting. The meeting included Healthwatch, our governors, commissioners, and local councillors as well as our health and care teams. The priorities were then endorsed by our Board of Directors prior to publication.

Patient Safety

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

Older people living in care homes have complex heath and care needs. Meeting these needs and ensuring that we work closely with our colleagues in the care home sector is a key priority. Crucially we are committed to ensuring that we identify early as possible when older people are deteriorating so we are well placed to intervene and support patients to remain in their own home and prevent admission to hospital. In 2020 significant work was progressed in partnership with our care home colleagues to implement a framework that would ensure, we are identifying and supporting at the earliest opportunity.

RESTORE2 is a physical deterioration and escalation tool for care/nursing homes. It is designed to support homes and health professionals to recognise when a resident may be deteriorating or at risk of physical deterioration and act accordingly using the resident's care plan to inform care.



The implementation of the tool forms part of the enhanced health in care homes framework and we had committed to implementing the tool into 30% of care homes (55 homes) across Torbay and South Devon by April 2021. Supported by the education team and their partner, Wellbeing Solutions, by February 2021 47 care homes and 11 domiciliary care providers have been trained in how to spot the deteriorating patient and take the appropriate action. This is three more than the initial target of 55, which was set pre-pandemic.

Due to the success and the importance of this work during COVID-19, a train the trainer programme was also launched and made available for any staff working in the care sector. The workshop gives care professionals the opportunity to understand the tool in its entirety and

enables them to run their training sessions with their own staff and assess them appropriately. Fourteen care providers have participated in the train the trainers programme.

It is testament to the teamwork involved and the commitment to the project that that the team have managed to implement this at a time when there has been unprecedented pressure on care providers. The tool has proved to be effective and useful to all care home residents, especially during the pandemic.

In 2021/22 the plan is to continue to spread the tool into the remaining care homes and increase its use within the domiciliary sector. The work will report via the Home First Group as part of the enhanced health in care homes framework implementation. The impact of the tool will be measured, to check the training has become embedded and that care provider staff are using the tool regularly.

Clinical effectiveness

Priority 2: to replace our Information Technology (IT) data network to reduce likelihood of system failures and to deliver improvements in speed, bandwidth and resilience to provide a platform for IT transformation.

We have a poor digital infrastructure and in order to improve IT delivery across our services, the Health Informatics Service has started to replace our entire network. This includes the Local Area Network (LAN), wireless network (controllers and access points), the Wide Area Network (WAN) and a proportion of building cabling and network cabinets. The project was estimated to take 18 months.

Due to the pandemic there were delays starting the project and also the cost and complexity of the project meant that the procurement processes and contract award were quite protracted. However, despite these problems a detailed survey of our network and Wi-Fi infrastructure was undertaken late summer and completed by the autumn.

Discussions around the final procurement have then progressed and were completed in 2020 with the final contract award and issue of purchase orders now in place.

We are pleased that the new supplier has now completed detailed design for the new network. We have purchased the associated equipment and it is held in secure storage ready for delivery.

Work has progressed to update our Wi-Fi controller infrastructure. This will enable the rollout of new state-of-the-art wireless transmitters across our hospital and community sites, which will commence from mid-March 2021. The plan is new digital infrastructure will be up and running by autumn 2021.This in turn will then support our new digital strategy which was published in 2020/21.

Patient experience

Priority 3 and 4: end of life care

We are committed to ensuring that every person nearing the end of their life receives attentive, high quality, compassionate care, ensuring that the needs of patients and their families are provided for in a way that they would wish them to be. As part of that commitment, understanding their experience is crucial and two end of life projects were chosen as part of the 2020/21 improvement priorities. These were:

- To introduce a patient feedback tool (FAMCARE) for family and loved ones about their experience of the end of life care their relative received from our services.

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

During COVID-19 there has been a significant amount of work undertaken to support those at the end of their life, their families and carers and the staff that have supported them at this really difficult time. This was coordinated through a system wide group which was set up including the local hospice, Rowcroft, Marie Curie service, general practice, NHS Devon Clinical Commissioning Group, and ourselves to focus our collective end of life resources on ensuring that we had a capacity and capability to meet any potential increase in demand.

The work of this group resulted in a range of practical tools including an electronic prescription medication administration record chart from general practice to community staff. This improved the timeliness of medicines required for end of life care across the geographical foot print and will continue long term. Additional equipment was purchased to meet potential increases in need and educational resources were developed that supported carers and loved ones to develop skills and competence in end of life care. A helpline was also set up to provide compassionate support and advice to both health and care professionals and local people.

Compassionate visiting for end of life patients was permitted during the COVID-19 pandemic, but restrictions were still required. Due to the challenges of visiting during the COVID-19 pandemic we introduced compassion hearts across out health community, including care homes. These knitted or fabric hearts are held by patients during their last hours or days of life and then passed on to their families, along with the offer of a lock of hair. This initiative will continue in the longer term and we have been grateful for the donation of so many hearts by staff and members of the public.

The ability to flex and adapt the end of life care provision across the health and care system to ensure high quality end of life care remained our central focus during the pandemic.

A whole new range of resources, guidance and tools have been developed in response to COVID-19 and as a result of the collaborative working with partners. These have been naturally prioritised over the last year in advance of the two improvement priorities originally chosen. (Pages - Palliative and end of life care for patients with COVID-19 (torbayandsouthdevon.nhs.uk))

As the second wave of COVID-19 receded in early Spring, we continued to use the existing family and patient experience feedback tool with the bereavement team, with plans to introduce the tool in 2021/22. As a result of the successful trail of bereavement bags in a small number of clinical areas, we have implemented the use of the bereavement bags across all our inpatient settings.

Our end of life group has refreshed our organisational priorities for 2021/22 and include:

- to consolidate adoption of the draft end of life care locality offer within our five integrated service units
- to introduce the feedback tool (FAMCARE) for family and loved ones, focused on their experience of the end of life care their relative received from our services
- to build on the advanced care planning pilot completed 2019/20 in recognising the last year of life and supporting individuals to develop their personal plans
- to develop a route to receive feedback from staff providing end of life care delivery across all our services
- to fully implement end of life care plans for patients in their own home that are aligned with inpatient plans to provide continuity across all our services
- to develop the end of life educational offer across all our services through the end of life educational sub group including in care homes and working with the enhanced health in care homes system wide programme.

Priorities for improvement in 2021/22

Looking forward: 2021/22

Patient safety

Priority 1: **to deliver against planned restoration of services to ensure safe and timely access and intervention and prevention of harm to patients, balancing the need for staff rest and recovery.**

Our focus for 2021/22 will be to ensure is that we continue our journey of improvements set out in both the CQC improvement plan and the adult social care improvement plan, embedding and sustaining our progress in the coming year. We will continue to sustain and improve the safety culture in relation to incident reporting and investigation and undertake a safety culture survey to ensure we are better placed to respond to and address areas that hamper our improvement journey.

While this year's priorities have been developed differently from previous years, where broader stakeholder engagement would have been sought, a picture of quality improvement has emerged as a consequence of the pandemic. There is now a pressing and immediate priority to ensure that patients and the public access treatment and care in a timely way and in line with national standards. As we continue to adapt to the COVID-19 picture of health, recovery and restoration of services and timely access to diagnostics and treatment to minimise and eliminate harm to patients as a result of delays in diagnosis and treatment.

Clinical effectiveness

Priority two: in partnership with our multi-agency colleagues, we will strengthen and enhance our approach to caring for children and young people who present with mental health illness, including eating disorders and autism.

We will be introducing a number of measures to ensure the psychological wellbeing of our patients and staff including a risk assessment framework that enables us to implement therapeutic interventions and support enhanced care planning.

The NHS long-term plan makes a renewed commitment to the growth and investment in mental health services. As part of our organisational strategy, we will take a more focused approach in 2021/22 to developing strategies and pathways of care to support all patients experiencing mental health problems.

During 2020/21, it became increasingly apparent that COVID-19 has exacerbated challenges for adults and children experiencing pre-existing mental health problems. A recent study, published by the Lancet in May 2021, reveals that the mental health of the UK population declined at the onset of the pandemic.

Our own experience of patients presenting across our services, and in particular attendance through the emergency department has increased. A key focus for us in the coming months will be to work in partnership with key stakeholders to ensure that we develop an integrated mental health

strategy that enables timely intervention and effective strategies to support all patients, adults, children and young people accessing all our services.

Crucially it is important that we ensure we provide safe and effective treatment within the acute services once patients are admitted. In response to rising incidents and levels of escalation within the inpatient setting, a specific program of work will be progressed focused on children and young people. As we develop our wider multi-agency strategy, we must ensure the experience for patients and staff is safe and compassionate, achieving the very best in clinical outcomes for this specific group of patients when admitted to the acute setting.

Patient experience

Priority three: to enhance the experience of patients through robust listening and feedback opportunities, building partnerships with patients around the co-design of their care, services and care models.

To identify and embed improvements in the experience of patients who are discharged from acute setting

During 2020/21 the COVID-19 -19 pandemic impacted significantly on the opportunities to proactively seek feedback from patients and service users on their experience of our services. Urgent and essential services continued but many of the routine services were reduced in line with Government guidance for a significant part of 2020/21.

Our feedback and engagement team revised their model in line with the national COVID-19 secure requirements but continued to respond to all complaints and concerns, raised by people using our health and care services within the national timeframes. The team also developed a “sending messages of love“ programme for inpatients who could not be visited by their family and loved ones. This service has been invaluable and will continue into the future.

The real time patient feedback led by volunteers in our inpatient wards was becoming embedded and achieving momentum but had to be paused during the pandemic. In 2020/21 we will focus on reinstating this service while ensuring the model meets current restrictions. The friends and family test was also suspended nationally to allow NHS services to respond effectively to the global pandemic. This method of receiving feedback from across our acute community health and care services has been reintroduced. We are complementing traditional paper based options of receiving this feedback with digital options and the use of QR codes.

During 2020/21 virtual consultations through attend anywhere were implemented and replaced face to face consultations for a number of services. Where clinically appropriate, these consultations will continue and, therefore, developing opportunities to receive meaningful feedback from people accessing care via this route will be pivotal to refine and improve the model.

In 2021/22 our feedback and engagement group will co-design, in collaboration with patients, service users and partners a patient experience strategy. This strategy will be underpinned by the experiences people who use our services share with us and enable us to understand what works well and what we can improve and enhance, to consistently provide the best experience of our health and care services. This will be a significant piece of work during 2021/22 and will provide a platform to provide excellence in care.

A work plan will underpin the delivery of the patient experience strategy and within our governance structure will be overseen by the feedback and engagement group reporting to the quality improvement group and quality assurance committee.

In 2021/22 we progressed a comprehensive improvement program to support and enable discharge from hospital to the community. Significant improvements have been made in 2020/21 around the timeliness of discharge including the introduction of a professional standards framework, setting out accountabilities around safe discharge. However, themes from patient and family feedback over the last 12 months has revealed a growing concern by patients around their poor experience of discharge from the acute setting. In the coming months, we will continue our improvement journey, with a specific focus on ensuring that discharge is both safe and compassionate.

National improvement initiatives

Currently we are involved in a number of national improvement initiatives including:

Seven-day services

Torbay Hospital continues to work on developing seven-day services. There are 10 clinical standards which are used to measure progress in this area. Our report to our Board of Directors in July 2020 notes the following:

Seven-day service standards		Self-assessment
Standard 2	Emergency admissions seen by a suitable consultant within 14 hours of admission	Standards not met
Standard 5	Seven day a week access to diagnostic services such as CT, endoscopy etc.	Standards met
Standard 6	Seven day a week access to consultant directed interventions e.g. interventional radiology and endoscopy	Standards met
Standard 8	High dependency patients seen twice daily and other patients once daily by a suitable consultant	Standards not met
Standard 1	Patients should be involved in shared decision making	Currently we do not have robust measurement systems to measure all these standards see commentary below
Standard 3	An integrated management plan established within 24hrs of admission to hospital	
Standard 4	Enhanced handover of clinical care between clinical teams	
Standard 7	Seven day a week availability of liaison mental health services	
Standard 9	Readily available support services e.g. pharmacy, community care services	
Standard 10	Regular review of outcome in terms of patient experience, safety, and clinical outcome	

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

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

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

Standard 7: liaison psychiatry is available for both adults and children. The Liaison Psychiatry service has focused on their hour response times to the emergency department. The latest flash report shows that despite staff shortages the hour target to the emergency department was achieved in just below 80% (October 2019).

The team continues to comply with the 24-hour target to the hospital wards achieving 88% within 24 hours. The psychiatric liaison team has worked with the emergency department to reduce attendance in an identified cohort of patients who attend the emergency department frequently with mental health problems.

Standard 9. the development of community support services is a major component of the emergency offer. This includes development of integrated care and work with care providers and community hospitals. Recent developments include the discharge hub which is expanding to work 7 days a week over the winter and work to strengthen community care.

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

In 2021/22 we will continue to review our performance and plans and consider how we flex our workforce to support the continued pressures on our services.

Rotas and gaps

In 2020/21 our rotas had to be reviewed in order to meet the demand of the pandemic and prepare for increased COVID-19 workload. A key element of our response is carefully evaluating the valuable skills of our junior doctors and understanding where there were opportunities to temporarily and safely reassign individuals to areas of greater and more immediate, need. The key considerations for the safe reassignment of our doctors and dentists in training were as follows:

- Early and proactive reassignment
    - medical workforce and medical education collated data to identify the knowledge and skills of our junior doctors and any previous experience in order to align them to the most suitable reassignment placement
    - we aimed to provide appropriate notice to junior doctors of any reassignment
    - junior doctors were only reassigned for the minimum duration necessary to support essential service response and proportionate to clinical need
    - communication and agreement of reassignments with Health Education England.

- Risk assessments
    - all junior doctors were required to complete a risk assessment.

- Building competence and confidence
    - junior doctors reassigned to an unfamiliar team and settings received a focused induction
    - junior doctors were encouraged to speak up if they had any concerns.

- Supervision
    - all junior doctors were appropriately supervised during the reassignment
    - wherever possible clinical and educational supervision meetings continued during the reassignment.

- Health and wellbeing
    - it was essential that all junior doctors had access to sources of support to ensure they were best able to maintain good health and well-being.

Communication has been key and following the first COVID-19 wave weekly meetings were set up to review and discuss junior doctor reassignments and rotas. As of March 2021, all COVID-19 surge rotas have been stood down and the final reassigned trainees are returning to their planned rotations.

Rotas continue to be reviewed within the departments however all are compliant with the limits on working hours and rest periods as dictated in the terms and conditions for doctors in training. We currently have two rotas which fall within 1:2 weekends; the junior doctors have agreed to the rota pattern and it has been signed off by the guardian of safe working. However, we are working on finding a solution to reduce the frequency to 1:3.

Sign up to safety

Sign up to safety is a national patient safety campaign to help the NHS in England build a safer NHS and address the problem of unsafe care and avoidable harm. Although several years old now, we continue to pledge to improve patient safety as part of this work and also build from the speak out safely work.

The areas we continue to regularly report on for patient safety include the following:

Tissue viability and pressure ulcer prevention:

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

2020/21 pressure ulcer incidences:

There has been a 10.1% reduction in pressure ulcers acquired in our care when compared to 2019/2020. This equates to 89 less pressure ulcers acquired in our care.

Of the 269 reported category 3/4 pressure ulcers acquired in our care for the period 2020-2021, 12 were declared to STEIS as being due to lapses in care by our staff.

Of these 12 pressure ulcers, nine were related to community patients, with four being from one community nursing team. A thorough investigation was completed by the leads for tissue viability and community nursing, along with the community service manager for the integrated service unit.

The lapses in care related to documentation and the lack of basic assessments. Extensive education was initiated by the community nursing lead and tissue viability provided a tissue viability specialist nurse to the community nursing team for a period of four weeks to support them. No further issues have arisen in this area for the last six months.

Also, during the year:

- the tissue viability team have embraced the use of digital technology to support nurses and patients in community settings with remote appointments which has allowed reviews of pressure ulcers with a reduced risk to the patient

- the tissue viability team have also been involved in the PROMISE quality improvement project which involves pressure mapping at-risk patients, or those with recurring pressure ulcers, to help to provide appropriate equipment which will lower the patient's risk of damage. This project has now finished and we have been gifted both a mattress and chair pressure mapping devices for our future use. This pressure mapping is now an integral part of the daily tissue viability work and the aim is to loan this to occupational therapists within the community in order to support them with at risk patients

- the pressure ulcer prevention policy has been updated to clearly lay out the responsibilities of all staff as regards pressure area risk assessments

- due to the pandemic, online training has been offered to all staff reassigned to different roles to ensure that they have the necessary skills to assess and manage a patient's pressure area risks

- the tissue viability team have re-sent all relevant documentation to ward managers and matrons to disseminate to all clinical ward staff to ensure that all clinical staff are fully aware of the need for appropriate documentation and assessments to be completed.

We also plan further ward-based training in 2021/22 and will continue to report our tissue viability work via the quality improvement group and share learning.

Falls assessment prevention and treatment

Falls prevention remains a key priority in our approach to continuous improvement and overall safety goal, to seek out and reduce harm. In 2020/21, a range of measures were introduced to ensure we were taking the necessary steps to reduce the incidence of patient falls across the Trust.

In 2020/2021 there was a 1027 falls compared to 814 falls in 2019/20. This was a consequence of the reduced bed occupancy during the year as a result to the covid -19 pandemic

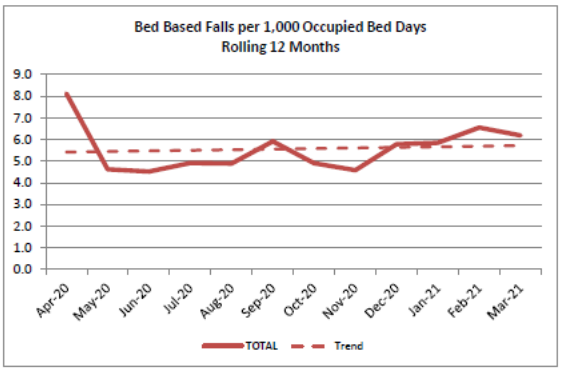
The national benchmark for falls per thousand bed days is 6.63. We remain below this at an average of 5.5.

Trustwide Bed Based Fall Incidents per 1,000 OBDs

Torbay and South Devon NHS
NHS Foundation Trust

Sources: Datix Incident Reporting (Falls), QIG Dashboard (Hospital OBDs).

All Wards - Summary



Bed Based Falls per 1,000 OBDs By ISU - 19/20 v 20/21 YTD

	2019/20 Year End	*2020/21 Year-to-date*	*Difference*
Torquay ISU	0.2	0.0	-0.2
Paignton and Brixham ISU	4.7	5.5	+0.8
Newton Abbot ISU	5.4	5.5	+0.1
Coastal ISU	4.1	4.7	+0.5
Moor-to-Sea ISU	6.8	6.5	-0.2
TOTAL	5.3	5.5	+0.2

Notes

1 This report is concerned with falls regardless of whether or not they have been recorded as having been 'caused by us'. (Figures reported in the QIG Dashboard exclude these)
2 Please note that 'Bed Based' includes BOTH Hospital and I/C Care Home falls.
3 Louisa Cary ward is excluded.
4 The Bed Based Intermediate Care figures are only concerned with falls that have involved Patients occupying beds provided under an Intermediate Care contract.
5 Please note that as result of the COVID-19 situation, from April to July 2020, Turner Ward was relocated to Teign Ward, Newton Abbot Hospital.

Bed Based Falls per 1,000 OBDs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Previous Year	5.8	5.4	5.9	5.8	5.7	5.1	5.8	4.2	5.4	5.0	4.5	4.8
Current Year	8.1	4.6	4.5	4.9	4.9	5.9	4.9	4.6	5.8	5.8	6.6	6.2

During 2020/21 our two falls prevention leads have continued to support falls prevention throughout the pandemic and adapted their programmes of work.

Achievements during the year include:

- an assisted lift response team to support South Western Ambulance Service NHSFT with non-injured fallers in the community
- all community wards now have flat lifting equipment
- hip fractures are now classed as severe on incident reporting in line with national recommendations from the Royal College of Physicians
- a falls winter campaign on hydration following a very successful pilot in six of our care homes and successful bid to roll this out
- a pilot to ascertain gap between actual and reported falls on two wards
- the purchase of 20 new TABS monitors to alert staff to patients moving who require assistance and who may not use call bells
- continued active membership of frailty partnership group
- COVID-19 compliant 'revised strength and balance programme with digital elements'
- a public health campaign with Torbay Council re deconditioning avoidance at start of March 2020 lockdown

- falls prevention training has been maintained for staff across all our settings in either a blended or digital format with post fall training for F1 and F2 doctors being more formally introduced in 2021

- enhanced health in care homes projects to support non-injured fallers and better engagement with those who have cognitive loss with the aim of preventing falls

- continued participation in the national inpatient falls audit (NAIF) with action plans resulting from incidents and learning disseminated across all our services through falls newsletters and via the falls and frailty steering group

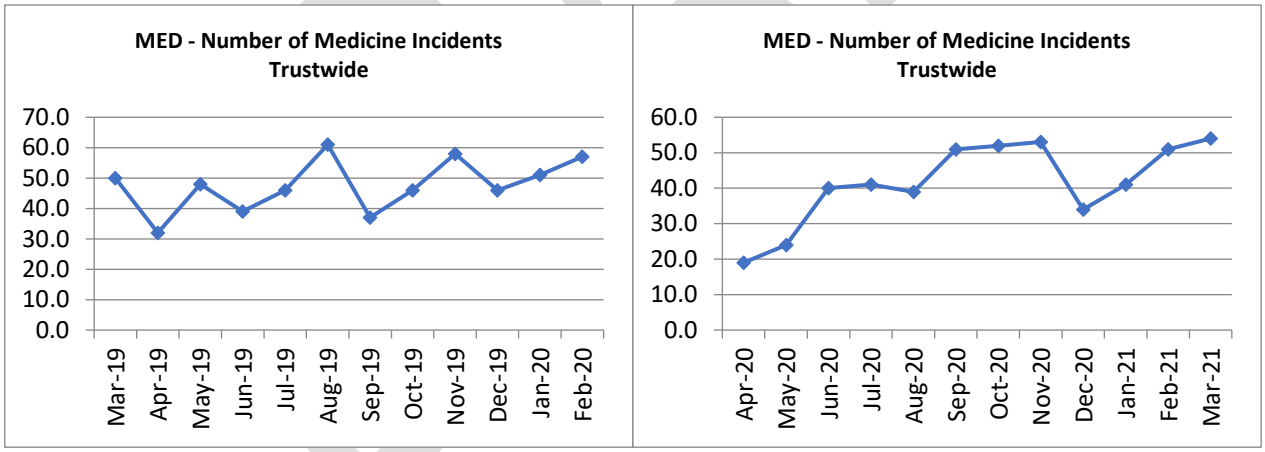
- completion of a vision pilot with the joint emergency team (JETS) team.

The falls prevention leads will continue to report the inpatient falls rate and the improvement work through the quality improvement group

Medications safety

We continue to actively encourage the reporting of medication incidents, as part of our just culture in reporting and managing patient safety incidents.

The table below demonstrates the number of medication incidents per month during 2020/2021, with 54 at the highest. Since December 2020 there has been an upward increase.



The main area of concern in regard to medication incidents is related to omitted doses and this will be an area of focus for 2021/2022

All medication errors are automatically sent to the medicines governance team who work with the clinical governance co-ordinators and integrated service units to review incidents, make recommendations and suggest actions for improvement.

During the past year pharmacy has maintained its service to all our services in providing medicines to patients safely and effectively during the COVID-19 pandemic. There have been a number of trials for the treatment of COVID-19 and pharmacy has supported these and the implementation of treatments as they have become available for our patients. More recently, pharmacy has been part of the team implementing and running our COVID-19 vaccination

programme ensuring that staff are trained to prepare the vaccines and that the vaccine has been stored appropriately.

There has also been a focus on working with the integrated service units to ensure that medicines are used safely and effectively and that medicines security is maintained. This work has initially taken place with Moor to Sea and Paignton and Brixham acute wards and the aim is to extend to all the integrated service units. This work has seen joint working to identify medicines related issues, actions and improvement work. For example, this has led to reviews of stock of Parkinson's Disease medicines along with the provision of education sessions for staff with the aim of reducing omitted doses. Work is also being undertaken to look at how pharmacy can assist the ward teams with their medicines round competencies to support the safe administration of medicines.

Other work has included:

- a controlled drugs (CDs) eLearning package which has been completed and rolled out. Staff are being encouraged to complete the eLearning and this will be monitored and feedback provided to area managers. Recording errors will also be monitored for improvement

- the implementation of CD bottle adapters which has continued to see a reduction in incidents involving stock discrepancies

- audit work which is now performed in greater collaboration with the wards, this is happening across all our services with the aim that any required improvements are agreed and clear

- supporting medicines safety newsletters covering a range of topics including advice on prescribing medicines in patients with an acute kidney injury to promoting our formulary and antibiotic (bug buster) apps

- the continued management of national medicine supply shortages to ensure that patient safety is not compromised.

Going forward into 2021/22 we will:

- improvement work to reduce the number of omitted doses

- continue to develop the collaborative work with the integrated service units looking to spread across all our services

- look to develop a learning dashboard for ward managers on medicines to enable them to track completion of learning so that essential learning e.g. safe use of insulin and desirable learning e.g. a day in the life of controlled drugs, can be monitored

- work to develop a robust process for assurance that medicines round competencies are being completed

- re-visit the insulin safety project

- investigate the use of a wireless fridge temperature monitoring system.

The electronic prescribing project implementation which we have reported in previous quality accounts has had to be suspended due to some issues that arisen that may have had a potential to impact on clinical safety. A review of the project is scheduled to take place in the summer 2021 with recommendations around pre-requisites of the system in order to re-start any implementation

Duty of candour and incident investigation:

In 2020/2021 we have ensured that we have adhered to the legal requirements of duty of candour and to meet the 100% target.

Incidents 2020/2021	Duty of candour %
STEIS reportable incidents (44)	100

There were a small number of cases when next of kin details were not obtainable for drug and alcohol clients but attempts were made to obtain these. Duty of candour details in the investigations show this has been documented.

The total number of severe/moderate/death as reported as an incident requiring further investigation was 336 in 2020/2021 of these 39.8% (118) were completed but not required by the duty of candour legal framework.

Our incidents and how we respond to incidents remain integral to our organisation both managed and coordinated within our robust clinical governance reporting structures. An investigation will support us in understanding what happened and where opportunities to learn or improve practices can be completed. These investigations will present recommendations, and local and organisational action and improvement plans will be used to ensure this learning is embedded into our organisation. These are managed by our experienced central and local management teams, we have continued to invest in additional posts this year, allowing us to continually improve and create a learning environment.

In the last year we have strived to improve our duty of candour obligation and have significantly improved the way we document duty of candour and the way in which we communicate with patients and their families to ensure their voice and questions are included within our investigation processes.

We are continually working on ensuring the language in our reports is presented in a way that is accessible to all and supports an environment of learning and improvement. In the coming year we will audit our approach to duty of candour and incident management from both the efficiency and effectiveness of our internal process, but also to hear from our patients and families to ensure they receive the best experience. Likewise, we will be reviewing the systems that support our reporting framework to ensure it is used to the optimum usage to complement our processes and the people we care for.

We have strong partnership working across all our services and with our Clinical Commissioning Group (CCG) colleagues to ensure we continually learn from our incidents and work in partnership

with our patients and families. All our internal processes are subject to thematic analysis and audit, overseen and monitored by our serious adverse events group.

Speaking up

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

In 2020/21, we agreed to focus on:

- embedding the anti-bullying network and use of policy to aid resolution across the organisation
- increasing the network of freedom to speak up champions
- roll out national training in raising and responding to concerns
- working with stakeholders to identify how to improve safety culture
- identify hotspots to provide early intervention and support in speaking up.

In 2020/21 the speaking up vision was embedded into the development of our people plan in order to further increase awareness of the routes available to all staff in how they can feel safe and confident in speaking up. This is enabling an increasing number of staff speaking up via the freedom to speak up guardians with concerns including patient safety, quality of care and cultures of bullying and harassment. Staff can also speak up through their line management chain or contact the guardian generic email, with further individual information on a specific speaking up intranet page. Digital induction training and training delivered face to face and via microsoft teams has continued for specific groups of staff.

Three levels of training have been provided by Health Education England and are being disseminated through the National Guardian Office. This includes for workers, manager and senior leaders.

In 2021/22, we have agreed to focus on

- a review of the self-assessment tool for NHS Trusts and Foundation Trusts to ensure that the expected standards are being met in supporting speaking up
- a review of the freedom to speak up guardian model to ensure it meets the needs of the organisation
- undertake a gap analysis against recommendations from case reviews at other NHS organisations
- a review of our freedom to speak up: raising concerns (whistleblowing) policy against the National Guardian Office policy review framework
- to rollout speak up, listen up, follow up national training for workers, managers and senior leaders.

Statements of assurance from our Board.

Review of services

During 2020/21 Torbay and South Devon NHS Foundation Trust provided and/or sub-contracted 52 relevant health services.

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

The income generated by the relevant health services reviewed in 2020/21 represents 89% of the total income generated from the provision of relevant health services by Torbay and South Devon NHS Foundation Trust for 2020/21.

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

Participation in clinical audits

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

During 2020/21, 37 national clinical audits and 3 national confidential enquiries covered relevant health services that Torbay and South Devon NHS Foundation Trust provides.

During that period Torbay and South Devon NHS Foundation Trust participated in 69% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation Trust was eligible to participate in during 2020/21 are as follows:

National audits	Eligibility	Participation
Antenatal and new born national audit protocol 2019 to 2022	Yes	Yes
BAUS Urology Audits	Yes	Yes
British Spine Registry	No	N/A
Case Mix Programme (CMP)	Yes	Yes
Cleft Registry and Audit Network	No	N/A
Elective Surgery (National PROMS Programme)	Yes	Yes
Emergency Medicine QIPs (RCEM)	Yes	Yes
Falls and Fragility Fracture Audit Programme (FFFAP)	Yes	Yes
Inflammatory Bowel Disease (IBD) Audit	Yes	N/P

Learning Disabilities Mortality Review Programme	Yes	Yes
Mandatory Surveillance of HCAI	Yes	Yes
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes
National Audit of Cardiac Rehabilitation	Yes	Yes
National Audit of Care at the End of Life (NACEL)	Yes	Yes
National Audit of Dementia	Yes	Yes
National Audit of Pulmonary Hypertension	No	N/A
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Yes
National Bariatric Surgery Register	No	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Cardiac Audit Programme (NCAP)	Yes	Yes
National Clinical Audit of Anxiety & Depression	No	N/A
National Clinical Audit of Psychosis	No	N/A
National Comparative Audit of Blood Transfusion Programme - 2020 Audit of the management of perioperative paediatric anaemia.	Yes	Yes
National Diabetes Audit – Adults	Yes	Yes
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes
National Emergency Laparotomy Audit (NELA)	Yes	Yes
National Gastro-intestinal Cancer Programme	Yes	Yes
National Joint Registry	Yes	Yes
National Lung Cancer Audit (NLCA)	Yes	Yes
National Maternity and Perinatal Audit	Yes	Yes
National Neonatal Audit Programme (NNAP)	Yes	Yes
National Ophthalmology Database Audit	Yes	Yes
National Paediatric Diabetes Audit (NPDA)	Yes	Yes
National Prostate Cancer Audit (NPCA)	Yes	Yes
National Vascular Registry	Yes	Yes
Neurosurgical National Audit Programme	No	N/A

NHS provider interventions with suspected/confirmed carbapenemase producing Gram negative colonisations/infections	No	N/A
Out-of-hospital Cardiac Arrest Outcomes Registry	No	N/A
Paediatric Intensive Care Audit (PICAnet)	No	N/A
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes
Prescribing Observatory for Mental Health UK	No	N/A
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Serious Hazards of Transfusion Scheme (SHOT)	Yes	Yes
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes
Surgical Site Infection Surveillance	Yes	Yes
The Trauma Audit & Research Network (TARN)	Yes	Yes
UK Cystic Fibrosis Registry	No	N/A
UK Registry of Endocrine and Thyroid Surgery	Yes	Yes
UK Renal Registry National Acute Kidney Injury Programme	Yes	Yes

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

The national clinical audits and national confidential enquiries that Torbay and South Devon NHS Foundation participated in, and for which data collection was completed during 2020/21, 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
Antenatal and newborn national audit protocol 2019 to 2022	Not yet available	Not yet available
BAUS Urology Audits	Not yet available	Not yet available
Case Mix Programme (CMP)	Not yet available	Not yet available
Elective Surgery (National PROMS Programme)	Not yet available	Not yet available
Emergency Medicine QIPs (RCEM)	Not yet available	Not yet available

Falls and Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database Annual Report 2020	410	100
Inflammatory Bowel Disease (IBD) Audit	Not yet available	Not yet available
Learning Disabilities Mortality Review Programme (LeDeR)	7	100
Mandatory Surveillance of HCAI	Not yet available	Not yet available
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Outcomes of Patients included in the 2017/18 Clinical Audit Outcomes of Patients included in the 2018/19 Clinical Audit Pulmonary Rehabilitation Clinical Audit 2019 Adult Asthma Clinical Audit	 345 335 8 175	 100 100 100 100
National Audit of Breast Cancer in Older Patients (NABCOP)	1097	100
National Audit of Cardiac Rehabilitation	Not yet available	Not yet available
National Audit of Care at the End of Life (NACEL)	53	100
National Audit of Dementia	Not yet available	Not yet available
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Not yet available	Not yet available
National Cardiac Arrest Audit (NCAA)	56	100
National Cardiac Audit Programme (NCAP)	Not yet available	Not yet available
National Comparative Audit of Blood Transfusion Programme - 2020 Audit of the management of perioperative paediatric anaemia.	Not yet available	Not yet available
National Diabetes Audit – Adults Inpatient Diabetes	64	100
National Early Inflammatory Arthritis Audit (NEIAA)		
National Emergency Laparotomy Audit (NELA)	195	100
National Gastro-intestinal Cancer Programme Bowel Cancer Audit Oesophago-Gastric Cancer	 225 128	 100 100
National Joint Registry	765	100
National Lung Cancer Audit (NLCA)	238	100
National Maternity and Perinatal Audit	Not yet available	Not yet available
National Neonatal Audit Programme (NNAP)	Not yet available	Not yet available
National Ophthalmology Database Audit	1790	100

National Paediatric Diabetes Audit (NPDA)	Not yet available	Not yet available
National Prostate Cancer Audit (NPCA)	781	100
National Vascular Registry	Not yet available	Not yet available
Perioperative Quality Improvement Programme (PQIP)	Not yet available	Not yet available
Sentinel Stroke National Audit Programme (SSNAP)	603	100
Serious Hazards of Transfusion Scheme (SHOT)	Not yet available	Not yet available
Society for Acute Medicine Benchmarking Audit (SAMBA)	Not yet available	Not yet available
Surgical Site Infection Surveillance	Not yet available	Not yet available
The Trauma Audit & Research Network (TARN) Clinical Report Issue 1 - Thoracic abdominal injuries Clinical Report Issue II - Orthopaedic Injuries Clinical Report Issue III - Head & Spinal Injuries	 336 532 498	 100 100 100
UK Registry of Endocrine and Thyroid Surgery	Not yet available	Not yet available
UK Renal Registry National Acute Kidney Injury Programme	Not yet available	Not yet available

Patient outcome programme incorporating national confidential enquires	Cases submitted	% cases
Child Health Clinical Outcome Review Programme (NCEPOD)	Not yet available	Not yet available
Maternal and Newborn Infant Clinical Outcome Review Programme (MBBRACE) Perinatal Mortality Surveillance Report 2020	 2237	 100
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) Bowel Obstruction Study Out of Hospital Cardiac Arrest Study	 3 5	 60 100

The reports of 19 national clinical audits were reviewed by the provider in 2020/21 and Torbay and South NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Ref	Recommendations / actions
0710	**Falls and Fragility Fracture Audit Programme (FFFAP) National Audit of Inpatient Falls**
	- Written patient information in acute - Falls champions to ensure leaflets given out routinely to those at risk patients. Mini audit to check compliance, complete patient handling and bed rail section on leaflets. - All hip fracture to be reported as 'severe' on TSDFT incident reporting system - Ensure all hip fractures are recorded as severe this will ensure they are immediately identifiable from the other fractures. - Ascertain gap between reported and actual falls - Already compare data retrospectively and use per thousand beds days. Hip fracture will be reported as 'severe'. Falls and Fragility Steering Group will promote learning through feedback to staff via FFSG, falls newsletter and training. Periodically review no harms and near miss and check correct & consistent. - Trial under reporting guide https://www.rcplondon.ac.uk/file/3417/download to see how this compares to our results every 4 months from 10 qualified nurses. Include bank, agency and 'borrowed' nurses, if there are any

working on the ward.
- Time of medical review within 30 minutes – acute bed based care - Highlight to staff that patients with a suspected injury from a fall we should be fast bleeping/urgently contacting the DR within 30 mins.
- Involve governance teams, Falls newsletter.
- Walking aid policy/SOP - Waiting for approval at Care Clinical Policy Group.

0753 Falls and Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database

- Admission to an orthopaedic ward within 4 hrs of admission with a hip fracture - Flow managers accountability for this metric.
- Future scanning show mismatch between surgical skills with regards to timely provision of a THR and periprosthetic fracture management - DI and GH to look at trauma rotas and see if any alternative rotas may facilitate more even skill mix availability.
- Slightly below average on percentage of people returning to their original residence - MDT deep dive of 50 case notes to identify themes that may be amenable to intervention.

0755 – (LeDeR) Learning Disabilities Mortality Review Programme

- TSDFT to identify LeDer reviews - Engage with Heads of Service to seek expressions of interest from suitably qualified staff. Recruit 10 LeDer reviewers and arrange training via the Clinical Commissioning Group online e-learning portal. Engage trained LeDer reviewers to complete outstanding investigations as allocated by the CCG. (12 p/annum).
- Address inequalities for people from BAME groups - Engage with TSDFT Equalities Officer. Progress and contribute to strategic plans aimed at addressing inequalities particularly in relation to people with Learning Disabilities and Autism.
- Promote the application of key legislation including the Mental Capacity Act (2005), the Autism Act 2009 and the Equality Act (2010) - Action - Address as a matter of urgency the issue of low awareness about the MCA among those affected, their families and carers, professionals and the wider public. TSDFT to strengthen governance in relation to adherence to the MCA and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.
- Ensure assessment and documentation of Capacity and Best Interests decision making processes are available, understood and applied.
- Promote the use of Independent Mental Capacity Advocate and Knowledge around the legal framework that guides when they should be appointed.
- Ensure family involvement in decision making via formal Best Interests processes is promoted.
- Promote the provision and documentation of reasonable adjustments, engage with and influence the need for 'joined up' NHS and social care information technology systems.
- Ensure staff are prepared to respond to Care Quality Commission inspections as the MCA will be a standard against which providers are inspected.
- Address unnecessary deaths by pneumonia and aspiration - Improving the training of families, paid carers and professionals about risk factors for aspiration pneumonia.
- Introduce the Oliver McGowan Mandatory Training in Learning Disability and Autism once developed by NHSE.
- Death by Influenza - action need for reasonable adjustments to be made for people with learning disabilities when offered influenza vaccinations
- Death of Young people - action required: - To promote and improve communication between children's and
- adults' services.
- To audit multi-agency involvement in transition planning for children and young people and to act accordingly. To review process and documentation for undertaking MCA assessments in young people 16 years and over to ensure they correspond to the legislative requirements. To improve communication with families particularly regarding transition planning and the decision-making process once a young person becomes 16 years of age and is subject to the Mental Capacity Act.
- Death of people over 75 greater attention to forward planning as people age, including appropriate accommodation options. Greater recognition about how a person's experiences at younger ages can impact on their life in later years. The provision of training about the physical, psychological and social needs of older people with learning disabilities, particularly for staff working in supported living settings and generic care or nursing homes. A holistic approach that integrates elderly assessment checks and learning disabilities annual health checks, and results in joint care planning and the sharing of information across the agencies that support the individual.
- Health Interventions - Adapt (and the adopt) the National Early Warning Score 2 regionally, such as the Restore2, to ensure that it captures baseline and soft signs of acute deterioration in physical health for people with learning disabilities.
- Issue identified - Training staff around Autism and Learning Disabilities - Work with Education Department to develop a programme of training resources that promotes wider understanding of the needs of people with a Learning Disability or Autism.

0828 National Diabetes Audit Programme (NADIA) National Diabetes Inpatient Audit

- Foot screening for diabetic inpatients on admission - To contact director of nursing for advice on how to move forward with progress on this initiative.
- Monitor compliance with staff completion of 'safe use of insulin' module as part of mandatory training - To work with nursing leads and education department to ensure this happens and compliance can be measured.

0830 National Diabetes Audit Programme (NADIA) National Diabetes Inpatient Audit - Harms

- Need to escalate significant diabetes harms review from MDT level to higher level trust governance meetings - To discuss with trust governance lead about how this process might work.

0778 National Neonatal Audit Programme (NNAP)

- Reduce separation of mother and baby in late preterm babies (34 to 36 weeks gestation) - Action - Introduction of Transitional Care Ward. A business case for the introduction of a Transitional Care Ward was submitted in 2019, but not achieved due a funding shortfall. This business case will be re-submitted.
- Check Badger data accuracy - Regular (monthly) review of data to ensure missing data and areas of non-compliance are checked against patient notes to check accuracy of data.
- Create new template ward round sheet - This template will be similar in format to that used on the children's ward for ease of use. It will require those present on ward rounds (family and staff) to be mentioned by name. This will allow for greater evidence of parent communication to be documented.
- Improve use of Badger system - Disseminate information on each set of junior doctor inductions of how to use the Badger system and provide a laminated guide to use.
- Extend nursing roles and training - Introduce Extended Nurse Practitioners (ENP) to the SCBU team. Our first ENP is due to start working in November. This role will include supporting junior doctors in their roles and in completing communication tools such as Badger.

0847 Sentinel Stroke National Audit Programme (SSNAP)

- Poor admission to ward within 4 hours data resulting in domain 2 areas being low especially initial assessment time by stroke nurse, consultant and swallow screen - Updating of Stroke Proforma and Stroke Specific resource site on ICONS to ensure up-to-date information for all clinicians.
- Poor admission to ward within 4 hours data resulting in domain 2 areas being low especially initial assessment time by stroke nurse, consultant and swallow screen - Robust training programme for medical registrars – post and post attendance questionnaires.
- Poor admission to ward within 4 hours data resulting in domain 2 areas being low especially initial assessment time by stroke nurse, consultant and swallow screen - Stroke added to mandatory training days for Emergency Department nursing staff.

0797 Each Baby Counts

- Recommendation: - Recognition of risk - Skill Drills Delivery suite once out of COVID-19 restrictions.
- Review handover process for the MDT.
- Involvement of neonatal team for ideas on how to improve on areas highlighted in report.
- Share report with Obstetric and Anaesthetic Team.

0776 National Lung Cancer Audit (NLCA)

- Access to Physiological testing - Action required - Ensure this is available at either Torbay or Derriford (our surgical centre)
- Access to staging investigations - Ensure the appropriate staging "Bundles" are performed for those fit for treatment.

0758 National Asthma and COPD Audit Programme (NACAP) Outcomes of Patients included in the 2017/18 Clinical Audit

- Only 31% asthmatics had a respiratory review in first 24 hours of admission (47% Devon (Sustainability & Transformation Partnerships) (STP) - Need to increase Specialist Nurse and Consultant workforce.

0761 National Asthma and COPD Audit Programme (NACAP) Outcomes of Patients included in the 2018/19 Clinical Audit

- Only 27% asthmatic patients had respiratory review in 24 hours of admission - Need to extend learning and outcomes to Emergency Department and Medical teams.
- Less than 5 patients had Peak Expiratory Flow Recording (PEFR) recorded within an hour of arrival - Need to extend learning and outcomes to Emergency Department and Medical teams.
- Only 28% asthmatic patients had systemic steroids within an hour of arrival - Need to extend learning and outcomes to ED and Medical teams.

- Less than 5 patients had 5 elements of British Thoracic Society discharge bundle provided - Need to extend learning and outcomes to ED and Medical teams. Ongoing attempts to use discharge summaries on infoflex to allow this.
- Only 57% had smoking cessation advice - need to work more with lifestyles team and reconsider reinstatement of smoking cessation champions.

0703 National Asthma and COPD Audit Programme (NACAP) Pulmonary Rehabilitation Clinical Audit 2019

- Only 58% stable COPD patients started Pulmonary Rehab within 90 days of referral - Increase capacity for Pulmonary Rehab.

0570 National Audit of Dementia – Round 4

- Communication during COVID-19 - Is it possible to identify carers that could receive questionnaire's?
- Nutritionally complete finger food menus - Investigate with dieticians about the nutritional value of our finger foods.
- "This is me" use - audit of inpatients with dementia to see how well this is utilised. This could be in acute and community hospitals.
- 4AT delirium screening for dementia patients - Audit of dementia patients for use of 4AT.

0627 National Diabetes Insulin Pump Audit

- Below national average pump provision - review Clinician practice at MDT.
- Increasing paediatric pump numbers - Expansion of MDT to support increased pump numbers.
- HbA1c performance below national average - Review pump contracts, processes and MDT availability.

0661 National Gastro-intestinal Cancer Programme – Oesophagi-gastric Cancer

- Ensure protocols are in place with neighbouring hospitals for the referral of all cases of high-grade dysplasia to the specialist MDT - NHS trusts/local health boards should set out clear pathways for referral to specialist treatment centres, where necessary - Action - Protocol for Barrett's oesophagus referral to be agreed by upper GI MDT.
- Investigate reasons for patients being diagnosed with cancer after emergency admission to identify opportunities for improving earlier detection. - NHS trusts/local health boards should review referral protocols with local GPs and assess whether initiatives are required, such as OG cancer awareness campaigns within the local community. Action: - Audit of emergency admissions diagnoses cases in the 2019 audit period.
- Review waiting times through the oesophagi-gastric cancer care pathway and identify ways to improve the progression of patients from referral through to diagnosis and treatment - Together with commissioners, MDTs should review waiting times through the care pathways and discuss ways to improve the progression of patients from diagnosis through to staging and treatment. Action: - Breach analysis part of ongoing workflow. Plans to streamline MDT pathway.
- NHS organisations should investigate the reasons why patients receiving non-curative chemotherapy are not completing the prescribed regimen - Action: - Oncology team to audit as part of their workflow.

0544 National Lung Cancer Audit Report (NCLA)

- Lower than expected pathological confirmation rate in good performance status, early stage NSCLca. Action - 1) MDT discussion. Close liaison with interventional radiologists and neighbouring Trusts to ensure all appropriate diagnostic procedures are considered and available. 2) Audit to explore reasons/trends for not confirming pathological diagnosis.
- Ensure adequate Lung Cancer Nurse Specialist (LCNS) support for our population of patients - Action:- Need to monitor the impact that the recent appointment of an additional LCNS (March 2020) will have on ensuring appropriate patient support. This may only become apparent in the 2022 NCLA (looking at 2020).
- Ensure all appropriate patients (Stage I-II, Good PS 0-2) with NSCL have curative intent treatment options considered. Action: Audit the patients in 2018 who did not undergo curative intent treatment to understand reasons for this.

0701 Perioperative Quality Improvement Programme (PQIP)

- Try and improve patient experience of pain in recovery - Open a medicines study using local anaesthetic infusions.

0726 TARN coding accuracy audit compared to imaging

- Improve descriptive accuracy of reporting trauma imaging - Action required: TARN friendly reporting CRIB sheets.

0735 UK Parkinson's Audit

- Difficulty educating ward staff and community staff due to time restraints - Consideration of Parkinson's education day for all to attend.

- Access to written information at clinic - discuss about provision of leaflets with community hospital.
- Trial use of NMS forms prior to clinic - post out to LT and GG patients.
- Improve discussions around advanced care planning - use of nurse team, home visit, improve communication, referral pathway with Rowcroft.

The reports of 3 national confidential enquiries were reviewed by the provider in 2020/21 and Torbay and South Devon NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

0605 Long term Ventilation (NCEPOD)

- Commissioning arrangements – standardisation of local commissioning arrangements - Escalate and discuss with CCG or relevant lead.
- Improve provision of written and online information for families - Create information leaflet for families.
- Improve provision of psychology support for LTV patients – Escalate to CD/Psychology Lead and CCG Lead.
- Improve link with adult LTV team and transition arrangements locally - Liaise with LTV lead and work towards a pathway.
- Create registry/log of LTV training of staff - Liaise with High Dependency Unit Nursing Lead and Community Nursing Lead.

0821 Saving Lives, Improving Mothers' Care – Rapid Report: Learning from SARS-CoV-2 related and associated deaths in the UK (MBRRACE-UK)

- No local guidance for caring for women from Black, Asian and Minority Ethnic (BAME) - Adopt and put into practice the new BAME Local Maternity Service wide Standard Operating Procedure (SOP).
- More detailed information to be included in the Perinatal Mental Health SBAR referral form - During mandatory training educate staff within Maternity services.

0538 Surveillance data on maternal deaths (MBRRACE-UK)

- Following resuscitation from an arrest with a likely cardiac cause, coronary angiography ± percutaneous coronary intervention is the appropriate initial diagnostic investigation. Resuscitation guidelines 2015 (UK Resuscitation Council 2015) - Included in new Cardiac Disease and Arrest Guideline.
- Echocardiography is recommended in any pregnant patient with unexplained or new cardiovascular signs or symptoms. (Regitz-Zagrosek et al. 2018) - Included in new Cardiac Disease and Arrest Guideline.
- When aortic dissection occurs in a young woman, the underlying diagnosis should be assumed to be an inherited aortopathy until proven otherwise. Saving Lives, Improving Mothers' Care 2016 (Knight et al. 2016) - Included in new Cardiac Disease and Arrest Guideline.
- Syncope during exercise can suggest a cardiac origin, and should prompt cardiac evaluation. ESC Guidelines for the diagnosis and management of syncope 2018 (Brignole et al. 2018) - Included in new Cardiac Disease and Arrest Guideline.
- [Electrical] cardioversion is safe in all phases of pregnancy. Immediate electrical cardioversion is recommended for any tachycardia with haemodynamic instability and for pre-excited atrial fibrillation. In the event of maternal cardiac arrest, resuscitation (and delivery) should be performed according to existing guidelines. In case of emergency, drugs that are not recommended by international agencies for use during pregnancy and breastfeeding should not be withheld from the mother. ESC guidelines for the management of cardiovascular diseases during pregnancy 2018 (Regitz-Zagrosek et al. 2018) - Included in new Cardiac Disease and Arrest Guideline.
- Nonselective beta-blockers should be continued throughout pregnancy and during the post-partum period (at least 40 weeks after delivery) in patients with congenital LQTS ESC guidelines for the management of cardiovascular diseases during pregnancy 2018 (Regitz-Zagrosek et al. 2018) - Included in new Cardiac Disease and Arrest Guideline.
- It is important to be mindful of the possibility of a cardiac diagnosis when repeated attempts are made to access medical care, particularly when extreme anxiety and breathlessness are prominent symptoms. Saving Lives, Improving Mothers' Care 2016 (Knight et al. 2016) - Included in new Cardiac Disease and Arrest Guideline.
- New onset of cardiorespiratory symptoms and/or absence of valve clicks in women with prosthetic heart valves should prompt careful echocardiography and early review by a senior cardiologist to exclude the possibility of valve thrombosis. Saving Lives, Improving Mothers' Care 2016 (Knight et al. 2016) - Included in new Cardiac Disease and Arrest Guideline.
- If there are concerns about patient compliance or access to diagnostic testing then there should be a low threshold for admission to hospital for implementation of changes to the anticoagulation regimen during pregnancy or postpartum as per ESC guidelines. (Regitz-Zagrosek et al. 2018) - Included in new Cardiac Disease and Arrest Guideline.

- Neither pregnancy, caesarean section birth or the immediate postpartum state are absolute contraindications to thrombolysis. (Knight et al. 2014) - Included in new Cardiac Disease and Arrest Guideline.

The reports of 27 local clinical audits were reviewed by the provider in 2020/21 and Torbay and South Devon NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Ref	Recommendations / actions
6573	**Anaesthetic "Cappuccini Test"**
	- Utilise Chicago Lightworks Employee roster programme to allocate a mentor and staff contact details - Include explicit mechanism of emergency help and who, during theatre brief
6585	**Safe and timely management of hyperkalaemia**
	- Flow chart to assist following the protocol and new documentation has been developed. The intention is to trial it on all acute medical wards - Investigate adding alert to biochemistry results - Reminder to everyone during audit meeting that first repeat potassium is key to safely managing these patients
6591	**Aldosterone Renin Ratio being used in the diagnosis and management of Hypertension**
	- Apply for research funding for a Research Nurse. - Appoint dedicated Research Nurse. - Screen all newly diagnosed obstructive sleep apnoea with hypertension for primary hyperaldosteronism by using Aldosterone renin ratio.
6595	**Recording Clinical Evaluations for Ionising Radiation (Medical Exposure) Regulations for Orthopaedics**
	- Share results with Orthopaedics - Advise/ educate Orthopaedic department of legal requirement to record clinical evaluations - Investigate whether automatic electronic question can be sent to requestor of image to advise they must report the image
6615	**Decompensated cirrhosis: The British Association for the study of the liver care bundle**
	- Update care bundle to show 'transfer to Allerton/ Cromie bed' under 'Inform Gastroenterology' - Add Low-molecular-weight heparin anticoagulant medication to care bundle - Emergency drive to hold care bundle, Emergency Department happy to perform tap if they know they need to do it - Update juniors training to improve confidence to perform ascitic taps
6616	**Breast pain clinic**
	- Breast awareness video and Breast pain video needed for iPads (Hiblio) - Further information letter to be sent to GP surgeries to inform them of the new clinic - Clinic is receiving inappropriate referrals, Clinicians to ensure incorrect referral is mentioned in discharge letter
6617	**Child Protection Medical Report writing**
	- Work with admin team to improve support for clinicians in all Torbay specialities - Discuss this work at named Doctors meeting to improve coordination between Torbay and Exeter
6618	**Adult inpatient venous thromboembolism (VTE) prevention in theatres**
	- Update VTE section of the drug chart to split the anti-embolism stocking and foot pump prescription box into two separate charts - Discussion with surgeons to determine who should be recording the VTE plan for theatres
6619	**Temperature Post Cardiac Arrest**

- Adopt a lower threshold for inserting intravascular cooling devices (Thermoguard) and starting invasive targeted temperature management - Education to discourage the active warming of patients who are stable within the target range of 32-36 degrees centigrade, particularly the higher end - Education to encourage more regular hourly recording of temperature in post cardiac arrest patients - Include details in the ICU pocket book for junior doctors starting and working on the unit - Disseminate results to the ICU nursing team.
6620 Chest x-rays for rib fractures
- Seek clarification on the referencing in the current trust guidance - Referrers to be informed and educated by their departments if changes to practice are required - Conflicting guidance - Enter into discussion with stakeholders in trauma imaging - discussion between Radiologist trauma lead with Emergency Department trauma lead
6631 Recording Clinical Evaluations for Ionising Radiation (Medical Exposure) Regulations for Max-Facs and Orthodontics
- Raise awareness of IR(ME)R regulations at speciality audit meeting
6632 Paediatric home enteral feeding clinic
- Introduce a new, fully resourced Out-patient clinic to enable patient review
6638 Stethoscope availability in Anaesthesia
- Procure six new stethoscopes - Ensure dedicated, labelled stethoscope is available in each area - Standardise the position/ location of stethoscope
6640 HIV Testing on ICU
- Contact Microbiology Consultant to ask for HIV to be added to the admission bloods order set so that all ICU admissions will have a HIV test provided they have not already had one in the year prior to admission. They will also discuss the 'Lab' blocking any tests requested if a patient has had a test within the last year (unless there is another indication) - ICU Guidelines to be updated
6647 Recording Clinical Evaluations for Ionising Radiation (Medical Exposure) Regulations for fracture clinic
- Look into possibility of introducing standardised letter template - Investigate introducing standardised proforma although the fracture clinic is currently going paperless
6650 Special Case Flagging
- Review and update the process for placing and removing flags
Audits completed and reviewed NOT requiring a plan or specific actions due to good results or compliance
6575 Foot and Ankle extracorporeal shockwave therapy
6587 Weekend vitreoretinal on-call
6593 Timely assessment and Care Plan paperwork to support Head and Neck cancer patients
6609 Bacillus Calmette-Guérin (BCG) Vaccinations
6611 Pathological margins of breast cancers excised with breast conserving surgery
6621 Air as contrast media for hip arthrogram
6622 Review of outcomes of colposuspension and fascial sling operations
6623 Large volume paracenteses (Elective day cases)
6628 Rotablation treatment at Torbay Hospital

6629	Basal Cell Carcinoma outcomes at three-year follow-up
6648	Silver Trauma Computerised Tomography scanning in Emergency Department

Research

The number of patients receiving relevant health services provided or sub-contracted by Torbay and South Devon NHS Foundation Trust in 20120/21 (as of February 21) that were recruited during that period to participate in research approved by a research ethics committee was 1840.

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

Torbay and South Devon NHS Foundation Trust was involved in conducting 209 clinical research studies during 2020/21 in 33 specialities.

During 2020/21 79 clinical staff participated in approved research at Torbay and South Devon NHS Foundation Trust.

In the past year more than 18 publications have resulted from our involvement with the National Institute Health Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

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

Examples of several studies which Torbay Hospital has led or participated in.

COVID-19: urgent public health research:

Infection – COVID-19	**RECOVERY TRIAL** ***In March 2020, the RECOVERY (randomised evaluation of COVID-19 therapy) trial was established as a randomised clinical trial to test a range of potential treatments for COVID-19. We have contributed to this globally important study.*** The RECOVERY trial was the world's first study to show that low dose dexamethasone; a cheap and available steroid; typically used to reduce inflammation **reduces death by up to one third in hospitalised patients with severe respiratory complications of COVID-19** and by one fifth in other patients receiving oxygen only. Subsequently the study has recently shown that tocilizumab - an anti-inflammatory rheumatoid arthritis treatment; reduces the risk of death for hospitalised patients with severe COVID-19. Patients who have significant inflammation and require oxygen, a combination of a systemic corticosteroid - such as dexamethasone - alongside tocilizumab reduces mortality by about

	one third for patients requiring simple oxygen and nearly one-half for those requiring invasive mechanical ventilation. Researchers also found that the drug reduces the length of hospital admission, and the risk of patients requiring mechanical ventilation. RECOVERY is now the second NIHR-supported study to demonstrate the effectiveness of tocilizumab as a treatment for COVID-19 patients, after results from the REMAP-CAP study. The RECOVERY trial has also shown the following treatments <u>were not effective</u> **in hospitalised COVID-19 patients:** • lopinavir-ritonavir (an antiviral treatment commonly used to treat HIV) • hydroxychloroquine • azithromycin (a commonly used antibiotic). The data showed no significant difference in the primary endpoint of 28-day mortality (19% azithromycin vs. 19% usual care). Convalescent plasma (collected from donors who have recovered from COVID-19 and contains antibodies against the SARS-CoV-2 virus). The recent results from the RECOVERY trial add significant and important information to our knowledge on how best to treat COVID-19. Through the study many of our local patients have had access to tocilizumab and other treatments.
Infection – COVID-19	**REMAP-CAP Trial** **South west patients contribute to study which finds arthritis drugs effective in improving survival in sickest COVID-19 patients:** Patients across the UK who are admitted to intensive care units due to COVID-19 are set to receive a treatment that can reduce the time spent in hospital by up to 10 days, an international study supported by the National Institute for Health Research has found. Results from the REMAP-CAP clinical trial, which is running locally at five hospitals - University Hospitals Plymouth NHS Trust, Royal Cornwall Hospitals NHS Trust, Royal Devon and Exeter NHS Foundation Trust, Somerset NHS Foundation Trust and Torbay and South Devon NHS Foundation Trust - evaluated the effect of treatments on a combination of survival and length of time patients need support in an intensive care unit (ICU). Patients receiving tocilizumab and a second drug called carlumab - both types of immune modulators - have a significant impact on patient survival and can reduce the relative risk of death by 24% when administered to patients within 24 hours of entering intensive care.
Infection – COVID-19	**SIREN study** **Study supported locally finds past coronavirus infection provides some immunity for at least five months, but people may still carry and transmit the virus:** NHS trusts across the south west rallied to support a study which has given key insight into immunity to COVID-19. The SIREN study, developed by Public Health England (PHE), has released results which indicate recovering from coronavirus (COVID-19) provides some immunity for at least five months. Beginning in June 2020, the study involved regular

	testing of tens of thousands of volunteer healthcare professionals. The study was supported locally by staff from Somerset NHS Foundation Trust, Royal Cornwall Hospitals NHS Trust, University Hospitals Plymouth NHS Trust, Yeovil District Hospital NHS Foundation Trust, Northern Devon Healthcare NHS Trust, Royal Devon & Exeter NHS Foundation Trust, Torbay & South Devon NHS Foundation Trust, Cornwall Partnership NHS Foundation Trust and Devon Partnership NHS Trust.
Infection – COVID-19	**GENOMMIC Study** This COVID-19 research has been a fantastic way to demonstrate how the clinical teams and research have worked together in gathering the samples and data required for these important studies. This study has identified potential treatments for COVID-19 after the discovery of five genes associated with the most severe form of the disease. Genetic evidence is second only to clinical trials as a way to tell which treatments will be effective in a disease. Existing drugs that target the actions of the genes reveal which drugs should be repurposed to treat COVID-19 in clinical trials, experts say.

Selection of cancer studies:

Cancer (bladder)	**Patient-reported quality of life outcomes in patients treated for muscle-invasive bladder cancer with radiotherapy ± chemotherapy in the BC2001 Phase III randomised controlled trial** BC2001, the largest randomised trial of bladder-sparing treatment for muscle-invasive bladder cancer, demonstrated improvement of local control and bladder cancer-specific survival from the addition of concomitant 5-fluorouracil and mitomycin C to radiotherapy. The study also assessed the impact of treatment on the health-related quality of life (HRQoL) of BC2001 participants and showed that quality of life of bladder cancer patients treated with radiotherapy±chemotherapy deteriorates during treatment, but improves to at least pre-treatment levels within six months. Addition of chemotherapy to radiotherapy does not affect patient-reported quality of life.
Cancer (breast)	**Synchronous versus sequential chemo-radiotherapy in patients with early stage breast cancer (SECRAB): a randomised, Phase III, trial** The optimal sequence of adjuvant chemotherapy and radiotherapy for breast cancer is unknown. SECRAB. Was a prospective, open-label, multi-centre, phase III trial looking to assess whether local control can be improved without increased toxicity by comparing synchronous to sequential chemo-radiotherapy, conducted in 48 UK centres. The study results show that synchronous chemo-radiotherapy significantly improved local recurrence rates. This was delivered with an acceptable increase in acute toxicity. The greatest benefit of synchronous chemo-radiation was in patients treated with anthracycline-CMF.

Cancer (breast)	**Hypofractionated breast radiotherapy for one-week versus three-weeks (fast-forward): five-year efficacy and late normal tissue effects results from a multicentre, non-inferiority, randomised, phase three trial** A large number of Torbay patients took part in the pioneering fast forward radiotherapy clinical research trial which found that a one-week course of radiotherapy – rather than the standard three-week treatment – will benefit women with early stage breast cancer. These results, have significant implications for both our patients and ourselves as an organisation. Patients will now have to spend a lot less time travelling to receive treatments which will be crucial in ensuring reduced patient contact during the COVID-19 pandemic. The ability to reduce the number of patient visits also has huge implications for NHS resources with an estimated saving of 50 million per year if all trusts adopt this finding as standard of care. As soon as the results were published our local radiotherapy team worked tirelessly to develop and put in place protocols so that this new practice could be adopted. This is crucial to our COVID-19 recovery plan and will help free up capacity and resources in the service during this difficult time.
Cancer (colorectal)	**3-month versus 6-month adjuvant chemotherapy for patients with high-risk stage II and III colorectal cancer: 3-year follow-up of the SCOT non-inferiority RCT** Patients diagnosed with bowel cancer are likely to have surgery to remove the tumour. Patients diagnosed with a more advanced stage of the disease are then likely to be offered what is known as adjuvant chemotherapy. The study assessed the efficacy of 3-month versus 6-month adjuvant chemotherapy for colorectal cancer and to compare the toxicity, health-related quality of life and cost-effectiveness of the durations. Overall, the study showed that 3-month adjuvant chemotherapy for patients with bowel cancer is as effective as 6-month adjuvant chemotherapy and causes fewer side effects.
Cancer (malignant haematology)	**Characteristics associated with significantly worse quality of life in mycosis fungoides/sézary syndrome from the prospective cutaneous lymphoma international prognostic index (PROCLIPI) study** Mycosis fungoides (MF) and sézary syndrome (SS) are the most common cutaneous T-cell lymphomas. MF/SS is accompanied by considerable morbidity from pain, itching and disfigurement. The study aimed to identify factors associated with poorer health-related quality of life (HRQoL) in patients newly diagnosed with MF/SS. **Conclusions:** This is the first prospective study to investigate HRQoL in newly diagnosed patients with MF/SS. The results show that HRQoL is worse in women and in those with alopecia and confluent erythema. MF/SS diagnosis has a multidimensional impact on patient HRQoL, including a large burden of cutaneous symptoms, as well as a negative impact on emotional wellbeing. The results show that a comprehensive

	validated cutaneous T-cell lymphoma-specific questionnaire is urgently needed to more accurately assess disease-specific HRQoL in these patients.
Cancer (malignant haematology)	**The UK NCRI study of chlorambucil, mitoxantrone and dexamethasone (CMD) versus fludarabine, mitoxantrone and dexamethasone (FMD) for untreated advanced stage follicular lymphoma: molecular response strongly predicts prolonged overall survival** This trial was the first to prospectively assess molecular response and the impact on outcomes for 400 patients. Long-term follow-up data shows that no cases of progression occurred in minimal residual disease (MRD) negative patients after six years of follow-up. Although there was no difference in outcomes between arms, this is the first prospective study to report MRD negativity resulting in significantly improved overall survival (OS).

CQUIN

In 2020/21, CQUINs were suspended due to the pandemic. However, using this framework we have focused our efforts on the quality improvements and wider learning within patient experience and patient safety.

Care Quality Commission

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

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

We have no conditions on registration. The CQC has not taken enforcement action against us during 2020/21. We have not participated in any special reviews or investigations by the CQC during the reporting period. During the period April 2020 to March 2021, we received no CQC inspections.

In July 2020, the CQC published the report from the announced inspection of six of our core services in March 2020 (Provider section - RA9 Torbay and South Devon NHS Foundation Trust (10/03/2020) INS2-5746184371 (cqc.org.uk)). In response, we developed an improvement plan to address the requirement notices and 'should do improvements'. Progress towards this improvement plan is monitored through our individual service leadership teams and reported to the our CQC and compliance assurance group.

NHS England and NHS Improvement conducted an announced use of resources assessment with an on-site one-day visit in February 2020. The final report for the assessment was published in July 2020 by the CQC (Use Of Resources - RA9 Torbay and South Devon NHS Foundation Trust (10/03/2020) INS2-5746184371 (cqc.org.uk)). Our rating for use of resources changed from good to requires improvement, and the report identified key areas for improvement. We have developed a work plan in response, and the progress is monitored by the finance performance and digital committee.

With the exception of the use of resources, our overall ratings from the CQC have not been reviewed during 2020/21. This is in accordance with the CQC's regulatory approach to only review overall ratings when a trustwide well-led inspection is conducted.

Our trustwide well-led inspection planned for March/April 2020 was cancelled by the CQC due to the COVID-19 pandemic. Therefore, we commissioned an external well-led review which was conducted and published in January 2021 with the Board developing an improvement plan.

Our current CQC ratings are shown in the table below.

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

Data quality

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

Our data quality is managed primarily by our health informatics service and our information team working together to ensure there are appropriate governance processes in place to manage and improve data quality.

NHS number and general practitioner registration code

We submitted records during 2019/20 to the secondary uses service for inclusion in the hospital episode statistics.

The percentage of records in the published data, as of February 2021:

which included the patient's valid NHS number was:

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

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

- 98.5% for admitted patient care.
- 97.9% for outpatient care.
- 98% for accident and emergency care

Information governance

Our information governance assessment report is no longer available and the system has been replaced by the "data security and protection toolkit (DSP toolkit)".

Our toolkit publication for 2020/21 was standards met.

All incidents where a breach of confidentiality has occurred were recorded on our incident system in line with our organisation's policies; 159 were reported.

All breaches of confidentiality are scored in line with current guidance provided by the Information Commissioner's Office (ICO) with four incidents in 2020/21 meeting the requirement for onward reporting. Risks to information are recorded on the organisation's risk management system in line with our policy. All data incidents, risks and data security and protection toolkit evidence is regularly reviewed at information governance steering group chaired by our senior information risk officer (SIRO).

Clinical coding

We undertake an annual data security protection toolkit of clinical coding audit and met the mandatory requirements of the toolkit. The audit was completed by an NHS Digital approved auditor

Data quality improvements

In 20201/21 we reported that we would take actions on the following to improve data quality:

- implement the recommendations from the external review, assigning a dedicated data quality workforce
- review national SUS coding, to maintain acceptable quality levels
- mitigate the changes and anomalies to data capture, necessitated due to pandemic prevention and detection
- improve the density of coding relating to palliative care by implementing additional data feeds from our local hospices
- increase coding provision to support the recording of mortality, to align with the summary Hospital-level Mortality Indicator.

During the year we engaged an external consultancy to review our coding offering. The results demonstrated an adequate level of accuracy. Coding provisions have been redesigned to allow input to summary mortality hospital-level indicator. As a result of the pandemic we did not implement the recommendations of the external review, assigning instead a dedicated data quality workforce.

In 2021/22 we will improve data quality in the following areas:

- implement the recommendation from the external review. Our information team is currently going through a business case process to extend workforce, this includes enhancing the data quality provision which will facilitate closer working with operational colleagues to improve end to end data input and reporting process
- develop an overarching data quality strategy as part of our information strategy (currently being developed)
- update data quality policy
- extend the data quality work in all areas of the organisation, for example improve data visibility and highlighting gaps in our community services.

Mandated quality indicators

This will be update at the end of March with Q4 data

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

Domain 1: Learning from patient deaths

Data will be provided to stakeholders on publication - being collated

27.1	During 2020/21, (April 2020 to Mar 2021) of Torbay and South Devon NHS Foundation Trust xxx patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: xxx in the first quarter; xxx in the second quarter; xxx in the third quarter; xxx in the fourth quarter
27.2	For the period April 2020 to Mar 2021 xx case record reviews have been carried out in relation to the above number of the deaths included above. The number of deaths in each quarter for which a case record review or an investigation was carried out was: xx in the first quarter; xx in the second quarter; xx in the third quarter; xx in the fourth quarter
27.3	x death representing <x% of the patient deaths reviewed via Structured Judgement Framework (SJF) review during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: x for the first quarter; x for the second quarter; for the third quarter; x for the fourth quarter. These numbers have been estimated using the Structured judgement framework based on the Royal College of Physicians guidance.
27.4	The themes from learning from death reviews has revealed that there was a need to focus on communication and process in relation to some interventions, in relation to some interventions these include; • to ensure good and timely care during end of life and after death. • to provide observations of equipment being used at regular intervals
27.5	The Trust has been implementing the new Medical Examiners with 5 recruited to post in year. The policy and process are being employed. Full application of the medical examiners will be realised in 2021/2022.
27.6	TSDFT continues to learn from deaths, within 2020/2021 the areas where improvement is required is; • communication with families throughout end of life and after death • communication between professional groups regarding treatment and following death We have provided the following to assist in our improvements in communication • training video for all staff • timely and appropriate use of treatment escalation plans
27.7	In 2020/21 there were xx deaths involving patients with a learning diabilities . Of thesed deaths the key leaning included:

	• poor communication with patients and families in regards to treatment plans In 2020, The deaths of people with leanring disabilities from COVID-19 (2020) LeDeR programme Univeristy of Bristol Report provided an insight to improvements that TSDFT must consider in our approach that have included; • treat me well group has developed an improvement plan to include specific areas within the Trust such as the Emergency Department • promote and improve communication between children's and adults' services. • promote the use of Independent Mental Capacity Advocate and Knowledge around the legal framework that guides when they should be appointed. • ensure family involvement in decision making via formal Best Interests processes is promoted.
27.8	x% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structure Judgement framework.
27.9	x% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Preventing people from dying prematurely

	Dec 19- Nov 20	July 18 – June 19	July 17- June 18	July 16 – June 17
SHMI	1.0063	0.9473	0.9159	0.8530
National High – Low	1.18 -0.69	1.19 – 0.69	1.26 - 0.69	1.22 – 0.73
Band *(Band 2 = as expected Band 3 = lower than expected)*	2	2	2	3
Observed deaths	1,575	1,685	1,780	1,808
Expected deaths	1.565	1,780	1,943	2,119
Spells	40,500	46,085	46.557	49,473

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

The Summary Hospital-level Mortality Indicator, or SHMI, is a measure of the number of patients that have died in hospital or within 30 days of being discharged from hospital. SHMI considers several factors including a patient's condition.

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

The highest Trust score is 1.18 and the lowest Trust score is 0.69. There is no national average. The Trust is performing in line with the national benchmark (1.0).

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

- Compliance with data standards for this indicator.

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

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

Palliative care coding (contextual indicator for SHMI)

	Nov 19 – Oct 20	July 18 – June 19	July 17- June 18	July 16 – June 17
Palliative care coding % deaths	34	25	25.3	22.8
England average	36	36	32.9	31.2
High	59	59	58.7	58.6
Low	8	15	13.4	11.2

Source of information: https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2021-03/palliative-care-coding

The highest Trust score is 59% and the lowest Trust score is 8%. The national average is 36%.

There has been an increase in the number of deaths with Palliative care coding however this remains within the Trust has remained within normal range and is below the national average

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

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

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

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

Helping people to recover from episodes of ill health or injury

Hip replacement	Apr 19- Mar 20	Apr 18 - Mar 19	Apr 17 – Mar 18	April 16 – Mar 17
Adjusted Health gain score	0.452	0.451	0.504	0.482
National average	0.453	0.457	0.458	0.44
Highest Trust performance	0.528			0.54
Lowest Trust performance	0.344			0.30
Knee replacement				
Adjusted Health gain score	0.324	0.331	0.349	0.353
National average	0.335	0.337	0.337	0.32
Highest Trust performance	0.419			0.403
Lowest Trust performance	0.215			0.245

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

The Patient Reported Outcome Measures (PROMs) data is published nationally in arrears. There is no national average.

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

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

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

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

Patients readmitted to a hospital within 30 days of being discharged

	March19–April 20	April 18-March 19	April 17 – March 18	April 16 – March 17
0-15 years old				
% readmissions	10.1	13.0	11.2	10.4
National Average	12.5	12.5	11.9	11.6
=>16 years old				
% readmissions	15.3	15.	14.3	13.8
National Average	14.7	14.6	14.1	13.6

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

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

- The benchmarking data is taken from HES using national datasets

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

- Regular monitoring and feedback to clinical and operational teams.

Domain 4: ensuring people have a positive experience of care

Overall patient experience – national inpatient survey

The national inpatient survey includes eligible patients aged 16 years or older who have spent at least one night in hospital during July 2019. The survey excludes maternity, which has a separate CQC maternity inpatient survey.

Field work for the survey (the time that questionnaires were sent out and returned) took place between September and December 2019. This included 1250 inpatients and responses were received from 627 patients, a response rate of 52.82%.

The national response rate was 45% and therefore Torbay and South Devon NHS Foundation Trust was 7.8% higher than the national response rate.

The Trust scored in the top 20% of Trusts for 12 questions and the bottom 20% of Trusts on 2 questions.

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

Inpatient survey	2020	2019	2018	2017
Overall view of inpatient services **(for feeling that overall, they have a good experience)**	8.3/10	8.3/10	8.4/10	8.4/10

Source of information: CQC

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

The Survey demonstrated that Torbay and South Devon NHS Foundation Trust strengths where the trust scored high included:

- Care: Help from staff to keep clean, access to own medicines whilst in hospital, involvement in and confidence in decisions about care, privacy when discussing condition/treatment, pain management
- Staff: confidence and trust in nurses, teamworking
- Leaving hospital: Involvement in decisions about discharge, discussing need for aids and adaptations, knowing who to contact if worried after leaving hospital; health and social care support upon leaving hospital.

The areas the Trust scored low and in the bottom 20% of trusts were:

- Hospital stay: During your hospital stay: Were you ever asked to give your views on the quality of your care?
- Information: Did you see or were you given any information explaining how to complain to the hospital about the care you received?

The Feedback and Engagement Group as part of its work programme for 2021/22 will focus on these areas of deficit and drive improvement working closely with the ward managers and Associate Directors for Nursing and Professional Practice.

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

Staff survey	2020	2019	2018
Torbay and South Devon NHS Foundation Trust	67.6%	65.3%	67.3%

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

In 2020 the national average score was 66.9%. The best performing Trust achieved 84% with the lowest performing Trust achieving 46.6%

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

- Nationally published data set commissioned by NHS England

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

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

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

Staff survey	2020	2019	2018
Torbay and South Devon NHS Foundation Trust	19.5%	18.1%	18.3%

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

In 2020 the national average score was 19.0%. The best performing Trust achieved 12.2% and the worst performing Trust achieved 26.3%.

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

- Nationally published data set commissioned by NHS England

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

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

Domain 5: Patient safety

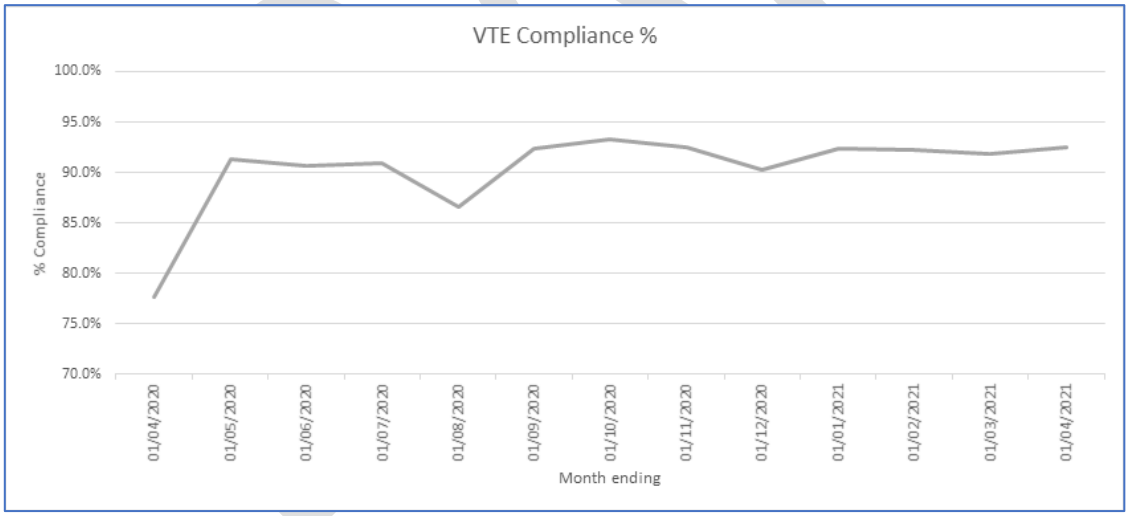
Patients admitted to hospital who were risk assessed for venous thromboembolism

	Q3 2020/21	Q3 2018/19	Q3 2018/19	Q3 2017/18
% VTE assessed UNIFY return	Not available	92.58%	92.23%	91.37%
National standard	Not available	95.00%	95.00%	95.00%
Highest performing	Not available	100.00%	100.00%	100.00%
Lowest performing	Not available	71.59%	54.86%	76.08%

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

2020/21 data has not been published nationally as VTE data collection and publication was suspended to release capacity in providers and commissioners to manage the COVID-19 pandemic. The Trust us though has continued to collect data and report it internally. For 2020/21 the Trust reported for VTE:

- Torbay Hospital 87.5% overall.
- Community hospitals 93.1% overall.



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

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

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

- Setting up a multi professional VTE Improvement Group to drive improvement meeting fortnightly.

- Weekly performance by inpatient ward is shared with ward managers and key medical staff and is reviewed through the wards SAFER group.

- Proactive work with ward teams to support data capture into electronic systems for reporting.

- VTE education with junior doctors

Rate of C. difficile infection

C.difficile rate per 100,000 bed days – 2yrs and over	Apr 19- Mar 20	April 18- Mar 19	April 17- March 18	April 16 – March 17
Torbay & South Devon NHS Foundation Trust	25.1	11.7	18.5	19.6
Best performing	0	0	0	0
Worst performing	51	79.7	90.4	82.6

The c difficuile rate is published in arrears. In the financial year 2019/2020 the C. difficile rate per 100,000 bed days is 25.1 (hospital onset status)

The best performing trust was 0 and the worst performing trust rate 51 per 100,000 bed days. The national average is 13.6 per 100,000 bed days. The data is published in arrears.

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

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

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

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

Number of patients' safety incidents recorded

Table 1

	April20 – March 2021	April 2019 – Mar 2020	April 18 – Mar 2019	April 17 – March 18
Number of incidents reported	7156	7633	7255	6894

Source of information: Trusts Risk Management System Datix

Table 1 records the numbers of incidents reported over the last 12 months, as highlighted in the table above, are within the expected range for the Trust and incidents have been reported from all areas of the organisation. It is lower than the previous meeting

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

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

- Accurate data recording.
- Monthly review of the data via the Quality Improvement Group. All incidents are reviewed centrally and within the Integrated Service Delivery Units.

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

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

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

	2020/21	2019/20	2018/19	2017/18
Number of incidents severe harm or death	44	13	11	23
Number of incidents of moderate harm	332	366	486	460
% of all severe or death incidents	0.6%	<0.1%	<0.1%	<0.1%

Source of information: Trusts Risk Management System – Datix

The number of incidents of severe harm or death is 44, and there have been 332 moderate incidents for the period from April 2019 to March 2020. There is no national benchmark.

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

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

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

- The Trust actively shares learning from serious events at an Integrated service unit level as well as from a Trust -wide perspective via the Serious Adverse Events (SAE) group.

- The Trust utilises SAE Alerts as well as the monthly 5-point safety to help spread safety messages from incidents that have occurred within the Trust.

Part 3: Our performance in 2020/21

Overview of the quality of care based on our performance

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

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

Our delivery structure is based on having two population based operational delivery systems and five locality integrated service units as follows.

Torbay delivery system comprising of:
- Torquay locality
- Paignton and Brixham locality

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

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

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

2020/21 has been a challenging year with services responding to the impact of COVID-19. The top priority throughout has been to support the NHS response to the COVID-19 pandemic while maintaining capacity to deliver services for our most vulnerable patients.

During this period services have had to respond to the impact of COVID-19 and implementing revised processes for personal protective equipment, social distancing, and infection prevention and control. Services have been focused on the delivery of emergency care and urgent elective care to minimise any clinical harm that could arise as a result of COVID-19 escalation. Significantly, during this period capacity for the most urgent pathways i.e. cancer pathways has been maintained.

We have seen reduced capacity for routine care due to infection prevention and control measures and this has resulted in an increase in waiting times for many patients. While clinical prioritisation

and review have been undertaken throughout it is recognised that many patients will, and are still, experiencing delays in accessing routine care for new and follow up pathways.

In 2020/21, we did not deliver the level of performance expected against all of the key NHSE&I performance standards and in particular those relating to elective routine pathways of care.

The challenge into 2021/22 will be to increase activity levels to reduce these long waits whilst maintaining a COVID-19 response and complying with necessary infection prevention and control measures.

A summary of the key clinical access performance standards for the year to date as at month 10 2020/21 used by regulators to assess our performance is set out below.

Indicator/target	Quality indicator	Target/ standard	20/21	19/20	18/19	17/18
Maximum time of 18 weeks from point of referral to treatment (RTT) - incomplete pathways	Experience	92%	61.4%	76.2%	81.0%	81.6%
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge Ⓐ	Experience	95%	88.9%	86.1%	81%	89.7%
Maximum six week wait for diagnostic procedure	Effectiveness	<1%	41.5%	11.3%	10.1%	4.2%
Cancer 62 day wait for first treatment from urgent GP referral for suspected cancer Ⓐ	Effectiveness	85%	77.3%	74.3%	73.7%	83.1%

With regard to:

Referral to treatment standard: In 2020/21 activity levels have reduced due to the diversion of clinical capacity into the COVID-19 response. Overall numbers waiting have increased as well as the number of longest waiting patients over 52 weeks for treatment. From a position of 53 patients waiting over 52 weeks in April 2020, this has increased to 2,049 by the end of March 2021. This represents a significant challenge over the coming year, and beyond, to recover the lost activity and reduce these waiting times. In response to the increasing number of patients waiting and the long waits, regulators have introduced additional clinical prioritisation criteria and guidance so that we can clearly demonstrate that the higher priority patients are being seen first and that clinical reviews are undertaken for those patients who will remain waiting for treatment.

Cancer standards: we maintained our commitment to prioritise delivery of cancer standards throughout the COVID-19 pandemic. Maintaining this capability has been built into all our decision making and escalation plans over the year. As a result, performance against cancer standards has remained consistent throughout the year despite not achieving the national standard, with clinical capacity ringfenced at all times to maintain cancer pathways. Following an initial drop in referrals in the first wave of COVID-19, referral levels from August 2020 had returned to pre-COVID-19 levels. Despite some service disruption as we responded to the escalation and reinstatement of services, overall service capacity from diagnostics to treatment for these pathways has been maintained.

Diagnostics: In 2020/21, we have been reliant on additional insourcing to meet the increasing demand for diagnostics tests across CT, MRI and endoscopy. This capacity has been supported with continued investments whilst planning has continued to establish both in-house and system solutions to the diagnostic challenge.

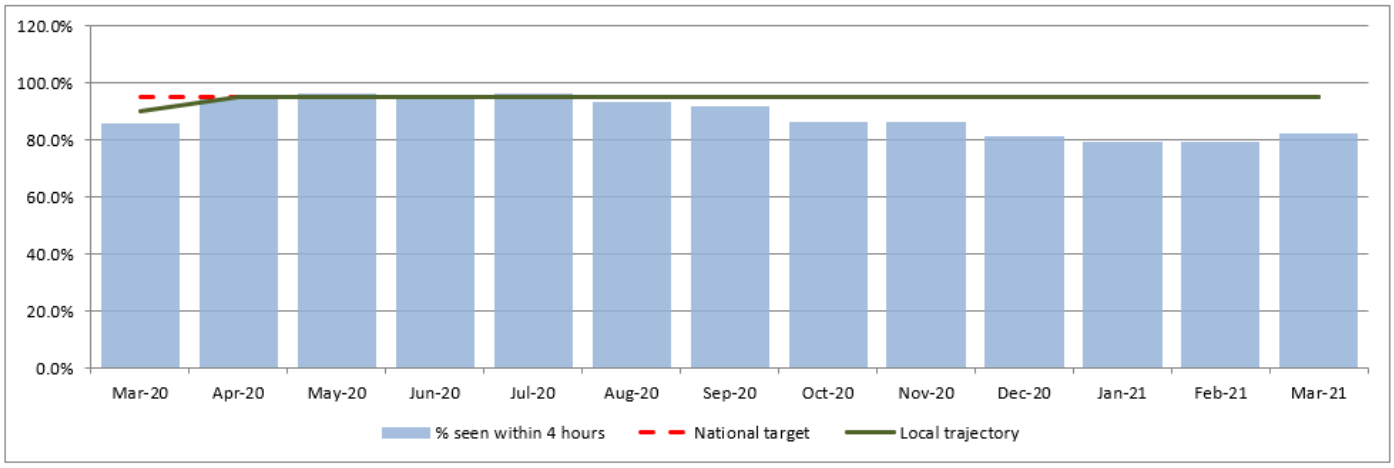
The impact of COVID-19 on staffing, social distancing, and infection control measures has severely reduced the number of scans completed and seen in a normal session. Clinical prioritisation is in place to ensure emergency and urgent patients are prioritised but this has led to a lengthening of waiting times for the more routine referral across several high-volume tests including CT, MRI and endoscopy. Over the year solutions have been found to bring back increased capacity with waits now stabilizing and planned to reduce into next year.

A&E wait time standards: The onset of COVID-19 required a full pathway redesign and use of additional clinical areas to deliver a safe COVID-19 compliant pathway of care. Overall volumes of patients attending for emergency assessment did fall in the first wave of COVID-19 but has since recovered to pre-COVID-19 levels. The new pathways not only segregated the COVID-19 triage and treatment pathways, we also utilised to a far greater extent the direct admission for screened GP emergency referrals direct to the medical and surgical teams.

Overall performance for the full year as measured against the 4-hour standard from arrival to discharge has been below the national standard, however, we have seen a significant reduction in the number of patients experiencing corridor care (to zero) as part of the emergency department assessment process. During the year a major redesign and estates improvement work of the emergency department has been completed, with this creating greatly expanded clinical areas and improving patient and staff experience.

During the second and third waves of COVID-19 the loss of inpatient bed capacity overlaid with winter pressures has impacted on the timely flow of patients requiring admission to a hospital bed and so, performance was impacted during these periods as seen in the chart below.

Chart of monthly performance against the emergency department 4-hour standard.



Local priorities

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

Other national and local priorities	Quality indicator	Target 2020/21	2020/21	2019/20	2018/19	2017/18
DNA rate	Effectiveness	5%	5.1%	TBC	5.2%	5.48%

Stroke care: 90% of time spent on stroke ward	Effectiveness	80%	77.3%	90.2%	86.9%	80.5%
Timeliness of social care assessment	Effectiveness	>70%	TBC	70.7%	78.6%	78.5%
Urgent intermediate care referrals per month (new)	Effectiveness	113	212	219	172	161
Mixed sex accommodation breaches of standard	Experience	0	0	0	0	0
52-week referral to treatment incomplete pathways year end position	Experience	20	2049	53	91	33
Delayed transfer of care (bed days lost)	Experience	4548	Not available	4693	5847	5311
Cancelled operations on the day of surgery	Experience	<0.8%	1.5%	1.3%	1.3%	1.3%
Number of children with child protection plan	Safety	None set	207	191	146	160
Never events	Safety	0	4	2	2	1
Reported incidents – major and catastrophic	Safety	<84	42	10	14	23
Safeguarding adults - % of high-risk concerns where immediate action was taken to safeguard the individual	Safety	100%	100%	100%	100%	100%

Plans for 2021/22:

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

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

Over the last year we have worked very closely with our partner organisations and neighbouring providers. This collaborative approach to planning and delivering services will continue and

increasingly shape how services are joined up and service capacity is viewed over a network rather than individual organisations.

Operational delivery

2020/21 has been a challenging year with services responding to the impact of COVID-19. The top priority throughout has been to support the NHS response to the COVID-19 pandemic whilst maintaining capacity to deliver services for our most vulnerable patients.

During this period services have had to respond to the impact of COVID-19 and implementing revised processes for Personal Protective Equipment (PPE), social distancing, and infection prevention and control (IPC). Services have been focused on the delivery of emergency care and urgent elective care to minimise any clinical harm that could arise as a result of COVID-19 escalation. Significantly, during this period capacity for the most urgent pathways i.e. Cancer pathways has been maintained.

We have seen reduced capacity for routine care due to IPC measures and this has resulted in an increase in waiting times for many patients. Whilst clinical prioritisation and review have been undertaken throughout it is recognised that many patients will, and are still, experiencing delays in accessing routine care for new and follow up pathways.

In 2020/21, the Foundation Trust did not deliver the level of performance expected against all of the key NHSI performance standards and in particular those relating to elective routine pathways of care.

The challenge into 2021/22 will be to increase activity levels to reduce these long waits whilst maintaining a COVID-19 response and complying with necessary IPC measures.

A summary of the key clinical access performance standards for the year to date as at month10 2020-2021 used by regulators to assess our performance is set out below.

Indicator/Target	Quality Indicator	Target/ Standard	20/21	19/20	18/19	17/18
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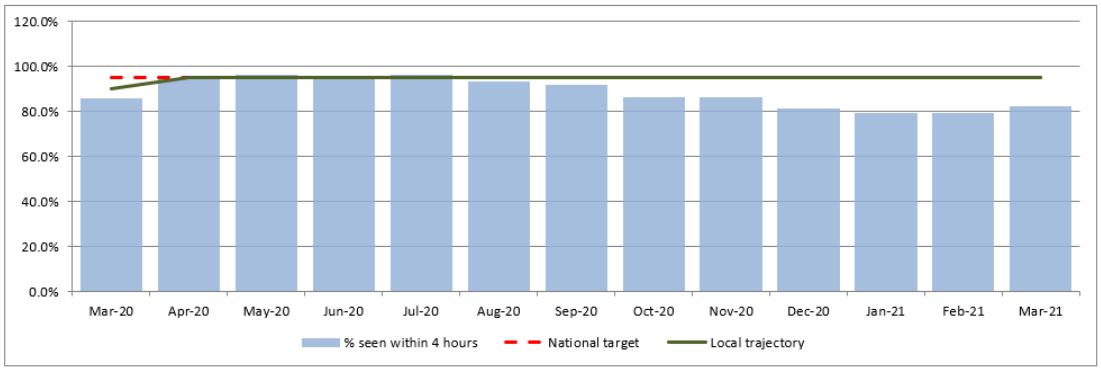

Chart of monthly performance against the emergency department 4-hour standard

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Safeguarding adults - % of high-risk concerns where immediate action was taken to safeguard the individual	Safety	100%	100%	100%	100%	100%

Plans for 21/22:

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Annex 1 – Engagement in developing the quality account (to be added)

Prior to the publication of the quality qccount we have shared this document with:

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

Statements from Commissioners, Governors, OSCs and Healthwatch

Statement from Torbay Council's Health Overview & Scrutiny Board on Torbay and South Devon NHS Foundation Trust Trust's Quality Account 2020/21

Statement from Healthwatch (Torbay) on Torbay and South Devon NHS Foundation Trust quality account 2020/21

.

Statement from Devon County Council's Health and Adult Care Scrutiny Committee on Torbay and South Devon NHS Foundation Trust quality account 2020/21

Statement from NHS Devon Clinical Commissioning Group on Torbay and South Devon NHS Foundation Trust quality account 2020/21

Statement from Trust Governors on Torbay and South Devon NHS Foundation Trust quality account 2020/21

Annex 2

Statement of Directors' responsibilities in respect of the Accounts

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 20120/21 and supporting guidance; detailed requirements for quality reports 2020/21;

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

    - board minutes and papers for the period April 2020 to xxx;

    - papers relating to quality reported to the board over the period April 2020 to xxx;
    - feedback from commissioners dated xx;
    - feedback from governors dated xxx;
    - feedback from the local Healthwatch organisations dated xx;

    - feedback from Overview and Scrutiny Committee dated xx and xx;

    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxx;

    - the 2019 National Staff Survey xxx;

    - the Head of Internal Audit's annual opinion of the Trust's control environment dated xxx;

    - CQC inspection report dated xxx and xxx;

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;

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

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

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

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

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

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

- .....Date.....xxxx.....Chairman

- …….Date …xxx…… Chief Executive

To be completed with stakeholder returns