

South Devon Healthcare NHS Foundation Trust
SDHFT Board of Directors
SDHFT Public Board of Directors Meeting
Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital
27 May 2015 13:30

AGENDA

- 1 Apologies - D Allen
Owner : Chairman
Note

- 2 Minutes of the Board Meeting held on the 27th May 2015 and outstanding actions 1.30
Owner : Chairman
Approve
 - 📄 Minutes of the Public Board of Directors - 6th May 2015.pdf 5

- 3 Declaration of Interests
Owner : Chairman
Note

- 4 Quality, Patient Safety and Experience

- 4.1 Report of the Director of Professional Practice, Nursing and People's Experience 1.35
Owner : DPPNPE
Note
 - 📄 Director of Nursing Report - Infection Control.pdf 14
 - 📄 Director of Nursing Report - WS2 Minutes.pdf 33

- 5 Strategy and Vision

- 5.1 Report of the Chairman 1.45
Owner : Chairman
Note

- 5.2 Report of the Chief Executive 1.55
Owner : CE
Note
 - 📄 Report of the Chief Executive.pdf 40

- 5.3 Integrated Care Organisation Update - Clinical Due Diligence 2.05
Owner : DPPNPE

	Discuss		
	 Clinical Due Diligence.pdf		44
6	Workforce and Organisational Development		
6.1	Report of the Interim Director of Human Resources Owner : IDHR		2.10
	Note		
7	Engagement and Partnerships		
	Note		
8	Council of Governor Issues Owner : Chairman		2.15
	Note		
9	Performance		
9.1	Monthly Finance and Performance Report Owner : DoF/COO/DPPNPE		2.20
	Note		
	 Report of the Director of Finance - Public.pdf		59
9.2	Report of the Chief Operating Officer Owner : COO		
	Note		
9.3	Report of the Director of Estates and Commercial Development Owner : DECD		2.35
	Note		
	 Report of the Director of Estates.pdf		113
10	Owner : Chairman		
10.1	HIS Half Yearly Report Owner : HISD		2.45
	Note		
	 HIS Half Yearly Report.pdf		121

12	Governors' Question Time Owner : Chairman Discuss	2.55
13	Date of Next Meeting - 1.30 pm, Wednesday 1st July 2015 Owner : Chairman Note	
14	Exclusion of the Public Owner : Chairman	3.00

**MINUTES OF THE SOUTH DEVON HEALTHCARE
FOUNDATION TRUST BOARD MEETING
HELD IN THE ANNA DART LECTURE THEATRE, TORBAY HOSPITAL
ON WEDNESDAY 6TH MAY 2015**

PUBLIC

Present:	Sir Richard Ibbotson	Chairman		
	Mr D Allen	Non-Executive Director		
	Mr J Brockwell	Non-Executive Director		
	Mr L Burnett	Non-Executive Director		
	Mr J Furse	Non-Executive Director		
	Mrs J Lyttle	Non-Executive Director		
	Mrs S Taylor	Non-Executive Director		
	Mrs M McAlinden	Chief Executive		
	Mr P Cooper	ICO Programme Director		
	Mrs L Darke	Director of Estates and Commercial Development		
	Ms L Davenport	Interim Chief Operating Officer		
	Mrs E Hobson	Torbay and Southern Devon Health and Care Trust Representative		
	Mr G Hotine	HIS Director		
	Dr J Lowes	Medical Director		
	Mr M Ringrose	Interim Director of Human Resources		
Mrs J Viner	Director of Professional Practice, Nursing and People's Experience			
In Attendance:	Mrs S Fox	Board Secretary		
	Ms J Gratton	Interim Director of Communications		
	Mr R Muskett	Deputy Director of Finance		
	Mr R Scott	Corporate Secretary		
	Ms S Evans	Unison Representative		
	Ms S Burns	Unison Representative		
Mrs C French	Lead Governor	Mr R Allison	Governor	
Mr T Bannon	Governor	Mrs A Harvey	Governor	
Mrs L Hookings	Governor	Mrs W Marshfield	Governor	
Mr P Welch	Governor	Mrs A Hall	Public Observer	

ACTION

72/05/15

Apologies

There were no apologies.

73/05/15

Minutes of the Board Meeting held on the 1st April 2015 and Outstanding Actions

The minutes of the meeting held on the 1st April were approved as an accurate record of the meeting.

The following actions were discussed:

- a) **Bristol CCG Suite of KPIs for dementia to be obtained** – these had been received and would be taken forward by the Dementia Steering Group.
- b) **Draft Quality Accounts** – these would be presented to the Board of Directors at the end of May for approval.
- c) **Annual Plan 2015/16** – actioned.

74/05/15 **Declarations of Interest**

Nil.

Quality, Patient Safety and Experience

75/05/15 **Report of the Director of Professional Practice, Nursing and People's Experience**

The Board noted the report which provided updates on the Lampard Report; Safe Staffing; and the Workstream 2 meeting held on the 20th March 2015.

76/05/15 **Report of the Medical Director**

The Board noted the report of the Medical Director which informed the Board that Dr Morven Leggott had been appointed to the post of Associate Medical Director for Women, Children's, Diagnostics and Therapies.

77/05/15 **Safety Scorecard**

The Medical Director presented the report for noting and highlighted the recent data rebasing exercise which has resulted in a tighter funnel plot. The Trust was just below the national average, which was good, but the margin was becoming tighter.

The Director of Professional Practice, Nursing and People's Experience queried Appendix 7 which was the number of Trust-wide patient incidents by month. It was noted that this included the pharmacy team recording any intervention led and undertaken by them when dealing with medicines and prescriptions, resulting in a sharp rise in incidents in February 2015. The Medical Director said that he was aware of this and it would be addressed.

Strategy and Vision

78/05/15 **Report of the Chairman**

The Chairman informed the Board that following the recent changes in legislation in respect of the implications of Corporate Manslaughter, the Board would require some training in this respect and this would be provided in the near future.

The Board noted that the Chairman, along with the Chief Executive; Corporate Secretary; and PA to the Chief Executive along with Governor observers, were undertaking to look at Board ways of working via the Trust's Quality Improvement Programme.

79/05/15 **Report of the Chief Executive**

The Chief Executive wished to place on record her thanks for the system-wide work that had enabled the Accident and Emergency 4 hour target performance to improve. The target had ended April at 94% and was currently at 95.8%.

Mr Allen commented that it was interesting to note that this Trust was experiencing attendances at its Emergency Department of a similar level to much larger neighbouring trusts, apart from the Royal Devon and Exeter, which made the

performance all the more praiseworthy. The Chairman added that he was surprised about how the complexity of patients attending the Emergency Department had changed, and it was noted that this was a national issue, with patients presenting with higher levels of acuity.

Mr Furse asked whether the learning from the work undertaken to improve the performance could be applied to other areas of the hospital. The Chief Executive said that the one thing that had appeared to have made the most significant improvement was to change the flow for GP expected patients. She added that the Trust needed to be clear about what changes had resulted in improvements so that the Trust could invest in the right areas.

80/05/15 Critical Care Unit and Main Entrance Full Business Case (FBC)

The Director of Estates and Commercial Development presented the FBC and highlighted the following:

- ♦ The Board fully understood the clinical need for a new Critical Care Unit and a robust process had taken place, involving all stakeholders, to identify a preferred option and contractor.
- ♦ There been some design changes since the Outline Business Case (OBC) the main one being the forced depth of the steel frame because the land infill was from the original build of the hospital. This had resulted in an increase in the construction cost of £1m over the OBC, however following a robust value engineering exercise the cost had been reduced to within £600,000 of the original budget which was within the expected variation from the OBC.
- ♦ The costs included a contingency of £630,000.
- ♦ The Finance Committee had endorsed the request of an additional £500,000 via loan funding to support the revised position.
- ♦ Construction would be completed in September 2016.
- ♦ Affordability was included in the Trust's long-term financial model (LTFM), but there would be a challenge in 2017-18 when staffing numbers could increase, however numbers could be held until it was clear the costs could be offset through skill mix etc (the cost would be around £120,000).
- ♦ The Chairman asked what was driving the predicted bed number of 14 and it was noted that the current unit could not cope with current demand which had resulted in the cancellation of operations due to a lack of high dependency beds and that 14 was in fact lower than the national norm for the Trust's population.
- ♦ It was noted that the build also provided 'future-proofing' with the option to add additional beds and also two additional wards, if required.
- ♦ In terms of actions taken to redirect flow during the construction, the main entrance would be at Level 2, and all traffic and bus routes etc would be diverted.
- ♦ The main entrance at Level 4 would close on the 26th May and there was a communications plan in place in terms of the changes.
- ♦ It was suggested that a member of the Royal Family be asked to attend the opening of the new Unit and it was agreed the Chairman would take this forward.

Ch

The Board then approved the following recommendations:

- ♦ The Full Business Case for the build and fit out of a new fourteen bedded critical care unit and a new main entrance at a cost of £14.581m.
- ♦ An increased loan application of £500,000 to the Foundation Trust Financing Facility (FTFF) to mitigate any risk of overspending the project (£12.7m to £13.2m).
- ♦ The commitment of £7,000m of the FTFF loaned capital for 2015/16 and £6,706m for 2016/17 to fund the project.

81/05/15 New Linac Bunker and Two Replacement Linear Accelerators FBC

The Director of Estates and Commercial Development presented this report and highlighted the following:

- ♦ The business case was driven by the need to replace the two existing linear accelerators. The accelerators had a life expectancy of 10 years - one was 12 years old and the other 10 years old.
- ♦ One of the existing bunkers was too small for the new machine so a new bunker needed to be built.
- ♦ The main challenge in terms of the build was to manage the service during the build process and the FBC detailed how this would be achieved.
- ♦ The original design had been changed to provide a better entrance for cancer patients and as part of this redesign it had been possible to reduce the building time by four months. It had, however, increased the cost due to the use of denser blocks but these had been kept to within £31,000 of the OBC and also included £125,000 of contingency sots.
- ♦ The build would be completed by January 2016.
- ♦ The costs were included in the Trust's LTFM, however changes in tariff had resulted in an additional £200,000 cost pressure not included in the model. This had been discussed in some length at Finance Committee and a number of mitigating actions had been taken. Also, the Trust's Specialist Commissioners had confirmed transition funding of up to £1m over three years which would taper off as income increased.

The Board then approved the following:

- ♦ The FBC for the build and fit out of a new Linac bunker and two replacement Linear accelerators at a cost of £7.558m.
- ♦ The commitment of £4.914m of the FTFF loaned capital for 2015/16 and £2.021m for 2016/17 to fund the project.

Workforce and Organisational Development

82/05/15 Report of the Interim Director of Human Resources

The Board noted the report, in particular the vacancy control mechanisms recently put in place so that staff could be assured no compulsory redundancies would be made as a result of the ICO. This had resulted in some very positive feedback from staff.

It was also noted that the Trust would be looking to recruit some more overseas nurses, against a backdrop of a national shortage of nurses. This Trust had retained the overseas nurses it had recently employed, which was unusual as Trusts normally found that overseas nurses moved on after initial employment. It was felt this was because of the positive way the Trust has managed their cultural needs during induction and ongoing employment. It was felt this was something that should now be publically celebrated.

The Director of Professional Practice, Nursing and People's Experience said that she would be producing a report that detailed nursing spend due to escalation and compare this to established ward spend.

IHR/
DPPNPE

Mrs Taylor queried the South West Consortium and the Interim Director of Human Resources explained that a group of Trusts had formed a consortium to try to manage down the costs of the employment of locum medical staff. This consortium had tendered for medical locum services and was now using one company with a standard fee which was up to 20% less than normal fees. If this arrangement was successful then the consortium might look at other groups of staff, particularly nurses.

Finally, Mr Furse wished to place on record the improved quality of Human Resources reporting and this was noted.

Engagement and Partnerships

83/05/15 Council of Governor Issues

Following the approval of the recruitment of an Associate Non-Executive Director role, the Corporate Secretary was commencing the recruitment process.

It was noted that all but one Non-Executive Director appraisals had taken place and that Mrs Lyttle had accepted the role of lead Non-Executive Director in terms of CIP delivery. Mr Allen has also agreed to be the lead Non-Executive Director for Estates.

Performance

84/05/15 Monthly Finance and Performance Report

The following was noted:

Performance

- ♦ There had been an increase in falls and pressure ulcers so a deep dive of the Quarter 4 incidents and complaints data was being undertaken. It was felt there was no trend to this increase, but was due to demand and challenges around flow.
- ♦ There had been an increase in the number of complaints received in Quarters 1 and 2, but this had reduced in Quarter 3. It was noted that the increase was not statistically significant and no trends had been identified.
- ♦ The current pressures continued to affect the Trust's 62 day screening to treatment target, RTT and Cancelled Operations.
- ♦ Mrs Taylor queried Care Planning Summary performance and it was noted that this would improve once the IT solution was in place. The Care Planning Summaries were being required to fulfil a number of functions for example VTE, dementia find and acute kidney injury. The Chief Executive stated that the Care Planning Summaries were an important tool between the community and the Trust.

- ♦ Mr Brockwell queried the RTT issues in April and the Chief Operating Officer said that there continued to be significant challenges and the next stage of work to address the backlog was taking place with the funding of a Vanguard Unit to help reduce the Ophthalmology backlog. The long term solution would be the redesign of pathways and to this end the Intensive Support Team for RTT would be supporting the Trust.
- ♦ Mr Furse queried the cost of implementing improvements and increasing income compared to the penalties if targets were not met. The Deputy Director of Finance said that there was a possible £5m penalty under the national contract, but under PbR any work that was outsourced would be paid for at tariff. In the last financial year no penalties were applied.

Finance

- ♦ The Trust had achieved a continuity of service risk rating of 3 at year end, against a plan of 3, with headroom of £1m.
- ♦ The Trust achieved its revised forecast end of year deficit £200,000 ahead of plan.
- ♦ The drivers affecting Trust income were the same as in previous months.
- ♦ Mr Burnett said that the CIP challenge facing the Trust in the coming year should not be underestimated.
- ♦ It was understood that his Trust and the Care Trust were the only organisations in the peninsula to have met their forecasted end of year budget.

85/05/15 2015-16 Budget

The Deputy Director of Finance gave the following briefing:

- ♦ The Trust's Annual Plan was based on the Stage 3 LTFM submission made to Monitor and assumed a contract with the CCG of £160.4m plus transaction funding and a risk share agreement in place.
- ♦ The LTFM was based on the forecast outturn in December, with some small adjustments to reflect the end of year position.
- ♦ Contract discussions were still ongoing with the CCG and at present the Trust was working to the national tariff contract, therefore penalties would apply.
- ♦ It was noted that the Finance Committee had asked for CIP performance to be analysed by calendar month so any slippage could be quickly identified and resolved.
- ♦ In terms of transaction funding for the ICO it was noted that discussions were still taking place with NHSE, the TDA and Monitor and to that end the Board to Board with Monitor scheduled to take place on the 8th May had been postponed until the end of May/early June.
- ♦ There was funding in the capital plan to manage the Trust's most significant risks, with some requiring additional loan funding. There was a lot of risk around the capital programme in terms of expected income and it was hoped this would be finalised over the coming weeks.

- ♦ The Chief Executive assured the Board that the capital plan had been robustly analysed to ensure the highest risks to the Trust were being addressed.
- ♦ The Annual Plan narrative stated that it was based on the FBC submitted to Monitor and was dependent on the ICO being approved. It also detailed a CSSR of 2 and highlighted risks in terms of RTT 18 week performance in Quarters 1 and 2 and the 4-hour target in Quarter 1.

The Board then approved the following:

- ♦ The 2015/16 budget and Annual Plan Submission to Monitor.
- ♦ The Executive to manage the implementation of the capital programme, approving and phasing expenditure to reflect funding agreements as they were secured and delivery of revenue budgets.
- ♦ To authorise the Chair/Chief Executive to approve the narrative document having first sought comments from all Board Members.
- ♦ To note, discuss and approve the self-certification statements as completed.
- ♦ To note and approve the declaration of risks against healthcare targets and indicators as completed.

86/05/15 Report of the Chief Operating Officer

Nil.

87/05/15 Report of the Director of Estates and Commercial Development

The report of the Director of Estates and Commercial Development and in particular Estates performance was noted.

The Director of Professional Practice, Nursing and People's Experience queried the increase in staff-related manual handling incidents and asked if there were any trends identified. The Director of Estates and Commercial Development said that there was no trends identified, but that the Health and Safety Committee was monitoring the data.

88/05/15 Governors' Question Time

Mrs French expressed disappointment the Fracture Liaison Service would be ceasing in three months' time. The Chief Operating Officer explained that the Trust had been served notice on the service by the CCG, who had thought there was a notice period of three months. In fact the notice period was 12 months and the Trust was using this time to work on the future of the service with the CCG. She added that staff were being kept fully up to date with the negotiations.

Mrs French then congratulated the Director of Estates and Commercial Development on the good state of repair of the Trust's estate which had been highlighted through the recent CQC mock inspections.

Finally, Mrs French wished to thank the Trust for rolling out the text reminder service.

89/05/15 Date of Next Meeting

1.30 pm, Wednesday 27th May 2015.

Exclusion of the Public

It was resolved that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

ACTION SHEET
BOARD OF DIRECTORS
PUBLIC
6TH MAY 2015

Minute	Action	Officer	Date
80/05/15	Critical Care Unit and Main Entrance FBC – Chairman to investigate whether a member of the Royal Family could attend the opening of the new unit.	Ch	Future meeting
82/05/15	Report of the Interim Director of Human Resources – report to be produced detailing nursing spend due to escalation compared to established ward spend	IHR/DPPNPE	Future meeting

REPORT SUMMARY SHEET

Meeting Date:	May 27 2015
Title:	Annual Infection Prevention & Control Report
Lead Director:	Director of Nursing and Professional Practice
Corporate Objective:	Safest Care
Purpose:	Assurance
Summary of Key Issues for Trust Board	
<u>Strategic Context:</u>	
<p>Ensure regulator compliance and to achieve the best possible outcomes. NHS England compliance targets: CDiff - to report less than 11 cases associated with a lapse in care MRSA - to report zero cases</p> <p>CCG: CDiff - 22 cases</p> <p>CQC Intelligent Monitoring compliance dataset to Dec 2014: CDiff - expected 18.82. Observed 22 (no risk) MRSA - expected 1.27. Observed 0 (no risk)</p> <p>Improving the environment for those with cognitive impairment including dementia is a key objective set by our Governors in 2015.</p>	
<u>Key Issues/Risks and Recommendations:</u>	
<p>Risk that annual deep clean and estates work programme for 2015/16 may not be completed as the hospital decant ward (Warrington) is used to meet urgent care escalation capacity. The Infection Prevention and Control Team are working with Estates and Operations to develop a plan that enables wards to decant.</p> <p>Recommend that progress is monitored quarterly with exception report included in the performance report.</p>	
<u>Summary of ED Challenge/Discussion:</u>	
Potential for capital programme to increase single room capacity for isolation.	
<u>Internal / External Engagement including Public, Patient and Governor Involvement:</u>	
<u>Equality and Diversity Implications:</u>	
None	

PUBLIC

Infection Prevention & Control Annual Report 2014/15

And Annual Plan 2015/16

S Hoque DIPC
L Kelly Lead IPCN

Ratified Joint Infection Prevention and Control Committee
Board date June 2015

Contents

Summary

1. Introduction
2. *Clostridium difficile*
3. Norovirus and other viral gastroenteritis
4. MRSA & MSSA bacteraemias
5. *E. coli* bacteraemias & ESBLs
6. Performance of Infection Control against KPIs 2014/15
7. Antimicrobial Report
8. Decontamination Report
9. Estates and Cleaning
10. Water Safety
11. Critical Ventilation including Theatre Ventilation compliance with both Appendix 1 & 2 HTM 03-01 part b Operational Management.
12. Surveillance, Audit & Education
13. Outbreaks & Serious Incidents Requiring Investigation
14. Infection Control Annual plan for 2014/15

References

Appendices

Summary

The Infection Prevention and Control Teams (IPCT) of South Devon Healthcare Foundation Trust (SDHFT) and Torbay and South Devon Healthcare Trust (TSDHCT) working together within the Joint Infection Prevention and Control Committee continue to prevent infection through the whole patient journey. The Terms of Reference are in appendix 1. This year the Committee reported directly to Workstream 1 – Patient Safety and minutes to Workstream 5.

The Trust reported no MRSA bacteraemias from 1/4/14 to 31/3/15 and the Trust target was zero. In addition there was a corresponding 45% reduction in MSSA bacteraemias.

The Trust reported a total of 24 hospital acquired *Clostridium difficile* (*C difficile*) against a contractual target of 11 with a lapse in care, however no fines were incurred by the Trust because the CCG noted that only 4 were attributed to a 'lapse in care'.

1. Introduction

The aim of this report is to give assurance of infection, prevention and control and to report the performance of the IPCT to the Trust board, patients, staff, public and Commissioners it also sets out the next annual plan of the IPCT.

The acute trust – SDHFT - IPCT consists of the Director of Infection Prevention and Control (DIPC), Lead Nurse Infection Prevention and Control (IPC), three Specialist nurse IPC practitioners, one IPC nurse, IPC Administrator and an A&C grade.

2. *Clostridium difficile*

Targets for C. difficile

The South Devon and Torbay CCG set the *C. difficile* toxin positive (CDT+) target measured EIA, for SDHFT, at no more than 11 episodes of infection from 1/4/14 to 31/3/15. This target was breached at 24 episodes of CDT+ but on review by the CCG only 4 were due to a 'lapse in care'. A 'lapse in care' can be defined as a breach of the IPCT's policies on Hand hygiene, Standards of Care, Isolation & *C difficile* or Antimicrobial Prescribing policies or Cleaning Policies or two or more patients on the same ward, within 28 days having the same type of *C difficile* (outbreak).

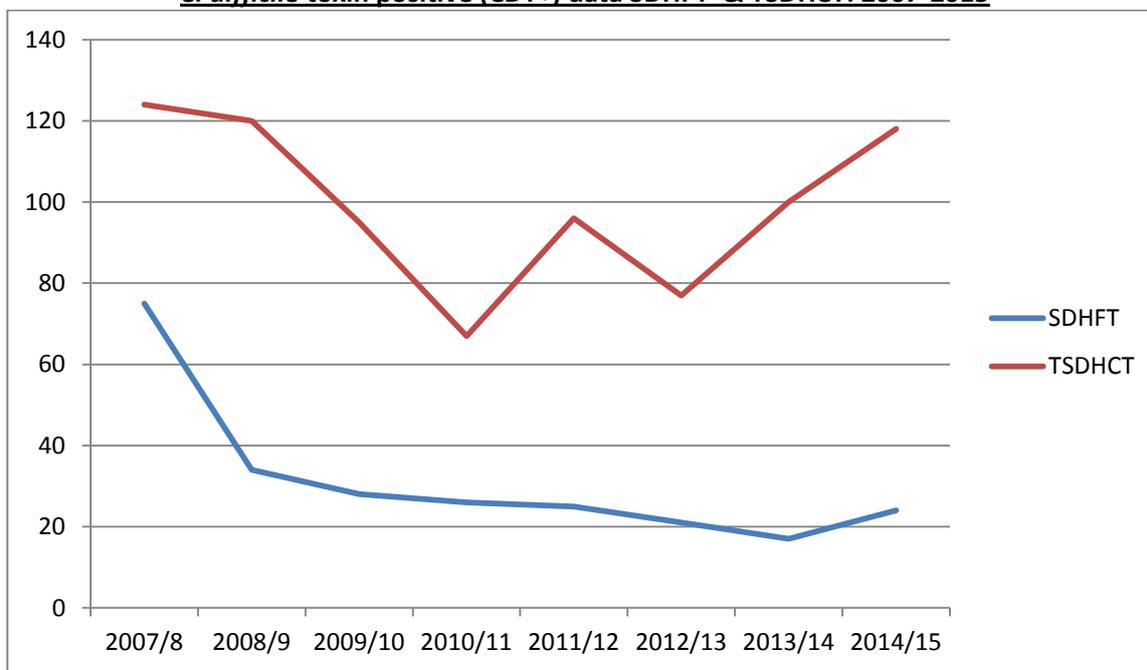
C. difficile outbreak:

There was one *C. difficile* outbreak, on Turner the Haematology/Oncology ward and involved two patients with *C difficile* toxin production, in April 2014, and actions included enhanced, 2 hourly cleans of all patient toilets on the ward and weekly deep cleans of the Haematology/ Oncology Day Case ward (RGDC). Education of ward staff on 'signing-off' cleaning of commodes with green Clinell stickers and weekly hand hygiene audits on Turner and RGDC. There were weekly outbreak meetings for 4 weeks until all actions and no further patients with *C difficile* toxin or *C difficile* PCR positive results (CDTPCR+).

The reason for more C difficile this year compared with last year may be due in part to;

- I. ward repeat testing of CDTPCR+ samples until a CDT+ result is obtained (2 patients in total)
- II. stools being taken a few hours too late after admission (4 patients in total) as these would normally be assigned as 'Community', CDT+ results
- III. the Antimicrobial Pharmacist left in October 2014 and there has not been an appointment until recently and the new pharmacist is junior and will need to train on antimicrobial stewardship.
- IV. there has been an increase in recurrence rates of *C. difficile* infection from 16% last year to 24% this year. In response, SDHFT plan to change *C. difficile* treatment algorithms and introduce faecal microbiota transplantation, in house.
- V. due to bed occupancy fewer hydrogen peroxide decontaminations of siderooms have been done. A business plan for a faster, quieter HPV machine has been submitted.

C. difficile toxin positive (CDT+) data SDHFT & TSDHCT: 2007-2015



3. Norovirus and other viral gastroenteritis

Much of the Infection Control work to control Norovirus overlaps with that of CDT+ control. From November 2014 to January 2015 there were 4 ward closures (Ainslie, Midgley & Simpson twice);

Summary of Norovirus and other Diarrhoea ward closures (excludes bay closures)

- the total days of 4 wards' closure was 24 days (39 days 2013/14)
- with 44 patients affected (43 patients 2013/14)
- 22 staff affected (28 staff 2013/14)
- 1 patient relative affected (1 relative 2013/14)

Incomplete Actions that arose from the RCAs on ward closure due to Norovirus 2014/15

- Increased numbers of EAU and Ainslie ward siderooms – currently with Capital Projects Phase I & II.
- Consultant and secretary offices share kitchens and toilet facilities with wards – currently with Capital Projects Phase I & II.
- Hetherington block need 4 bedded bays with en-suite bathrooms and doors to each bay.

4. MRSA & Meticillin Sensitive Staph. aureus (MSSA) bacteraemias

There are no MRSA bacteraemias. To make efficiency savings and implement the DHs NOW Report recommendations published in 2013; SDHFT no longer screens Day Case patients for MRSA.

There have been 8 SDHFT, MSSA bacteraemias in 2014/15 (13 in 2013/14) and the RCAs concluded that 2 were caused by peripheral cannulae, 4 by central lines, one by an out of hospital cardiac arrest, 2 source unknown. The KPI of a 5% reduction was achieved.

Actions the trust has put in place, to reduce MSSA bacteraemias due to peripheral and central cannulae, are a Nurse-lead Central venous access team (VAT). This team will also provide education to the ward nurses on caring for Peripherally Inserted Central Catheters (PICC) and Mid lines.

Surveillance on infection rates for the VAT from September 2013 to February 2014 were **1.3 per 1,000 device days**. This is good news because the 2012 (pre-VAT) data showed a CVC infection rate of **3.8 per 1,000 device days** for General Medicine/Surgery 2012 and **2.2 per 1,000 device days** for Oncology/Haematology 2012.

MSSA Bacteraemia Audit November 13 – November 14

Data has been collected of all MSSA bacteraemia positive blood cultures received in the microbiology lab from November 2013 – November 2014 and over 80% acquired in the community, 31% were 80+ years old.

Co-morbidities were looked at, 20% of patients had diabetes Mellitus, 17% Malignancy, 16% bone/soft tissue infection.

Looking at the diabetic patients, 32% had foot ulcers and were attending podiatry and 44% were admitted with pneumonia.

Actions:

- A paragraph regarding signs and symptoms of infected diabetic foot ulcers has been added to the podiatry patient information leaflet.
- Auditing of PICC by Vascular Access Team
- Auditing of CVC by ITU IC link nurses

5. E. coli bacteraemias & ESBLs

The rate of extended beta lactamase (ESBL) producing E.coli bacteria in urine and blood cultures is monitored and guides empirical antibiotic guidelines because ESBLs are one of the markers of antibiotic resistance in bacteria.

Results of ESBL producing E.coli in blood and urine from 2012 to 2015 in both Acute trust and Community.

	2012/13	2013/14 (6 months data)	2014/15 (6 months data)
ESBL rate in blood cultures	14%	0%	4% (0% acute trust)
ESBL rate in urine samples	5%	4%	not done

In 2014/15 there were 23 SDHFT acquired E.coli bacteraemias, casenote review revealed the causes listed below:

The KPI of a 5% reduction in E.coli bacteraemias - compared to 2014/15 was attained.

Presumed source E.coli bacteraemia	Number of bacteraemias	Actions performed
Central venous access	0	
Peripheral cannulae	0	
Urinary catheter insertion	3	Education on wards to complete urinary catheter care plan and consider educating junior Drs in Urology on antibiotic prophylaxis.
Urosepsis	2	No actions
Biliary sepsis	1	No actions
Hospital acquired pneumonia	2	No actions – one was an aspiration
Post-op stoma infection	1	No actions
Transfer from another hospital	1	No actions
Unknown	3	No actions

6. Performance of Infection Control against Infection Control Key Performance Indicators 2014/15

This is not a comprehensive list of all the Actions because each KPI represents at least 10 actions to be completed.

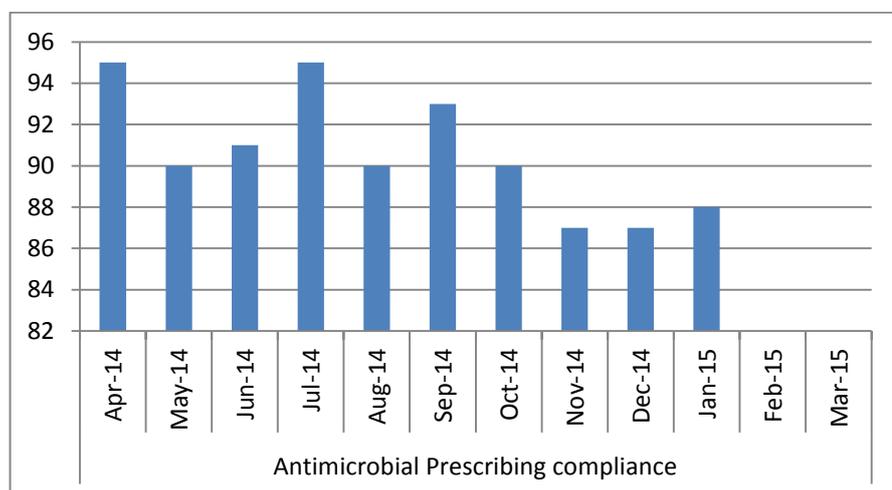
<u>Joint Annual Programme of Work 2014/15 for SDHFT:</u>		<u>Action/ Leads</u>	<u>Planned Completion date</u>	<u>RAG rating & date made</u>
i MRSA Control & MRSA /MSSA bacteraemia control	KPI one– stay within CCG / Monitor Ambitions for MRSA bacteraemia.	DIPC	March 2015	Green
	KPI two- Reduce MSSA bacteraemias by 5%	DIPC	March 2015	Green
ii C.difficile control & Norovirus outbreaks	KPI three – stay within CCG/ Monitor Ambitions for <i>C. difficile</i> Total number of C difficile patients is non compliant but Total Number of ‘Lapses In Care’, is compliant.	All ICNs & DIPC	March 2015	Amber
	KPI four – No ward closures due to Norovirus for > 14 days.	All ICNs & DIPC	March 2015	Green
iii Urinary catheter care/ESBLs/ E. coli bacteraemias	KPI five - Reduce E coli bacteraemias by 5% in SDHFT.	All ICNs & DIPC	March 2015	Green

Not achieving the KPI for *C. difficile* was because of more admissions with CDT and an increase in recurrence rates so guidelines for Faecal Microbiota Transplants will be introduced as well as GP specific algorithms on managing *C. difficile*.

7. Antimicrobial Report

The Antimicrobial Team (AMT) provides Antimicrobial Stewardship throughout the Trust. The AMT consists of the Antimicrobial Pharmacist and Consultant Microbiologist. The Antimicrobial Pharmacist has left the trust in October 2014 and another pharmacist is undergoing training in this post from February 2015 and this is reflected in the Saving Lives Antimicrobial Audit results below.

Results of monthly Antimicrobial compliance audits can be seen below;



The Antimicrobial prescribing policy is documented in CG1098 which sets the trust standards for antimicrobial prescribing, it also sets the standard for which monthly audits are completed in all ward areas for display on the ward’s dashboard. The results of these audits are sent to consultants, ward managers, pharmacists and infection, prevention & control.

Detailed Antimicrobial Prescribing Guidelines are available for adults (CG0040) and paediatrics (CG1118) on the trust intranet site and an “App” covering both acute hospital adult and paediatric guidelines has been developed for Android and Apple users for download to Smart phones and Tablets.

8. Decontamination

Laryngoscope handle decontamination has been unified across the trust with all laryngoscope handles being sent to HSDU, this was facilitated by the purchase of handles for all clinical areas (laryngoscope blades remain disposable throughout the trust).

The Tristel™ Sporicidal wipe system for non-lumen probes used on mucosal surfaces was re-audit and actions were put in place and will be followed up at the monthly Decontamination Group Meeting.

There have been no issues with automated endoscope disinfectors.

A Trust Equipment Loan policy (includes the new MRHA guidance) has been introduced and loans from other supplier/organisation must be registered through the Agresso Ordering System. A decontamination certificate and decontamination Guidance (cleaning, disinfection and if required sterilisation instructions) must accompany the loan and if the guidance does not comply with the Trust’s decontamination facility then the supplier is approached for written assurance that the Trusts methods of decontamination are acceptable.

The Trust now uses ReNova for the repair of scopes after a previous company had been found to have faulty soldering but all damaged scopes have either been replaced or repaired.

9. Estates & Cleaning

Areas Refurbished

Estates has refurbished Dunlop and George Earle ward wash basins, taps, IPS panels, walls and flooring in siderooms, to improve cleaning and infection control.

Midgley ward, parts of Cheetham Hill ward, Labour ward and A&E remain outstanding.

Infection, Prevention and Control were consulted on the improvements on RGDC, Out-patients and the Cardiac Catheter Lab.

Cleaning

The PLACE inspection was good for ward cleanliness, hand hygiene and equipment cleanliness.

Enhanced Cleaning is present in the following areas; ICU, Turner, Cromie, Allerton (gastroenterology admissions and surgical 'EAU-type' admissions). RGDC is opening on Saturdays and requiring cleaning as well as deep cleaning of toilets at the weekend.

Annual Deep Clean RAG Rating for 2014/15 shows; all areas in the trust received the annual Deep Clean except for A&E <75% completed, EAU 4, ICU, Turner, which are >75% but <95% completed. This has been mainly due to access restrictions due to bed pressures and not being able to always decant the ward so outstanding areas will be done 'bay by bay'. Obviously, areas in Womens' and Children's and Augmented care have to be done 'bay by bay', regardless. To assist in this Hotel Services have created a spreadsheet for Deep Cleaning which links to ward plans and have deployed Deep cleaning staff to use hydrogen peroxide vapour (Bioquell) in areas that are less busy at night.

The trust has introduced Tristel™ (chlorine dioxide) as a cleaning product to replace Actichlor Plus because the Tristel™ kills *C. difficile* spores at the routine concentration used.

Waste

2014 was the first year SDHFT undertook the pre-acceptance audit internally, historically it had been done in a slightly different format by an external contractor. The individual waste audit report is sent to the relevant area and a meeting request made to discuss the action plan. The action plans are reviewed by Work Stream 5.

Waste audits, including bin placement, incorrect assembly of sharps bins and completion of documentation have been undertaken and the areas with poor compliance are: Allerton, Cheetham Hill, Cromie, Elizabeth, Ella Rowcroft, George Earle, RGDC, Turner

10. Water Safety

Water Systems Management Group

This group (both SDHFT & TSDHCT) meets every two months to review water safety and ensure compliance with HBN 01-04 including recent updates on Pseudomonas control. The Legionella water test results are reviewed as well as the flushing logs.

Pseudomonas testing of augmented care areas twice yearly did not revealed 3 positive sites that were rectified with immediate effect and were found to be negative on retesting.

Legionella pneumophila has only been isolated from the Breast Care Unit outlets and after the dead leg was found and removed all samples have been Legionella pneumophila negative from July 2014 to date.

SDHFT uses heat to control Legionella and in addition to most trusts has a copper/ silver ion system in place but there have been issues with the latter and an action plan is in place. Progress against the Legionella Risk Assessments are reviewed at the Joint Infection Prevention & Control Committee Meeting.

11. Critical Ventilation including Theatre Ventilation compliance with both Appendix 1 & 2 HTM 03-01 part b Operational Management.

Theatres A&B had a new air handling unit installed and commissioned in April 2014.

Ultra clean air theatres require engineering checks twice a year and all other specialist ventilation require annual engineering checks. All areas have passed except for the main ICU because it cannot be accessed (but the siderooms can) and the mortuary supply (extract is satisfactory). The Special Theatre A and one room on Turner ward, are outstanding.

12. Surveillance, Audits & Education

Laboratory~Ward based Deep Surgical Site Infection (SSI) rates for Prosthetic Orthopaedic Surgery from April 2012 to Sept 2014.

Summary Report with Benchmarking April2012 - September 2014

For April to September 2014, the post-op infection rates for total hip replacements (THR), total knee replacements (TKR) and Hemi-arthroplasties are all very close to the national average (See table) and all actions set last year have been completed. Also in November 2014 the antibiotic prophylaxis for orthopaedic implant surgery was changed from cefuroxime to teicoplanin and gentamicin because this would cover a wider spectrum of infective bacteria and it also falls in line with antibiotic prophylaxis used in the SW.

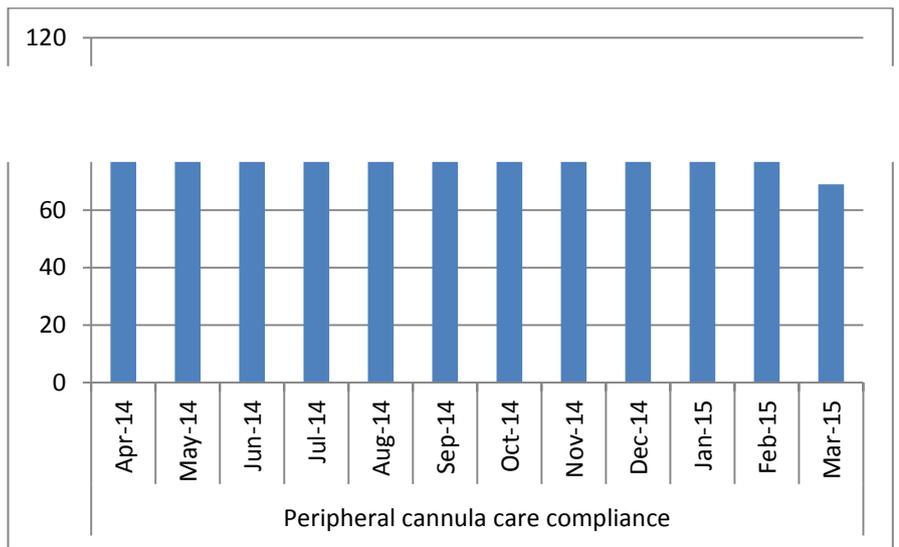
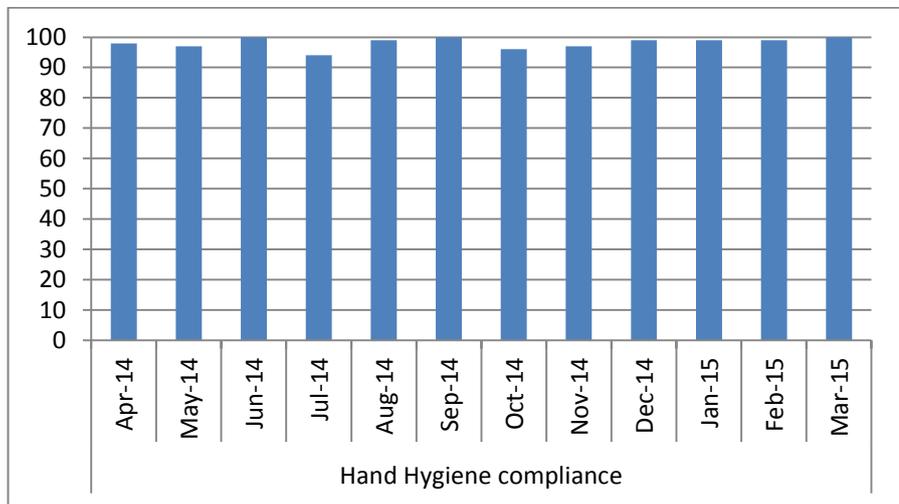
	THR Infection rate	TKR Infection rate	Hemi-arthroplasty Infection rate
April-Sept 2012	169 ops rate=3%	144 ops rate =2.8%	98 ops rate= 4.1%
Oct 2012-March 2013	184 ops rate = 0.5%	137 ops rate = 2.9%	101 ops rate=1%
April-Sept 2013	173 ops rate = 0.6%	127 ops rate = 3.9%	109 ops rate=0.9%
Oct 2013 – March 2014	164 ops rate = 1.2%	166 ops rate = 2.4%	109 ops rate = 0%
April-Sept 2014	230 ops rate= 0.4%	216 ops rate=1.4%	rate=0%

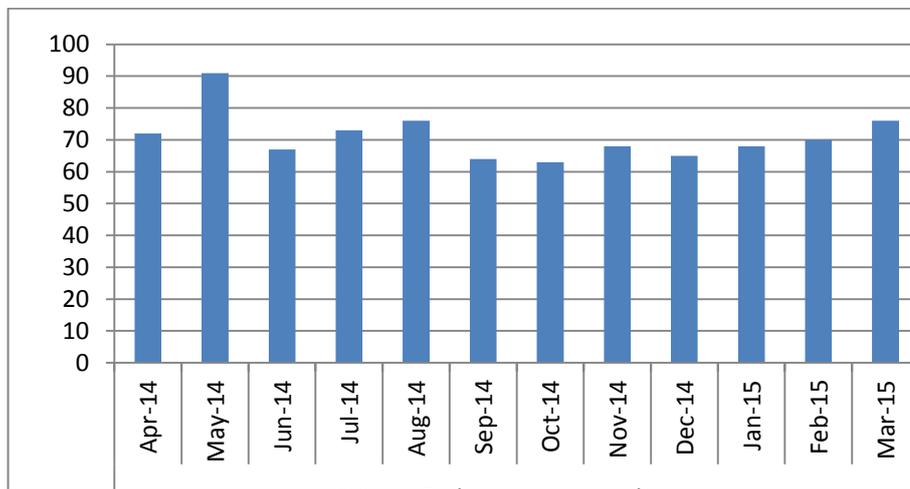
UK Mandatory Surveillance (Risk score of 1) (Risk score of 2)	(2011) 1.1% 2.3%	(2011) 0.8% 1.3%	n/a
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Saving Lives Audits

The Saving Lives Observation Audits are done monthly, on every ward, by the IPCT the results are reviewed by the Assistant Directors of Nursing (ADNs) who present a quarterly action plan to the Joint Infection Control Committee Meeting. The IPCT check the recording of insertion, dressings, VIP scores and removal of 3 peripheral cannulae per ward. The Hand Hygiene Audits use the Modified Lewisham Audit Tool whereby an observation of hand hygiene (using the WHO 5 Moments). Finally, the urinary catheter audit checks 3 per ward for documentation of insertion, need for catheter assessment and appropriate fixing.

A summary of the Saving Lives audits and subsequent actions are shown below:





The actions to improve the Saving Lives Urinary Catheter compliance have focused teaching wards by the IPCT and the Urinary Catheter Working Group will be implementing the patient held document, 'Urinary Catheter Passport'. To facilitate this it will be a KPI for the Joint Infection Prevention and Control Committee.

Personal Protective Equipment/ Isolation Audit

In November 2014 a trustwide audit of, 20 clinical areas', compliance with PPE and Isolation practices was made and feedback was given at the time of the audit. Results and further actions are listed in the table below:

Result	Action	Completion	Comment
Correct isolation sign on the door = 25%	Correct Isolation signs to be given	Jan 2015	Action complete
	Suggest that the Safety brief clearly identifies the reason for a patient's isolation	Jan 2015	
Appropriate use of PPE = 50%	Copy of audit to be sent to the ward manager	Dec 2014	Action complete
Correct hand hygiene = 70%	ADN's for each directorate to be forwarded the results	Feb 2015	
	ADNs asked for their action plan on achieving success if continued lack of compliance	Mar 2015	
Door closed/valid reason for not closed = 40%	Action added for Matrons to check isolation signs and door closure adherence on their monthly audits.	Feb 2015	
All	Repeat audit to be undertaken in September 2015	Sept 2015	
All	Outcome of the audit to be reported at the Infection Control Committee	Mar 2015	

Public Health England (formerly HPA) National Surgical Site Infection Surveillance reports Reports 2012/13

The National Surgical Site Infection Surveillance (SSIS) uses standard methodology and post-discharge surveillance to benchmark trusts on post-operative infection rates. For infections involving prosthesis

most of the data will be on superficial infections as data is only collected for 3 months post-op. Results are published 6 months later and are satisfactory.

Site of surveillance	Duration of surveillance	SDHFT SSI Rate	National SSI Rate
Caesarean section – not yet formally reported but in-house calculation	June-Aug 2014	11%	awaited but published studies = 9.8% (See References)
Total knee replacement	Apr-June 2014	0%	0.5%
Total Hip Replacement	Oct-Dec 2013	1.2%	0.6%
Abdominal hysterectomy	Oct-Dec 2013	0%	1.5%

Compliance with Infection Control Induction and Mandatory Training

Figures provided by medical education at the Horizon Centre.

	% of New Starters (All Fixed Term Temp & Permanent) to SDHFT that have attended NHS Induction)		All staff (All Fixed Term Temp & Permanent) that are compliant with Infection Control	
	2013/14	2014/15	2013/14	2014/15
Nurses	83%	83%	75%	79%
Doctors	92%	90%	77%	77%
AHP	84%	83%	74%	80%
Hotel Services	44%	38%	62%	60%
Porters	0%	13%	86%	73%

Bank Staff IP&C Mandatory Training Issues;

1. The Recruitment and Temporary Staff Manager is currently working on a project to ensure bank workers are compliant in their Mandatory Training. To give some assurances (to the board) all new bank workers are compliant in mandatory training for the first 12 months, because we have systems in place to ensure they cannot work until this has been completed. There is a plan for those workers who have been with the Trust for over 12 months to enable e-learning rather than classroom training, otherwise the bank staff will take up all the training places which will impact substantive staff.

2. Of porters and hotel services staff who were given a permanent contract (this is bank going to permanent contracts), only 1 out of 8 bank porters was compliant with mandatory training. The Hotel Services manager, in future, will ensure they update on all their mandatory training before they are issued with their contract.

Mandatory Infection Control, Personal Protective Equipment (PPE) & Ebola Training- development of Hiblio videos

Ebola is a rare but severe infection caused by Ebola virus and can cause fatal Viral Haemorrhagic Fever (VHF). Since March 2014, there has been a large outbreak of Ebola virus in West Africa, with widespread and intense transmission in Guinea, Liberia and Sierra Leone. This is the largest ever known outbreak of this disease prompting the World Health Organization (WHO) to declare a Public Health Emergency of International Concern in August 2014. Cases have also occurred in Mali, Nigeria, Senegal, Spain, the UK and the US.

Along with all hospitals SDHFT has developed VHF plans and delivered VHF training (which includes enhanced PPE) to over 50 staff. Staff treating VHF or suspected VHF also require mask fit testing and H&S are continuing to organise this.

To facilitate training the IPCT have developed Hiblio training videos for PPE (VHF, infectious droplet and standard) and hand hygiene so that the non-VHF videos can also be used as part of Mandatory Infection Control Training and improve compliance by having e-learning (see appendix 2).

13. Outbreaks and Serious Incidents Requiring Investigation

There have been two SIRI (Serious Incident Requiring Investigation) reported on the STEIS (Strategic Executive Information System) database and one was an outbreak of *C difficile*, another a patient with *C. difficile* in part 1 of the death certificate.

Organism, Ward(s) affected & Nos. affected	Date of samples	Date of RCA	Outcome
<i>C. difficile</i> outbreak	3/4/14 , 16/4/14	6/5/14	Enhanced, 2 hourly cleans of all patient toilets and weekly deep cleans of the Haematology/ Oncology Day Case ward (RGDC). Education of ward staff on 'signing-off' cleaning of commodes with green Clinell stickers. Weekly hand hygiene audits on Turner and RGDC. Weekly outbreak meetings for 4 weeks until all actions and no further patients with <i>C difficile</i> toxin or <i>C difficile</i> PCR positive results.
<i>C. difficile</i> part 1b on death certificate, in one patient.	3/12/14	5/02/15	The <i>C. difficile</i> should have been part 2 of death certificate and a locum consultant on the Medical ward should have been questioned by the DIPC but a trainee Bereavement Officer did not inform the DIPC until after the death certificate was issued.
MRSA cross infection on George Earle ward	26/9/14 to 21/1/15	21/1/15	Three patients acquired MRSA colonisation from an MRSA carrier who had not had admission screening, in Bay3 on the ward. There was spread to 3 other patients in Bay4. Bay3 was Bioquelled and 3 weeks of weekly MRSA screens instigated, for both Bay 3 & 4,

			only one further patient was detected.
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14. Joint Infection Prevention and Control Annual Forward plan for 2015/16

Joint Annual Programme of Work 2014/15:		Action / Leads	Completion date
i MRSA Control & MRSA /MSSA bacteraemia control	KPI one– stay within CCG / Monitor Ambitions for MRSA bacteraemia.	All ICNs & all DIPCs	March 2016
	KPI two- Reduce MSSA bacteraemias by 5% in SDHFT & TSDHCT	All ICNs & all DIPCs	March 2016
	Request SDTCCG engage with procurement GP Practices in flagging MRSA positive patients on their computer patient records or any other system that alerts GPs when prescribing. (<i>Also CDT+, CDTPCR+, ESBL</i>)	SDTCCG & SDHFT DIPC	March 2016
	Continue reporting Saving Lives Hand Hygiene audits & peripheral cannulae in SDHFT (monthly if score <95% and quarterly if score >95%) and TSDHCT (quarterly) hospitals.	all ICNs	ongoing
	Continue to monitor bank workers, who have been with the trust >12 months, compliance with IPC mandatory training, by liaising with Recruitment / Temporary Staffing Manager	DIPC	ongoing
	<u>Surveillance</u> Trauma and Orthopaedic National Surveillance of THR & TKR (PHE).	SDHFT ICN & T&O Directorate	March 2016
	Vascular Surgery post-op infection National Surveillance (PHE)	SDHFT ICN & Surgical Directorate	March 2016
	Ongoing, lab-based, ward, T&O prosthetic joint, deep Surgical Site Surveillance (SSI) reported to Surgeons at Governance meetings bi-annually.	DIPC	ongoing
	Central line associated blood stream infection (CLABSI) and catheter related blood stream infection (CRBSI) surveillance for PICC and Midlines.	DIPC	March 2016
ii C.difficile control & Norovirus outbreaks	KPI three – stay within CCG / Monitor Ambitions for CDT+	All ICNs & all DIPCs	March 2016
	KPI four – No ward closures due to Norovirus for > 12 days.	All ICNs & all DIPCs	March 2016
	<u>Hand Hygiene</u> Compliance with IPC induction and mandatory training delivered to all clinical staff >85%	DIPC & Horizon	March 2016

	Centre	
If Saving Lives Hand Hygiene score is <100% ensure the area does weekly Hand Hygiene audits until 100% is reached.	All ICNs	ongoing
<u>Wards</u> Zoning of known <i>C difficile</i> positive patients to certain wards and siderooms		
Instigate a business case to replace plastic & metal bed pan holders with disposable pulp bedpan holders in both SDHFT & TSDHCT.	Lead ICNs	March 2016
Annual Deep Clean of all clinical areas. In addition SDHFT will pro-actively consider using HPV in Hetherington Unit from May 2015 to avoid increased incidence of <i>C. difficile</i> .	Lead ICNs & Hotel Services SDHFT & TSDHCT	March 2016
<u>Audit</u> SDHFT will collate monthly Matron's audits on ward cleanliness and C4C results and feedback to ADNs when this hasn't been performed for 2 consecutive months.	All ICNs	March 2016
IPS audits of all clinical areas every 2-3 years. Or if no actions have been completed to actively engage with all parties to facilitate enablement of actions.	All ICNs	March 2016
TSDHCT to perform RCAs on all patients with recurrent <i>C difficile</i> and report action plans to this Committee.	TSDHCT ICNs	ongoing
<u>Prescribing</u> Review and approve updated treatments for <i>C. difficile</i> (eg.first and second recurrences)	SDHFT DIPC & SDT CCG	March 2016
Continue monthly reporting of Saving Lives antimicrobial audits. And ensure action plans in place.	Antimicrobial Pharmacist	ongoing
<u>Estates</u> One sideroom on Cheetham Hill & all of Midgley ward requires a sanitary ware change, patients' & Staff toilets refurbishment. A&E: Fit a new sink & IPS panel in restraint room, cubicle 8 &11. Refurbish sinks, taps & IPS panels in adult cubicles 1-7, 10, DOA room, three in Resus & sluice, paediatric cubicles 1,2 & examination area 2 and refurbish male staff toilet.	Estates	March 2016

	Support Estates with a business case, presented at Work Stream 5, for trustwide renewal of Macerators.	SDHFT DIPC & Estates	March 2016
	Increased numbers of Ainslie ward siderooms – currently with Capital Projects Phase I & II. Hetherington block consultant and secretary offices share kitchens and toilet facilities with wards – currently with Capital Projects Phase I & II.	Estates	March 2016
iii Urinary catheter care/ESBLs/E. coli bacteraemias	KPI five – expand the Urinary Catheter Patient Passport scheme from nurse lead clinics to acute and community hospitals.	All ICNs & all DIPCs	March 2016
	TSDHCT & SDHFT to report Saving Lives ongoing catheter care audit results and actively seek action plans and assurances from ADNs & equivalent in TSDHCT to improve urinary catheter care.	TSDHCT & SDHFT ICN	March 2016
	Study epidemiology of E. coli bacteraemias acquired in TSDHCT to establish times of admission to hospital and whether seen by GP beforehand.	TSDHCT ICN & SDHFT DIPC	March 2016
Miscellaneous	Receive Water Safety Reports Annually	Water Safety Group	ongoing
	Review Critical ventilation annual validation	SDHFT DIPC	ongoing
	Facilitate FFP3 mask fit testing compliance by requesting H&S Committee to address training.	TSDHCT & SDHFT DIPC	March 2016
	Restructure SDHFT ICN areas of responsibility in Summer 2015 due to retirement and training of newly appointed staff. Name a Deputy DIPC. Review TOR and attendance of ADs from TSDHCT & ADNs from SDHFT.	SDHFT ICNs & DIPC	July 2016

References

The Health and Social Care Act 2008: Code of Practice in the prevention and control of infections and related guidance. Department of Health 2010

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<http://www.nice.org.uk/guidance/phg/hcai/QualityImprovementGuide.jsp>

The National One Week Prevalence Audit of MRSA Screening. Final report prepared for the Department of Health by the NOW study team. Delivered January 2013

<http://www.ucl.ac.uk/medicine/documents/doh-now-report-2013>

Surveillance of Surgical Site Infections in NHS hospitals in England 2010/2011

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131972352

Wilson J, Wloch C, Saei A, *et al.* Inter-hospital comparison of rates of surgical site infection following Caesarean section delivery: evaluation of a multicentre surveillance study. *J Hosp Infect* 2013;**84**:44-51.

C. difficile references

Updated Guidance on the management of *C. difficile* infection. PHE May 2013.

http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317138914904

Accessed 21/1/14

Appendix 1.

South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust Joint Infection Prevention and Control Committee

Constitution and Terms of Reference

1. Title

The Committee shall be known as the Joint Infection Prevention and Control Committee (IPCC).

2. Strategy

To drive delivery of a South Devon Healthcare and Torbay and Southern Devon Health and Care Joint Infection Prevention and Control programme which follows the whole patient journey.

Obtain Assurances from the Divisions in SDHFT and Directorates/Zones in TSDHCT that this is performed and report to the trust boards.

3. Function

- a. Review annual reports and agree annual plans
- b. Monitor progress against annual plans and escalate significant risks to appropriate board(s)
- c. Review national guidance and statutory changes, and take appropriate actions
- d. To roll out and monitor trustwide / community-wide projects in infection control
- e. To develop, implement and monitor policies and procedures, taking the opportunity when due for review, to develop one policy across the health community
- f. To receive infection control reports (eg.from ADNs) and take / recommend appropriate actions. This includes;
- g. Audit and Surveillance
- h. Incident reports
- i. Root cause analyses
- j. Training
- k. Monitoring the IPC Risk Register
- l. Ensure there is a current Major Outbreak Plan as part of the health community contingency planning

3. Membership

The membership of the Infection Prevention and Control should include:-

- a) Director of Infection Control and Prevention / Executive Lead for both organisations;
- b) Lead Infection Control Nurses and or deputies, for both organisations;
- c) Non-Executive Director (either Trust);
- d) CCDC Public Health England or representative;

- e) Occupational Health Physician or Nurse;
- f) Representative of Medical Staff Committee;
- g) Patient Safety Lead or representative
- h) Representative Governor (service user);
- i) Antimicrobial Lead Pharmacist or representative
- j) Director of Estates and Facilities or representative(s);
- k) Care Home Representative
- l) Quality and Safety representative for the CCG

When required the following people will be invited

- a) Decontamination Lead;
- b) Clinical Specialties;
- c) Information / Performance analyst (either Trust)
- d) Care Quality Commission Lead (on board of both organisations);
- e) AHP Representative;
- f) Others as appropriate;

4. Frequency of Meeting

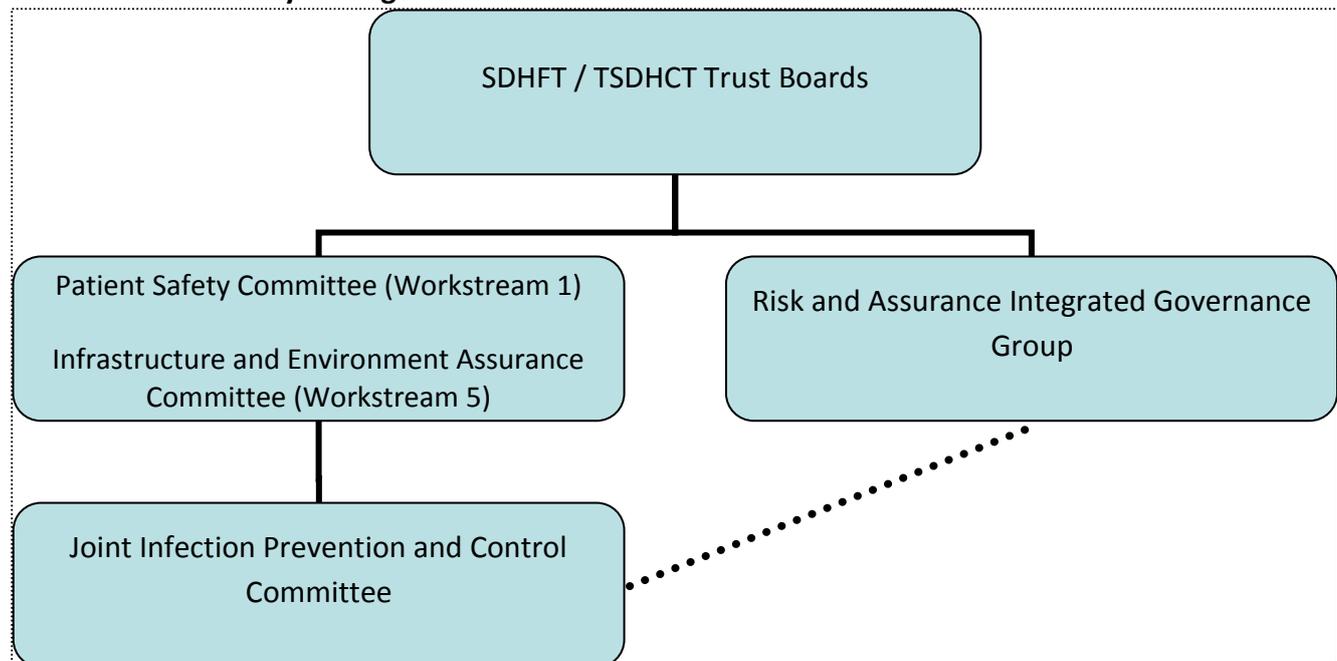
The meeting is bi-monthly.

For the committee to be quorate 60%, must be present and include either a Director of Infection Prevention and Control / Executive Lead.

5. Distribution of minutes

Minutes will be distributed to members, Chair of Workstream 1 Meeting, Chair of Workstream 5 Meeting and invitees as appropriate.

6. Accountability Arrangements



Revised March 2015

Appendix 2 - Mandatory Infection Control, Personal Protective Equipment (PPE) & Ebola Training-development of Hiblio videos

Hiblio video on How to Wash your Hands

<http://vimeo.com/hiblio/review/112791422/f7a0581a1a>

Donning PPE for Standard Isolation Control

<iframe src="//player.vimeo.com/video/117927154?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe>

Doffing PPE for Standard Isolation Control

<iframe src="//player.vimeo.com/video/117927155?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe>

Donning PPE for Airborne or Risk of Splashing Infections

<iframe src="//player.vimeo.com/video/117926273?color=ffffff&title=0&byline=0&portrait=0" width="500" height="281" frameborder="0" webkitallowfullscreen mozallowfullscreen allowfullscreen></iframe>

Doffing PPE for Airborne or Risk of Splashing Infections

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Donning high risk waterproof suit PPE

<http://vimeo.com/hiblio/review/112790699/375405c43c>

<iframe src="//player.vimeo.com/video/112789754" width="500" height="281" frameborder="0" webkitallowfullscreen

Doffing high risk waterproof suit PPE

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REPORT SUMMARY SHEET

Meeting Date:	May 27 2015
Title:	Work stream 2 Engagement and Experience
Lead Director:	Director of Nursing and Professional Practice
Corporate Objective:	Best Experience
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

WS2 is the key internal mechanism to ensure collaboration with CCG, Healthwatch and CQC to identify priorities. WS2 fosters collaboration with patients and service users to inform plans and improve experience.

Key Issues/Risks and Recommendations:

Review of 2014/15 priorities showed progress in all areas. Persistent themes relate to 'noise at night', 'staff attitude' and 'discharge'. These areas have associated action plans which will continue.

Friends and Family responses continue to be a challenge. Divisions are clear of the need to improve compliance in this area.

Summary of ED Challenge / Discussion:

2015/16 work plan priorities and timescales agreed:

Engagement	map existing system wide activity and identify gaps
Experience	roll out F&F to outpatient areas
Bereavement	review current service and make recommendations for improvement
Communication	Bitesize version of "it starts with me" to be delivered to the wards / depts. "Talkback". Plan approach. Test out with a department and a clinical area.
Quality Account	Contribute to design of Single Point Of Contact. Improve medicines information for carers
CQUIN	Continue work to improve experience for those with Dementia and Delirium Implement 'Hello my Name is' across the Trust

Internal / External Engagement including Public, Patient and Governor Involvement:

Governor member present.

Equality and Diversity Implications:

None

WORKSTREAM 2 MEETING NOTES

Date: 17 April 2015
Time: 09.30-11.30

Prepared By: Maureen Quartermaine
Contact Number: 54842

THEME: Planning for 2015-16

KEY POINTS/DECISIONS			ACTI ON
1 & 2	<u>Members Apologies & Attendance</u>		
*	Carol Pearson	Experience & Engagement Lead	CP
*	Cathy Bessent	Deputy Director of Nursing	CB
A	Cathy Gardner	Head of Operations	CG
*	Emma McCluskey	Equality & Diversity Manager	EM
*	Gary Hotine	HIS Director and IT Operations	GH
*	Jane Viner	Director of Professional Practice, Nursing & People's Experience -Chair	JV
A	Katy Heard	Carers Lead for T&SDCT	KH
A	Kerri Jones	Associate Medical Director	KJ
*	Lesley Darke	Director of Estates & Commercial Development	LD
	Louise Waterton	Communication Team	LP
	Paul Procter	Head of Performance	PP
A	Sally Taylor	Non- Executive Director	ST
*	Sam Holden	CCG	SH
*	Susan Martin	Quality Lead	SM
	<u>In Attendance</u>		
*	Lynne Hookings	Governor Observer	LH
	* Denotes members present A Denotes members apologies R Denotes apologies given & representative in attendance		

This work stream is responsible for the following Care Quality Commission Outcomes:

Outcome 1: Respecting and Involving people who use the service

Outcome 4: Care and Welfare of service users

Outcome 17: Complaints

3	<u>Notes of March Meeting:</u> Taken as agreed	
4	<u>Matters arising:</u> See action list <ul style="list-style-type: none"> • Surgical actions from March meeting with ADN • Health watch draft directory will be sent to us when available • Link for compliments and feedback to Health watch • Noise at Night- simulation at HI show case day may not work too well. Innovation Lead and CP working with the council. • New CQC standards for May- awaiting confirmation from Risk and Assurance Group then we can update 	

<p>5</p>	<p><u>2015-16- the workstream to decide and agree schedule and priorities</u></p> <p>The work stream agreed that it will review progress from the Organisation against the following:</p> <p>Experience and Engagement Strategy:</p> <p>Engagement:</p> <ul style="list-style-type: none"> ➤ Involvement of Divisions and HI in engagement and co-design ➤ Understand what we currently do: <ul style="list-style-type: none"> – Community mapping exercise. To bring to WS2 in June. – Once mapping exercise complete WS2 to consider next engagement priorities <p>Experience:</p> <ul style="list-style-type: none"> ➤ F&F will now be in the standard contract and not a CQuin. This will now be continued through the Divisions with the PET supporting OPA/day cases and PTS ➤ Bereavement Project to improve the experience of relatives and friends. ➤ Communication: <ul style="list-style-type: none"> -- “Noticing and encouraging others to feedback and celebrate excellent customer service and staff going the extra mile - Explore “Fabulous NHS” - Bitesize version of “it starts with me “ to be delivered to the wards <ul style="list-style-type: none"> -“Talkback” <ul style="list-style-type: none"> ○ Plan approach ○ Test out with a department and a clinical area (possibly PSD and EAU) <p>Quality Account Priorities:</p> <ul style="list-style-type: none"> – SPOC – Improve multi-agency working across Torbay and South Devon through developing and extending the existing multi-disciplinary teams working across the community – Carers and medication <p>CQuin priorities:</p> <ul style="list-style-type: none"> -Dementia and delirium -Patient Experience: <ul style="list-style-type: none"> Always events: “hello my name is” 	<p>Action: CB to work with the divisions to support understanding, accountability and responsibility</p> <p>Action: CP/CCG/T&SDCT to attend planning meeting</p> <p>Action: JV/CB to liaise with Divisions. CP/JB to support OPA/DC/PTS</p> <p><u>Action:CP</u></p> <p>Action: JV/CB/CP</p> <p>Action: CP/KJ/SM</p> <p>Action:SM to ensure quarterly reports come to WS2</p> <p>Action CB/CP/GH</p>
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	<p>“you said we did” TBD- organisation specific</p> <ul style="list-style-type: none"> – Patient Leadership network – Technology- Promoting use of hospital WIFI 	
6	<u>Carer Strategy until 2018</u> –KH to be tabled – May	Action: KH - May
7	<p><u>Accessible Information Policy (translation and interpretation) for ratification –EM</u></p> <ul style="list-style-type: none"> • This policy has been reviewed and well received by DAAG and is going to T&SDCT Experience and Engagement Committee today • Policy agreed by the workstream 	Action: EM to arrange sign off , publication and communication to staff
8	<u>Healthwatch update</u> – Non attendance	
9	<p><u>Q4- CQuin reports- SM</u></p>  <p>Workstream 2 cquin Q4.pdf</p>	
10	<p><u>Items for information only:</u> <u>Patient Services Monthly report</u></p> <ul style="list-style-type: none"> • March showed increase in complaints, also an increase in discharges • Quarterly reporting from now on • Complimentary quotations for report • Exception reporting monthly identify 3 or 4 parameters and report those as exception with a quarterly report <p><u>Friends and Family Test:</u></p> <ul style="list-style-type: none"> • Planned joint F&F and befriending roles in A&E • FFT ownership to transfer to Divisions <p><u>Real Time inpatient experience survey results</u></p>  <p>Summary Ward V12.pdf</p> <p><u>Risk Register</u></p> <ul style="list-style-type: none"> • E&D taken off WS2 risk register as they have separate risk register  <p>EDHR Risk Register Apr15.xlsx</p> <p><u>Additions to risk register</u></p> <ul style="list-style-type: none"> • CQuins • Update to CQC standards 	<p><u>Action: CB/CP</u></p> <p><u>Action:JV/CB/CP</u></p>
11	<p><u>From the items on the agenda discussed today what assurance do we have against our CQC outcomes? - LH</u> Discussions today gave full assurance against our CQC outcomes.</p>	
12	<p><u>Any other business:</u> <u>Workstream 2 Terms of Reference:</u> Agreed in draft – for final sign off at May meeting</p>	<u>Action: May</u>

13	Date and time of next meeting: 15 May 2015 09.30-11.30	
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<u>DATE</u>	<u>ACTION LIST</u>	<u>Members Initials</u>
May 2015		
20.03.15 17.04.15	Enhanced Recovery Programme – Joint School	Action: JV
19.12.14 17.04.15	Carer Strategy for next 3 years and will bring to WS2 for May	Action: KH
17.04.15	<p><u>Surgical Division</u></p> <ul style="list-style-type: none"> • ED pathway update, communication and Devon Doctors – what do they take away? – Back to May Meeting • Early surgical admissions not going to surgery until late – Action Plan • PP currently consulting with Matrons regarding what they would like included in the ward dashboard currently planned for April and will bring draft copy to May meeting. • How do we advise patients regarding cancelled/delayed elective appointments/surgery? 	<p>Action: JV/CB-May</p> <p>Action: surgical Division</p> <p>Action: PP - May</p> <p>Action: Surgical Division</p>
17.04.15	<p><u>Healthwatch update</u></p> <ul style="list-style-type: none"> • To share draft signpost directory with CP/SH/AG when available • Would like to receive more compliments and items of interest regarding the hospital to be included in their literature, to help promote a more positive image for all concerned. 	<p>Action: PH</p> <p>Action: JB/CB/JV</p>
17.04.15	<p><u>Friends and Family Test</u></p> <p>No progress regarding over 16's, Action plan to be brought to next meeting.</p>	Action :JV
17.04.15	<p><u>Patient Services Monthly report</u></p> <p>Review of content of this report to be decided at the April meeting</p>	Action: All
17.04.15	<p><u>Experience and Engagement strategy</u></p> <p>To be signed off at the next meeting</p>	Action: All May
17.04.15	<p><u>Items for information only:</u></p> <p>Vascular engagement work-</p> <p>Joint project including CCG, RDE and John Harrison and CP will provide updates as available.</p>	Action: CP
17.04.15	<p><u>Any other business:</u></p> <p>KJ – Horizon open day 26 June with a workshop for shared decision making and possible live simulation to include night time noise appraisal</p> <p>JV to refresh CQC with new standards for May meeting</p>	<p>Action:KJ</p> <p><u>Action: JV</u></p>
17.04.15	<p><u>Workstream 2 Terms of Reference:</u></p> <p>Agreed in draft – for final sign off at May meeting</p>	<u>Action: May</u>
June 2015		
17.04.15	Actions from Complaints now going onto Safeguard which is currently undergoing testing regarding	<u>Action: CP - June</u>

	sending reminders for outstanding actions. Bring update to June meeting	
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Chief Executive's Business

June 2015

Emergency Department pressures

I would like to take this opportunity to pay tribute to staff across our hospital and community services for their commitment and hard work during this continued busy period. Emergency Department performance has continued to improve over recent months with an average of 93.9% of patients seen, treated or discharged within 4 hours in the month of April and 94.7%, so far, for May. The figures for Emergency Department performance across the UK are published on a monthly tracker on the NHS England website. The figures for the performance of hospitals in the Peninsula for w/e 10 May 2015 are detailed below:

Hospital Numbers Attending ED % Seen in 4 Hours

Hospital	Numbers Attending ED	% Seen in 4 Hours
Torbay Hospital (SDH)	1,517	93.6%
Plymouth Hospitals (PHNT)	1,913	85.3%
RCHT	1,264	69.6%
RD&E	2,037	95.0%
NDHT	834	87.8%

Figures are taken from NHS England

Infection Control

In recent weeks, like a number of other hospitals, we have seen an increase in patients attending with symptoms of norovirus. Managing these patients with enhanced infection control measures has impacted on bed availability and patient flow. This is having a significant impact on the hospital and plans are in place to effectively minimise the risk of this outbreak. This situation is being very carefully monitored and we are working closely with our colleagues in primary and community care to manage the impact.

Our staff have put immense effort into containing and minimising the risk of infection. A cleaning programme is in place to deep clean effected wards and bays and ensure safe care.

We are doing a detailed analysis of this outbreak to ensure learning is embedded.

Communications have gone out to all our staff to remind them of the importance of following infection control procedures. We are also communicating with visitors and the public so they understand the situation and we are encouraging responsible visiting and to rearrange and not come in for outpatient appointments if they are unwell.

Delivering RTT Targets

We have a small number of specialties where there is an ongoing challenge to deliver our RTT targets. To tackle this we have been developing plans to address the delays and plan for long term solutions, working with CCG colleagues to redesign pathways in order to better meet demand and ensure that there is timely access to services.

This work is being facilitated through clinically-led Action Learning Sets. In addition the Trust and the CCG have invited the Intensive Support Team for RTT to work with us to update our diagnostic and help us develop our action plan. This Diagnostic is due to take place on 20 and 21 May 2015.

A summary of speciality specific issues is detailed in the Performance report to be discussed later in this meeting.

Meetings

I have continued a programme of meetings with key stakeholders as part of my induction and in the past few weeks have met with the Chief Executives and Chairmen of Plymouth Hospitals NHS Trust and the Royal Devon and Exeter NHS Foundation Trust. I have also visited and met the Chief Executive of Rowcroft Hospice.

I attended a Joined-Up Leadership Development Meeting on 20 and 21 May. The purpose of this was to explore and agree the core purpose of the Joined-Up Board and identify future working, issues and themes. A Pioneer and Joined Up Update is attached to my report.

I am continuing my programme of induction and getting out to visit a number of locations within the two Trusts. I have taken part in an infection control walkabout here at the hospital. I have carried out a number of visits in Torbay and Southern Devon Health and Care Trust including visiting the Paignton Zone and several community hospitals. I also attended a Torbay Pharmaceuticals Staff Meeting



Pioneer & JoinedUp May 2015 Update

International Support visit and conference

Dr Grace Terrell, the Chief executive of Cornerstone, a health care provider in the US, visited Torbay 22nd April and we were inspired to hear how they had transformed patient experience and outcomes by creating a person centred model of care, arranging workforce, budgets and services around people and local populations across community and acute settings. We hope to have a dvd of the session available shortly. In the meantime you can hear Grace speak by clicking on this link

<https://www.youtube.com/watch?v=6OX3z456xDc>

On 23rd April 3 of us heard more from innovative health care providers in the US, Alaska and New Zealand. Their success centred on truly multi-agency teams where clinicians and other professionals work equally alongside 'health navigators' or 'coaches,' selected not for any professional training or qualification but for their ability to engage and empathise with people to:

- Establish "what matters to me"
- Help them to understanding their illnesses, social, emotional and relationship problems
- Help them to do the things they need to keep well – develop a care plan/life plan which is agreed and works for them
- Advise how to best to navigate the care system – act as an advocate, and make using the system easier. Be seen as much a friend as a professional.
- Help them make connections in their community to support them to stay well physically and emotionally.
- Use their clients experience and feedback to improve the overall system of care

This way of working allows physicians and other professionals to work at the 'top of their licence,' or do what they were trained to do. In one US model 'Extensivists,' Physicians predominantly experienced hospital doctors working in general medicine better manage patient flow and beds, seeing their patients both inside and outside hospital including, in post hospital rehabilitation facilities, known as specialist nursing facilities.

Information sharing toolkit

The toolkit is complete and will shortly be available on websites. The next phase is to fully extend the principles of the toolkit to cover other services including, criminal justice, housing, ambulance and fire services as well as community voluntary sector organisations. The information sharing group is also developing shared access to secondary population wide

JoinedUp



pseudonymised health and social care data to help target population health and social care issues through local multi-agency team working.

National Pioneer Support

The way in which Pioneer sites are supported nationally is changing. NHS England will provide support to pioneers and the new vanguard sites. They are asking how we'd like to be supported in future. Our request is for more practical, hands on, support to make changes while maintaining core business and transformation funds.

Integrated Personal Commissioning

A project officer, Helen Cox-Davies, is now in post and working on the project plan. Meetings have already taken place with Leatside surgery and Totnes Caring. As a result a small number of patients with long term conditions who would benefit from more person centred, outcomes based, health and social care plans with integrated funding are being identified. Helen is also working with Torbay CDT to identify people through the Aging well BIG Lottery project.

REPORT SUMMARY SHEET

Meeting Date:	May 27 2015
Title:	Clinical Due Diligence
Lead Director:	Director of Nursing and Professional Practice
Corporate Objective:	Best Experience / Safest Care
Purpose:	Assurance
Summary of Key Issues for Trust Board	
<u>Strategic Context:</u>	
<p>In May 2013 the South Devon Healthcare NHS Foundation Trust (SDT) commissioned an external clinical due diligence review of Torbay and Southern Devon Health and Care Trust (TSD) as part of the initial stages of the integration process. Whilst the report highlighted a number of challenges it concluded that there were no material concerns that would impact the integration process. An update to this report was completed in April 2015 to ensure that no new issues had emerged that might adversely affect the integration process.</p>	
<u>Key Issues/Risks and Recommendations:</u>	
<p>The update specification is set out in section 1 of the report. This included a review of issues raised in the first report and the identification of any recent clinical performance variance.</p>	
<u>Summary of ED Challenge / Discussion:</u>	
<p>The attached report hi-lights a number of on-going challenges and details the clinical performance indicators that are outside target. These are reported though the TSD governance reporting process and SDT is sighted on the challenges and variance to performance. The report provides evidence of associated action plans to mitigate the risk. No material issues were identified.</p>	
<u>Internal / External Engagement including Public, Patient and Governor Involvement:</u>	
<p>Torbay and Southern Devon Health and Care Trust Staff and other stakeholders were interviewed as part of the process.</p>	
<u>Equality and Diversity Implications:</u>	
None	

PUBLIC

REFRESH

Clinical and Social Care Governance Due Diligence

Updated Review of

Torbay and Southern Devon Health and Care NHS Trust (TSDHCT)

Prepared for South Devon Healthcare NHS Foundation Trust (SDHFT)

Susan Burnett & Andy Nash

	CONTENTS	Page
1	Introduction & Terms of Reference	1
2	Limitations	1
3	Review methods	2
Findings		
4	Ordinary residence cost pressure	2
5	Care home fees	2
6	Community concern – community hospital consultation	3
7	Pressure on social care budgets – risk sharing	3
8	Key performance data	5
9	Safeguarding	8
10	Child and Adolescent Mental Health Services	10
11	Community Nursing and Allied Services	10
12	Risk Management & Information Presented to the Board	11
13	Other issues for consideration	11
Appendices		
1	List of interviews held at TSDHCT	12

We would like to thank the staff at TSDHCT for their help and cooperation, enabling us to conduct this review.

1 Introduction & Terms of Reference

South Devon Healthcare NHS Foundation Trust (SDHFT) has been selected as the preferred bidder to acquire Torbay and Southern Devon Health and Care NHS Trust (TSDHCT). As part of the process of acquisition SDHFT is required to undertake a clinical and social care governance due diligence review of TSDHCT to enable the Board of SDHFT to understand the safety and quality issues risks and the opportunities of this potential transaction. SDHFT therefore require appropriate independent advice to inform this process. A full review was undertaken and a report prepared in May 2013. The acquisition is now in the final stages and SDHFT require some of the issues raised in the first review to be 'refreshed'.

This report is based upon the terms of reference/requirements agreed with SDHFT in March 2015, as follows:

Risk identified in 2013	Current review to consider
Ordinary residence cost pressures	Has there been escalation of the numbers and associated costs that creates a material risk?
Care home fees	This issue has not been resolved, what are the implications for the acquisition?
Community concern	Do the current consultation activities being led by CCG impact on ICO?

Other risks described in the first report and worthy of review are included in the table below:

Pressure on social care budgets could undermine integration	Have the recent decisions made by the council regarding social care provision adversely impacted on quality and safety?
Information presented to the board for some important issues is too high level for robust assurance	Is there confidence that risks escalated to the TSDHCT Board reflect accurately the risks of the organisation?
Risk management is not fully embedded in the organisation	Does the current corporate risk register reflect the risks within the organisation?
There are several KPIs which are reported as being below, or well, below target, and have been reported as such for some time	An update on current KPIs is required to include safeguarding adults and children

2 Limitations

The purpose of this 'refreshed' clinical and social care due diligence review is to provide the Board of SDHFT with the appropriate assurance about the issues and risks of concern as set out by the trust. A caveat here is that the review has relied on the data that is available and the openness of those interviewed and involved in the review process.

For this 'refreshed' review a short timescale was required and as such we have not been able to go into the same amount of detail as in the first piece of work in 2013. As such the current review cannot be equated with complete assurance that a Trust is safe as clearly we have not been asked to assess all processes.

3 Review methods

In the review we have examined a range of reports and information provided by the Trust. We have also conducted interviews with staff in the Trust and in both Torbay and Devon Councils. The views of the local CCG and Healthwatch Group were also sought.

Please note: We have not looked outside the areas requested by SDHFT and the key areas of risk highlighted in the first report.

Please note: the term ICO refers to the proposed new Integrated Care Organisation

FINDINGS

4 Ordinary residence cost pressures

Until the 1st April 2015, when the new Care Act comes into effect, when someone with care needs moves from one council area to another, the “new” council becomes responsible for care fees once the person has residence in the area – this is known as ‘ordinary residence’. Since Torbay is an attractive coastal area to live, many older people and those providing care homes for all ages, view the locality favorably and this has created a net inward movement and a rise in social care cost pressures.

The Care Act 2014 comes into effect in April 2015 and from this time the original council area where someone lives, continues to be financially responsible, wherever the person with care needs moves to. As such ‘ordinary residence cost pressures’ will not be an issue from April for any new residents in Torbay. Providing care will remain an issue, but not the associated fees.

It was reported from those we spoke to, and in the reports provided, that legacy cost pressures remain but are being robustly managed by Torbay Council and any residual costs will remain with the council. As such, ‘ordinary residence cost pressures’ are not a risk to the ICO.

It should be noted that the planning committee in the council review all applications for new care homes in the area and this should continue to be monitored by the ICO to enable forward planning of care services.

5 Care Home Fees

Care homes in Torbay have taken the council to Judicial Review over the level of care home fees. The council lost the initial judgment and is now in the appeals process. It was made clear during our interviews that the council will underwrite any shortfall (which could be significant) should the appeal be lost, and that funds have been set aside to cover this risk. We were told that any funding to cover the shortfall will be in addition to the current social care budget and that this, in itself, would not lead to any further reduction in social care services, since the funds would need to be found from other council budgets. We recommend that SDHFT gain written assurance that this is the case.

We were told that Torbay has the wrong balance of care homes (nursing, residential etc) and that changes will need to be brought into effect in the coming years through the contracting process and through care home closures when standards are not being met. This will be the responsibility of the contracting team in the ICO and as such the skills and expertise in the current team will need to be retained and developed.

A further area of development that will be required in the coming year is that of quality monitoring of care homes. Care homes are currently participating in the Quality, Effectiveness, Safety Trigger Tool (QuESTT) but on a voluntary basis. The ICO will need to consider in future how to build this into the contracting process – how to assure the ICO, the Council and other stakeholders that where the trust has placed contracts with care homes, these homes are delivering good quality care.

6 Community Concern – Community Hospital Consultation

The CCG is currently consulting on a change of use of the community hospitals in Teignmouth and Dawlish and is in the initial phase of discussions surrounding the small hospitals in Ashburton and Bovey Tracey.

From our review of the plans and discussion with those involved in the consultation it would appear that the plans, once implemented, will be of benefit to the new combined trust through a reduction of clinical risk (for example in combining two neighbouring, small minor injuries units to providing one more substantial unit).

Prior to any changes emerging from the consultation coming into effect, the risks set out in our first report remain, particularly in Bovey Tracey where local GP cover has been withdrawn and is now being provided by GP's in Dawlish.

From a financial perspective there is likely to be a need for bridging funds to run parallel services whilst the small hospitals are being reconfigured – for example increasing home care services in Bovey Tracey whilst bed provision is reduced (should this option be agreed). We reported in 2013 about the difficulty the trust was having in recruiting community nurses and understand that this is still an issue. Because of this, running parallel services may prove difficult and the new organisation will need a positive strategy to develop and encourage more nurses to work in the community.

7 Pressure on Social Care Budgets – Risk Sharing

There has been a 15% reduction in the social care budget over the last two years and further significant savings will be required in the coming years, particularly in the area of contracting for care home places. This will be the responsibility of the ICO.

It was reported that TSDHCT has managed the current round of budget cuts well and in a robust manner. For example, the learning disability service has been redesigned in line with national policy, moving people from high cost care homes into the community, with access to general care and support services. Also, reviews have been undertaken of residential care placements where costs have been high and, where possible, new, lower cost models of care have been introduced. This work will need to be continued in the ICO.

We were told (but have not seen the figures) that the Supporting People¹ budget has been subject to large cuts over the last year, however the impact of this is unclear. There was a suggestion by some interviewees that some services (particularly those for young people) have seen a rise in referrals since these cuts - this could be related but we have not seen any evidence to support this. The relationship between take up of council run services provided to support vulnerable groups and any effect on referrals to related health services is a complex area, but worthy of investigation to understand the economics. Low cost community interventions may prevent spending in areas such as CAMHS for example.

We had sight of a letter from the Trust's Director of Finance/Deputy CE to the Director of Social Services which clearly sets out the social care cost pressures for 2015/16 These are being managed through the Social Care Programme Board.

It is our view that the recent decisions made by the council regarding social care provision will not in themselves undermine integration. In fact reductions in the social care budget appear to be more of a risk if the organisations do not merge. The ICO will have more flexibility in respect of service redesign, the use of pooled budgets and staffing mix than are currently available in the two organisations.

We have seen no evidence to lead us to conclude that budget decisions made by the council have adversely impacted on quality and safety though this is something that the ICO will need to monitor closely.

We are of the view that is a need for the ICO to further develop the ability to forecast the population and the associated costs as they may change in the years ahead. It was reported that some forecasting has been done but this is for different care groups, but this has not been brought together into an overall forecast with associated plans.

7.1 The Care Act 2014

The Care Act 2014, which comes into effect in April 2015, will bring implementation cost pressures. Some of these pressures will be met by central government through grant funding, however there is an anticipated shortfall of £313,000 between the amount of grant funding and what is actually required. We were told that this is broken down as follows:

- Additional assessments and reviews of carers - shortfall of £5,077
- Early assessment of self funders - shortfall of £207,875
- Advocacy services £65,686
- Additional carer services - shortfall of £100,000

One potential risk arising out of the Act which will need to be monitored is deferred payments, whereby people in need of care can offset any costs against the sale of their property when they die. This is currently only available to people having part of their care costs provided by the council. In future this will be available to anybody needing care who wishes to avail themselves of a 'deferred payment'. Deferred payments will attract interest. This area of the Act was described to us as "volatile" but it is a national issue, as much as it is a local risk. We understand that £327,916 is available to Torbay as a revenue grant from central government. £60,000 of this has been passported to the Trust from the council to cover an officer post. The rest is being held by the

¹ The Supporting People programme (SP) was launched in 2003 with a ring fenced budget of £1.8bn. The level of funding reduced in subsequent years and in 2009 the ring fence was removed allowing local authorities to spend their allocation as they saw fit. Concerns have been expressed that local authorities have made cuts in their SP funding to fund cost pressures elsewhere.

council to fund a full time solicitor post and until a decision is reached on which organisation will be responsible for holding and servicing the debt.

There is a Care Act Project Board, established by Torbay Council and chaired by Caroline Taylor, with 7 work streams. There is also a Care Act Delivery Group set up by TSDHCT to provide organisational assurance that implementation plans are in place and making progress. We recommend that SDHFT view the work plan for this group since a considerable amount of work is underway to ensure that staff are ready for implementation, including a considerable amount of training.

7.2 Care and Support at Home – Living Well

It has been recognized that the current capacity will not meet the rising demand for care in peoples own home. We were told that, currently, there is insufficient capacity for the hours required for care and support at home. This is due to a number of factors, not least low pay and non-standard hours for care workers, compared to other local employers. The Care Trust has recently tendered this service and awarded the contract to a company – The Mears² Group .Through this contract it is envisaged that the ICO will have greater scope for providing care at home, developing the service to encompass new areas not currently available, and thus further reducing hospital admission and facilitating early discharge. As such there is a current risk in the system but plans in place to resolve this and more. This contract will need careful monitoring to ensure that quality improves and safety is maintained.

7.3 Risk sharing

A new financial risk sharing agreement has been drawn up between the CCG, the Council and what will be the new Integrated Care Organisation (ICO). Risk is calculated as a percentage of budgets. This agreement is important for continuity of service and hence for ongoing quality and safety. However, we are unable to comment on this agreement other than to say that interviewees believe that this is a robust agreement with adequate risk sharing to provide a degree of security to each organisation. This is an area where SDHFT may require review by financial experts.

8 Key Clinical Performance Data

8.1 Social Care Performance Data

The Care Trust is responsible for the delivery of social care on behalf of Torbay Council. This section of the report does not deal with the performance of Devon Council as that council has not delegated responsibility for the delivery of social care to the Trust. It does, however, cover mental health social care delivered by the Devon Partnership Trust as this is commissioned by the Care Trust on behalf of the Local Authority.

The Adult Social Care Outcomes Framework (ASCOF) is the Department of Health's main tool for setting direction and strengthening transparency in adult social care. The framework was first published in March 2011, and since then has been kept under constant review to ensure a continued

² From Mears Group website: Mears employs almost 17,000 people in every region of the UK. In partnership with social housing clients, they maintain, repair and upgrade the homes of hundreds of thousands of people in communities from remote rural villages to large inner-city estates. Their care teams provide support to around 30,000 people a year, enabling older and disabled people to continue living in their own homes. They focus on long-term outcomes for people rather than short-term solutions and invest in innovations that make a positive impact on people's quality of life and on their community's social, economical and environmental well-being.

focus on measures that reflect the outcomes which matter most to users of adult social care services and carers.

Indicators are compared nationally, regionally and with similar local authorities. ASCOF figures for 2013-14 are available at <http://ascof.hscic.gov.uk>. The analysis of indicators for 2014-15 is not yet available; when it is available the Trust should undertake their own analysis.

We have had sight of the Chief Operating Officer's comprehensive performance report which went to the Social Care Programme Board on 28th February 2015. This sets out a monthly report and the performance trends from April 2014 to date.

The report shows the following:

Green (on target)

- Clients receiving Direct Payments: On target previous 11 months
- Percentage of people receiving a statement of needs: On target previous 11 months.
- Timeliness of social care assessment: On target previous 11 months.
- Timeliness of care package: On target previous 11 months.
- Number of permanent care home placements: On target previous 11 months.
- Carers receiving needs assessment, review, information, advice: On target previous 11 months.
- No of adult safeguarding alerts: green for year to date figure.
- Number of adults with learning disabilities in settled accommodation: On target previous 11 months. [see section on placed people] We were told that there is a strategy in place to reduce the number of people with LD in inappropriate care home placements.
- Percentage of adults in contact with secondary mental health services in settled accommodation: slightly below target for 4 months in the previous 11 months.
- Average monthly number of days of delayed transfers of care per 100k population: On target previous 11 months. (But see below).

Amber rated (slightly below target)

- Clients receiving a review. This has dropped since December 2014. A note in the performance report says that there are data and performance issues being addressed. This target is green rated for mental health.

Red rated (below target)

- Percentage of clients receiving self-directed support. This has dropped throughout the previous 11 months from green. The performance report notes that the indicator remains a challenge and there are expectations that this will improve with the new model of care. NB This target is green rated for community mental health.
- Number of overdue reviews. Red rated previous 6 months. A note in the performance report says that there are data and performance issues being addressed.
- Number of overdue reviews for out-of-area placements. Red rated for previous 8 months. The performance report notes that there are 12 reviews outstanding and that these

placements have been checked for CQC compliance and with the Local Authority where the person is resident, pending full reviews being undertaken.

- Proportion of clients supported in a care home: Red rated for previous 11 months.
- Percentage of safeguarding strategy meetings held within 5 days – red rated for previous 11 months ;
- Percentage of safeguarding case conferences held within 20 working days of strategy meeting – red rated for previous 5 months;
- Number of repeat safeguarding referrals in last 12 months – red rated for previous 2 months. See Section 9 on safeguarding below.
- Percentage of age adults in contact with secondary mental health services in employment. This maybe due to a lack of available local employment but it is worth further discussion with the provider mental health trust. This has been low for a number of years and is low compared nationally, regionally and with similar local authorities.
- Permanent admissions to care homes.

Comment

There are a number of ASCOF indicators which are red rated. The Trust is taking action to address these but concerted action will need to be taken by the ICO to ensure performance improves in these areas.

The ASCOF indicators show that the average monthly number of days of delayed transfers of care as being on target and the average number of delayed transfers of care which are attributable to social care as dropping. However, the Trust KPIs report that the number of bed days lost due to problems with obtaining packages of care and care home placements as being red rated at 9%. The Trust should further explore this apparent inconsistency. [The ASCOF annual analysis for 2013/14 showed the Care Trust performing exceptionally well against national, regional and similar local authority comparators].

ASCOF performance indicators are set out in the Annual Strategic Agreement agreed with the Local Authority and performance is monitored at the Social Care Programme Board.

The Board minutes for 15th February 2015 note

- Self directed support – forecast to miss end of year target
- Reviews – number of overdue reviews increasing and increased again in January. Risk to public not high.
- Safeguarding still on red.

8.2 Key performance indicators (KPIs)

We have reviewed the Trust's "Focus on Performance" report for 25th March 2015. This report provides an *update on key issues on an exception basis*. The report provides a narrative as well as figures.

Improving metrics

- Number of patients with a length of stay over 30 days
- Delivery of the Cost Improvement Programme savings plan.

Community Hospital Metrics

- Admissions green rated but increase in admissions of 4% (143 extra patients). “Second highest figure this year”
- Number of bed days lost red rated at 9% . Due to problems with obtaining packages of care and care home placements. See Social Care Performance section.
- Self directed support – red
- Overdue reviews 12 outstanding – to be completed in March and April. See Social Care Performance section.
- CAMHS – 76 people waited over 18 weeks to be treated
- Face to face new birth visits red rated at 84%
- Number of grade 3/4 pressure ulcers – 29 reported (28 reported “unavoidable”)
- QUESST – amber rated
- Safeguarding - red rated. See Section 9 below.

HR Metrics

- Extra bank staff used to support escalation opened
- Sickness absence red rated
- Appraisal rates – amber rated
- Mandatory training improved – apart from that for information governance (an issue/risk raised in our previous report)

For the purposes of this report there is generally a good correlation with social care performance reporting apart from the apparent inconsistency about delayed transfers of care noted above.

9 Safeguarding

There has been a slight rise in referrals for adult safeguarding from March 2014, 36 referrals, with a high of 55 in September 2014 and the latest figures for February of this year show 40. The trust is currently reporting a risk in terms of dealing with all adult safeguarding within the 5 day requirement for a multi-agency strategy meeting from the receipt of a Safeguarding Adults referral. This is red rated and has been for the previous 11 months. Similarly, the percentage of safeguarding case conferences held within 20 working days of the strategy meeting is red rated and has been for the previous 5 months. The number of repeat safeguarding referrals is also red rated and has been for the previous 2 months.

The Trust’s Social Care Performance report for February 2015 notes :“Agreement has been approved through the Trust’s Quality and Safety Committee to proceed with the implementation of a new set of performance indicators as recommended by the South West ADASS group. This amends the timescales required in the indicators around holding both strategy meetings and case conferences. The aim is to place less emphasis on process but ensuring that safeguarding responses focus on the “what are your preferred outcomes to this situation” approach. The new set of

indicators will be considered by the Torbay Safeguarding Adults Executive Group on 18 March and implemented on 1st April”.

Those interviewed reported that they were assured that people are safe despite the meetings not taking place within the time frame.

We were told that there is insufficient staff in the team to deal with referrals in a timely manner.

We recommend that SDHFT review the adult safeguarding service to provide their own assurance that people are safe and in order to develop plans to ensure the team is of sufficient size to manage the caseload.

The ICO Board will be required to assure the Council, who retain statutory responsibility, that safeguarding duties are being discharged according to good practice and the law.

9.1 Deprivation of Liberty Safeguards (DOLS)

There is currently insufficient capacity in TSDHCT for high and medium DOLS risk assessments. A submission has been made to the Council for a rise in the budget of £250,000 to pay for legal costs and court of protection arrangements. We were told that there is a backlog of low priority cases which this additional funding will not cover. This will be a cost pressure in the ICO if the Council cannot agree to these additional costs.

9.2 Placed People

There has been a rise in the number of ‘placed people’ especially children.

Each placed person should be reviewed under the QA process. There is currently a delay in the full reviews of all but the high cost placements – here the reviews have taken place as part of cost reduction planning.

This is an area of risk on the CCG risk register with concern that they will not receive assurance required about the quality and safety of care provided to placed people in Torbay and South Devon. The risk is associated with a) a lack of clarity on roles and responsibilities for contracting and monitoring care and b) a lack of capacity to undertake continuing health care (CHC) appeals for South Devon within existing resources.

9.3 Looked After Children

The Looked After Children’s services were subject to a CQC inspection in early 2014 and the report is available on the CQC web site:

<http://www.cqc.org.uk/sites/default/files/20140818%20CLAS%20Torbay%20Final%20Report.pdf>

An action plan was drawn up by TSDHFT and progress this is reported to the Board. In the latest board report the following is reported:

The action plan has progressed well through monthly meetings with all providers led by South Devon and Torbay Clinical Commissioning Group. The collaborative work to progress all actions and ultimately provide assurance that services which support children and their families across the health community are safe, high quality and effective. The last progress review meeting was held on 17 March 2015 and I can report that only two actions remain outstanding. One is in relation to the new Minor Injury Unit IT system,

joint with South Devon Health Care Foundation Trust that has an anticipated implementation date of June 2015. The second aligns to work currently in progress within the organisation to improve timely access to Child and Adolescent Mental Health services. Two audits to check system change will take place in April 2015 and form part of the action plan. This provides assurance that progress to full compliance continues with the majority of actions now fully compliant with the recommendations set.

The CCG have identified as a risk the lack of a population profile for Looked After Children and Young People (LACY) in its area of responsibility. The main risk is the inability to plan services appropriately.

9.4 Training for safeguarding

We did not see these figures – so recommend that SDHFT review them on acquisition.

10 Child and Adolescent Mental Health Services (CAMHS)

CAMHS is a small service in Torbay. This service was raised as an area of risk in our previous report in 2013 and this risk remains. Since 2013 there has been a rise in referrals and in overall activity levels leading to an overspend. The commissioners have been approached for additional funding and an action plan has been drawn up to improve the waiting times.

NB: The CAMHS service is a red risk on the CCG risk register too, including the risk of children not having access to out-of-hours psychiatric assessment.

We recommend that SDHFT review the action plan and appoint a lead at board level to oversee its implementation. We also recommend that the ICO reviews the service in conjunction with the CCG and with neighbouring CAMHS services. The increasing caseload, the waiting times and the difficulty recruiting into this service may introduce new risks, hence the priority needed for a review of this service and a decision about its future configuration.

In our previous report we highlighted the risk of rising presentations to A&E and in the Paediatric Services in SDHFT due to the waiting times for the CAMH Service.

NB: Adult mental health services are provided by Devon Partnership NHS Trust and this area of work did not form part of our review.

11 Community Nursing and Allied Services

TSDHCT manage a range of public health services formally in the PCT and now commissioned by the Council. These are as follows:

- Obesity services
- Drug and alcohol services
- Falls prevention
- Staying Healthy
- School nurses & health visiting

In 2014 the Drug and Alcohol service was highlighted as a risk area and visited by Public Health England. One area of concern was 'retention of clients'. We were assured by the service manager that the risks have been reduced. There is an issue in this service with access to the national IT system to view and report on performance. We understand that due to glitches in the national system, the local team cannot access performance data. This may be resolved when the ICO is formed but is worth noting and reviewing in due course.

12 Risk Management and Information Presented to the Board

We reviewed the Trust's Risk Register and the CCG's risk register and found that they were complementary. The risks identified in the Trust's risk register appeared to us to fully reflect the risks identified in the documentation we reviewed and from information we were given in interviews. We were not made aware of any risks that were not in the risk register.

13 Other issues for consideration

The Care Trust is responsible for the delivery of social care on behalf of Torbay Council but also works in partnership with Devon County Council. We spoke to a representative of Devon County Council who told us that the council is generally supportive of the move towards an ICO.

In our 2013 report we noted the risk of the electronic records system that was being developed in TSDHCT. We understand that this has now been stopped and that a joint TSDHCT-SDHFT system is being introduced. There is a continuing risk of using a mix of paper and electronic systems and in how to ensure information sharing between all agencies and services when each use different systems – and when key staff in TSDHCT use paper records.

Appendix 1: participants in the review process

	Name	Position
1	Cllr Scouler	Cabinet lead for Social Care (could not be interviewed due to sickness)
2	Richard Clack	Director of Finance and Deputy CE , TSDHCT
3	Jane Viner	Director of Nursing SDHFT
4	Simon Tapley	CCG Director of Commissioning and Transformation/Deputy Accountable Officer
5	Gill Gant	CCG Director of Quality Assurance and Improvement
6	Cathy Williams	Interim Chief Operating Officer, TSDHCT
7	Paul Looby	Executive Head of Finance, Torbay Council
8	John Bryant	Head of Commissioning, Adult Social care
9	Dawn Butler	Assistant Director of Operations for Children & Public health
10	Caroline Taylor	Director of Adult Social Care, Torbay Council
11	Sally Slade	Head of Adult Social Care, Devon County Council
12	Julie Foster	Associate Director, Adult Social Care, TSDHCT
13	John Harrison	Head of Performance, Contracting and Information, SDHCFT
14	Pat Harris CEO Kevin Dixon, Chair	Torbay Healthwatch

REPORT SUMMARY SHEET PUBLIC

Meeting Date:	26 May 2015
Title:	Finance Committee – Finance and Performance Report Month 1 2015/16
Lead Director:	Paul Cooper - DFPI and Liz Davenport – Chief operating Officer
Corporate Objective:	Safest care; No delays; Best experience; Promoting health; Delivering improved value. To ensure the Trust meets its financial duties and performance metrics.
Purpose:	Assurance

Summary of Key Issues for Trust Board

Financial Performance against the COSRR for Monitor, including exceptions to plan. A full report is provided to the Finance Committee.

The purpose of this report is to brief members of the committee on the exceptions to the delivery of the key standards and performance assessments. Performance against key standards are summarised in the performance dashboard. The full performance report is presented to the Finance Committee.

The report, for completeness also includes the final narrative circulated to the Board since the last meeting and recently submitted to Monitor in support of the Annual Plan for 2015/16.

Key Issues/Risks and Recommendations:

The Performance Report highlights the following:

Quality Indicators

- CQC intelligent monitoring rating has dropped to a 3.
- Reported VTE assessment on admission is not meeting expected levels
- Cancelled operations due to emergency admissions and other hospital pressures

Monitor compliance

- Improvement against the 4 hour target (93.9%), although still not meeting the 95% standard
- RTT admitted pathways (82.4%) not meeting the 90% performance standard
- RTT incomplete pathways (91.3%) not meeting the 92% performance standard
- Deterioration in Diagnostic performance, sustainability and impact on 18 week pathways
- Stroke pathway low levels of compliance with 90% target for time on a stroke ward

Performance and Quality Requirement – Contract indicators

- Contract penalties against performance standards have been applied in April
- Admitted RTT - The placing of the order for the mobile theatre to support the additional capacity required to treat the backlog of patients waiting for cataract surgery has been approved. The final business case for this and the longer term staffing and capital plans to increase capacity will be reviewed by the May Finance committee. Outsourcing to other providers is in place for Plastic surgery, Ophthalmology and some General surgery cases.

Financial Performance

- Overall delivery of the plan for the month including CIP, and vacancy factor
- Over performance on National Tariff at National Terms and Conditions driving the surplus
- Increased staff costs associated with operational pressures.

Summary of ED Challenge/Discussion:

Performance Actions

- Agreed investment in Vanguard unit to address backlog position in Ophthalmology
- Meeting with stroke team asking for a plan to ring fence stroke beds from 1st June
- Agreed next phase of work to develop the hospital pathways in the 4 hr target improvement plans.
- IST Team have visited to review the RTT performance

Finance Actions

- CIP delivery being reviewed by operational and finance teams
- Investment timings being agreed with operational teams
- Review of Non-qualified Nursing investment.

Internal/External Engagement including Public, Patient and Governor Involvement:

Finance Committee Members:

NEDS.

Governor Representative

Chairman Observer

Finance Performance and information Teams as required

Director of FPI

Director of Operations

Director of IT

The Performance standards are shared across the Executive Team with exceptions to key targets and monitor indicators highlighted on a weekly basis. A copy of the performance report is shared with the board of governors.

Divisional Teams weekly and monthly.

Directorate and Divisional Boards

Equality and Diversity Implications:

This Committee/Group will observe the requirements of the Freedom of Information Act 2000 which allows a general right of access to recorded information held by South Devon Healthcare, including minutes of meetings, subject to the specified exemptions

Board of Directors**Section 1: Public Board Report****Report Title: Quality, Performance and Finance Exception Report Month 1 – April 2015****Introduction and Summary**

This report sets out the exceptions to the Trust's Performance Targets and Income and Expenditure position for the period ended 30th April 2015.

1. Quality indicators - Safety, Quality, Experience:

The Quality indicators incorporated into the performance dashboard give the Board assurance on the quality and safety of care given to patients.

1.1 Performance variances

1.1.1 CQC Intelligent Monitoring rating.

The Intelligent Monitoring tool has been developed to give inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. Intelligent Monitoring is built on a set of indicators including patient experience, staff experience and performance.

The Intelligent Monitoring report is publicly available in line with the CQC's commitment to transparency. The model will change and be refined as they gain greater insight and receive feedback.

CQC will use the indicators to raise questions about the provisions and outcomes of care, but will not use them on their own to make final judgements. The judgements will always be based on a combination of what is found at inspection, Intelligent Monitoring analysis and local information from the Trust and other organisations.

CQC shares the Intelligent Monitoring reports with Trusts for two weeks before the final publication to allow Trusts to tell them about any factual accuracy concerns. Members of the public can provide feedback once the report is made available on CQC's website.

When the reports were first published in 2013, SDHFT were banded as a 6 (lowest risk rating). We maintained this rating until November 2014. Our risk rating dropped to a 5, but at the time of publication in December 2015, we dropped to a 4. We have just received our latest draft report, which is rated as a 3.

The areas that are triggering this score have been reviewed and all have action plans in place. The new areas are 'Friends and Family', inpatient response rate and 'Referral to Treatment' waiting times for admitted patients.

The list of indicators identified as triggering this score is shown below.

Section	Indicator Description
Patient safety Incidents	Proportion of reported patient safety incidents that are harmful (01-Dec-13 to 30-Nov-14)
Venous Thromboembolism	Proportion of patients risk assessed for Venous Thromboembolism (VTE) (01-Oct-14 to 31-Dec-14)
Audit	SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Jul-14 to 30-Sep-14)
A & E Survey	A&E Survey Q7: From the time you first arrived at the A&E Department, how long did you wait before being examined by a doctor or nurse? (01-Jan-14 to 31-Mar-14)
	A&E Survey Q18: Were you given enough privacy when being examined or treated? (01-Jan-14 to 31-Mar-14)
Access Measures	Composite indicator: Referral to treatment (01-Dec-14 to 31-Dec-14)
	Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis): percentage within 18 weeks (01-Dec-14 to 31-Dec-14)
Reporting Culture	Inpatients response percentage rate from NHS England Friends and Family Test (01-Jan-14 to 31-Dec-14)

Actions taken against several of the indicators are now well advanced and are expected to return to 'meeting expected levels' in future CQC intelligence monitoring reports. These indicators are

1. Reporting of patient safety incidents
2. Stroke unit audit outcome (SSNAP) and 4: A&E waiting times.

1.1.2 VTE assessment on admission.

Reported compliance for VTE assessment on admission remains below the national standard of 95% with 89% reported in April. This level of performance has triggered application of penalties against the Month 1 contract position.

2 Monitor Compliance

2.1 The Monitor Annual Plan for 2015/16 declared risks against the following target indicators.

- A+E 4 hour performance – plan to be compliant from the end of Q1
- RTT admitted performance – plan to be compliant from the end of Q2.

In April, performance variances are reported against:

1. A+E 4 hour target with 93.9% achieved against the 95% standard
2. RTT admitted patients treated with 82.4% achieved against the 18 week standard of 90%
3. RTT incomplete pathways with 91.3% against the standard of 92%.

2.2 Performance Highlights

2.2.1 Cancer Performance Indicators.

In April, All the Cancer standards are forecast to be achieved with the final validation and data submission to be completed.

2.3 Performance Variances

2.3.1 Clostridium Difficile (*C. difficile*)

The “Monitor Compliance Framework” reports against the number of *C.difficile* cases, following root cause analysis (RCA) that can be attributed to a ‘lapse in clinic care’.

The Target set for 2015/16 is 18 cases of *C.difficile* with a lapse in care.

In April, there were three confirmed *C.difficile* cases. Two of these cases have been assessed as being due to a ‘lapse in care’.

2.3.2 Four hour standard for time spent in Accident and Emergency (A+E).

The four hour standard of 95% has not been achieved in April with 93.9% reported.

In April, the new pathway for emergency GP referrals has been introduced. The initial signs are that this has had an immediate impact on reducing A+E overcrowding and this is being reflected in reduced delays against the 4 hour standard.

The Emergency Care Intensive Support team (ECIST) have continued to validate our plans and provide feedback on areas of further resilience and focus within the hospital.

Bi-weekly meetings are being held with Commissioners, community provider and social care to review progress against the community wide emergency care action plans.

2.3.3 Referral to Treatment (RTT) Targets

The Admitted, RTT standard is not achieved in April.

Additional capacity is scheduled for Quarter 1 in Plastic Surgery (outsourcing) and Ophthalmology (outsourcing and mobile theatre). This activity is necessary to achieve the improvement trajectory to deliver compliant RTT performance from the end of Quarter 2.

Ophthalmology

The use of a mobile theatre has been approved to support a waiting list initiative to increase the in-house capacity for cataract surgery. The final planning and logistics for the mobile theatre are being completed with an anticipated start date of early / mid-June. The mobile unit has the potential to see 60 patients a week. The final planning includes the recruitment of locum staff to support the in-house teams in the provision of this additional capacity.

Outsourcing continues to both Mount Stuart Hospital and Derriford, capacity and take up remains limited and will not deliver the additional capacity needed to achieve the RTT recovery plan. A new provider has received CQC approval in the Exeter area. This will offer further patient choice and potential capacity to increase the number of patients treated. The initial planning suggests capacity of up to 36 patients per week and could be available from early June. Once in place and subject to patient choice this has the potential to offset the time that the mobile theatre is required.

The Ophthalmology ‘Action Learning Set’ has now met several times and progress is being seen. This includes the development of revised guidance to referrers and criteria for second cataract together with the sharing of ideas to help best use available capacity across all the pathways of care, to best meet patient needs.

A business case for longer term sustainable capacity has been submitted to the Finance committee.

Plastic Surgery

Outsourcing of patients has continued to help manage the backlog position for plastic surgery. The latest forecast is for 60 patients to be outsourced in Q1. The outsourcing together with several additional in-house lists indicates that the backlog will reduce to less than 40 by the end of June, and on track to achieve the agreed trajectory.

General Surgery

The backlog remains around 100 cases above plan. Additional weekend lists have commenced with a total of 7 lists confirmed to the end of August. The 'Action Learning Set' has been established with GP's and commissioners. This will support a wider review of demand management and the challenges being faced to increase capacity to meet demand and the RTT standards.

3. Commissioning for Quality and Innovation (CQUIN)

3.1 2015/16 CQUIN

3.1.1 No exceptions to report

4. Performance and Quality Requirement – Contract indicators

4.1 These performance indicators reflect the key performance measures that are included in the provider contract. This is a mixture of nationally prescribed indicators (only those not already covered in the Monitor section) and locally agreed quality indicators that have been included in the contract schedules.

4.2 Performance Variances

4.2.1 Contract penalties

The contract penalties expected, and provided for in the financial position, against the April performance standards are summarised below:

Indicator	Contract Penalty
RTT Admitted	62k
RTT non Admitted	9k
RTT incomplete	102k
A+E 4 hour	7k
Ambulance handover	15k
VTE assessment	78k

4.2.2 Diagnostic Waits Over 6 Weeks

In April, there were a total of 186 patients waiting over 6 weeks against the monitored diagnostic tests. This represents 4.5% of the total number of patients waiting for diagnostic tests above the National tolerance of 1%.

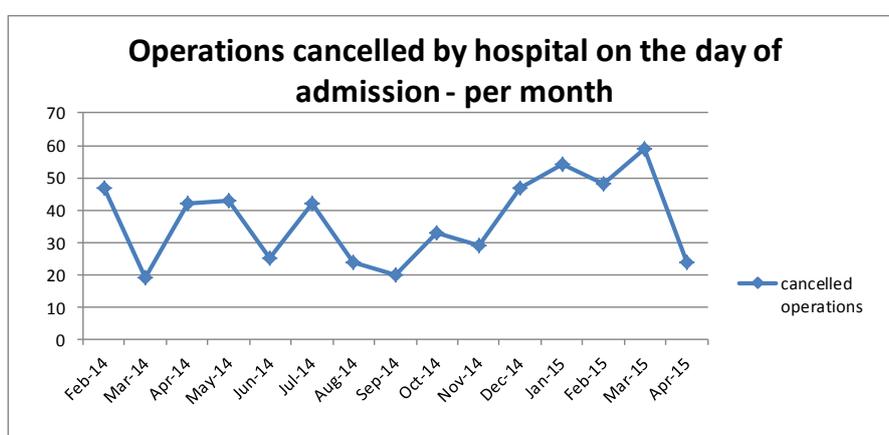
The greatest numbers of patients waiting over 6 weeks are in radiology for Ultrasound (92), CT (48) and MRI (35).

Growth in demand remains a challenge in these areas and business cases have been submitted to provide increased capacity to meet the on-going demand. Performance will remain a risk whilst additional sessions continue to be needed to support the routine capacity.

4.2.3 Cancelled operations

During April, 24 patients were cancelled by the hospital on the day or after admission. This number of cancellations represents 0.7% (target maximum threshold 0.8%) of total elective admissions in the period. The table below sets out the reasons for cancellation.

Reason for cancellation	Number
Emergencies / priority patient / trauma	14
Insufficient Theatre time	4
No ICU / HDU bed	4
No Bed	1
Staffing	1
Total	24



4.2.4 Timeliness of care planning summaries

Performance for the timeliness of care planning summaries within 24 hours of discharge has remained below target in April for both the weekday and weekend measures. In April 57% completed care planning summaries were completed and communicated to the patients GP within 24 hours.

Appendix 1 – Performance dashboard Month 1 – The performance dashboard shows the Trust position for a rolling 12 month period to the end of April 2015 against key Quality and Performance targets. The dashboard summarises the cumulative year to date position against the same period the previous year.

5. Monitor Risk and Other KPI Measures

5.1 This report sets out the Trust's Income and Expenditure position for the period ended 30th April 2015. The Trust has, for the first month of the financial year, delivered a £669k deficit against a planned deficit of £989k. The EBITDA (Earnings before interest, tax, depreciation and amortisation) is £332k surplus, against a planned budget surplus of £7k. This position assumes a contract with Southern Devon and Torbay CCG at National Tariff and full National terms rather than the risk share arrangement that is in the Integrated Care Organisation plans.

The table below shows the Trust summary of EBITDA and total performance against plan and current budget for month 1:

Summary of Position at 30 April 2015			
	Budget	Actual	Variance
	YTD	YTD	to Budget
	£'000	£'000	£'000
Total Gross Income	-20,318	-20,522	-204
Penalties	292	276	-16
Total Net Income	-20,026	-20,246	-220
Operating Expenditure	20,019	19,907	-112
EBITDA	-7	-339	-332
Financing Costs	1,013	1,008	-5
Donated Asset Income	-17	0	17
Impairment Costs	0	0	0
	996	1,008	12
Grand Total	989	669	-320

5.2 The current summary of key performance indicators is in the table below:

DESCRIPTION		THRESHOLD	YTD PLAN/ BUDGET	YTD ACTUAL	RED/ GREEN	See Appendix
MONITOR FINANCIAL RISK RATING	Risk Rating per Plan or above	-	2	2	GREEN	App. A
STATEMENT OF COMPREHENSIVE INCOME (SOI) YTD	Deficit Variance	> 10.0% adverse variance	989	669	GREEN	App. B
CONTRACT INCOME PERFORMANCE AGAINST PLAN (Excl Penalties)	Variance to Plan	> -0.1% adverse variance	(17,010)	(17,263)	GREEN	App. D
FURTHER IE KPI's	4/16 measures RED = RED OVERALL	Detail in App A			GREEN	App. A-C
ANALYSIS OF SOCI WORKFORCE INC CIP TARGETS	(see purple section of SoCI)	> 0.1% variance	13,128	13,309	RED	
PAY RUN RATE	In month actual spend	-		Month 1 13,309	RED	
COST IMPROVEMENT PLANS IN YEAR			Not processed in Month 01			
VACANCY FACTOR ACHIEVED	Variance to Plan of £2.2M	> -10.0% adverse variance	Not processed in Month 01			
CORPORATE FINANCE MEASURES	> 2 Red				GREEN	

5.3 The overall COSRR of the Trust is a 2 as at 30 April 2015, in line with Plan. Within this:

(a) The COSRR for liquidity is 3, in line with Plan.

(b) The COSRR for Debt Service Cover is 1, in line with Plan.

6. SoCI (Statement of Comprehensive Income) Summary

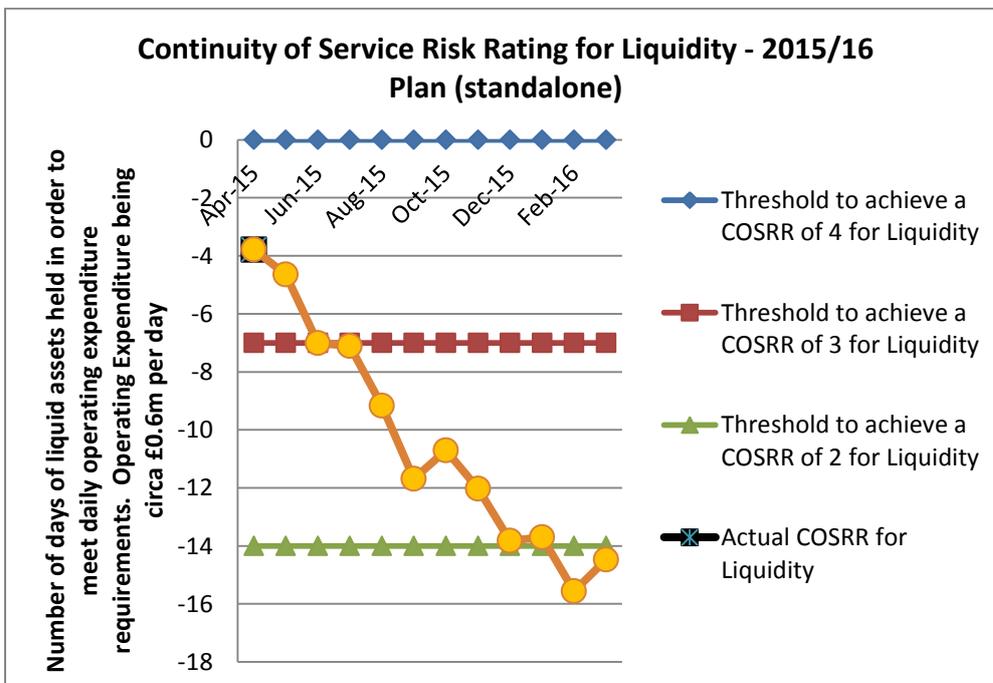
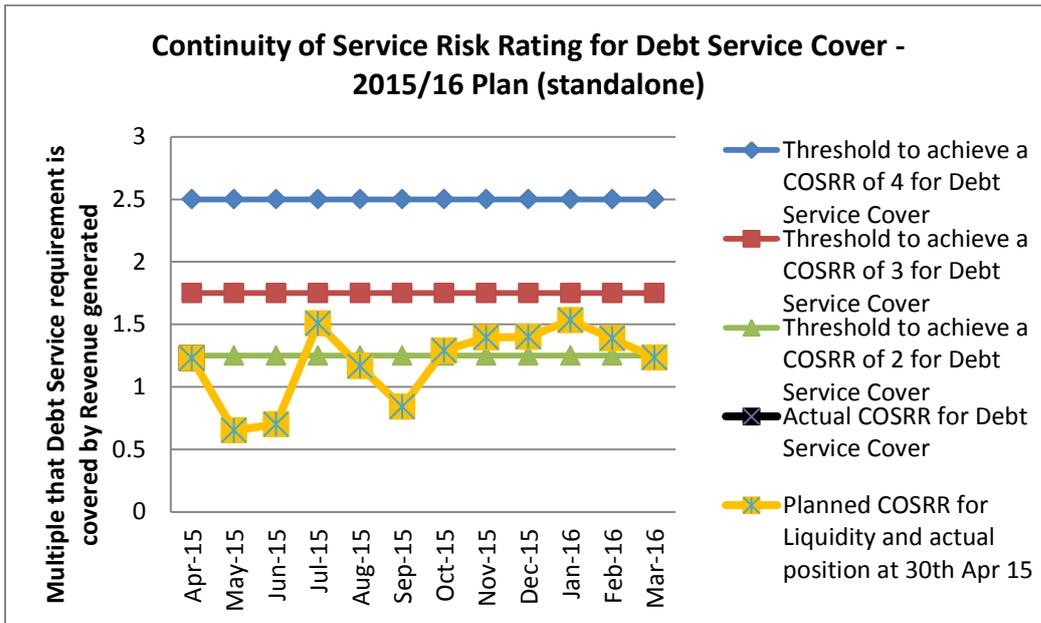
6.1 Income and Expenditure Statement April 2015

The KPIs indicate:

- Contract income above planned levels
- Pay costs above planned levels
- CIP behind plan

7. Continuity of Service Risk Rating (COSRR) Position

7.1 The below charts show the liquidity and the debt service cover.



8. Exceptions - Finance

8.1 Forecast

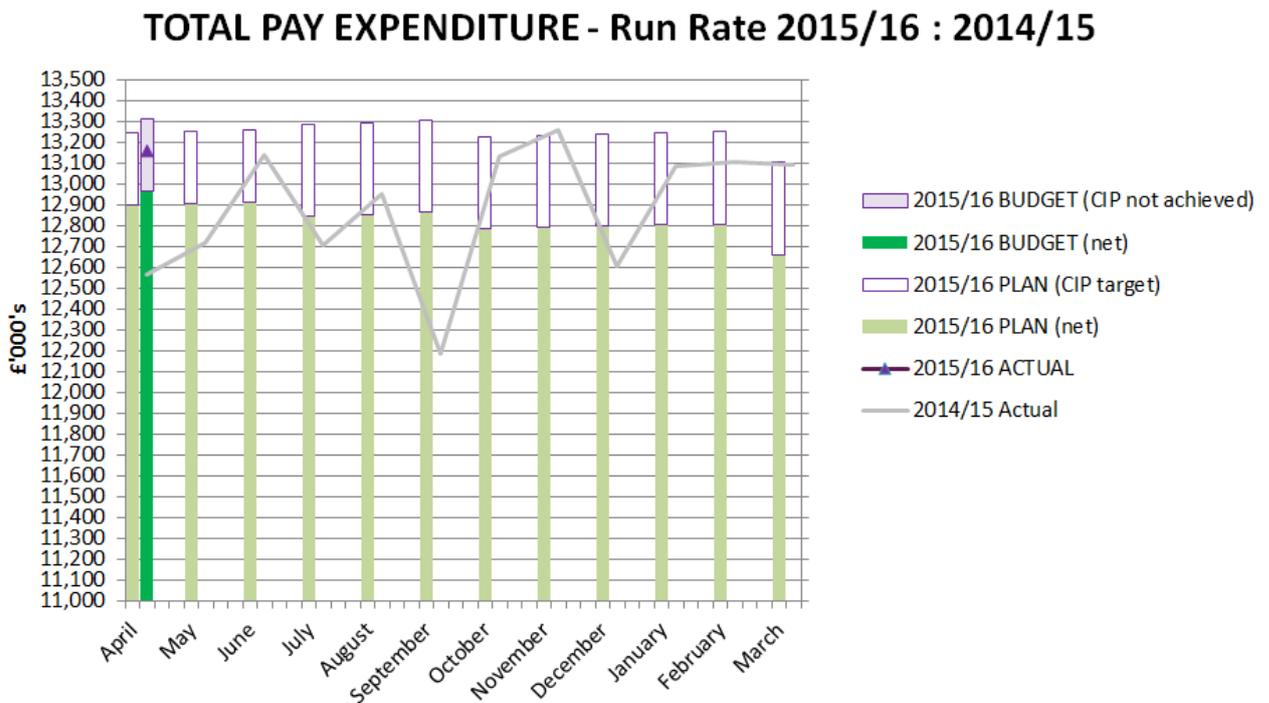
The Trust submitted an annual plan for an EBITDA Surplus of £8,040k and an overall deficit of £4,923k. This was a reduced overall deficit from the April draft plan due to a reduction in depreciation costs planned.

8.2 Expenditure

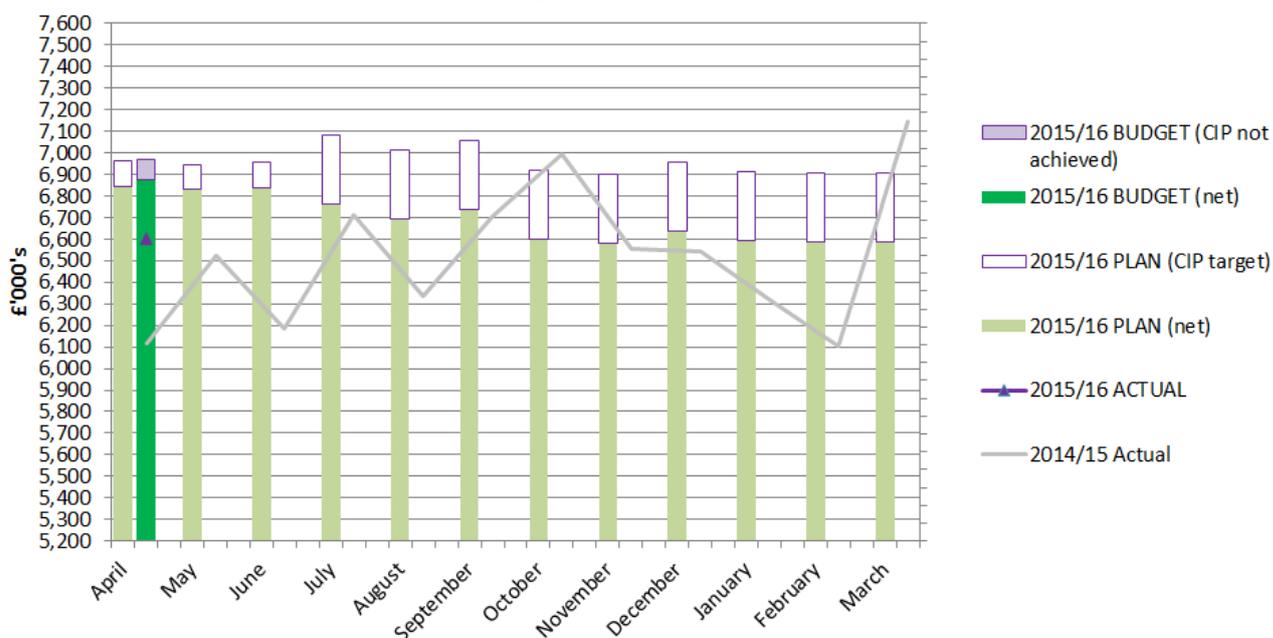
Employee costs are above plan in month 1 however the escalation ward has been open in April, and the CIP plans for month 1 are behind plan.

The charts below show the run rate of expenditure against plan:

The green columns reflect budgeted expenditure (which has flexed from original plan and revised plan) and the purple columns reflect the budgeted CIP savings not achieved in the month. The purple lines show the actual expenditure levels.



NON PAY EXPENDITURE (incl Drugs) - Run Rate 2015/16 : 2014/15



9 Capital Balances

YTD Capital Plan (revised) £'000	Spend to Date £'000	Variance £'000
1,422	1,312	110

- 9.1 The Trust submitted its 2015/16 Annual Plan to Monitor during May 2015. The Annual Plan incorporated a total capital expenditure plan for the Integrated Care Organisation totalling £29.1m. Of this, £25.0m relates to capital expenditure planned on South Devon Healthcare NHS FT sponsored projects. Appendix B to this report contains a detailed analysis of the South Devon Healthcare Sponsored schemes. The planned expenditure for Torbay and Southern Devon's sponsored capital programme will be added to the Appendix B upon integration.
- 9.2 As at 30th April 2015 there is a small variance between planned capital expenditure and actual expenditure incurred totalling £0.1m. This variance is within the 15% tolerance set by Monitor. If the Trust is +/- 15% variance on its capital expenditure program to Plan at the end of a reporting quarter, Monitor are likely to request a revised capital expenditure plan for the Trust. Finance will work with capital scheme leads to update the forecast frequently to ensure that any potential variances are identified as soon as possible, reported and where appropriate, action taken to mitigate.
- 9.3 As in previous year's the Trust's capital programme is funded from two sources of finance. One being from internally generated cash through revenue activities and the other being from external sources of finance. Internally generated sources of finance are reliant upon the Trust delivering its planned Continuous Improvement Programme (CIP).
- 9.4 CIP progress will be closely monitored during the course of the year. If the delivery of CIP is slower than planned, this will have an adverse impact on either the Trust's liquid resources (i.e. principally cash) and consequently the Trust's planned Continuity of Service Risk Rating for liquidity or alternatively may necessitate a reduced capital expenditure program in order to maintain the planned liquid resource position.

- 9.5 A number of the planned capital expenditure schemes for 2015/16 are also reliant upon external finance. External finance has already been secured to support the following schemes in 2015/16 from the Independent Trust Financing Facility (ITFF).

	Planned 2015/16 Spend £'000
Critical Care Unit and new Hospital Front Entrance	6,700
Radiotherapy; New Bunker and replacement Linear Accelerator	4,914
On – site Car Parking Facilities	1,780
Sub-total	13,394

- 9.6 The following schemes are also reliant upon external finance which has yet to be secured. Finance will work closely with scheme leads to develop business cases for these projects to ensure that these are prepared as soon as possible and submitted to the ITFF for funding consideration.

	Value of expenditure reliant upon external finance £'000
Phase 1 of Electronic Document Management System – part of the IM&T Strategy	925
Phase 1 of Emergency Department - Reconfiguration	215
Phase 1 of Mortuary Works and Fracture Clinic	200
Sub-total	1,340

- 9.7 Within the Annual Plan, design fees have been budgeted to enable the enhancement of the on-site Ophthalmology Surgical facilities. However the costs of the construction works themselves have not been incorporated into the planned spend. Once the requirements of the service have been finalised and the design of the facility has been fully costed, the Trust will have one or two choices to fund the development. Namely the use of a circa £1.8m contingency fund incorporated into the capital expenditure program or securing further additional external finance from the ITFF. The potential to secure additional finance to support the Trust's capital program will be kept under close review and further discussions will take place with the ITFF.

- 9.8 Finally, The Trust's ICO financial plan also relies upon other sources of external finance in order to maintain its liquidity position, this principally being the receipt of £8.2m of PDC from the Trust Development Authority and repayment of the long term social care debt on Torbay and Southern Devon Health and Care Statement of Financial Position totalling circa £2m from Torbay Council.

10 Cost Improvement Programme (CIP)

- 10.1 We do not report the detailed Month 1 delivery position within the General ledger, due to other budget setting priorities. Therefore there is no further supplementary schedules or forecast delivery analysis available this month. The overall month position indicates that, in net budget terms both CIP and Vacancy Factor have been delivered in Month 1.

10.2 2015/16 CIP Targets

The 2015/16 CIP targets have been produced as part the 5 year strategic planning process.

In previous years, a global target, generally around 4%, has been set for each budget that reflects the overall efficiency target for the organisation.

For 2015/16, and reflecting on previous year's delivery, there has been a change in the way the targets have been calculated and apportioned this year. Interdivisional, cross cutting schemes have been developed. These are supported centrally but will deliver savings within each respective Division / Corporate Department. CIP targets have been apportioned to budgets that are expected to benefit from the implementation of these schemes.

It is requested that the following targets are formally approved by the board:

Area	15/16 CIP Plan Target
<u>Clinical Divisions</u>	£
Medical Services Division (Incl. Emergency)	2,693,000
Surgical Services Division	2,772,000
Women's, Children's & Diagnostics Division	1,368,000
Total Clinical Services	6,833,000
<u>Support Divisions</u>	
Chief Executive Directorate	34,000
Director - Nursing & Quality Directorate	69,853
Estates and Facilities Division	404,104
Director - Finance, Performance & Information Directorate	376,000
Director - Human Resources Directorate	83,270
Director - Medical Director	18,409
Pharmacy Services Directorate	102,680
Pharmacy Manufacturing Directorate	200,000
Reserves and Provisions Directorate	807,690
Total Support Divisions	2,096,006
Total	8,929,006

SDHFT Performance Report - April 2015

Appendix 1 - Performance report

	Target 14/15	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Red	Amber	Green
QUALITY																
Safety thermometer - % Harm Free	95%	98%	98%	98%	97%	98%	98%	98%	99%	99%	99%	98%	99%	<95%		>=95%
Safety thermometer - Falls	4	2	2	6	4	2	1	0	2	2	3	5	1	>=4	Between	<3
Safety thermometer - VTE	1	0	1	1	2	1	4	1	2	2	1	1	1	>=1		<1
Safety thermometer - Catheters and UTI	1	0	1	0	0	1	0	0	0	0	1	0	0	>=1		<1
Pressure Ulcers Category 2	<3	4	2	1	5	3	4	5	0	1	3	3	1	>=3		<3
Pressure Ulcers Category 3	0	0	0	0	0	0	0	0	0	0	0	1	0	>=1		<1
Pressure Ulcers Category 4	0	1	1	0	0	0	0	0	1	1	0	0	0	>=1		<1
Number of MRSA cases	0	0	0	0	0	0	0	0	0	0	0	0	0	>0		<=0
Infection control - Number of MSSA cases	13	0	2	1	1	1	2	1	0	0	0	0	0	>=2	Between	<1
Infection control - Number of E-Coli cases	24	2	2	1	1	0	3	4	0	0	0	0	0	>=3	Between	<2
Infection control - Number bed closures due to infection control measures	<171	66	108	18	30	12	0	252	124	141	156	104	358	>=171	Between	<100
Infection control - Hand hygiene	95%	89%	96%	96%	99%	98%	95%	96%	92%	98%	98%	100%	94%	<95%		>=95%
Reported incidents - Moderate (excluding VTE events)	<100	46	28	25	22	40	26	30	26	14	22	25	98	>150	Between	<100
Reported incidents - Major	<5	0	0	0	0	0	3	0	0	1	1	0	10	>=20	Between	<5
Reported incidents - Catastrophic	<1	0	0	0	0	0	0	0	0	0	2	1	3	>=1		<1
Reported incidents - Total	<470	546	573	557	533	528	598	623	525	529	808	473	347	>=470		<470
Written complaints - Number received	<30	22	19	45	17	27	33	24	22	23	28	38	29	>=30		<30
Written complaints - Number exceeding the 8 week response date (at month end)	<6	8	6	9	7	12	8	11	11	5	6	7	7	>=6		<6
Long stays - Number of patients with a LoS >14 days at month end	95	108	96	101	112	96	88	102	102	112	119	114	91	>=95	Between	<90
Mortality - HSMR (Dr Foster) - Benchmark = Data Year	85.0%	98.0%	86.3%	92.7%	110.5%	99.1%	119.8%	97.6%	102.7%	107.6%	83.4%	79.6%	0.0%	>=1	Between	<=85%
Never Event reports	0	0	0	0	0	0	0	0	0	1	0	1	0	>=1		<1
CQC Compliance - Intelligence monitoring score		6	6	6	6	6	5	5	4	4	4	3	3	<=2	Between	>=5
Fractured neck of femur achieving Best Practice Tariff	>90%	69.2%	41.5%	52.2%	71.4%	53.8%	77.8%	81.5%	66.7%	28.0%	37.1%	30.2%	70.0%	<90%		>=90%
Stroke patients spending 90% of time on a stroke ward	80%	76.5%	67.7%	57.1%	65.5%	64.2%	80.4%	67.4%	44.2%	61.9%	58.5%	60.0%	70.8%	<80%		>=80%
VTE - Risk assessment on admission Monthly report	95%	91.0%	90.8%	92.2%	91.9%	91.8%	92.0%	90.5%	91.1%	90.2%	81.6%	89.0%	89.9%	<95%		>=95%
Choose and Book - % of slot unavailability	10%	17.1%	17.4%	20.0%	34.7%	21.8%	19.6%	18.6%	16.4%	9.4%	14.7%	20.7%	24.1%	>10%	Between	<=5%
Clinic letters timeliness	95%	95.5%	90.9%	95.5%	100.0%	86.4%	95.5%	95.5%	72.7%	68.2%	95.5%	90.9%	81.8%	<95%		>=95%
Medication errors - Reported on Incident Reporting system	20	13	15	34	16	20	10	21	8	16	25	16	6	>20	Between	<=15
MONITOR - compliance framework indicators																
Number of Clostridium Difficile cases - Lapse of care	11 (Year)	0	0	0	0	0	0	0	0	1	1	0	1	>=2		<2
Cancer - 31-day wait for second or subsequent treatment - Surgery	94%	97.4%	93.8%	91.2%	93.3%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	97.1%	95.7%	<94%		>=94%
Cancer - 31-day wait for second or subsequent treatment - Drug	98%	100.0%	100.0%	100.0%	97.8%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	<98%		>=98%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	94%	89.5%	100.0%	100.0%	95.9%	98.3%	100.0%	98.8%	98.4%	98.3%	100.0%	98.4%	98.1%	<94%		>=94%
Cancer - 62-day wait for first treatment - from urgent GP referral	85%	91.9%	93.9%	87.8%	88.1%	87.4%	87.2%	95.6%	91.0%	87.2%	86.4%	85.2%	96.2%	<85%		>=85%
Cancer - 62-day wait for first treatment - from consultant screening service referral	90%	100.0%	100.0%	88.9%	92.3%	100.0%	100.0%	90.0%	100.0%	72.7%	71.4%	91.7%	100.0%	<90%		>=90%
Cancer - 31-day wait from diagnosis to first treatment	96%	99.4%	98.6%	98.3%	96.7%	99.4%	98.2%	97.3%	97.6%	96.5%	100.0%	98.0%	98.7%	<96%		>=96%
Cancer - Two week wait from referral to date 1st seen	93%	96.6%	93.6%	95.0%	91.6%	96.4%	98.2%	98.1%	97.9%	96.8%	97.2%	96.4%	94.7%	<93%		>=93%

	Target 14/15	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	Red	Amber	Green
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	93%	97.8%	95.7%	92.2%	76.9%	95.5%	99.0%	100.0%	98.3%	93.9%	98.9%	96.8%	98.8%	<93%		>=93%
Referral to treatment waiting times – admitted	90%	83.7%	76.0%	92.1%	84.0%	77.0%	88.4%	74.5%	77.5%	76.7%	75.0%	76.3%	82.4%	<90%		>=90%
Referral to treatment waiting times – non-admitted	95%	96.1%	95.2%	95.9%	95.5%	95.4%	95.6%	95.0%	95.6%	95.1%	94.7%	95.8%	95.0%	<95%		>=95%
Referral to treatment - % Incomplete pathways	92%	94.6%	95.2%	94.5%	94.0%	93.9%	93.3%	92.7%	92.3%	92.0%	92.1%	92.1%	91.3%	<92%		>=92%
A&E - patients seen within 4 hours	95%	85.0%	84.2%	82.0%	90.6%	93.9%	95.4%	90.4%	83.2%	86.9%	81.0%	88.2%	93.9%	<95%		>=95%
Compliance with requirements for people with a learning disability																
Performance and Quality requirements contract indicators																
Diagnostic tests longer than the 6 week standard	0	33	19	17	16	33	17	36	116	123	41	42	186	>30		<=30
Diagnostic tests longer than the 6 week standard	1.0%	0.9%	0.6%	0.5%	0.5%	1.0%	0.5%	1.2%	3.2%	3.2%	1.0%	1.0%	4.5%	>1%		<=1%
Mixed sex accomodation breaches of standard (reported on UNIFY)	0	0	0	0	0	0	0	2	1	0	1	0	0	>=1		<1
On the day cancellations for elective operations (hospital initiated)	0.8%	1.4%	0.8%	1.4%	0.9%	0.8%	0.9%	1.0%	1.5%	1.5%	1.5%	1.6%	0.7%	>0.8%		>=0.8%
Cancelled patients not treated within 28 days of cancellation	0	4	1	3	3	2	0	3	5	7	1	2	0	>3		<=3
RTT - percentage of treatment functions achieving 90% RTT (Admitted)	100.0%	62.5%	57.1%	76.9%	66.7%	46.7%	73.3%	60.0%	57.1%	56.3%	50.0%	56.3%	56.3%	<80%	Between	>=85%
RTT - percentage of treatment functions achieving 95% RTT (Non-admitted)	100.0%	70.6%	64.7%	76.5%	64.7%	70.6%	64.7%	52.9%	58.8%	56.3%	52.9%	70.6%	76.5%	<80%	Between	>=85%
RTT - percentage of treatment functions achieving 92% RTT (Incomplete)	100.0%	94.1%	100.0%	94.1%	88.2%	76.5%	76.5%	82.4%	76.5%	70.6%	76.5%	82.4%	82.4%	<80%	Between	>=85%
RTT incomplete pathways > 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	>0		<=0
Ambulance handover delays > 30 minutes	0	48	88	106	40	24	27	34	56	55	72	34	20	>=75	Between	<50
Ambulance handover delays > 60 minutes	0	0	4	4	2	1	0	0	1	0	6	4	0	>=10	Between	<5
Trolley waits in A+E > 12 hours from decision to admit	0	0	0	0	0	0	0	0	0	0	0	0	0	>0		0
Care Planning Summaries % completed within 24 hours of discharge - Weekday	77%	74.7%	70.7%	64.6%	71.5%	66.5%	65.5%	62.9%	57.3%	59.8%	45.1%	55.8%	57.0%	<77%		>=77%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	60%	45.0%	54.2%	38.4%	37.4%	40.7%	41.7%	47.1%	38.8%	40.3%	30.6%	41.0%	34.2%	<60%		>=60%
Data book local indicators not included elsewhere																
A&E - Total visit time (95th percentile)	≤ 04:00	05:57	06:03	06:13	05:13	04:37	04:00	05:24	06:31	05:55	07:14	05:48	04:35	>04:00		<=04:00
A&E - Percentage of patients with a visit time of less than or equal to 4 hours	95%	85.0%	84.2%	82.0%	90.6%	93.9%	95.4%	90.4%	83.2%	86.9%	81.0%	88.2%	93.9%	<95%		>=95%
A&E - Unplanned reattendance rate	≤ 5%	4.7%	4.8%	4.5%	4.9%	5.1%	5.0%	5.0%	5.3%	5.2%	5.5%	5.8%	6.3%	>5%		<=5%
A&E - Percentage of patients who leave without being seen	≤ 5%	3.8%	4.5%	5.9%	3.4%	2.6%	2.4%	2.2%	2.9%	1.9%	3.2%	3.0%	2.5%	>5%		<=5%
DNA rate overall Trust	6.0%	5.6%	5.5%	5.5%	5.8%	5.5%	5.5%	5.4%	5.8%	5.7%	5.2%	5.6%	5.0%	>6%		<=6%
Smoking during pregnancy	19.4%	19.5%	12.6%	19.0%	17.0%	16.2%	14.0%	20.5%	14.9%	15.4%	13.4%	15.0%	15.0%	>19.4%		<=19.4%
Breastfeeding initiation rates(% initiated breast feeding)	76.3%	69.3%	77.2%	70.0%	74.0%	72.4%	78.9%	71.6%	76.8%	74.2%	76.5%	75.6%	77.0%	<76.3%		>=76.3%
Ethnic coding data quality	80.0%	94.0%	94.0%	93.0%	92.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	95.0%	<80%		>=80%
Primary PCI within 150 minutes of calling.	75.0%	66.7%	100.0%	80.0%	77.8%	91.7%	100.0%	66.7%	88.9%	85.7%	75.0%	81.8%	100.0%	<75%		>=75%

Memorandum lines	Annual Plan:	Current Month	Current Month	Current Month	Year to Date	Year to Date	Year to Date
	TRUST TOTAL £'000						
Memorandum lines							
Total Revenue	(244,592)	(20,033)	(20,252)	(219)	(20,033)	(20,252)	(219)
Total Expenses	249,203	21,038	20,919	(119)	21,038	20,919	(119)
Comprehensive (Surplus)/Deficit Net of Impairment	4,423	989	669	(321)	989	669	(321)
Comprehensive (Surplus)/Deficit	4,923	989	669	(321)	989	669	(321)
Total Operating Revenue for EBITDA	(244,507)	(20,026)	(20,246)	(221)	(20,026)	(20,246)	(221)
Total Operating Expenses for EBITDA	236,467	20,019	19,907	(112)	20,019	19,907	(112)
EBITDA	(8,040)	(7)	(340)	(333)	(7)	(340)	(333)
EBITDA Margin Metric (YTD)	3.29%	0.03%	1.68%		0.03%	1.68%	
Operating (Surplus)/Deficit	1,611	713	393	(321)	713	393	(321)
PMU Comprehensive (Surplus)/Deficit	(5,945)	(452)	(484)	(32)	(452)	(484)	(32)
Subsidiary Comprehensive (Surplus)/Deficit	203	17	16	(1)	17	16	(1)
Trust Comprehensive (Surplus)/Deficit Net of Impairment, PMU and Subsidiary	10,165	1,425	1,136	(288)	1,425	1,136	(288)
NHS Clinical Revenue							
NHS Acute Activity Income							
Elective inpatients							
Tariff revenue	(15,812)	(1,154)	(1,214)	(60)	(1,154)	(1,214)	(60)
Non-Tariff revenue	(522)	(23)	(14)	9	(23)	(14)	9
Elective activity revenue, Total	(16,334)	(1,177)	(1,228)	(51)	(1,177)	(1,228)	(51)
Elective day case patients (Same day)							
Tariff revenue	(20,650)	(1,595)	(1,554)	41	(1,595)	(1,554)	41
Non-Tariff revenue	(657)	(68)	(83)	(15)	(68)	(83)	(15)
Elective Day Case activity revenue, Total	(21,306)	(1,663)	(1,636)	26	(1,663)	(1,636)	26
Non-Elective patients							
Tariff revenue	(55,243)	(4,750)	(4,862)	(112)	(4,750)	(4,862)	(112)
Non-Tariff revenue	(888)	(86)	(70)	17	(86)	(70)	17
Non-Elective activity revenue, Total	(56,131)	(4,836)	(4,931)	(95)	(4,836)	(4,931)	(95)
Outpatients							
Tariff revenue	(32,897)	(2,539)	(2,505)	34	(2,539)	(2,505)	34
Non-Tariff revenue	(8,888)	(743)	(687)	56	(743)	(687)	56
Outpatients activity revenue, Total	(41,785)	(3,282)	(3,192)	90	(3,282)	(3,192)	90
A&E							
Tariff revenue	(9,047)	(760)	(662)	98	(760)	(662)	98
A&E activity revenue, Total	(9,047)	(760)	(662)	98	(760)	(662)	98
Other NHS activity							
Direct access & Op, all services	(4,783)	(374)	(336)	38	(374)	(336)	38
Unbundled chemotherapy delivery	(1,324)	(114)	(122)	(8)	(114)	(122)	(8)
Unbundled external beam radiotherapy	(2,750)	(221)	(156)	65	(221)	(156)	65
Maternity Pathway tariff	(5,206)	(434)	(400)	34	(434)	(400)	34
Tariff revenue, Total	(14,064)	(1,143)	(1,014)	130	(1,143)	(1,014)	130
CQUIN revenue	(4,727)	(394)	(394)	(0)	(394)	(394)	(0)
Critical care (outside tariff) Adult, Neonate, Paediatric	(6,175)	(569)	(525)	44	(569)	(525)	44
High cost drugs revenue from commissioners	(14,138)	(1,178)	(1,118)	60	(1,178)	(1,118)	60
Other drugs revenue (all types all bands including Chemotherapy)	(5,031)	(418)	(468)	(51)	(418)	(468)	(51)
Other non-tariff revenue	(19,082)	(1,590)	(2,095)	(504)	(1,590)	(2,095)	(504)
Non-Tariff revenue, Total	(49,153)	(4,149)	(4,600)	(451)	(4,149)	(4,600)	(451)
Other NHS activity revenue, Total	(49,153)	(4,149)	(4,600)	(451)	(4,149)	(4,600)	(451)
Total NHS Tariff income	(147,713)	(11,941)	(11,810)	132	(11,941)	(11,810)	132
Total NHS Non-Tariff income	(60,108)	(5,069)	(5,453)	(384)	(5,069)	(5,453)	(384)
NHS Acute Activity Income, Total	(207,821)	(17,010)	(17,263)	(252)	(17,010)	(17,263)	(252)
Other tariff revenue (penalties)	3,500	292	276	(16)	292	276	(16)
NHS Clinical Revenue, Total	(204,321)	(16,719)	(16,987)	(268)	(16,719)	(16,987)	(268)
Non Mandatory/Non protected revenue							
Private patient revenue	(504)	(42)	(71)	(29)	(42)	(71)	(29)
Other Non Mandatory/Non protected clinical revenue	(786)	(66)	(12)	54	(66)	(12)	54
Non Mandatory/Non protected revenue, Total	(1,291)	(108)	(82)	25	(108)	(82)	25
Other Operating Revenue							
Research and development revenue	(1,626)	(145)	(128)	17	(145)	(128)	17
Education and training revenue	(6,824)	(603)	(624)	(21)	(603)	(624)	(21)
	(8,450)	(747)	(752)	(4)	(747)	(752)	(4)
Parking revenue	(687)	(53)	(58)	(5)	(53)	(58)	(5)
Catering revenue	(573)	(46)	(53)	(7)	(46)	(53)	(7)
Accommodation revenue	(554)	(46)	(50)	(3)	(46)	(50)	(3)
Revenue from non-patient services to other bodies	(10,060)	(838)	(837)	2	(838)	(837)	2
Misc. other operating revenue	(18,573)	(1,468)	(1,429)	39	(1,468)	(1,429)	39
Other Operating revenue, Total	(30,446)	(2,452)	(2,426)	26	(2,452)	(2,426)	26
Operating Revenue, IFRS, Total	(244,507)	(20,026)	(20,246)	(221)	(20,026)	(20,246)	(221)
Operating Expenses							
Raw Materials and Consumables Used							
Drugs	26,321	2,066	2,124	58	2,066	2,124	58
Clinical supplies	23,220	2,024	1,926	(99)	2,024	1,926	(99)
Non-clinical supplies	1,749	176	184	7	176	184	7
Raw Materials and Consumables Used, Total	51,291	4,266	4,233	(33)	4,266	4,233	(33)
Employee Expenses							
Employee expenses, permanent staff (Note 1)	154,003	12,902	12,893	(8)	12,902	12,893	(8)
Employee expenses, agency & contract staff (Note 1)	1,889	227	416	189	227	416	189
Employee Expenses, Total	155,892	13,128	13,309	181	13,128	13,309	181
Consultancy expense	144	9	17	9	9	17	9
Purchase of healthcare services from non-NHS bodies	1,369	177	145	(32)	177	145	(32)
Misc. other Operating expenses	27,772	2,439	2,202	(237)	2,439	2,202	(237)
Operating Expenses within EBITDA, Total	236,467	20,019	19,907	(112)	20,019	19,907	(112)
EBITDA	(8,040)	(7)	(340)	(333)	(7)	(340)	(333)
Donations & Grants received of PPE & intangible assets (see comment)	(200)	(17)	0	17	(17)	0	17
Donations & Grants received of cash to buy PPE & intangible assets (see comment)							
Donations & Grants received of PPE & intangible assets (see comment)	(200)	(17)	0	17	(17)	0	17
Depreciation and Amortisation							
Depreciation and Amortisation - purchased/constructed assets	8,822	691	686	(4)	691	686	(4)
Depreciation and Amortisation - donated/granted assets	529	46	46	0	46	46	0
Depreciation and Amortisation, Total	9,351	737	732	(4)	737	732	(4)
Impairment (Losses) / Reversals net - purchased/constructed assets	500	0	0	0	0	0	0
Impairment (Losses) / Reversals net - donated/granted assets							
Impairment (Losses) / Reversals net (on non-PFI assets)	500	0	0	0	0	0	0
Operating Expenses excluded from EBITDA, Total	9,651	720	732	12	720	732	12
Operating Expenses IFRS, Total	246,118	20,739	20,639	(100)	20,739	20,639	(100)
(Surplus) Deficit from Operations	1,611	713	393	(321)	713	393	(321)
Non-Operating income							
Finance Income [for non-financial activities]							
Interest Income	(85)	(7)	(5)	2	(7)	(5)	2
Non-Operating income, Total	(85)	(7)	(5)	2	(7)	(5)	2
Non-Operating expenses							
Finance Costs [for non-financial activities]							
Interest Expense							
Interest Expense on Non-commercial borrowings	1,175	98	90	(8)	98	90	(8)
Interest Expense, Total	1,175	98	90	(8)	98	90	(8)
PDC dividend expense	2,210	184	190	6	184	190	6
Finance Costs [for non-financial activities], Total	3,385	282	280	(2)	282	280	(2)
Non-Operating expenses, Total	3,385	282	280	(2)	282	280	(2)
(Surplus) Deficit before Tax	4,911	988	667	(321)	988	667	(321)
Income Tax (expense)/ refund	13	1	1	0	1	1	0
(Surplus) Deficit After Tax	4,923	989	669	(321)	989	669	(321)
Profit/(loss) from discontinued Operations, Net of Tax							
(Surplus) Deficit After Tax from Continuing Operations	4,923	989	669	(321)	989	669	(321)

Cost Improvement Programmes				
Pay Expense savings CIP recurrent	5,028	351	0	(351)
Pay Expense savings CIP non-recurrent			0	0
Pay Expense savings CIP, TOTAL	5,028	351	0	(351)
Drugs expense savings CIP recurrent	114	4	0	(4)
Drugs expense savings CIP non-recurrent			0	0
Drugs expense savings CIP, TOTAL	114	4	0	(4)
Clinical Supplies expense savings CIP recurrent	1,015	37	0	(37)
Clinical Supplies expense savings CIP non-recurrent			0	0
Clinical Supplies expense savings CIP, TOTAL	1,015	37	0	(37)
Non-clinical Supplies expense savings CIP recurrent	713	26	0	(26)
Non-clinical Supplies expense savings CIP non-recurrent			0	0
Non-clinical Supplies expense savings CIP, TOTAL	713	26	0	(26)
Misc. Other Operating Expenses CIP recurrent	2,058	75	0	(75)
Misc. Other Operating Expenses CIP non-recurrent			600	600
Misc. Other Operating Expenses CIP, TOTAL	2,058	75	600	525
Other non operating expense savings CIP, recurrent	0	0	0	0
Other non operating expense savings CIP non-recurrent			0	0
Other expense savings CIP, TOTAL	0	0	0	0
Cost Improvement Programmes, Total	8,929	493	600	107

Workforce Totals NOTE 1 Analysis of Workforce Numbers and Pay Costs				
Clinical Staff				
Consultants (not locums)	31,666	2,676	2,440	(236)
Locum Consultants	107	9	71	62
Agency Consultants	915	86	128	42
Consultants CIP	(1,605)	(226)	0	226
Consultants (Total)	31,084	2,545	2,639	94
Junior Medical - career grade	4,110	325	295	(30)
Junior Medical - trainee grade	11,882	952	974	22
Junior Medical -Agency	551	44	82	37
Junior Medical -CIP	0	0	0	0
Junior Medical (Total)	16,542	1,322	20	29
Registered Nurses - Acute, Elderly & General	31,691	2,652	2,525	(127)
Registered Midwives	4,186	348	347	(1)
Agency Nurses, Midwives	684	94	150	56
Nurses, Midwives- CIP	(809)	(30)	0	30
Nurses and Midwives (Total incl Bank)	35,752	3,064	3,022	(42)
Allied Health Professional	10,365	785	772	(13)
Other Scientific, Therapeutic and Technical Staff	9,165	761	663	(97)
Health Care Scientists	4,427	373	405	32
Sci, Tech & Ther - CIP	(673)	(25)	0	25
Sci, Tech & Ther (Total incl bank)	23,283	1,894	1,841	(54)
Sci, Tech & Ther - agency, contract	4,567	367	394	27
Healthcare assistants etc	10,558	983	949	(34)
Other - CIP	(559)	(20)	0	20
Other (Total)	14,566	1,330	1,343	14
Admin & Clerical	26,160	2,207	2,145	(62)
Executives	985	79	88	9
Chair & NEDs	124	10	11	1
Agency & Contract	145	18	44	27
Other non-clinical staff	10,512	866	825	(41)
Other non-clinical staff- CIP	(1,382)	(50)	0	50
Other non-clinical staff- Vacancy Factor	(1,878)	(157)	0	157
Non-clinical staff (Total)	34,666	2,973	3,113	140
Total Staff Costs	155,892	13,128	11,978	181
Analysis of staff costs				
Permanent Staff	154,003	12,902	12,893	(8)
Locums, Agency & Contract Staff	1,889	227	416	189
Pay expense contingency (if present in plan)				
Total Staff Costs	155,892	13,128	13,309	181

Workforce Totals NOTE 1 Analysis of Workforce Numbers and Pay Costs				
	WTE PLAN 201501	WTE BUDGET 201501	WTE CONTRACTED 201501	WTE Variance 201501
Clinical Staff				
Consultants (not locums)	202.36	202.43	183.29	-19.13
Locum Consultants	1.00	1.00	6.74	5.74
Agency Consultants	1.95	1.95	0.00	-1.95
Consultants CIP	-0.98	-0.98	0.00	0.98
Consultants (Total)	204.33	204.40	190.03	-14.36
Junior Medical - career grade	43.36	44.34	35.10	-9.24
Junior Medical - trainee grade	209.93	211.47	188.60	-22.87
Junior Medical -Agency	1.88	1.88	0.00	-1.88
Junior Medical (Total)	255.17	257.69	223.70	-33.99
Registered Nurses - Acute, Elderly & General	792.81	789.54	724.80	-64.75
Registered Midwives	87.02	87.02	87.95	0.93
Agency Nurses, Midwives	18.00	18.81	3.29	-15.52
Nurses, Midwives- CIP	-3.89	-3.89	0.00	3.89
Nurses and Midwives (Total incl Bank)	893.94	891.48	816.04	-75.44
Allied Health Professional	242.93	242.33	222.85	-19.48
Other Scientific, Therapeutic and Technical Staff	240.75	239.60	200.67	-38.93
Health Care Scientists	80.71	82.71	91.85	9.14
Sci, Tech & Ther - CIP	-11.12	-11.12	0.00	11.12
Sci, Tech & Ther (Total incl bank)	553.27	553.52	515.37	-38.15
Sci, Tech & Ther - agency, contract	197.34	196.88	196.74	-0.14
Healthcare assistants etc	451.36	454.26	387.93	-66.34
Other - CIP	-1.99	-1.99	0.00	1.99
Other clinical				
Other (Total)	646.71	649.15	584.67	-64.49
Admin & Clerical	910.31	930.57	901.94	-28.63
Executives	6.37	6.37	6.63	0.26
Chair & NEDs	7.00	7.00	7.00	0.00
Agency & Contract	8.20	8.20	0.00	-8.20
Other non-clinical staff	429.90	431.97	370.19	-61.78
Other non-clinical staff- CIP	-21.52	-21.52	0.00	21.52
Other non-clinical staff- Vacancy Factor	-51.41	-51.41	0.00	51.41
Non-clinical staff (Total)	1,288.85	1,311.18	1,285.76	-25.42
Total WTE	3,842.27	3,867.42	3,615.57	-251.85

South Devon Healthcare NHS Foundation Trust
Capital Programme Month 01 2015/2016
Position as at 30 April 2015

Scheme Type	2015/16 Initial Full Year Monitor Plan £	Month 01 Initial Current Month Monitor Plan £	Month 01 Current Month Expenditure £	(Over)/Under Spend versus Initial Monitor Plan Current Month £	Year to Date Approved Initial Monitor Plan at Month 01 £	Year to Date Expenditure at Month 01 £	(Over)/Under Spend versus Initial Monitor Plan YTD £	Forecast Outturn Full Year £	(Over)/Under Spend versus Initial Monitor Plan Forecast Year End £
A HIS Schemes	4,062,152	53,968	51,650	2,318	53,968	51,650	2,318	4,064,312	(2,160)
B Estates Schemes	13,428,033	931,301	914,259	17,042	931,301	914,259	17,042	13,429,937	(1,904)
C Medical	3,749,016	321,023	322,734	(1,711)	321,023	322,734	(1,711)	3,749,016	0
D Other	281,000	0	0	0	0	0	0	281,000	0
E PMU	1,679,000	115,629	21,473	94,156	115,629	21,473	94,156	1,679,000	0
F Contingency	1,780,000	0	0	0	0	0	0	1,780,000	0
Sub Total	24,979,201	1,421,921	1,310,116	111,805	1,421,921	1,310,116	111,805	24,983,265	(4,064)
G Prior Year	0	0	2,300	(2,300)	0	2,300	(2,300)	2,300	(2,300)
Total	24,979,201	1,421,921	1,312,416	109,505	1,421,921	1,312,416	109,505	24,985,566	(6,365)

Summary:	2015/16 Initial Full Year Monitor Plan £	Month 01 Initial Current Month Monitor Plan £	Month 01 Current Month Expenditure £	(Over)/Under Spend versus Initial Monitor Plan Current Month £	Year to Date Approved Initial Monitor Plan at Month 01 £	Year to Date Expenditure at Month 01 £	(Over)/Under Spend versus Initial Monitor Plan YTD £	Forecast Outturn Full Year £	(Over)/Under Spend versus Initial Monitor Plan Forecast Year End £
Green	24,729,201	1,421,921	1,295,882	126,039	1,421,921	1,295,882	126,039	24,729,201	0
Amber	0	0	6,365	(6,365)	0	6,365	(6,365)	6,365	(6,365)
Red	0	0	0	0	0	0	0	0	0

Project	Scheme Name	2015/16 Initial Full Year Monitor Plan £	Month 01 Initial Current Month Monitor Plan £	Month 01 Current Month Expenditure £	(Over)/Under Spend versus Initial Monitor Plan Current Month £	Year to Date Approved Initial Monitor Plan at Month 01 £	Year to Date Expenditure at Month 01 £	(Over)/Under Spend versus Initial Monitor Plan YTD £	Forecast Outturn Full Year £	(Over)/Under Spend versus Initial Monitor Plan Forecast Year End £	Traffic Lights Scheme Risk Indicator	Comments
HIS Schemes												
80767	Emergency Department System	206,351	5,000	8,392	(3,392)	5,000	8,392	(3,392)	206,351	0	Green	
80788	Wireless	85,000	0	0	0	0	0	0	85,000	0	Green	
80888	Clinical Portal	313,167	5,000	9,879	(4,879)	5,000	9,879	(4,879)	313,167	0	Green	
80889	Vital PAC	0	0	914	(914)	0	914	(914)	914	(914)	Amber	
80895	PACS Re-Procurement	80,000	0	0	0	0	0	0	80,000	0	Green	
80909	Cyberlab	299,985	10,000	5,988	4,012	10,000	5,988	4,012	299,985	0	Green	
80910	e-Prescribing	513,000	5,000	7,722	(2,722)	5,000	7,722	(2,722)	513,000	0	Green	
81027	Letter Replacement Project	145,058	12,088	623	11,465	12,088	623	11,465	145,058	0	Green	
81028	MIG / ITK	52,906	0	0	0	0	0	0	52,906	0	Green	
81116	Backup Storage and Tape Drivers	300,000	0	0	0	0	0	0	300,000	0	Green	
81117	Patient Knows Best	36,181	0	2,451	(2,451)	0	2,451	(2,451)	36,181	0	Green	
81118	Clinical Handover System	549,539	5,000	2,639	2,361	5,000	2,639	2,361	549,539	0	Green	
81121	New NHS numbers for babies	0	0	1,246	(1,246)	0	1,246	(1,246)	1,246	(1,246)	Amber	
81125	Emergency Department System (80767) Enabling Works	5,199	0	(84)	84	0	(84)	84	5,199	0	Green	
81143	EDMS	1,015,766	11,880	11,880	0	11,880	11,880	0	1,015,766	0	Green	
81166	Case notes Uplift	56,000	0	0	0	0	0	0	56,000	0	Green	
81169	Mobile Device Management Tools	175,000	0	0	0	0	0	0	175,000	0	Green	
81170	RCP Sintero	25,000	0	0	0	0	0	0	25,000	0	Green	
81173	Connection Fee - New N3 contract - approved at Finance Committee Feb 2015	204,000	0	0	0	0	0	0	204,000	0	Green	
Total: HIS Schemes		4,062,152	53,968	51,650	2,318	53,968	51,650	2,318	4,064,312	(2,160)	RED	
Estates Schemes												
80718	Decentralisation of Boilers	0	0	1,777	(1,777)	0	1,777	(1,777)	1,777	(1,777)	Amber	
80864	Estates Work to Coronary Care Unit, Cardiac Catheter Lab & Dunlop Ward	30,000	10,000	930	9,070	10,000	930	9,070	30,000	0	Green	
80915	Leaking Roof and Roof Lights - Rose Garden	20,000	0	0	0	0	0	0	20,000	0	Green	
81006	Radiology Patient Environment Improvement Works to Facilitate MRI and Linac	0	0	128	(128)	0	128	(128)	128	(128)	Amber	
81010	Long Term Condition & HUB - Annexe	90,000	0	0	0	0	0	0	90,000	0	Green	
81038	Replace condensers main steam main	370,000	0	0	0	0	0	0	370,000	0	Green	
81044	Sanitary ware upgrade (year 2)	50,000	0	0	0	0	0	0	50,000	0	Green	
81047	Window replacement - Amber risks	12,000	0	0	0	0	0	0	12,000	0	Green	
81095	New ICU - Phase 1 (new ICU and main entrance).	6,700,000	486,755	486,765	(10)	486,755	486,765	(10)	6,700,000	0	Green	
81096	Linear Accelerator Bunker and Enabling works	2,710,000	382,866	382,866	0	382,866	382,866	0	2,710,000	0	Green	
81098	Dementia Works	22,000	0	0	0	0	0	0	22,000	0	Green	
81099	Car Park Priming	1,782,000	41,680	41,680	0	41,680	41,680	0	1,782,000	0	Green	
81101	Level 4 Corridor	27,011	0	3,736	(3,736)	0	3,736	(3,736)	27,011	0	Green	
81102	Fire Damper Install	29,000	0	0	0	0	0	0	29,000	0	Green	
81103	Legionella Risk Assessment Works	100,000	0	0	0	0	0	0	100,000	0	Green	
81104	Water Quality Improvements	100,000	0	0	0	0	0	0	100,000	0	Green	
81106	Control of Infection	9,682	0	0	0	0	0	0	9,682	0	Green	
81107	Roofing	30,148	0	0	0	0	0	0	30,148	0	Green	
81127	Enabling Works for Radiotherapy etc. Junior Doctors / QC / Ophthalmology	0	0	(13,622)	13,622	0	(13,622)	13,622	0	0	Green	
81129	ED Reconfiguration Works	250,000	0	0	0	0	0	0	250,000	0	Green	
81138	Ophthalmology Clinic Space - Phase 1	101,192	10,000	10,000	0	10,000	10,000	0	101,192	0	Green	
81139	Nutwell unit emergency Mortuary capacity	12,000	0	0	0	0	0	0	12,000	0	Green	
81141	Level 1 Corridor - Mortuary	60,000	0	0	0	0	0	0	60,000	0	Green	
81142	Fracture Clinic	150,000	0	0	0	0	0	0	150,000	0	Green	
81147	Roofing	51,000	0	0	0	0	0	0	51,000	0	Green	
81148	Emergency Chiller	57,000	0	0	0	0	0	0	57,000	0	Green	
81149	Tower wards clean utility (drug cupboard) cooling	20,000	0	0	0	0	0	0	20,000	0	Green	

Project	Scheme Name	2015/16 Initial Full Year Monitor Plan £	Month 01 Initial Current Month Monitor Plan £	Month 01 Current Month Expenditure £	(Over)/Under Spend versus Initial Monitor Plan Current Month £	Year to Date Approved Initial Monitor Plan at Month 01 £	Year to Date Expenditure at Month 01 £	(Over)/Under Spend versus Initial Monitor Plan YTD £	Forecast Outturn Full Year £	(Over)/Under Spend versus Initial Monitor Plan Forecast Year End £	Traffic Lights Scheme Risk Indicator	Comments
81151	Fire Alarm system estates - failed	15,000	0	0	0	0	0	0	15,000	0	Green	
81152	Fire Doors	20,000	0	0	0	0	0	0	20,000	0	Green	
81153	Control Panel Annexe	10,000	0	0	0	0	0	0	10,000	0	Green	
81154	Control Panel Catering	25,000	0	0	0	0	0	0	25,000	0	Green	
81155	Fire Alarm Residences	40,000	0	0	0	0	0	0	40,000	0	Green	
81156	Essential Equipment - Catering Regeneration trollies	30,000	0	0	0	0	0	0	30,000	0	Green	
81157	Essential Equipment - Replacement Freezer and Coffee machine	26,000	0	0	0	0	0	0	26,000	0	Green	
81158	Essential Equipment - Manual Handling machines	20,000	0	0	0	0	0	0	20,000	0	Green	
81159	Replace condensers	25,000	0	0	0	0	0	0	25,000	0	Green	
81160	Workshop Safety Improvements	25,000	0	0	0	0	0	0	25,000	0	Green	
81161	Belisha Beacons on zebra crossings	9,000	0	0	0	0	0	0	9,000	0	Green	
81162	Control of Infection	150,000	0	0	0	0	0	0	150,000	0	Green	
81163	Kitchen	25,000	0	0	0	0	0	0	25,000	0	Green	
81164	Sluice	25,000	0	0	0	0	0	0	25,000	0	Green	
81165	Backlog Maint - Contingency Sum	50,000	0	0	0	0	0	0	50,000	0	Green	
81172	Asbestos Removal	150,000	0	0	0	0	0	0	150,000	0	Green	
Total: Estates Schemes		13,428,033	931,301	914,259	17,042	931,301	914,259	17,042	13,429,937	(1,904)	RED	
Medical												
80897C	CTG Monitors	197,000	174,125	174,125	0	174,125	174,125	0	197,000	0	Green	
81073I	MEPG - CA1 612 Replacement and Additional Cardiac Catheter Laboratory Equipment	586,333	96,408	98,119	(1,711)	96,408	98,119	(1,711)	586,333	0	Green	
81074N	MEPG - CA1 Merge Eyecare Software and Fundus Camera	7,000	0	0	0	0	0	0	7,000	0	Green	
81094A	Additional theatre equipment for repatriation of Orthopaedic work	121,729	50,490	50,490	0	50,490	50,490	0	121,729	0	Green	
81134B	MEPG - CA1 702 - 3 X Ultrasound Machines for AAA screening	57,600	0	0	0	0	0	0	57,600	0	Green	
81134C	MEPG - CA1 704 - Sternum Saw Theatres	23,446	0	0	0	0	0	0	23,446	0	Green	
81134D	MEPG - CA1 689 Acutronic Ventilator; Theatres	16,217	0	0	0	0	0	0	16,217	0	Green	
81134E	MEPG - CA1 664B - Replacement Tissue Processor - Histopathology	36,000	0	0	0	0	0	0	36,000	0	Green	
81134F	MEPG - Linear Accelerators	2,203,691	0	0	0	0	0	0	2,203,691	0	Green	
81134Z	MEPG Contingency for in year failures	500,000	0	0	0	0	0	0	500,000	0	Green	
Total: Medical		3,749,016	321,023	322,734	(1,711)	321,023	322,734	(1,711)	3,749,016	0	RED	
Other												
81144	Clinical Space for Glaucoma and Macular Ophthalmology services - costs not yet determined?	40,000	0	0	0	0	0	0	40,000	0	Green	
81146	MRP/ERP system	155,000	0	0	0	0	0	0	155,000	0	Green	
81167	Cystic Fibrosis Compliance Work	46,000	0	0	0	0	0	0	46,000	0	Green	
81168	Endoscopy Facility Environment Improvements	40,000	0	0	0	0	0	0	40,000	0	Green	
Total: Other		281,000	0	0	0	0	0	0	281,000	0	RED	
PMU												
80859	PMU Business Continuity	871,000	100,000	0	100,000	100,000	0	100,000	871,000	0	Green	
80872	PMU Expansion Project	558,000	15,629	11,303	4,326	15,629	11,303	4,326	558,000	0	Green	
	PMU Licensing - Intangible	250,000	0	10,170	0	0	10,170	(10,170)	250,000	0	Green	
Total: PMU		1,679,000	115,629	21,473	104,326	115,629	21,473	94,156	1,679,000	0	RED	
Contingency												
81122	General Contingency 2014/15	0	0	0	0	0	0	0	0	0	Green	
81171	Contingency - To be distributed during the course of the year	1,780,000	0	0	0	0	0	0	1,780,000	0	Green	
Total: Contingency		1,780,000	0	0	0	0	0	0	1,780,000	0	RED	
		24,979,201	1,421,921	1,310,116	121,975	1,421,921	1,310,116	111,805	24,983,265	(4,064)		
Prior Year												
162156	PMU - Freehold	0	0	2,300	(2,300)	0	2,300	(2,300)	2,300	(2,300)	Amber	
Total: Prior Year		0	0	2,300	(2,300)	0	2,300	(2,300)	2,300	(2,300)	Amber	
		0	0	2,300	(2,300)	0	2,300	(2,300)	2,300	(2,300)		

South Devon Healthcare 
NHS Foundation Trust

Strategic Plan Document for 2015-16

South Devon Healthcare NHS Foundation Trust

1.1 Strategic Plan for y/e 31 March 2016

This document completed by (and Monitor queries to be directed to):

Name	Paul Cooper
Job Title	Director of Finance, Performance and Information
e-mail address	p.cooper1@nhs.net
Tel. no. for contact	01803 655761
Date	14 May 2015

The attached Strategic Plan is intended to reflect the Trust's business plan over the next year. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;
- The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;
- The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;
- All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and
- The 'declaration of sustainability and resilience' is true to the best of its knowledge.

Approved on behalf of the Board of Directors by:

Name (Chair)	Richard Ibbotson
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Signature 

Approved on behalf of the Board of Directors by:

Name (Chief Executive)	Mairead McAlinden
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Signature 

Approved on behalf of the Board of Directors by:

Name (Finance Director)	Paul Cooper
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Signature 

1.2 Declaration of sustainability and resilience

<ul style="list-style-type: none"> • <u>Declaration of sustainability</u> 	
<p><i>The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years' time.</i></p>	<p>Confirmed</p>
<p><i>Re: declaration of sustainability: The Trust has submitted for stage three assessment under the Monitor transactions process a business case for the acquisition of Torbay and Southern Devon Health and Care NHS Trust. Acceptance of the business case and support of Monitor and the TDA is necessary to ensure the ongoing viability, not only of the Trust but the wider health and care community. This declaration is made on the basis that the proposal as currently submitted is approved. It describes a significant reconfiguration of services across the community, which will ensure the continued delivery of high quality care to a growing and increasingly ageing population. Alongside this, the business case describes a sustainable financial future. However, in 2015/16 the COSRR is expected to fall to a 2, for one year before the financial efficiencies borne from system redesign are realised. From 2016/17 forward, a COSRR of three is expected to be maintained.</i></p>	
<ul style="list-style-type: none"> • <u>Declaration re: resilience</u> <p><i>After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.</i></p>	<p>Confirmed</p>

1.3 Executive Summary

This strategic plan describes the further development of an integrated health and social care system serving the population of Torbay and Southern Devon.

We know that demand in our health and care system is set to rise at a level faster than available resources will accommodate. This document includes a detailed, public health lead assessment, clearly describing the care needs of a growing, increasingly elderly population.

Our plans for an increasingly integrated health and social care model are supported by South Devon Healthcare NHS Foundation Trust's (SDHFT) planned service merger, through the acquisition of Torbay and Southern Devon Health and Care NHS Trust (TSDHCT), to create an Integrated Care Organisation (ICO).

In doing so, we will develop or redesign services that meet these demands and that are co-ordinated and integrated in ways that benefit service users. We will develop services that are responsive and flexible and which link, without break, with services of our partner organisations such as primary care and mental health services. All services will be included in this redesign, from acute specialist services and inpatient activity, to continuing health and social care at home.

A major feature of the services we develop will be the promotion of self-care. This will cover the promotion of healthy lifestyles and include support and training of service users and carers in self-management of even the most complex chronic health conditions. Many of the services will be about supporting people in their lives rather than focussing on ill-health. We will base service development on the 'Life-course model' to cover all phases of people's lives, with a particular focus on 'family-centred care'. We will support the development of services planned within Local Commissioning Groups and services centred in health and social care zones.

We will develop services that are seamless and provide continuity. Our services will not be constrained by the traditional physical and professional barriers of health and social care. Staff involved in the care of individuals within a community setting, will continue to be involved in the care of that person if they need to be admitted to hospital. Staff who have traditionally worked in the hospital will support or deliver care in the community when needed.

Services will be redesigned to provide the most accessible and best quality evidence-based care possible. This will result in a change in focus from the hospital to the community, and may result in a change in the member of the team providing care. The hospital will become smaller and there will be a shift towards specialist teams providing support to colleagues in the community and in primary care, allowing them to care for people closer to home. We will develop new means of contracting to support this new care model and to remove obstacles to the provision of patient-centred care.

In presenting a Full Business Case in support of our proposed transaction, we have developed detailed service level plans that describe how these changes flow through into a long term financial model that supports the Trust's ongoing viability. We look forward to completing Stage 3 of the Monitor Transaction process and look forward to receiving a risk rating on our proposal in June 2015.

This document and its accompanying financial templates have been prepared on the basis that the transaction proceeds according to the current schedule on 1st August 2015. The Trust expects a satisfactory conclusion to the negotiations currently underway to agree the financing package, now widely accepted as being necessary that will enable completion. Clearly, should the transaction not proceed or be materially delayed, this plan will need to be reconsidered. In that event the Trust would discuss an appropriate resubmission with Monitor.

The strategic direction is clear, and driven by the need to design a health and care system that can be accommodated within the resources available. The challenge for the Trust in 2015/16 is to deliver the transaction and to begin the process of service redesign whilst maintaining focus on addressing the service pressures experienced in 2014/15, most notably in the Emergency Department 4 hour and Referral to Treatment Time standards. This document describes a focus on both agendas; delivering the long term strategy and detailed plans at service level that maximise resilience in the short term.

The Trust is planning for a normalised (post-impairment) deficit of £5.7m in 2015/16. There is increasingly limited opportunity to deliver efficiencies in within the confines of the current system. The new care model, once implemented will create further opportunity, but this is not expected to be possible in any great extent until 2016/17. Through careful management of its cash reserves, the Trust expects to maintain a positive risk rating throughout.

There are a number of significant capital investments planned in 2015/16. As well as addressing some long-standing issues on the main hospital site, there significant investments planned, particularly in Information Technology that will be critical to the delivery of the new care model

This year will see significant changes in the Trust. There are many challenges to overcome but, through this plan we believe that we will build the foundations of a sustainable health and care system that will provide high quality, integrated care for many years to come.

1.4 Strategic Context

1.4.1 Strategic Statement

In its 'Strategic Plan 2014-19', South Devon Healthcare NHS Foundation Trust (SDH) sets out a clear strategy for the development of an Integrated Care Organisation (ICO) through the acquisition of Torbay and Southern Devon Health and Care NHS Foundation Trust (TSD).

In submitting this 'Strategic Plan for the Year Ended 31 March 2016' the Board of SDH confirms that this strategy remains its clear and preferred direction of travel.

1.4.2 Strategic Plan 2014-19

Our 'Strategic Plan 2014-19' described the challenge facing our health and care community.

The needs of a growing and increasingly elderly population will place enormous pressure on services, particularly those that respond in urgent and emergency care situations. That pressure is being experienced now. We serve a population with an age profile that is already well ahead of the national average and, with an increase of 20% in the population aged over-65 expected by 202, this will only get more challenging. Demand for hospital based services, left unchecked is expected to increase by around 4% per annum.

Both commissioners and providers are under significant and growing financial pressure. The cost of meeting the expected growth in demand, if continuing to provide services in their current configuration, outstrips the available funding. From a provider perspective, the two organisations will, by 2019/20 need to be making annual efficiency savings of £25m per annum (6.3% of total costs). This is well beyond that which has been required or delivered in recent years. From a Commissioner perspective, activity levels will drive a contract liability under national terms and conditions well in excess of the affordable levels. Maintenance of the current service model into the future is not financially sustainable for the wider community.

It is clear that, as a system we require significant service redesign if future demands are to be accommodated within available resources across the health and care system. The options available to the local health and care community, narrow down to the driving of service change through horizontal or vertical integration.

For SDH, it quickly became clear that the best option to ensure services improve sustainably and at pace and scale was for the two trusts to merge – a vertical integration. From a strategic perspective, the Board reached this conclusion in the following basis:

Fit with commissioning intentions: The emphasis of all Commissioners in the South Devon area is on joined-up care for all of their patients, ensuring that linkages between all aspects of the care system – primary, community, secondary and tertiary – are as effective as possible. Whilst effective care linkages are possible in a horizontally integrated model, they are most likely to be achieved, and for the largest number of patients, in a vertically integrated model.

Fit with national policy: Either vertical or horizontal models would be supported within the national policy framework, however with the publication of the Five Year Forward View, the establishment of the Pioneer programme, the development of the Better Care Fund and Monitor's guidance on the future of small and medium sized District General Hospitals, there is a clear leaning towards vertical integration for Trusts of our type. The development of competition policy and its application in the context of NHS services has also been a consideration. Within this developing landscape it has become clear that vertical mergers of services, with no overlap in service between respective parties, are less contentious than horizontal mergers, under which patient choice is much more clearly affected. As the proposed merger of Foundation Trusts in Poole and Bournemouth was under the consideration of the competition authorities as this strategy was being developed, the Board were conscious of the challenges posed through wide system horizontal integration.

Maintaining local access for local people: Our local population have told us that they value local service provision, perhaps above all else. In any form of horizontal reconfiguration of services, it will be impossible to drive financial benefit without centralising some services currently provided from the Torbay site in another location, be that Exeter or Plymouth, making access for residents of South Devon more difficult.

Patient experience: Patient survey results are very much aligned with the output of a recent and wide ranging public engagement process run by South Devon & Torbay CCG (SDTCCG). The most important issues to patients are that their care services are well co-ordinated, joined together and with access as close to home as possible. All of these would be best achieved in a vertically integrated model. This emphasises the importance of the patient's experience of the system, rather than an episode of care which would be the focus of a horizontally integrated model.

Potential to drive financial benefits: Despite the financial outlook being more challenging, our modelling suggests significant to drive financial efficiencies through a care model that focuses on better maintaining a population in community settings and avoiding, wherever possible the need for expensive hospital based care. Creating capacity to accommodate higher volumes of acute care through a horizontally integrated model, whilst perhaps addressing the issues around acute Trust viability, would not resolve the funding challenge experienced by Commissioners. Only by changing the model of care and reducing reliance on hospital services can both Commissioner and Provider viability be addressed in parallel.

Clinical sustainability: The volumes of acute activity performed would not reduce, so demand for scarce clinical resource would continue to be a challenge under a horizontally integrated model. A horizontal model, reducing demand for admission and skilling-up a wider range of health professionals to better support people in a community based setting would, we considered, best reduce this demand.

Meets the demographic challenge: The most significant challenge facing the local health economy is to care for an increasing number of frail elderly people, often with number of complex, long term conditions. The complexity of care packages for this patient group means that co-ordination is, perhaps the most important aspect of their care; an aspect that the Board felt is best delivered through a model of vertical integration.

In parallel with this strategic direction being developed at SDH, the Board of TSD were, under the requirements of the Transforming Community Services (TCS) agenda, considering options for their future organisational form. A thorough assessment of TSD's financial position demonstrated that, although there was potential for a viable Foundation Trust bid, TSD would, with its current business model, be unlikely to retain, Foundation Trust status in the longer-term. As a result, the TSD Board resolved not to pursue an independent future but, in agreement with the then Strategic Health Authority, to open a competitive process to identify a suitable merger partner.

The Board of SDH considered this resolution and, in support of its stated strategy, concluded that it should bid to become that partner. SDH was the only bidder and was successful at the pre-qualification stage of the established procurement process. SDH has subsequently had an Outline Business Case for the acquisition of TSDHCT approved by the Trust Development Authority (TDA).

Having been designated 'preferred bidder status', the Trust has worked in close partnership with TSDHCT and has developed a good understanding of the financial and operational positions of the partner organisation. Preliminary due diligence has been completed and a Final Business Case (FBC) developed.

The FBC was presented to Monitor in February 2015, supporting our proposal to create a single, integrated health and social care provider organisation to serve our local community.

1.4.3 Service Development Plans

Working jointly with TSD and alongside local commissioners, our FBC and associated service integration plan, has identified eight initiatives that will in aggregate deliver the fundamental changes to the care model that the community seeks. These initiatives are all aligned with a principle that services should wrap around the person and family to create a single system of health and care delivery, and include:

Single point of contact: Describes the development of a multi-media gateway to both signpost appropriately and to mobilise the appropriate assessment and equipment needed.

Community care – locality teams and community hospital beds: Describes the realignment of community resources to further support the self-care and prevention agenda and to help move from a reactive model of care to a proactive model of care. This may include looking at existing community hospitals and utilising them in a different way.

Frailty service: Describes a whole system pathway of care starting with risk stratification of the top 2% most vulnerable and the close working between the Newton Abbot locality 'Pioneer' hub and the facilities at Newton Abbot Community Hospital linked to the specialist services provided by the healthcare of older people team and the medical admissions avoidance team to better support our cohort of frail elderly patients.

Multiple Long Term Conditions service: Describes a new service for people with multiple LTCs. The aim is to provide coordinated multidisciplinary management of coexisting medical conditions in one place at one time; outside of the acute setting where possible and avoiding multiple appointments per condition.

Outpatient service redesign: Describes the development of a number of clinical services with the objective of providing care closer to home, self-care and assessment avoiding multiple appointments per condition.

Referral Management Project: This plan sets out one of the projects from Outpatient service redesign 'in focus.' The intention is to focus on implementing a referral management framework which enables dialogue between primary and secondary care to manage patients in the most appropriate and efficient way and form an integral part of the over-arching community wide strategy for referral optimisation. This will ensure that face to face appointments are no longer the automatic default position and that care plans, advice and guidance or specialist support with an existing care plan can be delivered in alternative ways where appropriate, reducing the waiting time for patients as well as unnecessary trips to the acute trust.

Outpatient Innovation 'In Focus': Muscular-Skeletal Triage: This plan sets out another of the projects from Outpatient service redesign 'in focus.' The project aims to provide a triage service for MSK patients through the community physiotherapy team. The intention is to provide a consistent assessment, active treatment in conjunction with the patient and then any onward referral to secondary being targeted to the right specialist area.

Inpatient Innovation 'In Focus': Heart Failure: This plan sets out one of the projects intending to impact upon inpatients (either reducing length of stay or avoiding an admission.) The project aims to develop a service where patients with heart failure are treated in an outpatient setting rather than the more traditional treatment as an inpatient (national evidence has

demonstrated that a third of current heart failure in-patients can be managed on an outpatient basis).

Through these, and subsequent changes we will deliver care to patients that:

- Identifies those people most at risk, providing early support and, where necessary intervention to effectively manage their condition at its earliest stages;
- Is provided as close to home as possible;
- Still offers swift and effective 'acute care' where it is necessary, but avoids it wherever possible;
- Promotes self-care and self-efficacy, engages the capacity of the voluntary and third sectors and support carers;
- Is integrated at an individual user level to as great a degree as possible – patient-centred coordinated care as recommended by National Voices – bringing together the right services to 'wrap around' the person;
- Is integrated across the range of providers, engaging effectively with service provider partners, e.g. primary care, mental health services, local councils;
- Be accessible and responsive to service users and to health professionals needing advice and support;

In delivering this care model, we expect significant changes in the infrastructure of our delivery system, including:

- Fewer hospital beds and better developed reablement facilities;
- A shift in use of specialist teams, as far as possible, from face to face clinical care, to support of primary care and community colleagues, with the aim of enabling continued management of people in the community and avoiding unnecessary referral;
- Local Multi-Agency Teams, working from Locality Hubs, co-ordinating the care and managing personalised care plans for the frail and those most at risk;
- Significant investment in Information Technology; ensuring that all systems are accessible to all health and care professionals through mobile technology where necessary;
- Educational and information-sharing systems using social media including Hiblio videos for service users and for staff education and support;

This transaction will bring significant benefits to the development of the new model of care, including:

- We can make changes faster - improvements to adult social care, community and acute services will not have to work around organisational boundaries, needless transactions and conflicting incentives.
- We can be more ambitious – by overseeing a wider range of services and involvement in a much greater proportion of the care provided, the scale of potential improvements can realistically be greater.
- We can provide more sustainable clinical solutions where patient benefits and community-wide interests are prioritised above individual organisational concerns.
- We will provide many of the services that will empower individuals to take ownership of their own health and care needs – helping manage demand in the system.
- The single organisation will provide services with more financial stability – thereby securing its position within the integrated care model for local people's future.

1.4.4 Strategy – Assessment and Further Developments During 2014/15

In submitting this 'Strategic Plan for the Year Ended 31 March 2016', the Board has considered whether there has been any changes in strategic, operational or financial performance or in the external environment or policy arena that would question this strategic plan. In overall terms, and far from questioning the strategy, the events and experience of 2014/15 have reinforced the rationale and need for the service integration described

1.4.4.1 Performance Against the Key Strategic Objective

At the time that the 'Strategic Plan 2014-19' was submitted, the Trust's stated intention was to submit its application to Monitor's Transaction Assessment process in October 2014. However, in the summer of 2014, Monitor revised its assessment policy; moving from a one stage to a three stage process. In discussion with Monitor colleagues in the Provider Appraisal team, the Trust Board agreed a course of action that resulted in a Stage 2 review in October 2014, moving quickly to a Stage 3 in early 2015. This enabled early familiarisation with the proposal and the process for both Monitor and Trust staff, and ensured that, before submitting the Stage 3 documentation, the Trust was able to address any key concerns identified in the Stage 2 process. Although slightly delaying the final submission, the Board is confident that its approach has benefited the assessment process, which is now coming to an end.

1.4.4.2 Trust Performance 2014/15

SDH has experienced a range of performance challenges in 2014/15. These have been analysed in detail, discussed at Board and shared with Monitor colleagues. Key performance variances are as follows:

Four hour ED waiting time standard: In common with many other NHS providers, SDH has experienced significant pressure in delivering the 4 hour standard. These pressures have been particularly acute since January 2014. There are multifactorial and complex reasons for the pressures but most are driven by a change in the shape of demand including age and complexity of the patients presenting.

Chart 1 : Emergency Department Attenders by Age Band

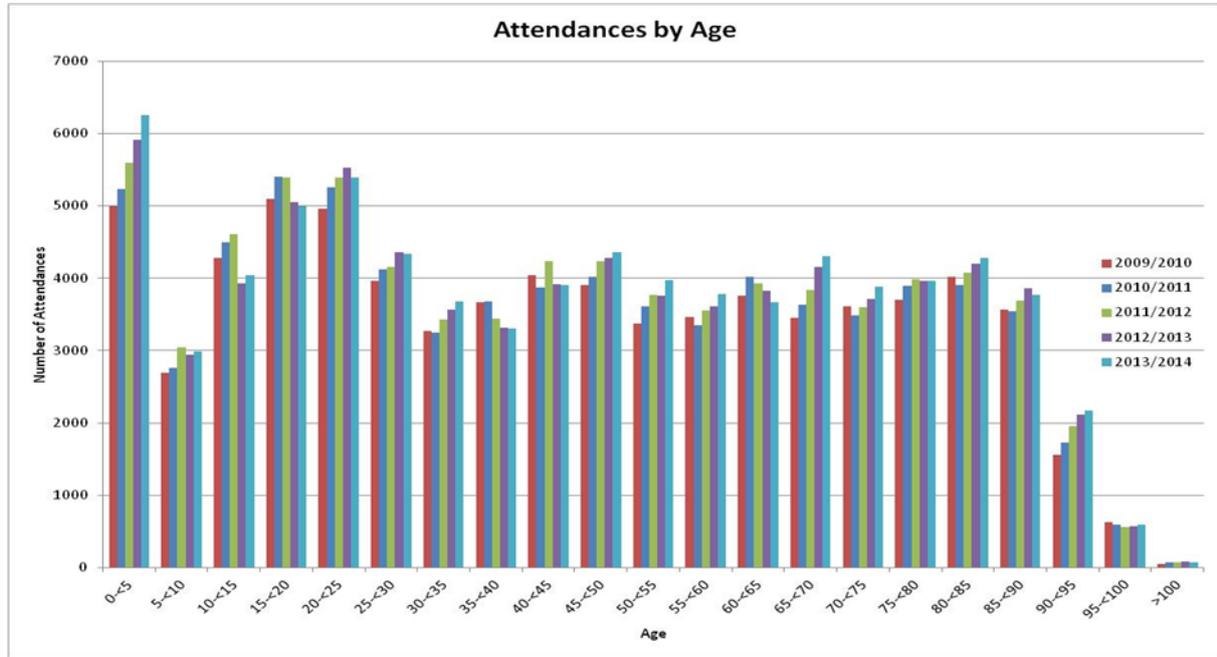


Chart 2 : Ambulance Arrivals in the Emergency Department

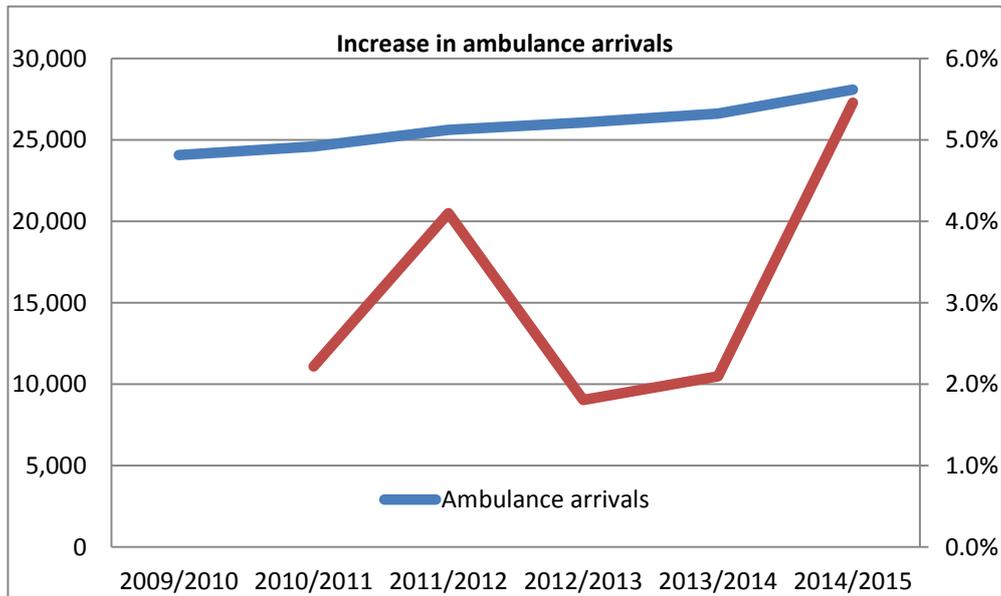
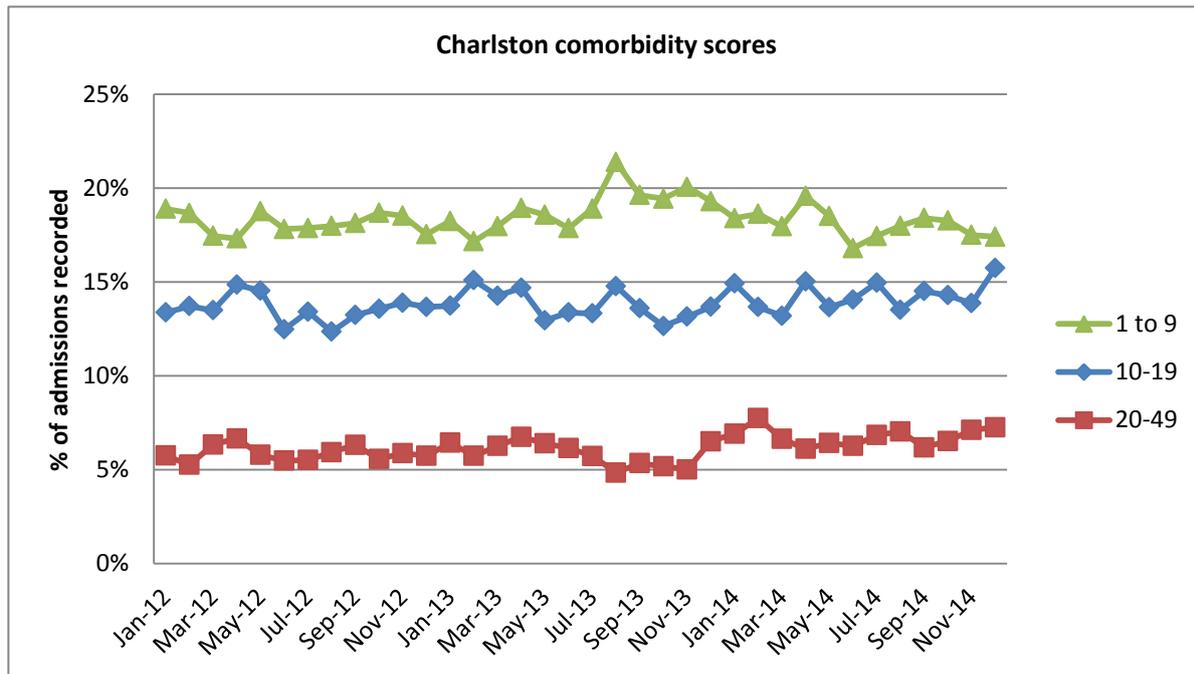


Chart 3 : Charlston Index for All Emergency Admissions



From Charts 1 to 3 above it is clear that the age and complexity of patients presenting in the emergency Department have both increased. Ambulance arrivals, which are a good proxy for case mix had, historically grown at an average of 2.7% until 2014/15 when the growth increased to 5.5%. The Charlston comorbidity index is a predictive measure of mortality for patients who have a range of comorbid conditions. It has been used as a proxy for patient complexity when seeking to understand the pressures services are managing. The above chart analyses all non-elective admissions into groupings of increasing complexity as indicated by the index score, these are then expressed as a percentage of all admissions by month. There may be a discernible trend from January 2014 of the patients with scores indicating increased complexity.

The increased presentation at the 'front door' of the hospital has been matched by a significant increase in emergency admission. In 2014/15 emergency admissions were 6.5% above plan.

Referral to treatment time (RTT) standards: Driven by growth in referral rates, RTT standards in some specialties, particularly Ophthalmology, Dermatology and Plastics, have presented a challenge to the Trust during 2014/15.

In Ophthalmology, growth in referrals for cataracts has been unprecedented over recent months. This is linked to the additional treatments available for macular and glaucoma patients. These positive developments result in more people retaining their sight, thereby increasing the number of patients subsequently developing treatable cataracts. The impact of cataract, glaucoma and macular activity all increasing has been experienced across the NHS provider sector. The resulting pressure on activity and RTT backlog numbers has resulted in the ophthalmology backlog of 18 week RTT patients increasing from 35 in January 2013 to 404 by the 31st March 2015. This specialty now accounts for nearly 50% of the Trusts total RTT backlog.

Pressures in Dermatology are Linked to the NHS "Be Clear on Cancer" campaign after which the service along with many others nationally has experienced unprecedented growth. Devon and Cornwall have the highest rates of skin cancer nationally and therefore always have high standardised attendance rates for dermatology. The medical team is small, less than two WTE and has been carrying a vacancy for over a year now. Despite many attempts we have not been able to fill the post. Despite these pressures the team has managed to deliver both the NHS plan cancer standards and the RTT standards. The impact on RTT has however been felt in plastic surgery as the resulting increases in referrals from dermatology feed through to plastic surgery procedures. The impact has been to increase the plastic surgery backlog from 10 in January 2014 to 110 by 31st March 2015. The plastic surgery service is bought in from Exeter and Plymouth Trusts and although additional activity has been sought, these trusts have also had capacity issues and have struggled to respond.

Capacity to treat elective patients has, across all services been affected by reduced bed capacity associated with the significant increase in non-elective admissions

Financial performance: In 2014/15, the Trust posted its first ever deficit. The deterioration in SDHFT's financial performance does need to be seen against a back drop of increasing financial pressure in the acute Trust sector. In Monitor's own portfolio of medium sized acute organisations, of which SDHFT is one, 31 of 38 Foundation Trusts were in deficit at the end of Quarter 3, with a net deficit of £239m. Many of the pressures being described in this paper are common to the wider sector.

Table 1 : SDH Financial Performance 2010/11 to 2014/15

	2010/11 Actual £m	2011/12 Actual £m	2012/13 Actual £m	2013/14 Actual £m	2014/15 Reforecast £m
Income	211.3	219.4	231.7	241.0	243.7
Expenditure	(196.4)	(202.9)	(217.5)	(228.1)	(233.7)
Financing costs	(13.3)	(26.8)	(15.2)	(14.4)	(14.5)
Net surplus / (deficit)	1.6	(10.3)	(1.2)	(1.5)	(4.6)
Impairment	0.9	15.3	3.8	2.2	0.5
Normalised	2.5	5.0	2.6	0.7	(4.1)

The deterioration in financial performance, starting in 2013/14 but more particularly in 2014/15 is clear in Table 1 above. Key points in driving this position are as follows:

- CIP targets have been delivered in all years up to 2013/14, although the proportion delivered non-recurrently has grown throughout the period.
- Up until that point it was possible to compensate each year through achieving a rate of growth in income that offset the efficiency requirement implicit in the national tariff,
- That rate of income growth slowed slightly in 2013/14 and dramatically in 2014/15, largely as a result of the tariff for emergency admissions,
- In parallel, CIP delivery has become more challenging, which particularly reflects the challenge of reducing front line pay costs in the face of significant operational pressures,
- Not only that, but in 2014/15 the Trust has experienced significant cost pressures, largely in the form of agency staffing, in opening escalation capacity and temporarily filling vacancies in posts to which proven difficult to recruit but remain critical to delivering on operational standards,
- These pressures are felt most severely in the urgent care system and, consistent with this picture, SLR data clearly shows increasing losses accruing in those specialties that manage the bulk of the Trust's emergency admissions.

Common thread: There is a clear common thread running through this analysis of the Trust's performance. Increasing demand driven by an ageing and more complex population have placed significant pressure in a range of services; the immediate impact has been manifest in a failure to achieve core waiting times standards. With much of this pressure in urgent and emergency care, the associated growth in income has not covered the cost of meeting the additional demands, creating financial pressure. A reduced capacity to deliver CIP when core services are under such pressure has exacerbated this position.

The Integrated Care Organisation represents a solution to many of these problems. Service developments are designed to reduce demands on traditional secondary care services. The strategy clearly remains relevant and the service pressures that it is designed to resolve have, if anything increased during 2014/15 and made its delivery all the more important.

1.4.4.3 External Environment

The landscape of provision within the local health and care system remains unchanged. There are no new entrants or significant changes in the balance of referral between providers that changes the strategy as currently defined.

In the commissioning environment, there is growing financial challenge. Modelling included in the FBC shows that acute income, calculated under the national draft tariff published in January, being significantly in excess of the value proposed in the LTFM. After 5 years tariff based income exceeds the agreed resource envelope by some £14m.

The management of the cost base in the ICO will make it possible to discount income levels, more closely matching CCG affordability envelopes year on year and therefore significantly reducing risk. In that context, a national tariff based contract does not create the right incentives for the ICO. We are looking to incentivise investment in preventative services, development of proactive community based support services and to reduce acute admissions. The Trust and its Commissioners have, therefore developed a Risk Share Agreement, whereby variance from the planned LTFM income position (both adverse and favourable) are shared equally.

The potential gap between a tariff based contract and the proposed resource envelope has widened under the recently adopted Enhanced Tariff. The Trust's current contract proposal for acute services is a gross value of £160.4m supplemented by transitional support of £4.3m; a total of £164.7m for 2015/16. Predicted volumes at national tariff amount to a little in excess of £168m.

The ICO model is intended to minimise the cost of system delivery. The more challenging resource position of our main commissioner and the destabilising impact upon them of the Enhanced Tariff, makes its delivery and the roll out of the risk share agreement the most significant contributor to the financial health of the wider health and care system.

1.5 Delivery of the Strategy

1.5.1 Delivering the Service Model

The Trust's strategy to create an ICO will deliver with the service model established in the Five Year Forward View. The plan has been developed in partnership across the local health and care system, with full engagement and support from providers – SDH and TSD – and commissioners, both South Devon and Torbay Clinical Commissioning Group and Torbay Council.

The key service developments that will deliver the ambition of the Five Year Forward View have been summarised in Section 1.4.3 above. The outcome of this programme will be to ensure delivery of care standards in large part through reshaping demand, dealing with more patients in a community setting and reducing demand on the most expensive acute facilities. Table 2 below sets out the expected reductions in demand, which represents the key goal over the next five years, with much of the impact driven through actions planned in 2015/16.

Table 2 : Impact of Care Model on Hospital Based Activity

		Baseline (2014/15 FOT)	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
A&E attendances	Demand without ICO	80,972	81,931	83,537	85,142	86,748	88,353	89,959
	ICO impact	-	(8,485)	(25,454)	(33,938)	(33,938)	(33,938)	(33,938)
	Demand with ICO	80,972	73,447	58,083	51,204	52,810	54,415	56,021
Non-elective admissions	Demand without ICO	34,713	35,071	35,416	35,780	36,158	36,550	37,001
	ICO impact on Care Homes	-	(188)	(563)	(750)	(750)	(750)	(750)
	ICO impact on LTC	-	(927)	(2,782)	(3,709)	(3,709)	(3,709)	(3,709)
	ICO impact on MH	-	(36)	(107)	(142)	(142)	(142)	(142)
	ICO impact on emergencies	-	(102)	(307)	(409)	(409)	(409)	(409)
	Demand with ICO	34,713	33,818	31,658	30,770	31,148	31,540	31,991
Outpatient attendances	Demand without ICO	408,594	412,479	422,172	431,864	441,557	451,249	460,942
	ICO impact	-	(7,493)	(22,478)	(29,971)	(29,971)	(29,971)	(29,971)
	Demand with ICO	408,594	404,987	399,694	401,893	411,586	421,278	430,971

The Trust has developed a detailed Post Transaction Integration Plan, which includes detailed plans as to how the service developments described in this document will be delivered. Full details of the schemes summarised here, including costings, staff implications and key performance indicators can be found in that document. Table 3 below sets out the key measures of success.

Table 3 : Key Performance Indicators

Critical success factor	Key Area	Key measurable outcomes (refer to metrics section 7.5)
maintain and improve the quality of health and care outcomes delivered for the community it serves, reflecting the changing nature of the community's needs	Care Model	Reduced length of stay Reduce mortality Reduce morbidity Earlier diagnosis and intervention Empower people in their own self care
move the balance of services away from reactive to proactive, with a greater focus on prevention and self-management	Care Model	Improve identification of people at risk Earlier diagnosis and intervention Screening uptake Reduced demand
provide services in the most appropriate locations, as close to patients homes as possible;	Care Model	Increase access to remote care and 24/7 Reduce hospital admissions Reduce outpatient appointments Reduced length of stay
reduce interfaces between separate health and care services, within and without the ICO;	Care Model	Joined up teams Reduced number of info systems Single care record Reduce multiple patient histories Reduced handovers
meet all mandatory performance and financial targets	Org Integration and Care Model	Continue to deliver against targets throughout organisational change
manage increasing demand within a restricted cost base , with greater flexibility to invest resources for the benefit of the community;	Organisational Integration, Corporate Service Developments and Care Model	Demand reduction Change nature of demand Increase productivity "System pathways" Costs contained within resources Pooled budgets Reduce back office costs
develop an appropriately skilled and dedicated workforce	Organisational Integration and Corporate Service Developments	Workforce satisfaction Complaints and significant events Temporary staffing levels

The planned transformation of service is expected to drive significant financial benefit, largely driven by the reduction in acute capacity – both beds and clinics. Most significant is the impact of the Frailty Services and their impact on both the numbers of patients admitted to the acute setting and their length of stay. In total, we expect to be able to close a total of 62 beds across our health and care system. This represents another key strategic target for the organisation. In total, once fully implemented gross savings are expected to amount to £12.4m.

Investment is required to effect these changes. In broad summary, investments are required principally in community based staff and packages of care, designed to maintain patients in their own homes for longer. Investment is also required at the 'front door' of the hospital to enable rapid diagnosis and the earliest discharge to these community based services.

Table 4 below summarises the savings and investments by scheme, and the resultant net saving of £6.4m which is expected to be delivered in full by 2017/18. This table describes the ways in which we expect to re-allocate resources across the health and care system to achieve long term sustainability.

Table 4 : Financial Impact of Care Model

Element	Activity Change			Savings		Investments		Net impact £
	Bed Reduction	ED Attendance Reduction	Outpatient Appointment Reduction	Pay	Non Pay	Pay	Non Pay	
				£	£	£	£	
3a Acute Frailty	24	4,000	-	893,405	169,743	849,224	-	
3b Community frailty	-	-	-	175,000	-	310,000	-	
3c Single Point of Contact	-	-	-	-	-	-	20,000	
3d Community Localities	-	-	-	383,790	63,980	425,580	610,332	
3e Community Hospitals	18	3,000	-	2,016,579	1,318,105	-	101,000	
4a – e Acute Innovations	15	24,000	29,500	4,767,850	1,683,171	1,374,420	30,000	
MAAT	8	4,000	-	399,196	65,543	289,312	10,000	
Intermediate Care	-	-	-	-	499,276	-	-	
A&E Investment	-	-	-	-	-	1275,000	-	
Medical skill mixing*	-	-	-	-	-	-	-	
TOTAL	65	35,000	29,500	8,635,820	3,799,818	5284,772	771,332	TOTAL £6,379,834

In addition to the efficiencies driven through the care model, there will be additional savings achieved through the further merger of back office functions. Relatively modest in comparison to some transactions, and largely reflecting the existing scope of collaboration between the two organisations, the expected savings are set out in the table below.

Table 5 : Corporate Department Efficiencies

Headline project	Net saving
Estates and facilities management	£362k
IT*	£167k
Finance	£326k
Performance information	£140k
Procurement	£44k
Board, corporate governance and risk	£383k
HR	£564k
Total	£1,891k

1.5.2 Efficiency Measures

Alongside the efficiencies and benefits driven through the care model and the effect of organisational integration, the Trust is targeting a CIP programme of £15.7m across the combined organisation.

Table 6 below sets out the key themes of the programme:

Table 6 : CIP Programme

Theme	Target Areas for Savings	Theme Total £'000
Bank and Agency Reduction	Bank and Agency Reduction	£1,020
System Efficiencies	Discretionary spend	£2,833
	Staff Salary Sacrifice Car & Shopping Vouchers	
	Printing and Electronic Communication Strategy	
	Budget Slippage	
	Microbiology VAT saving	
	Leave Accrual Released to I&E	
EFM	EFM Savings	£347
Income	Private Treatment	£795
	Additional income via Utilisation of new Cardiac Lab	
	Increasing market share	
	eLearning Strategy	
	Bowel Scope	
	Use of Estates out of hours	
	On-line medical sales	
	Private Therapy Income	
	Advertising on Trust premises / vehicles	
	Additional clinical income thru commissioning opportunity	
	Car Washing in Car Parks	
Process Improvement	Outpatient Productivity	£213
	Improved clinical pathways	
	Reduce internal drug spend - Troponin	
	Open Access to Plain Xray	
Procurement	Drug savings	£1,294
	Procurement efficiencies	
	Procurement PPSA Savings 2015/6	
	Clinically led procurement	
	Challenge all supplier contracts	
	Reduce Lab Consumable costs	
	Bulk Buy Consumables	
Workforce	Workforce - Benchmarking	£1,460
	Medical Workforce Productivity	
	Nursing Workforce Productivity	
Community Services	Income generation	£3,133
	Productivity	
	Non-Pay	
	Community hospitals	
	Community staffing	
	Corporate	
Adult Social Care	Eligibility	£3,900
	Domicillary care contract	
Other		£250
TOTAL		£15,244

1.5.3 Investments in Infrastructure

The Trust has a significant programme of investment planned in 2015/16.

1.5.3.1 Torbay Pharmaceuticals

The development of Torbay Pharmaceuticals remains a key strategic priority for the Trust.

The new facility built during 2014/15 to support the ongoing expansion of Torbay Pharmaceutical has now largely completed its fit out and is beginning the process of regulatory checks and approval. A detailed transfer plan has been developed, under which manufacturing services will move to the new unit in the Autumn of 2015, and be fully operational from January 2016.

1.5.3.2 Major Estates Projects

The Trust has secured loan financing for, and will start work on three major projects in 2015/16.

The re-provision of the Critical Care Unit at Torbay Hospital has been a long standing priority for the Trust. The environment in the existing facility does not meet current standards and we will need, over the next three to five years to increase the numbers of critical care beds available to our population. A key tenet of the ICO plan is to have a smaller hospital, but its patients will be the most acute and complex. It is essential that we have sufficient capacity to care for those who are critically unwell.

The Trust will be replacing its Linear Accelerators in a programme beginning in 2015/16. The current machines are nearing the end of their reliable life. Estates works to create bunker capacity will be completed in 2015/16 alongside the installation of the first replacement machine. The second will follow in 2016/17.

The Trust will also be extending its car parking capacity in 2015/16. An inability to find a car parking place remains the most significant source of complaint from our public and has been a key priority for Governors for some time. Planning permission has now been granted and works will complete in 2015/16.

1.5.3.3 Community Infrastructure

We plan to develop the current community bed stock to support the changing model of care, reducing the reliance on beds as we provide more care as close to home as possible. The plan includes streamlining and increasing the efficiency of existing Minor Injury Units, reducing the number of 'sub-acute' beds and introducing more 'rehabilitation units' in localities with a lack of Nursing Home/intermediate care bed availability.

This development is working in conjunction with the SDTCCG consultation plans with each of the 5 localities, which commenced in Dec 2014, so that the needs of the population are met with more streamlined and efficient facilities to support this.

1.5.3.4 Information Technology (IT)

There are significant investments required in strategic IT infrastructure that will support the delivery of 'out of hospital' based care. Most significant, and delivered in 2015/16, will be the development of a clinical portal. Critical to the success of a care model that treats patients outside of the acute hospital is rapid access to appropriate information where and when it is necessary. The clinical portal enables, through mobile technology, all systems within our system – GP, hospital and community care – to be accessed by appropriately authorised staff from any location.

Other supporting development planned to commence in 2015/16 include:

- The installation of a new Emergency Department system, that will work across the main ED and all minor injury units
- The development of a Single Community Care record for community services
- The implementation of an electronic prescribing system that will operate across the whole health care system, including primary care.

1.5.4 Delivering the Proposed Transaction

SDH continues to work towards a 'go live' date for its proposed transaction of 1 August 2015.

The key dates in the timeline for this approval are as follows:

- | | |
|--------------------------------|--|
| • TDA Gateway 3 (provisional) | 21 st May 2015 |
| • Monitor Board to Board | 29 th May 2015 |
| • Provider Appraisal Committee | 16 th June 2015 |
| • TDA Gateway 3 (back up) | June 2015 (precise date to be confirmed) |
| • TDA Gateway 4 | 23 rd July 2015 |

The TDA has established a governance structure around the transaction which is progressing well. The first meeting of the key oversight group – the Transaction Board – was held on 13th May 2015. Beneath this, there are legal, finance and quality and safety groups each meeting regularly.

The Trust has proposed a financing package that will be required for the transaction to proceed. The TDA, from their review process have confirmed their agreement with the quantum being requested. Negotiations are moving forward, now being led by the Transaction Board but, at the time of submitting this plan have not been concluded.

The proposed financing package is as follows:

Trading Risk in Torbay & Southern Devon Health and Care Trust: The trading position of TSD, despite submitting a breakeven plan for 2015/16, holds significantly more risk than that predicted at the outset of the transaction process. Exposure to this risk will detract from the ICO's ability to invest in delivering critical service model changes that will ensure long term system viability.

We currently predict a shortfall in 2015/16 (£4.0m) and 2016/17 (£2.6m) totalling £6.6m.

Investment in Transaction Delivery: SDH has absorbed significant costs of progressing the transaction, costs that have been recognised by Monitor as 'exceptional' for reporting purposes. These amount to £1.5m and have absorbed cash that would otherwise have been available for investment in delivering service change.

Investment in Service Transformation: As an acquiring Trust, SDH recognises the significant change management associated with such a significant redesign of care models and systems. To under-resource this change would jeopardise the realisation of benefits critical to success. The importance of this aspect of the case was identified by professional advisors and stressed by Monitor during the Executive Challenge meeting conducted in concluding their Stage 2 review of the transaction in December 2014.

The estimated costs of transition are in the table below. Broadly they include project management office (PMO), delivery team, project delivery cost and other programme wide cost. With our proposed care model being entirely congruent with the Five Year Forward View, SDH initially submitted a bid against the Transformation Fund, intended to support health communities in developing care systems of this nature. We believe that our plans map well to the draft criteria for the fund that are currently in circulation. Our bid was submitted in the 'Smaller Viable Hospitals' category.

Unfortunately the decision timetable for this category has been delayed. The FT has engaged through both Sam Jones, Director of the Future Models of Care Programme and NHS England Area and Regional Directors in an attempt to progress funding through this route. We are awaiting a formal response but, informally understand that no decision is likely until at least June 2015. In the interim, the Chair of the Transaction Board has agreed to progress alternative sources of funding with NHs England on our behalf.

In total, transition costs amount to £12.3m over six years as follows:

Table 7 : Transformation Costs

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Total
PMO	£225,917	£225,917	£225,917	£225,917	£225,917	£225,917	£1,355,503
Delivery team	£1,012,278	£952,876	£893,474	£687,554	£687,554	£0	£4,233,736
Project delivery costs	£2,989,725	£2,887,225	£600,000	£0	£0	£0	£6,476,950
Other costs	£115,000	£40,000	£15,000	£15,000	£0	£0	£185,000
Total	£4,342,920	£4,106,018	£1,734,391	£928,471	913,471	£225,917	£12,251,188

Working Capital: To maintain a liquidity rating of 3 throughout the LTFM period, and to ensure sufficient liquidity to effect changes as planned, SDH will, to supplement these funding sources seek to secure a working capital loan of £6m in FY 2016/17.

In addition, the FT has assumed early settlement of long term client debt, amounting to £2.3m from Torbay Council as part of the LTFM. In the event that this is not secured an additional working capital facility of that value would be required.

At present, the required financial support is reflected in the Trust's LTFM on the following basis:

- £8.2m of PDC, nominally linked to the TSD trading risk
- £12.2m of revenue grant to cover service transformation
- £6m working capital loan

Negotiations are expected to conclude over the coming weeks. The Trust has set out a number of alternative funding scenarios that can be accommodated within the LTFM. In the event that the final package varies from that described at present a revised LTFM can be submitted.

The Council of Governors have been engaged throughout the development of the acquisition proposal. They have considered the FBC in some detail; writing formally to the Chair with 'in principle support' subject to the receipt of a satisfactory risk rating from Monitor.

1.6 Plan for Short-Term Resilience

1.6.1 Quality Priorities

The trust has identified five quality improvement priorities for the year. These have been developed through discussions with clinical teams, care colleagues, our commissioners and the senior clinical and business leaders in our organisation.

In recognition of the development of a joined-up care system we have worked closely with the TSD to develop a shared set of improvement priorities. We have also taken into account the views of key stakeholders when discussing and agreeing the priorities for 2015/16. These priorities have been signed off by both Trust Boards.

1.6.1.1 Priority 1: Redesigning the reliability, accuracy and timeliness of information at the point of handover

During a patient's stay it is often necessary to transfer the care of that patient to another hospital, care agency and/or another department/ward within the hospital. These hand overs are described as a transfer of care and, as such, need to be planned and properly performed to ensure the patient's wishes and safety remains paramount. Evidence has shown that poor communication at these handovers can have detrimental effects on the patients' health and harm can occur e.g. medications not being sent with patients and next of kin details not available

The aim of this initiative is to design a reliable and capable process, for these transfers that involves the patients and carers, health professionals and relevant agencies in passing on and receiving the relevant information, medication and equipment at each and every juncture. It is being designed in collaboration with acute and community hospitals, community care providers, patients and family members and the relevant multidisciplinary teams across a number of health sectors in producing a transfer care bundle that is fit for purpose, understandable and completed in a timely and reliable way.

Objective 2015/16: create & test a 'transfer of care bundle' across a number of pathways with direct patient/carer involvement
Individual objectives.

- Understand the size, number and scope of transfers within the health and care community and the issues that affect the transfer
- Design in, direct patient, relative and carer involvement
- Design a 'transfer of care bundle' and test extensively making changes and re testing based on in situ learning

1.6.1.2 Priority 2: Establish a single point of contact for people to access community based health and social care services

The aim of this new service is to make it as easy as possible for people to access the advice, assessment and support which they need over the telephone This will include providing information about local services as well as undertaking assessments with people while they are on the 'phone and agreeing to arrange and provide support and assistance at home on the basis of the telephone call. The service will also provide people already receiving services with a direct line of communication if they want to discuss any aspects of those services or have concerns about the care they are receiving.

The new service (SPoC) will also support health and social care staff working out in the community by co-coordinating and arranging services to provide urgent care and support at home to avoid the need for someone to be admitted to hospital or a care home. The SPoC and Care Direct Plus, which already serves Southern Devon, will provide support for people who are likely to need one off or short term interventions and would not normally need to be visited at home as part of the assessment process.

Objective 2015/16: set up a single point of contact service (SPoC) in Torbay.

Individual objectives:

- Set up the single point of contact for Torbay.
- Set up a Directory of Services that contains up to date information about the services and support which are available to people in Torbay.
- Measure and monitor the changes and evaluate the first year of its operation. People who use this service will be involved in the evaluation process.
- Develop linkages between the single point of contact service and specialist long term condition services based at Torbay hospital.
- Improve the understanding of the aims of the single point of contact service and Caredirect Plus service with the Torbay hospital ward hospital and the long term condition specialist teams.

1.6.1.3 Priority 3: Improve the involvement of carers in the management of medications on admission and at discharge

We believe that carers are key member of the health and care team and we are committed to improve the involvement of all carers in all aspects of a patient's journey. Carers are often the people who know their family members best and are an invaluable source of support and information. Information sharing is a two way process. Clinical staff need to understand a patient's background, their health, and if admitted to a hospital, any medications being taken. For carers, prior to their loved ones discharge, they need information about changes to medication regimes, possible side effects and methods of

administering the drugs.

Feedback from the national NHS inpatient survey tell us that most hospitals perform poorly in ensuring people are given appropriate information about medications at discharge. We have chosen to focus on working with carers and build on the good work in 2014/15

Objective 2015/16: to test the process for identifying and involving carers in medicines reconciliation

Individual objectives:

- Design a reliable process to identify carers when patients are admitted to a ward in a community hospital or at Torbay Hospital.
- Design and test with carers, pharmacy and the ward teams a reliable process to involve carers in medicines reconciliation on admission.
- Design, test and develop a process to include carers' involvement in discharge medication regimes including medication changes, side effects and modes of administration.

1.6.1.4 Priority 4: improve multi-agency working across Torbay and South Devon

Multi-disciplinary teams typically include community nurses, physiotherapists, occupational therapists and social workers. Their joint aim is to provide people at risk of admission to hospital or care homes with the intensive support they need to remain living safely at home.

These multi-disciplinary teams will complement the work of the Single Point of Contact Service in Torbay and Care Direct Plus in South Devon. The multi-disciplinary team will provide support for people whose circumstances are uncertain or require face to face contact to assess their needs and coordinate the care they need.

Objective 2015/16: Develop and extend the multi-disciplinary teams in Torbay and the complex care teams in South Devon, through integrated working with clinicians in Torbay Hospital and developing closer working relationships with other local services. This includes GPs and local voluntary organisations.

Individual objectives:

- Set up two multidisciplinary teams, one for Torquay and one for Paignton & Brixham.
- Pilot in at least two localities (one in Torbay and one in South Devon) to see how these multidisciplinary teams can be supported by specialist teams. This may involve moving out-patient clinics and other clinical support activities out into the community from Torbay hospital.
- Pilot in at least two localities how these enlarged multi-disciplinary teams can work in partnership with other local services, including general practice and voluntary organisations.
- Measure, monitor and evaluate the changes included the impact of the enlarged multi-disciplinary teams on patient/client experience. People who use this service will be involved in the evaluation process.

1.6.1.5 Priority 5: create a reliable and consistent ambulatory emergency care service available 7 days a week

The underlying principle of ambulatory emergency care is that a significant proportion of adult patients requiring emergency care can be managed safely and appropriately on the same day either without admission to a hospital bed or through admission for only a few hours. Nationally many organisations have implemented ambulatory emergency care as part of an action plan to address the non-achievement of the 4-hour standard in A&E. Ensuring 98% of patients spend less than 4 hours in the emergency department has been a significant challenge for the Torbay hospital, particularly over this last year. 32

As part of a larger piece of work to try and address this problem and to improve the patient experience of emergency care, small tests of change have been in operation on the two Emergency Assessment Units since July 2014.

Our plan is now to expand the ambulatory emergency care service to ensure only those people who require bed based care are admitted and ensuring medical patients receive assessment by a physician as soon as possible after attending. In addition it is anticipated that this will significantly improve patient flow through the emergency department and healthcare system.

Objective 2015/16: create a reliable and consistent ambulatory emergency care service available 7 days a week

- Provide an Ambulatory Emergency Care Unit comprising 8 chairs, 4 trolleys within 2 bays on an Emergency Assessment Unit that will be open 7-days a week.
- Reduce the proportion of medical patients requiring an overnight stay when safe and appropriate to do so.
- Improve the experience of emergency care for medical patients seen within the Ambulatory Emergency Care Unit.
- Reduce the number of bed days utilised by patients with ambulatory case sensitive conditions.
- Contribute to an improvement in patient flow through the emergency department as measured by achievement against the 4-hour standard.

1.6.1.6 CQUINN Targets

SDH and TSD have agreed a joint CQUINN programme with South Devon and Torbay Clinical Commissioning Group. The programme is summarised in Table 8 below.

Table 8 : CQUINN Programme

Number	Goal Name	Description of Goal	CQUIN
1	Acute Kidney injury	Improvement in recording AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge,	National
2	Sepsis	Improvement in sepsis screening & antibiotic administration	National
3	Dementia & delirium	Improvement in dementia & delirium screening, assessment & management alongside improved staff training and support for carers	National
4	Unplanned emergency care	Reduction the Proportion of Avoidable Emergency Admissions to Hospital & Improvement in recording diagnoses and Re-attendance Rates of Patients with Mental Health Needs at A&E	National
5	Nutrition & hydration	Improvement in nutrition & hydration care system wide	Local
6	Incident investigation	Improvement in incident investigation care system wide	Local
7	Patient experience	Improvement in patient experience care system wide	Local
8	Staff experience	Improvement in staff experience care system wide	Local

1.6.2 Operational Requirements

1.6.2.1 Resource Plans

Activity plans, designed to achieve the national standards, have been developed with input from the each Directorate within the Trust and from our Commissioners. These have been agreed using a full year's activity to August 2012 and set at a level which is intended to reflect a continuation of historic referral, conversion rates, waiting lists and activity. Growth in referral has been modelled in line with current experience and reflecting changing demographics. Non-recurrent activity has then been added to reflect the need to reduce the total waiting list in order to sustainably achieve the 18 week RTT standard. This has added significant volumes in a number of specialties, mainly Ophthalmology.

The ICO will also, for the first time report community activity. Data quality is limited with significant amounts of manual records in use. TSD is seeking to implement a community IT system that should improve the quality of data supporting community activity. Information is reported from Quarter 2, with the Quarter 2 position representing a consolidation of the half year post transaction.

Table 9 below summarises the activity plan agreed with Commissioners:

Table 9(a) : Activity Plan - Acute

Activity - Acute & Specialist		Out-turn Year Ending 31-Mar- 2015	Plan Q1 Quarter Ending 30-Jun-15	Plan Q2 Quarter Ending 30-Sep- 15	Plan Q3 Quarter Ending 31-Dec- 15	Plan Q4 Quarter Ending 31-Mar- 16	Plan Year Ending 31-Mar- 16
Elective inpatients	Spells	4,935	1,333	1,342	1,295	1,355	5,325
Elective day case patients (Same day)	Cases	31,778	8,139	8,352	8,873	8,805	34,169
Non-Elective	Spells	33,200	7,628	8,189	8,361	7,803	31,981
Outpatients - first attendance	Attendances	87,851	23,472	23,529	24,099	22,972	94,072
Outpatients - follow up	Attendances	213,757	57,253	57,736	61,314	58,275	234,578
Outpatients - procedures	Procedures	69,416	17,653	17,951	18,752	17,695	72,051
A&E	Attendances	78,163	20,848	21,276	19,179	18,614	79,917

Table 9(a) : Activity Plan - Community

Activity - Community	Plan Q1 Quarter Ending 30-Jun-15	Plan Q2 Quarter Ending 30-Sep- 15	Plan Q3 Quarter Ending 31-Dec- 15	Plan Q4 Quarter Ending 31-Mar- 16	Plan Year Ending 31-Mar- 16
Total number of contacts		212,499	97,475	97,475	0

Informed by this baseline, future growth expectations, the impact of both CIP and the care model changes described earlier in this document, the Trust has compiled a detailed workforce plan for the next five years. The expected workforce numbers for 2015/15 are set out in Table 10 below.

Table 10 : Workforce Plan

	Out-turn Year ending 31-Mar- 15	Plan Q1 Quarter Ending 30-Jun-15	Plan Q2 Quarter Ending 30-Sep- 15	Plan Q3 Quarter Ending 31-Dec- 15	Plan Q4 Quarter Ending 31-Mar- 16
Analysis of Workforce Numbers					
Medical and Dental staff	425.0	460.7	470.9	470.9	470.9
Registered Nurses, midwives and health visiting staff	848.5	886.4	1,284.3	1,274.4	1,270.3
Qualified Scientific, Therapeutic and Technical Staff	698.8	749.4	1,053.0	1,050.7	1,050.7
Support to clinical staff	486.4	478.0	910.0	903.9	899.8
Managers and Infrastructure Support	1,315.0	1,303.8	1,725.5	1,702.7	1,690.0
Total WTEs	3,773.7	3,878.3	5,443.7	5,402.6	5,381.7

The workforce challenge in creating the ICO is to be increasingly effective in the use of our shared people resources, in the context of national recruitment and retention challenges in key professional employment markets. This can be done by making improvements to the model of care through integration as described in this business case.

Our strategy includes:

- Equipping our leaders to develop the organisations effectiveness and to lead a consistent health and care system as one joined up organisation;
- Further develop our culture in line with the laws of integrated care to live the values and behaviours, manage risk and deliver one system to patients removing perceived barriers;
- Realign and flex our people resources from an acute hospital setting to community settings to support Mrs Smith and her family in the community. To facilitate care and treatment closer to home and develop our peoples thinking about flexibility in working across settings. This includes giving a greater provision of specialist medical support in community settings closer to home ;
- Make changes to the ratios between our registered and non-registered roles away from a very profession centric workforce to one of skilled care workers to provide career progression, to manage supply issues in the employment market, provide career pathways and use our resources more effectively;
- Introduce new and different generic role designs at both a professional level e.g. Associate Physician and care worker level, alongside the developing multi-agency teams. This particularly relates to more joint health and social care roles to work across settings to facilitate quicker personalised and joined up care e.g. rehabilitation support workers. This also involves having skilled people in roles which enable rapid, proactive and appropriate assessment and care planning that enables the most effective and relevant package of support to be delivered to the individual in the correct setting or referral to other agencies;
- Educating, developing and training our workforce to take a holistic, preventative approach to caring for people in all settings;
- To ensure efficiency and system gains in respect of people resources in particular support functions are delivered e.g. through shared service. Such gains in expansion of skills and knowledge can only benefit the wider organisation and have a positive effect on the effective implementation of the Care Model.

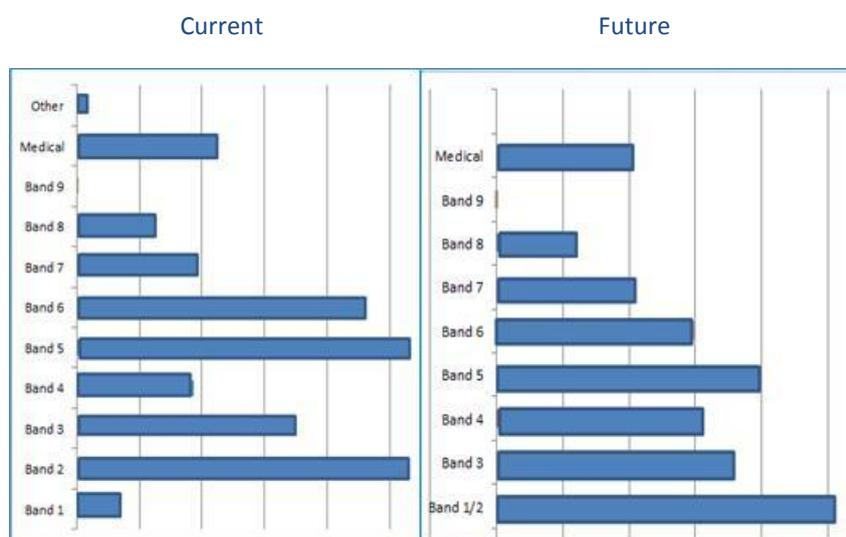
The current overall picture for the workforce for both SDH and TSD shows that the current design heavily relies on professional roles. There is potential within the workforce to reduce the number of roles and create progression routes through the organisation into professional roles with a more balanced design. The organisation can do this by introducing skilled workers and introducing new and different specialist roles to support specialties e.g. physicians associates and advanced nurse practitioners. Therefore our objectives will be to develop career progression routes and change the skill mix of the organisation to unlock potential and manage capacity whilst realising savings.

Our ambition is to change the shape of the workforce, improving skill mix, reducing numbers and introducing new and differently configured role types. We will use the King's Fund service design principles in which act to achieve this aim. The key changes to workforce and assumptions are:

The Care Model will require up front start up investment and additional posts in year one and two posts;

- The decrease in demand for inpatient services, lengths of stay and reducing growth in outpatient appointments in the acute setting will allow realignment of medical, registered nursing, clinical support posts to the community setting. Revised skill mix expectations are set out Chart 4 below.
- There will be a shift from qualified to skilled staff in realigning posts to community settings;
- Development of Single Point Of Contact (SPOC) will result in realigning and reducing staff. Set up of SPOC will realign the workforce currently within community services teams.
- Increased utilisation of staff across the whole health and social care system to prevent referrals and admissions will lead to efficiency savings in WTE over five years
- Proportionally more CIP Saving and Care Model Saving in corporate services functions;

Chart 4 : Workforce Skill Mix



Plans to develop the estates and IT infrastructure are included in section 1.5.3 of this plan.

1.6.2.2 Key Performance Risks

Emergency Department 4 Hour Standard: In July 2014, the Trust and our local CCG asked for support from the NHS Emergency Care Intensive Support Team (ECIST). The report from ECIST resulted in the Trust developing an extensive action plan which is being managed through the local system resilience group. The Trust has also secured on-going support from ECIST and through membership of the ambulatory care network.

The action plan is owned by the Trusts Chief Operating Officer and overseen by the governed local System Resilience Group supported by the Urgent Care Board.

As an illustration some of the key actions already in place are:

- Establishment of an Acute Medical Unit to receive direct admissions from GPs
- Establishment of short stay paediatric assessment unit;
- Review use of medical time to maximise shop floor cover' ambulatory area, discharge lounge, and clinical decision unit, particularly during evenings and weekends;
- Collaborative work with the GP out of hours service and GP's from the CCG to support the department at peak times;
- Further development of the Psychiatric Liaison Service;
- Fast track models for specific conditions including fractured neck of femur and stroke;
- Investment in discharge management and social care capacity.

The operational team across the hospital continues to adapt and respond as quickly as possible to support improvement to the patient experience in ED. The Trusts main CCG commissioner has agreed a trajectory for improvement that delivers the standard by the end of July 2015.

Performance standards have improved considerably during April and May of 2015/16 and the Trust is forecasting sustainable delivery from Quarter 2.

Referral to Treatment Standards: Section 1.4.4 of this plan describes those specialties in which the Trust has experienced capacity / demand pressures during 2014/15.

Plastic surgery :

- Use outsourcing with local private provider – process established and has capacity to meet current and anticipated peaks in demand from repeat of skin awareness campaign and referrals from Dermatology;
- In-house capacity for delivery using visiting consultants has been reviewed and plans to maintain continuity of capacity for 2015 confirmed;

Upper GI surgery:

- Clinical teams have capacity to pick up additional lists when available and resources align.
- Agreement to run Saturday operating lists across General Surgery specialties to create additional in week lists for Upper GI surgery. This is pending internal agreement.
- Outsourcing (low numbers) agreed with local private provider
- Clinical review of hernia service to review pathway and approach being offered with aim to increase range of clinicians contributing to the service provision. This forms part of the action learning set approach described in the main paper.

Ophthalmology:

- Increase in demand for cataract surgery and clinical priority non-admitted pathways for macular and glaucoma recognised by commissioners.
- Action learning set established (primary and secondary care clinical leadership)
- Outsourcing to local NHS and non-NHS providers in place.
- In house theatre constraints being addressed through business case to improve theatre capacity.
- Short term increase in capacity with mobile theatre being evaluated.
- Nursing workforce plan in place to increase numbers and build resilience into the ophthalmic specialist nurse who support the cataract and macular treatment pathways.

1.6.3 Financial Forecasts

1.6.3.1 Headline Financial Forecast

A summary of the overall financial plan for 2015/16 is set out in Table 11, with quarterly phasing set out in Table 12.

Table 11: Financial Plan Summary

	units	sense	Actual 2012-13	Actual 2013-14	Out-turn 2014-15	Plan 2015-16
Summary Income and Expenditure Account						
Operating income (inc in EBITDA)						
NHS Clinical income	£m	(+ve)	195.767	201.947	203.382	289.146
Non-NHS Clinical income	£m	(+ve)	1.246	1.253	1.314	50.256
Non-Clinical income	£m	(+ve)	34.282	37.112	38.562	37.580
Total	£m		231.295	240.312	243.259	376.982
Operating expenses (inc in EBITDA)						
Employee expense	£m	(-ve)	(143.193)	(149.599)	(156.221)	(209.881)
Non-Pay expense	£m	(-ve)	(74.320)	(78.513)	(77.211)	(154.569)
PFI / LIFT expense	£m	(-ve)	0.000	0.000	0.000	(0.895)
Total	£m		(217.513)	(228.112)	(233.432)	(365.345)
EBITDA	£m		13.782	12.200	9.826	11.637
<i>margin %</i>	%		6.0%	5.1%	4.0%	3.1%
Operating income (exc from EBITDA)						
Donations and Grants for PPE and intangible assets	£m	(+ve)	0.372	0.046	0.811	0.200
Operating expenses (exc from EBITDA)						
Depreciation & Amortisation	£m	(-ve)	(8.746)	(9.312)	(9.102)	(11.816)
Impairment (Losses) / Reversals	£m	(+/-ve)	(3.225)	(1.584)	(5.624)	(0.500)
Restructuring costs	£m	(-ve)	0.000	0.000	(1.200)	0.000
Total	£m		(11.971)	(10.896)	(15.926)	(12.316)
Non-operating income						
Finance income	£m	(+ve)	0.118	0.074	0.081	0.111
Gain / (Losses) on asset disposals	£m	(+/-ve)	0.008	(0.006)	(0.033)	0.000
Gain / (Losses) on transfers by absorption	£m	(+/-ve)	0.000	0.000	0.000	(6.028)
Other non - operating income	£m	(+ve)	0.000	0.000	0.000	0.000
Total	£m		0.126	0.068	0.048	(5.917)
Non-operating expenses						
Interest expense (non-PFI / LIFT)	£m	(-ve)	(0.395)	(0.682)	(1.162)	(3.019)
Interest expense (PFI / LIFT)	£m	(-ve)	0.000	0.000	0.000	0.000
PDC expense	£m	(-ve)	(2.490)	(2.263)	(2.248)	(2.741)
Other finance costs	£m	(-ve)	0.000	0.000	0.000	0.000
Non-operating PFI costs (e.g. contingent rent)	£m	(-ve)	0.000	0.000	0.000	0.000
Other non-operating expenses (including tax)	£m	(-ve)	0.000	(0.022)	0.000	(0.012)
Total	£m		(2.885)	(2.967)	(3.410)	(5.772)
Surplus / (Deficit) after tax	£m		(0.576)	(1.549)	(8.650)	(12.167)
Profit/(loss) from discontinued Operations, Net of Tax	£m	(+/-ve)	0.000	0.000	0.000	0.000
Surplus / (Deficit) after tax from Continuing Operations	£m		(0.576)	(1.549)	(8.650)	(12.167)
Memorandum Lines:						
Surplus / (Deficit) before impairments and transfers	£m		2.649	0.035	(3.025)	(5.639)
One off income/costs	£m		(2.845)	(1.544)	(6.045)	(6.328)
Normalised Surplus / (Deficit)	£m		2.269	(0.005)	(2.604)	(5.839)
<i>margin %</i>	%		1.0%	(0.0%)	(1.1%)	(1.6%)

Table 12: Annual Plan Phasing

	S Devon		S Devon	ICO	ICO	ICO	ICO
	2014/15		2015/16	2015/16	2015/16	2015/16	2015/16
	Plan		Q1	Q2	Q3	Q4	Full Year
	£m		£m	£m	£m	£m	£m
Income and Expenditure							
Income	244.1		60.4	128.6	94.7	93.5	377.2
Operating expenses	(233.4)		(59.5)	(127.7)	(89.7)	(88.5)	(365.3)
EBITDA	10.6		0.9	0.9	5.0	5.0	11.8
Non-operating revenue			-	-	-	(6.0)	(6.0)
Non-operating expenses	(19.3)		(3.4)	(5.0)	(4.5)	(5.1)	(18.0)
Net surplus / (deficit)	(8.6)		(2.5)	(4.1)	0.5	(6.1)	(12.2)
<i>Nominalised surplus</i>	(3.0)		(2.5)	(4.1)	0.5	0.4	(5.7)
<i>...included in the above :</i>							
Impairment/Asset disposal loss	(5.6)					(6.5)	(6.5)

The deficit in Quarter 1 reflects the CIP delivery profile in SDH. The Quarter 2 position is driven by the consolidation of the half year results of TSD, which shows a combined deficit of £1m. Quarter 3 reflects increased tariff income over the quarter, the impact of the ICO CIP and transaction savings along with the increased sales from the Torbay Pharmaceuticals facility flowing through giving a small surplus. Quarter 4 is affected by the loss on disposal of the assets relating to the West Devon Contract for community services that NEW Devon CCG will move to a Plymouth located provider. Prior to that loss on disposal Q4 has a small surplus.

1.6.3.2 Strategic Initiatives

The financial plan reflects, as agreed with Monitor, reflects the proposed acquisition of TSD effective from 1 August 2015.

By virtue of the transaction, full year income and expenditure of TSD will be consolidated into SDH's financial result for 2015/16. The significant variances between 2014/15 and 2015/16 seen in Table 11 above are, in the main explained by this factor.

The transaction is processed during quarter 2, for which the plan set out above represents planned quarter 2 performance for the existing business, uplifted by the consolidated half year of TSD.

The financial plan set out in this document is consistent with that currently under assessment in support of the proposed transaction.

1.6.3.3 Income

Table 13 below sets out income by main commissioner for 2015/16.

Table 13 : Income by Commissioner

		Acute £'000	Community £'000	Other £'000	Total £'000
Clinical	South Devon & Torbay CCG	160,399	61,147		221,546
	NEW Devon CCG	5,195	1,936		7,131
	NHS England	32,120	3,783		35,903
	Torbay Council	2,101	39,945		42,046
	BCF		12,699		12,699
	Other	5,798	18,275	200	24,273
Non-Clinical		29,241		4,343	33,584
Total					377,182

For our host Commissioners, South Devon & Torbay CCG (SDTCCG) and Torbay Council, the plan described above represents income as expected under the proposed Risk Share Agreement for the Integrated Care Organisation. In broad outline, income is based around a fixed contract sum that combines health and social care income. Where actual income or expenditure drive a variance in the planned surplus / deficit, the impact will be shared on a 50 / 50 basis by host commissioners and Provider.

NHS England and NEW Devon are both full national contracts operating under the Enhanced Tariff.

As described in Section 1.6.2, SDTCCG have worked with the Trust and more specifically the individual specialties to agree the

demand plan for acute services, which would, if delivered drive gross income of £168m; a level some £12m in excess of that which is affordable by SDTCCG. The baseline assumption for the ICO, and included in this financial plan is £160.4m. Substantially less than compared to the ICO proposal, this underlines the commitment being made by the Trust to devise a service model that fits far more closely to our Commissioner’s resource envelope than would otherwise occur.

At the point of writing, and until the transaction completes, the Trust is operating under a national tariff and national contract arrangement for acute services; the Trust has opted for the Enhanced Tariff Offer. Community services are operating on a block contract basis within TSD.

There is risk to both parties in terms in this arrangement. However the Trust’s assessment is that, working from a baseline value of £168m, the net impact of penalties, risk of under-performance, CQUINN risk will not drive an income level lower than the proportionate share of £160.4m in the early part of the year and until the transaction proceeds.

Additional income has been processed, as set out in Section 1.5.4 in respect of revenue support to effect the Care Model changes set out in this plan.

1.6.3.4 Expenditure

The following assumptions around cost have been developed as part of the SDH long term financial modelling:

Table 14 : Cost Assumptions

	15/16 %
Employee Inflation	1.65
Non Pay inflation	2.68
Other income	1%

- Employee inflation has been based on the national pay award supplemented by an assessment of incremental drift, clinical excellence awards and other pay pressures;
- Non-Pay inflation has been based on historic trends for drugs separately looking at pass through and hospital drug spend and a bottom up review of expected cost pressure by divisions;
- Capital charges have been based on the capital programme and assume appropriate Foundation Trust Financing Facility Loans will be available and used to fund the long term assets at current interest rates.
- Corporation tax on Pharmacy Manufacturing Unit has been assumed to be nil in line with current taxation of Foundation Trusts.

Expenditure budgets have, in addition been adjusted to reflect:

- Across the combined budget, a CIP target of £15.2m; outline plans to achieve this are set out earlier in this document;
- Additional costs of building capacity to meet demand;
- The impact of the care model changes

In reviewing its savings potential, the Board’s assumption that cost improvement programme will continue to be an increasingly difficult challenge, has been reflected in the planned deficit position. This reflects the need to maintain the quality of patient services.

1.6.3.5 Capital

The Trust has developed a capital expenditure plan that focuses on ensuring business continuity, addresses high risks in a timely manner and also enables the Trust to invest in some key Information & Management Technology (IM&T) projects. These IM&T projects will both improve the safety of patient care and will also ensure that patients can continue to be treated in the most appropriate environments.

The total value of the planned capital expenditure in 2015-16 totals £29.1m, of which £25.0m relates to planned investment in South Devon Healthcare NHS FT sponsored projects. The balance of £4.1m relates to planned investment in Community Hospitals and other Community Services that upon the successful acquisition of Torbay and Southern Devon Health and Care NHS Trust, the Trust will become responsible for on 1st August 2015.

The Trust will be reliant upon further external investment in order to deliver these capital plans in full during 2015-16. Some of this external investment has already been secured through the Independent Trust Financing Facility (ITFF) but a number of planned loans to fund investment have yet to be secured. Loan applications will be submitted to the ITFF upon completion of Outline Business cases.

The principal projects that the Trust plans to deliver during 2015-16 and the source of finance is set out below.

Trust wide Backlog Maintenance Program: The Trust is planning to invest £4.4m in building maintenance projects during 2015-16. Schemes such as replacement of non-compliant sanitary ware, water safety improvement works, replacement condensers and re-roofing works. These will be funded from internal Trust cash resources. Investment is also planned within the Mortuary, Fracture Clinic and the Emergency Department. These latter schemes will be commenced during 2015/16 with anticipated completion in 2016/17. The planned investment in 2015-16 is reliant upon ITFF funding totalling £0.4m. These loans have not yet been secured. Loan applications will be submitted to the ITFF upon completion of Outline Business Cases.

Construction of a new Critical Care Unit and Hospital Front Entrance: The Trust's current Critical Care facilities are not compliant with technical standards, the privacy and dignity of patients is heavily compromised, and there is restricted space around the patient's bed. The plant that serves the current facility is aging and there are no decant facilities within the Trust to enable this plant to be replaced without severely compromising service. In addition there are insufficient numbers of Critical Care beds. This is evident in the number of elective procedures cancelled due Critical Care Unit capacity and also by the Trust having the lowest number of critical care beds per head of population in the South West Peninsula. The Trust has now finalised the design of the new facility, a contractor has been appointed and finance from the ITFF has been secured. The total planned investment in 2015-16 totals £6.7m. The project is due to be completed in 2017.

Construction of a new Linear Accelerator Bunker and associated works: The Trust provides Radiotherapy treatments to a large number of patients within the South Devon Area. The Trust's two Linear Accelerators are operated at near capacity and are in need of replacement. The Trust plans to replace the older machine in 2015-16 and the slightly newer machine in 2016-17. However in order to replace one of the two machines a third 'bunker' will first of all need to be constructed. This is because treatment demand could not be met by the Trust through the use of one machine and neighbouring Trusts have no significant additional treatment capacity. Further, attempting to run a Radiotherapy service on one aging Linear Accelerator would pose too greater a risk to Patient safety where treatment episodes have to be delivered in rapid succession. Finance for the project has been secured from the ITFF, a contractor has been appointed and construction works have started. The sum of investment on building works that will take place during 2015-16 totals £2.7m

St Kilda – Construction of a new Secondary care and Primary care facility at Brixham Hospital: This project is currently sponsored by Torbay and Southern Devon Health and Care NHS Trust. The total project cost is circa £6.9m of which £2.5m is planned for 2015-16. This project is dependent upon ITFF funding. A loan application for the scheme will be submitted upon completion of the FBC. The project will provide a purpose built 36 bedded integrated health and social care 'hub' for the population of Brixham, bringing together primary care, community health services and social care.

Expansion and Improvement of Car Parking Facilities: External Finance from the ITFF has been secured for this project. The project will enable substantial increases in the number of patient and visitor spaces on site. The total value of the proposed investment in 2015-16 is £1.8m

Implementation of an Electronic Document Management System (EDMS) to support Clinical Decision making: The Trust is investing significant sums of money in IM&T projects that will both improve Clinical Care and create efficiencies. A key component of this overall investment is investment in EDMS. The successful implementation of EDMS will enable the Trust to vastly reduce the need to maintain paper copies of Patient's Medical Records which in turn will improve the speediness of clinical decision making and produce significant levels of CIP. The project is likely to take two years to deliver in full. The investment of £1.0m in 2015-16 is reliant upon external ITFF funding. A loan application will be submitted to the ITFF upon completion of a Full Business Case.

Implementation of a Shared Community Care Record Application: This project is also currently sponsored by Torbay and Southern Devon Health and Care NHS Trust. The project will be delivered from internally generate cash resources. The project will replace paper communications for Health and Social Care staff by interfacing systems. The total planned investment in 2015-16 is £1.2m.

Other IT schemes – Intangibles IM&T and Tangibles: The combined value of these schemes in 2015-16 totals £3.3m. These schemes are being funded from internally generated cash resources. The spend in 2015-16 will enable amongst other schemes, the implementation of a Clinical Portal (i.e. a 'hub' where all patient related clinical data will be stored), electronic order communications for pathology test requests and results, clinical handover systems for use by Acute Medical and Nursing Staff and the upgrading of some of the Trust's IM&T infrastructure/hardware. The investment will also enable the commencement of the Electronic Prescribing System implementation.

Medical Equipment: The Trust plans to invest a total of £3.8m on Equipment during 2015-16. The two largest components of which are the replacement of one of the Trust's two Linear Accelerators (£2.2m) and the replacement of the Trust's aging Cardiac Catheter Laboratory equipment (£0.6m). A further £1.0m will be invested in replacing other items of Medical Equipment. The replacement Linear Accelerator is funded by a secured ITFF loan. The other items of Medical Equipment are being funded from internally generated cash resources.

Other – Capitalisation of development costs to secure and maintain pharmacy manufacturing licences: The Pharmacy Manufacturing Unit (PMU) currently provides the Trust with a significant revenue scheme which is used to subsidise the cost of the Healthcare provided by the Trust. The Trust has over recent years invested significant sums in expanding production capacity through ITFF secured loans. The Trust plans to invest further sums of money to secure pharmaceutical manufacturing

licences to protect and enhance market share of revenue. The proposed £0.3m of investment in 2015-16 will be financed from internally generated resources.

Other – Purchase of PMU equipment to complete the fit out of the new facility and to meet business continuity needs: The further investment of £1.4m in 2015-16 will enable the fit out of the new PMU facility to be completed. The investment will be financed from internally generated resources.

Other – Estates and Facilities – Replacement equipment: A relatively small sum of £0.1m has been set aside to enable part of Estates and Facilities Management equipment to be replaced in year. Funds for which are from internally generated cash resources.

Included within the 2015/6 planned Statement of Comprehensive Income (SOCl) is an anticipated impairment charge of £0.5m. This impairment charge relates to the forecast Modern Equivalent Asset valuation adjustment that will be necessary to apply to the capitalised cost of specialised building assets that are brought into use during the financial year. The annual valuation adjustment is provided by the District Valuation Office.

1.6.3.6 Statement of Financial Position

The statement of Financial Position, which reflects the trading activities and capital investments above, is set out in Table 15.

Table 15 : Statement of Financial Position

			Actual 2012-13	Actual 2013-14	Out-turn 2014-15	Plan 2015-16
Non-current Assets						
Intangible assets	£m	(+ve)	3.080	1.835	1.411	9.726
Property, Plant & Equipment	£m	(+ve)	96.295	119.637	121.225	169.059
On-balance sheet PFI	£m	(+ve)	0.000	0.000	0.000	18.886
Other	£m	(+ve)	1.885	2.315	2.243	2.228
Total	£m		101.260	123.787	124.879	199.899
Current Assets						
Cash and cash equivalents	£m	(+ve)	16.615	18.472	12.061	18.813
Other current assets	£m	(+ve)	16.228	18.284	14.999	18.838
Total	£m		32.843	36.756	27.060	37.651
Current Liabilities						
Overdrafts and drawdowns in committed facilities	£m	(-ve)	0.000	0.000	0.000	0.000
PFI / LIFT leases	£m	(-ve)	0.000	0.000	0.000	(0.551)
Other borrowings	£m	(-ve)	(0.929)	(2.800)	(3.366)	(3.723)
Other current liabilities	£m	(-ve)	(20.779)	(25.640)	(19.279)	(29.678)
Total	£m		(21.708)	(28.440)	(22.644)	(33.952)
Non-current Liabilities						
PFI / LIFT leases	£m	(-ve)	0.000	0.000	0.000	(20.726)
Other borrowings	£m	(-ve)	(16.007)	(35.023)	(37.293)	(51.277)
Other non-current liabilities	£m	(-ve)	(3.734)	(3.715)	(3.587)	(3.587)
Total	£m		(19.741)	(38.738)	(40.880)	(75.590)
Reserves	£m	(+ve)	92.654	93.365	88.414	128.008

1.6.3.7 Continuity of Service Risk Rating

The Continuity of Service Risk Rating (COSRR) for each quarter is set out in Table 16 below:

Table 16 : Continuity of Service Risk Rating

			Actual 2012-13	Actual 2013-14	Out-turn 2014-15	Plan 2015-16
Capital Service Cover						
<i>Material Adjustments to:</i>						
Revenue Available for Capital Service	£m	(+/-ve)	0.000	0.000	0.000	0.000
Capital Service	£m	(+/-ve)	0.000	0.000	0.000	0.000
Revenue Available for Capital Service	£m		13.900	12.252	9.907	11.736
Capital Service	£m		(3.212)	(4.233)	(6.745)	(9.788)
Capital Service Cover metric	0.0x		4.33	2.89	1.47	1.20
Capital Service Cover rating			4	4	2	1
Liquidity						
<i>Material Adjustments to:</i>						
Working Capital for CoSRR	£m	(+/-ve)	0.000	0.000	0.000	0.000
Operating Expenses within EBITDA, Total	£m	(+/-ve)	0.000	0.000	0.000	0.000
Working Capital for CoSRR	£m		5.413	1.947	(1.634)	(2.350)
Operating Expenses within EBITDA, Total	£m		(217.513)	(228.112)	(233.432)	(365.345)
Liquidity metric	Days		8.96	3.07	(2.52)	(2.32)
Liquidity rating			4	4	3	3
2* Override			No	No	No	No
Continuity of Service Risk Rating			4	4	3	2

The deficit position is driving the debt service element of the COSRR to be a '1' in 2015/16. The creation of the ICO adds to the challenge for this ratio as TSD has two Private Finance Initiative funded community Hospitals.

The financing arrangements to cover the balance sheet deficit in TSD and the ICO change fund could also impact on this rating if these are finally agreed to be loan funded. They could also compromise future borrowing capacity for the new ICO.

The liquidity element of the COSRR remains a '3' reflecting the relatively good cash and cash equivalent position SDHCT carries forward into 2015/16, the assumption that the change fund is provided by NHS England and that Torbay Council takes back the historic client debt associated with Adult Social care that currently sits in TSDHCT books.

This drives a COSRR of 2 across the first year of the ICO whilst the care model changes are implemented and the synergies of integration are being delivered.

1.6.3.8 Sensitivities

As part of its FBC, the Trust has modelled an extensive range of downside financial scenarios and proposed mitigations. Those affecting 2015/16 have been summarised in Table 17 below. In summary these reflect a 20% reduction in CIP delivery, a 12 month delay in delivering care model savings and a 50% reduction in the planned growth in surplus derived from Torbay Pharmaceuticals.

Table 17: Sensitivities

Sensitivities 2015/16	£m
Decrease in Pay CIP Delivered	£2.7
Delay in Pay synergies	£2.5
Decrease in TP* Other Income Growth	£0.4
Downside Total	£5.6

(*TP, Torbay Pharmaceuticals)

The most significant planned mitigation against these risks is the operation of the Risk Share Agreement under which, to the extent that any downside increases the Trust's planned deficit, our Commissioners will provide funding for 50% of their impact. There is sufficient liquidity in the Trust's position to accommodate any balance in 2015/16.

Annual Plan 2015-16 Submission

Response to Monitor's Feedback from April 2015 Submission

➤ **Review of key assumptions**

- Financial pressure:

You have elected to adopt the 'Enhanced Tariff Option' option for your 2015/16 tariff services. Under this option, the gross tariff deflator requirement is assumed to be 3.5% (or 3.3% excluding capital costs inflation). Excluding the impact of non-NHS income inflation/deflation and capital costs inflation, the net financial pressure modelled in your draft plan for 2015/16 is 3.9%.

This is materially different to Monitor's guidance, and has not been referenced in the narrative accompanying the plan. While we want and expect you to make local estimates on your expected pressure, please ensure that this difference is clearly explained, or that the relevant revisions are made, in your final operational plan.

The tariff deflator we used for the April annual plan/March LTFM is 1.9% (estimate) prior to the release of final 15/16 PbR guidance which is 1.6%.

With regard to CIP – 3.9% is the average CIP target for the ICO (£15.2m total)

SDH is 3.47% which is within the requirement by Monitor of 3.5% (£8.2m)

TSD is 4.44% (£6.2m which include £3.9m of Adult social care). TSD will not be affected by the ETO for its health care contracts it will use the standard deflator. Adult social care has a differential CIP requirement as set by Torbay Councils, which is in excess of the health deflator and reflects the differential settlement for social services and health budgets.

- Activity:

Your forecast cost weighted activity growth¹ in 2015/16 is estimated at 7.9%. At national level, we expect the overall activity growth pressure, before application of any demand management reduction, to be approximately 3.0% per year.

It is very important for us to understand how your local assumptions vary from the national expectation. Therefore to help us better understand your activity growth assumptions we would like you to include a further break down of these assumptions. This should componentise your growth rate by at least the following categories: 'underlying demand growth', 'impact of the Better Care Fund (BCF)', 'impact of commissioners (other)' – including demand management reduction and 'other' (with accompanying explanations).

You may update our cost weighted ratios if these do not adequately reflect the split

of services at your foundation trust.

We note that your NHS clinical income growth 2015/16 apportioned to activity movements (underlying demand, impact of commissioners and strategic initiatives - activity) is 2.4%. As noted earlier, your cost weighted activity growth in 2015/16 is 7.9%. We would like to understand the cause of this difference in greater detail (which may be that our cost weightings are not reflective of your organisation), therefore please comment on this in your final operational plan.

This is the first time we have seen the monitor cost weightings for activity and as the letter explains they may not reflect local circumstances. The question is therefore whether local growth rates from 2014/15 out-turn and plan to 2015/16 plan are reasonable. The attached analysis (appendix 1) seeks to illustrate these growth rates and breaks them down between underlying referral movements and activity needed in order to reduce the overall waiting list numbers to deliver sustainable RTT.

In summary:

- 1) Underlying demand (referral) growth = 1.78% using capacity or 1.71% using demand
- 2) Volumes needed to reduce waiting list size = 0.81% capacity or 0.78% demand
- 3) Total growth = 2.59% or 2.48%

Under the risk share agreement the better care fund is left in the overall funding envelope and is therefore not an issue for Torbay.

➤ **Alignment to commissioners:**

We have identified instances of material misalignment with your commissioners on contract income and activity. These are detailed further in Annex 1.1. It is important that you engage with the commissioners identified and resolve these differences prior to the submission of your final plan. Unresolved differences should be explained and justified in your final operational plan, with adequate mitigating contingency plans in place where necessary.

[Table 1-Missing Data](#) is an issue for New Devon CCG so no action for us.

[Table 2 – Income](#)

[SCG/DCIOS](#) – We have an agreed year end position for 2014/15 with Specialised Commissioning and Devon Cornwall and the Isles of Scilly Area Team. This is the value stated in our return, 2014/15 is therefore not an ‘assumption’ as it relates to an agreed historic value.

Recent contract discussions have resolved the majority of the 2015/16 outstanding negotiation issues with NHSE teams. We understand that any differences should now be rectified and agreed following our meeting on Friday the 24th April.

[South Devon and Torbay CCG](#) – There is a recognised difference in the contract value of £4.4m, the Trust has planned for £160.4m and the CCG have planned for £156m. Both organisations understand the difference and that the Trusts assumptions on income are prudent.

Activity plans and contracting currencies are all agreed and the difference relates to the CCG affordability. Reducing the income plan with the CCG would not in our view be realistic in a full PbR environment, which gross of any penalties etc would drive a contract value of around £168m. The CCG’s QIPP plans were received on the 30th April and we are now reviewing these in detail to understand how much could reasonably be adjusted in our income plans. At this stage it is too early to say given the date the plans were received.

Reference to ‘Community’ must relate to the Care Trust income under the ICO?

[Table 3 - Activity](#)

[SCG/DCIOS](#) – TSD have shared the plan with commissioners and none of their queries were around our activity. Therefore, TSD assume the activity will match in final submission.

[CCG](#) – TSD are using the same plan, with baselines/activity that has been agreed by the CCG. Therefore, TSD assume the activity will match in final submission.

➤ **Modelling and other areas of further explanation:**

- Modelling of financial pressure:

You have elected to adopt the 'Enhanced Tariff Offer' option for its 2015/16 tariff services. Under this option foundation trusts will receive a higher marginal rate on extra emergency admissions of 70% (up from 30%), but a lower marginal rate on specialised services of 70% (down from 100%).

In the annex submitted to Monitor you have indicated that the impact of this has been modelled in line with our guidance in the 'NHS clinical income bridge – 'other adjustments' line, however when reviewing the detailed financial template it is not clear that this is the case.

We have released technical guidance on applying Monitor's 2015/16 financial pressure assumptions which can be found on our website². We acknowledge that you may not have seen this when compiling your draft plan. Please update your final operational plan as appropriate.

Please see below a bridge analysis between the Trust's 14/15 FOT and the proposed income value included in the 15/16 plan:

	£m
FOT	201.8
Add local CCG discount less penalties 14/15	1.9
Add 30% to 70% 08/09 MR benefit	3.8
Add Growth	2.0
Add Tail-gun	1.8
Add Income Template issues	0.5
Drugs Growth	2.0
Add change from move to NSRC tariffs	0.8
Add PTP growth	<u>0.3</u>
Sub Total	214.9
Less Tariff deflator	-3.0
Less Penalties/Discount to CCG	-7.5
Less SCG 30% marginal rate	<u>-0.5</u>
TOTAL	203.9

Other areas of feedback:

We noted an adjustment on 'NHS clinical income bridge – 'other adjustments' of £4.0m described as "SDH income adjustment to match CCG income", please provide some further information on what this balance is. If it is an adjustment to align your expected income with that of the commissioner this should only be done if your expectation is that you will not be paid for the over-performance on the contract. Our position on plans is that they should reflect what the most likely case even if this differs from the CCG's view, albeit we would of course encourage agreement on what is a realistic level of activity and income on both sides.

The original tariff offer meant a lower overall plan for the CCG. The reduction of £4.0m in NHS Clinical income represents the adjustment made by the Trust to match the income envelope offer from the CCG. Under ICO a different contracting arrangement was proposed which included risk share. In the final annual plan the CCG contract has been adjusted back to the £160.4m offer although at the submission stage the Trust is currently operating under a full national tariff arrangement with penalties operating in full. Discussions with the CCG and NHS England continue to work towards the risk share agreement that enables the ICO changes to occur without the need for contractual discussions for each individual service change.

We would like to obtain more detail on the following movements; please ensure this is included in your final operating plan submission:

- The reason(s) for the movement in non-recurrent income from £7.3m in 2014/15 to £20.3m in 2015/16
- The reason(s) for the movement in non-recurrent expenditure from £5.7m in 2014/15 to £4.3m in 2015/16

Non-Recurring Income April submission:

The Non-recurring Income detailed as being removed in 1415 is £1.9m other income, and £5.4m intercompany transactions with Torbay and Southern Devon Health and Social Care Trust (TSD) that will be unwound on integration.

In the 15/16 Non Recurrent income section, we have £4.3m Vanguard income assumed, £0.937m other income generation non-recurrently.

Within contract Healthcare income we had; £2.4m of back log with our main Commissioner.

We also had non recurring items relating to the integration of TSD of £12.6m. Contract Income of £9.5m relating to TSD's loss of a West Devon contract and £3.0m intercompany transactions unwinding with South Devon HFT.

Non-Recurring Expenditure April Submission:

Non recurring 1415 CIP Pay £(2.745m)

ICO* 1415 pay costs £0.94m

Agency spend 1415 £3.667m

Non recurring 1415 CIP Non Pay £(2.808m)

Other non-recurring expenses £1.122m

Total £0.176m

Total excluding the CIPs b/fwd. £5.729m cost reduction

*ICO (integrated care organisation set up costs)

Note the intercompany costs unwound in the FYE of prior year cell NOT the N/R costs cell which was an error and should be added to the non recurrent cost to match non recurrent income.

1516 N/R costs in April Submission are:

Transition costs £1.238m (ie the pay element of the Vanguard income)

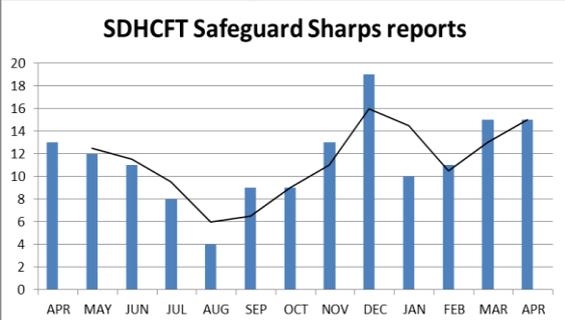
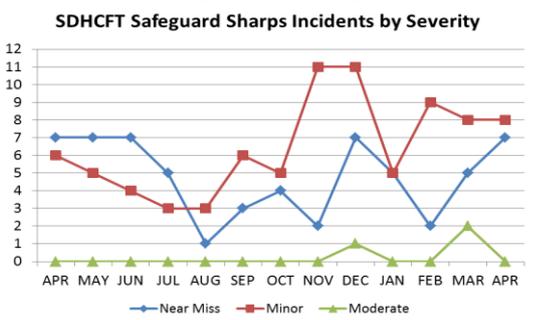
Transaction costs £3.105m (non pay element of Vanguard income)

Total £4.3m expenditure

Appendix 1 - Activity

setting	2014/15 Plan V2.0		2013/14 Baseline 2014/15		2014/15 Month 12		15/16 V1.7 of the plan Demand		15/16 V1.7 of the plan Capacity		DEMAND		Explanation
	Events	Income £	Events	Income £	Events	Income £	Events	Income	Events	Income	% change	% change	
A&E	77,661	£7,937,382	77,619	£7,949,601	78,163	£8,116,226	79,518	£9,007,080	79,518	£9,007,080	1.73%	10.98%	15/16 tariff increased A&E tariffs
ACC	3,153	£3,392,817	2,984	£3,317,415	3,307	£3,462,727	3,314	£4,051,649	3,314	£4,051,649	0.21%	17.01%	Move to NSRC from local tariff
Day Case	31,465	£25,086,377	30,909	£24,734,719	31,778	£24,993,458	34,219	£25,567,399	31,316	£23,828,210	7.68%	2.30%	sensible
Elective	5,999	£17,293,043	5,447	£16,515,240	4,935	£15,768,818	5,287	£16,178,944	5,210	£15,959,926	7.13%	2.60%	Activity - 14/15 20% down on plan and 10% down on 13/14
New	106,311	£14,995,057	104,798	£14,402,663	105,893	£14,976,444	103,667	£15,236,378	102,041	£14,976,113	-2.10%	1.74%	Demand is down as 2,000 less events than 14/15 and 3,800 down re capacity. Was there lots of NR investment to deliver OP 1st?
F-Up	258,141	£27,121,587	258,421	£26,982,672	265,131	£28,349,824	288,288	£30,270,777	265,106	£28,048,148	8.73%	6.78%	Reasonable
NCC	2,688	£1,170,279	2,816	£1,235,753	3,017	£1,333,963	3,115	£1,622,794	3,115	£1,622,794	3.25%	21.65%	Move to NSRC from local tariff
Non-Elect	26,481	£49,485,861	26,038	£49,153,257	27,830	£53,263,481	26,390	£50,358,147	26,390	£50,358,147	-5.17%	-5.45%	15/16 tariff decreased NEL tariffs
Non-Elect	3,362	£5,141,662	5,128	£5,206,330	5,370	£5,350,565	5,071	£5,205,402	5,071	£5,205,402	-5.57%	-2.71%	15/16 tariff decreased NEL tariffs
Radiology	0	£1,793,028	42,013	£1,444,571	43,222	£1,519,341	46,132	£1,646,332	46,132	£1,646,332	6.73%	8.36%	
Radiology	0	£3,538,800	32,493	£3,172,855	27,959	£3,058,952	27,669	£2,873,598	27,669	£2,873,598	-1.04%	-6.06%	
Grand Tot	515,262	£156,955,894	588,666	£154,115,077	596,605	£160,193,800	622,670	£162,018,500	594,882	£157,577,399			

REPORT SUMMARY SHEET

Meeting Date:	27 th May 2015																																																																																				
Title:	Facilities Management, Health and Safety & Medical Devices Key Performance Indicators: Exception report																																																																																				
Lead Director:	Director of Estates & Commercial Development																																																																																				
Corporate Objective:	1. Safest care; 3. Best experience; 6. Delivering improved value:																																																																																				
Purpose:	Information/Assurance																																																																																				
Summary of Key Issues for Trust Board																																																																																					
<u>Strategic Context:</u>																																																																																					
Compliance with Acts, National standards, and Regulatory Frameworks e.g. CQC, in relation to Estates and Facilities Management, The Environment, Health and Safety, and Medical Equipment.																																																																																					
<u>Key Issues/Risks and Recommendations:</u>																																																																																					
<p>The key issues/risks from the paper presented are:</p> <ul style="list-style-type: none"> Continued increased number of incidents and levels of harm from Sharps injuries;- Clinical subgroup of the H&S committee are currently developing an action plan. 																																																																																					
<div style="display: flex; justify-content: space-around;"> <div style="width: 45%;"> <p>SDHCFT Safeguard Sharps reports</p>  <table border="1"> <caption>SDHCFT Safeguard Sharps reports (Estimated Data)</caption> <thead> <tr><th>Month</th><th>Reports</th></tr> </thead> <tbody> <tr><td>APR</td><td>13</td></tr> <tr><td>MAY</td><td>12</td></tr> <tr><td>JUN</td><td>11</td></tr> <tr><td>JUL</td><td>8</td></tr> <tr><td>AUG</td><td>4</td></tr> <tr><td>SEP</td><td>9</td></tr> <tr><td>OCT</td><td>10</td></tr> <tr><td>NOV</td><td>13</td></tr> <tr><td>DEC</td><td>19</td></tr> <tr><td>JAN</td><td>10</td></tr> <tr><td>FEB</td><td>11</td></tr> <tr><td>MAR</td><td>15</td></tr> <tr><td>APR</td><td>15</td></tr> </tbody> </table> </div> <div style="width: 45%;"> <p>SDHCFT Safeguard Sharps Incidents by Severity</p>  <table border="1"> <caption>SDHCFT Safeguard Sharps Incidents by Severity (Estimated Data)</caption> <thead> <tr><th>Month</th><th>Near Miss</th><th>Minor</th><th>Moderate</th></tr> </thead> <tbody> <tr><td>APR</td><td>7</td><td>6</td><td>0</td></tr> <tr><td>MAY</td><td>7</td><td>5</td><td>0</td></tr> <tr><td>JUN</td><td>7</td><td>4</td><td>0</td></tr> <tr><td>JUL</td><td>5</td><td>3</td><td>0</td></tr> <tr><td>AUG</td><td>2</td><td>3</td><td>0</td></tr> <tr><td>SEP</td><td>3</td><td>6</td><td>0</td></tr> <tr><td>OCT</td><td>4</td><td>5</td><td>0</td></tr> <tr><td>NOV</td><td>2</td><td>11</td><td>0</td></tr> <tr><td>DEC</td><td>7</td><td>11</td><td>1</td></tr> <tr><td>JAN</td><td>5</td><td>5</td><td>0</td></tr> <tr><td>FEB</td><td>2</td><td>9</td><td>0</td></tr> <tr><td>MAR</td><td>5</td><td>8</td><td>2</td></tr> <tr><td>APR</td><td>7</td><td>8</td><td>0</td></tr> </tbody> </table> </div> </div> <ul style="list-style-type: none"> The demand on estates response maintenance services has increased and performance has dropped over the last two months with amber and red ratings on the dashboard this month. This could be an early warning sign of an estate under pressure. 		Month	Reports	APR	13	MAY	12	JUN	11	JUL	8	AUG	4	SEP	9	OCT	10	NOV	13	DEC	19	JAN	10	FEB	11	MAR	15	APR	15	Month	Near Miss	Minor	Moderate	APR	7	6	0	MAY	7	5	0	JUN	7	4	0	JUL	5	3	0	AUG	2	3	0	SEP	3	6	0	OCT	4	5	0	NOV	2	11	0	DEC	7	11	1	JAN	5	5	0	FEB	2	9	0	MAR	5	8	2	APR	7	8	0
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Recommendations:																																																																																					
<ul style="list-style-type: none"> Workstream 5 and Trust Board to monitor and receive assurance on the action plan in place to address the Sharps incidents. A comparative analysis to be undertaken on response maintenance to assess the risk and consider if this is a symptom of an increasingly fragile estate with increased failures. 																																																																																					
<u>Summary of ED Challenge/Discussion:</u>																																																																																					
Performance and the new set of indicators for 15/16 have been challenged, discussed and agreed in executive forums for both SDHCFT and TSDHCT namely Workstream 5 and the capital and infrastructure steering group.																																																																																					
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A Governor observer sits on Workstream 5.																																																																																					
<u>Equality and Diversity Implications:</u>																																																																																					
All requirements considered as they apply to the EFM agenda																																																																																					

Report to: Trust Board
Date: May 2015
Report From: Director of Estates & Commercial Development
Report Title: Facilities Management, Health and Safety & Medical Devices Key Performance Indicators: Exception report

1. Review of 2014/2015 Indicators

A new suite of Key Performance Indicators (KPI) for the financial year 2015/16 have been reviewed and approved by Workstream 5. This has resulted in a number of enhancements to improve the scope and/or quality of reporting.

2. South Devon Healthcare exception report for April 2015

Table 1 below identifies changes between months. Where indicators remain red, more information is shown in Table 2 together with any areas of concern/note for the Trust Boards attention. The detailed monthly performance table is shown in Appendix A

Table 1 Changes between March 2015 and April 2015 Scorecard Indicator

Green 	Amber 	Red 	March 2015 Position	April 2015 Position
Improving Indicators				
4.1b: % of OUTSTANDING/To Be Done Schedule Service Work Requests (<2months from Required by Date) [67% up to 76%]				
4.2d: % of OUTSTANDING/To Be Done Reactive Work Requests (<3 months from Required by Date) [76% up to 81%]				
Deteriorating Indicators				
6.5: % of Compliant Fire Audits				
Red Rated Indicators with no change				
1.1g: % of Estates Reactive work resolved within target - <1- 4 Day (Urgent)				
4.1a: % of COMPLETED Scheduled Service Work Requests (in month) [48% down to 42%]				

Table 2: Red rated indicators in Month or Areas with Specific Cause for Concern		Anticipated timeline for improvement
1.1g	% of Estates Reactive work resolved within target - <1- 4 Day (Urgent) Estates services are stretched, performance across these indicators indicate estates resources targeted at responsive maintenance away from PPM . This could be a symptom of an increasingly challenged estate.	Qtr 1 2015-2016
4.1a	% of COMPLETED Scheduled Service Work Requests (in month) [48% down to 42%] A significant backlog from the two previous months is being addressed by allocating more of technician time to schedule servicing; equates to 160 out of total 383 Work Requests. Areas where there is a high percentage of non-availability are the Respiratory Clinic; devices are with patients.	Qtr 2 2015-2016
6.5	% of Compliant Fire Audits This month 4 local audits were carried out with 3 being non-compliant due to fire doors being wedged open. Staff awareness is constantly being raised at all training sessions and when conducting the audits.	July 2015

Appendix A: Estates and Facilities – KPI's South Devon Healthcare Foundation Trust –April 2015

	Area		Target	Monthly Performance												Current year to date (Complete Months)			Risk Threshold		
	Description		Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	Status	RAG Thresholds		
Estates																					
1.1a	Number of PPM items planned per month		Variable	1017												1017					
1.1b	PPM (Estates) % success against plan		100%	89%											100%	89%		R<85%	A85-94%	G>95%	
1.1c	Planned Maintenance % called for but not available		0%	0%											0%	0%		R>15%	A15%-6%	G≤5%	
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	31											31					
1.1e		Emergency – P1	<2 Hour	100%	90%											100%	90%		R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	217												217				
1.1g		Urgent – P2	<1- 4 Days	100%	88%											100%	88%		R<90%	A90-94%	G≥95%
1.1h		Routine – P3 + P4	Total Requests	Variable	345												345				
1.1i	Routine – P3 + P4	<7- 30 Days	100%	86%											100%	86%		R<85%	A85-89%	G≥90%	
1.2	Number of Estates Internal Critical Failures		0	0											0	0		R1	-	G0	
Facilities																					
2.1	Compliance Very High Risk Cleaning Audit		98%	100%											98%	100%		R<95%	A95-97%	G≥98%	
2.2	Compliance High Risk Cleaning Audit		95%	98%											95%	98%		R<90%	A90-94%	G≥95%	
2.3	Compliance Significant Risk Cleaning Audit		85%	99%											85%	99%		R<80%	A80-84%	G≥85%	
2.4	Compliance Low Risk Cleaning Audit		75%	92%											75%	92%		R<70%	A70-74%	G≥75%	
2.5	No. of Environment Health (food hygiene) events		0	0											0	0		R1	-	G0	
Waste																					
3.1	Total Tonnage per month all waste streams		157	127											157 or Less	127		R≥173	A158-172	G≤157	
3.2	% of Total tonnage Recycled Waste		31%	30%											31%	30%		R≤24%	A25-30%	G≥31%	
3.3	% of Total tonnage Landfill Waste		37%	34%											37%	34%		R≥44%	A38-43%	G≤37%	

3.4	% of Total tonnage of Clinical Non-Burn waste	18%	19%											18%	19%		R≥25%	A19-24%	G≤18%
3.5	% of Total tonnage of Clinical Burn waste	11%	12%											11%	12%		R≥17%	A12-16%	G≤11%
3.6	% of Total tonnage of Clinical Offensive waste	3%	5%											3%	5%		R≤1%	A2%	G≥3
3.7	Number of Waste Audits undertaken per month	10	10											10	10		R≤5	A6 - 7	G≥8
3.8	% of Compliant Waste Audits	100%	100%											100%	100%		R<90%	A90-94%	G>95%
3.9	% Compliance of Statutory Waste Audits	100%	100%											100%	100%		R<90%	A90-94%	G>95%
Health & Safety																			
5.1	Number of RIDDOR Incidents	0	0											0	0		R≥3	A1-2	G0
5.2	Number of days lost (due to incidents in month)	65	23											65	23		R≥81	A66-80	G≤65
5.3	Non-patient incidents resulting in minor harm	30	24											30	24		R≥36	A31-35	G≤30
5.4	Non-patient incidents resulting in moderate harm	1	3											1	3		R≥4	A2-3	G≤1
5.5	Number of near misses	16	18											16	18		R≤10	A11-15	G≥16
5.6	% of Staff receiving H & S training in month	90%	89%											90%	89%		R<80%	A 80-89%	G≥90%
Fire																			
6.1	No. of Fires	0	0											0	0		R1	-	G0
6.2	Number of fire alarm activations	12	7											12	7		R>15	A12-15	G<12
6.3	Fire alarm activations attended by the Fire Service	6	3											6	3		R>11	A6-11	G<6
6.4	No of Fire Audits undertaken	8	4											8	4		R<4	A8 - 4	G>8
6.5	% of Compliant Fire Audits	100%	25%											100%	25%		R<90%	A90-95%	G>95%
6.6	% Fire Safety Risk Assessments (Reform Order) in date	100%	90%											100%	90%		R<90%	A90-95%	G>95%
6.7	% of Staff receiving Fire Safety training in month	90%	82%											90%	82%		R<80%	A 80-90%	G>90%

Appendix B: Medical Devices / Women, Children, Diagnostics & Therapies Division – KPI's Southern Devon Healthcare Foundation Trust –April 2015

	Area	Target	Monthly Performance												Current year to date (Complete Months)			Risk Threshold			
			Description	Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	Status	RAG Thresholds	
	Medical Devices																				
4.1	No of devices for Schedule Service (in month)	Variable	385												Variable	385					
4.1a	% of COMPLETED Scheduled Service Work Requests (In Month)	100%	42%												100%	42%		R<70%	A71%-79%	G≥80%	
4.1b	% of OUTSTANDING/To Be Done Schedule Service Work Requests (<2 Months from Required Date)	100%	76%												100%	76%		R<60%	A60%-79%	G≥80%	
4.1c	% of OUTSTANDING/To Be Done Schedule Service Work Requests (over rolling 3 Year Period)	0%	4%												0%	4%		R>10%	A5% -9%	G<5%	
4.2a	% of REACTIVE Work Requests, Category Emergency, COMPLETED within 1 Working Day	100%	100%												100%	100%		R<85%	A85-94%	G≥95%	
4.2b	% of REACTIVE Work Requests, Category Urgent, COMPLETED within 3 Working Days	100%	100%												100%	100%		R≤80%	A81%-94%	G≥95%	
4.2c	% of REACTIVE Work Requests, Category Routine, COMPLETED within 10 Working Days	100%	100%												100%	100%		R<80%	A81%-89%	G≥90%	
4.2d	% of OUTSTANDING/ To Be Done Reactive Work Requests(<3 Months from Required By date)	100%	81%												100%	81.1%		R<60%	A60%-79%	G≥80%	
4.3	No. of Devices requested/not found for Scheduled Service	Variable	118												Variable	118					
4.4	No. of incidents involving Medical devices	4	3												4	3		R≥9	A5 - 8	G≤4	

Report to: Acute Board
Date: May 2015
Report From: Director of Estates & Commercial Development
Report Title: Health and Safety Performance Update for SDHCFT

1. Analysis of Performance

Table 1 below, shows the number of incidents reported by month over a rolling 13 month period of from 1st April 2014 to 30th April 2015 (inclusive).

Table 1

TRUST	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAR
SDHCFT	49	51	53	64	62	48	60	57	49	44	45	43	35	625

Chart 1 below shows that there has been a decrease in the number of incidents reported in April for the six month in a row. 35 reported incidents well below the average of 48 per month.

Chart 1

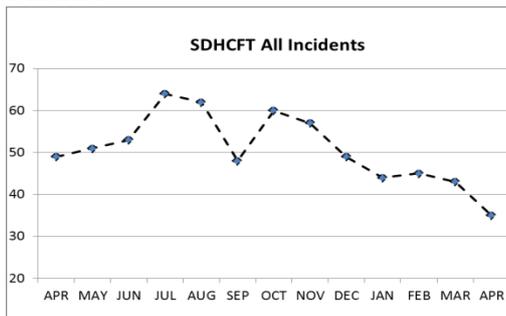


Chart 2

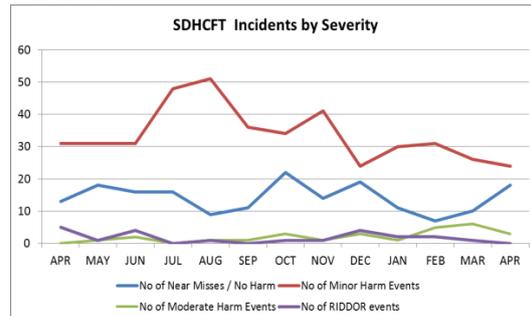


Chart 2 above shows the total monthly incidents by severity for SDHCFT. Although not shown here the Health and Safety team have reported two RIDDOR incidents due to Violence and Aggression experienced in the workplace. Security are dealing with the incident investigation and these are included in their report and not the chart above in order to avoid duplication of reporting.

Chart 3 below shows the breakdown of categories of incidents, and during April the highest numbers of incidents reported were related to Sharps, and as seen in Chart 4, Sharps remain the highest category overall.

Chart 3

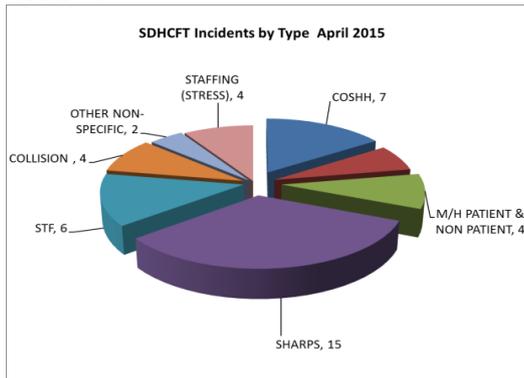
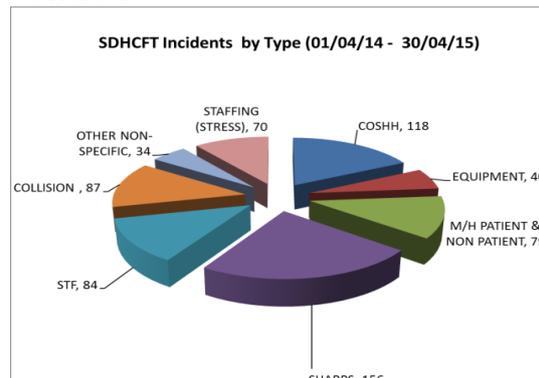


Chart 4



2. Key Issues:

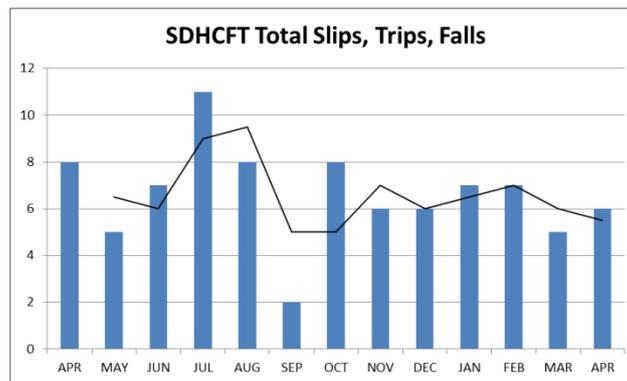
2.1 Days Lost

The monitoring of incidents that have occurred since 1 April 2014 shows that 1348 working days have been lost due to accidents at work. This number continues to rise as staff remain absent at this time due to accidents at work. The issues regarding absenteeism, and inaccuracies in reporting has been discussed by the Health and Safety Committee and the Promoting Wellbeing Group. As a result a Working Party including representatives from HR, Health and Safety, Occupational Health and Workforce Planning, has been established to specifically investigate staff sickness absence.

2.2 Slips, Trips and Falls (STF)

Chart 5 below shows the level of STF incidents remain fairly constant. There were 6 incidents reported during April 2015. Of these reports, all involved employees, and three involved slips on wet floors. The Non-Clinical Health and Safety Group have investigated slips, trips and falls for any common factors and are in the process of trialling a new method of dealing with spillages in common areas such as corridors and entryways.

Chart 5



2.3 Manual Handling

Charts 6 and 7 below illustrate the number of reported incidents relating to Manual Handling of Inanimate Objects and Patient Handling over the last 13 months. April showed a slight decrease in both categories.

Chart 6

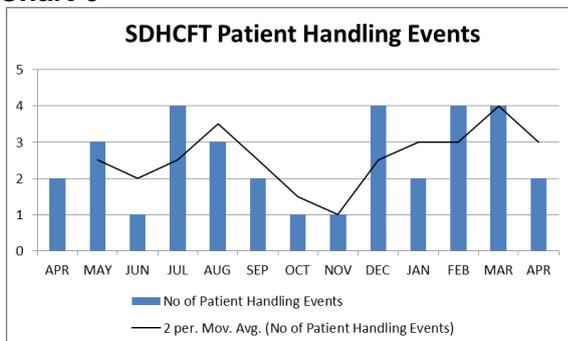
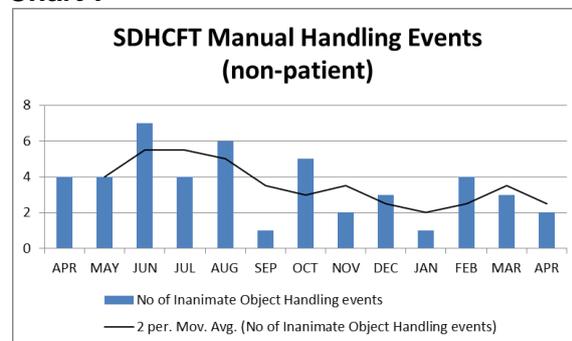


Chart 7



2.4 Sharps

Chart 8 (overleaf) shows the number of reports of sharps incidents on Safeguard following injury from sharps from 1st April 2014 to 30th April 2015. During April, there were 7 reports due to poor

disposal, 5 non-needlestick and 3 during use of a needle. Due to the continuing high number of reports the Health and Safety Clinical Group were tasked with producing a detailed action plan to address the situation. This has been discussed at this group meeting and the members agreed each incident must have a full investigation and a procedure has been drafted for this action.

Chart 8

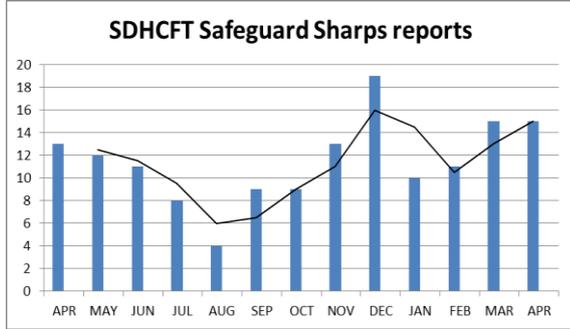
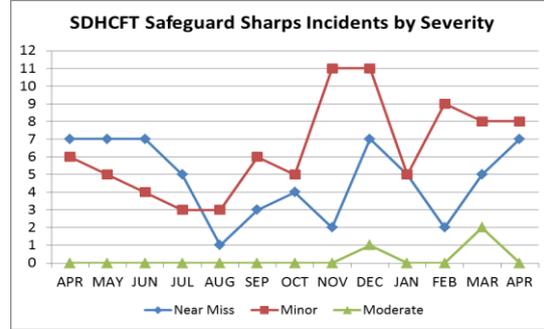


Chart 9



2.5 Stress

As can be seen in Chart 10 below there was a reduction in referrals received by OH for work stress during April 2015. These referrals were spread over various departments within the Trust and there is no common work area identified within the data supplied. The incidents reported on Safeguard (Chart 11) are minimal.

Chart 10

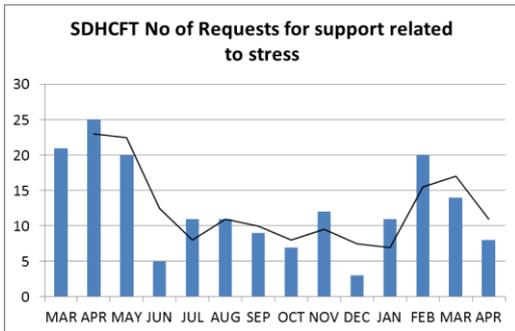


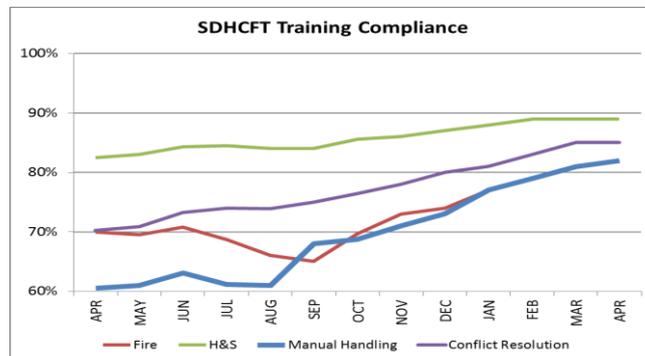
Chart 11



2.6 Training

Chart 12 below shows that the mandatory training figures for SDHCFT still continue to improve and are now all above 80%.

Chart 12



3. Conclusion

The Board are asked to note the monthly Health and Safety performance report up to end of April 2015.

REPORT SUMMARY SHEET

Meeting Date:	27 th May 2015
Title:	HIS Half-Yearly Report – Trust IT Projects Update
Lead Director:	Gary Hotine, Director of Health Informatics
Corporate Objective:	Safest care; No delays; Best experience; Promoting health; Delivering improved value.
Purpose:	Assurance
Summary of Key Issues for Trust Board	
<u>Strategic Context:</u> The ICT Strategy has previously been approved by the Trust Board. The IT Programme that supports the Strategy consist of numerous projects that are summarised in this report.	
<u>Key Issues/Risks and Recommendations:</u> The ICT Strategy is supported by significant financial investment, some subject to national funds with commensurate Trust obligations regarding delivery and benefits. Delivery of the ICT Strategy is also a significant enabler for a number of Trust-wide and Divisional CIP. The delivery of the ICT Strategy is also a core requirement for the lead Commissioner in their support for the ICO. Financial constraints for 2015/16 investment will impact the pace of delivery of the IT Programme. The delivery of the ICT Strategy mitigates several risks identified on the HIS/Corporate Risk Register, and also supports the delivery of health records to the standards required of the Care Quality Commission's relevant Key Lines of Enquiry (KLoEs). The senior manager of Health Records has had to take leave at short notice due to illness and the HIS Director is personally managing their direct reports to maintain focus on the department's action plans.	
<u>Summary of ED Challenge/Discussion:</u> IT Projects that are directly supporting of the ICT Strategy reports formally through a Project Board with ED involvement, either as Chair or full membership. Regular exception reporting of all project's status is delivered regularly to Workstream 3 (Finance Committee) which has CE, DoF, COO, DoHIS and other ED attendance. Additionally, the Senior Business Management Team receives regular updates on these projects. By exception the Executive Directors' meeting receives updates on specific projects. All of the above provide challenge and discussion.	
<u>Internal/External Engagement including Public, Patient and Governor Involvement:</u> Significant internal clinical engagement is undertaken with the Chief Clinical Information Officer taking a lead role. Certain projects have direct patient/public users of the systems being implemented and feedback is provided by this route. Governors sit on Workstream 3 and therefore are formally engaged, and in addition a lead governor was involved in the review of the ICT Strategy and is informally updated periodically on the progress of the Programme.	
<u>Equality and Diversity Implications:</u> Each individual project has been assessed against Equality & Diversity criteria to understand and where possible mitigate any implications.	

PUBLIC

Trust IT Projects Update

Clinical Portal/Repository (IT programme priority #1)

Active Project RAG Status

G

In the last six months the implementation phase of the project started with the InterSystems' HealthShare product. The clinical safety evaluation identified a potential issue regarding the presentation of laboratory results information. To mitigate this the integration of the Trust's laboratory viewer has been integrated whilst the necessary testing progresses to address the issue identified. The testing and configuration of the functionality to support clinical teams managing specific condition-cohorts of patients by alerting them when patients are admitted to A&E or admitted as inpatients is nearing completion with the Heart Failure service. Additionally, the Chief Clinical Information Officer (CCIO) has identified the first phase rollouts of phase 1 functionality (Acute information) to staff working in the community who will significantly benefit.

Electronic Prescribing (IT programme priority #2)

Active Project RAG Status

G

The re-launch of our ITT took place as planned in November and the procurement was successful in achieving multiple bidders with products that met our requirements. We have since selected a Preferred Bidder and are in the process of notifying both these and the unsuccessful bidders. The expectation is that contracts will be signed at the end of the summer with the implementation starting in the Autumn. This will result in the first go-live activity in Q2 2016.

[IT programme priority 3 is non-SDHCFT]

Order Comms (OCS) (IT programme priority #4)

Active Project RAG Status

A

Following positive feedback the decision was made by the OCS Project Board to recommend roll out community-wide (i.e. both GP and Acute). The updated business was submitted through the Leadership Group, Finance Committee (Workstream 3) and the Trust Board and approved in February. Commencement of the implementation has started with a phased roll-out beginning this Summer.

Clinical Handover and Task Management System (IT programme priority #5)

Active Project RAG Status

G

The procurement of a system to support clinical handover and clinical task management has completed with the NerveCentre solution being purchased. The kick off meeting took place on the 15th May and the project governance has been established with the Medical Director chairing the Project Board. We are also using the Horizon Institute IHI methodology to augment the standard PRINCE2 project management methodology to support the implementation. A number of additional benefit areas have been identified which will help the Trust address challenges around CQUIN achievement in several areas (e.g. sepsis, acute kidney injury, care planning summary production). A key enabler is equipping clinical staff with iPod Touch/iPhone/iPad devices, and the 'bring your own device' strategy has received prioritised funding this financial year in support of this, enabling staff to receive a co-payment each month for using their personally-owned devices instead of being issued with a Trust-provided one.

Clinical Document Management System (CDMS) (IT programme priority #6) Active Project RAG Status

A

This project was approved by the Board subject to the second national technology fund providing half of the costs. Unfortunately we did not receive this and as a result have to identify the shortfall from local funds. This is in progress with a loan being the preferred solution, but the timescale in approving and attaining this means the project cannot start in earnest until this is in place, which is expected in the autumn. A CDMS is critical to the overall ICT Strategy as it provides a solution for the multitude of areas dependent on paper in lieu of specialised IT systems for clinical notes. It is expected to take at least a decade to provision these areas with IT systems, so having a CDMS solution deployed in the coming 18 months is vital as without it clinicians would not be able to see the whole patient record via the Portal, essential to putting the Portal and associated IT at the centre of clinical processes.

Letter Replacement Project (IT programme priority #7)

Active Project RAG Status

G

Approximately 70% of specialties have now been implemented. The project has reached a tipping-point where specialties are fighting to have the system introduced to them. Following a request from Dr Sinclair as part of a mitigation plan to address a clinical safety issue, we have prioritised Ophthalmology ahead of Trauma and Orthopaedics and Obstetrics/Gynaecology.

ED & MIU Project (IT programme priority #8)

Active Project RAG Status

R

The on-going issues we have experienced in getting the system live have slowly been addressed. A commitment was given to the Board to have the system live at the end of June 2015. Pre-user acceptance testing (UAT) identified some additional issues which have affected this by a handful of weeks. A formal go-live date now has been set for 21st July (2015). With the creation of the ICO on 1/8/2015 it had been suggested that this would be the best go-live date, but was rejected for operational reasons. We continue to review the coding functionality and technical side of "Draw No More" as this will be a key enabler of achieving the national CQUIN around A&E coding performance.

PatientsKnowBest (PKB) (IT programme priority #9)

Active Project RAG Status

G

The processes to scale the registration of patients using elective pathways via the DRSS have had to be suspended following the unplanned and previously unidentified requirement that DRSS introduced to fund a revenue stream of circa £45k to support them in this. We have therefore revisited the planned approach and will be process re-engineering the Breast Care Unit (BCU) clinical workflow using PKB and other ICT-Strategy delivered solutions to facilitate this. This will take around a year to deliver, but will result in a comprehensive solution for patient/carer/client electronic interaction with services, not just the BCU. In addition the IT support for health coaches and patients using PKB as part of the ICO Care Model is being evaluated as a potential 'quick win' by Prof. Ben Benjamin.

Medisoft (IT programme priority #10)

Active Project RAG Status

G

The first phase - AMD (Macular) - went live from the 24th November 2014. The second phase - Diabetic Retinopathy – went live on 4th March 2015.

UltraGenda (PAS Replacement) System (IT programme priority #11)

Active Project RAG Status

A

Due to capital availability it will only be possible to move forward with the implementation of an Interface from UltraGenda to PAS. The IAO has visited the Heart of England NHS Trust to revalidate the approach. Having done so we have now scheduled for the key HIS interface engineer attend the same trust as part of a lessons-learnt exercise in the technical integration work. We need the benefits from the Cancer Services phase 1 (Ricky Grant) implementation to assist with creating the Business Case and the capital required as part of the 2016/17 capital programme to progress the subsequent phases.

MIG (IT programme priority #12)

Active Project RAG Status

A

Due to on-going issues with all primary care systems used in Southern Devon providing working interfaces, and commercial issues associated with use of the MIG, no progress has been made. We are monitoring an alternative technology due to be delivered as part of the national "GP Systems of Choice 2" contract. Additionally, the HIS has engaged directly with the primary care systems suppliers to identify alternatives.

Consolidated Printing (IT programme priority #13)

Active Project RAG Status

G

The first stage of this project has identified and delivered CIP savings of £40k. The HIS project manager resource has been provided to the CIP Director to support this project.

[IT programme priorities 14, 15, and 16 are non-SDHCFT]

Additional Spectralis (Eye Clinic) (IT programme priority #17)

This project has completed and the additional cameras in Ophthalmology are in use and integrated with the IT system.

Car Parking (IT programme priority #18)

Active Project RAG Status

A

Due to the delay in progressing the car parking project little IT progress in support of this has been made in the last six months.

VitalPAC

A decision was made to implement the fluid balance part of the system and the project manager is planning the rollout of this. The clinical benefits are now widely felt to be adding value to the Trust. This project is likely to transition to 'business as usual' (BaU) during the next six months.

CCW Upgrade

There had been significant problems with the system and we worked with the supplier to resolve these. The system is now fully live in Coronary Care. The project closure report was taken to Workstream 3 and will be updated once the two cardiac catheter laboratories are both working in parallel, which will enable the full benefits realisation assessment to also be reported to the Workstream.

BoardPacks

Following a successful implementation in support of the Board's paperless way of working, and following the resolution of some key supplier issues, the system is now additionally supporting several of the Board's Workstreams. The system is now used across SDHFT, TSDHCT & SDTCCG, including cross-organisational meetings. There are also plans by the Company Secretary to use BoardPacks to support key Governor Roles.

Theatre Listing Booking

This project is to streamline the theatre listing process. The work has started but is punctuated due to the A&E/ED system work which must take priority.

Neurophysiology

The EEG and EMG systems were installed early in September, with additional IG discussions taking place regarding how the EEG equipment communicates data to the servers, which would offer better functionality for the staff using the system. The system subsequently went live as planned.

BadgerNet Upgrade

Support for the neonatal unit's Badger v3 system ceased on the 31st December. The project to migrate to BadgerNet was completed in advance of this and the new system is live.

OIS in Ophthalmology

The system became fully operational in January and is an enabler for Ophthalmology to provide virtual clinics.

Galaxy System Migration

The system was successfully migrated on the 14th May and avoided a six-figure database licensing financial cost pressure.

PICIS Upgrade

The system was migrated at the end of March successfully and now has all anaesthetics recording in theatre done electronically on Windows 7 devices as the previous ones (Windows XP) were becoming unsupported by Microsoft.