South Devon Healthcare NHS Foundation Trust

SDHFT Board of Directors

SDHFT Public Board of Directors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

01 July 2015 13:30

AGENDA

1	Apologies - Lesley Darke Owner : Chairman Note	1.30 pm
2	Minutes of the Board Meeting held on the 27th May 2015 and outstanding actions Owner : Chairman Approve	
	15.05.27 - Board of Directors Minutes Public.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 (Inpatient Survey/CQC Update/Child Safeguarding) Owner : DPPNPE Discuss/Assurance	1.35 pm
	DoN CQC update.pdf 13	
	DoN Inpatient Survey.pdf 17	
	DoN Safeguarding Children.pdf 25	
4.2	Report of the Medical Director (Revalidation) Owner : MD Information/Assurance	1.55 pm
	Report of the Medical Director - Revalidation.pdf 45	
5		
5.1	Report of the Chairman Owner : Chairman Note	2.10 pm
5.2	Report of the Chief Executive	2.20 pm

Owner : CE

Note

Report of the Chief Executive.pdf 96

5.3 Car Parking Business Case 2.30 pm
Owner : DECD

Decision

Car Parking Business Case.pdf 107

6 Workforce and Organisational Development

6.1 Report of the Interim Director of Human Resources 2.50 pm
Owner : IDHR

Information/Assurance

Report of the Interim Director of HR.pdf 147

7 Engagement and Partnerships

8 Council of Governor Issues 3.00 pm
Owner : Chairman

Note

9 Performance

9.1 Monthly Finance and Performance Report 3.05 pm
Owner : DoF/COO/DPPNPE

Information/Assurance

Performance and Finance Report - Public.pdf 163

9.2 Report of the Chief Operating Officer
Owner : COO

Information/Assurance

9.3 Report of the Director of Estates and Commercial Development
Owner : DECD

Information/Assurance

Report of the Director of Estates.pdf 185

10 Assurance

Owner : Chairman

10.1 Audit and Assurance Annual Report 3.15 pm
Owner : A&A Chair

Decision

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11 Governors' Question Time 3.20 pm
Owner : Chairman

Discuss

12 Date of Next Meeting - 1.30 pm, Wednesday 27th May 2015
Owner : Chairman

Note

13 Exclusion of the Public 3.30 pm
Owner : Chairman

South Devon Healthcare NHS
NHS Foundation Trust

MINUTES OF THE SOUTH DEVON HEALTHCARE FOUNDATION TRUST BOARD MEETING HELD IN THE ANNA DART LECTURE THEATRE, TORBAY HOSPITAL ON WEDNESDAY 27TH MAY 2015

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	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	Chief Operating Officer
	Mrs E Hobson	Torbay and Southern Devon Health and Care Trust Representative (part)
	Mr G Hotine	HIS Director
	Dr J Lowes	Medical Director
	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
	Mrs L Storey	Deputy Director of Human Resources

Mrs C French	Lead Governor	Mr R Allison	Governor
Mr D Brothwood	Governor	Mrs S Gardner-Jones	Governor
Ms B Inger	Governor	Mrs A Hall	Public Observer

Before commencing the meeting the Chairman informed the Board that the Trust had recently been awarded a Top Hospitals Award by CHKS. He wished to place on record the Board's congratulations on receiving this award, especially given the current levels of demand the Trust was managing.

The Chairman then asked the Board to note that for this and future meetings a table would be put up on the whiteboard showing how each Board report linked to the Trust's Corporate Objectives.

ACTION

90/05/15 **Apologies**

Apologies were received from Mr Allen and Mr Ringrose. The Chairman wished the Board to be aware that Mr Ringrose was not in attendance at the request of both him and the Chief Executive, as he was required to attend a Care Trust Board meeting and provide training to new Torbay Council Councillors today.

91/05/15 **Minutes of the Meeting held on the 6th May 2015 and Outstanding Actions**

The minutes were approved as an accurate record of the meeting held on the 6th May 2015.

The following actions were discussed:

a) **Critical Care Unit and Main Entrance FBC** – member of Royal Family to open new unit – the Director of Estates and Commercial Development was establishing with the contractors a date when the unit would be ready for a royal visit. Once that had been ascertained the Chairman would take steps to secure a Royal visit.

b) **Report of the Interim Director of Human Resources** – nursing spend – this would be presented to the Board when the agenda allowed.

92/05/15 **Declaration of Interests**

Nil.

Quality, Patient Safety and Experience

93/05/15 Report of the Director of Professional Practice, Nursing and People's Experience

a) **Infection Control Annual Report**

The following was highlighted:

- The Trust had a target of less than 11 cases of CDiff associated with lapse in care for the year, and had experienced four.
- There had been no cases of MRSA.
- The local target for CDiff was 22 and the Trust had experienced 24. The CCG understood the reasons behind the numbers.
- When the report had been written the Trust had not had an norovirus outbreak for four years. Following that the Trust experienced an outbreak affecting a number of wards, particularly in the Hetherington Block. There did not appear to be any reason for the outbreak, but once it had finished a deep dive would be undertaken. It did appear that there was an issue around reporting of cases in the community before the outbreak in the Trust and this was being taken forward with Public Health.
- In terms of the outbreak and early indications it was noted that within the Trust a first trigger was vomiting in the Emergency Department and in this case it was known that surveillance was not as robust as it should have been. The impact on beds had been significant and was in different wards thereby reducing efficiency.
- Mr Furse queried the fact that it had been a long time since the last outbreak and queried the Trust's procedures. The DPPNPE said that the Trust had a Standard Operating Procedure to manage an outbreak and this had been followed. There were issues, however, with the information coming to the Trust from the community which was being addressed.
- The Chief Executive raised the Key Performance Indicators (KPIs) in the report around no bed closures due to norovirus of over 12 days and the Trust could be at the stage of breaching that target. She said that the Trust's environment made it difficult to implement full infection control

procedures and this needed to be considered when planning future investment – particularly in relation to side rooms. It was noted that an impact of the outbreak would be a reduction in the Emergency Department 4 hour target, and also the need to open escalation wards and associated costs.

- The use of single rooms in community hospitals was suggested and that this could be more easily facilitated once the Trust was an ICO. The Medical Director said that it was important not to see the ICO as the answer. The Trust needed to have closer links with Public Health and their intelligence to give the Trust an early warning of an outbreak to allow earlier planning and the ICO would not deliver this. The Chief Executive said that the use of community hospital beds was considered as part of the solution, however there were a number of reasons why it would not work this time, but it should be explored in the future as part of alternative pathways.

- The report contained performance against KPIs and only one was amber in relation to CDiff performance. It was noted that there was very good joint working across the community in terms of infection control.

- The report detailed a forward plan which was comprehensive and covered both the acute and community sector and was signed off by the CCG in collaboration with Public Health.

b) **Workstream 2 Minutes – 17th April 2015**

The Board noted the minutes, in particular the Workstream's priorities for the coming year. The Chairman noted that the Emergency Department risk register would no longer be reviewed by Workstream 2 and he asked where it would now be discussed. It was noted that it would be at Workstream 1.

94/05/15 Report of the Medical Director

The Medical Director informed the Board that he had asked that Workstream 1 receive a report on risks related to medical equipment produced by the Medical Electronics team. He was concerned that the Trust was at risk in respect of a lack of equipment since the rolling replacement programme ceased some time ago.

Strategy and Vision

95/05/15 Report of the Chairman

The Chairman said that the Board to Board with Monitor was taking place on Friday of this week, as part of the ICO transaction process. He reminded the Board that this meeting was part of the overall transaction process, albeit an important step.

The Chairman had been given early sight of the new public website that would go live on the 1st June. He encouraged the Board to have a look and added that it would provide the Trust with a better platform from which to work and convert to a website for the new ICO.

96/05/15 Report of the Chief Executive

The Chief Executive reported the following:

- The norovirus outbreak had affected the Emergency Department 4 hour performance which between the 18th and 25th May had dipped as low as 67%. It was now steadily improving, however not materially enough to change the month end average. The Chief Executive said that she could not have asked more of the Trust's staff in managing this outbreak and increased demand.

- The RTT challenge reminded in a small number of specialities.
- The Chief Executive had continued her induction visits and meetings.
- The first meeting of the TDA Transaction Board had taken place and the Chief Executive had met with the Chair of the Board. The TDA had particularly commended the clinical partnership between the two trusts and the joint work between the two Medical Directors and Directors of Nursing.

97/05/15 Integration Care Organisation Update – Due Diligence

The Director of Professional Practice, Nursing and People's Experience said that the Due Diligence report had been reviewed and updated since it was first published in 2013. The KPIs for the Care Trust had also been reviewed and no material issues had been found as part of this work. The report did set out the areas for the Trust to focus on in the first quarter of the acquisition period and work was taking place to resolve many of them during the implementation planning.

Mr Brockwell asked if written assurance from Torbay Council was being sought and the Director of Professional Practice, Nursing and People's Experience confirmed that it was.

Mr Furse noted the pressure on the social care budget and asked whether there was a risk to the Trust in terms of its forecasting as suggested by the report. The Director of Professional Practice, Nursing and People's Experience explained that the comment in the report was in respect of the Trust understanding its demographic and applying the right model in terms of care planning for that demographic in conjunction with the Council, CCG etc.

98/05/15 **Workforce and Organisational Development**

Nil.

Engagement and Partnerships

99/05/15 Council of Governor Issues

The Corporate Secretary said that the date for the ICO development session for new Governors had been confirmed as the 17th June at 3.00 pm.

Performance

100/05/15 Monthly Finance and Performance Report

The following was noted:

a) **Performance**

- The meeting noted that the CQC had published its latest draft CQC intelligence monitoring report and the Trust's rating had moved from a 4 to a 3. A full report would be provided at the next meeting.
- There would be an increase in bed closures due to the recent norovirus outbreak.
- Vigilance in terms of hand hygiene needed to continue.

- The number of incidents had increased from zero to 10 and the majority of these were falls. A deep dive was taking place looking at the incidents, however there did not appear at present to be any pattern to them. The outcome of the review would be taken to Workstream 1.

- Work continued to try to improve Friends and Family performance.

- The Chairman noted the number of regulators that Trust needed to respond to when it was having difficulties ie CQC; Monitor; NHS England; CCG; and media and asked if there was a way of reducing the time spent dealing with queries. This was acknowledged and the Director of Professional Practice, Nursing and People's Experience said that as themes would be common, one answer should be developed and then a more joined-up response could be made and a communications strategy put in place.

- The difficulties with RTT performance continued with Ophthalmology waits making up 50% of the challenge. Plans continued to be managed to address the backlog and the Trust was working with its commissioners to look at forward planning and how to redesign pathways for the future. In addition the Intensive Support Team had spent two days with the Trust and it was positive to note that they had not identified anything new to the Trust. They had highlighted very good practice, strong leadership and operational, clinical and commissioner engagement. Suggested areas of improvement were around the Trust's reporting systems and policy infrastructure and the team also suggested the Trust used their demand modelling tool.

- There had been deterioration in diagnostic performance which was linked to increased demand. Remodelling of the pathway had commenced to improve performance in the long term and also deal with the backlog.

- Stroke performance continued to be an issue. The Stroke team had been tasked with formulating a plan to enable the Trust to ring-fence stroke beds and this would be put in place from the 1st June.

- The Board noted that the number of cancelled operations would increase due to demand and the effect of the recent norovirus outbreak.

- The Chief Executive queried the staffing of the Vanguard Unit being brought in to help address the Ophthalmology backlog and the Chief Operating Officer said that an appointment had not yet been made but the team had a number of names and were in the process of validating skills etc.

- Mrs Taylor queried the drop in production of care planning summaries. The Medical Director said that although the new IT system would improve completion of them, the drop in performance was an indicator of system pressure. He added that that as the Trust could not wait for the new IT system to be in place to improve performance he had introduced a Task and Finish Group to take forward actions to improve performance.

b) **Finance**

- The Trust had realised a Continuity of Service Rate of 2, in line with plan.

- A surplus of £300,000 had been realised at month 1 – this was at full PbR, if the Trust moved to a risk share agreement this would reduce to £100,000.

- Not all of the CIP savings had been processed yet, but it appeared that they were in line with plan.

- The Chairman queried the first month's surplus and asked if it could be secured given current operational demands and likely ongoing demands. It was noted that any escalation action was not included in budgets, so would need to be funded from any surplus. The Chairman asked if the Trust was therefore being proactive in terms of planning for further escalation demands and it was noted that a deep dive had recently been undertaken on nursing staffing to reduce the need for agency staff and that a deep dive on medical staffing was also taking place. It was also noted that in terms of CIP performance, the Trust would have a challenge in terms of project realisation in the latter half of the year.

The Board then formally approved the CIP targets as detailed in the Finance Report.

101/05/15 Report of the Chief Operating Officer

Nil

102/05/15 Report of the Director of Estates and Commercial Development

The Director of Estates and Commercial Development highlighted the following from her report:

- The indicators around waste and medical devices had been amended to provide more meaningful data to the Board.

- There had been a small increase in sharps incidents, particularly in relation to disposal of sharps and the Health and Safety Committee were looking at the reasons for this and developing an action plan to improve performance.

- The estates maintenance performance had been dropping over the last couple of months and after some initial analysis this appeared to be due to an increase in severity of issues. Some more work would be undertaken and a paper then presented to the Board.

103/05/15 HIS Half-Yearly Report

The HIS Director highlighted three items:

- **Electronic Prescribing** – the project had moved to preferred bidder stage with an Italian company being identified. There were some risks as this company had not implemented a system for a whole community before, but they were felt to be the lowest risk bidders and the area in which they had no knowledge was not one of the more complex areas.

- **Clinical Handover and Task Management System** – the NerveCentre solution had been purchased with very positive feedback from users. Implementation would now take place at speed.

- **Emergency Department and MIU system** – the go live date was now three weeks later than planned (21st July).

The Chief Executive wished to commend the HIS Director and his team on this work and said that she felt there was a lack of understanding of the benefits of the new technology being implemented in the Trust and how it would benefit the ICO and suggested a communications strategy be considered to improve understanding. HISD/ IDC

104/05/15 **Governor Question Time**

Mrs French queried the Vanguard Unit that was being brought in to help reduce the Ophthalmology backlog. The Chief Operating Officer explained that it would be operational from the 18th June, sited next to the Eye Clinic, and had been commissioned for 12 weeks with an option to extend for up to six months. It was a temporary solution with the Trust having plans for a sustainable solution into the future.

Mrs French then asked if the Trust was subject to any penalties due to its RTT performance and it was noted that the Trust was subject to penalties and these were detailed in the Finance paper.

Finally Mrs French said that the last set of Board minutes stated that the Board required Corporate Manslaughter training and asked when this was taking place. It was noted that it was scheduled for the September Board Development session (the date being based on the availability of training providers).

105/05/15 **Date of Next Meeting**

1.30 pm, Wednesday its July 2015, Anna Dart Lecture Theatre.

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

27TH MAY 2015

Minute	Action	Officer	Date
103/05/15	**HIS Half-Yearly Report** – communications strategy to be considered to brief staff on the benefits new IT technology would provide.	HISD/IDC	Ongoing

South Devon Healthcare NHS
NHS Foundation Trust

Director of Nursing Report Summary Sheet

Meeting Date:	1st July 2015
Title:	Care Quality Commission monitoring update
Lead Director:	Director of Nursing and Professional Practice
Corporate Objective:	Best Experience / Safest Care
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Reporting on Trust position against CQC key Lines of Enquiry

Key Issues/Risks and Recommendations:

Summary of Challenge / Discussion:
Currently working on the CQAT to provide wards and departments with a score that will allow benchmarking. Reviewing the CQAT process to ensure peer inspections continue

Internal / External Engagement including Public, Patient and Governor Involvement:
The trust clinical quality inspection team includes staff from TSD, SDT, volunteers and Governors. The CCG have been invited to participate.

Equality and Diversity Implications:
None

PUBLIC

CQC Assurance

The CQC have now announced the inspection visits to be undertaken up to and including October 2015, this Trist will not be visited in this peroid. An announced visit should be anticipated between November 2015 and March 2016.

Assuming the ICO will be operational by this period, our inspection will be across the services currently provided by SDHFT and TSDHSCT. Agreement has been reached through the Joint Leadership Group representing the executive teams of both Trusts to implement a joined up approach to preparation for the pending inspection visit. A specific joint project has been set up to plan for the logistics of the visit.

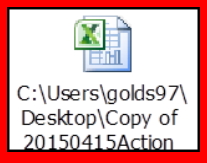
The CQC Assurance Group as of 25th June will be an integrated group, with senior management representation from both organisations. The group will look at the organisations self-assessments (of which 59% are now complete), with the remainder due by end June.

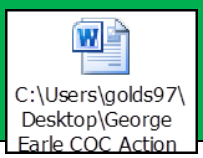
The group will review the outcomes of the Quality Assessments that are being undertaken, and in particular will look at those areas identified as concern (Risk Register below),

To date we have completed 11 visits; 10 inpatient areas and Level 2 outpatients department. Further visits have been planned for July to December, which should enable us to complete visits to all areas within the Acute Trust. Similar visits have started in T&SDCT, and these will be included in our schedule of visits from August.

In addition, we have planned out of hours visits from July to December.

SIRO	Lead	Date reviewed	Principal Risk	Update/Actions Measures
MD	SCr	14-May-15	Proportion of reported patient safety incidents that are harmful (Intelligent Monitoring Report)	We picked up this issue in July 2014 IRM and as a result we looked at the reporting system, and addressed a number of issues which had led to our harm rate being reported as such. Please note our harm rate had not changed and had been the same for a number of years. The next update to this data set used by the CQC will be circa June/July 2015 and will be greatly changed. This should move our position into one of 'no evidence of risk'.
	ShMa	14-May-15	SSNAP Domain 2: Overall team centred rating score for key stroke unit indicator (Intelligent Monitoring Report)	C:\Users\golds97\Desktop\SNNAP action plan

COO	SuMa	14-May-15	Proportion of patients risk assessed for Venous Thromboembolism (VTE) (Intelligent Monitoring Report)	Flagged in Nov 2014 at Workstream 1 via the IMR. The data is now included as a mandatory field on the infoflex CPS. This will ensure that all VTEs undertaken will be included on CPS and be available for upload to Unify. This will need some focus and a Care Plan Summary (CPS) improvement plan.
COO	CGr	14-May-15	A&E Survey Q18: Were you given enough privacy when being examined or treated? (Intelligent Monitoring Report)	Introduction of AMU 15 April 2015 to ensure access to dedicated team and facilities for assessment. This has reduced the waiting time to access clinic space for assessment. SSPAU has created capacity for short stay assessment of children. Plan to develop estates plan for ED for implementation in 2016/17.
COO	CGr	14 Mary 2015	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? (Intelligent Monitoring Report)	Detailed action plan in place- attached. Plan to meet target on a recurrent basis from 1 July 2015. Improved position April 2015 94%.
COO		14 Mary 2015	Monthly Referral to Treatment (RTT) waiting times for completed admitted pathways (on an adjusted basis): percentage within 18 weeks (Intelligent Monitoring Report)	RTT improvement plans being developed internally and additional capacity funded. Action Learning sets facilitated by CCG to re- design pathways with aimed of securing resilience. IST team working with the Trust with a view to developing alternative strategies.
DoN	ADNs	14 Mary 2015	Inpatients response percentage rate from NHS England Friends and Family Test (Intelligent Monitoring Report)	Throughout 2014 we have struggled to meet the national F&F response rate despite the introduction of a number of tests of change to improve the process. In response to this we are strengthening the Divisional ownership of this performance indicator and will be meeting with Divisional leads to set out an action plan for delivery on a consistent response rate by the end of Q2.
DoE	MB	14 Mary 2015	Dental Portakabin in OP (Clinical Quality Assessment Tool peer inspection)	Reviewed alternative accommodation and service provision outside of the Trust (i.e. community, private sector). Replacement of the portakabin is not feasible. Room identified within OPD, Estates developing plan.
DHIS	LW	14-May-15	Health Records compliance with standards. (CQAT Peer Inspection)	 C:\Users\golds97\ Desktop\Copy of 20150415Action
MD	Sg	14-May-15	Consent -, training, recording of consent to treatment (CQAT peer inspection)	Audit & re-audit completed. Presented to CMG 18/5/15. Meeting with Med Director 3/6/15. Policy with external solicitors for review. Awaiting programme of training from solicitors

COO	HPa	14-May-15	Phloebotomy (OP's Level 2) - Environment & staff management (CQAT peer inspection)	Awaiting action plan from Department lead.
DoN	CB	14-May-15	Communication to patients on ward noticeboards (CQAT peer inspection)	Feedback given to individual wards at time of Quality Audits. Feedback report given to matrons to look at own areas
DoE	KR	14-May-15	Mealtimes - patients hand washing before meals (CQAT peer inspection)	Feedback given to individual wards at time of Quality Audits. Feedback report given to matrons to look at own areas. Feedback given to facilities management team.
DoN	LK	14/05/2015	Infection control - accessibility of gel, (CQC peer inspection)	Feedback given to individual wards at time of Quality Audits. Feedback report given to matrons to look at own areas. Infection control team aware and providing support to areas.
DoN	DN	14 Mary 2015	Medicines management (CQAT peer inspection)	Feedback given to individual wards at time of Quality Audits. Feedback report given to matrons to look at own areas. Pharmacy aware and providing support to areas.
DoN	MBI	14-May-15	George Earle: clinical assessments (CQAT peer inspection)	Feedback & meeting held with Matron. Action plan attached.  C:\Users\golds97\Desktop\George Earle COC Action

South Devon Healthcare NHS
NHS Foundation Trust

Director of Nursing Report Summary Sheet

Meeting Date:	1st July 2015
Title:	Inpatient Survey Annual Report
Lead Director:	Director of Nursing and Professional Practice
Corporate Objective:	Best Experience / Safest Care
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Annual indicator of patient experience

Key Issues/Risks and Recommendations:

- Stable position
- A few ongoing areas which are in the agreed workplan for WS2

Summary of Challenge / Discussion:

- The areas for improvement are ones that the Trust are aware of through its other feedback mechanisms and are in Divisional and Workstream work plans for 2015/16. The greatest challenges will be understanding and limiting the noise at night and improving privacy in A&E.

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

Equality and Diversity Implications:
None

PUBLIC

National Survey of Adult Inpatients 2014

1.0

The twelfth survey of adult inpatients involved 154 acute and specialist NHS trusts. Patient Perspective administered the local survey and provided a report to Picker who collated all Trust`s responses for the CQC.

1.1

For SDHCFT a total of 479 patient responses were received providing a 58% response rate. This compares to 55% in 2013. The 70 questions are divided into 11 sections which are scored as Green (better than most Trusts), Amber (the same as most Trusts), Red (worse than most Trusts). We have no red rated and 1 green rated section. **Table 1** below shows our Trust`s results as rated by the CQC in comparison with our neighbouring Trusts.

Table 1

2014	Section	SDHCFT	RCH	RD&E	Plymouth	ND	T&S
01	Emergency and ED care	Same	Same	Same	Same	Same	Same
02	Waiting list and planned admissions	Same	Same	Same	Same	Same	Same
03	Waiting to get a bed on a ward	Same	Same	Same	Same	Same	Same
04	The Hospital and Ward	Same	Same	Same	Same	Same	Same
05	Doctors	Same	Same	Same	Same	Same	Same
06	Nurses	Same	Same	Same	Same	Same	Better
07	Care &Treatment	Same	Same	Same	Same	Same	Same
08	Operations & procedures	Better	Same	Same	Same	Same	Same
09	Leaving Hospital	Same	Same	Same	Same	Same	Same
10	Overall views on care & Treatment	Same	Same	Same	Same	Same	Same
11	Overall experience	Same	Same	Same	Same	Same	Same

2.0. Headline results:

Strengths:

- Specialist was given all the necessary patient information by person referring (Q8)
- Admitted to a mixed-sex room or bay (Q11)
- Cleanliness of wards and bathrooms (Q17, Q18)
- Food quality and choice (Q21, Q22)
- Nurses answering questions clearly (Q27)
- Information about surgery (Q43 to Q49)
- Involvement in discharge decisions (Q50)
- Information to family/friend on discharge (Q62)
- Patients treated with respect and dignity (Q66)

Areas for improvement:

- ✓ In A&E, privacy when being examined (Q4)
- ✓ Waiting time to get a bed on a ward (Q9)
- ✓ Noise at night from patients and staff (Q15, Q16)
- ✓ Availability of hand-wash gels (Q20)
- ✓ Amount of information given on condition/treatment (Q34)

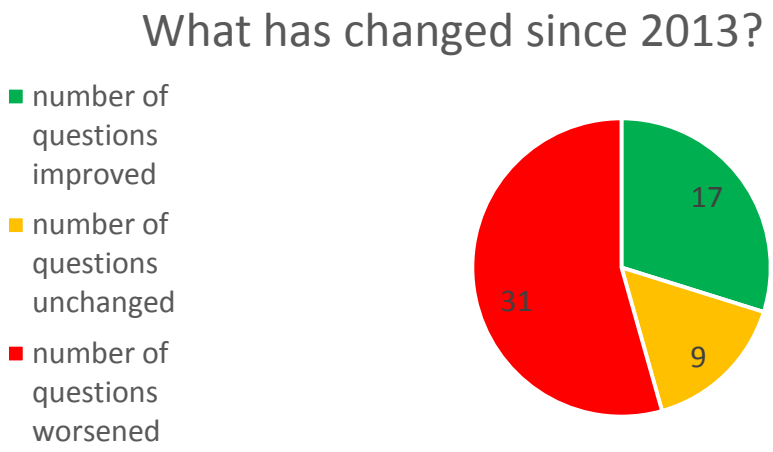
These results give us a clear indication of our areas to continue to improve upon and where we need to focus our efforts to improve. The areas for improvement highlighted are areas that we have identified in other patient experience surveys and form part of Divisional action plans and Workstream 2 priorities for 2015/16. The availability of hand gels is an area that that has been noted in the Inpatient Survey for a few years. There is no evidence that there is a lack of availability of hand gels in the hospital but there is a process issue which has been identified when beds are moved throughout the hospital. This can lead to too much hand gel in one area and not enough in another. This process review is with the ward managers. There are some areas in the hospital where they have been removed for clinical reasons.

3.0 Detailed analysis

The information below is the data created by Patient Perspective and their aim is to highlight to the Trust the important findings exactly as reported by the patients. These scores are not weighted or standardised. Where the results are better or worse than last year, this is an exact comparison of the 2014 data to the 2013 data. Although some of the changes may be small, this gives a good indication of the overall direction the results are heading.

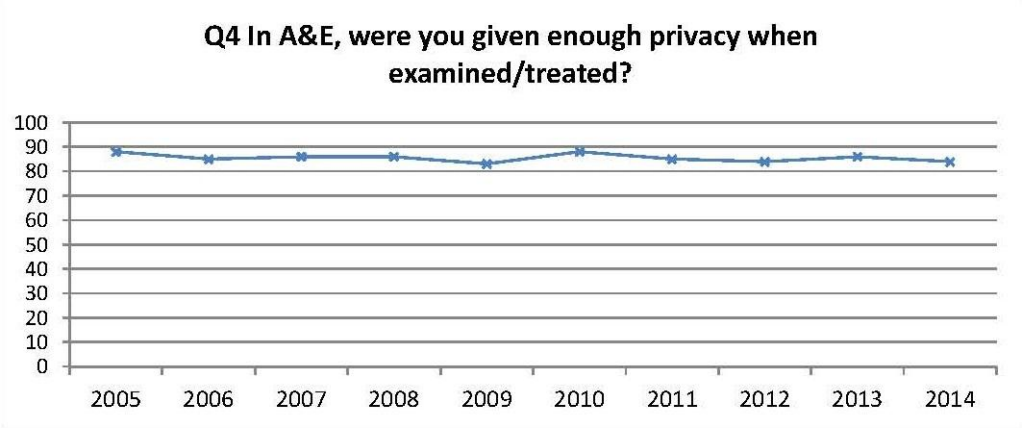
3.1

This level of detail is demonstrated by the Pie Chart below- none of the changes are statistically significant and many are nominal. They are being reviewed in detail and checked against other indicators in the 2015/16 period.

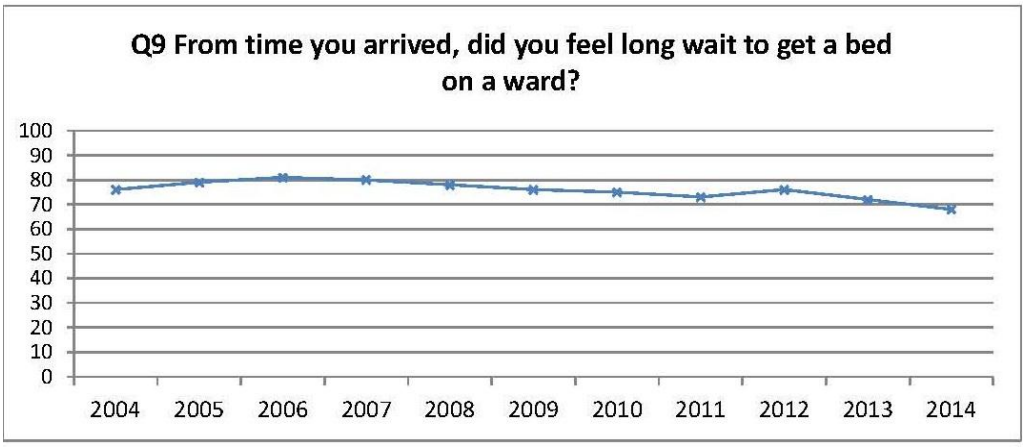


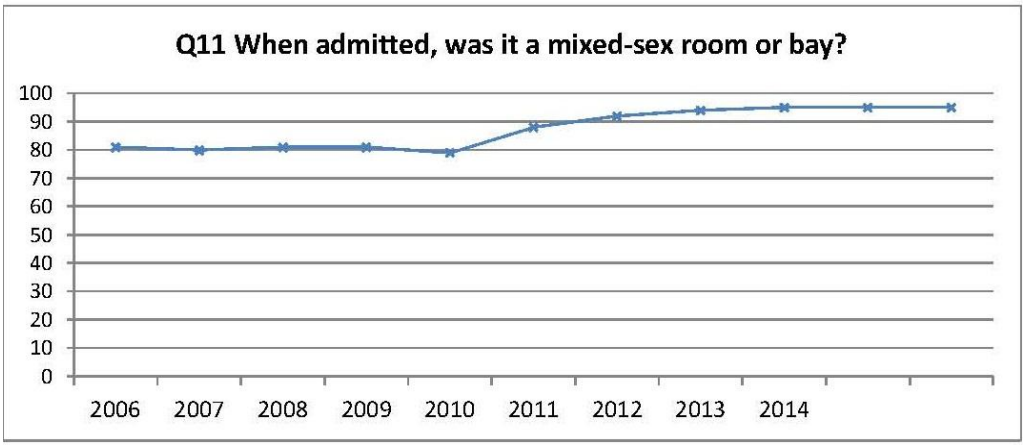
3. 2

We are also able to see how the Trust has been performing over time. Below is a selection of questions showing performance since 2004/5. A selection of these trend graphs are shown below and demonstrate over time the pattern of changes. These also provide reassurance over time where there has been demonstrable improvement and areas we need to focus on



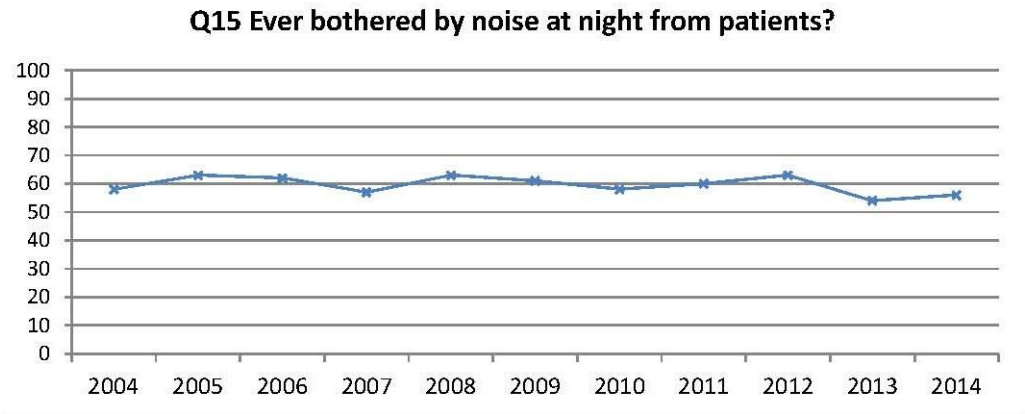
The chart above is showing privacy in A&E. It shows a small deterioration against current trend and is an area that the Trust is aware of.



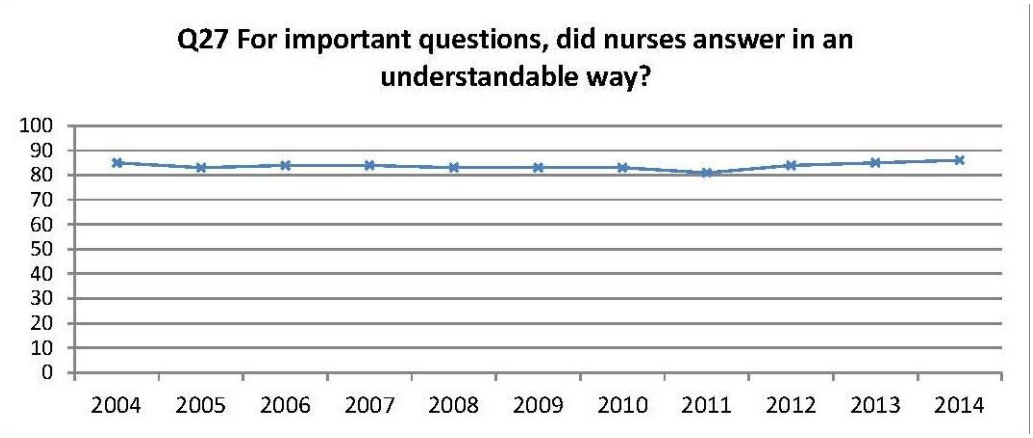


Question 9 above, shows that over time the respondents feel they have a long wait for a bed and this would be supported by other surveys and data in the Trust.

Question 11 shows that since 2011 the Trust changes to ensure patients are not experiencing care in mixed sex bays is successful. This continues to be sustained.



Q15 shows some fluctuation in respondents views about noise at night. We can see a slight downward trend over the last 2 years and this mirrors the other feedback we receive.

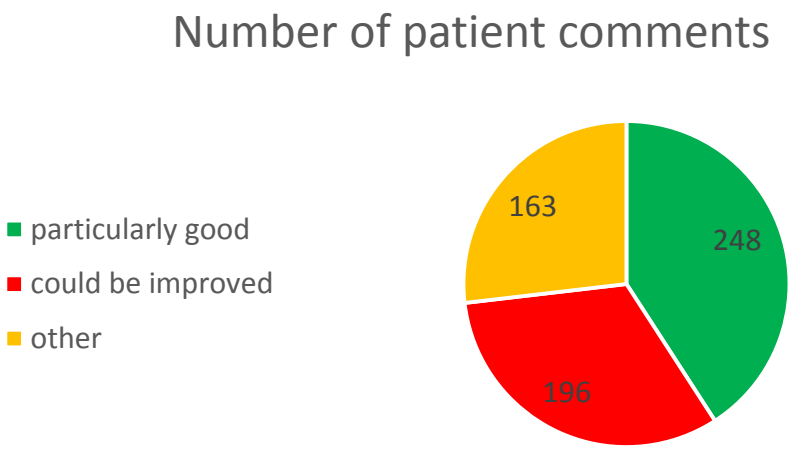


The graph above shows an overall consistent view of respondents to how the nurses answer questions with a slight increase over the last 2 years.

4.0 - Patient comments:

There were over 450 patient comments on the National Inpatient Survey. The respondents are asked if anything was particularly good about their stay and anything that could be improved. They can also provide any other comments. All of these have been reviewed and noted. There was high praise for care, kindness and competence by hospital staff , some comments about night time care, including noise and staff attitude, mixed comments about the quality of the food and discharge experience, waiting to be seen , communication and parking were comments on in the “could be improved “ section.

The PIE chart below shows the total number of comments as “particularly good”, “could be improved” and “other”. All comments that can defined as “anything particularly good” or “could be improved” have been noted in **Table 2** below. The 163 “other” comments have not been included in any analysis as they were general comments by respondents that did not clearly fall into “particularly good” or “could be improved” categories. These included comments about other hospitals or providers, their clinical condition or about the questionnaire.



The patient written comments are grouped under the section below. Please note that the patient`s whole journey were commented on under a specific clinical headings. The areas for improvement are noted across all clinical areas.

Table 2

Clinical Area	Anything particularly good?	Could be improved?
Accident and Emergency	4	4
Cardiology	9	4
Clinical hematology	6	3
ENT	8	7
Gastroenterology	9	4
General Medicine	53	39
General Surgery	55	30
Geriatric Medicine	17	16
Gynecology	7	5
Ophthalmology	3	1
Oral Surgery	6	4
Respiratory Medicine	24	16
Trauma and Orthopedics	42	18
Urology	7	3

4.1 - "Wordall" - all the comments show by number of times a word was used in the commentary.

The word cloud below provides a visual representation of the patient comments with positive comments about staff receiving the highest number and appearing as the largest text.

4.2 Patient quotes:

The doctors were excellent. My doctor came to see me every day and I was in hospital for nine days. The Ward Manager was very approachable and helpful. The hospital staff that did the cleaning and food were also very kind and helpful.

Night noise could be improved. Not from people who are ill during the night but chatter by personnel at nurse station during early hours could be reduced by introducing plastic screens similar to banks etc. Bleeps from blood pressure machines could be switched off. Noise from closing off blinds in corridors could be stopped by putting slow closes on them. Noise from medicine trolleys could be reduced by using better wheels etc. They rumble like trains when used in the small hours of the night.

5.0 - Summary and actions:

Overall, the results from the Adult Inpatient Survey are positive and indicate a continued good level of care delivered to our patients. Particularly of note is the standard of care delivered around operations and procedures.

The areas that are identified as in need of improvement are areas that have been identified by the Divisions and Work stream 2 from other feedback mechanisms and are in the Work stream 2 work plan for the year and are shown below in Table 3.

2015-16- Workstream 2

The work stream agreed that it will review progress from the Organisation against the following:

Experience and Engagement Strategy:

Engagement:

- Involvement of Divisions and HI in engagement and co-design
- Understand what we currently do:
  - Community mapping exercise.

Experience:

- Friends &Family Test
- Bereavement-Project
- Communication:

5.1 Actions:

We continue to support the "Working with us Panel" volunteers who ask patients due to be discharged the "Real Time Patient Experience Survey". This includes questions also asked in the National Inpatient Survey and allows Work stream 2 to benchmark monthly data against the annual National Inpatient Survey. The areas noted as particularly good have been fed back through the Divisions. **Table 3** presents the workstream 2 action plan for the national inpatient survey results.

Table 3: Action plan

Areas for Improvement	Action	Accountable Owner	Workstream	Monitoring process
In A&E, privacy when being examined	Medical division and EFM review of environment plus capacity issues	Medical DGM /COO	2 and 5	Divisional Boards
Waiting time to get a bed on a ward	Demand and capacity review	COO	1 and 2	Patient Flow Board
Noise at night from patients and staff	Project set up with HI and Experience and Engagement.	DoN	2	WS2
Availability of hand-wash gels	Process change(transfer of hand gels with beds) and	DoN	1 and 2	ICC

	reminder to all staff transferring patients with the ward managers			
Amount of information given on condition / treatment	Part of the Talk Back/communication action plan for WS2	DoN	2	WS2

South Devon Healthcare NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st July 2015
Title:	Safeguarding Children Annual Report
Lead Director:	Director of Nursing and Professional Practice
Corporate Objective:	Best Experience /Safest Care
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:
Statutory requirement for Board to receive an annual report for safeguarding children service.

Key Issues/Risks and Recommendations:

- Increased numbers of staff requiring Levels 2/3 training following review and reallocation of training levels in line with Intercollegiate Guidance issued in 2014.
- Deficit in provision of safeguarding supervision related to limited team capacity.

Summary of Challenge/Discussion:

- Assurance sought that safeguarding training compliance is on the corporate risk register .
- Clarification sought regarding the resolution plan for IT issues and level 3 training –the installation of Google Chrome across the Trust will resolve the problem and is currently underway.
- The risk highlighted in relation to child protection supervision is currently reflected on the WCDT risk register. Clarification is to be sought regarding the position of the business case in the Trusts approval process..
- What contribution will the Trust be expected to make to the improvement plan arising from Devon CC inspection? The issues raised are the same as those identified in previous Torbay Ofsted inspection and are therefore already in a workplan and monitoring programme.
- CAMHS issues and the current impact on the inpatient paediatric ward needs to be escalated in terms of risk assessment and risk management planning. This issue has been escalated to the Commissioner for a coordinated response. Currently this at corporate risk level.
- Plans for achieving compliance in training numbers are in place and will require ongoing monitoring through divisional processes.

Internal/External Engagement including Public, Patient and Governor Involvement:
There have been significant advances in working together across both organisations in preparation for the ICO.

Equality and Diversity Implications:
None

South Devon Healthcare NHS
NHS Foundation Trust

Report Title: Safeguarding Children Team Annual Report 2015

Date: July 2015

Executive Summary of Report

During the year 2014 to 2015 we have again demonstrated our flexibility as a team and an ability to prioritise.

Achievements 2014/15:

1. Safeguarding Children Training Review

The Named Nurse, in conjunction with staff in ESR / OLM, has undertaken a trust wide reallocation of staff training levels, in accordance with the Intercollegiate document guidance. The review has trebled the staff numbers required to complete both Level 2 and Level 3 safeguarding children training. This is a positive indication of the support for the Safeguarding Children agenda at Executive level within the Trust.

2. Safeguarding Awareness Month – November 2014

The Safeguarding Children Team organised a number of display boards over the month to raise awareness and highlight recent initiatives.

The Team also completed Level 2 Safeguarding Children Training for the Trust Board, presented by the Named Doctor and Named Midwife.

Buzz video conversations have been filmed providing additional information regarding "Making a referral" and "Child Sexual Exploitation". The videos remain in the top 5 video conversations accessed by Trust staff.

Additional information was provided for staff throughout the month, including a "Blog" by The Chairman of SDHCT and 4 staff bulletin updates focusing on topical issues. These continue to be available on the Safeguarding Children webpage on "Contact".

3. Recruitment

The Named Consultant / Named Nurse resigned from her post in July 2014. The new Named Nurse was recruited in August 2014 and made substantive in March 2015. Recruitment into the Paediatric Liaison post has also been successful with 2 nurses job sharing the post from May 2015.

The Named Doctor retired in June 2015 and the post of Named Doctor is now shared between 2 Consultant Paediatricians. The Trust has also recruited Named Doctor for Child Death Process, who chairs all child death meetings alongside the Child Death Coordinator.

4. Integration Team Meetings

Since January 2014 the two safeguarding teams across both Trusts have been meeting on a regular basis, both as a full team meeting and as a Named Professionals meeting, to establish working relationships. The team have been working collaboratively to plan for the integration of the Trusts, later in the year.

5. Child Protection Supervision

The importance of child protection supervision has been widely recognised across the Trust. The clinical teams who are implementing supervision sessions for staff are currently supported by trained supervision supervisors, the Paediatric Liaison team or the Named Professionals.

6. Audit

We continue to follow an audit programme, primarily developed to provide assurance that lessons from Serious Case Reviews have been embedded into practice. This is to ensure compliance with safeguarding requirements and is in line with CQC recommendations. Feedback and supervision is then provided to all staff.

7. Work with Torbay and Devon Local Authorities

Significant work has continued with both local authorities over the course of the year. Torbay MASH has been established since January 2015 and work to support the operational and strategic changes that are required is on-going. Devon has recently undergone inspection from CQC and work is continuing with partner agencies, including supporting the work of the Childrens Improvement Board. Multi-Agency-Case-Audit (MACA) has also been facilitated for both Local Authorities with feedback being provided via Best Practice Forums. The most recent forum was hosted by Torbay Hospital and focused on Domestic Abuse.

8. Paediatric Liaison Service

Referrals to this service continue to increase to a new peak in April 2015 of 260 contacts. The service has increased the clinical areas covered by daily contact to provide more frontline staff with support and guidance.

9. CQC Looked After Child Inspection May 2014

Both Trusts received a Safeguarding Children Inspections from the Care Quality Commission. Following the written report a joint working party identified specific actions for each of the Trusts, CCG and Looked After Child Service. South Devon Healthcare Trust does not have any outstanding actions and changes in practice have been embedded**,** which can be show in Audit.

Challenges for 2015/16:

1. Safeguarding Children Training Compliance

Due to the review there is a significant increase in staff numbers required to undergo training, particularly at Level 2 and 3. Current compliance levels reflect this. There is an on-going work plan to achieve compliance levels over the following 3 years. Level 2 training is currently completed via

eLearning using ESR. The process presents some challenges for access which effects compliance. Staff feedback shows a preference for face to face training due to improved impact but this is not a feasible option given current staffing levels within the safeguarding and training team. Training compliance remains a managed risk for the organisation.

2. Level 3 training and processes

Whilst this is improved by the training review, the process should ideally be managed by the Education Directorate to enable staff to have a single point of contact. It has also been complicated by changes to the Local Safeguarding Board websites. The Safeguarding Boards now have a joint website but many of the Trust computers are unable to access elements of the website, mainly to facilitate IT access for training. There is collaborative work with the Trust IT service and Devon County Council IT Team to attempt to resolve this issue but, currently it remains a problem.

3. Child Protection Supervision

The capacity of clinicians to both, receive and deliver, meaningful child protection supervision presents a risk to the organisation. There is a business case in process for 2 further members of staff for the Safeguarding Team. These staff positions are essential to the development of this process.

4. Devon – "requires improvement" from OFSTED

Devon has been found to require improvement at the latest inspection, including the LSCB, of which SDHCT is a member.

5. Mental Health care provision for young people (CAMHS)

CAMHS activity presents additional safeguarding challenges depending on the clinical area that they are admitted to, should they require inpatient treatment. Whilst frontline staff endeavour to work together to provide support and safety for the young people, the complexity of the care that they require and the lack of care options available to meet their needs has significant safety implications for the organisation. This has been reflected in reported incidents.

Plans for 2015/16:

1. Business case

The decision is still awaited on the business case. Further progress on the child protection supervision agenda and further projects is not possible without increased capacity.

2. Level 3 training

Training leads for the 3 main areas of risk – Maternity, Child Health and the Emergency Department, have a plan of action to work towards Trust compliance for Level 3 training. This plan will be overseen by the Named Nurse for Safeguarding Children who will continue to support and link to the remaining staff outside of the high risk areas to enable them to access the required training.

3. Supervision sessions

Child Protection Supervision sessions for high risk teams are to be integrated into the mandatory study days. The Emergency Department has begun the process. A "tailor made" session is facilitated by the Named Nurse for Safeguarding Children. The Maternity / Midwifery teams have a planned session

presented by the Named Midwife and Safeguarding Midwife. The Child Health session is currently in negotiation.

4. Integration of the organisations

The Safeguarding Teams for both organisations have been working closely to plan for the integration. There are plans to build on the success of last years Safeguarding Awareness Month, hoping to include the adult safeguarding teams. A working party to align policies and guidelines has been identified.

Main Report

1. **Arrangements for Designated Professionals**

Working Together to Safeguard Children (2015) states that" Clinical Commissioning Groups (CCGs) will employ, or have in place, a contractual agreement to secure the expertise of designated professionals (i.e. designated doctors and nurses for safeguarding children and for looked after children). Designated Professionals, as clinical experts and strategic leaders, are a vital source of advice to the CCG, the local authority and the Local safeguarding Children Board, and advice and support to other health professionals."

There is a Designated Nurse and a Designated Doctor Safeguarding Children for South Devon and Torbay Clinical Commissioning Group. In addition there is a Designated Nurse and a Designated Doctor for Looked- After Children. There have been challenges for these posts over the last year due to staff sickness, but the covering arrangements have minimised any interruption to service support.

The Designated Doctor for Northern Eastern and Western Devon Clinical Commissioning Group (*New* Devon CCG) has recently been successfully recruited having been a vacant post for some months. There is a Designated Nurse and two Safeguarding Nurses in *New* Devon CCG.

2. **Arrangements for Named Professionals**

(WTTSC)Working Together to Safeguard Children (2013) states that "all providers of NHS funded health services should identify a named doctor and a named nurses (and a named midwife if the organisation provides maternity services) for safeguarding. It also states that "Named professionals have a key role in promoting good professional practice within their organisation, providing advice and expertise for fellow professionals, and ensuring safeguarding training is in place. They should work closely with their organisation's safeguarding (Board) lead, designated professionals and the Safeguarding Children Boards".

Safeguarding Named Professionals in the Torbay and South Devon Health Community:

Named Nurse South Devon Healthcare Foundation Trust (1.0 wte).
Named Midwife, South Devon Healthcare Foundation Trust (0.2 wte)

Named Doctor, South Devon Healthcare Foundation Trust & Torbay and Southern Devon Health and Care Trust (0.3 wte) (currently held as job share)

Named Nurse, T&SDH&CT (1.0 wte supported by 2.6 wte supervisors).

Child Protection Lead, Devon Integrated Children's Services (Virgin Care) NHS Devon (Southern Locality 1.0 wte).

Named Doctor, NHS Devon (0.2 wte Southern Locality).

3. Safeguarding Children Governance:

In order to meet our organisational responsibilities under Section 11 of the Children Act 2004 our Director of Nursing is currently the SDHFT representative on both Devon Safeguarding Children Board (DSCB) and Torbay Safeguarding Children Board (TSCB).The Associate Director of Nursing and Midwifery deputises in her absence. Both Torbay and Devon SCB meets 4 times per year. The SCB share the same chairperson. This has already increased collaborative working.

Trust Executive Safeguarding Children Committee (TESCC):
This committee met 4 times in 2013-2014. It is now chaired by the Associate Director of Nursing and Midwifery. The Deputy Director of Nursing also attends. TESCC has continued to support and monitor the Named Professionals and safeguarding work across the Trust. Audits are presented or summarised to TESCC members and progress regarding SCR actions is scrutinised. In preparation for the integration process, the Named Nurse for TSDHCT has been attending TESCC and the Named Nurse for SDHCT has been attending the TSDHCT Integrated Safeguarding Committee.

Integration of Safeguarding Children Teams:
A work plan was developed with both a strategic group and joint team meetings subsequently convening to scope joint work. As highlighted above, both Named Nurses sit on both Trust Safeguarding Committees. As part of the integration process, Named Professional meetings are held bi-monthly and full joint safeguarding children / looked after children team meetings are held quarterly. There is an associated action plan which includes the development of joint safeguarding children guidelines.

4. Inter-Agency Working

Children from Devon and Torbay who are / have previously been subject to Child Protection plans continue to be flagged on the Trust electronic systems. Children who are / have previously been "looked after" (in foster care) are also flagged.Devon's Multi-Agency Safeguarding Hub (MASH) continues though was significantly reviewed following the Devon OFSTED inspection. Devon is implementing an Early Help strategy which sits alongside MASH. Changes in how referrals go into Devon (either going to Early Help **or** MASH) will mean a shift in practice for our staff as previously MASH provided a single point of entry or enquiry.

Torbay Safeguarding Hub has been re -launched as a MASH from January 2015. The referral process follows the same principles as Devon, with a pathway for Early Help referrals. The Named Nurse is a member of the MASH Development Project meetings. Health representation for Torbay's MASH is currently provided by TSDHCT Safeguarding Children Team. They are supported by SDHCT through information gathering / sharing from the Trusts electronic systems, such as PAS and WINDIP, by the Child Protection Administrator and clinical analysis provided by the Named Nurse. This analysis is provided by the Paediatric Liaison Nurse in the Named Nurses absence. The information from the Midwifery Team is provided by the Named Midwife / Safeguarding Midwife. There is also an established communication link from the Sexual Medicine Service, in order to ensure best practice for any information sharing from this service directly into the MASH.

Professionals can still seek consultation and advice as to the best approach from both Torbay and Devon. Escalation processes have been reviewed for both Safeguarding Childrens Boards and are available for staff to access on the intranet pages. Our Emergency Department staff will continue to make all referrals through to MASH (Devon / Torbay) to prevent an increase in risk by changing our

processes at this point.

5. Legislation & Guidance

Working Together to Safeguard Children (2015) outlines our responsibilities under Section 11 of the Children Act.

"Our organisation should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- A clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- A senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- A culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- Arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- For health provider organisations, named professionals for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect;
- Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- Safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- Appropriate supervision and support for staff, including undertaking safeguarding training:

WTTSC (2015) goes on to specify that "employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role; staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and all professionals should have regular reviews of their own practice to ensure they improve over time. Clear policies should be in line with those from the Safeguarding Children Board for dealing with allegations against people who work with children.

Whilst it has been difficult to evidence all of this practice, in particular the culture of listening to children and taking account of their wishes and feelings, feedback from the work of the multiagency case audits is assisting in targeting specific areas where practice can be improved. This has been evidenced in the changes made to the looked after child processes.

Further legislation to support the Safeguarding Children procedures for SDHCT staff have been reviewed and made available for all Trust staff via the Safeguarding Children pages on the Intranet. These include the South West Child Protection Procedures, Think Family Protocol, South West Peninsula Child Sexual Exploitation Protocol and the reviewed Threshold criteria for both Torbay/Devon Childrens Services.

6. Training and Supervision

The new *Intercollegiate Guidance* (March 2014) was issued by the Royal Colleges.
The Named Nurse, in conjunction with staff in ESR / OLM, has undertaken a trust wide reallocation of staff training levels, in accordance with the Intercollegiate document guidance. The review has reflected the positive feedback from the CQC report, which highlighted the identification and intervention of safeguarding alerts by frontline staff. The review has trebled the staff numbers required to complete both Level 2 and Level 3 safeguarding children training. This is a positive indication of the support for the Safeguarding Children agenda at Executive level within the Trust.

Clearly this has had significant implications on our compliance. There is an understanding that for Level 3, a 3 year plan is in place for the staff training. This will ensure a process that can be maintained. To ensure continuing compliance with the 3 year plan, a monitoring system has been initiated by the Named Nurse, supported by 3 allocated training leads in Maternity, Child Health and the Emergency Department, the Training Lead Officer for the Local Authority and ESR / OLM workforce. This ensures all training information is fed back on a monthly basis to the Trust and, in turn, to Managers and individual members of staff.

The impact of significant numbers of healthcare staff attending the multiagency training has been highlighted by the Named Nurse to the Training and Learning sub group of TSCB, on which the Named Nurse now participates as a regular committee member. There is a financial implication for the Trust to ensure the continuation of the training plan.

a. Delivery of Level 1 Training

In line with *WTTSC* (2015) and the Intercollegiate document, all new staff receive all mandatory induction, which has been face to face. Information is provided on local safeguarding arrangements, including the named safeguarding professionals, how to access the safeguarding webpage and guidelines. Two short films have been developed by the Safeguarding Team across both Trusts in collaboration with Hiblio to meet the Level 1 competencies. In preparation for integration, there is an agreement that staff for both TSDHCT and SDHCT will receive the same training package. In light of the changes required by the Intercollegiate Document recommendations, some additional information will be required to add to the Level 1 training. This process will be completed in collaboration between the Named Nurse, the training team based at the Horizon Centre and the Hiblio team.

b. Delivery and uptake of Level 2

4 taught face-to-face Level 2 training sessions are now offered annually across both Trusts in order to meet the diverse needs of the workforce. Due to the increase in staff numbers requiring Level 2 training, additional sessions have been facilitated by the Named Nurse and training department at the Horizon Centre. The Training Lead for Mandatory Training is also providing support to outlying teams. The agreed Level 2 e-learning training package (approved by the Royal College of Paediatrics and Child Health) should be accessed by the majority of allocated staff. Staff feedback regarding difficulties accessing the ESR system to complete their mandatory e-learning has presented a direct risk to compliance. Access information has been reviewed by the Named Nurse and published via the staff bulletin, staff newsletters and on the Safeguarding Children webpage on the Intranet. Contact details for ESR and the Named Nurse are also published to enable troubleshooting contacts for staff.

c. Inter-Agency Training at Level 3

SDHCT staff book Level 3/Group 3 training via the Torbay Learning Pool system. Our Training strategy and the training information available for staff via the Trust website was amended to reflect this.

The Core Level 3 Foundation TSCB Inter-Agency training package was adapted by the TSCB Training Sub-Group to use a trainer and a drama company where the audience can see live scenarios being enacted and practice challenging professionals, families etc. Staff will then access a Refresher course which updates the core competencies, within 3 years. All TSCB Level 3 Courses are quality – assured by TSCB Training Sub-Group members, in line with the recommendations of the Intercollegiate document.

Last year, following feedback from medical colleagues regarding capacity concerns there was an agreement that medical staff could access an e-learning Level 3 training package (Like the Level 2 Package approved by the Royal College of Paediatrics and Child Health). This raised concerns that Medical Staff would be at a disadvantage compared to the Nursing staff, whose training is measured to show compliance with the Intercollegiate recommendations. The review of the booking process, direct intervention / support by the Named Nurse and access to training dates for the year, at the beginning of the year, has enabled medical staff to make arrangements to access multiagency training. This is reflected in the booked staff on the courses already taking place this year.

d. Training of Child Protection Supervisors

We have held 4 half-day updates for Child Protection Supervisors. These have included packages incorporating internet safety, safeguarding disabled children, child sexual exploitation and communication skills. These updates also include an opportunity for Supervisors to receive supervision. There is excellent engagement in these sessions and we keep the content meaningful and relevant. There is also positive trust- wide networking and learning from each other. Sessions continue to receive extremely positive evaluations. There is an increase in the number of supervisors reflecting innovative practice around the challenges of safeguarding children supervision delivery. Both TSDHCT and SDHCT staff are represented in the Supervisors group.

e. Electronic Staff Record (ESR) and training reports

There has been a historical risk associated with the ESR system inability to report accurate compliance for Level 2 or Level 3 training. This was determined to be an unacceptable risk. The Named Nurse for SDHCT and the ESR team have worked together since October 2014 on this issue. In March 2014, a new recording method is in place using the ESR / OLM system, which has been manipulated to give an accurate and reliable compliance record for all levels of safeguarding children training. The recording system in place for Level 3 includes monthly updates from the Training Lead in the TSCB, direct to ESR/OLM. Compliance figures for the Trust are sent to the Named Nurse. This information is shared with the Training Leads for Maternity, Child Health and the Emergency Dept. This allows for monitoring of the training programme associated with the 3 year training plan. This plan is to gain compliance over 95% at Level 1, 2 and 3 within the 3 years.

Current compliance is:-

SGC L1 – 86.20% (3654 people have completed this training out of the 4239 people that are required to complete this level)

SGC L2 – 50.60% (1655 people have completed this training out of the 3271 people that are required to complete this level)

SGC L3 – 24.85% (128 people have completed this training out of the 515 people that are required to complete this level)

This is compared to Level 1 – 84.7%, Level 2 – 40.8% and Level 3 – 18.9%, in March 2015.

There have been 2 sessions for Level 3 training between March and mid- June. ESR/OLM are supporting this system with email reminders to staff who are not compliant with safeguarding children training , informing them which level is required and how to access the training. This has been a significant project, which has been undertaken with limited capacity for both teams but with outstanding results. The system has been adopted by TDSHCT and parameters for compliance and certification of available courses has been agreed by both Named Nurses to ensure parity across both Trusts, in preparation for integration.

f. Training needs of Named Professionals

In the year 2013/2014 Named Professionals have accessed sufficient and appropriate training as required by their role. The new Intercollegiate Document (March 2014) describes clearly the competencies which Named Professionals should meet at Level 4.

g. Child Protection Supervision

The Chair of Devon/ Torbay Safeguarding Children Board has made it clear that under Section 11 requirements, organisations have to be able to produce robust evidence that supervision is taking place.

Most Serious Case Reviews highlight quality supervision as being a deficit in agencies' practice, particularly supervision where practitioners are challenged and have space to reflect on their practice and decisions made. Devon and Torbay Safeguarding Childrens Boards set up a working party that has published standards for Child Protection Supervision across the Partnership. The principles are intended to provide an overarching supervision policy framework for all staff working in multi-agency organisations across Devon and Torbay Childrens Services. It provides a supervision framework and minimum standards to support individual performance for all staff working with child protection cases, regardless of their role or area in which they work.

As a partner agency, SDHCT have agreed to adhere to these principles. The main staff group affected are those who require Level 3 training. The majority of these staff work within Maternity, the Emergency Department and Child Health. Whilst these staff have a variety of supervision options available to them including group supervision, formal 1:1 supervision and "ad-hoc" informal supervision, there is a challenge to provide formal supervision in all clinical areas.

The capacity of clinicians to both, receive and deliver, meaningful child protection supervision continues to present a risk to the organisation. The capacity of the Named Professionals means that delivery of Trust-wide supervision continues to be a substantial risk to the organisation. There is a business case in process for 2 further members of staff for the Safeguarding Team. These staff positions are essential to the development of this process.

Whilst there have been a number of Child Protection Supervisors trained, the role is additional to their clinical role and capacity for all staff across the Trust is an issue. The supervisors have been very proactive and are all facilitating child protection supervision using innovative methods which are applicable and relevant to their staff. The Sexual Health Team is able to provide formal and informal supervision and have robust processes for documentation. The Speech and Language therapy teams and Clinical Psychology teams are also utilising methods to support staff in accessing meaningful child protection supervision. Time and accessibility remain the main barriers for clinical staff within SDHCT.

Child Protection peer supervision for Paediatricians is now being delivered monthly which is in line with the requirements of the Royal College of Paediatrics and Child Health guidance.

The Designated Doctor for Torbay and South Devon CCG is accessed by the Named Professionals for advice as needed and the Named Nurse, Named Midwife and Named Doctor receive formal supervision on a regular basis from the Designated Nurse and Designated Doctor.

Investigation of incidents which highlight that safeguarding procedures have not been followed will result in supervision being offered.

It is important to recognise that we have made progress, but that we have probably moved supervision on as far as we can in South Devon Healthcare given the current resource of the Safeguarding Children Team. From networking with colleagues in other acute trusts we are aware that delivery of supervision in acute trusts is a particular challenge because of capacity, workload and conflicting priorities.

7. Clinical Governance

The number of reported incidents regarding safeguarding has increased this year. This is in part due to the work undertaken over the past year to educate staff on the importance of reporting these incidents and also the increase in the numbers of admissions on the Childrens Ward / Special Care Baby Unit related to safeguarding and vulnerable children. It is essential to ensure that we are able to capture the data which can inform continuing discussion and to support multidisciplinary service improvement/provision. This is particularly essential regarding mental health services for children and young people. Over the last year we have worked hard to try to establish regular meetings with the safeguarding team, to discuss these incidents and actions arising. An escalation policy has been produced to support staff when dealing with difficult or challenging situations. The learning from these meetings has been and will continue to be shared via our Trust wide children and Young people's Clinical Governance meeting which are held monthly and also via our Quality & safety meetings which are held bi-monthly.

8. Child Protection Medicals / Meetings

101 child protection medicals were completed from 1 April 2014 to 31 March 2015. Referrals were accepted from Children's Services, GP, A&E and MIU, (other departments i.e. Maxillofacial) and identified as required during inpatient stays. The clinic numbers as below for the PAED/ME clinics – these are used for meetings, strategy and DAF/SHEF referrals.

year	No. clinics	No. patients
13/14	54	73
14/15	62	86
15/16	14	21

For the PAED/CP child protection clinics

year	No. clinics	No. patients
13/14	73	96
14/15	74	100
15/16	13	22

9. Child Death Reviews

Working Together to Safeguard Children March 2015 lays out statutory guidance about how organisations should work together to safeguard and promote the welfare of children. Within this guidance is a requirement for Local Safeguarding Children Boards to undertake reviews into all deaths of children under 18 years of age who are normally resident within their area. In order to make this process as effective and informative as possible, the four LSCBs of Cornwall and Isles of Scilly, Devon, Plymouth and Torbay have agreed to a joint process, sharing resources and information to improve the quality of outcomes. As a Joint Child Death Overview Protocol, it is to be adhered to by all agencies:

http://webarchive.nationalarchives.gov.uk/20130802215759/http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/childdeathreview/a0070753/child-death-review-process

An unexpected death, for the purpose of this process, is defined as a death that was not anticipated as a significant possibility, for example 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death. Child Death Overviews will seek to identify patterns and trends in child deaths that may be used to safeguard children in the future under Working Together Chapter 5:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

The Peninsula Child Death Overview process is supported by a multidisciplinary Rapid Response Team (RRT) for unexpected deaths, collating the minimum data set, and information from other agencies involved with the child, and feeding this information into the joint Child Death Overview Panel for reviews to be undertaken.

1. Investigations into baclofen pump therapy and the monitor for adverse events.
2. Child Abuse Investigation Unit (Police) calling cards not to be given out to bereaved parents.
3. Bystanders to be booked automatically into Emergency Department to remain 'on radar'.
4. CRUSE Rapid Response process to be finalised for bereavement support.
5. South West Ambulance Service Trauma booklet – ways of accessing support.
6. Health Visitor to maintain regular contact with bereaved mother and to monitor for postnatal depression.

10. Serious Case Reviews (SCRs)

WTTSC (2015) identifies four possible different types of review as a result of a child death. A serious Case Review, a Child Death Review, a review of child protection incidents which fall below the threshold for a Serious Case Review or an audit of practice in one or more agencies. More clearly

defined SCR criteria have been included in this update and it is mindful to staff to include this consideration in every day practice.

In June 2013 a national panel of experts was appointed which will assist Safeguarding Children Boards in dealing with the criteria for Serious Case Reviews (SCRs) and the appointment and review of those carrying out SCRs. Guidance states that these reviews should be carried out in a way which is proportionate to the case being reviewed and follow a set of principles which include transparency, independence and family involvement. There is no standard format but SDHCT works closely with the Local Safeguarding Childrens Boards, to both define methodologies but also take part in reviews.

All reviews of cases which meet the SCR criteria now result in a report which is published on the Safeguarding Children Board's website, and should be suitable for publication without being amended or redacted. In a geographical area such as Torbay this has posed challenges regarding the family's right to anonymity.

Two Health management reviews have been conducted. C48 reviewed the circumstances of Methodone ingestion by a toddler. C46 reviewed circumstances leading to a baby being shaken, including presentation of the older sibling with a fracture. Frontline staff, from both SDHCT and TSDHCT, were heavily involved in identification of incidents, internal reviews and change of working practice, but also proactively engaged in the LSCB review process and sharing of that learning. There is an on-going challenge to embed learning from Serious Case Review, at local and National level.

Learning

Learning from our Serious Case Reviews from the last few years continues to be disseminated in supervision and incorporated in other face-to-face training. Our audit programme also incrementally charts the progress of embedding these lessons in practice. C40, which concerned the death of a 4 week old baby, has identified learning regarding the consideration of Fathers needs when assessing children's needs. In line with the recommendations, an awareness campaign regarding the fragility of babies and the dangers of shaking has been undertaken. This included raising staff awareness via a Best Practice Forum. C42 highlighted the impact of domestic abuse on the family and the importance of parent / adult presentations where vulnerabilities are identified. Across the multiagency community the "Think Family" approach has been integrated into working practice and projects to increase staff awareness of domestic abuse are ongoing.

11. Audit

As stated in last year's annual report, an audit programme is followed and results are presented or fed back via TESCC. Below are some examples of the various Safeguarding Audits or Surveys undertaken across the Trust.

Safeguarding Children – Audit Status

Year	Audit Ref	Title	Project Lead	Status
14/15	6088	Re-audit of Repeated Attendances in Children *(Trust guideline 1450) (SCR-C24)*	S Imong	**Estimated completion 30/11/14** Complete. Results to be reported to TESCC.

14/15	i-0058	Printout of Previous Attendances for Children in the ED	M Davison	Active, results to date attached.
14/15	i-0059	Safeguarding Children in the ED	P Hiles	Active
14/15	6265	Unborn Baby Protocol (previous audit 5014)	R Glasson	**Estimated completion 31/3/15** Complete. Results to be reported to TESCC at July meeting.
14/15	6350	Teenage Pregnancy Pathway	S Lovell	**Estimated completion 30/6/15** Data collection complete.

Safeguarding Children – Audit Programme

Year	Title	Project Lead	When Due
14/15	6314 - Young People attending A&E where alcohol, violence or drugs are a factor *(SCR-C26)*		June '15
14/15	6317 - Safeguarding in A&E		June '15

a. Teenage Pregnancy Care Pathway

Following Operation Mansfield SCR, an audit to scrutinise compliance with Trust guidance for teenage pregnancies was requested by TSCB. This audit is to be repeated this year by the Public Health Midwife, as part of the ongoing audit programme for analysis of change of practice.

b. ED Audits

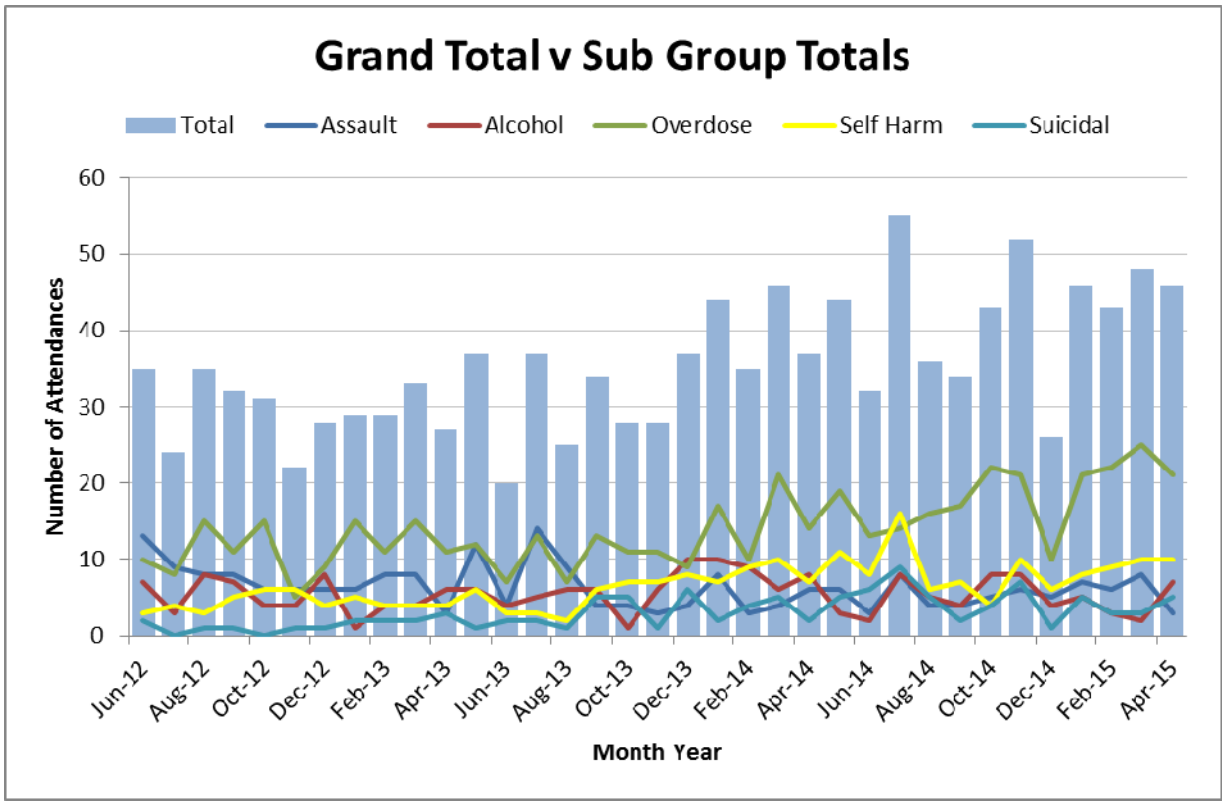
i. Safeguarding Children in ED

Previous audits have been undertaken to focus on safeguarding children areas/issues which have shown poor compliance. Following the CQC inspection in May 2014, a recommendation was made by the inspectors that oversight of the records for the paediatric attendances to the Emergency Department was made by the Safeguarding Team, in order to monitor safe practice.

There were plans already in process for a new information technology system to be used in the Emergency Department and also in the outlying Minor Injury Units. The system will support mandatory fields for information, which would ensure compliance with particular safeguarding questions. This would be measurable through audit. In order to provide assurance that this process would be monitored until the IT system was operational, the Named Nurse completes an audit of 20 patient records each week on a random day of the week. The feedback from this audit is reported to the Emergency Department management team and then feedback is provided to all staff via the daily safety briefings. Good practice is fed back to individual staff by the Named Nurse and supervision is arranged if required should any concerning practice be identified. The trend associated with the audit parameters shows a rise and compliance is achieved in most areas. The feedback system ensures monitored increases for the following week when an issue is raised. The results are also reported at TESCC. This has been in action

since September 2014 and will continue for the first 6 months of use of the new system to ensure that all aspects of the audit are embedded into practice.

ii. Young people attending ED where alcohol, violence or drugs are a factor



Following the Operation Mansfield SCR, guidance was developed for ED, in the form of a flowchart, regarding referrals to be made for young people attending where alcohol, drugs or violence were a factor but the child was not admitted to Louisa Cary. The work has continued to be audited and has shown that the referral process has been embedded into practice. Following the implementation of the new electronic system for the Emergency Department, the questions relating to presentations that require referral to the Paediatric Liaison Service or to alcohol / substance misuse services will be included as a mandatory field. This will ensure a continued 100% compliance. This information is also starting to map potential evidence for commissioning of services and targeted projects to be completed with groups of young people. This has been discussed with the Designated Nurse as a future project.

c. Multi-Agency Case file Audit (MACA)

Working Together to Safeguard Children 2013 outlines the requirement for a regular cycle of multi professional auditing; a process which complements the single agency audits carried out in order to identify areas of good practice, and explore how potential weaknesses in service delivery can be improved and developed.
The decision was made to adopt a new approach to auditing health records in preparation for the regular Multi-Agency Case Audits undertaken by the Quality Assurance Sub Group.

Representatives were identified from all relevant health disciplines. Once the cases for audit were confirmed, each representative was asked to scrutinise their involvement with each case ahead of the audit, and complete the template identifying single agency and multi-agency issues. This detail was then used to inform the audit process in terms of identification of risk, decision making, multi-agency working, and the experience and outcomes for the child involved.

TSCB and DSCB both run this process differently. TSCB audits 6 cases and Devon 4 cases but the areas are split into localities, of which there are 4. TSCB has the Named Professionals and managers in attendance at the discussion process, whereas DCSB have frontline practitioners at the discussion process. Both TSCB and DSCB require the service managers to complete the audit tool prior to the MACA. Areas of good practice and areas for improvement are highlighted during the meeting and brought back to the individual service providers. Individual feedback is provided to practitioners and the Named Nurse presents the findings to the Child Health Directorate Meeting. Recommendations and actions are discussed within the wider Child Health Team. Multiagency feedback is provided via Best Practice Forums and they are attended by SDHCT staff.

12. **Disclosure and Barring Service(DBS)**

These checks (previously CRB) continue to be carried out for all new staff joining the organisation or who change job roles in line with DBS guidance at the appropriate level. Training for Trust personnel has been provided this year to update on new issues relevant to the service.

13. **Maternity Services:**

The maternity service has continued to experience high volumes of safeguarding children issues being identified during pregnancy and the early postnatal period. During 2014, 291 interagency communication forms (ICF) were completed by midwives, identifying pregnant women with safeguarding and vulnerability factors, such as substance misuse, domestic abuse, mental health, teenager, etc

Following the South West Child Protection Procedures Unborn Baby Protocol, 181 of these followed the medium/high level concern process. Of these, 59 unborn babies were made subject to child protection plans. For the first 6 months of 2015, 137 forms have been completed, with 24 unborn babies being subject to child protection plans born in this period. Due to the sustained high numbers of child protection plans, midwifery attendance at child protection meetings has continued to have considerable implications for the service.

ISSUES	**2014**
Total number of forms received	**291**
Unborn baby protocol – high/moderate risk	181
EPO/PPO/ICO/CP Plan#	59 plans 12 orders ** and 1 Section 20
Removal to care of Local Authority#	11
Mother and baby/foster placement#	22
Learning difficulties*#	9
Mental health*#	119 + 3 partner
Teenager*#	60
Domestic Abuse*#	113 + 21 previous
Drugs and alcohol misuse*#	54 + 1 previous and 1 partner

Prev. Children's Services involvement		123
Late Booker		16
No lone/home visits*#		36
Information received re pregnancy with vulnerability but pregnancy non – ongoing	Total	40
	ICF	7
	No ICF	33

Please note:
* This does not represent all cases as these may not be notified via the safeguarding children route.
# Some cases may fall into several categories.
**Not all orders documented on database as information not always communicated by CYPS

The Safeguarding Children Midwife role was appointed to in March 2014. Over the past year the role has been established and has had a very positive impact for the Maternity Service, within the wider Trust and amongst partner agencies. This is in no small part due to greater availability for support, meeting attendance and information sharing. In conjunction with the Named Midwife for Safeguarding Children, she has had a major role in continuing to embed safeguarding supervision within the Maternity Service. The Safeguarding Children Supervisors within Maternity continue to attend 4 half-day updates annually

14. Perinatal Mental Health Service

A significant number of referrals which were made to Children's Services regarding potential safeguarding risk to unborn had a maternal mental health element. The Perinatal Mental Health Team now in its 4th year in Torbay, managed by Devon Partnership Trust, continues to support maternity services in meeting the perinatal mental health needs of women in Torbay and South Devon. This service, which is hosted within the Antenatal Clinic, is well received by both service users and professionals.

Women with previous mental health concerns or women with emerging symptoms can be referred to the service. The team share safeguarding supervision with midwifery colleagues to share knowledge and ensure consistent practice. The Consultant within the service has recently been appointed as named doctor for safeguarding children in Devon Partnership Trust. The referral rate continues to be around 37% and the team has expanded by 2 wte mental health practitioners, 0.5wte equivalent administration support and an extra afternoon per week of Consultant input. The team is also now commissioned to work with young women under 18 although the clinical pathway is still in development. The perinatal service also provides training including safeguarding awareness training to adult mental health colleagues.

15. Looked - after - Children

Looked after Children mainly enter foster care placements because of abuse or neglect. This results in higher proportional rates of both physical and mental health needs for this group of young people than the rest of the population. This group of young people often has complex health and social care needs with increased rates of smoking, substance misuse, "risky" behaviors and teenage pregnancy.

Torbay has a higher rate of Looked After Children (LAC) than the national average, with a significant increase in the numbers of LAC over recent years. There are currently approximately 300 children looked after by Torbay and a further approximate 100 children looked after by South Devon. This rise in numbers has placed increased pressure on the capacity to meet the health needs of LAC.

Health Services for LAC across TSDHCT and SDHFT have recently been reviewed and there is increased capacity to work across both the acute and community trusts to improve health outcomes for LAC. Funding was identified by providers, including SDHCT, to expand the role of the Lead Nurse for LAC to work across both providers. The LAC Health Team consists of a Designated Nurse (0.3 wte) and Designated Doctor (1PA) within the CCG, an Associate Specialist with role as medical adviser for adoption and LAC (4.5PA) within SDHFT and Lead Nurse for LAC (1.0 wte) within TSDHCT . The team is also currently supported by a School Nurse on 6 month secondment to assist with the Review Health Assessments.

Initial Heath Assessments (IHA) are undertaken by a pediatrician on all LAC when they first become Looked After. From April 2014 to March 2015, 105 IHAs were completed for Torbay LAC and 68 for Devon LAC. Within SDHFT adoption medical assessments are also completed for LAC who have plan for adoption and these children are seen 6 monthly for their Review Health Assessments (RHA) and updating of adoption medical reports. 28 RHAs were carried out for Torbay / Devon LAC from April 2014 to March 2015. RHAs for all other LAC are completed within the community.

All foster carers and adopters are seen for assessments of their health by their GP. From these health assessments reports on the implications of their health on their ability to care for a child are completed by the medical adviser for adoption & fostering.

The Looked After Children Service was reviewed by CQC in May 2014. An action plan was formulated across the Health Partnership and actions were taken to improve the service in line with the recommendations. Changes have included:

1. GP's and Public Health Nurses are now notified when a child or young person becomes "Looked after" and the practitioners are invited to provide information to inform the initial health assessments.
2. The children/ young people are offered a choice of venue, either Torbay Hospital of Newton Abbot Hospital, for their initial health assessment clinic appointment.
3. There is a very tight timescale required for initial health assessments which has been very difficult to achieve. There has been a working party formed, which includes representatives from the Local Authority Childrens Services, to work towards improving notification times and processes. Within SDHCT, IHA timescales are regularly monitored to enable flexible working to ensure delays are avoided. This information is reported to the Childrens Partnership meetings in the form of a dashboard.

16. Sexual Health / Sexual Medicine Service

The sexual medicine service sees large numbers of young people (aged under 18). It is the service policy that all under 18's have a risk assessment completed at first appointment and this is reviewed at every follow up attendance. The assessment looks at lots of potential risks which include safeguarding concerns and risk of exploitation. tSMS see young people (YP)in YP specific clinics and main stream clinics on many different community sites in Torbay and Devon. The service also has an outreach team who run clinics in all Torbay secondary educations site, South Devon College, Pupil referral units etc.

The Outreach Team is part of Torbay Sexual Medicine Service (tSMS) and was commissioned in 2010. It is comprised of 2 Registered Nurses/Midwives, 1 Registered Nurse and a Boys' and Young Men's Worker. The Team is commissioned to work with young people (YP) aged 13 – 24 within the geographical area of Torbay and as part of tSMS offers access to an integrated sexual medicine service. Due to the nature of the education system, the Teamwork with many young people who reside outside

of the TQ1-TQ5 area but access education within Torbay. The strength of the service lies in the total flexibility of its approach to delivery. YP are seen at schools, home, Pupil Referral Units, cafes and even the beach if that is how or where they will engage with the Team to enable them to access the service they need. Having 'open' access to the Team via mobile phone allows YP who have not attended several appointments (DNA'd) or disengaged, to re-engage on their terms when they wish to. Another added benefit of this open access is that YP will text the Team requesting appointments for their friends who also need advice/support. This approach is supported by NICE (2014). Counselling will always include assessment of the young person's ability to consent to treatment. If they are under 16, assessment under the Fraser Guidelines and an assessment of 'Gillick Competence' will be undertaken. Clients can also be assessed under capacity to consent. All aspects of this service are available to young people aged from 13. During this work the Outreach Team actively encourage a young person to discuss with their parent/carer or another trusted adult that they are thinking about becoming sexually active/are sexually active.

Senior clinical staff have been part of the Torbay multi-agency steering group that produced the CSE risk assessment tool. Following the tool release a review of the under 16 and young adult (16 & 17) assessments was undertaken. The outcome of the review was to include some additional questions to ensure all risk factors of CSE had been considered. An example of one of the questions added is: Have you ever experience the loss of someone who was important to you? This had not been considered before and loss / bereavement is a trigger factor

In April 2015 the outreach team leader has disseminated the toolkit to all tSMS staff at the monthly team meeting. The outreach team, who work only with under 24's are highly skilled at writing referrals and completing CSE risk assessments. They are a support to the staff in the main service.

In January 2015 the service introduced a new Safeguarding supervision template for the young person's record. This was following the CQC inspection. The information in the records that the CQC reviewed presented a challenge to demonstrate that all the information and actions that taken place, when transferred to the patient's electronic record. This template is completed by a supervisor contains a bullet point of the issues, risk factors, protective factors, actions taken and referrals. This is kept in the young person's record but also a supervision proforma completed for staff member who completed the risk assessment which highlights good practice, learning or areas of development for that staff member. The service currently has 4 trained safeguarding supervisors. They are available for day to day support and they also weekly review and complete a supervision record for a percentage of all under 16 assessments completed each week. This is a time intensive process due to the high numbers of under 18's seen by the service, but it is vital to ensure safety of Young People and to support and develop the clinical team.

In Feb 2015 the monthly clinical team meeting was an update following the Supervisors update meeting, focusing on Internet Safety following a presentation by VirtalSafe / Torbay Safer Communities.

tSMS has also delivered sexual health training to foster carers within Torbay; this included safeguarding risks. The aim was to give foster carers information and enable them to signpost YP in their care to relevant services. Next sessions booked for 17 July.

17. Paediatric Liaison Service

The Paediatric Liaison Service is an information sharing service and forms part of the Safeguarding Children Team. Referrals can be made by staff to identify any information relevant to a child/young persons hospital attendance that should be shared with other professionals. This may be for support for

children or parents, referral to additional services. The role is a job share (1.0 wte) Band 6 Nursing role. The Nurse has daily contact with frontline staff in the Emergency Department, EAU 3, EAU 4 and Louisa Cary Ward. They collect referrals to the liaison service and any MASH referrals that have been made. The Nurse is available for any informal (ad-hoc) supervision and they provide feedback to individual members of staff regarding particular cases. The Paediatric Nurse also attends Special Care Baby Unit weekly for the ward round to ensure that staff are supported with any safeguarding/ information sharing issues, supporting the information provided by the Safeguarding Midwife.

Training for the F2 Doctor rotation for the Emergency Department and Child Health includes a session delivered by the Paediatric Liaison Nurse regarding information sharing and safeguarding children practices. The Paediatric Liaison Nurse also shares attendance to Devon MARAC with the Named Nurse.

> The CQC inspection noted that:
> "The provision of the paediatric liaison nurse service in the acute hospital trust is good and well established. The paediatric liaison nurse is diligent in ensuring required actions and communication with other disciplines and agencies happens promptly. In one case, effective multi-agency coordination by the paediatric liaison nurse had clear beneficial outcomes for a highly vulnerable young person. We saw examples of good identification of risk and the need for support by clinicians and appropriate referrals from both adult and paediatric cases to the paediatric liaison nurse. Over recent years, clinicians' awareness of safeguarding issues and the need to take action has increased."

Summary

The organization is carrying significant risk. This risk is due not only to the lack of resource allocated to the Trust- wide Safeguarding Team, but also the pressures within the organization which affect delivery of training and supervision, and the workload pressures which impact on clinical practice in some very high risk areas such as ED.

This year has been a year of change. The reorganization of the training and the definitive reliability of the compliance data have enabled an accurate level of safeguarding children information for the Trust. The 3 year plan will allow SDHCT staff to be compliant with the Intercollegiate guidance for their safeguarding children training requirements. The change in Named Professionals has not destabilized the process and the safeguarding team has worked collaboratively with the safeguarding team in TSDHCT. This will ensure continued progress following integration, without any additional risk to the children and families using our services.

Safeguarding children affects every aspect of the whole organization (not just child health). There remains a significant amount of work to do to embed quality practice across the organization, but it is important to recognize the attitudinal change towards safeguarding children shown by Trust staff, from the frontline to the Trust Board.

This completes the Safeguarding Children Annual Report 2014-2015.

South Devon Healthcare NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	1st July 2015
Title:	Medical Director's Report – Revalidation update
Lead Director:	Dr John Lowes, Medical Director
Corporate Objective:	To update the Board on developments that is within the responsibility of the Medical Director.
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Update Board on the revalidation profile of the medical workforce. (Internal Audit Report and Annual Organisational Audit 2014 – 2015 attached)

Key Issues/Risks and Recommendations:

To provide assurance to the Foundation Trust Board with links to corporate objectives.

Summary of ED Challenge/Discussion:

1) There are 18 doctors with unapproved, incomplete and missed appraisals and 16 with approved but incomplete appraisals. What are the reasons for this?
2) How are the recommendations of the internal audit report being actioned and monitored?

Response:
1) 14 doctors < 12 months in post, 1 maternity leave, 1 sickness absence. 15 doctors in 12 – 15 months window. 2 > 15months, 1awaiting appraisal – booked.
2) In progress and led by Medical Director.

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

Equality and Diversity Implications:

Many of the issues raised will include or provide assurance about our equality and diversity work and our involvement work.

PUBLIC

Annual Organisational Audit (AOA)
End of year questionnaire 2014-15

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**02945**
Document Purpose	Questionnaire
Document Name	A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex C – Annual Organisational Audit**
Author	NHS England, Medical Revalidation Programme
Publication Date	24 March 2015
Target Audience	All Responsible Officers in England
Additional Circulation List	Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Regional Directors and Directors of Commissioning Operations, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees
Description	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.
Cross Reference	The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012
Superseded Docs (if applicable)	A Framework of Quality Assurance for Responsible Officers and Revalidation, 4 April 2014
Action Required	Responsible Officers to submit an annual return to their higher level responsible officers in accordance with this guidance.
Timings / Deadline	**From April 2015**
Contact Details for further information	england.revalidation-pmo@nhs.net http://www.england.nhs.uk/revalidation/

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

Annual Organisational Audit (AOA)

End of year questionnaire 2014-15

Version number: 2.1

First published: 4 April 2014

Updated: 24 March 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

This questionnaire has been approved by the Review Return of Central Returns Steering Committee (ROCR) Licence Number ROCR/OR/2127/005MAND

Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national-level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher-level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA has been simplified and shortened considerably from its predecessor, (ORSA), with a focus on what is happening, with what outcome, along with an assessment of the designated body's organisational capacity to ensure a robust consistent system of revalidation. Learning from the experience of ORSA, the AOA has been designed to reduce the administrative burden upon organisations and to be of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2014/15;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England (as the Senior Responsible Owner for medical revalidation in England), the England Revalidation Implementation Board (ERIB) and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer
Section 2: Appraisal
Section 3: Monitoring Performance and Responding to Concerns
Section 4: Recruitment and Engagement
Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though this duty may be appropriately delegated. The questionnaire should be completed **during April and May 2015** for the year ending 31 March 2015. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 30th March 2015.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right. For the year 2014/15 the data will be collected by the former NHS England area team structure that was in existence for most of the period. Further guidance will be issued to regional teams in due course.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 30th September 2015.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 30-31
and www.england.nhs.uk/revalidation

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’

3 Section 1 – The Designated Body and the Responsible Officer

https://rms.wsybcsu.nhs.uk/AOAReport.aspx?mode=view&questionnaireId=32db397b-ba3c-406a-9d10-4375a3e6b523

Section 1	The Designated Body and the Responsible Officer
1.1	**Name of designated body:**
	South Devon Healthcare NHS Foundation Trust
	Lawes Bridge
	TORQUAY
	Devon
	Postcode TQ2 7AA
	Responsible officer: Title Dr GMC registered first name David — GMC registered last name Sinclair GMC reference number 2718826 — Phone 01803 656403 Email david.sinclair@nhs.net
	Medical Director: Title Dr GMC registered first name David — GMC registered last name Sinclair GMC reference number 2718826 — Phone 01803 656403 Email david.sinclair@nhs.net
	Clinical Appraisal Lead (if applicable): Title Dr GMC registered first name Maree — GMC registered last name Wright GMC reference number 3405141 — Phone 01803 656403 Email maree.wright@nhs.net
	Chief executive (or equivalent): Title Dr First name John — Last name Lowes GMC reference number (if applicable) 2631387 Phone Email john.lowes@nhs.net

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☑
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Trust Development Authority, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (area team at the start of the reporting period)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Other charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☐ ✓
		NHS England (National)	☐
		Department of Health NHS	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		A suitable person	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☐ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☐ N/A

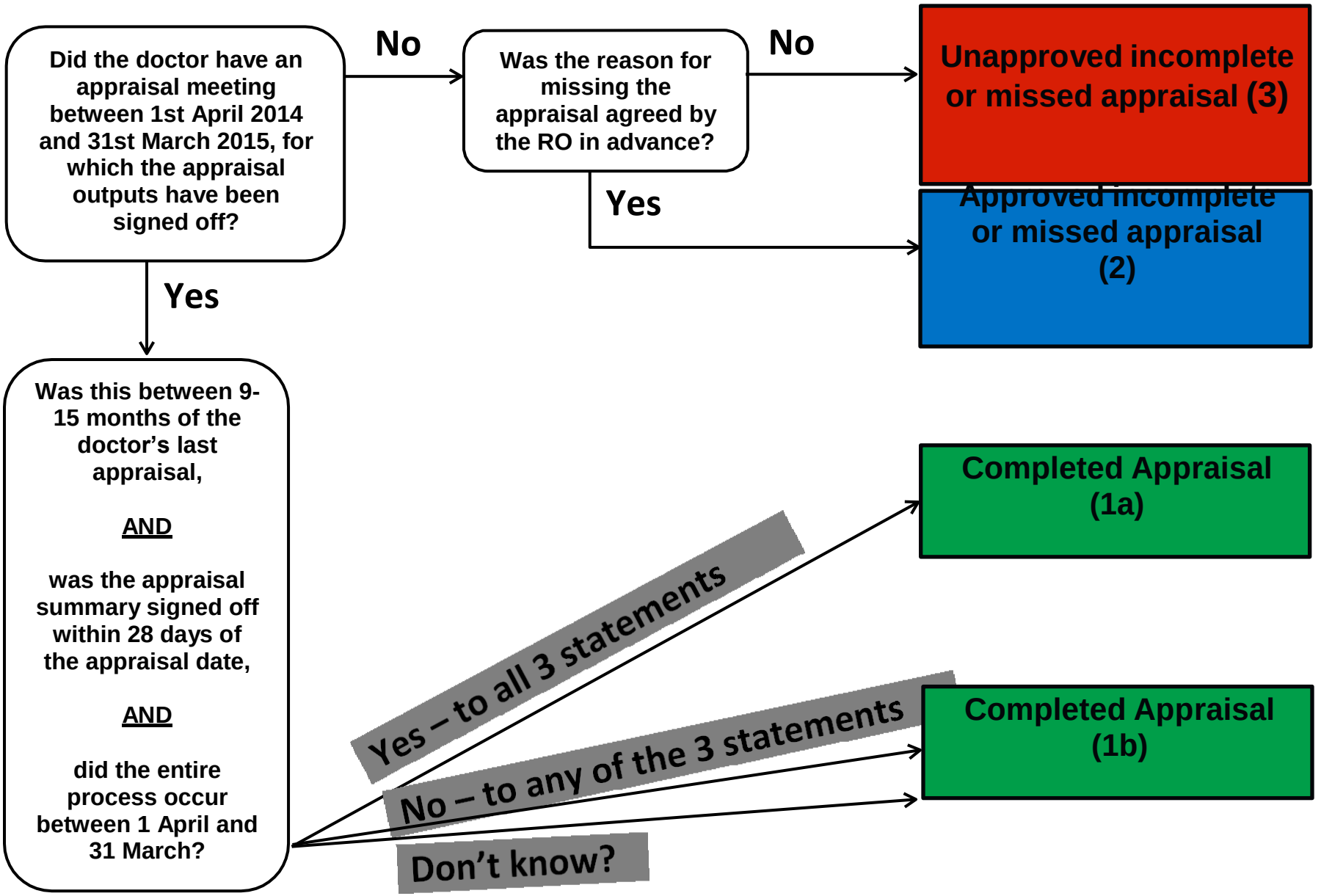
1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☐ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken. • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☐ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☐ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☐ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☐ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission or Monitor). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☐ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☐ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2015 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	188	129	40	6	13	188
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	33	19	8	1	5	33
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	28	13	6	9	0	28
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	249	161	54	16	18	249


Did the doctor have an appraisal meeting between 1st April 2014 and 31st March 2015, for which the appraisal outputs have been signed off?
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this between 9-15 months of the doctor's last appraisal,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
No – to any of the 3 statements
Don't know?
Completed Appraisal (1a)
Completed Appraisal (1b)

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2015** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place between 9 and 15 months of the date of the last appraisal, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraisal and the doctor, but one or more of the following apply: - a period of time of less than 9 months or greater than 15 months from the last appraisal has elapsed; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation. Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*.	

	Column - Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2015.	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2014/15 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible offic has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☐ Yes ☐ No

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☐ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: ○ Personal information. ○ Scope and nature of work. ○ Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. ○ Review of last year's PDP. ○ Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: ○ Summary of appraisal, ○ Appraiser's statement, ○ Post-appraisal sign-off by doctor and appraiser.	☐ Yes ☐ No

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Medical Appraisal and Revalidation in England* (NHS Revalidation Support Team, 2013).	☐ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☐ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☐ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☐ Yes No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☐ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☐ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See *Good Medical Practice: Supplementary Guidance: Writing References* (GMC, 2007) and paragraph 19 of *Good Medical Practice* (GMC, 2013) for further details.	

7 Section 5 – Comments

Section 5	Comments	
5.1	Please see detailed below a breakdown of the data submitted by South Devon Healthcare NHS Foundation Trust: Total Number of doctors within the Trust 249 Number of completed appraisals 215 Discrepancy 34 New members of staff <twelve months in post 14 Maternity Leave 1 Sickness absence 1 Had appraisal over 12 months but within 15 months 15 Had appraisal over 12 months and over 15 months 2 Awaiting appraisal (Over 12 months and over 15 months) 1 TOTAL 34 Please note that as at 31 March 2015 the Responsible Officer, Medical Director and Chief Executive were interim positions within the Trust.	

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Appraisal Guidance for Consultants* (Department of Health, 2001)
8. *Appraisal Guidance for General Practitioners* (Department of Health, 2004)
9. *Revalidation: A Statement of Intent* (GMC and others, 2010)
10. *Good Medical Practice* (GMC, 2013)
11. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
12. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
13. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
14. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
15. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
16. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012)
17. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
18. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
19. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
20. *Information Management for Medical Appraisal and Revalidation in England* (NHS Revalidation Support Team, 2013)
21. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
22. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
23. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
24. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
25. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
26. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002)
27. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011)

South Devon Healthcare NHS Foundation Trust

Final Internal Audit Report: Doctors' Revalidation

Report Reference: SDHC 14/15

January 2015

Distribution List (for action)
David Sinclair – Interim Medical Director
Maree Wright – Appraisal Lead
Patricia Martin – Recruitment Manager
Jessica Piper – Medical Education Manager

Additional Copies (final report, for information)
Rodney Muskett – Deputy Director of Finance
John Lowes – Interim Chief Executive Officer
Paul Cooper – Director of Finance, Performance and Information
Richard Scott – Company Secretary
PriceWaterhouseCooper- External Auditors

ASSURANCE OPINION RATING		
Assurance Opinion	**Previous Audit**	**2014/15**
Design of the Controls	N/A	Green
Operation of the Controls	N/A	Green
Overall Assurance Opinion	N/A	Green

ASSURANCE IMPACT ASSESSMENT		
Impact Assessment	**Previous Audit**	**2014/15**
Potentially Adverse Impact on the Organisation's Objectives	N/A	Low

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the 2014-15 internal audit plan, we have undertaken an audit review of the Trust's Doctors' Revalidation programme.

In December 2012, the General Medical Council (GMC) introduced a revalidation process to ensure doctors are fit to practise. The GMC began revalidating doctors' licences starting with medical leaders and responsible officers, with the aim of completing the revalidation process by 2016.

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. Organisations need to have robust systems of appraisal and clinical governance to support revalidation. The organisation's Responsible Officer (RO) has a statutory duty to make sure they are in place.

The Trust's Responsible Officer is the Interim Medical Director, who completed the revalidation process in May 2013. There are just over 200 doctors expected to go through the revalidation process and it is planned to revalidate them all for the first time by March 2016.

Objectives and Scope of the Audit

The primary objective of this review was to provide assurance that the Trust has implemented a sound system of internal control surrounding doctors' revalidation. The following objectives were included:

- To confirm that arrangements for appraisals and the revalidation of doctors are adequate, and reflect GMC guidance, and are supported by appropriate policies.
- To confirm that arrangements for the identification of staff for inclusion in the revalidation process (including those employed as Consultants, Speciality Doctors, Trust Grade Doctors, Locums, Honorary Contractors) are adequate.
- To confirm that the Revalidation Management System (RMS) captures those staff due for revalidation.
- To confirm that arrangements for the prioritisation, scheduling, booking and monitoring of staff due appraisals and revalidation are appropriate.
- To confirm that decisions regarding recommendation for revalidation have adequately considered relevant clinical governance information.
- To confirm that arrangements for obtaining assurances from other employers (other Trusts, third party agency suppliers, independent contractors) regarding staff that work in Torbay Hospital settings are adequate.
- To confirm that performance reporting to the Trust Board is adequate.
- To confirm that the Trust's revalidation arrangements allow it to adequately meet its statutory obligations.

OVERALL CONCLUSION

This was a high level review covering the governance arrangements in place for the revalidation of doctors in line with the GMC requirements. We can provide assurance that the Trust has implemented a suitable and robust system to record and monitor the requirement to revalidate doctors within the timescale set by the GMC. The staff we liaised with were fully engaged with the process and able to demonstrate a good knowledge of the revalidation process. No significant concerns are raised with the revalidation programme the Trust has in place.

We found several areas of good practice as outlined below, along with suggested areas for improvement. The details can found in the Detailed Findings section of this report.

Good Practice

Significant work by the Revalidation Support Office (RSO) and the Trust's Responsible Officer (RO) has been put into establishing systems and processes to manage doctors' revalidation. The team within the RSO were proactive and fully conversed with the process of actively identifying and controlling the appraisal process.

During our review, we gained positive assurance that the systems are robust through reviewing documentation and discussion with relevant staff regarding the following areas of good practice:

Policy & Guidance for Staff
The 'Medical & Dental Staff Appraisal Policy' has been reviewed and was due to be republished as the 'Appraisal and Revalidation Policy' once ratified by the appropriate body and covers the requirements for doctor revalidation as specified by the GMC in detail. Additionally a guidance document has been produced for staff on the use of the Equiniti 360° Revalidation Management System (RMS) (see below) for the management of appraisals and revalidations; and these documents, together with the support of the RSO, provide suitable arrangements to enable the revalidation programme to work.

Support and resources
Within the overall framework in place, both the Trust and the RO are able to meet their statutory and regulatory obligations under doctors' revalidation. In order to support the RO, the Trust has appointed an Appraisal Lead, a Trust Revalidation Lead and a Revalidation Support Officer. There is also a network of trained appraisers with regular oversight and quality control provided by the Appraisal Lead. Good working relationships and communication exist between the Revalidation Team, Medical HR and Medical Education Department.

Identification of Staff
The Trust has adequate procedures in place to identify the correct type of medical staff for inclusion within the revalidation process. There are a range of different staff groups which are subject to the revalidation process, however, the Trust is only responsible for those staff who are attached to it as their main employer. Locum doctors employed via an agency are not the responsibility of the Trust, neither are those who are on honorary contracts. There is a good working relationship between the RSO and the Medical HR and Medical Education Departments to ensure doctors working within the Trust are identified and managed accordingly in respect to the revalidation programme. A low risk recommendation has been made in respect to new appointments as detailed in the Areas for Further Action section below.

RMS
In order to facilitate and control the appraisal and revalidation process, the Trust has implemented RMS, a web based programme which enables ROs to manage the organisation of appraisals and portfolios for their doctors and produces the necessary outputs for an RO to make valid recommendations to the GMC. The system meets GMC guidelines and is endorsed by a cohort of Royal Medical Colleges. The RSO provides regular oversight, support and assisted access for both appraisers and appraisees using RMS.

Scheduling of Appraisals and Revalidation
The Trust has in place a suitable programme to ensure that all doctors identified in the first cycle are being regularly submitted for revalidation. There is evidence of on-going monitoring and oversight of progress being made.

Formal appraisal documentation
Within its appraisal system, the Trust has embedded the GMC standard model appraisal forms for the medical appraisal of its doctors, which underpin the four main domains and supporting attributes of the GMC's Good Medical Practice Framework for appraisal and revalidation. This includes the consideration of aspects of clinical governance such as complaints, incidents and litigation which have involved the doctor being revalidated. Each doctor has to demonstrate their whole practice against this framework and provide evidence against the six main types of supporting information for each appraisal and for every revalidation cycle.

This approach enables the RO to make an informed decision for revalidation of a doctor based on the clinical governance information collected throughout the appraisal process.

Additionally, there are adequate processes in place to link with other organisations where the Trust's doctors may be working to enable sharing of information which would support a recommendation for revalidation. It should, however, be acknowledged that due to the multiple sources of workforce, there is always the risk that doctors working within the Trust may not be fully within the revalidation process or that a doctor should be connected to the Trust when they are not. It should be highlighted that the process ultimately relies on the doctor as a medical professional to actively engage and take personal responsibility for their licencing status and for the Trust to facilitate and support that process as much as can be reasonably expected.

Performance Reporting to the Trust Board
The Trust Board receives a monthly exception update report detailing information on the number of appraisals (undertaken or deferred). It also receives confirmation on external reporting returns to NHS England and receives a Revalidation Annual Report.

Statutory Obligations for Reporting Externally
The Trust has in place suitable arrangements to allow for the discharge of its statutory obligations in relation to reporting of the revalidation of medical staff to NHS England. The Trust Board is required to sign off the Statement of Compliance annually. We were advised that this was submitted to NHS England in August 2014 for the year 2013/14.

Areas for Further Action

The following areas have been identified for consideration to enhance the current systems in place:

Reporting of new appointments
To ensure the efficient and timely identification of all doctors within the revalidation and appraisal process, and especially for locum appointments, it should be reinforced to all departments of the need to accurately record and provide the necessary details to Medical HR Office and the Revalidation Support Office. A regular timetabled update of new appointments from Medical HR to the RSO could also be introduced.

Identification of external Responsible Officers
To enable the appraisal and revalidation process to run smoothly and in line with NHS Employers guidance, it is considered best practice to request all doctors' existing RO details at the point of appointment during standard pre-employment checks, to ensure that the doctor is fully engaging with the revalidation requirements.

Comprehensive clinical performance database
To ensure that clinical governance is fully considered for doctors during revalidation, it may be considered necessary to enhance the clinical performance database to cover more data collected on senior grades of doctors (i.e. for consultants and SAS grades). This will aid staff in the appraisal and revalidation process.

Opinion Rating

It is the our view that the overall assurance opinion on the design and operation of controls is **Green** as recorded in the table on the face of this report and in accordance with the opinion definitions at Appendix A of this report.

Audit Impact Assessment

The Audit Impact Assessment is intended to convey to readers of the report and in particular members of the Audit Committee the overall risk significance of the area under review and how this may impact Trust objectives. This will reflect factors both within and outside of the control of the organisation.

Consequently it reflects both:

a) The overall risk significance of the area under review.
b) Our Audit Assurance Opinion.

In our opinion the potentially adverse impact on the achievement of Trust corporate objectives and targets is considered by Internal Audit to be **Low** as recorded in the table on the face of this report and in accordance with the opinion definitions at Appendix A of this report.

We would like to acknowledge the help and assistance given by the Revalidation Support Office and Medical HR during the course of this review.

Jenny McCall, Director of Audit

REPORT DATA

Date Work Undertaken	September 2014
Date of Issue of Draft Report	28 November 2014
Date of Return of Draft Report	7 January 2015
Date of Approval of Final Report	16 January 2015
Lead Auditor	Paul Hindom
Client Lead Manager(s)	Maree Wright, Appraisal Lead
Client Lead Director	David Sinclair, Interim Medical Director
Governance/Regulatory Links	Workstream 4 CQC Outcomes 13 & 14 General Medical Council and NHS England

Action Plan

Audit South West
Internal Audit, Counter Fraud and Consultancy Services

Rec No	Recommendation	Risk Rating	Management Response	Manager Responsible	Action Date
1	In order to minimise delays in notifying the RSO of all new medical posts appointments, the Medical HR Team should provide this information on a regular timetabled basis (preferably each month) and be built in to standard operating procedures.	Low Harm/Damage	Revalidation Office to be included in the distribution list for the monthly Medical HR Board Report.	Patricia Martin, Recruitment Manager	On going
2	In line with NHS Employers guidance, the Trust should ensure that as part of the standard pre-employment checks, details of all appointed doctors' existing Responsible Officers are being obtained. This should also be including locum agency doctors. The Trust could use the standard 'Transfer of Information' form to send to the applicant's previous employer to obtain the necessary information to be passed on to the Revalidation Support Office.	Low Harm/Damage	Transfer of Information form to be included in pre-employment documentation process by Medical HR team. Details will be sent to the Revalidation Officer who will obtain the Transfer of Information data.	Jessica Piper, Medical Education Manager	On going
3	The Trust should consider expanding the range of performance measures and data sources shown within the dashboard for senior grades of doctors (i.e. consultants & SAS) portfolios, in order for the appraisal and revalidation process to be as accurate and complete as possible.	Low Harm/Damage	Provision of performance data is under review with the Health Informatics team – the feasibility of adding complaints and litigation data is currently being reviewed.	Jessica Piper, Medical Education Manager	31 December 2015

1 Governance arrangements

The Trust has implemented adequate arrangements for doctors' appraisal and revalidation. Since 2013, in response to the GMC requirement for all licenced doctors to be revalidated by 2016 and then every 5 years, the Trust has established a framework to facilitate this requirement and to provide the necessary support and resources. This ensures that all medical staff actively take part in the process and that the Responsible Officer for the Trust can effectively meet his statutory and regulatory obligations for the revalidation of doctors.

To confirm that the Trust has robust systems for doctors' appraisals, we reviewed the systems that have been put in place to manage the process. We were able to confirm through discussion with key staff and review of specific documentation, that the Trust is ahead of its target number of doctors to be revalidated and assurance is gained through the results of this review that all doctors should be revalidated by 2016 in line with the GMC requirement. The Trust began submitting recommendations for revalidation during 2013 – starting with senior medical professionals attached to the Trust and has successfully revalidated ninety three doctors up to the end of October 2014 (which is over 43% if based on the original total of 216).

Appraisal and revalidation process evidence

- Appointed Responsible Officer (RO) – In accordance with the rules, the Trust as a designated body, has appointed its Medical Director as the RO who, as senior medical professional and most suitably qualified, will have overall responsibility for the effective implementation and operation of appraisals and revalidation. He is accountable to the Trust Board. His primary role is to personally make recommendations to the GMC on each doctor's fitness to practice based on his assessment of their practice through annual appraisals over a five year cycle.

- Key individuals in the Revalidation Support Office – in order to provide support and to assist the RO in discharging his statutory duties, the Trust has resourced the services of a Support Team consisting of the following:
    - Trust Appraisal Lead – appointed by the RO to oversee the quality and delivery of the appraisal process within the Trust. They also have responsibility to provide leadership and training for appraisers, peer support, internal/external reporting and quality assurance for the RO.
    - Trust Revalidation Lead and Support Officer – both posts work closely alongside the RO and Appraisal Lead to help coordinate and provide administrative support to the appraisal and revalidation process. 'Prescribed connections' to the Trust are also monitored on a regular basis by the Revalidation Support team and by close liaison with the Medical HR Officer. The support office also monitors access with RMS and coordinate appraisal dates.

- Network of Trust appraisers – a network of skilled and disciplined Appraisers have been appointed by the Appraisal Lead to ensure the effective delivery of the appraisal programme within the Trust and to take part in quality control and further training. These Appraisers are expected to conduct between three and five medical appraisals each year and there are approximately 60 appraisers in total to cover the amount of doctors - currently circa 235 (indicating a ratio of 1:4). Their own performance and appraisal is regularly reviewed by the Appraisal Lead as part of the quality assurance process and will be supported in on-going professional development (such as attending Appraiser Group Meetings) to ensure consistently high standards are maintained across the Trust. There is sufficient evidence to document that appraisers have adequate resources and tools to enable them to carry out effective medical appraisals. The appraisers have detailed job and personal specifications; Appraiser Review and feedback Forms are in existence and are reviewed by the Appraisal Lead for quality assurance purposes; a Quality Assurance tool (called Progress) is used by the Appraisal Lead on selection of a sample of completed appraisals during each year. There is ongoing training available to all Appraisers and they can attend Appraiser Group Meetings for peer discussions and external ideas on best practice.

- Appraisal and Revalidation Policy - The Trust has in place an up-to-date and comprehensive Appraisal Policy (latest version approved Sept 2014) that is publicly available to all employees. The policy is to ensure that the Trust's requirements for appraisal and revalidation are clear, understood and

implemented fairly. The policy applies to all consultants and doctors contracted directly by the Trust on a substantive or locum basis. The policy clearly sets out the scope of those medical professionals intended to be captured within the appraisal and revalidation process and Doctors themselves are responsible for notifying the GMC and connecting themselves to the Trust as their designated employing body. The Revalidation Support Team and Medical HR also monitor correct prescribed connections to the Trust.

- Annual appraisal process – appraisals happen on an annual basis within each appraisal year, this is in line with the GMC rules on regular appraisals. An appraisal is designed to be a positive process that gives doctors feedback on past performance, charts continuing progress and identifies development needs. Annual appraisals are at the heart of the revalidation process and every doctor is responsible for ensuring that they are appraised annually on their whole practice so they will need to make arrangements to share information from each of their employers (including practice). A doctor will be revalidated every five years and therefore the RO will need to use the previous five annual appraisals as evidence of good practice for him to make his recommendation to the GMC. In this 'first cycle' it is recognised that there will be less than five annual appraisals.

It is mandatory for all doctors to use the Trust's electronic appraisal management system, the Equiniti Revalidation Management System (RMS) for annual appraisals. It is Trust policy for each appraisee to ensure they participate in the annual appraisal cycle to meet the requirements of revalidation. Guidance can be found on GMC website and in the *'Appraisal and Revalidation Handbook for Appraisees'* - accessed via the Revalidation Support Office (which is an internally developed e-book). It is also Trust policy for doctors to ensure that they maintain their RMS portfolio and to record supporting evidence, including clinical performance data which is provided across all GMC 'domains' for their whole practice.

The appraisal form and process is within the system is based on the *GMC Good Medical Practice Framework* for appraisal and revalidation and all doctors need to have demonstrated their practice against the four main domains (listed below) which cover the spectrum of medical practice. Each domain is described by three supporting attributes, which is also in line with the GMC guidance.

GMC: Domain	Domain title	Included in annual appraisal output forms on RMS?
1	Knowledge, skills and performance	Yes
2	Safety & quality	Yes
3	Communication, partnership & teamwork	Yes
4	Maintaining trust	Yes

Over the five year revalidation cycle, and via annual appraisals, doctors will have to demonstrate evidence of all six types of supporting information (listed below) in line with the GMC framework encompassing their whole practice to enable revalidation of each doctor and must be provided and discussed at least once in each five year cycle. Our testing of the Trust's documentation has shown that the supporting information requirements are embedded in the Trust's revalidation process and are being accurately reflected against.

GMC: supporting information	Type	Included / frequency
1	Continuing Professional Development (CPD)	Yes – built in as required annually for the Trust
2	Quality improvement	Yes – required once per revalidation cycle
3	Significant events	Yes – required annually
4	Feedback from colleagues	Yes – required once per revalidation cycle
5	Feedback from patients	Yes – required once per revalidation cycle
6	Review of complaints and compliments	Yes – required annually

- Revalidation process – from the Trust appraisal output summaries and Personal Development Plans (PDPs) over a 5 year cycle from RMS, the Responsible Officer will have the necessary documentation and supporting information to assist him in making a positive recommendation to the GMC for revalidation based on the doctor's proposed revalidation date (set by the GMC). If the RO has information to indicate that revalidation is not to be recommended he is able to request to defer the date of recommendation or alternatively, he is able to report to the GMC a notification of the doctor's non-engagement in revalidation.

Evidence of systems to support the appraisal and revalidation process

- RMS – has been in use within the Trust since February 2013. It is a web based appraisal system for medical professionals developed by Equiniti and is used by over 200 healthcare clients across the UK and abroad as well as 80 NHS Trusts. It is the market leader and a specialist provider of appraisal and revalidation software and training solutions specifically for the health care sector. All medical professionals connected to the Trust have to use RMS to record their medical portfolios and appraisal documentation in order for the revalidation process itself to be as straightforward as possible. The Revalidation Support Team also monitors the progress and timing of individual appraisals via RMS to ensure appraisals are not delayed or missed unnecessarily.

- GMC Connect - This is a web-based system run by the GMC providing secure access to doctors' profiles and relevant information. When a decision has been made to recommend a doctor for revalidation, the RO uses the GMC Connect website to advise the GMC of his recommendation. The final decision is made by the GMC and, once approved, the GMC then set the date for the next revalidation. All doctors have access to GMC Connect to view and update their profile. The Revalidation Support Office will assist doctors in setting up their GMC online account. The GMC account also notifies the RO of all doctors connected to the Trust. The GMC will also provide reports to each RO notifying them of connected doctors which are 'under notice' (i.e. within four month window of their revalidation date). This helps trigger the process for preparing recommendation packs early and also prompts the doctor.

- In-house spreadsheets – one used by the RSO as a 'master' appraisal spreadsheet to record each doctor by speciality and also to record current, previous and future appraisal dates and free comments tab, and from that; a further smaller spreadsheet used as a 'watch-list' for those appraisees who, based on reporting extracted from RMS, have slipped from the process. We saw evidence on this of 'chasing up' to get their individual appraisal process back on track in line with the Trust's policy to actively engage in regular appraisals.

Overall, the Trust has implemented a suitable and robust system to record and monitor the requirement to revalidate doctors within the timescales set by the GMC and the Trust. The staff we liaised with were all fully engaged with the process and able to demonstrate a good knowledge of the revalidation process. It is evident that the Trust has provided the means and support necessary for doctors to achieve revalidation. Ultimately, it is the responsibility of each connected doctor to maintain their medical registration and licence to practise with the GMC - and this is also a condition of employment, not least a legal and professional body requirement. No concerns are raised with the revalidation system the Trust has in place.

Risk Identified	Recommendation
Controls in place are appropriate/effective to control risks associated with this area.	None – control operating/compliant

2 Identification of staff

The Trust has adequate procedures in place to identify the correct type of medical staff for inclusion within the revalidation process.

There are two low level recommendations which should be brought to the attention of management regarding regular flow of details of newly appointed doctors to the Revalidation Support Office (RSO) and, also, more formalised identification during the appointment process of a doctor's' existing Responsible Officer, including those of locum agencies. Otherwise, there is strong evidence to show the good, proactive work being done by the (RSO) to ensure the smooth running of the revalidation process.

The Medical Profession 2010 regulations require all Responsible Officers (RO) to only revalidate and make recommendations to the GMC about those 'registered medical practitioners' who have a 'prescribed connection' to their designated body. There is a clear set of rules within the regulations whether a doctor has a connection to a designated body. For most doctors, this is quite straightforward because their designated body will be the organisation in which they undertake most, if not all, of their practice.

The scope of the Appraisal and Revalidation Policy within the Trust backs up this requirement, in that the Trust recognises its responsibility as a designated body for the purposes of revalidation to all consultants, specialty doctors, associate specialists, staff grade, clinical assistants, hospital practitioners, trust Grade doctors and clinical fellows (medical staff) contracted directly by the Trust on a substantive or locum basis. This is within the regulations.

General practitioners who conduct work within the Trust will undertake their medical appraisal through the employing body for which they are on the performance list. Doctors in training will participate in a process of appraisal and revalidation led by the Deanery and the Director of Medical Education.

University Academics with honorary contracts are advised to contact the RSO for advice and guidance as they are unlikely to be attached to the Trust as their main employer. Locums employed directly by the Trust will also be the responsibility of the RO for this Trust. For locums employed via an agency, their own RO may be someone within the agency or can be identified via the GMC website.

Trust employed doctors:

- ESR (Electronic Staff Record) system is used Trust-wide to capture relevant staff records pertaining to all members of staff employed by the Trust. This will include details of all consultants, specialty doctors as well as locum equivalents employed directly by the Trust. The RSO is able to extract details of these groups of doctors by isolating their relevant payroll codes / grades. The report is also used to confirm details of doctors who have joined or left the Trust. In addition to this, the RSO receive regular reports of starters and new appointments from the Medical Education Department and Medical HR. There is evidence of regular communication and good working relationships between the relevant departments on providing information on new starters and leavers as well as queries regarding employment and contract status. All new appointed doctors are also required as part of the employment process to undergo an induction visit to meet with the RO and Revalidation Support Office, where they are able to discuss the appraisal process and choosing their appropriate appraiser.
- There are no concerns based on our testing regarding identification of direct Trust employed doctors and their details can be easily added to the RMS database and GMC Connect. Therefore the vast majority of doctors working within the Trust can be identified and captured within the appraisal and revalidation process relatively straightforward.

Trust grade doctors:

- For all non-consultant and non-specialty grade doctors who are not on substantive posts but are directly employed by the Trust (i.e. those doctors not on training contracts but are licenced to practice, such as level CT1 or 2 or old Registrar level), their employment status and details on ESR cannot be isolated

by the RSO and therefore details of these doctors are provided via a report from the Medical Education Department. Trust grade doctors are a sort of mobile workforce for the Trust, however, they tend to be appointed twice every year. They represent a relatively small proportion of the total doctors for the Trust (numbering approximately 20, or <10% of the total).

- From our testing and discussions there is evidence of adequate controls in place and good links have been established with Medical Education personnel to obtain and provide the relevant information to the RSO, to enable them to bring all relevant trust grade doctors into the appraisal and revalidation process.
- We have gained sufficient assurance that this particular 'cohort' of medical staff is correctly captured within the Trust's revalidation system where appropriate.

Honorary contractors:

- Honorary contracts are issued by the Trust to any doctor who is undertaking unpaid work. They do not apply to anyone undertaking voluntary work or work experience. They are issued to doctors who are undertaking research within the Trust, or whilst on a clinical/work placement generally on a relatively short-term basis. As the Trust is not their designated substantive employer, their RO will be with their own organisation and will therefore not be part of the Trust's revalidation and appraisal process. The appointment of honorary contractors is facilitated by Medical HR, who will issue each contractor with a formal contract and record their employment details on a database. The Medical HR Officer will provide a monthly report to the RSO containing all details of contractors which have been appointed (or changes to those contracts). The RSO can keep a record and are aware of all doctors who are currently working within the Trust. Our evidence would suggest that the number of honorary contractors can range from 80 to 100 and length of post can vary from one week to several days per month over the course of a year.
- There is a Trust template and policy for the issuing of honorary contracts with requirements for standard pre-employment checks to be carried out.
- From our testing and discussions there is evidence to support that Honorary contractors are being adequately recorded and relevant information of doctors in these positions is being provided to the RSO. There is evidence to suggest that Medical HR on some occasions does not receive the necessary information from the originating Trust department, which can delay the contract issuing process and flow of information onwards and this has been flagged as a low risk recommendation.

Locum doctors:

- These can either be locum doctors employed directly by the Trust on short-term substantive posts, or employed via an agency. These appointments are handled by Medical HR and details of these posts are then provided monthly to the RSO. If they are employed by the Trust then they are attached to the Trust's RO and become the responsibility of the Trust for their appraisal and revalidation status. Locums that are employed by an agency will have their appraisal and revalidation status carried out by their agency's appointed RO (or in the case of having been employed by several agencies, then their most substantive one). It is also for the individual doctor to ensure they are connected to the appropriate designated organisation's RO for the purposes of revalidation, and there is plenty of support provided by the GMC to assist them if in doubt.
- Medical HR will go through the normal recruitment procedure for employing locums based on medical resourcing requirements and suitability of candidates. Medical HR will follow the *"Appointment and Employment of Locum Doctors for Medical & Dental Staff"* policy and carry out the standard pre-employment checks and verifying doctors registration details. However, our testing seems to indicate that details of locum's revalidation status and RO details are not being requested or specifically verified. This has been flagged as a low risk recommendation in the table below.
- Medical HR will provide to the RSO, details of new appointments for both agency locums and Trust employed locums via a monthly report. This enables the RSO to record the necessary appraisal and revalidation details on RMS and GMC Connect.
- From our testing and discussions there is evidence to support that Locum doctors are being correctly recorded and included in the revalidation process where appropriate.

Overall, the Revalidation Support Office is able to correctly identify and record the details of the different groups of doctors who are contracted to work within the Trust. There are adequate procedures and policies in place to ensure that all relevant doctors' details are being obtained as part of their employment process. Our testing shows that generally, the correct types of doctors are being included in the revalidation process.

Risk Identified There is a risk if reports of new medical staff are not sent to the Revalidation Support Office (RSO) regularly then a doctor's revalidation status may possibly be affected resulting in reduced hospital capacity. **Likelihood (2) x Consequence (2) =4 - Low harm/damage**	**Recommendation 1** In order to minimise delays in notifying the RSO of all new medical posts appointments, the Medical HR Team should provide this information on a regular timetabled basis (preferably each month) and be built in to standard operating procedures.
Risk Identified If details of a doctor's previous Responsible Officer is not obtained prior to commencement of their employment, there is a potential risk that the Trust maybe employing a doctor who has not been properly validated by the GMC. **Likelihood (2) x Consequence (2) =4- Low harm/damage**	**Recommendation 2** In line with NHS Employers guidance, the Trust should ensure that as part of the standard pre-employment checks, details of all appointed doctors' existing Responsible Officers are being obtained. This should also be including locum agency doctors. The Trust could use the standard 'Transfer of Information' form to send to the applicant's previous employer to obtain the necessary information to be passed on to the Revalidation Support Office.

3 Revalidation Management System

It can be concluded that the Revalidation Management System (RMS) as used by the Trust, captures those staff due for medical revalidation and effectively manages the appraisal and revalidation process. The system also provides necessary reports to enable the Responsible Officer and his team to make informed decisions regarding the revalidation status of the Trust's doctors.

In order to meet the GMC regulatory requirement to ensure that all doctors are correctly revalidated and over a five year appraisal cycle, the Trust has implemented since February 2013 the Equiniti 360° Revalidation Management System. This is a web based appraisal and revalidation programme which will record and store every doctor's portfolio in order to facilitate the annual appraisal process. The package has been developed by Equiniti and is specifically tailored for the healthcare sector. It is currently being used in 80 NHS Trust hospitals and is seen as the standard nationally recognised package to be used.

Within the Trust, the system can be accessed by every doctor from a networked computer and via the Contact intranet home page.

It is mandatory for all doctors to use the system within the Trust. There is evidence of web support, user manuals and in-house guides as well as on-going assistance and guidance provided by the RSO.

The vast majority of doctors (over 200) were already set up on RMS back in 2013, following the original submission to the GMC for the first cycle of Trust employed doctors to be revalidated. The RSO will initially set up all new doctors with access on RMS based on the information provided from ESR, Medical Education and Medical HR departments. Each doctor must activate their account with a user name and password. The RSO also updates details within RMS of doctors who no longer work for the Trust.

The system is designed to record all relevant portfolio information for each doctor. It is a requirement of each doctor to record the whole scope of their practice and with supporting evidence. The doctor will update their profile, choose their appraiser and preferred appraisal date. The system will also send reminders to all users of upcoming appraisal dates.

The system allows the user to upload supporting evidence throughout the appraisal year in preparation for their individual appraisal. The appraisal documentation is in line with GMC model guidance as well as Trust policy. The appraisal portfolio can be self-reviewed in preparation for the appraisal meeting and can also be reviewed by the allocated appraiser. This ensures that the actual appraisal discussion and meeting goes through smoothly and that all relevant areas have been covered. If the appraiser is not happy with the quality of the portfolio within RMS, then they can inform the appraisee and the meeting can be delayed.

Following the appraisal meeting and discussion, the appraiser can formulate a Personal Development Plan (PDP) within RMS and also generate the appraisal summary report – which is a succinct, informative summary of the appraisal discussion. These reports must be agreed and signed off by both the appraiser and appraisee to complete the process. This is must be done within 28 days following the appraisal meeting.

The Equiniti system (via a separate module) also automatically manages the revalidation requirement for at least one 360° feedback questionnaire to be completed by either an appropriate colleague or patient. It is Trust policy however, that 360° feedback forms are completed every 3 years.

For the doctor to be recommended for revalidation by the RO, they must be provided with the last 5 annual appraisals as evidence of good practice. This will include each appraisal summary report and PDP. RMS will also generate the Appraiser Feedback to be completed by the appraisee online and can be accessed by the Appraisal Lead as part of the quality assurance process.

Throughout the whole process, the status and quality of each user's account can be monitored by the RSO, Appraisal Lead and RO if required. The Appraisal Lead also reviews the quality of the appraisal output summaries.

The system also allows adhoc reporting of progress reports, appraisal status and general information to assist the team in keeping the process on track. Based on our discussion with team members and review of key documentation, the RMS provides adequate control and recording of the doctors' appraisal process within the Trust and will help control the revalidation cycle for all doctors.

Risk Identified	Recommendation
Controls in place are appropriate/effective to control risks associated with this area.	None – control operating/compliant

4 Scheduling

The Trust has in place a suitable programme to ensure that all doctors initially identified in 2012 will be revalidated as appropriate in line with GMC requirements. There is evidence of on-going monitoring and oversight of progress being made. In addition, there is an adequate network of trained appraisers and support staff to provide resource to the revalidation programme.

During 2012, the Trust was required by the GMC to identify and record all medical professionals attached to the organisation to be submitted for revalidation. To fulfil its regulatory duties, the Trust was also required to appoint its senior medical professional as the nominated Responsible Officer (RO). To enable the RO to discharge their responsibilities effectively, in line with the regulations, the Trust also had to provide sufficient resources and support, including identifying and recruiting suitable appraisers as well as updating standard compliant documentation and quality control.

We obtained a spreadsheet which showed that the Trust identified 216 doctors which needed to be revalidated by 2016, in line with the GMC requirements. GMC guidance required that all ROs be revalidated first. Each RO had to liaise with the GMC and allocate 'preferred revalidation dates' for every doctor between 2012 and March 2016. The RO was required to implement a suitable manageable plan for allocating revalidation dates, based on medical need, seniority, personal preference and readiness.

Once this exercise was done towards the end of 2012, each doctor and RO was issued notice of their revalidation dates by the GMC. The Trust could then use this data to get every doctor set up on RMS with their particular personal profile, as well as revalidation dates.

The Trust set itself a target over the following years to ensure that all of its identified doctors were recommended for revalidation to the GMC by March 2016. By March 2014 it was aiming for approximately 25% of the total to be revalidated, by March 2015 it is aiming for another 35% and then the remaining 40% in the following year. This is in line with the GMC's own plan for implementation of ensuring 20% of licenced doctors by 2014, another 40% by March 2015 and the remaining 40% by 2016.

Based on evidence obtained of Board reporting during this review, by March 2014 54 doctors were revalidated (representing 23% of the total identified) which had increased to 75 by 31 August 2014 (or approx. 35% of the original total of 216). We obtained details of latest numbers of doctors which have been revalidated and this showed 93 doctors up to 29 October 2014.

The Trust also has in place an adequate system for capturing new doctors who have joined the organisation since 2012 for their prospective revalidation dates. We obtained various in-house forms as part of the audit showing examples of doctors being added to both RMS and GMC Connect. Also, examples were obtained of doctors being removed and accounts being deactivated. We obtained evidence to show that currently there are 7 doctors within the system which have had their revalidation dates deferred – dates ranging from 4 months to 1 year and with reasons such as awaiting 360° feedback, more appraisals being needed, sick leave. We obtained a latest report from GMC Connect which showed 239 doctors currently with a prescribed connection to the Trust. Of this total, there was one doctor identified as having a late submission date for revalidation (due 22/09/14). This doctor is currently under investigation at the R D & E Hospital and therefore appears on the RSO list of deferred revalidations (there is a revised planned date for revalidation of January 2015). There were no other 'late submissions' and this indicates that doctors are being revalidated when due.

The RSO also receives (as does the relevant individual doctor) a report from GMC Connect showing all their doctors who are 'under notice', which are those doctors within 4 months of their revalidation date. This report is used by the RSO to trigger upcoming revalidation meetings with the RO. We obtained the latest version of this report which reflects the RSO's own records of scheduled upcoming 'recommendation' meetings.

We can provide assurance all doctors initially identified in 2012 have either started to be revalidated or are in the revalidation cycle and are on track, with each doctor having a proposed date for their revalidation. There are adequate controls and monitoring of the process and the targets set are reasonable.

Risk Identified	Recommendation
Controls in place are appropriate/effective to control risks associated with this area.	None – control operating/compliant

5 Clinical governance

Clinical governance information is being sufficiently included as part of the appraisal process and is in line with Trust policy as well as GMC requirements for revalidation. The Responsible Officer is able to make an informed decision for revalidation of a doctor based on the clinical governance information collected throughout the appraisal process.

Every doctor's clinical portfolio should demonstrate that the doctor fulfils the requirements of the *GMC's Good Medical Practice Framework for Appraisal and Revalidation.* Organisations have an obligation to assist doctors in collecting supporting information for the appraisal process. The review of 'significant events' is one of the GMC's six supporting information criteria to be provided and discussed for appraisals and revalidation and is required annually.

A significant event (also known as an untoward or critical incident) is defined as any unintended or unexpected event which could or did lead to harm of one or more patients. This includes incidents which did not cause harm but could have done, or where the event should have been prevented. These events, as part of clinical governance, should be collected routinely by the organisation.

It is Trust Policy to provide performance data on serious incidents, complaints and litigation for all doctors. Such information can include a list of incidents or complaints received by the Trust concerning either a named clinician, a team in which the doctor practises or a particular directorate/ward in which the doctor is working. This will be made available for the doctor to include in their online RMS portfolio and the doctor will need to reflect on this prior to their appraisal.

Doctors are also encouraged to gather local data regarding complaints and compliments which might have come (for example) directly towards clinical areas/directorates. Appraisers will consider this information during appraisal. It is a GMC requirement that all complaints received in connection with a clinician are included in the annual appraisal.

Where the complaints report produced by the Trust is not comprehensive, the doctor is required to bring other complaints with them to each appraisal. This may include complaints received from other designated organisations. It is important to note that complaints should be seen in the appraisal context as another type of feedback that permits doctors to review and develop their practice.

Details and data around clinical governance in the Trust will come from a variety of sources but predominantly will be from Safeguard and PALS. This data is made available to all doctors and they will retain it within the build up of their portfolio on RMS. The RSO and the RO can also access other clinical governance means by liaising with the Trust's Litigation Department or, via the GMC or from local knowledge and feedback gained within the organisation itself on a doctor if there are particular issues or concerns.

Doctors can access the clinical performance drive within the Trust, which includes a database of performance data for some of the higher grade consultants and surgeons. However, this is not comprehensive for all grades of doctors. All doctors will still need to obtain further details from the behind the data numbers (e.g. for

significant incidents on Safeguard) to be uploaded on to RMS and used as supporting information within their portfolios. This is normally obtained from Patient Safety or the RSO will assist. In the absence of this data, the process relies on each clinical director to report to the doctor, RO or appraiser any concerns or details of significant incidents.

A key control is also the requirement of all doctors within RMS itself to formally sign off on a statement of probity and health declaration and therefore accepting the GMC's medical professionalism obligations on being honest, trustworthy, acting with integrity and being in good health. Clinical governance considerations are also included as standard procedure within the Trust's 'revalidation recommendation checklist' for the RO to sign off against.

From our review of this area we can provide assurance that clinical governance concerns are embedded within the appraisal and revalidation process at the Trust and that all parties have access to the necessary data to be able to include significant events within the supporting information criteria, as required by the *GMC Good Medical Practice* guidance. There is one low level recommendation in relation to making the performance dashboard more comprehensive for all grades of doctors within the Trust.

Risk Identified	**Recommendation 3**
If clinical governance systems data is incomplete and is therefore not fully considered for appraisals and revalidation, then there is a potential risk of doctors being not fit to practise and ultimately affecting patient safety. **Likelihood (1) x Consequence (4) =4- Low harm/damage**	The Trust should consider expanding the range of performance measures and data sources shown within the dashboard for senior grades of doctors (i.e. consultants & SAS) portfolios, in order for the appraisal and revalidation process to be as accurate and complete as possible.

6 Links with third parties and other agencies

There are adequate links with other organisations where the Trust's doctors may be working to enable sharing of information. It should however be acknowledged that due to the multiple sources of workforce, there is always the risk that doctors working within the Trust may not be fully within the revalidation process or that a doctor should be connected to the Trust when they are not. It should be highlighted that the process ultimately relies on the Doctor as a medical professional to actively engage and take personal responsibility for their licencing status and for the Trust to facilitate and support that process as much as can be reasonably expected.

It is essential that strong links are established with other organisations and agencies to ensure a good two-way flow of information as required. The RO for the Trust attends meetings with a national network of Responsible Officers and is able to use those meetings to be made aware of concerns and to raise concerns if required.

Doctors other work commitments outside the Trust

Doctors employed by the Trust are able to work in different divisions of the Trust and for other organisations such as private healthcare. If a concern regarding a doctor's practice is raised formally by a patient, it is managed through the PALS or Patient Engagement route where the incident or event is documented, investigated and resolved liaising closely with all people involved. Trust staff have a duty of care to report concerns regarding a doctor's poor practice and, if such a situation arose, this would be managed through the doctors direct line manager.

A doctor's other work commitments are documented within a job plan including private healthcare work. Should an incident occur where the doctor was responsible or involved, onward reporting is possible, if required. We obtained evidence of an example standard request to Mount Stuart Hospital, Torquay, for connected doctors carrying out private work there, whereby liaising with the General Manager regarding any concerns and gaining assurance of their fitness to practise.
It is Trust policy that when a doctor has moved to the Trust from another organisation and becomes their substantive employer, then they will be obligated to participate in the Trust's own appraisal process. With the support of the Medical HR team and RSO, an appropriate appraiser will be allocated and arrangements will be made for any relevant appraisal records and sharing of information to be transferred. This is ultimately the responsibility of the doctor but they will be fully assisted by the Trust if this is proving difficult.

There is a standard NHS England developed template *Transfer of Information form*, for organisations to use to facilitate the easy transfer of doctors' practice from the previous Responsible Officer. This is reciprocal arrangement so that the Trust's own RSO is obliged to provide details too if so required. This is required for clinical governance concerns also as part of any revalidation process.

Use of Locum agencies:
Locum doctor appointments should be made with the same care as a substantive doctor's appointment. All locum doctors should meet the entry criteria for the post. Locum doctors must be properly qualified and experienced for the work they will be required to undertake. Locum doctors should not be engaged for employment until all necessary employment checks have been conducted satisfactorily, either by the Trust or by a locum agency that subscribes to a national approved framework.

For the use of agency locums, Medical HR will recruit and appoint the doctors using the Trust's database of approved medical agencies. These agencies are part of the Crown Commercial Service Framework. This is a government approved framework of NHS employment providers who, amongst other things, have signed up to the *NHS Standard on Employment Checks*. These employment checks are embedded in the *CCS National Agency Framework* and therefore annual audit checks of agencies, to assure compliance with the standards, is met in relation to contracted and sub-contracted staff.
Therefore, locum agencies that are part of a negotiated framework are required to appoint their own RO and must provide annual appraisals for all its doctors connected with that agency. Many locum doctors will be registered with several different agencies and must therefore decide whom their most substantive agency employer is to attach themselves to with the GMC.

Medical HR will vet all locum doctors prior to appointment for their suitability and obtain standard levels of assurance from the agency provider. There is a suitable Trust policy on the appointment of locum doctors which includes guidance and standard forms to be used in the process.

Honorary contractors:
These are short-term appointees carrying out unpaid work within the organisation. As the Trust will not be the designated substantive employer, these doctors will not be attached to the RO here and therefore not responsible for their appraisal or revalidation. Honorary contractors are issued with standard contracts for the length of their appointment and the Trust will still carry out pre-employment checks including GMC registration status, although not specifically their RO details or revalidation status.

There are adequate controls and procedures in place to ensure all doctors working within the Trust are properly identified and controlled with respect to revalidation.

Risk Identified	**Recommendation**
Controls in place are appropriate/effective to control risks associated with this area.	None – control operating/compliant

7 Performance reporting

Based on our testing we can provide assurance that Board reporting regarding appraisal and revalidation progress is relevant and sufficient for the purposes of quality assurance of the process and is in line with regulatory requirements, namely NHS England's Framework of Quality Assurance (FQA).

Assurance of the revalidation and appraisal process is achieved by the following:

- Monthly exception reporting to the Trust Board – this is the monthly update report and is now in exception report format. The Board therefore receives up to date numbers on revalidation recommendations (as well deferrals). There is also data on total number of appraisals carried out. There is exception reporting on late or missed appraisals with additional commentary and action plan to resolve. The reports are prepared by the RO and Appraisal Lead and we obtained evidence that these were being regularly prepared. We can provide assurance based on the testing undertaken, The numbers being reported were accurate to the records held as at that time.

- Quarterly updates - The Trust Board also receives progress updates and confirmations on external reporting returns to NHS England. These are based predominantly on the Framework of Quality Assurance (FQA requirement for Quarterly Reports to be electronically submitted each quarter throughout the year). We obtained a copy of the latest September return – submitted in October 2014.

- Revalidation Annual Board Report – this is to provide the Board with assurance that the Trust's statutory responsibilities are being discharged in accordance with GMC regulations. The Board will receive data regarding the number of doctors with a prescribed connection to the Trust during the appraisal year (the most recent being ending March 2014) as well as total number of completed appraisals and outstanding appraisals. The outstanding appraisals are also analysed for the Board and sub-analysed for reasons. The Report also confirms the number of revalidation recommendations made. The Board is also made aware of the total number of trained appraisers as well as quality assurance of the appraiser network. Based on the information provided within the Report and the assurances given, the Board will be asked to endorse the Revalidation Programme and to sign off on its statutory responsibilities (this is known as the *Statement of Compliance* in accordance with the NHS England Quality Assurance Framework). As part of our testing we were able to vouch the Statement that was signed off in August 2014.

We can provide assurance that these reports are adequate for the purposes of regular Board reporting and provide assurance on the systems and procedures in place.

Risk Identified	**Recommendation**
Controls in place are appropriate/effective to control risks associated with this area.	None – control operating/compliant

8 Statutory obligations

Based on the systems and processes in place within the Trust, the Interim Medical Director as senior medical professional for the designated body is adequately able to meet the statutory obligations for his position as RO. In addition to this, the Board are able to sign off the annual Statement of Compliance in accordance with the regulations, based on the systems in place and the information provided from the RMS system. We have obtained evidence that the Trust Board have an effective system in place to monitor and support their medical staff, including its RO, throughout the GMC's revalidation process.

The main statutory requirements for revalidation are covered by the *General Medical Council (Licence to Practise and Revalidation) Regulations 2012*, and *The Medical Profession (Responsible Officers) Regulations 2013.*

Under the Medical Profession 2013 Regulations, as the appointed senior medical professional within the organisation, the RO has a statutory obligation to be responsible for making suitable recommendations to the GMC about each doctors' fitness to practise. The Trust, as a designated body, also has a duty to provide necessary systems, resources and support to enable the RO to effectively carry out his or her duties.

The RO and Trust Board are required to report quarterly and annually to NHS England (as 'Senior Responsible Officer'). The Trust must therefore, under the *NHS England's Framework of Quality Assurance*, provide confirmations and data reports quarterly and annually regarding the progress of their revalidation and appraisal programme, as well as other doctors' data.

The Trust Board sign this off through an annual *Statement of Compliance* – which is recommended to the Board contained within the Annual Board Report. We have seen the Statement of Compliance relating to the year ending March 2014 which was submitted in August 2014. We have also seen the quarterly returns to NHS England which were prepared by the Revalidation Team and are up to date.

The Trust uses the *Equiniti Revalidation Management System* (RMS) to manage and control the doctor appraisal system. The system uses standardised forms and outputs which are based on GMC requirements. The Trust has provided a network of trained appraisers to assist in carrying out regular appraisals and is overseen by an Appraisal Lead, who also provides quality assurance to the process. The Revalidation Support Office actively monitors, co-ordinates and support doctors within the Trust to ensure that the appraisal and revalidation process runs smoothly and stays on track.

There are no concerns regarding the process and statutory obligations for the Trust. The Equiniti RMS system and supporting processes adequately provide the necessary information.

Risk Identified	**Recommendation**
Controls in place are appropriate/effective to control risks associated with this area.	None – control operating/compliant

Audit Report Information

Audit South West
Internal Audit, Counter Fraud and Consultancy Services

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CONFIDENTIALITY

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit.

INHERENT LIMITATIONS OF THE AUDIT

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

RATING OF AUDIT RECOMMENDATIONS

The recommendations in this report are rated according to the organisation's risk-scoring matrix. The recommendations have been arrived at by assessing the risk in relation to the Trust as a whole. This should enable recommendations made in different reports to be compared when deciding the priority and level of risk faced by the organisation.

AUDIT ASSURANCE ASSESSMENT TABLE	
There are some weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of key system, function or process objectives.	**Red**
There are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process.	**Amber**
No control weaknesses were identified. or Our work found some low impact weaknesses in the design and/or operation of controls which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. We can therefore conclude that the design and/or operation of the key controls is sound.	**Green**

AUDIT IMPACT ASSESSMENT TABLE	
There could be a significant impact on the achievement of organisational objectives.	**High**
There could be a moderate impact on the achievement of organisational objectives.	**Medium**
There could be a minimal impact on the achievement of organisation objectives.	**Low**

Chief Executive's Business
July 2015

Internal

ICO Update

Following our Board to Board meeting in May, colleagues from Monitor visited the Trust on Tuesday, 23 June 2015 to follow up on issues discussed at the meeting. They met with myself and the Chair and spent time reviewing aspects of the operational and financial plans with the Chief Operating Officer and Director of Finance, Performance and Information. They also had the opportunity to meet the Non-Executive Directors who were unable to travel to London for the Board to Board meeting. Additional information and assurance was been provided, both at the meetings and subsequently, that we expect to be helpful as Monitor enters the final stages of its assessment process.

On Thursday, 25 June 2015, the NHS Trust Development Authority convened a meeting of all interested parties – NHS England, Monitor, Clinical Commissioning Group and our two Trusts – to progress a funding solution that will support the establishment of the Integrated Care Organisation. The meeting was productive. Importantly for this Trust all parties confirmed support for the transaction, accepted the quantum of required funding and recognised the significant contribution already made by this organisation. A potential funding solution was identified involving actions by a number of the stakeholders at the meeting, and will be further developed within the next two weeks.

Performance Challenges - Emergency Department
Pressures on emergency departments across the country continue, something that has also been experienced in the emergency department in Torbay Hospital. Achieving performance standards continues to be a challenge, with an average of 90% of patients seen, treated or discharged within 4 hours so far in the month of June.

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 21 June 2015 are detailed below:

Numbers attending ED and percentage seen in 4 Hours

Hospital	Numbers Attending ED	% Seen in 4 Hours
Torbay Hospital (SDH)	**1,559**	**87.7%**
Plymouth Hospitals (PHNT)	1,782	87.7%
RCHT	1,278	74.5%
RD&E	1,990	96.1%
NDHT	843	91.9%

Figures are taken from NHS England

The recent outbreak of diarrhoea and vomiting affected several of our wards and lasted eight weeks. This has had an impact on this month's ED performance as there have been delays in patients being able to be discharged which has a knock on effect on how quickly people can be treated.

Our thanks to staff including those on wards, cleaning teams and community colleagues, who worked hard to minimise the impact on our patients.

Perfect Week
Working with our partners in TSDHCT 'Perfect Week' is one of the initiatives we have undertaken to look at how we can make improvements to the way we work.

The focus of the 'perfect week' was to improve patient flow by freeing up clinical staff so their time is spent delivering patient care rather than troubleshooting problems or barriers. It was a week of learning and doing things differently - breaking the cycle - so that we can use what works well to kick-start sustainable practices.

This ran from Wednesday 17 June to Wednesday 24 June and we are now analysing the feedback and will report back to the next meeting our findings. On Tuesday 22 June we achieved 100% as part of this initiative.

In order to have a 'perfect week' staff from different areas volunteered to support the wards at Torbay hospital and in the community who were part of this. I would like to thank all of the staff who took part in this week from both Trusts as well from the CCG.

Flood at Torbay Hospital
Unfortunately in the early hours of 5 June 2015 a burst pipe caused a flood at the hospital. The water was discovered in the corridor between Ainslie and Ella Rowcroft. The water covered and affected a large area and also leaked through the ceiling and onto the level 4 corridor below. There was a fantastic response from both the staff who were on duty and those who had to be called in who worked tirelessly to clear the water and get things back to normal. No patients were directly affected as this was not in any of the wards.

This is a perfect example of how the dedication of our staff, working together, ensure that our patients continue to receive the best possible care even in the face of something as challenging as this.

Community Services

Dartmouth Minor Injuries Unit
For some time TSDHCT has faced significant challenges in maintaining sustainable and safe staffing levels at a number of minor injury units, and some rely heavily on temporary arrangements.

Unfortunately, the national shortage of qualified staff continues to have an impact on recruitment in rural locations. An ongoing recruitment drive to fill every vacancy, current and foreseen, on a substantive basis has included national advertisements aimed at paramedics, emergency care practitioners as well as nurse practitioners to widen the pool of potential candidates. Despite repeated recruitment attempts, it has not yet been possible to fulfil these posts. Efforts are continuing.

TSDHCT had to suspend the Dartmouth minor injury services from 29 May 2015. Patients are being redirected to nearby MIUs at Brixham and Totnes, or where appropriate Dartmouth Medical Practice. A service covering core hours will be run for Regatta Week in August. Local stakeholders and the public have been informed and will be kept up-to-date.

Coastal Location – CCG Review
The CCG have been reviewing and consulting on the services they wish to commission in the Coastal Locality of Teignmouth and Dawlish. Services needed to be provided in a different way due to a rise in demand and reduction in resources.

The CCG Governing Body, on the 25th June, approved the option that includes 12 specialist rehabilitation community beds at Teignmouth Hospital, 16 acute community beds at Dawlish Hospital, a locality MIU in Dawlish open 8am-8pm with x-ray 8am-8pm, 7 days a week, outpatient clinics in Teignmouth and a community hub at Teignmouth. An additional 12 community staff, of whom eight would be community nurses. The option provides a saving of £220,000 per annum.

Pioneer Update – please find attached the June Pioneer and Joined Up update.

Events

Volunteers' Tea Party
On 11 June I attended the volunteers' Tea Party to say a special 'thank you' to the 800 volunteers for this Trust and TSD, who give up their time to help make a difference to many patients and their carers.

The volunteers' tea party fell within National Volunteers' Week (1 - 7 June) which is a week when thousands of volunteers, in a range of diverse roles across the UK, are celebrated for their valuable contribution.

Blue Shields Awards
On 10 June I, along with the Chairman, attended the Blue Shields Awards that recognise the hard work and dedication of health and social care NHS staff and volunteers from across Torbay and Southern Devon.

The awards recognise individuals or groups whose energy, commitment and dedication ensures that high quality and effective services are delivered to patients, services user and staff.

There were 19 winners and 13 highly commended awards across 16 categories, including individual, team, partnership, innovation, volunteer and lifetime achievement. This was a fantastic opportunity to reward those people who are making a real difference to patients.

External

Information

CCG
Simon Bell (Chief Finance Officer) will shortly be leaving the South Devon and Torbay CCG on 31 July. They have begun the process of selecting a permanent replacement in the meantime have appointed Simon Davies, who has worked in the local healthcare system, as interim CFO.

Government Announcements

Monitor and TDA Closer Working
The government has decided its intention to take the principle of closer working a step further by ensuring that both Monitor and the TDA report to a single leader David Bennett, Monitor CEO has decided to step down from but will remain in post until the transition has progressed.

The full details of how the two organisations will work together have yet to be determined, although I can tell you that Monitor is to retain its economic regulation functions as well as its FT role.

Closer working between the two organisations will enable the health system to achieve the best value for money, and deliver the efficiencies and service changes needed for future sustainability.

NHS England to tackle failing services
Simon Stevens at NHS England announced that areas of the NHS in England are being placed in special measures as a way of tackling failing services. He said the new approach would involve the whole system, including community services and social care, as well as hospitals. Locally this includes the NEW Devon area as well as Essex, North Cumbria and as the first areas to be tackled. All have reported significant financial problems, and some of the hospitals in the areas are already in the old system of special measures. This is formally known as the "new success regime". The specific reasons for NEW Devon being included are below.

Officials from NHS England, Monitor and the NHS Trust Development Authority will be parachuted in to provide enforced support to the areas, but Mr Stevens said it stopped short of a takeover, with local managers remaining in place.

Northern, Eastern and Western Devon

- In 2014/15 the Local Health Community was identified as part of the Challenged Health Community Work, and from that significant and increasing Health Community deficits were forecast if action is not taken.
- All partners in the system need to work more closely together to develop a service and financial strategy that delivers National Operational Performance Standards and financial balance.
- The Success Regime will ensure leadership across the community is aligned to a clear strategy; will support the local leaders to deliver change across organisational boundaries; and build on the potential for new models of care to support change.

Jeremy Hunt: NHS facing very, very big challenge – speech to NHS Confederation
In a speech to NHS Confederation annual conference, the Health Secretary that the NHS in England must stop wasting money if it is to meet the "very very big challenge" it faces.

He reiterated that while the government was giving the health service an extra £8bn by 2020 it would still need to find £22bn in "efficiency savings". This is the figure set out by NHS England chief executive in his five-year plan last autumn. To be achieved it would need the commitment of everyone working in the health service. He highlighted figures from a government review highlighted poor procurement processes and found prices paid for products varied by 35% rather than the recommended 1%-2%. This includes a two-fold variation in the amount paid for toilet rolls and a three-fold variation for a box of syringes.

He also said later this year the best performing hospitals would be invited to set up "hospital chains" allowing them to take on services in areas where there is poor performance

He also unveiled changes to the way waiting time data is published including that ED data will no longer be weekly published and that two of the three waiting time targets for routine hospital operations are also being scrapped.

The attached letter from Monitor, the Trust Development Authority and NHS England outlines the changes to the Referral to Treatment (RTT) operational standards and reporting arrangements.

Meetings

I have continued with my induction programme of meetings and I have also:

Attended an Aging Well programme meeting
Attended an IPC Leadership Summit
Met with Duncan Selby CEO of Public Health England
Attended a Health and WellBeing Meeting
Led several staff Bitesize sessions in both Torbay hospital and community settings engaging staff on the Integrated Care Organisation (ICO).

Pioneer & JoinedUp June 2015 Update

Pioneer Hubs

A wellbeing co-ordinator has been recruited by Age UK in the Newton Abbot Hub. Working as part of the Multi-disciplinary team they will have guided conversations with older people to develop individual well-being plans, provide on-going support to self-manage health and well-being, as well as supporting people to access community activities and providing advice and information on access to health and social care services.

Early indications since the hub went fully live show demand for therapy has increased while demand for nursing has decreased slightly. Full analysis of data and outcomes will be completed at the end of the first quarter. The lead GP and community matrons are working to increase the number of people referred to the Newton Abbot Hub.

In the Children and Families Hub at the end of April there had been 9 referrals through the social prescribing pilot since the start of January. All GPs in Chilcote are now referring. The pilot will be thoroughly evaluated when 20 cases have been reached which will include patient testimonials. The Hub pathway is being reshaped to align health trainers to GP practices in Hele, Watcombe and Barton as 'wellness co-ordinators' building on the Newton Abbot. This will interface with the Early Help pathway and buddies within the community and children's centre. The delivery group is looking at utilising Pioneer funds to trial this model which will form part of the SWIFT plan.

The Family Lifestyle Intervention project for overweight and obese children is being co-delivered by the Community and there have been five participants so far. Pioneer evaluation is focusing on this project and considering the wider experience of staff and community members in co-delivery. Barton school will be involved in piloting a whole school approach to healthy schools.

The Community provider is seeking to pilot a breastfeeding co-ordinator post to provide close-focused support to mums in the hub area post discharge in the interim period before health visitors are involved in their care.

Stop smoking training has been delivered to the community groups and a regular workshop takes place at the Acorn Centre.

It has been agreed by the Children's Hub delivery group that SWIFT will take on the project management of the Children's Hub building on the work in Hele, Watcombe and Barton and expanding this to other localities. The next focus will be Paignton and social care issues through local multi-agency team working.

National Pioneer Support & New Models of Care

Our vanguard application received very had very positive feedback and we have been identified as a 'fast follower' of the selected vanguard sites. As a result we have been offered support by the Kings Fund and we are talking to NHSE about the type of pioneer support we need to take forward our plans at pace. At the Pioneer Support Group on 17th June we heard about changes to the way NHSE plans to support Pioneer and Vanguard sites. There will be more 'hands on' support with the potential to bid for investment in projects. A draft support plan will be considered by JUB on 3rd July 2015. Areas highlighted include:

- Financial support to deliver LMATs (Local Multi-Agency Teams)
- Co-ordination of our model of care workstreams including, pioneer, ICO, IPC and Ageing well
- Support to roll out our information sharing toolkit
- Support to integrate our approach and plans for prevention

Integrated Personal Commissioning (IPC)

On 9th June a number of staff including, The Pioneer/JUB Manager attended the IPC leadership summit. As part of this Mairead McAlinden, CEO South Devon Healthcare Foundation Trust (SDHCFT), Liz Davenport, Chief Operating Officer SDHCFT, Bob Alford, CEO Totnes Caring and Simon Sherbersky, lead Officer of Torbay Community Development Trust, attended a session with Simon Stevens, head of NHSE and Carolyn Downes, head of the LGA to discuss taking IPC forward. Chief finance Officers from the CCG, Torbay Council and SDHCFT also met last week with others across the region to agree how cost modelling would be developed to inform roll out of IPC.

On 5th June the Coalition for Collaborative Care facilitated a workshop where we considered our readiness for integrated personal commissioning and support planning and agreed next steps. The event was well attended by staff from the CCG, Community voluntary sector, healthwatch, local authorities, Torbay Hospital and Torbay and the Care Trust.

We agreed next steps in implementing and leading the changes required not just to our processes but more importantly to the way we work together and involve people in all decisions about their care and support.

Cultural commissioning

Torbay Community Development Trust, in partnership with a number of cultural organisations and public service commissioners from the Council and Clinical Commissioning Group, has been awarded a place in a national programme of support to improve the contribution of culture to social outcomes. Torbay was one of five selected from a very strong national field. This is an exciting opportunity to work with local arts and cultural organisations to deliver better social and health outcomes. The award is in the form of experienced consultancy support to help us do this. A number of people met with the consultant leading this project on 11th June and these interviews will inform next steps in the programme.

To: CCG Accountable Officers
CCG Clinical Leaders
Chief Executives of NHS Providers

NHS England Publications Gateway Reference: 03615

24th June 2015

Dear Colleague

Changes to the Referral to Treatment (RTT) operational standards and reporting arrangements

Simon Stevens wrote on 4 June 2015 to let you know that he had accepted Sir Bruce Keogh's recommendations on improvements to current waiting time standards and reporting arrangements. This letter sets out the operational arrangements required to enact these changes.

RTT

The admitted and non-admitted operational standards are being abolished, and the incomplete standard will become our sole measure of patients' constitutional right to start treatment within 18 weeks.

This means that from the date of this letter (24th June 2015), no provider or commissioner will receive any form of sanction, whether in the form of regulator investigation/intervention or the levying of financial sanctions, for failing the admitted or non-admitted standards.

Over the course of the year the Department of Health, NHS England, Monitor and the NHS Trust Development Authority will formalise these changes through alterations to the Standing Rules Regulations, the NHS Standard Contract, the CCG Assurance Framework, the Risk Assessment Framework and the Accountability Framework respectively.

Contracts and sanctions

Commissioners should not levy any financial sanctions associated with the admitted and non-admitted standards with effect from 1st April 2015. Where sanctions have already been applied in respect of these two standards in the 2015/16 financial year, commissioners should make arrangements to repay the funding withheld to the relevant providers.

NHS England will shortly consult on a National Variation to make in-year changes to the 2015/16 Contract to formally remove the financial sanctions for the two completed pathway standards. This will also propose increasing the value of the sanction which applies where providers are unable to achieve the incomplete pathway standard, in line with our commitment to the incomplete standard as the single new measure of RTT performance. We intend that the National Variation will be implemented by 1st October 2015. This means that providers have three months to improve their incomplete performance before contract sanctions increase.

As the completed pathway standards are set out specifically in the Standing Rules Regulations, removal of the standards themselves from the Contract will only follow once revised regulations have been passed by Parliament and the standards removed from the Standing Rules Regulations.

The Department of Health is currently preparing to put forward the necessary proposals to remove the admitted and non-admitted standards from the Standing Rules Regulations. Subject to Parliamentary approval, this should be completed by 1 October 2015 and removal of the standards themselves from the NHS Standard Contract will then be taken forward, probably as part of the process of updating the Contract for 2016/17.

Patients' legal right to start non-emergency consultant-led treatment within 18 weeks of referral is unchanged.

At this stage, no changes must be made to Schedule 4A (Operating Standards) in local commissioning contracts (whether signed or unsigned at the date of this letter). Contracts as yet unsigned should be finalised on the basis of the published 2015/16 NHS Standard Contract and signed as soon as possible. NHS England will in due course provide guidance on the implementation of any National Variation. Until the National Variation is put in place, however, we do not expect CCGs to enact contractual sanctions for underperformance against the admitted and non-admitted operational standards.

Commissioners must of course continue to apply contractual sanctions where providers fail to achieve the RTT incomplete pathway standard or the other operational standards and national quality requirements set out in Schedules 4A and 4B of the Contract.

NHS England will also consider whether further changes need to be made to the CCG Quality Premium scheme as a consequence of these changes to RTT standards.

Regulation

Monitor and TDA will be reflecting these changes in their approach to the regulation and oversight of Foundation Trusts and NHS Trusts respectively. Monitor will set out details of the changes required to the Risk Assessment Framework (RAF) when it publishes the outcome of the current consultation on the RAF in early July. Similarly TDA will update the Accountability Framework for NHS Trusts.

Data reporting and publication

Until notified, commissioners and providers should continue to submit all four existing monthly RTT collections. To maintain transparency and safeguard against these changes having unintended consequences, there will be some minor amendments to the monthly RTT collections in due course to remove the adjusted admitted part of the collection and to add some items (number of clock starts, decisions to admit and validation removals) to understand better the waiting list dynamic. Notification will be given as to when these changes will occur.

The collection of information on admitted (unadjusted) and non-admitted pathways will continue alongside the information on incomplete pathways.

The NHS needs this information to ensure that patients are treated fairly and do not have to wait longer than necessary for treatment. CCGs need to ensure the data being reported is a

true and honest reflection of waiting times and highlight where action is needed to reduce inappropriately long waits. In the interests of transparency and fairness, local access policies should accord with the RTT Rules Suite, and be published on provider websites.

Starting with the publication of June data in August, the following statistics will be published monthly on the same date by NHS England: RTT, Cancer, Diagnostics, A&E, Ambulance, NHS 111 and Delayed Transfers of Care.

Changes to cancer and A&E collection

Weekly collection and publication of A&E data will stop from 1st July. NHS England will consult with users shortly on how best to implement these changes. Further detail will be available via Unify2 in due course.

Providers will be required to submit Cancer data for the month of June and Quarter 1 2015/16 by 17.00 on Tuesday 4th August to the Open Exeter Cancer Waiting Times system (this deadline is as currently advertised). The reports generated from these submissions will be used to produce the publication for June data and Q1 data.

Non-reporting

We will also be developing a much more stringent approach to non-reporting of mandatory data, particularly for providers about to undergo Patient Administration System (PAS) upgrades. This is to ensure that ceasing reporting only happens in the most exceptional circumstances and that there is a clear and transparent process to re-commence reporting as quickly as possible.

Summary

We understand that both commissioners and providers are currently under significant pressures. It is our intention that the simplification of RTT standards and reporting requirements will support you in focusing on what really matters in what we all recognise will be a challenging year.

Yours sincerely,

Sarah Pinto-Duschinsky
NHS England

Lyn Simpson
NHS Trust Development Authority

Stephen Hay
Monitor

REPORT SUMMARY SHEET

Meeting Date:	1st July 2015
Title:	Site-wide Parking improvements: Full Business Case
Lead Director:	Director of Estates & Commercial Development
Corporate Objective:	1. Safest care; 3. Best experience: 6. Delivering improved value:
Purpose:	For approval

Summary of Key Issues for Trust Board

Strategic Context:

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.

The difficulties with car-parking on the acute Hospital site are well documented and car-parking consistently appears as the number one cause of complaints and a significant issue for our patients and members of the public. Making improvements is a priority for the Governors and the Board.

A car parking strategy was developed in early 2013 and has undergone a widespread consultation process. The Strategy initially was developed in partnership with Torbay Council and presented in the Outline Business Case Approved by the Board in August 2014.

Key Issues/Risks and Recommendations:

This Full Business Case details the proposed investment of c£1.97m in improvements to the car parking infrastructure including on site systems, three pay on exit car parks, signage, surfaces, safer car parks and the delivery of c200 more public car parking spaces, 50% more disabled spaces, and an increase of 55 staff permit spaces.

For this not to be funded from monies given for the delivery of patient care, affording the £1.97m investment necessitates an increase in both public and staff parking charges to cover the costs of the improvements. This increase in charges has been widely consulted upon and has been recommended and is supported by both staff and public consultation groups as the minimum to cover the costs that bring significant benefits to both the public and staff. Together the Trust and the subgroups have worked really hard to keep charges below the level of most other Hospitals.

The Trust Board should be sensitive to the impact on, and the potential adverse reaction of some members of public and staff to the increased charges necessary to fund this very positive development.

Recommendations:
The Trust Board asked to:

- Agree the final site wide solution for the improvement to the car parking and configuration across the site
- Agree the resultant final parking charges as recommended by the staff and public sub-groups

Summary of ED Challenge/Discussion:

The minimum cost of public parking is £2 i.e. for 2 hours, this seems lengthy and costly for short visits.
In coming to this conclusion the subgroup (which included public and Governor representation) considered an analysis of parking need that showed few people stay for less than 2 hours. This tariff is the same or lower than three other comparators. On-going evaluation will be undertaken of the changes and the Trust will be actively seeking feedback from the public. If this becomes an issue the Trust has the means and ability to introduce an hourly charge if necessary.

Internal/External Engagement including Public, Patient and Governor Involvement:
The Trust's car parking strategy was publically consulted on during 2013. It was well received by all bodies and comments from particularly the local neighbourhood group were taken into account in the final proposal.

The key stakeholders consulted is detailed below:

Group/Individual
Local Councillors
Mayor of Torbay
Local Residents neighbourhood group (twice)
Trust Disability Action Group (DAAG) – (twice)
Trust Clinical Executive Group
Trust Clinical Management Group
SDHC Trust Board
SDHC Governors (twice)
Torbay Council
Trust Medical Staff Committee (MSC)
Trust Local Consultation Negotiating Committee (LCNC - Staffside) (twice)

The strategy has been on the public facing Trust website since early 2013 for comment. During the development of the preferred option two consultation groups, representative of the key stakeholders have been established to continue the close dialogue and ensure the presented solution is acceptable and supported by key groups and stakeholders. The groups discussed and recommended the car parking charges and new parking policy enclosed in the full business case as equitable and the minimum needed to cover the costs of the investment.

Equality and Diversity Implications:

A full equality impact assessment has been undertaken on the plan. The Trust's disability action group has twice been consulted on the configuration and proposed site wide improvements and in addition members have been part of the subgroups representative of both patients and staff. The proposed solution is fully DDA compliant and represents a significant improvement to facilities, safety of services and a 50% increase in the number of disabled spaces.

Full Business Case

Site Wide Car-Parking Solution

Final Draft June 2015

Document Reference

Date	Description / Notes
	Trust Corporate Objectives
25/08/2012	Car Parking Strategy Consultation presentation and documentation
05/12/2013	Strategic Outline Case - Car parking Feasibility proposal Trust Board
1/06/2014	Charges briefing paper for Executive Directors
June/July 2014	Presentations lLCNC, MSC and LNC

Process and comments

Date	
13/02/2014	LCNC
24/02/2014	CMG
12/03/2014	MSC
10/07/2014	LNC

Approvals

Item	Date	
Timeline, Car parking charges and quick wins	30 June 2014	Executive Directors
Car parking OBC	7th July	Clinical Executive Group
Outline Business Case	14th July	Director of Finance
Outline Business Case	15th July	Executive Directors
Outline Business Case	29th July	Finance Committee
Outline Business Case	6th August	Trust Board
Full Business Case	17th June	Executive Directors
Full Business Case	23rd June 2015	Finance Committee
Full Business Case	1st July 2015	Trust Board

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Executive Summary

The difficulties with car-parking on the acute Hospital site are well documented and car-parking consistently appears as the number one cause of complaints and a significant issue for our patients and members of the public. Making improvements is a priority for the Governors and the Board.

Public parking has been shown to be at capacity with occupancy running extremely high for the majority of the day in most car parks. The afternoon peak which is dictated by the visiting hours leads to significant issues for patients and the public relating to the lack of parking. Car parks are consistently full with overspill into surrounding private roads. Lack of disabled parking capacity currently results in poor and unsafe parking practices, as disabled drivers, unable to find a space abandon their cars in non-designated areas including ambulance drop off areas.

Staff parking on site is limited and controlled through a staff travel plan which includes permit eligibility criteria according to distance and need. Currently demand for staff parking permits exceed supply, and there is a waiting list in place. Staff using their car for work and leaving site during the day find it almost impossible to park on their return.

It is clear and widely accepted (including by Torbay Council) that additional car parking provision is required for both the public and staff as well as a system for actively managing the car parks and a significant improvement to the layout and infrastructure of all the car parks.

A car parking strategy was developed in early 2013 and has undergone a widespread consultation process. The Strategy initially was developed in partnership with Torbay Council and presented in the outline business case in August 2014

This business case details the proposed investment of c£1.97m improvements to the car parking infrastructure including on site systems, signage, surfaces and safer car parks and the delivery of c200 more car parking spaces, 50% more disabled spaces, an increase in the number of staff permit spaces.

Affording the £1.97m investment necessitates an increase in both public and staff parking charges to cover the costs of the improvement. This increase in charges has been recommended and is supported by both staff and public consultation groups as the minimum to cover the costs that bring significant benefits to both the public and staff. The new charges remain cheaper than most other Hospitals across the region.

The Trust is comfortable and confident that the business and financial model proposed is affordable, based on conservative assumptions, relatively low risk and presents a solution to resolve the Trust car parking issues at no net additional cost to the Trust.

The delivery timetable starts in August 2015 with completion by Christmas 2015.

The Trust Board are asked to approve this full business case for this long awaited improvement to car-parking on the site.

1. Introduction

Torbay Hospital serves the South Devon Area and is run by South Devon Healthcare NHS Foundation Trust. The Foundation Trust catchment area covers 300 square miles - from South Dartmoor to the length of coastline which stretches from the mouth of the River Exe (Dawlish), past the Teign and Dart estuaries (beyond Dartmouth). Torbay Hospital therefore serves a resident population of approaching 300,000 people, plus about 100,000 visitors at any one time during the summer holiday season. Over 70,000 patients a year come through Torbay Hospital's Emergency Department. On an average working day over 200 patients attend the emergency department, 75 operations are performed, over 1,250 patients are seen in outpatient clinics and 7 babies are born.

Construction of the Hospital on the site commenced on 26th June 1926 and opened for patients in September 1928. The Hospital has expanded significantly over the years most notably since the late 1960s when the first significant expansion took place. Car parking provision has changed little since the second main phase in the 1970's.The site covers an area of 21 Ha with 10 main buildings and numerous smaller buildings situated around the site, the latter mainly providing accommodation for offices and support staff.

The site provides parking for 1653 vehicles 54 disabled and 388 public (total 442) and c1211 staff spaces giving a staff public ratio of 73/27% significantly less than the recognised best practice. The main system on site is pay and display with a payment and permit system in place for staff. As the site has expanded, particularly over the past 50 years, many of these projects have been delivered independently with no long term development strategy. This has led to a number of entrances and a site that is served by two vehicle junctions. Due to the poor layout of the site it is difficult for visitors to orientate themselves and the site has poor connectivity for staff and visitors who are accessing the site on foot or public transport.

1.1 National Context

Charging for parking at Hospital sites is a sensitive issue but the norm in England. Charges should be set at a level to avoid any subsidy from monies received for the delivery of patient care and to cover the cost of building, maintaining and operating the car-parks, therefore keeping construction and maintenance costs to a minimum is important in keeping parking charges low.

The British Parking Association recommend the following when setting hospital parking tariffs:-

- Parking tariffs and tariff structures will be reasonable.
- They will reflect supply and demand, and the cost of maintaining the facility and providing the service.
- Tariff structures should be set to reflect local conditions, local tariffs and the needs of all hospital users.
- They should take account of the hospital's environmental policy.
- Systems need to be in place to protect the legitimate use of hospital car parks.
- Tariffs should also take into account what the impact on local residents would be if the level of charges drove motorists to park in local streets.

Consideration needs to be given to ensure that the public and patients do not subsidise staff parking and vice versa.

1.2 Local Context

Improving the patient experience

Car parking is a fundamental part of the patient and public's care pathway. It provides the first impression of Torbay Hospital and can often be the first experience of the care and treatment they will receive within the NHS. If parking is stressful and difficult for patients and members of the public it can have a profoundly negative effect on their experience at the start of their visit.

Feedback from our patients tells us that they find it difficult to park on the Torbay Hospital site, sometimes driving around the car parks for long periods searching for spaces. In some cases patients are unable to attend their out -patient appointments as they are unable to park. Listening to the feedback, and to deliver our strategy to provide a quality and safe patient experience, the Trust is determined to change the way car parking is managed, to make it easier and better for our patients, members of the public and visitors to the Torbay Hospital site, whilst at the same time, looking after the needs of our staff.

Improvement in the safety of the site and parking services is fundamental to the delivery of a number of the Trusts strategic objectives.

1. **Safest care:** Ensure that the site is safe and car parks comply with the parkmark compliance standards.

2. **No delays:** To minimise the time taken for people to access and receive care, through service improvement and re-design of pathways.

3. **Best experience:** We will ensure experience of our services is the best possible, learning and taking action from concerns raised by governors, members surveys, complaints and other feedback mechanisms.

4. **Promoting health:** We will promote healthy lifestyles and public health in all contacts with our community, encouraging people to take responsibility for their lifestyles and well-being.

5. **Personal, fair and diverse:** We will ensure our services are equitable that services are accessible to all within our community.

Integrating Hospital and Community Care

The South Devon Community and the future Integrated Care Organisation have a shared vision based on the principle that care in the future should be provided at home and in the community and only in hospital when it is right for the patient who needs support of the specialist infrastructure provided. In addition, services will move towards providing care at a more convenient time for patients into the evenings and seven days per week. This is likely to lead to more people being treated at home or in community hubs and less in hospitals and may change the shape of the hospital in the future creating smaller more acute facility. Whilst these changes will not have a significant impact on parking demands for the hospital in the short term, it may reduce demand in the future, consequently a flexible model is required.

Site Master Plan and Estates Strategy

The Trust is committed to developing its estate to support the delivery of high quality clinical services and meeting the Trust's core aim of achieving excellent patient outcomes. The shared community estates vision is to transform and develop the estate to deliver 'a quality patient environment and patient experience delivered through an energy and low cost estate which is fit for purpose, functionally suitable, well maintained, flexible and responsive to the changing needs of the services'.

Transport Links

Torbay Council has provided a number of improved pedestrian and cycle links to Torbay Hospital including the recent construction of a cycle route at Lowes Bridge. New bus services such as the 67 have also been introduced. These improvements continue to support the Trust's green travel plan and the increased use of sustainable travel.

The South Devon Link Road (SDLR) is a £109 million investment into South Devon's road network and will ensure reduced journey times and more reliable journey times both for car users and bus passengers. The SDLR is programmed for completion in December 2015. The new road will not lead to increased demand on the site for parking but will assist with patients and visitors arriving on time for appointments etc.

The Local Transport Plan also identifies a potential rail halt at Edginswell which could serve Torbay Hospital. At the time of writing the report, the Local Transport Board has identified potentially £1.5 million funding for the project, however, this will not be sufficient to cover the total construction costs so alternative funds are being sought. Construction is likely to be in 2016. However, should the project reach a successful conclusion it would significantly reduce the need to travel by car for many staff and visitors and is likely to reduce the demand for parking in the future.

1.4 Car Parking Strategy and key objectives

In 2013 a car parking strategy was finalised for a site wide improvement and changes to car-parking for public and staff that fits with overall site development plans, delivers our objectives and improves the experience for our patients and visitors. The main essence of the Trusts strategy is an increase in the number of public and disabled spaces and drop off zones, provision of adequately sized and accessible spaces, centralisation of separate parking for staff and visitors, and easier to use pay on exit systems. The key objectives are detailed below:

1. Making it easier to access services and find entrances and exits

- Separate public, staff and deliveries traffic flows where possible
- Create a sense of destination and arrival for the public at entrances that are clearly defined and accessible
- Intuitive way finding and directional signage
- Drop off areas only (no parking apart from disabled) and turning circles at each of the core patient/public entrances

2. Improving access to safe, easier to use and sufficient car parking

- More public parking spaces consolidated around main entrances to allow easy access to services
- Increased number of appropriately sized disabled parking bays close to entrances
- Separate public and staff parking
- Pay on exit parking where possible

3. Making the site safer for pedestrians

- More pavements and footpaths that are directly linked to entrances to services
- Pedestrian crossings adjacent to car-parks and entrances
- Renewed road and pavement surfaces so they are safe.
- Speed controls where appropriate
- Reduce the number of cars parked on road verges, at entrances and other ad hoc parking across the site.

4. Ensuring that the public and patients do not mix with deliveries and service vehicles

- Create a deliveries hub at the back of the site away from public traffic
- Locate contractor compounds at the back of the site.

- Provide dedicated contractor and service vehicle parking spaces so that public spaces remain available
- Control the number of contractor vehicles
- Schedule deliveries so that where possible they are not at peak times for staff and visitors.

5. **To Deliver the Trusts corporate responsibility for green travel by: offering alternative options for public and staff to get to the Hospital other than by car**
   - New bus services to the Hospital with new bus stops and bus route on site
   - Provision for motorbikes and pushbikes linked to cycle paths and cycle routes
   - Cycle loan scheme
   - Information for public and staff on alternative ways to get to the Hospital

6. **To deliver on our commitment to our staff by: ensuring appropriate parking provision is made for our staff**
   - Creating new staff parking areas that are easy to access and separate from the public
   - More essential users parking space and flexibility to increase/decrease numbers as required.
   - Providing new and centrally located covered pushbike parking and motor cycle parking bays.
   - Providing the right number of appropriately sized parking spaces that allow for safe parking and entrance and exit to car parks.
   - Departmental parking when on call close to service

1.5 Car Parking Strategy Public and Staff consultation

The Trust's car parking strategy was publically consulted on during 2013/2014. It was well received by all bodies and comments from particularly the local neighbourhood group were taken into account in the final proposal. The key stakeholders consulted are detailed in table 1 below:

Table 1. Car parking strategy: Consultation with key stakeholders

Group/Individual
Local Councillors
Mayor of Torbay
Local Residents neighbourhood group (twice)
Trust Disability Action Group (DAAG) – (twice)
Trust Clinical Executive Group
Trust Clinical Management Group
SDHC Trust Board
SDHC Governors (twice)
Torbay Council
Trust Medical Staff Committee (MSC)
Trust Local Consultation Negotiating Committee (LCNC - Staffside) (twice)

The strategy has been on the public facing Trust website since early 2013 for comment. During the development of the preferred option two consultation groups, representative of the key stakeholders have been established to continue the close dialogue and feedback to ensure the preferred solution is acceptable and supported by key groups. The Strategy has evolved through consultation into the preferred solution presented in this case.

2. Economic case

2.1 Lack of Public parking capacity

Difficulties with parking on the Hospital site are well recognised and have been a significant cause for concern for some time. It is the number one cause of negative feedback from the Public, local residents, the Governors and political representatives to the Trust. The significant lack of parking has been recognised by Torbay Council and the Mayor who are very supportive in sourcing an increase in parking spaces and an urgent solution to the problem.

Public parking is at capacity with occupancy running extremely high for the majority of the day in most car parks. The afternoon peak which is dictated by the visiting hours leads to significant issues relating to the lack of parking. Car parks are consistently full with overspill into surrounding private roads. This has led to the local Highway Authority, Torbay Council, introducing a Controlled Parking Scheme in roads adjacent to the Hospital to protect local residents. There is a constant stream on complaints from local residents about inappropriate parking relating to the hospital.

The existing parking space ratio across the site of public to staff at 73/27 is significantly less than the best practice ratio of 60/40.

The Trust currently has 54 disabled parking spaces which at 12% is higher than the norm but insufficient due to the nature of the public and age of the population. This is a significant issue particularly for the South Devon community where elderly population is increasing and higher than that experienced nationally and on other Hospital sites. Lack of disabled parking capacity currently results in poor and unsafe parking practices, as disabled drivers abandon their cars in non-designated areas including ambulance drop off areas.

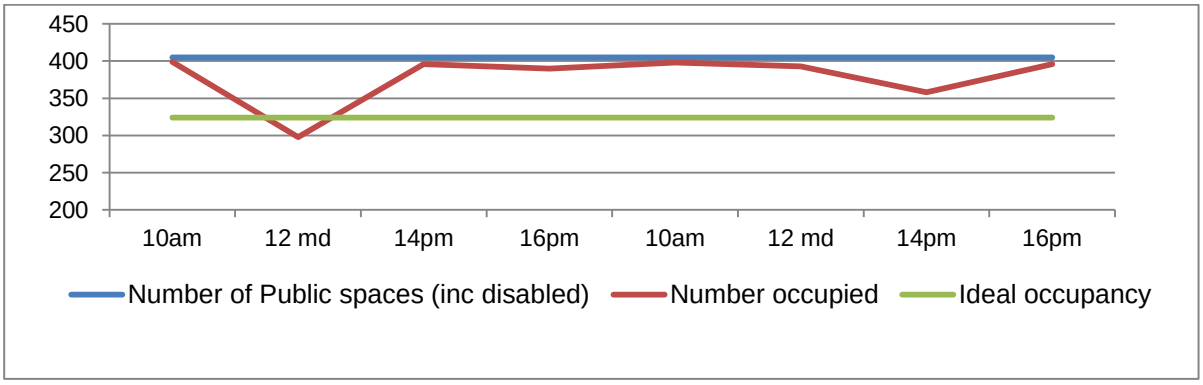
A large number of surveys including traffic counts within the car park and car activity at both the Cadewell Lane and Lowes Bridge entrances have been undertaken in partnership with the Council, together with a Staff Travel Survey.

The results of the surveys are consistent with the shared understanding that the car parks are running at or near to capacity for the majority of the normal working day during the week.

- The total staff and visitor car parking provision currently is approximately 1653 spaces. This capacity was easily reached by 10am.
- Surveys on site identified a high level of inappropriate and non-permitted parking, particularly amongst staff and there is significant anecdotal evidence that staff without a permit park in public parking spaces. This further reduces the available parking for patients and members of the public.
- In addition to the traffic surveys, junction modelling has been undertaken on the junctions of Cadewell Lane and Lowes Bridge. This ascertained that there is some but limited scope for increasing traffic (and therefore parking numbers) on the junctions. The detailed analysis can be found in the Torbay Hospital Parking Review document considered by the Trust Board in December 2013.

Table 2 demonstrates the capacity of the public car parks from recent site survey NOTE; This survey took place in July a holiday month.

Table 2. Public parking occupancy and capacity



2.2 Difficulties with the site layout and using parking facilities

In addition to the traffic surveys and junction modelling, an assessment was undertaken as to whether there are any potential improvements that could be made to the site layout and access arrangements which link the parking areas to the Hospital.

A number of issues were highlighted as requiring improvement.

- Lack of drop off points at the main entrance, day surgery, eye surgery and outpatients which forces vehicles to take up parking spaces for short periods.
- Public Parking around at the Women's Health unit would benefit from an increase in parking provision.
- Roadways which allow parallel parking cause congestion. Within the proposal it is recommended that such roads are considered to have either parking removed completely or remove some of the parking to ensure adequate width and passing places.
- Although it is recognised that significant improvements to pedestrian facilities in terms of footways signage and crossing points have been made, there are additional pedestrian improvements which are worth consideration such as new pedestrian routes from car parks to the hospital.
- There is little or no directional signage around the site; the main entrance is not very visible and parking spaces are difficult to locate. The Trust would benefit from additional signage to direct visitors to viable spaces, the efficiency of the available parking will be compromised.
- Visitor parking is disparate across the site will further compromising the ability of drivers to find available spaces. Public parking would benefit from being co-located to make it easier to locate and access.
- Public parking is pay and display. We know from feedback from our patients that this causes additional stress as patients worry whether they have put enough time on the ticket and that they have to have sufficient change for the machines at a time when they are rushing to get into the hospital. Our public have told us that some pay on exit provision would be much more beneficial and would improve the patient experience of parking.
- Generally the hospital is served well by bus routes however more rural areas and weekends and evenings have a limited service. As part of the proposal the Trust and the council would wish to support the bus infrastructure if it enables more staff and members of the public to come to the Hospital by bus.

2.3 Lack of Staff Parking capacity and poor infrastructure.

Staff parking on site is limited and controlled through a staff travel plan which includes permit criteria and cut off points according to distance and need. Currently demand for staff parking permits exceed supply, and there is a waiting list in place.

Up until September 2014 the Trust provided a staff pay and display car park on site for members of staff who do not fulfil the criteria for a parking permit. This was not only at odds with the Trusts parking strategy and green travel plan but also restricted the on-site parking for those fulfilling the permit criteria and needing a space on site. Any future plans would still ensure that only staff who fall within the criteria for a parking permit can park on site. The priority need is to provide staff on the waiting list with permits.

There is a nationally recommended and sensible ratio of allocated permits to the number of parking spaces. This takes into account shifts, holidays and working practices etc. The current ratio is running at 2.2 which is significantly above the 1.9 norm. This explains why staff with permits currently have difficulty finding a parking space. In future the Trust will aim to manage to a ratio of 1.8 permits to parking spaces with a maximum ceiling of 2. In line with our green travel plan the permit threshold will be set according to the car parking spaces available.

Staff leaving and returning to the site during the day find it almost impossible to find a parking space on return. This either causes immense frustration or dangerous parking as cars are left abandoned in inappropriate places.

Not all staff car parks have barriers leading to members of staff without permits inequitably parking in car parks without paying.

Staff car parks are cramped, surfaces are poor and there is a considerable amount of negative feedback from staff.

2.4 Improvements made to date

The Trust has been working towards the implementation of the car parking strategy over the last two years. This business case is the culmination of the work that has been undertaken and details a plan that both delivers the strategy and fits with the requirements on the Trust as a good employer and environmentally committed organisation. Actions taken on the delivery of the strategy and improvements to car-parking in advance of this business case are detailed in table 3. below.

Table 3. Actions to implement the car parking strategy and improvements to date

ACTION	DATE COMPLETED
Produced car parking strategy, site master plan detailing proposed site flows and car parking provision	September 2012
Consultation period – local councillors, Mayor of Torbay, CEG, CMG, DAAG, SDHCFT Board, SDHCFT Governors, Torbay Council, Local residents neighbourhood group x2, JCNC, Staffside	October 2012 to March 2013
Car parking strategy finalised	March 2013
Improve way finding and directional signage	Site signage project completed April 2013
Provision of additional footpaths and pavements, dropped kerbs, pedestrian crossings, speed controls	Complete February 2014

Contractors Parking provided at rear of Estates Building, control measures implemented to restrict number of contractors vehicles on site	July 2013
Provision of additional 55 staff parking spaces on old social club site to replace spaces lost through capital works	June 2013
Trust and Council partnership agreement to work up feasibility plan for improving car parking	April 2013
Partnership Outline Feasibility Plan delivered and approved by Trust Board	December 2013
NHS Staff Cycle Loan scheme re-launched	August 2012
Consultation and development of parking solution, charges etc	February to May 2014
Partnership final operational solution and plan completed for approval	June 2014
Three additional covered cycle shelters introduced	July 2014
Allocation of an additional 65 public car parking spaces at Lowes Bridge	September 2014
New car park systems procured via OJEU process	October 2014
On line staff permit system procured	December 2014

2.5 Summary of Need

Despite the actions taken to date it is clear and accepted that additional car parking provision is required for both public and staff as well as a system for actively managing the car parks and a significant improvement to the layout and infrastructure of all the car parks.

3. Development of the Preferred Option

3.1 Summary of Options and options appraisal

A number of options were considered in the Strategic outline case (feasilbility) to provide the additional c400 car parking spaces for the Hospital:

Demand Management. Torbay Council recognised the Trust has a robust green travel plan in place which includes a number of initiatives which promote the use of other modes of travel. Other measures considered included the issuing of less staff permits, increase in public transport provision and varying of visiting times across the wards. This option was not considered as a viable option in that it did not meet the broadly accepted need for additional parking spaces for both staff and public nor does it address the parking configuration and site safety issues. In addition it would not be deliverable as further reduction in parking permits and avoiding visiting in the day would have a fundamental and detrimental effect on the delivery of patient care.

Park and Ride. A solution to provide off- site parking for staff is viable, although unpalatable and impractical for some groups of staff. This option however is not feasible at this time as, despite a widespread search and close working with the council, there is no suitable site or land available.

Permanent Multi-storey Parking. A number of existing car parks could be redeveloped to provide a permanent multi-storey car park/s. The capital cost to construct these car parks would be significant and charges would have to rise significantly to recover the costs. This option was therefore rejected at this time on that basis.

Temporary Multi-storey Parking (decks). Although this option is likely to be cheaper than the provision of a permanent multi-storey car park the capital cost to erect these car parks would be significant and equally unaffordable. However this could be reconsidered in the future if required.

Surface Level Parking. The survey of the site indicated that there is sufficient suitable land across the site to facilitate the expansion and re-design of car parks and for construction of new surface level car parks if required. **This option was considered and endorsed as the most cost effective and least disruptive and therefore preferred option.**

3.2 Development of the preferred solution

The Trust had planned to go to the private sector in April 2013 with a view to commencing a process for securing a contractor to plan and deliver the car parking solution and possible private sector management of the on-going parking on the site.

Following very supportive and positive discussions with Torbay Council, who plan and provide parking services within the public sector, the Trust identified a different possible solution i.e. to work with the Council to undertake a detailed feasibility on the possibilities of working in a public sector partnership to deliver a build solution and the possible management of future services.

On that basis the Trust commissioned Torbay Council as car-parking experts to work with the Trust to undertake a feasibility study with a view to producing the best design and operational solution for the Trust car parks that would deliver the aims and objectives clearly articulated in the strategy.

In December 2013 the Council produced an outline feasibility report, finance model and car-parking solution for consideration by the Trust. The Trust Board endorsed the direction and outline plans presented, and gave approval to work up a business case in partnership with the Council. The OBC was presented to Trust Board in August 2014 and detailed the delivery of the final configuration of the parking solution, capital costings, detailed specifications and costings of the operational systems, the financial model, proposed partnership agreement and council costs and proposal of managing the car parks over the subsequent years.

The Planning Application developed by the council team detailed 398 new spaces to be created across the site. This was submitted by Torbay Council to The Development Management Committee on 10 November 2014. A significant number of planning conditions including a Section 106 payment of £300,000 added significant cost and restraints to the delivering the scheme. The list of conditions are detailed below.

- Additional Extended Phase 1 Habitat Survey of the main site and annexe site. Development of some areas cannot take place within the bird breeding season and ecological checks to be undertaken for roosting bats before any trees are removed.
- Protected Species Surveys for reptiles and badgers
- Arboricultural Method Statement and Tree Protection Plan
- Detailed Landscaping and Planting Plans
- Tree mitigation re-planting and submission of Tree Pit Designs
- Landscape and Ecological Management Plan
- Surface Water Drainage Strategy
- Updated Travel Plan to incorporate facilities for charging plug in and other low emission vehicles

- Lighting Strategy
- The Trust will also be required to pay the Section 106 sustainable transport contribution (c£300k)

Post OBC approval the process of developing the Full business case required a detailed design to be completed together with an understanding of the deliverability of the plans, the engineering consequences, impact of the planning conditions and costings The Council were unable to meet the Trust requirements and time lines in relation to completing a full design of the new car parking areas incorporating the mitigations that were required. Subsequently the Trust went out to tender and awarded this work to AECOM.

The final drawings, received in December 2014 highlighted a number of engineering problems with the original Council proposal, meaning that the numbers the council suggested could be delivered were not actually viable. This equated to a loss of 194 proposed new spaces on the football field and Kitson Hall areas. In addition there were significant concerns over the cost of delivery of the whole site solution. The costings received by the Trust for the newly engineered solution total cost came in at **£4,161,454** including build system and ecological and landscaping costs.

A new scheme was developed in discussion with the Planning department at the Council and designed in detail to include mitigation measures. The Trust also tendered the car park design to test the costs approaching a number of companies. TOR2 who deliver the construction services for the council proceeded to deliver a market tested cost for the construction of the car parks. The Trust team have undertaken a significant amount of work to maximise the numbers on site, keep the functionality of the systems and safety of the car parks within a budget of c£2m.

The re-designed engineering solution delivered a plan to create **201** additional parking spaces, which although disappointing was all that can be safely and compliantly delivered on the site. The revised plan was re-submitted for planning and was considered at the April 2015 Development committee. Planning was granted but as with the previous application, approval was subject to a number of ecological conditions and an albeit reduced S106.

Some of the significant changes that have resulted are detailed below.

Omissions:

- Electronic variable message signs at a cost of £66,649
- Additional car park on the land behind Bayview at a cost of £76,500 for 14 spaces this had some significant ecological conditions.
- Land behind Kitson Hall cost £786,000 construction for 98 spaces. This was the most expensive car park and in addition had some significant ecological and engineering conditions.
- Combining car parks D&E delivered an additional 42 spaces for construction cost of £800,000 but was significant cost. **Net loss of 154 spaces**

Additions:

- Adjustments of barrier placements created additional 31 spaces in various car parks
- Changed configuration in maternity to add 17 back in
- 30 spaces in the top staff car park
- 4 Electric charging points at a cost of £20,000
- 10 spaces in physio and fracture clinic
- 66 on road spaces to bring the numbers back to the **201** approved by planning

3.3 Preferred Option – Final Solution

This Full business case proposes a solution which provides a total of 1841 surface level parking spaces on the Hospital Site which delivers:

- Additional **207** public spaces and three public pay on exit car parks
- Increase in disabled parking from 54 to 100 spaces
- "Parkmark" award standard throughout all car parks safe, resurfaced, lined, lit, and proper sized spaces.
- A safer site and drop offs re-instated at all entrances across the Trust.
- Increased motorcycle and bike parking.
- New directional signage to car parks
- 65/35 staff public parking ratio.
- Two dedicated frequent users car parks for staff

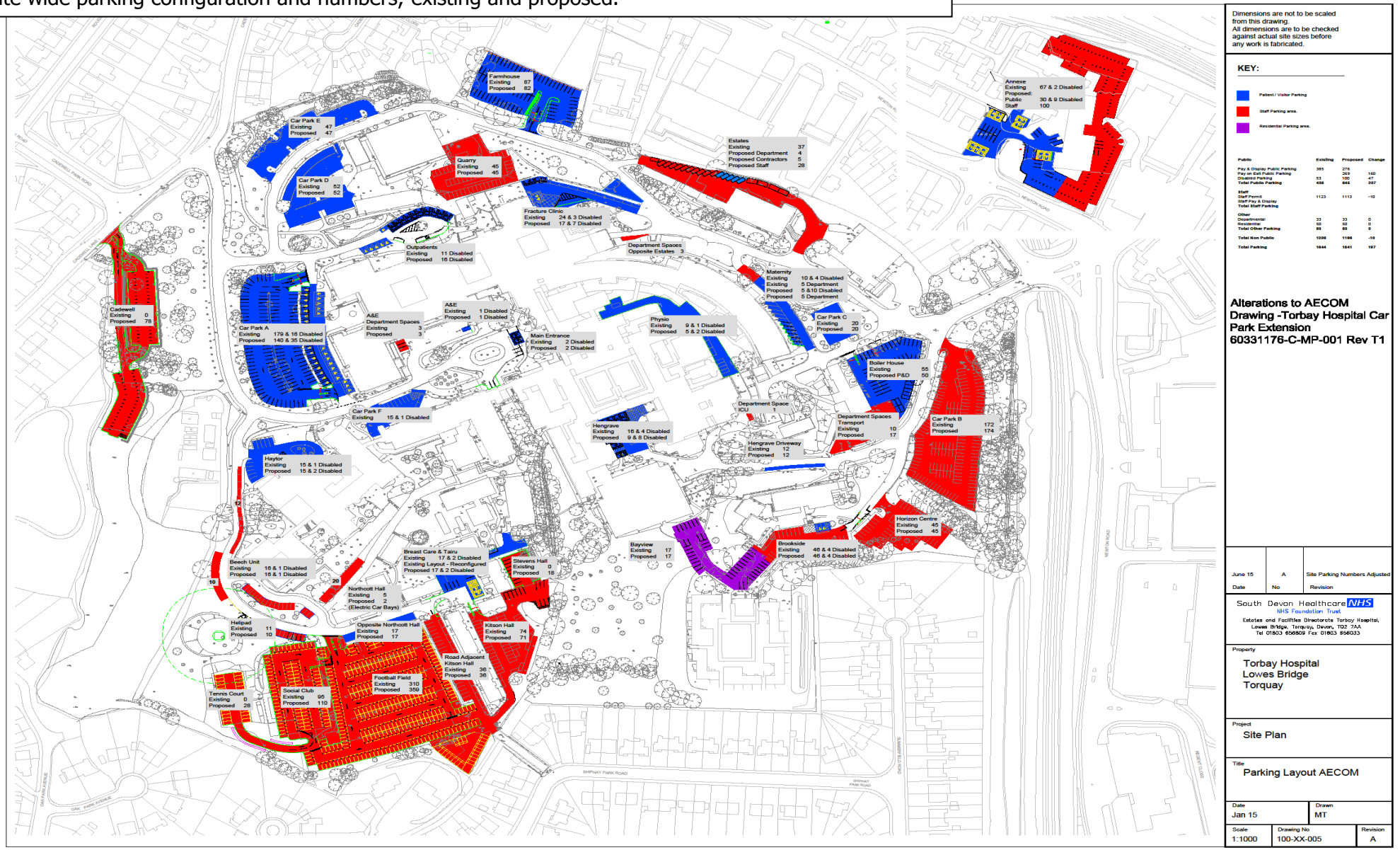
Through the consolidation of staff parking, the public will have access to a new parking area near the women's entrance (previously the boiler house car park) and additional public parking will also be provided at the Farm House Tavern Car Park. The plan increases and consolidates staff permit parking at the top of the site in the newly named Staff car park 1: Shiphay Park (previously the old Football Field Area). Two frequent user car parks will be provided (Horizon and Kitson) which will be allocated to staff who go to and from the site on a regular basis. A new staff car park will be created at the Cadewell Lane entrance. The detail is shown in diagram 3. overleaf.

The changes in the numbers of parking spaces from existing, that suggested in the OBC and the new FBC numbers are shown in table 4. Below

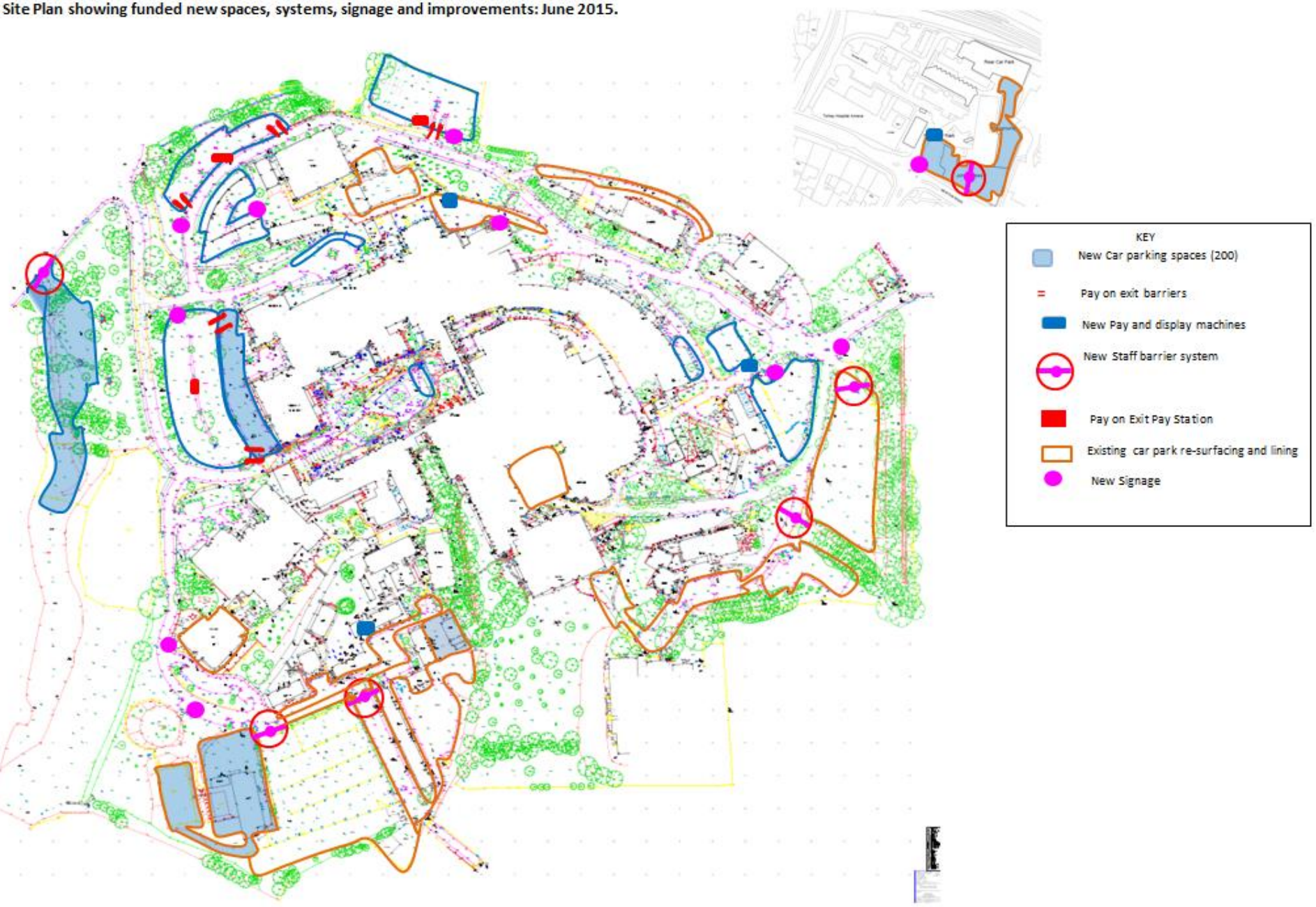
Table 4. Changes in numbers of parking spaces

		OBC July 14				FBC June 15			
		Existing	**Proposed**	**Change**	**% increase**	**Existing**	**Proposed**	**Change**	**% increase**
Public	Pay & Display Public Parking	388	183			385	323		
	Pay on Exit Public Parking		429	224	58%		222	160	42%
	Disabled Parking	54	104	50	93%	53	100	47	89%
	Total Public Parking	**442**	**716**	**274**	62%	**438**	**645**	**207**	47%
	Public parking %	27%	37%			27%	35%		
Staff	Staff Permit	1064	1117	-5		1058	1113	55	6%
	Staff non permit	68				65	0	-65	
	Total Staff Parking	**1122**	**1117**	**-5**		**1123**	**1113**	**-10**	
	Staff parking %	68%	58%			68%	60%		
Other	Departmental	29	27	-2		30	33	3	
	Residential	50	50			50	50	0	
	Total other parking	**79**	**77**	**-2**	-3%	**80**	**83**	**0**	0.2%
	Other parking %	5%	4%			5%	5%		
	Total Non Public	**1211**	**1194**			**1206**	**1196**	**-10**	
	Total Parking	**1653**	**1910**	**257**	**16%**	**1644**	**1841**	**197**	**12%**

Site wide parking configuration and numbers; existing and proposed.



Site Plan showing funded new spaces, systems, signage and improvements: June 2015.



3.4 Delivery

The solution will commence as soon as approved, with the construction of new parking spaces to maintain the maximum number of parking spaces and to minimise the impact on services. Phase 1, the first quick win, has seen the conversion of the Lowes bridge car park from staff Pay and display to public with an immediate gain of 65 public. The changes to the tariff and implementation of systems will start in September 2015 with the completion of construction by Christmas 2015. The timelines are shown in more detail in Section 5.

4. Financial Case

The basis of the business plan is to ensure any revenue costs for the borrowing of capital, enforcement, equipment and maintenance costs for the additional level of spaces is met through the parking policy and charges. Capital costs are fixed for 10 years, car parking charges are variable at the discretion of the Trust. The cost of the improvements has therefore necessitated an increase in parking charges in order to realise the benefits of the scheme. The costs of the improvements and associated income requirements are detailed in the following Sections.

4.1 Costs

Capital Costs

The Trust plans undertook a competitive restricted tender for the design and the construction and implementation of systems. ToR2 who undertake carparking works for Torbay council have provided detailed construction and systems costs for the Trust, a summary of which shown in table 5 below and overleaf. ToR2 is actually Kier who have already successfully tendered on the Linac bunker currently in construction. The cost of the plan including 20% of contingency and design fees was included **in the OBC at £1.9m**. Initial costing of the solution was c£4m. The Trust has undertaken a considerable amount of work to reduce the scope and cost of the scheme whilst retaining the additional car parking numbers and functionality of the systems. The OBC considered the affordability of a range of capital costs for the final solution from £1.8m to £1.9m, with a ceiling of £2m. The costs of the FBC parking scheme is £1.97m.

Capital funding route

The Trust Board approved at OBC stage an application to the FTFF for a loan of £1.9m. This was submitted and approved in October 2014.

Table 5. Summary of Capital Costs **SUMMARY OF PROJECT COSTS - CAR PARK BY CAR PARK**	Systems	Construction and fees	Ecology/ landscaping as directed by Council	Contingency	**TOTAL**
	£		**£**	**£**	**£**
GENERAL ITEMS	67,423.00	8,530.63		3,371.15	**79,324.78**
CAR PARK A	131,726.00	26,805.23		7,036.30	**165,567.53**
CAR PARK B	16,000.00	3,150.91		850.00	**20,000.91**
STAFF 1 - SHIPHAY PARK (previously FOOTBALL FIELD, SOCIAL CLUB & TENNIS COURT)	173,390.00	277,193.68	19,000.00	20,842.15	**490,425.83**
STAFF 2 - KITSON PARK (previously STEVENS HALL)		60,400.14		2,680.82	**63,080.96**
FARMHOUSE TAVERN	65,063.00	9,358.56		3,303.15	**77,724.71**
BOILER HOUSE	6,000.00	759.14		300.00	**7,059.14**
ROADWAY TO HORIZON INC. BAYVIEW SURFACE IMPROVEMENTS	41,072.00	15,346.33		2,504.09	**58,922.42**
STAFF 3 - CADEWELL PARK (Previously Cadewell lane)	30,725.00	507,838.47	26,000.00	25,057.76	**589,621.23**
ANNEXE (JOHN PARKES UNIT)	23,894.00	275,846.42	19,000.00	14,147.08	**332,887.50**
CAR PARK - NORTHCOTT	8,737.00	1,668.70		461.85	**10,867.55**
FRACTURE CLINIC	8,737.00	4,485.01		586.85	**13,808.86**
MATERNITY		9,803.63		435.13	**10,238.76**
CAR PARK - E	43,355.00	6,611.98		2,217.75	**52,184.73**
HAYTOR		5,632.62		250.00	**5,882.62**
	616,122.00	**1,213,431.47**	**64,000.00**	**84,044.07**	**1,977,597.54**

Revenue Costs

The maintenance costs in the model are directly attributable to the increased parking spaces, directional signage, barrier systems, cards tokens and payment machines in all car parks. Pay costs are related to a new administrative post to support the introduction of an electronic permit system and provision of help desk to support the introduction of the new systems. The revised S106 contribution is £175,000 which the Trust has agreed with the council to pay back over ten years from the car-parking revenue. The cost of capital is assumed at 3.5% over 10 years, the pay-back period could be extended to maximise short term income if required.

Table 6. Car parking Operating Costs

RUNNING COSTS WITH SDHT OPERATING THE SERVICE	14/15	OBC	FBC
Pay	£19,500	£39,500	£39,500
Maintenance	£33,500	£134,900	£104,799
Other Charges	£5,756	£30,537	£30,537
Enforcement	£4,800	£14,800	£14,800
Planning/environmental costs	£20,000	£100,000	£83,556
Total Operating Costs	**£83,556**	**£319,737**	**£273,192**
10 yr repayment on Loan £1.97m		**£180,000**	**£197,000**
Interest on Loan straight line 3.5%		**£38,200**	**£42,350**
Finance Costs		**£218,200**	**£239,350**
Total Costs	**£83,556**	**£537,937**	**£512,542**
Increased costs of new solution per annum			**£428,986**

The total additional annual cost of the major improvements to parking totals **£428,986** to be recovered through income received from parking.

4.2 Income assumptions

The Trust has always been clear that improvements to the car-parking experience across the site should not be funded from monies received from commissioners for patient care, but instead be re-covered from parking income. Neither staff nor the public should subside the other and therefore the improvements to the car-parks and affordability of the £1.97m construction costs necessitates an increase in parking charges for both the staff and the public accordingly.

Enforcements costs within the proposal are considered low and it is one of the areas the Trust would wish to keep as low as possible. The level of included income equates to less than one enforcement penalty notice per day across the entire site. Only £10,000 of additional Enforcement costs have been included in the new model as the new barriers and pay on exit systems will make enforcement easier. Income is based on a conservative **40% patient occupancy** per space and **1.8 staff permits per space** which is the lowest planning assumption. The operating costs and finance costs are shown in table 6 overleaf. Total increased income is £428,986 as shown in table 7 below, split between public and staff.

Table 7 Car parking income by year and category

INCOME	2014-15	FBC 2015-16	Increase in Income
Total Patient Income excludes disabled	£519,000	£788,135	
Total Staff Income	£232,016	£391,867	
TOTAL INCOME	**£751,016**	**£1,180,002**	**£428,986**

Over time, public space occupancy is likely to increase over 40% and permit allocation over the 1.8 per permit space. This may generate additional income for the Trust.

4.3 Parking Charges

The Trust is acutely aware that parking charges are a significant issue for members of the public as well as for staff, and has consequently sought to deliver the minimum increase required to cover the cost of improvement.

As part of the development of the parking policy and implementation of the parking strategy, two sub groups were formed. The Public group consists of membership from public Governors, Matron, DAAG, Equality and Diversity, Transport, PALs, League of Friends, Volunteer co-ordinator, Healthwatch. The Staff group consists of public Governors, Staff Governors, AHP, Nursing, Medicine, Equality and Diversity, Staff Side, Finance, Operations. The Groups were given specific objectives which included considering and making recommendations on the layout of the parking, systems solutions, concessions and parking charges. The proposed changes to charges reflect the recommendations of the staff and public sub-groups.

4.4 Public Parking Charges

The proposed Public charges agreed and recommended by the public stakeholder group are detailed in table 8 below. Even with the increase charges for patients remain lower or equivalent when compared to other Trusts and consistent with charges in Torbay Council car-park.

Table 8. Public parking charges, current and future in comparison to other acute Trusts

Time	Current Tariff	Proposed	Difference	Other Trusts (March 2015)			
				Plymouth	Cornwall	Exeter	Yeovil
20 minutes	-	Free in Pay on Exit Car Parks		15 mins free	2.60	20 mins free	30 mins 1.00
1 hours	90p	2.00	+ 1.10	1.20	2.60	2.50	2.00
2 hours	1.60	2.00	+ 40p	2.40	2.60	2.50	4.00
3 hours	2.70	3.00	+ 30p	3.60	5.10	4.50	5.00
4 hours	3.80	4.00	+ 20p	4.80	5.10	4.50	6.00
5 hours	5.00	6.00	+ 1.00	6.00	7.70	8.50	7.00
6 hours	6.00	8.00	+ 2.00	7.20	12.80	8.50	12.00
6-24 hours	6.00	8.00	+ 2.00	12.00	12.80	8.50	12.00
Weekly Ticket	£20.00	£20.00	NIL		24.07	26.00	

4.5 Public Concessions

The Department of Health issued guidance in December 2006 which stated “NHS Bodies are strongly recommended to have some kind of ‘Season Ticket’ arrangement allowing free or

reduced parking charges for patients (and relatives/prime visitors of patients) with a long term illness or serious condition requiring regular treatment." Therefore the Trust proposes to leave the current concessions in place unchanged.

The Trust is committed to adhere to these guidelines. The Trust parking strategy and finance model takes into account the following free or reduced parking charges and categories of patients, relatives and visitors:

- Patients, from diagnosis, making daily or frequent visits for the treatment of cancer (surgical intervention, radiotherapy, SACT)
- All registered disabled patients who hold a disabled badge or who are transporting a patient who holds a disabled badge and who park in a designated Blue Badge Holder space.
- Relatives of those patients who are critically unwell, typically in ICU or requiring high dependence care
- Resident parents of children in hospital or parents whose babies who are being cared for in the Special Care Baby Unit providing parent caring arrangements
- Relatives of patients at the end of their life
- Those who are visiting the bereavement office or collecting a death certificate
- Registered unpaid carers when they are caring for a friend or family member visiting or staying at Torbay Hospital

A weekly parking ticket will be available to purchase which will provide reduced parking charges for patients, visitors and relatives making regular visits to the Trust.

4.6 Staff Parking Charges

The site has insufficient space to provide parking for every member of staff who wish to bring their car to work. There are expectations on the Trust that it fulfills its environmental responsibilities through its green travel plan to encourage staff to use alternatives routes to get to work such as public transport, cycling and walking. The Council's expectations is that the Trust has in place a system to manage parking within the number of spaces that staff are reasonably allowed. Trust staff parking strategy is based on a staff side agreed sliding scale charge according to salary band and a permit system according to a criteria which includes hours worked, distance of travel, use of car for work and access to public transport. The application of the permit system precludes staff who live nearer the hospital who could use alternative means of getting to work from using their car. In the implementation of the new system the Trust has no plans to reduce the threshold of the permits.

It has been made very clear by the Council that the agreement to the increase in parking spaces within the plan is contingent on encouraging staff not to drive their car to work if possible. They do not consider the current Band 1 and 2 charge of 32 pence a day to park i.e. £5.50 per month a disincentive. Staff who cannot afford a car and rely on public transport have to pay public transport rates which are substantially greater. e.g. Torbay Stagecoach Mega Rider (includes a 10% discount) costs £45 per month, this increases by the rate of inflation annually.

During the initial feasibility stage the Council proposed a flat parking rate of £1 per day for every member of staff the same as for council staff. The Trust was is not comfortable with this as it represented a 213% increase for band 1 and 2 staff.

Staff parking charges have not increased for five years, the Trust has the lowest car parking tariff of any acute Trust in the region, with the lowest banding at £5.50 per month, considerably less than the bus fare.

Determination of the charges

The Staff subgroup gave consideration to a number of options relating to staff parking charges according to the principle of; fit with the existing sliding scale charging strategy and the overriding principle of equity. The scenario's ranged from a same percentage increase across all pay bands paid direct from salary to a flat payment across the board to pay as you go.

The group considered that 50 pence per day to park was a reasonable and fair minimum cost. When equitably applied across all staff groups and bandings (i.e. 32p to 50p) this equates to a 56% increase in parking charges across the board.

The recommended rates detailed below in table 9, gives staff with a permit the option of pay as you go or monthly payments based on a minimum payment of 50p per day. Staff who opt for the pay as you go option are likely to supplement their parking with alternative means of transport e.g. Bicycle.

Table 9. Existing staff charges and new staff charges

	Existing		New Charges		
Band	Monthly charge	Daily charge	Daily Charge	Monthly charge	New daily charge pay as you go
Band 1	£5.50	£0.32	£0.50	£8.58	0.50
Band 2	£5.50	£0.32	£0.50	£8.58	0.50
Band 3	£6.50	£0.38	£0.59	£10.14	0.75
Band 4	£7.00	£0.41	£0.64	£11.00	0.75
Band 5	£8.25	£0.48	£0.75	£12.89	0.75
Band 6	£10.00	£0.58	£0.91	£15.64	1.00
Band 7	£11.00	£0.64	£1.00	£17.19	1.00
Band 8 (mid a)	£13.20	£0.71	£1.10	£20.00	1.50
Band 8 (mid b)	£16.25	£0.86	£1.34	£25.00	1.50
Band 8 (mid c)	£18.70	£1.01	£1.57	£29.00	2.00
Band 8 (mid d)	£20.65	£1.20	£1.87	£33.00	2.00

Opting for the new flexible pay as you go and paying on a daily basis for those working less that 5 days in a week would obviously reduce the monthly cost of parking. Salary Sacrifice could also be an option for higher earners to reduce the cost of car parking charges. The revised rates compare well in comparison to other acute Trusts across the area as shown in table 10 overleaf:

Table 10. Comparison of staff charges across the Region via monthly payment

Car Parking Charges By Band mid point	New charges per month	New charges per day	RD&E pm	RD&E per day	Plymouth Onsite pm	Plymouth Onsite per day	Taunton pm	Taunton per day	Yeovil pm	Yeovil per day	RCHT pm
Band 1	£8.58	£0.50	£13.21	£0.71	£46.60	£2.50	£28.93	£1.49	£18.00	£0.99	£5.00
Band 2	£8.58	£0.50	£15.41	£0.83	£46.60	£2.50	£28.93	£1.49	£18.00	£0.99	£5.00
Band 3	£10.14	£0.75	£17.61	£0.94	£46.60	£2.50	£28.93	£1.49	£18.00	£0.99	£5.00
Band 4	£11.00	£0.75	£17.61	£0.94	£46.60	£2.50	£28.93	£1.49	£28.00	£1.53	£7.50
Band 5	£12.89	£1.00	£21.28	£1.14	£46.60	£2.50	£28.93	£1.49	£28.00	£1.53	£7.50
Band 6	£15.64	£1.00	£24.00	£1.28	£46.60	£2.50	£28.93	£1.49	£28.00	£1.53	£10.05
Band 7	£17.19	£1.00	£26.42	£1.42	£46.60	£2.50	£28.93	£1.49	£35.00	£1.92	£12.57
Band 8 (mid a)	£20.00	£1.10	£36.69	£1.93	£46.60	£2.50	£28.93	£1.49	£35.00	£1.92	£15.08
Band 8 (mid b)	£25.00	£1.34	£44.03	£2.26	£46.60	£2.50	£28.93	£1.49	£35.00	£1.92	£17.59
Band 8 (mid c)	£29.00	£1.57	£51.37	£2.62	£46.60	£2.50	£28.93	£1.49	£35.00	£1.92	£20.11
Band 8 (mid d)	£33.00	£1.87	£53.11	£2.71	£46.60	£2.50	£28.93	£1.49	£35.00	£1.92	£25.13
Band 9 top	£42.00	£2.26	£54.68	£2.79	£46.60	£2.50	£28.93	£1.49	£35.00	£1.92	£27.65

Staff body consultation

Staff groups have been fully involved in the development of the plan and the charges. The proposed rates are the minimum increase to staff tariff required to fund the staff parking improvements, and as such they are have been recommended by the sub-groups and accepted by the Medical Staff Committee (MSC) the Local Negotiating Committee (LNC- Doctors) and the Local Consultative Negotiating Committee (LCNC – wider staff union body). The new charges have been recommended to the Executive and subsequently to the Trust Board for approval as a fair and equitable new charging structure that covers the direct cost to improvements to staff parking.

4.7 Affordability

Capital

A strategic estate programme has already been developed as part of the acquisition OBC and the five year plan and financial envelope from 2014/15 to 2019/20 shared with Monitor.

This FBC and the c£1.97m capital costs sits within the Trusts 5 year capital plan, overall capital programme and overall affordability envelope from April 2015 to March 2020.

Revenue

The cash flow showing a break even position for this 1.9m Capital car parking solution and corresponding increase in parking charges is detailed in table 11 below.

Table 11. SDHT CAR PARK CASH FLOW £1.97m Capital

	2014-15	FBC 2015-16
Public	£519,000	£788,135
Staff	£232,016	£391,867
TOTAL INCOME	**£751,016**	**£1,180,002**
Net Change in Income		**£428,986**
Finance Costs		**£239,350**
Total Operating Costs	**£83,556**	**£273,192**
TOTAL EXPENDITURE	**£83,556**	**£512,542**
Net Change in expenditure		**£428,986**
I/E		**0**

4.8 Capital Cashflows

The outline project plan is detailed in Section 4. Consideration has been given to the phased delivery of the scheme to maximise the delivery of early wins whilst maintaining the greatest number of spaces and minimising disruption.

The capital cashflow for the c£1.97 capital solution determined from the phased delivery plan is shown in table 12 below. **This includes £84,000 of contingency**. For the purposes of the FBC the total cost including contingency has been profiled. The Trust will work hard not to spend the contingency unless absolutely necessary. The table details the expenditure of £118,000 in 2014/15 and 1,852,000k in 2015/16. The construction period is 4 months.

Table 12. capital cash flow

Year	Expenditure	Running Total
2014/15	£118,000	£118,000
2015/16	£1,852,000	1,977,598

This business case does not materially change the profile of the required capital and the capital envelope presented in the LTFM. The cost of capital and revenue affordability is therefore detailed in the LTFM and will be subject to the delivery of CIP plans to ensure that the level of capital investment remains affordable.

4.9 Finance Summary

The Trust remains in control of the key variables relating to finance i.e. the proposed solution capital costs, charges and levels of enforcement and is comfortable and confident that the business and financial model proposed is affordable, based on conservative assumptions, relatively low risk and presents a solution to resolve the Trust car parking issues at no net cost additional cost to the Trust.

5. Commercial case

5.1 Procurement

The nature of the project requires the co-ordination and integration of four distinct areas of works comprising:-

(i) Design, supply and installation of specialist equipment and systems.

(ii) Civil works in connection with constructing new car parks, alteration and improvements to existing car parks and associated builders work in connection with the specialist equipment and systems, CCTV cameras and new street lighting.

(iii) CCTV & Street Lighting.

(iv) Works carried out direct by the Trust including enabling works, road marking and signage and landscaping.

(i) Equipment & Systems Installation by WPS Limited

Responsibilities will involve the design and installation of the parking equipment and systems together with the installation of IT systems, cabling, controls etc. The selection of WPS as preferred contractor for the supply and installation of the Car Parking Equipment & Systems followed a OJEU compliant bid process whereby 6 suppliers tendered for the works. Tenders were assessed based on a Quality/Price submission.

The original tender of WPS was submitted on the basis of Equipment & Systems only with limited civils/builders works but following the necessity to value engineer to achieve budget the scope of certain car park civil works (which would have been carried out by the civils contractor) have been either reduced or omitted such that it is preferable that the Equipment & Systems supplier carries out the associated trenching and ductwork in those areas where works are limited to equipment and systems.

WPS have provided priced measurements for these works which have been market tested and checked and found to be correct in terms of measurement and value for money in terms of rates when compared to similar rates from other civil contractors.

In terms of cost certainty of the WPS works the position is currently detailed in the costed scope of works document as 93.86% fixed and 6.14% estimated.

(ii) Civils Works by Kier Construction

Responsibilities will involve taking forward the design commissioned by the Trust and the execution of the civil works comprising the construction of the new car parks, the upgrade of various car parks and sundry repairs where car parks are seen to be defective.

The civil works have been tendered on two occasions to a selection of contractors (see below) and in each case contractors have progressively withdrawn such that only one or two tenderers remained interested in submitting. Reasons given included lack of tendering resource, a reluctance to take on design responsibilities and a lack of appetite for what is a piece meal project in a buoyant market where more attractive opportunities exist elsewhere.

On this basis the Trust entered into negotiations with TOR2 under the "Scape" framework which is

a public sector framework arrangement negating the need to competitively tender. TOR2 (who are owned by Kier Construction) submitted a priced schedule of works for the project which have been market tested and checked and found to be competitive and have engaged with a proposed sub-contractor to programme and carry out the works. Leading on from these negotiations and mindful of the programme which runs parallel with the Linac project currently on site Kier have proposed that the project is contracted and administered alongside the Linac project. The Trust consider this to be a benefit in terms of shared resource and "on site" management with one principle point of contact, and has benefitted from some cost reduction on this basis.

The contractors invited to tender for the works originally included:-

Roadform
John Luffman Group
EJW Glendinning
JTT
Roadform
Dyer & Butler
Interserve

In terms of cost certainty and cost for the Kier works the situation is detailed as 82.97% fixed and 17.03% estimated.

(iii) CCTV by Sound and Visual & Street Lighting by SSE

Sound and Visual carry out much of the CCTV installations about the site and are familiar with the existing installations. It is considered prudent that they carry out the limited amount of works associated with additional CCTV and upgrades resulting from the proposed works.

SSE currently maintain the street lighting at the site and SSE will provide street lighting in the new car parks. Note: Sound & Visual and SSE have previously provided quotations for the works and following a reduction to scope will be requested to re-quote. At present allowances have been included for the CCTV and Street Lighting based on the original quotations.

(v) Direct Works by Trust

The Trust will be responsible for carrying out much of the enabling works in preparation for the main works, costs include for putting in place ecological mitigation measures arising from Planning Conditions, signage and white lining and landscaping works.

5.2 Project Plan

A detailed operational plan has been developed with a view to maximising car parking spaces as quickly as possible. A summary is shown in the table overleaf.

CAR PARK CONSTRUCTION PHASING 2015

	Construction Week Number			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
	Month			Jul-15				Aug-15				Sep-15					Oct-15				Nov-15					Dec-15		
No	Week Beginning Date	Spaces + -	BY WHOM	06-Jul	13-Jul	20-Jul	27-Jul	03-Aug	10-Aug	17-Aug	24-Aug	31-Aug	07-Sep	14-Sep	21-Sep	28-Sep	05-Oct	12-Oct	19-Oct	26-Oct	02-Nov	09-Nov	16-Nov	23-Nov	30-Nov	07-Dec	14-Dec	21-Dec
1	Maternity	5+	KIER FRAMEWORK AGREEMENT																									
2	Annexe **(Inc. Systems WPS)**	70+																										
3	Cadewell Lane **(Inc. Systems WPS)**	78+																										
4	Shiphay Park (old Football Field, Social Club, Tennis Court)**(Systems WPS)**	56+																										
5	Kitson Park (Stevens Hall)	18+																										
6	Bayview **(Minimal Surface improvements only)**	0																										
1A	Car Park E	0	WPS SMALL WORKS PARKING SYSTEMS																									
2A	Annexe	As above																										
3A	Fracture	-3																										
4A	Cadewell Lane	As above																										
5A	Farmhouse Tavern	-5																										
6A	Shiphay park (Football Field)	As above																										
7A	Kitson Hall Front Roadway	0																										
8A	Opp Northcott Hall, Roadway to Breast Care/Tairu	0																										
9A	Horizon Centre/Brookside Roadway	0																										
10 A	Car Park A	-20																										

The indicative delivery timetable for the project is shown overleaf in table 13. with the full programme in Annex 1.

Table 13. High Level Project Timetable

Phase Component	Target Date
Planning Consent	20/04/2015
Trust Board FBC approval	01/07/2015
Construction commence	03/08/2015
New permit system applications complete	01/09/2015
Go live new charges	01/09/2015
Construction completed	21/12/2015

6 Management Case

6.1 Governance

Project management arrangements for the delivery of this project is headed by the Director of Estates as Project Director supported by the established staff and public sub-groups who will continue to be instrumental in the determination, delivery and communication of the final solution. The Team will continue to be supported by finance. Additionally, the Trust has appointed External Consultants such as Cost Advisors and Consultant Services to advise on specialist areas where resources does not exist within the Trust.

In addition to the parking services manager who will be working on this project, the environmental services manager will act in the capacity of a full time and dedicated Project Manager and lead the project. The principal element of this role will be to coordinate the construction works, manage the communications plan and oversee the phasing of the delivery whilst maintaining parking capacity. The project Board will formally report to workstream 5 supported by the Trusts non-executive lead for capital the infrastructure who will also receive regular updates on progress against plan.

Project development and governance are overseen by the Project Board (which meets monthly). The Board will oversee all the project governance requirements and all key project documentation, including risk registers, project programme and financial records etc.

6.2 Risk Register

The scheme will be implemented under robust project management arrangements which will include active risk management using recognised guidelines. The following Risk Management framework has been established by the Trust for the identification, evaluation and mitigation of project risk.

The key risks to the project are summarised in the table overleaf.

Figure 15. Key Risks

Key Risk	Mitigating Action
Cost escalation due to unknowns.	Detailed surveys and design in place contingency included.
Operational disruption to car parking and the site as a result of works.	Detailed delivery plan in place. Dedicated project management.
Environmental works as a result of the habitat survey add additional costs and time to the project.	Environmental works costs included within the 1.97m budget alongside contingency. A number of habitat surveys have already been commenced and any mitigating works will be actioned immediately.
Patient and staff negative feedback whilst the works to improve services take place.	Engagement with the communications team and proactive and detailed and comprehensive communications plan in place.

The Risk Register will be reviewed on a regular basis by way of individual input and by joint input at designated risk workshops. Each risk has a "risk owner" who will be tasked to mitigate the identified risk at or before pre-arranged dates such that that risk does not present an unacceptable risk moving forward.

Following the completion of the project, as assessment will be made of the effectiveness of the scheme by carrying out a post project evaluation (PPE). The main objective of the PPE will be to assess the benefits that are being or have been derived from the project, compared with those that were envisaged.

6.3 Communications Plan

Stakeholder engagement and communication is absolutely essential in the successful delivery of the improvements to car-parking. Public and our staff will be kept continuously informed of progress and developments, and the consultation precedent already established will need to continue.

The communications team are actively involved, and with the support of the sub-groups and the Director of EFM, will lead the communications process. A comprehensive communications plan has already been established and is appended to this business case in annex 3.

The Objectives of the communications plan can be summarised as:

- To communicate the proposed changes to car parking services at Torbay Hospital to our staff and key stakeholders, including patients and members of the public, in a clear, open and timely way
- To highlight improvements.
- To maintain the confidence of staff, patients, and the public that public money is being spent appropriately
- To ensure that stakeholders understand the need for increased car parking charges and the principles underlying the pricing strategy

Our communication will:

- Be targeted to, and respectful of, the needs of our different stakeholder groups
- Be clear, timely, professional and honest
- Allow opportunity for feedback.

Communications will commence immediately following approval of the OBC by the Trust Board.

6.4 Conclusion

The case and requirement for improvements to car parking on the Hospital sites have been agreed and rehearsed within the Trust over the last few years. This FBC presents the preferred solution for the delivery of an affordable site wide car parking solution that supports strategic plans for the future.

This case fits with the Trusts objectives of improving the patient experience and quality of care, working in partnership and the strategic vision for the Trust and integrated care organisation. It is affordable and within the financial model and constraints of the capital programme presented as part of the LTFM and business case for the integrated care organisation.

The strategy before it, together with this business case, has been subject to robust internal scrutiny having been discussed and endorsed by the sub-groups, staff side groups (LCNC, LNC, MSC) and the Clinical Management Group. The case has been approved by the Executive Directors, and the Finance committee on the 23rd June 2015.

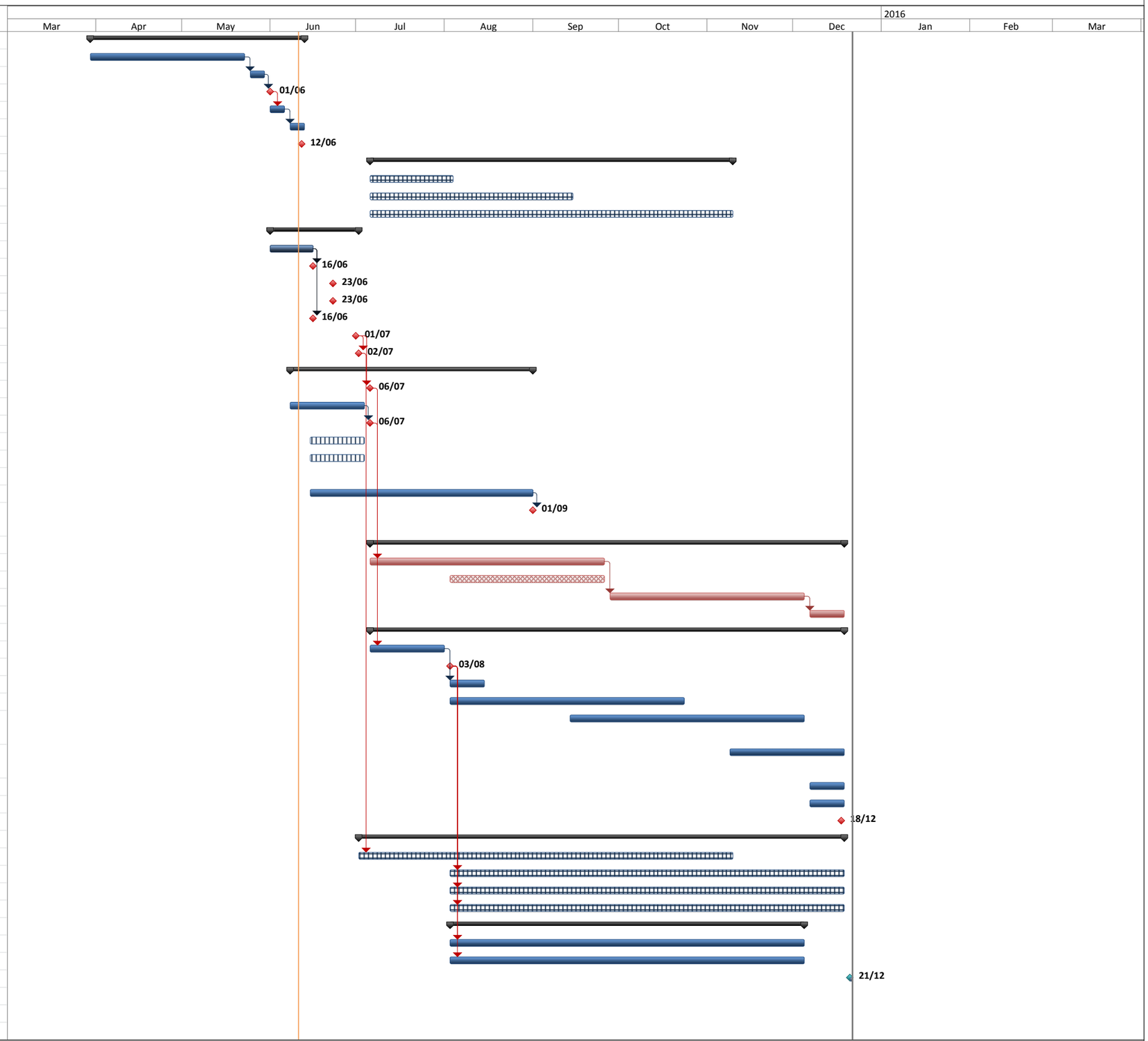
6.5 Recommendations(s)

The Trust Board asked to:

- Agree the final site wide solution for the improvement to the car parking and configuration across the site
- Agree the resultant final parking charges as recommended by the staff and public sub-groups

TORBAY HOSPITAL: CAR PARK WORKS - REV. A (10th JUNE 2015)

ID	Task Name	Duration	Start	Finish	Predecessors
1	**Design Development**	**55 days**	**Mon 30/03/15**	**Fri 12/06/15**	
2	Complete Design Development	40 days	Mon 30/03/15	Fri 22/05/15	
3	Trust Review Final Design	5 days	Mon 25/05/15	Fri 29/05/15	2
4	Trust Sign Off Design	0 days	Mon 01/06/15	Mon 01/06/15	3
5	Complete Final Design Package for Contract	5 days	Mon 01/06/15	Fri 05/06/15	4
6	Final Cost Review	5 days	Mon 08/06/15	Fri 12/06/15	5
7	Final Scope Agreed	0 days	Fri 12/06/15	Fri 12/06/15	
8	**Discharge of Planning Conditions**	**91 days**	**Mon 06/07/15**	**Mon 09/11/15**	
9	Annexe	21 days	Mon 06/07/15	Mon 03/08/15	
10	Cadewell Lane	51 days	Mon 06/07/15	Mon 14/09/15	
11	Kitson Park (previously Football Field etc.)	91 days	Mon 06/07/15	Mon 09/11/15	
12	**Full Business Case**	**23 days**	**Mon 01/06/15**	**Thu 02/07/15**	
13	Draft Full Business Case	11 days	Mon 01/06/15	Mon 15/06/15	
14	Submit to Finance Committee	0 days	Tue 16/06/15	Tue 16/06/15	13
15	Finance Committee Meet	0 days	Tue 23/06/15	Tue 23/06/15	
16	Finance Committee Approve	0 days	Tue 23/06/15	Tue 23/06/15	
17	Submit to Board	0 days	Tue 16/06/15	Tue 16/06/15	13
18	Board Meeting	0 days	Wed 01/07/15	Wed 01/07/15	
19	Trust FBC Approval	0 days	Thu 02/07/15	Thu 02/07/15	18
20	**Procurement**	**61 days?**	**Mon 08/06/15**	**Tue 01/09/15**	
21	Place WPS Order	0 days	Mon 06/07/15	Mon 06/07/15	18
22	Conclude TOR2 Negotiations	20 days	Mon 08/06/15	Fri 03/07/15	
23	Place TOR2 Order	0 days	Mon 06/07/15	Mon 06/07/15	22
24	Quotation for CCTV	15 days	Mon 15/06/15	Fri 03/07/15	
25	Quotation for Street Lighting	15 days	Mon 15/06/15	Fri 03/07/15	
26	Trust Procured Works				
27	Organise Permit System	56 days	Mon 15/06/15	Mon 31/08/15	
28	Permit System/New Pay & Display and Staff Charges Operational	0 days	Tue 01/09/15	Tue 01/09/15	27
29	**WPS Works**	**120 days**	**Mon 06/07/15**	**Fri 18/12/15**	
30	Mobilisation/Lead In	60 days	Mon 06/07/15	Fri 25/09/15	21
31	Early Implementation	40 days	Mon 03/08/15	Fri 25/09/15	
32	Final Implementation	50 days	Mon 28/09/15	Fri 04/12/15	30
33	Commissioning	10 days	Mon 07/12/15	Fri 18/12/15	32
34	**Kier Works**	**120 days**	**Mon 06/07/15**	**Fri 18/12/15**	
35	Mobilisation/Lead In	20 days	Mon 06/07/15	Fri 31/07/15	23
36	Construction Start	0 days	Mon 03/08/15	Mon 03/08/15	
37	Maternity	10 days	Mon 03/08/15	Fri 14/08/15	35
38	Annexe	60 days	Mon 03/08/15	Fri 23/10/15	
39	Staff 3 - Cadewell Park (previously Cadewell Lane)	60 days	Mon 14/09/15	Fri 04/12/15	
40	Staff 1 - Shiphay Park (previously Football Field etc.)	30 days	Mon 09/11/15	Fri 18/12/15	
41	Bay View	10 days	Mon 07/12/15	Fri 18/12/15	
42	Staff 2 - (previously Stevens Hall)	10 days	Mon 07/12/15	Fri 18/12/15	
43	Construction Completion	0 days	Fri 18/12/15	Fri 18/12/15	
44	**Trust Works**	**122 days**	**Thu 02/07/15**	**Fri 18/12/15**	
45	Enabling Works	93 days	Thu 02/07/15	Mon 09/11/15	19
46	Signage	100 days	Mon 03/08/15	Fri 18/12/15	36
47	White Lining	100 days	Mon 03/08/15	Fri 18/12/15	36
48	Landscaping	100 days	Mon 03/08/15	Fri 18/12/15	36
49	**"Other" Works**	**90 days**	**Mon 03/08/15**	**Fri 04/12/15**	
50	Street Lighting	90 days	Mon 03/08/15	Fri 04/12/15	36
51	CCTV	90 days	Mon 03/08/15	Fri 04/12/15	36
52	**Completion**	**0 days**	**Mon 21/12/15**	**Mon 21/12/15**	
53					
54					
55					



Project: Torbay Programme
Date: Thu 11/06/15

Task	Summary	External Milestone	Inactive Summary	Manual Summary Rollup	Finish-only	Critical Split
Split	Project Summary	Inactive Task	Manual Task	Manual Summary	Deadline	Progress
Milestone	External Tasks	Inactive Milestone	Duration-only	Start-only	Critical	

South Devon Healthcare NHS
NHS Foundation Trust

Car Parking Communication Plan

1. Background

Car parking can often be a patient's first touch-point with our Trust and therefore forms a critical part of their overall experience.

Feedback from our patients tells us that they find it difficult to park on the Torbay Hospital site, sometimes driving around the car parks for long periods searching for spaces. In some cases patients are unable to attend their outpatient appointments as they are unable to park. Difficulty in parking is stressful for patients and members of the public and can have a profoundly negative effect on their experience at the start of their visit.

In response to this feedback, we worked with staff, unions, patients, carers, and Torbay Council during 2013 and 2014 to develop a car parking strategy. As a result, a business case for improved parking facilities is being presented to the Trust Board in July 2015. The improvement plans have been developed in consultation with working groups of staff and public representatives.

The Trust plans to create an additional 207 car parking spaces on the site of Torbay Hospital, along with additional drop-off bays, motorcycling and cycling facilities. The changes will also make access to Torbay Hospital easier and safer for our patients, members of the public and visitors. The cost of developing the new facilities is around £1.9million with an annual maintaining cost of approximately £430,000. This will be funded by increased parking charges.

2. Aim

To inform staff, patients, visitors and others of parking improvements and changes in advance, and during the changeover, so that car park operations run efficiently after changeover.

3. Objectives

- To communicate the proposed changes to car parking services at Torbay Hospital to our staff and key stakeholders, including patients and members of the public, in a clear, open and timely way
- To highlight improvements that are in response to feedback
- To maintain the confidence of staff, patients, and the public that public money is being spent appropriately
- To ensure that stakeholders understand the need for increased car parking charges and the principles underlying the pricing strategy

3. Principles

Our communication will:

- Be targeted to, and respectful of, the needs of our different stakeholder groups
- Be clear, timely, professional and honest
- Allow opportunity for feedback

4. Key Messages

The messages below will be used to form the basis of communication.

Feedback on the current system

The Trust knows the current system is not working because:

- There are not enough car parking spaces to meet demand at peak times
- More and bigger disabled spaces are required
- The site is very congested and parking is not controlled
- There are safety issues with cars parked across loading bays and within areas that should be kept free for deliveries
- There are not enough drop off points at main entrances
- Staff are parking in spaces which are designated for patients and the public.
- Signage is not good enough
- Pay and display can be stressful, as people don't always have the right money on them, or know how long they need to park
- Accessing help when needed, or change for paying, is not easy

Proposed Changes – for patients and public

- 207 additional spaces with public parking closer to hospital entrances
- New directional signage will mean less time spent driving around looking for spaces
- Improved entrances, exit and traffic flows around the car parks making it quicker, safer and easier to find a parking space
- Nearly 100% more disabled spaces, with bigger bays, for blue badge holders
- New barriers and pay on exit systems will make parking quicker, easier and less stressful
- New road markings will improve safety
- Improved drop off areas will mean fewer people need to use car parks for very short stays
- Designated areas for contractors' vehicles will help to improve availability of spaces and the safety of the site

Proposed Changes – for staff

- More disabled spaces with bigger bays
- A choice of payment options for staff- pay as you go or pay monthly
- Better space to permit management to ensure staff with permits can find a space
- Introduction of a 'frequent flyers' car park for staff who have to leave the site frequently throughout the day to undertake their duties in the community
- The main staff Car Parks will be those the furthest away from the main buildings
- Parking on site only for staff entitled to permits

Parking charges

- Delivering these improvements and maintaining the service will cost more, so parking charges will have to increase for staff and public
- Even after the price rise, our charges will be amongst the lowest in the region
- We will introduce a new, free 15-minute parking tariff in our public car parks Staff parking charges were recommended by a small working group of staff and union representatives
- Staff parking will continue to be on a sliding scale according to salary band, with the minimum charge rising from 32p a day to 50p a day, and the same 56% increase applying across all salary bands

5. Timescale

July 2015	Board approval of plans
July 2015	Staff apply for new permits
August 2015	Construction Work commences on site
September 2015	New staff permits allocated Price increases take effect for staff and public

6. Key Stakeholders

Staff

Those required to cascade the information on the proposed changes

- Executive Team
- Divisional teams including, Clinical Directors, Divisional General Managers, Matrons, Associate Directors of Nursing

- Heads of Departments/Service
- Staff Governors

Other staff groups
- Senior clinical staff
- All staff including community midwives and night staff
- LCNC
- MSC
- Foundation Trust Governors
- Staff side Representatives

NHS and Social Care
- NHS England South West
- South Devon and Torbay CCG
- Torbay and Southern Devon Health and Care Trust

External
- MPs
- Councillors and Mayor
- HealthWatch
- PALS
- League of Friends
- Patient, carer & support groups
- Patients not involved in the above groups
- Public
- Voluntary organisations & regional charities

7. Monitoring and evaluation

We will monitor the effectiveness of our communication through a variety of mechanisms which could include:

- Web/intranet polls
- Media coverage (positive/negative)
- Engagement via social media channels
- Direct responses (compliments/complaints and verbal feedback)
- Response/feedback mechanisms on leaflets
- Car parking staff as changes are made
- Car parking survey in 2016

Proposed communication activity

Stakeholder	Desired Outcomes	Lead responsibility	Methods of Communication
Staff			
Those required to sign-off the detail in the Communications Plan • Executive Directors • Trust Board	▪ Sign-off for the communications plan	Director EFM	Presented at Executive Director meeting Presented at Trust Board
All staff, including those required to cascade the information on the proposed changes • CEG • CMG • Divisional teams including, Clinical Directors, Divisional General Managers, ADN's, Matrons • Heads of departments/service • Consultants/Medical Staff (MSC) • LCNC • Foundation Trust Governors • Staff Governors • Current permit holders	Staff understand: ▪ that in order to provide better services for all; more and larger spaces, better signage and more assistance, there will be a need for some staff to change how and where they park ▪ the need to increase car parking charges, and the principle of applying the increase equitably ▪ there is no parking in designated public car parks ▪ there is a choice of how to pay Our leaders feel supported and empowered in communicating the changes to their staff, and where applicable, patients	Chief Executive Executive Directors Director EFM Communications team	Powerpoint presentation for leaders to deliver, allowing opportunities for questions and feedback, at: ▪ CEG ▪ CMG ▪ All Managers Meeting ▪ Divisional Team Meetings Information on Contact ▪ Car parking strategy ▪ Presentation of key points ▪ Map showing new scheme ▪ Permit policy and application form ▪ Green travel information ▪ Links to public transport information ▪ Charging information ▪ FAQ (dynamic – updated as staff ask new qustions) All Staff Bulletin Emails to permit holders

NHS and Social Care Partners			
• NHS England South West • CCG • TSDHCT	Our partners understand: ▪ our need to improve our car parking ▪ the planned programme of work ▪ price changes ▪ how to raise issues and provide feedback	Chief Executive Executive Directors Director EFM Communications Team	Personal telephone and written communication
Key partners			
• MPs • Councillors and Mayor • League of Friends • Patient, carer & support groups • Voluntary organisations & regional charities	▪ Our partners understand our need to improve our car parking service ▪ They have confidence that the improvements will provide a better service ▪ They understand the need to increase car parking charges	Director EFM Communications Team	Tailored, written communication and presentations on request
Patients and Wider Public			
• Patients • Public • Media • Healthwatch	▪ They understand our need to improve our car parking service ▪ They have confidence that the improvements will provide a better service ▪ They understand the need to increase car parking charges	Director EFM Communications Team	▪ Direct communication with staff ▪ Information boards in car parks and reception areas ▪ Information leaflets and maps ▪ Website and social media feeds ▪ Additional staff in car parks during changeover times ▪ News release and press/radio advertisements

REPORT SUMMARY SHEET

Meeting Date:	1 July 2015
Title:	Workforce and OD report
Lead Director:	Martin Ringrose, Interim Director of Human Resources
Corporate Objective:	Safest Care/Promoting health/Personal, fair and diverse/Delivering improved value
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Education Governance Board. To provide the Board with assurance on workforce and organisational development issues.

Key Issues/Risks and Recommendations:

Workforce Key Performance Indicators (see Appendix A for overview) to include:

- Staff headcount
- Turnover
- Sickness absence
- Appraisal
- Mandatory Training

Recruitment/Bank and Agency Usage

We recommend the board note the attached report.

Summary of ED Challenge/Discussion:

The workforce numbers should be reported on a monthly basis to provide information on the progress to deliver the workforce reductions under cost improvement programme (CIP).

A risk assessment of workforce recruitment challenges, identifying those professions and specialties experiencing difficulties, the action plans to address and the risk impact of associated vacancies to be reflected in risk registers. Martin Ringrose to confirm the timescale to complete this work.

Internal/External Engagement including Public, Patient and Governor Involvement:
Governor Observer on Workforce and Education Governance Board (Workstream 4)

Equality and Diversity Implications:
None.

PUBLIC

Board of Directors
Workforce and Organisational Development Directorate
1st July 2015

1.0 Purpose and Content of the Report

1.1 Report Purpose
To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by Workstream 4 (Workforce and Organisational Development Committee).

To provide the Board with assurance on workforce and organisational development issues.

1.2 Report Content
A summary of progress on key performance indicators. These performance indicators are included in the Trusts monthly workforce and OD scorecard at appendix A and include key targets and monthly trends.

Detail on actions and initiatives linked to the objectives and key performance indicators.

2.0 Workforce and OD Corporate Objectives

2.1 Planned Objectives
The Directorate have agreed the following overarching objectives for 2015/2016 and they are included at the start of this report as they help set the context for the support to be provided.

2.2 Workforce Plan
To develop, implement and monitor a robust workforce plan to deliver a safe, high quality and efficient workforce for the ICO. This plan will include workforce redesign, education and development and change strategies.

2.3 Leadership and Culture
Develop leadership and culture throughout the organisation to ensure the values and beliefs of the organisation are embedded.

2.4 Friends and Family Test for Staff
Continue to embed the friends and family test survey for staff in parallel with the national staff survey and data interrogation ensuring actions are taken to improve outcomes.

2.5 Sickness Absence Management
Measurably reduce sickness absence rates by performance management and support including targeting areas with high rates.

2.6 Mandatory Training
To continuously improve interventions and mechanisms to ensure compliance and quality of mandatory training.

3.0 Progress on Key Performance Indicators

3.1 Workforce Targets for 2015/2016

Workstream 4 have agreed workforce targets for the current financial year as follows:

- Staff Turnover – within the range of 10% to 14%
- Sickness Absence – 4.20% at the start of the year reducing to 4% by the end of the year
- Appraisals – 90%
- Mandatory training 80% for all modules by the end of November 2015 and 90% for all modules by the end of the year, with the exception of those modules that have specific targets set externally.

It should be noted that the sickness absence target is a combined target for both Trusts in preparation for integration. The current sickness absence rate at TSDHCT is 4.43% which although higher than for SDHFT is just below average for community trusts with social care services.

The Workforce and OD scorecard at appendix A includes the current RAG rating against these targets.

3.2 Turnover

The turnover rate of 12.80% in May 2015 is within the target range of 10 to 14% but shows an increase from previous months and will continue to be monitored. Too low a turnover rate can hinder organisational change and too high a turnover can cause instability. A reasonable level of turnover is critical at this time given the need for changing the workforce as described in the workforce plan section of this report.

3.3 Sickness Absence

The sickness absence rate of 4.19% in April 2015 was within the target of 4.20%. An update in respect of measures to achieve the end of year target of 4.00% is included later in this report.

3.4 Staff Appraisals

The Trust further increased its completed appraisal rate to 83% in May 2015. This is consistent with the on-going improvement and compares with a rate of 58% at the same time last year. As detailed above Workstream 4 has agreed a target of 90% and additional initiatives to improve performance are being considered including further performance management in those areas of low achievement.

3.5 Mandatory Training

Based on the recently agreed targets only 3 of the nine key modules included are now rated amber. The average compliance of these modules has increased to 86%. Details of further plans to improve this position and achieve the 90% target for all modules by the end of November are included later in this report.

4.0 Workforce Plan

4.1 ICO Workforce Changes

As has previously been reported a workforce plan is developing for the Integrated Care Organisation (ICO). This plan includes the implementation of changes to the care model and CIP changes. This plan has been discussed and subject to scrutiny by Workstream 4.

The key focus of the care model which sits at the heart of the ICO is the shift in focus from acute care to community and care at home. From a workforce perspective this will entail the introduction of new and different roles at both a professional and care worker level across settings. In addition overall workforce numbers will change as a result of the impact of the care model, economies of scale and CIP requirements. The table below which has already been widely shared shows the overall workforce numbers and reductions by job family over the first 7 years of the ICO.

ICO Workforce WTE

	Baseline 14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	% Change
Consultants	184.00	183.05	175.76	170.36	169.16	167.46	164.96	164.96	10.35%
GP	8.99	8.99	8.99	8.99	8.99	8.99	8.99	8.99	0.00%
Dental	10.91	10.91	10.91	10.91	10.91	10.91	10.91	10.91	0.00%
Junior Medical	227.08	225.58	221.58	220.58	219.58	219.58	219.58	219.58	3.30%
Nursing, midwifery & health visitors (excluding HCAs)	1355.79	1323.76	1296.90	1205.14	1177.99	1166.99	1161.49	1155.99	14.74%
Other clinical staff -social care workers	233.81	233.81	233.81	233.81	233.81	233.81	233.81	233.81	0.00%
Other clinical staff costs (including HCAs)	934.69	936.73	905.80	819.81	785.30	772.86	766.86	760.86	18.60%
Scientific, therapeutic, & technical	582.22	575.22	561.60	561.82	545.67	530.52	522.52	514.52	11.63%
Non clinical staff	1831.49	1754.24	1728.67	1684.19	1648.78	1614.37	1594.37	1574.37	14.04%
Total	**5368.98**	**5252.29**	**5144.02**	**4915.61**	**4800.19**	**4725.49**	**4683.49**	**4643.99**	**13.50%**
Annul Reduction		**116.69**	**108.27**	**228.41**	**115.42**	**74.70**	**42.00**	**39.50**	
Cumulative Reduction			**224.96**	**453.37**	**568.79**	**643.49**	**685.49**	**724.99**	

4.2 Delivering Workforce Changes

The previous report outlined how achieving these changes will be controlled by the Scrutiny and Vacancy Panel within the clear context of change requirements and the use of a 'job shop' concept aligned to the future changes and which motivates and supports staff to develop new skills. The clear objective is to achieve the changes without the requirement for compulsory redundancies. This is confirmed by the following table which shows how the above reductions compare with the normal annual leavers profile and therefore the redeployment opportunity.

ICO Workforce WTE Changes

	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Annual Leavers
Consultants	0.95	7.29	5.40	1.20	1.70	2.50		11.98
GP								
Dental								0.40
Junior Medical	1.50	4.00	1.00	1.00				5.05
Nursing, midwifery & health visitors (exclude HCAs)	32.03	26.86	91.76	27.15	11.00	5.50	5.50	158.08
Other clinical staff -social workers								20.60
Other clinical staff costs (include HCAs)	-2.04	30.93	85.99	34.51	12.44	6.00	6.00	121.95
Scientific, therapeutic, & technical	7.00	13.62	-0.22	16.15	15.15	8.00	8.00	68.93
Non clinical staff	77.25	25.57	44.48	35.41	34.41	20.00	20.00	181.38
Total	**116.69**	**108.27**	**228.41**	**115.42**	**74.70**	**42.00**	**39.50**	**568.37**

NB - (minus) = Increase

These reductions provide a summary of significant changes which have been consolidated from the following workstreams:

- CIP plans from SDHFT
- CIP plans from TSDHCT
- Changes to corporate structures as a result of the ICO
- Implementation of the new care model

The changes required are being developed into an overall workforce plan to maximise redeployment opportunities and ensure equity for all staff. The next steps will be to further develop plans to identify more of the actual posts affected and to commence consultation and communication. In the meantime in order to protect staff as the ICO and CIP plans are developed the Scrutiny and Vacancy Panel arrangements have been strengthened. The Panel is now chaired by the Director of HR and posts have been categorised as shown below.

Category A – Approval for clinical front line posts and non-clinical posts that directly support clinical activity will be made based on service need and evidence of the normal considerations e.g. consideration of alternative solutions.
Category B – Approval for all other non-clinical posts and changes to those posts will require ratification by the Joint Leadership Group (JLG).
Category C – Approval for corporate posts and changes to those posts will be by exception only and any that are approved by the Panel will require ratification by the (JLG).

This strengthened Scrutiny and Vacancy Panel process has been in operation since the middle of April and due to the workload of the JLG proposals have been agreed to shift ratification to the respective Executive Teams. To date the following number of posts have been frozen.

Category A	3 Posts	2.00 WTE
Category B	2 Posts	1.60 WTE
Category C	5 Posts	4.17 WTE

The Trust is continuing to work on its CIP programme to enable the identification of changes to specific posts.

5.0 Pay and Pensions

5.1 Pay Award

Pension's auto-enrolment is a requirement for all employers. Each employer is given a staging date to enact auto-enrolment for all eligible staff. SDHFT's staging date was the 1st July 2013. However the Trust applied transitional delay which meant those staff employed at that date and not in the NHS Pension Scheme did not have to be auto-enrolled until the 30th September 2017.

Any new employee to SDHFT is not covered by the transitional arrangements and has been auto-enrolled. The staging date for TSDHCT is the May 2017, however when acquisition takes place eligible staff not in the NHS Pension Scheme transferring to the ICO from TSDHCT will need to be auto-enrolled. There is a clear process for auto-enrolment and staff affected will be contacted shortly to inform them of this process. There is a potential cost to the ICO which has been included in the Long Term Financial Model (LTFM).

6.0 Human Resources

6.1 Managing Sickness Absence

6.1.1 Current Actions

Building on a successful approach in the Medical Division which saw a positive impact on the level of sickness absence, a similar approach has been rolled out in other areas. This has involved the HR Managers raising the issue and profile of absence management at senior meetings and group awareness raising/training sessions within the clinical and non-clinical areas. In addition greater one to one support is provided to managers in 'hot spot' areas and also focused support for new managers. Other elements involve the setting up of regular 'drop in' sessions in various areas including Community Hospitals, ward areas, Horizon Centre etc. and in general closer management of sickness absence issues.

6.1.2 Future Actions

Building on the success of the 'Buzz TV' session for PDR (Appraisal) which to date has received 1,323 hits, sessions are being prepared for sickness absence management which will be suitable for both managers and staff. Other actions that are being considered include an adjustment to some policy provisions around the level of trigger points and the use of the Bradford Factor scoring system. In addition, more work needs to be undertaken in respect of raising the accountability of managers for managing sickness absence and also a greater concentration on long term sickness (LTS) is being planned. LTS accounts for around 65% of all sickness absences in both organisations and initiatives to make it easier for staff to return to work sooner are being planned. These initiatives include better identification and co-ordination of temporary work placements.

Finally, a specific piece of work is currently being undertaken to look at the top reasons for sickness absence with a view to identifying both prevention and management strategies.

6.2 Medical HR

6.2.1 Master Vendor Medical Agency

The procurement of a master vendor for medical agency has been progressing over the last year, working as a consortium with 8 other Trusts across the South West.

Following evaluation of the mini-tenders, Accident & Emergency Agency ("A&E") was identified as the winning bidder. Discussions have progressed with A&E and it became clear that they wish to amend some of the pricing information in the contract. Subsequent discussions with A&E have focussed on the actual price changes that would be made and the Consortium now has clarity that these would only relate to clinical specialisms within the "hard to fill" category which form approximately 15% of the fill rate for the contract.

The Consortium has considered a number of options with regard to the contract to give effect to the above. However, it has been recognised that for the majority of options (other than those involving retendering or the use of the new CCS Framework) this will mean changes to the contract terms and pricing which did not form part of the original tender and as such could lead to a losing supplier successfully challenging the award of the contract to A&E.

The proposed option is to amend the contract before it is entered into with A&E to reflect the changes in prices and notify the losing suppliers (total of 9) of the specific amendment to prices. This proposal has been discussed by the Heads of Procurement and they are in agreement to go ahead.

Timetable for the next steps:

Action	Duration	Timescale
Prepare letter in readiness to issue	1 Day	Thursday 4th June
Assume proceed - Aim to issue letter to the 9 Bidders	1 Day	Friday 5th June
Challenge Period Ends	30 Days	Saturday 4th July
Contract Mobilisation Period (Trust Signing and Formal Execution)	2 Weeks	Friday 17th July
Phase 1 Trusts Implementation (Plymouth, Yeovil, Taunton)	10 Weeks	Start: Friday 17th July/End: Friday 2nd October
Phase 2 Trusts Implementation (S Devon, Salisbury, Dorset)	10 Weeks	Start: Monday 17th August/End: Friday 30th October
Phase 3 Trusts Implementation (N Devon, Cornwall, Exeter)	10 Weeks	Start: Monday 21st September/End: 30th November
Go Live - All Trusts Contract KPI`s Measured	**Go Live**	**Monday 30th November**

6.2.2 Medical Recruitment

Following a long period of difficulty in recruiting to the Emergency Department we were pleased to have received three applications for the Consultant posts' and interviews are due to take place on the 25 June. We have also progressed with advertising a joint role with local GP Practices for a GP to work half time in a practice and half time in the Emergency Department, the closing date for applications is the 21 June.

6.3 Staff Friends and Family Test *(CQUIN for 2014/15)*

The national findings for quarter 4 (January to March 2015) have recently been published and are detailed below.

In comparison to our neighbouring Trusts, SDHCFT is ranked 2nd in the peninsula for recommendation of work and care. TSDHCT is ranked 3rd for work and 4th for care. Both are significantly higher than the national average

Org Name	% Recommended - Work	% Not Recommended - Work	% Recommended - Care	% Not Recommended - Care
England	**61.7%**	**18.9%**	**77.2%**	**7.5%**
Selection (excluding suppressed data)	**61.7%**	**18.9%**	**77.2%**	**7.5%**
CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	59%	24%	73%	12%
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	43%	36%	84%	5%
ROYAL CORNWALL HOSPITALS NHS TRUST	25%	51%	47%	25%
NORTHERN DEVON HEALTHCARE NHS TRUST	70%	11%	80%	5%
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	88%	2%	96%	2%
PLYMOUTH HOSPITALS NHS	58%	19%	80%	4%

TRUST				
DEVON PARTNERSHIP NHS TRUST	53%	26%	50%	22%
TORBAY AND SOUTHERN DEVON HEALTH AND CARE NHS TRUST	73%	7%	83%	6%
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	76%	9%	89%	2%

6.4 Staff Experience CQUIN 2015/16

The staff experience CQUIN aims to improve overall staff experience through the establishment of a Multi-Agency Staff Experience Network (MASEN) consisting of senior representatives from the following organisations:

- South Devon and Torbay CCG
- Torbay and Southern Devon Health and Care NHS Trust
- South Devon Healthcare NHS Foundation Trust
- Devon Partnership Trust
- Community Care Trust
- Mount Stuart

The network will look at common themes and trends, share learning and develop a work plan to work collaboratively to improve staff experience. This will include multi-agency discussion and feedback on pertinent themes and issues for staff.

As part of this work two 'Always events' have been mandated centrally to include 'Hello, my name is' and 'You said, we did'. The third 'Always event' is for Trusts to determine locally and we have identified 'See something, say something'. This event is aimed at helping staff to feel safe in raising concerns, whether this be about unsafe clinical practice or acceptable behaviour (issues raised in SDHCFT and TSDHCT Staff survey findings) or indeed any other concern staff may have. Project plans are currently being drafted with input from Communications Team and Patient Experience Lead

6.5 Employee Relations Cases

The table below shows the number of Employee Relations cases at SDHFT that entered a formal policy over the period January 2015 to 4th June 2015.

Nature of Case	Number of Cases
Capability	2
Disciplinary	20
Grievance	7
Whistleblowing	0
Acceptable Behaviour	1
Total	**30**

6.6 Recruitment

38 overseas nurses have been recruited during the latter part of 2014. Based on the success of the programme a further campaign is being organised, primarily focussing on Europe but longer term looking at the potential for recruiting outside of Europe. The plan is to develop a rolling programme of intakes to maintain existing staffing levels, as far as possible. The overall increase to the nursing pool Trusts has meant that the majority of

shift requests can be filled by the temporary workforce, thereby reducing the need for agency staff.

The potential of introducing a rotational programme for nurses, which would initially incorporate the Acute Hospital, Community Hospitals and Community Nursing is currently being planned. A proposal is currently being developed which will aim to set out the scope of the project, how the rotation arrangements will work and the financial implication of the arrangement. The next meeting is scheduled for 18th June 2015.

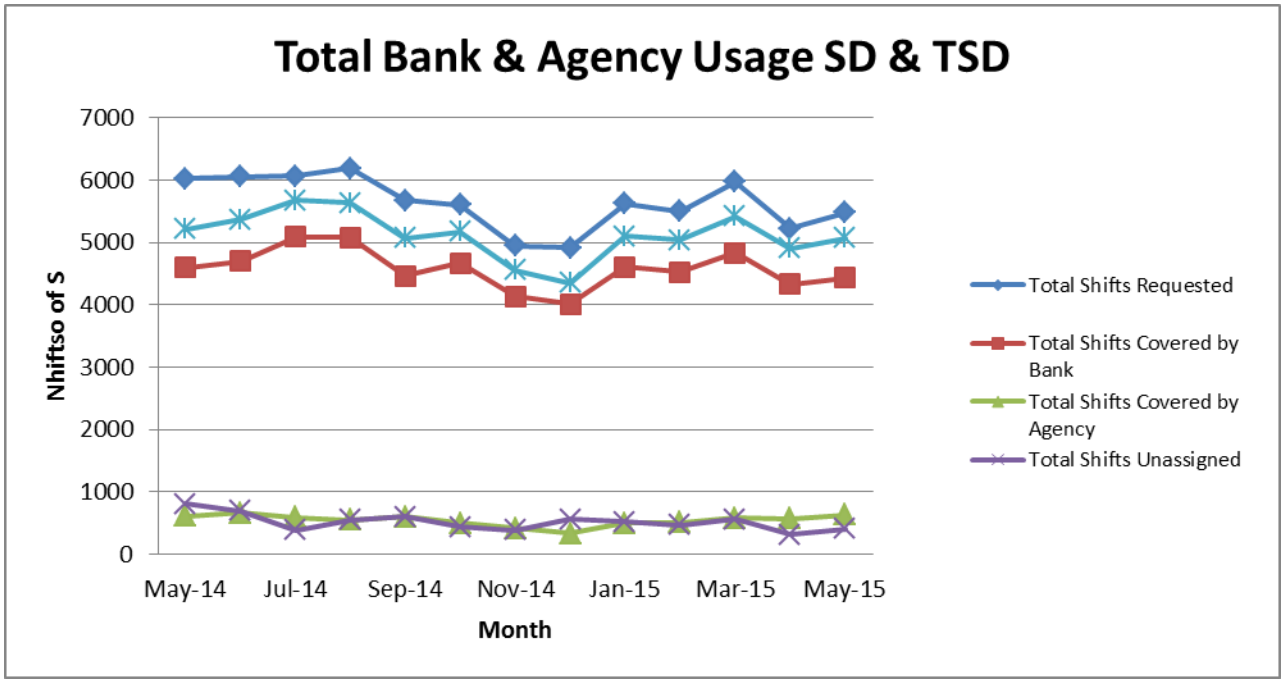
A stand has been reserved at the RCN national congress, 21 – 24 June 2015, with the intention of attracting nurses to work for us.

6.7 Temporary Staffing Activity

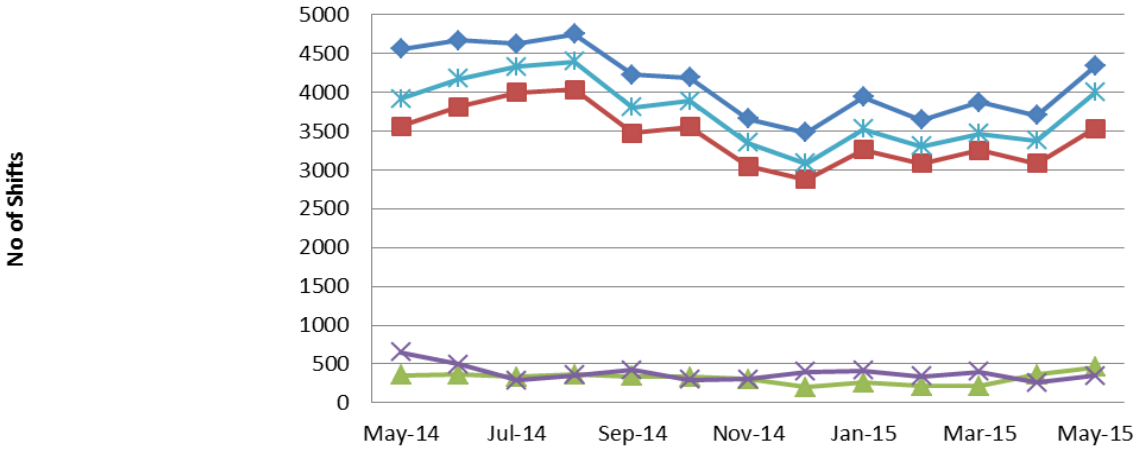
The Temporary Staffing Team continues to strive to fill the demand for shifts. In May 2015 the Temporary Staffing Team was able to fill 90% (5065) of the shifts through a combination of bank and agency. The number of requests for bank remains a cause for concern and actions are in place to constantly monitor and address the need for agency in particular.

All the Trusts who have been involved in the consortium for establishing a master vendor for all medical agency arrangements are considering extending this to include nursing staff. This arrangement will save money and prevent the situation whereby agencies use the general shortage of staff to increase their prices.

A large majority of shift requests are attributed to 'Increased Ward Dependency' and 'Supportive Observations'. A working group has been established to review those areas with high usage to look at options to support the relevant wards and reduce the requests for bank and agency. The next meeting is scheduled for 29 June 2015.

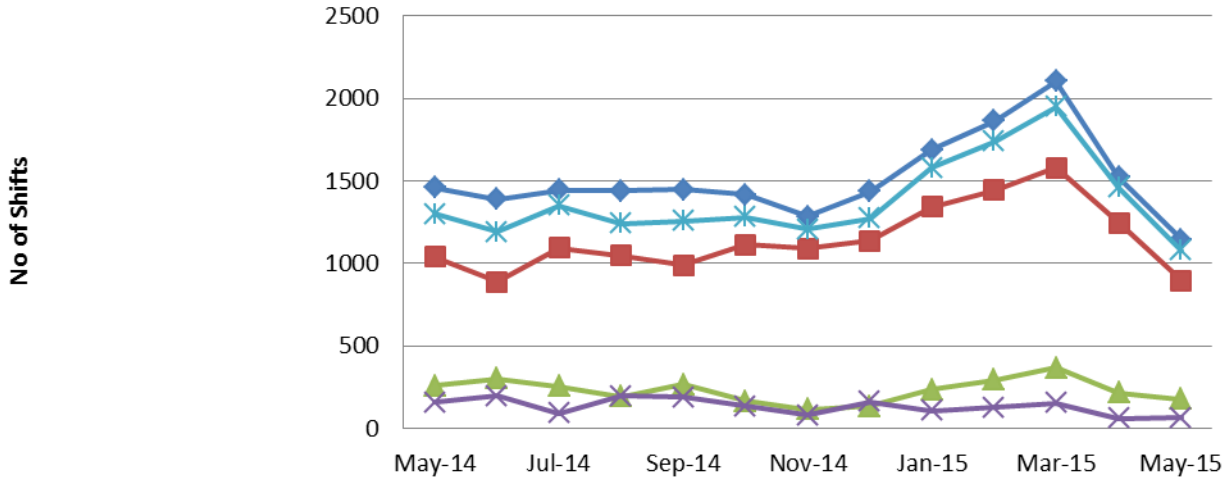


South Devon Healthcare Bank & Agency Usage



	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Total Shifts Requested	4560	4668	4620	4750	4227	4186	3656	3483	3936	3640	3869	3698	4333
Total Shifts Covered by Bank	3558	3810	3995	4033	3470	3556	3046	2877	3262	3083	3254	3082	3529
Total Shifts Covered by Agency	354	361	333	360	337	330	304	204	261	218	212	360	459
Total Shifts Unassigned	648	497	292	357	420	300	306	402	413	339	403	256	345
Total Shifts Covered	3912	4171	4328	4393	3807	3886	3350	3081	3523	3301	3466	3375	3998

Torbay & Southern Devon Bank & Agency Usage



	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Total Shifts Requested	1458	1388	1442	1439	1446	1416	1286	1434	1687	1864	2104	1520	1144
Total Shifts Covered by Bank	1040	888	1093	1047	990	1114	1090	1136	1344	1442	1579	1245	898
Total Shifts Covered by Agency	259	303	257	193	268	167	117	136	236	295	370	215	179
Total Shifts Unassigned	159	197	92	199	188	135	79	162	107	127	155	60	67
Total Shifts Covered	1299	1191	1350	1240	1258	1281	1207	1272	1580	1737	1949	1460	1077

6.8 Heath, Safety and Wellbeing@work

6.8.1 Flu Campaign 2015

Our target audience again for this year will be frontline workers, but as our workforce can be very fluid, we will include anyone who may potentially have an impact on clinical services in our baseline figures; however no member of staff will be prevented from accessing the vaccine. There will be an action group set up to look at how we can increase the update from across the health community from 44% to the recommended 75% front line staff being protected.

6.8.2 Wellbeing@work Event

A wellbeing@work event is being planned for 7th September in Horizon Centre. Professor Dame Carol Black will be our guest speaker - a medic by background and the UK's National Director of Health and Work on improving the welfare of working people.

7.0 Workforce and OD Systems

7.1 E-rostering

The draft business case for a new e-rostering and time and attendance system is currently being reviewed by nursing colleagues. It is essential that any proposal has the full support of those that will be key users and beneficiaries of the system. Once key stakeholders have had the opportunity to comment the final case will be submitted and if agreed a project plan and group will be formed to take the plans forward.

7.2 Nurse Revalidation

We are currently working with nursing colleagues reviewing appropriate systems to provide the Trusts with a process for managing nurse revalidation. Nurse revalidation will require every nurse to provide evidence of practice every 3 years to maintain their registration. System options include an in-house solution or an external provider. These options are currently being reviewed.

7.3 Managers and Employers ESR Self Service

Guidance is being issued to staff and managers to further support them in using the self-service modules on ESR. This includes offering training and support where requested.

8.0 Education and Development

8.1 Medical Education

Recommendations have been made from DOH, HEE and GMC that will all have an impact on the current and future medical workforce. The specific reviews that were undertaken were The Shape of Training Review, Five Year Forward Review and Broadening the Foundation Programme these set out recommendations for the future medical workforce. These include:

- Increasing numbers of doctors in General Medicine, Women's Health, Psychiatry and General Practice
- Developing integrated community posts in training programmes
- The expansion of new and innovative health & care roles (e.g. Physicians Associates)

Broadening the Foundation targets are:

- 80% of F1/F2 posts include a community based post by 2015
- 100% of F1/F2 posts include a community based post by 2017
- 22.5% of F1/F2 posts include a psychiatry post by 2015 - The Peninsula/HESW are not necessarily expecting to meet this target
- Remaining F1/F2 hospital based posts have a community facing element

The Director of Medical Education is leading on this with the HESW Foundation School and will link in to relevant parties that would include Medical Workforce Review Group and the ICO team.

Following the GMC annual survey on trainee doctor training SDHCT have been announced as being top in the Peninsular for the fourth year running.

8.2 Apprenticeships

A brand new apprenticeship qualification for integrated care is now live and open for registrations. This is a Health and Care Certificate in clinical skills at level 2 and level 3. Our City and Guilds centre will be applying for scheme approval by the autumn.

A cohort of 15 HCA Apprentices will be funded this year to support a project across the Trust. We are working closely with Tracey Collins (ADN for Surgery) who is leading on this. Apprenticeships continue to grow; we are aiming to increase new starts by 20%. We need to be working towards 5% of our workforce through the Talent for Care strategy.

8.3 Launch of Care Certificate

The implementation of the new Care Certificate has now been launched, and is in its first phase of full implementation. SDHCT are the flagship and are leading across the SW. We have around 50 managers booked onto the assessor training. This has been positively received across the community and the acute. We are working collaboratively with the private sector and are in the process of setting up a consortium to ensure we have robust quality assurance and measures in place. This will drive up standards and standardise assessment practice

8.4 Employability Hub

Our Employability Hub has been highlighted as an exemplar model by Health Education South West (HESW) and as such have granted us funds for a co-ordinator post to support other NHS organisations to replicate across the southwest.

Employability supports those from disadvantaged backgrounds to gain valuable work experience. The success of the Employability Hub continues – the table below shows the success since January 2015 across Torbay and South Devon. New 6 month paid work experience programmes are being developed. We are working with Shekinah to implement these by the end of the year. The new scheme will help to support back office functions by way of work experience for a period of 6 months.

Figure 1

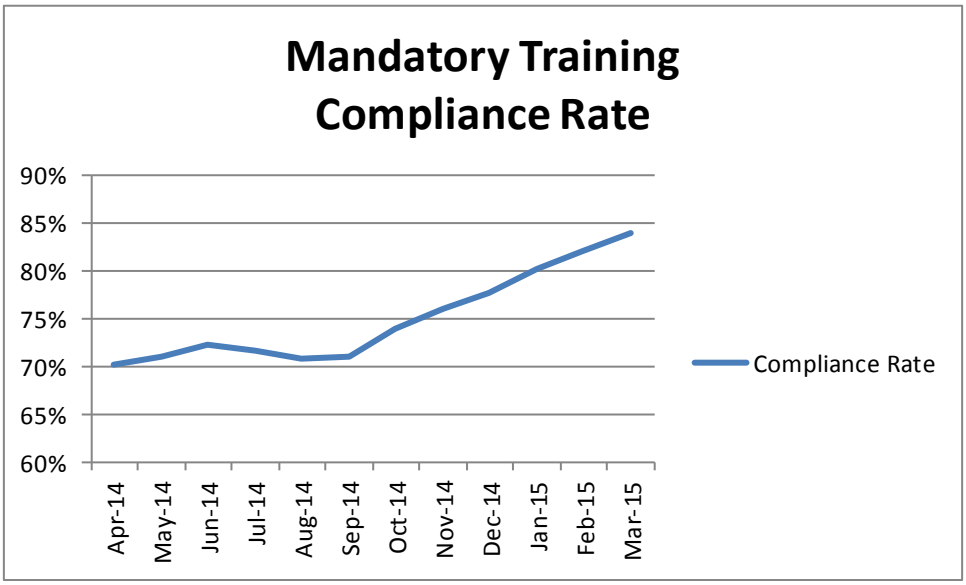
Referrals	Initial Placements	Progressed to Traineeships from initial placement	Progressed to Apprenticeships from initial placement	Progressed to employment from initial placement
20	6	6	2	NK

8.5 Mandatory Training

As detailed in section 3.5 of this report the compliance rates for all mandatory training is improving as shown in the scorecard at Appendix A. Of the 9 key modules 6 are now rated green and 3 amber. The graph below shows the increase in compliance based on the average of the 9 key modules.

The graphs below show the improving rate for completed mandatory training. This is based on the average compliance for the 9 key modules. Specific activity to improve compliance includes:

- Targeting hotel services staff to raise their compliance rates. Compliance has shifted from red to amber for this area and by the end of June will have some green topics. Stand - alone courses are booked at times that work around their shift patterns.
- Questions are being added to the Buzz films (mandatory training) to provide us with assurance that staff have watched the films and refreshed their knowledge.
- As a result of the revised intercollegiate document for Safeguarding Children there is a significant rise in the number of staff requiring level 2 training. E-learning is available but there is an increased demand for face to face delivery. Extra capacity is being identified but is limited.



The last report to the Board included further actions to improve this position and these are continuing as we seek to meet the target in each module.

9.0 Organisational Development

9.1 ICO

The Organisational Development Team continues to support the Communications Team with the engagement and involvement of staff in the ICO process including the latest bite-sized sessions. Dates are available across the whole community that include sessions early morning, evening and weekends. A session in July is planned to be filmed and captured for replay at any time from any PC in either organisation giving staff another option for engagement.

On-going support for teams affected by the bringing together of the two organisations is developing. The support is bespoke for each area and will consist of a range of interventions from team development and coping with change.

9.2 Resilience and Wellbeing

In response to requests from staff and managers and themes that have been identified through OD interventions a suite of programmes are being devised to support resilience and wellbeing. These programmes will provide staff and managers alike in tools and techniques for supporting oneself and team's wellbeing and resilience. To support this a feedback metrics will be devised to measure the effectiveness of training provided.

9.3 Managers Toolkit

Through several mechanisms a need has been identified to provide both existing and new managers' with a toolkit that consists of training and information that is crucial in supporting them in their role. Topics would include HR policies and procedures, understanding budgets, pay roll, health and safety and expectations of me as a manager to name but a few. This is currently being scoped with a group of staff including operational, HR and OD.

9.4 OD Consultancy

Continued collaborative working with other areas such as HR and operational teams who are identifying themes for development and support that include individual/team coaching and the creation of a new training programme for how to give feedback and have difficult conversations.

On-going support and interventions are being given to individuals and departments to increase both personal and team effectiveness. These range from 360 feedback with plans for action to sessions on values and behaviours and getting the best out of yourself and staff.

9.5 Equality Delivery System (EDS)

The Annual Equality event is taking place on 12th June and will grade equality-related performance against goals one and two of the EDS framework. Guest speakers will be in attendance to present our evidence over the last 12 months. Topics include Dementia and 'Building Bridges' and Bowel Screening. Healthwatch will be in attendance as independent verifiers and will also facilitate a session on 'Your Voice'. 'You said, we did' will also form part of this day with particular reference to improvements around translation and interpretation services, including offering BSL training to staff.

SDHFT Workforce and OD Scorecard 2015/2016

Appendix A

May-15

Indicator and (Target)	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Bank/Agency Spend Total	£1,255,657	£2,182,243	£2,986,883	£3,885,706	£4,874,108	£5,769,532	£6,771,561	£7,556,792	£8,090,180	£8,900,611	£9,589,122	£737,624	£1,590,091
Bank Monthly	£336,161	£488,033	£405,549	£455,615	£423,416	£357,079	£401,661	£299,997	£280,678	£392,172	£319,911	£321,918	£394,001
Agency Monthly	£347,408	£438,553	£399,091	£443,208	£564,986	£538,345	£600,368	£485,234	£252,710	£418,259	£368,600	£415,706	£458,466
Staff Headcount Number	4154	4151	4254	4144	4171	4206	4245	4256	4274	4268	4255	4255	4255
Starters (Exc Junior Doctors)	21.4	30.6	26.5	40.5	67.7	57.2	73.8	23.7	35.5	26.7	21.5	20.1	19.9
Leavers (Exc Junior Doctors)	23.0	28.9	31.5	40.2	43.9	34.7	29.9	23.6	24.5	32.0	42.2	26.2	32.5
Bank Usage (WTE)	152.54	217.73	185.66	210.50	183.94	122.89	179.30	133.13	125.20	173.34	154.08	144.73	172.97
Agency Usage (WTE)	54.17	45.35	49.29	39.18	65.41	55.37	45.84	27.66	50.15	24.53	57.37	58.51	81.36
Staff Turnover Rate % (Between 10% - 14%)	10.28%	10.50%	11.21%	11.20%	11.00%	11.23%	11.63%	11.45%	10.94%	10.96%	10.80%	10.78%	12.80%
Sickness Absence Rate % (4.20% or less)	4.00%	4.01%	4.07%	4.09%	4.18%	4.24%	4.25%	4.27%	4.21%	4.26%	4.23%	4.19%	
Bradford Score % over 250 Points	11.80%	12.02%	11.90%	11.87%	11.89%	11.83%	12.10%	12.10%	11.86%	12.41%	12.54%	12.53%	
Sickness Cost	£3,985,783	£4,042,668	£4,151,421	£4,221,271	£4,316,092	£4,385,121	£4,383,289	£4,362,063	£4,328,006	£4,356,680	£4,325,483	£4,288,033	
Skill Mix (Registered/Non-registered)	54/46	54/46	54/46	54/46	54/46	54/46	54/46	54/46	54/46	54/46	53/47	54/46	54/46
Staff appraised in last year (90% or above)	58%	58%	56%	59%	60%	69%	74%	83%	82%	83%	82%	83%	83%
Age Profile - % of staff over 55 years of age	20.0%	20.0%	20.0%	21.0%	21.0%	20.0%	20.0%	20.0%	20.0%	21.0%	21.0%	21.0%	21.0%

Training and Development - Percentage of staff compliant

Information Governance Training (95% or above)	72%	73%	72%	69%	69%	77%	80%	81%	83%	79%	85%	85%	85%
Fire Training (80% or above)	69%	71%	69%	68%	65%	70%	73%	74%	77%	79%	81%	82%	83%
Child Protection L1 (90% or above)	72%	72%	71%	72%	70%	73%	75%	77%	78%	81%	85%	85%	86%
Infection Control (80% or above)	70%	71%	69%	66%	65%	67%	69%	71%	76%	77%	79%	81%	81%
Equality & Diversity (80% or above)	70%	73%	74%	74%	75%	77%	79%	81%	83%	86%	88%	89%	90%
Conflict Resolution (80% or above)	71%	73%	74%	74%	75%	76%	78%	80%	81%	83%	85%	85%	87%
Health & Safety (80% or above)	83%	84%	85%	84%	84%	86%	86%	87%	88%	89%	89%	89%	88%
Manual Handling (80% or above)	61%	63%	61%	61%	67%	69%	71%	73%	77%	79%	81%	82%	83%
Safeguarding Adults L1 (90% or above)	71%	71%	70%	71%	69%	71%	74%	76%	78%	81%	85%	86%	87%
Average Compliance	**71%**	**72%**	**72%**	**71%**	**71%**	**74%**	**76%**	**78%**	**80%**	**82%**	**84%**	**85%**	**86%**

South Devon Healthcare NHS
NHS Foundation Trust

REPORT SUMMARY SHEET PUBLIC

Meeting Date:	1 July 2015
Title:	Finance and Performance Report Month 2 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

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

2)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.

Key Issues/Risks and Recommendations:

The Performance Report highlights the following:

1.0 Quality Indicators

- There are no CQC regulatory actions in place.
- CQC intelligent monitoring remains at 3.
- Reported VTE assessment on admission is not meeting expected levels

2.0 Monitor compliance

- 31 day to subsequent treatment – surgery is not achieved in May and remains a risk for Q1 – This will count as a point of the quarterly governance declaration. All other cancer indicators are achieved and forecast to achieved standard in Q1
- 4 hour target 89.8% achieved represents a deterioration in performance to previous month with impact of infection control measure across the hospital a major factor.
- RTT admitted pathways (76.5%) not meeting the 90% performance standard
- RTT incomplete pathways (91.7%) not meeting the 92% performance standard
- Q1 Governance declaration forecast is for a score of 4 and hits the threshold outlined by Monitor for a governance concern.

3.0 CQUIN schemes

- No exceptions to report.

4.0 Performance and Quality Requirement – Contract indicators

- Contract penalties against performance standards have been applied in May – a summary breakdown is given in the report.
- Admitted RTT - The mobile theatre to increase capacity of cataract surgery has arrived on site and commenced operations on 16th June.
- Outsourcing is in place for Plastic surgery, Ophthalmology and some General Surgery cases.

5.0 Financial Performance-

Month 2 financial position at National Tariff at national terms and conditions shows;

- Continuity of Service Risk Rating of 2 in line with the Annual Plan
- delivery of the Annual Plan income and expenditure position for the for the year to date with an over delivery of £0.2m
- within this the Trust has managed the operational pressures:
    - under performance on clinical contracts
    - increased staff costs associated with escalation and community associated infection
    - slow recurrent CIP delivery, non-recurrent cost reduction/ deferment is significantly in excess of plan.
- capital plan behind annual plan more than

Summary of ED Challenge/Discussion:

Performance Actions

- Action plan developed in response to IMAS RTT diagnostic including the establishment of a RTT Risk and Assurance group commencing July 2015
- Ophthalmology Vanguard Theatre operational as of week commencing 15th June
- Recruitment to increased ophthalmology capacity started in line with Board approved business case
- Increased short-term capacity agreed to address diagnostic waiting times with plan to be compliant by end of July 2015
- Action Learning sets (ALS) in place with commissioners to redesign pathways for services with demand pressures including Ophthalmology , Dermatology and Upper GI with a request that a Pain ALS is established
- Dermatology plan and business case developed for Executive Team review on 30 June 2015
- Perfect week initiative, part of the NHS England Breaking the Cycle programme held the week beginning 17 June

Financial result actions

- Operational teams are reviewing the clinical contract delivery for month 2 to confirm the reasons for the elective underperformance
- CIP delivery being reviewed by operational and finance teams to maximise the non- recurrent benefits seen to date and to consider moving to CIP
- Investment timings being reviewed with operational teams
- Review nursing reserve use by operational teams with nursing leadership and planning to close escalation facilities in the hospital.
- Operational teams reviewing penalty position to formulate actions to mitigate for future
- CQUIN scheme position being taken to Senior Business Management Team with proposed actions to mitigate any down side.

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 2 – May 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 31st May 2015.

1. Quality indicators - Safety, Quality, Experience:

1.1 Quality indicators incorporated into the performance dashboard.

These indicators give the board assurance on the quality and safety of care given to patients. The quality section of the performance report identifies any new performance variances and performance highlights, approved and presented by the Director of Professional Practice, Nursing and People's Experience.

1.2 Performance Highlights

1.2.1 CQC regulation compliance assessment

There are no CQC regulatory concerns being reported.

1.3 Performance variances

1.3.1 CQC intelligent Monitoring rating.

The Published CQC rating remains at 3 as reported in last report. Actions to address areas of risk are being monitored by the Executive team. These actions are on track and there are no areas identified for further escalation. The next assessment of CQC intelligent monitoring rating will be available in September.

1.3.2 Stroke pathway time spent on a dedicated stroke ward.

The number of patients admitted with acute stroke spending 90% or more of their hospital stay on the stroke ward did not achieve the standard of 80% in May. May performance is 51%. This is a result of the bed pressures experienced and not being able to maintain the 'ring fence' beds policy on the stroke ward during periods of high demand for emergency inpatients beds.

1.3.3 VTE assessment on admission.

Reported compliance for VTE assessment on admission remains below the national standard of 95% with 89% reported in May. This level of performance has triggered a level of penalties in the contract. The cumulative penalty for April and May is £123k.

2.0 Monitor Compliance

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.

- Q1 governance score of 2.

In May, performance variances are reported against:

1. Cancer 31 days for subsequent treatment in Surgery
2. 4 hour standard for time spent in A+E with 89.8% achieved against the target of 95%.
3. RTT admitted patients treated with 76.5% achieved against the 18 week standard of 90%
4. RTT incomplete pathways with 91.7% against the standard of 92%.

The Q1 Governance declaration forecast is for a score of 4 and hits the threshold outlined by Monitor for a governance concern.

2.1 Performance Variances

2.1.1 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 May, there were four confirmed C.difficile cases. One of these cases has been assessed as being due to a 'lapse in care'.

A further 4 cases have been reported in June (up to the 15th June), giving a cumulative position of 11 cases with 4 due to a lapse in care.

2.1.2 Cancer Performance Indicators.

In May, all the cancer standards with the exception of the '31 days wait for second or subsequent treatment – surgery', are forecast to be achieved, with the final validation and data submission to be completed.

The table below shows the number of patients and performance against each of the standards.

		April 2015				May 2015			
		Target	No. Seen	Breached	%	Target	No. Seen	Breached	%
14day 2ww ref		93.0%	723	39	94.6%	93.0%	0	0	100.0%
14day Br Symp		93.0%	85	1	98.8%	93.0%	0	0	100.0%
31day 1st trt		96.0%	154	2	98.7%	96.0%	155	2	98.7%
31day sub drug		98.0%	42	0	100.0%	98.0%	46	0	100.0%
31day sub Rads		94.0%	49	2	95.9%	94.0%	47	2	95.7%
31day sub Surg		94.0%	25	1	96.0%	94.0%	27	2	92.6%
31day sub Other		-	19	0	100.0%	-	7	0	100.0%
62day 2ww ref		85.0%	73.5	3	95.9%	85.0%	77.5	7.5	90.3%
62day Screening		90.0%	9.5	0	100.0%	90.0%	11	0	100.0%
62day Upgrade		-	3	0	100.0%	-	10.5	0	100.0%

For Q1, it is forecast that the 31 day to treatment for subsequent treatment - surgery, will not be met.

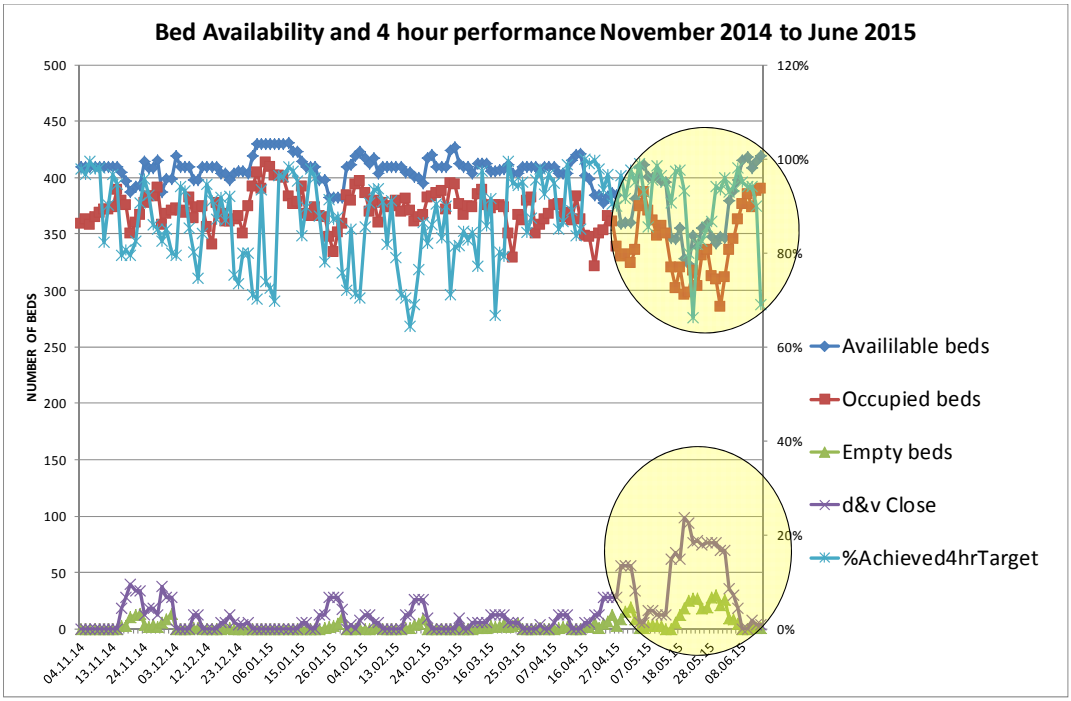
A total for 5 breaches for the period have now been confirmed against an anticipated tolerance of 4 patients not meeting the standard to achieve target.

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

The four hour standard of 95% has not been achieved in May with 89.8% reported. During May, there have been a number of norovirus type infections that have closed ward bays and whole wards to new admissions. These closures severely restricted bed capacity and delayed patient pathways for admission and assessment, with overcrowding and delays in the A+E department.

The bed pressures experienced have meant that the clinical areas for ambulatory assessment pathways of care recently established have at times in this period been used as general ward overflow to manage the bed capacity pressures.

The Infection Prevention and Control Team have worked closely with all staff to bring the Outbreaks under control. There were regular outbreak meetings during this time to plan discharges of patients which would allow prompt cleaning of the environment. This cleaning allowed patients to move into a safer environment preventing further cases and the ward to reopen. There is going to be a trustwide meeting on 18 June looking at what went well and what could be done better. However the teamwork throughout the trust has allowed this outbreak to come to a conclusion in a very timely safe manner.



The above chart shows the impact of infection and infection control measures on the number of available beds in the period.

It is interesting to see that despite having so many beds being unavailable (equivalent of a whole ward empty for much of this period) the actual performance against the 4 hour standard has been maintained at around 90%. This is higher than previous periods when there has been full bed capacity.

The GP pathway to ambulatory care for emergency admissions is one of the system changes believed to have increased resilience to maintaining patients flow despite having to operate with a reduced number of available beds.

The community bed capacity has also been restricted in this period as well as having delayed discharges on acute wards due to patients being ill with the norovirus type symptoms, and being unable to be discharged to a community setting until clinically recovered.

On 15th June all wards were free from any infection controls, this being the first time since April.

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.

Biweekly meetings are being held with commissioners, community provider and social care to review progress against the community wide emergency care action plans.

2.1.4 Referral to Treatment (RTT) Targets

Admitted Pathways
The Admitted, RTT standard is not achieved in May.

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 aggregate compliant RTT performance from the end of Q2 against all standards.

Ophthalmology
The mobile theatre has been commissioned with the first lists commenced on 16th June. The expected impact is to treat an additional 60 patients a week. Staffing for all the available lists for the whole period is being confirmed, with this being reliant on several locum surgeons joining the team for the anticipated 10 weeks duration the unit will be on site.
Once the backlog of long waiting patients are cleared, end of Q2, there remains a requirement to continue to at a slightly higher level of activity to maintain this position. This will be achieved with additional nursing recruitment to improve list throughput as well as estate works, now commissioned, to plan additional theatre capacity. Outsourcing will continue to be used in this period to further support the additional activity required.

Outsourcing of activity is in place with three providers being Mount Stuart Hospital, Plymouth Hospitals NHS Trust and a new recently CQC approved provider Medical Eye Centre in Exeter.

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.

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 – Additional capacity is now being scheduled with the running of additional all day Saturday lists to end of September. There are currently 9 confirmed lists and planning for a further 9 lists with total capacity to see 90 additional patients in this period. The additional capacity will start to show an improvement in the backlog position in June to the end of Quarter 2. The forecast is that the incomplete performance will remain below standard however, unless further additional list are run for the remainder for the year. A more resilient longer term plan has been submitted as part of the Divisions business planning priorities and seeks to invest in additional staffing to support extended day operating in main theatres as well as additional consultant cover for the emergency and elective services. These plans are under review as part of the wider business planning process for 15-16.

A Surgery '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.

2.1.5 RTT Performance summary – May 2015

- Admitted pathways - The overall percentage of admitted patients with first definitive treatment commenced within the 18 weeks is 76.5% against the target standard of 90%.

- Non-admitted pathways - The overall percentage of non-admitted patients with first definitive treatment commenced within the 18 weeks is 95.2% against the target standard of 95%.

- Incomplete pathways - The percentage of incomplete RTT pathways under 18 weeks is 91.7% against the standard of 92%.

3. Commissioning for Quality and Innovation (CQUIN)

3.1 **2015_16 CQUIN – No exceptions to report**

4. Performance and Quality Requirement – Contract indicators

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.

Performance Highlights

4.1.1 Single Sex Accommodation

After validation for justified clinical circumstances, there are no breaches of the single sex accommodation standard in May.

4.2 Performance Variances

4.2.1 Contract penalties

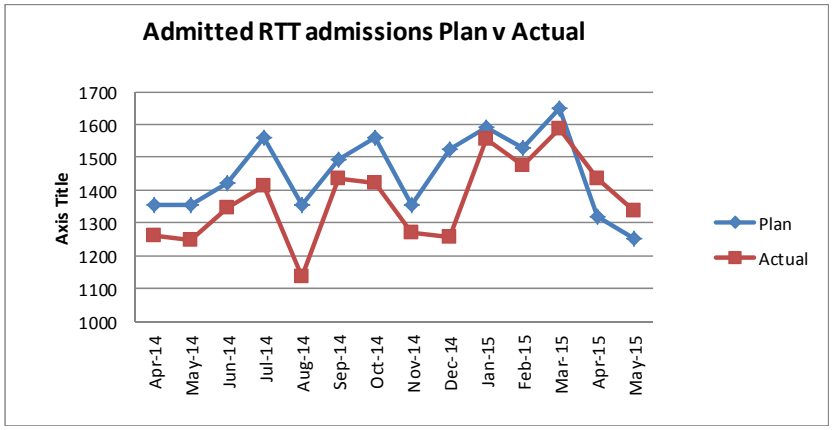
The contact penalties expected for May and cumulative for the year to end of May are summarised below:

Contract Penalty forecast M2

Indicator	April	May	Cumulative
RTT Admitted	£ 63,000	£ 92,800	£ 155,800
RTT non Admitted	£ 7,300	£ 9,000	£ 16,300
RTT incomplete	£ 105,000	£ 93,000	£ 198,000
A+E 4 hour	£ 8,600	£ 40,600	£ 49,200
Ambulance handover	£ 4,000	£ 8,000	£ 12,000
VTE assessment	£ 70,200	£ 53,000	£ 123,200
Diagnostic Tests > 6 weeks	£ 29,000	£ 30,000	£ 59,000
Total	£ 287,100	£ 326,400	£ 613,500

4.2.3 RTT activity against plan

The RTT activity against plan to the end of April can be seen in the chart below.



4.2.5 Diagnostic Waits Over 6 Weeks

In May, there were a total of 102 patients waiting over 6 weeks against the monitored diagnostic tests. This represents 2.5% of the total number of patients waiting for diagnostic tests above the National tolerance of 1%.

The longest waits are being seen in radiology for Ultrasound, CT and MRI.

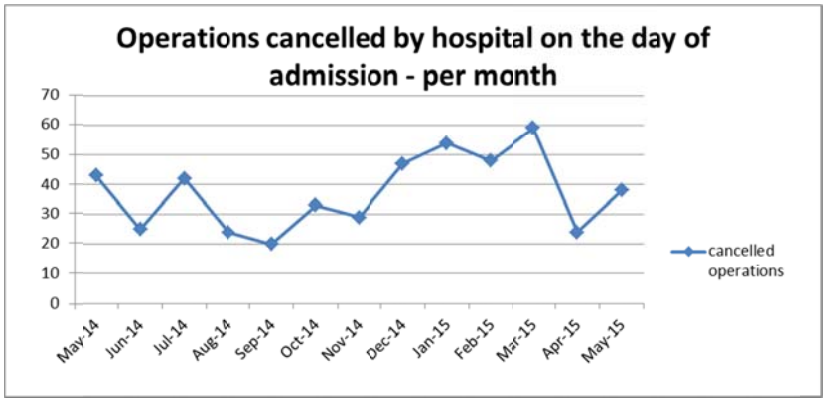
Annual growth in demand remains a challenge in these areas and business cases have been submitted to provide increased capacity to meet the on-going demand. Performance will remain a risk whilst additional sessions continue to be needed to support the routine capacity.

4.2.6 Cancelled operations

During May, 38 patients were cancelled by the hospital on the day or after admission. This number of cancellations represents 1.3% (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	12
Insufficient Theatre time	6
No ICU / HDU bed	4
No Bed	2
Staffing	6
Equipment	5
Admin	3
Total	38

Cancelled operations by hospital on day or after admission



4.2.7 Cancellations by hospital "on the day of admission" and not readmitted within 28 days.

Three patients requiring readmission in May did not meet the 28 day standard for returning for their surgery. The contract payment for this admission will fall as a penalty.

4.2.8 Timeliness of care planning summaries

Performance for the timeliness of care planning summaries within 24 hours of discharge has remained below target in May for both the weekday and weekend measures. In May 56% completed care planning summaries were completed and communicated to the patients GP within 24 hours.

6. Attached to this report

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

7 Finance Section - Monitor Risk Rating and Other KPI Measures

7.1 This report sets out the Trust's Income and Expenditure position for the period ended 31st May 2015. This has been produced on a full national tariff and full national terms and conditions basis.

7.2 The Trust has, for the two months of the 2015/16 financial year, delivered a £1.4m deficit against a planned deficit of £1.6m, £0.2m better than the annual plan. The EBITDA (Earnings before interest, tax, depreciation and amortisation) is £622k surplus, against a planned surplus of £518k.

7.3 The table below shows the Trust summary of EBITDA and Total Performance against plan:

Summary of Position at 31 May 2015			
	PLAN YTD £'000	**Actual** YTD £'000	**Variance to Plan** £'000
Total Gross Income	-40,796	-40,730	66
Penalties	583	620	37
Total Net Income	-40,213	-40,110	103
Operating Expenditure	39,695	39,488	-207
EBITDA	**-518**	**-622**	**-104**
Financing Costs	2,201	2,055	-146
Donated Asset Income	-33	0	33
Impairment Costs	0	0	0
	2,168	*2,055*	*-113*
Grand Total	**1,650**	**1,433**	**-217**

8.0 Monitor Risk and Other KPI Measures – (Detailed KPI's in Appendix A)

8.1 KPI's are as per 2014/15 measures and are for agreement at the Finance Committee meeting

DESCRIPTION KPI's AGAINST PLAN		THRESHOLD	YTD PLAN	YTD ACTUAL	RED/ GREEN	See Appendix	See Section	Change
MONITOR FINANCIAL RISK RATING	Risk Rating per Plan or above	-	2	2	GREEN	App. A	Sect 1	◄►
EBITDA VS PLAN	Variance to Plan	> 10.0% adverse variance	(518)	(622)	GREEN	App. A	Sect 1	⇧
CONTRACT INCOME PERFORMANCE AGAINST PLAN (Excl Penalties)	Variance to Plan	> -0.1% adverse variance	(34,407)	(34,022)	RED	App. D	Sect 3	⇩
COST IMPROVEMENT PLANS IN YEAR			986	123	RED	App. E	Sect 6	◄►
CORPORATE FINANCE MEASURES	> 2 Red				GREEN	App. H/I/J/K	Sect 8	◄►

8.2 The overall COSRR of the Trust is a 2 as at 31 May 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.

9.0 SoCI (Statement of Comprehensive Income) Summary

9.1 Income and Expenditure Statement for May 2015 can be seen at Appendix B. This statement summarises the Trust's income and expenditure (I&E) into Monitor categorisations.

The Trust is £217k better than plan at Month 2.

Within this position the Trust has managed the following operational pressures:

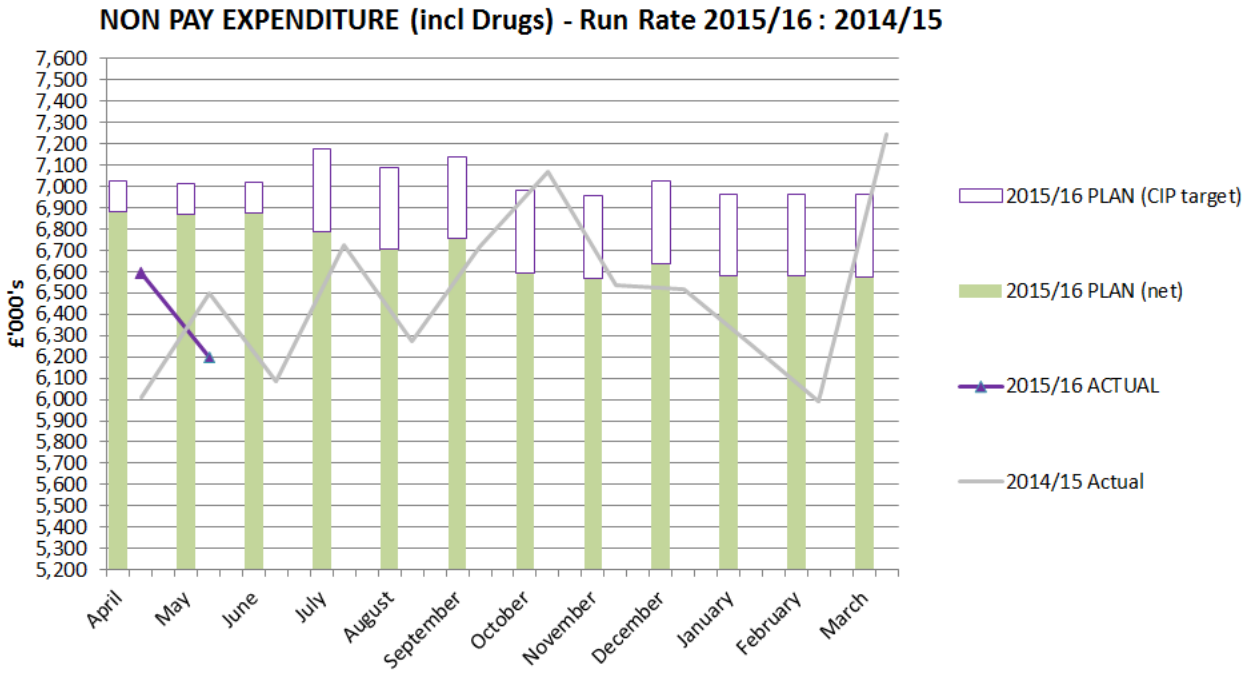
- Clinical income moving from an over performance in month 1 to an under performance in month 2; a £690k swing in the month. This reflects the emergency pressures and infection control related ward closures experienced, particularly in the latter part of the month.
- Escalation and nursing cost is in excess of what was planned for the first two months.
- Delivery of recurrent CIP is behind plan , delivery of non-recurrent spend slippage is above plan
- Non-pay reflects underspending on clinical supplies and services, drugs (offset by pass through income reduction), outsourcing to the independent sector not yet being taken up by patients.

Category		**Plan YTD £'000**	**Actual YTD £'000**	***Variance YTD £'000***
Contract Income		(33,702)	(33,402)	*300*
Other Income		(6,511)	(6,708)	*(197)*
Pay	Substantive	25,367	25,097	*(270)*
	Bank, Locum & Agency	825	1,590	*765*
Drugs		4,476	4,034	*(442)*
Clinical Supplies		4,069	3,658	*(411)*
Other Operating Expenses		4,959	5,109	*150*
EBITDA		**(518)**	**(622)**	***(104)***
Non-Operating Expenses		2,168	2,055	*(113)*
Total		**1,650**	**1,433**	***(217)***

9.2 Non Pay Expenditure for Month is set out in the table below:

Division	**Plan YTD £'000**	**Actual YTD £'000**	***Variance YTD £'000***
Medical Services	4,532	4,082	*(450)*
Surgical Services	2,902	2,718	*(184)*
Women's, Children's & Diagnostics	1,321	1,314	*(7)*
Estates Facilities Management	1,356	1,284	*(72)*
Support & Reserves	2,582	2,579	*(3)*
Torbay Pharmaceutical (TP)	783	818	*35*
Internal Audit	27	5	*(22)*
Total	**13,503**	**12,800**	***(703)***

The divisional variances reflect the non-pay controls in place.
The chart below tracks non Pay expenditure against plan and the deliverable CIP target throughout the year.

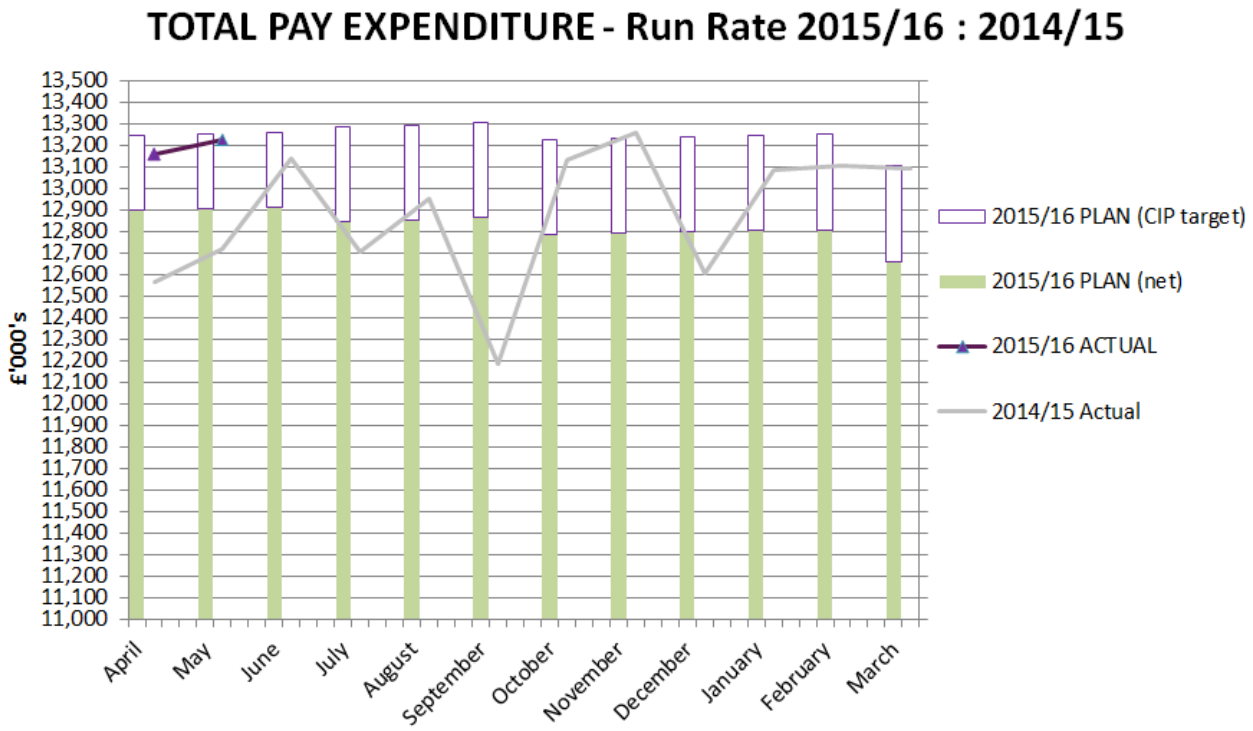


9.3 Total Pay Expenditure (including Agency) for Month 2 is set out in the table below.

Division	**Plan YTD £'000**	**Actual YTD £'000**	***Variance YTD £'000***
Medical Services	6,225	6,749	*524*
Surgical Services	6,950	7,079	*129*
Women's, Children's & Diagnostics	5,858	5,897	*39*
Estates Facilities Management	1,554	1,583	*29*
Support & Reserves	4,625	4,416	*(209)*
Torbay Pharmaceutical (TP)	647	661	*14*
Internal Audit	332	302	*(30)*
Total	**26,191**	**26,687**	***496***

The pay pressure reflects the operational challenges of the urgent and emergency system, enhanced during the recent D&V outbreak, and manifest in the opening of escalation capacity throughout April and May.

The underspend on support and reserves reflects the controls in place on administrative posts.



9.4 Temporary Staffing

The following table analyses medical staff agency spend by Division;

Division	**Plan YTD £'000**	**Actual YTD £'000**	***Variance YTD £'000***
Medical Services	105	207	*102*
Surgical Services	30	108	*78*
Women's, Children's & Diagnostics.	0	44	*44*
Non Clinical Divisions	162	1	*(160)*
Total	**296**	**360**	***64***

The main agency medical pressures are in Radiology and Orthopaedics.

10.0 Other Income

Income arising from contracts with commissioners is detailed below in Section 3.

The table below describes a level of non contract other income of £165k in excess of plan:

	Plan YTD	**Actual YTD**	**Variance YTD**
	£'000	**£'000**	**£'000**
Education & Research	(1,495)	(1,503)	(8)
Site Services	(314)	(348)	(34)
Non-patient services to other bodies	(1,677)	(1,712)	(35)
Miscellaneous other income	(2,810)	(2,898)	(88)
Total Other Income	**(6,296)**	**(6,461)**	**(165)**

11.0 Contract Income Reporting and Analysis by Commissioner

11.1 Healthcare Contract Income shows an adverse variance to budget of £422k. This adverse variance represents a significant movement of £690k from the £268k positive variance reported last month.

11.2 A more detailed analysis of variance by Commissioner & category is set out in the table below.

Commissioner	Electives £,000	Non-Electives £'000	Day Cases £'000	Outpatients £'000	A&E £'000	PTP £'000	Other Adjustments £'000	Total Variance £'000
SD&T CCG	140	(106)	162	488	135	75	(678)	216
New Devon CCG	(29)	(21)	7	29	(3)	(9)	(35)	(61)
SWSCG	77	92	(16)	194	0	253	(201)	398
NCA	29	(52)	0	(1)	19	(1)	(88)	(94)
DCIOS	2	(2)	17	(91)	0	0	(10)	(84)
Torbay Council	0	0	0	0	0	0	0	0
Devon County Council	0	0	0	0	0	0	0	0
TDH	0	(5)	0	0	1	0	0	(4)
Prisoner Health	3	(3)	1	2	(0)	0		3
Wessex AT - CDF						26		26
Sub Total	**222**	**(98)**	**171**	**620**	**152**	**344**	**(1,012)**	**400**
Timing difference								22
Total Healthcare Income	**222**	**(98)**	**171**	**620**	**152**	**344**	**(1,012)**	**422**

()= more income than plan

The value above includes a reduction for penalties of £620k over the first two months (month 1 £276k). This is made up as follows: -

Measure	Penalty £'000
RTT – Surgery	363
RTT – Medicine	14
RTT – WCD	0
Diagnostics	59
Four Hour Target	49
Ambulance Handover Times	12
VTE Risk Assessments	123
TOTAL	**620**

The Divisions are undertaking a review of the activity performance levels achieved during April and May to enable a clearer picture to be built of the likely impact this reduction has had on the RTT performance. This review will also enable a clearer prediction of the level of income that would accrue under National Tariff for the full year. Some of the causes for the movement will include the ward closures as a result of norovirus and the impact this has had on elective activity levels.

12.0 Cost Improvement Programme (CIP)

12.1 The Trust's Annual CIP Target for 2015/16 is £8.9m for the stand alone acute trust.

12.2 Cash Delivery & Delivery Assurance

The Trust has delivered non-recurrent cost reduction against the Monitor Plan in the first two months, which is covering the recurrent target and operational pressures.

	CIP 2015/16 Delivery		
	Current Yr Month 2	Current Yr Months 1 to 12	Recurrent FYE
	£m	£m	£m
Target	0.99	8.93	8.93
Delivered	-0.12	-0.88	-0.40
Shortfall	**£0.87**	**£8.05**	**£8.53**

With effect from Month 3, we will be better able to make a forecast delivery assessment for the CIP Schemes already identified.
In the interim, a schedule follows of the schemes delivering as at Month 2 closedown:

Scheme	Yr end CYE Delivery
	£'m
• EFM Slippage	£0.020
• Discretionary N/R Spend (Incl. Training)	£0.600
• EFM Management Review	£0.187
• Pharmacy budget setting	£0.069
Total	£0.876

13.0 Forecast Position to 31 March 2016

13.1 The Trust is planning to achieve a deficit of £4.9m in the year as a stand-alone organisation, with an EBITDA surplus of £8,040k. The quarter 1 planned deficit is £2,477k, with an EBITDA surplus of £535k.

13.2 At Month 2 the Trust is on plan but has operational pressures that are being covered by slippage.

14.0 Corporate Finance

14.1 As measured against the revised Plan submitted to Monitor, seven out of eight corporate service Indicators are risk rated as green. The only indicator risk rated as red is capital expenditure (year to date).

15.0 Capital summary:

YTD Capital Plan (revised) £'000	Spend to Date £'000	Variance £'000
2,579	**2,081**	**498**

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 £29.1m, £25.0m relates to Capital Expenditure planned on South Devon Healthcare NHS FT sponsored projects. Appendix H 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 H upon integration.

As at 31st May 2015 there is a variance between planned capital expenditure and actual expenditure incurred totalling £0.5m (19.3%). This variance is outside of the 15% tolerance set by Monitor. The most significant underspend component relates to the new Critical Care Unit build. Finance is currently obtaining from scheme leads expenditure profiles for the month of June 15 to determine whether the 15% tolerance to phased Plan will be breached at the end of quarter one.

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).

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.

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**

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 : Electronic Document Management System – part of the IM&T Strategy	925
Phase 1 : Emergency Department - Reconfiguration	215
Phase 1 : Mortuary Works and Fracture Clinic	200
Sub-total	**1,340**

Within the Annual Plan, design fees have been budgeted to enable the enhancement of the on-site Ophthalmology Surgical facilities. However the cost 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.

A significant number of the capital schemes contained within the Board approved outline capital programme for 2015/16 have been fully authorised for progression, but a number of schemes still require formal approval before funds other than costs necessary to prepare a business case, can be committed.

It should also be noted that the Trust's ICO financial plan 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.

16.0 Cash and Balance Sheet Summary

Cash balances are £1,745k higher than the revised Plan. This is due to the following reasons: -

		Cash impact £'000
	Planned cash position	**10,597**
i)	I&E position above/(below) revised Plan	216
ii)	Less capex elements within I&E variance (depreciation, donated asset income, impairment)	(85)
iii)	Receipt of PDC higher/(lower) than Plan	0
iv)	Capital expenditure (above)/below Plan	498
v)	Non-current Debtors (above)/below Plan	(298)
vi)	Stock (above)/below Plan	(122)
vii)	Current Debtors (above)/below Plan	2,055
viii)	Current Creditors (excl loan) above/(below) Plan	(594)
ix)	FTFF loan above/(below) Plan	(27)
x)	Non-current provisions above/(below) Plan	(25)
xi)	Other working capital variances	127
	Actual cash position	**12,342**

Current Debtors are £2.1m lower than plan principally due to debt and collection clinical activity levels being below plan.

SDHFT Performance Report - May 2015

Appendix 1 - Performance report

	Target 2015/16	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD 14/15	YTD 15/16	Red	Amber	Green
QUALITY																		
Safety Thermometer - % Harm Free	> 95%	98%	98%	97%	98%	98%	98%	99%	99%	99%	98%	99%	99%			<95%		>=95%
Safety Thermometer - Falls		2	6	4	2	1	0	2	2	3	5	1	7	4	8	>=4	Between	<3
Safety Thermometer - VTE		1	1	2	1	4	1	2	2	1	1	1	1	0	2	>=1		<1
Safety Thermometer - Catheters and UTI		1	0	0	1	0	0	0	0	1	0	0	2	0	2	>=1		<1
Pressure Ulcers - Category 2		2	1	5	3	4	5	0	1	3	3	1	1	9	2	>=3		<3
Pressure Ulcers - Category 3		0	0	0	0	0	0	0	0	0	1	0	0	0	0	>=1		<1
Pressure Ulcers - Category 4		1	0	0	0	0	0	1	1	0	0	0	0	2	0	>=1		<1
Infection Control - MRSA cases		0	0	0	0	0	0	0	0	0	0	0	0	0	0	>=1		<1
Infection Control - MSSA cases		2	1	1	1	2	1	0	0	0	0	0	0	1	0	>=2	Between	<1
Infection Control - E-Coli cases		2	1	1	0	3	4	0	0	0	0	0	0	3	0	>=3	Between	<2
Infection Control - Bed Closures		108	18	30	12	0	252	124	141	156	104	358	955	90	1313	>=170	Between	<100
Infection Control - Hand Hygiene		95.5%	96.0%	99.0%	98.0%	95.2%	96.0%	92.1%	98.4%	98.3%	100.0%	92.5%	n/a			<95%		>=95%
Transfers Between 22:00 and 06:00		22.4%	19.9%	22.6%	19.8%	20.8%	17.3%	18.3%	16.8%	17.4%	16.0%	19.7%	23.6%	22.1%	21.5%	>=20%		<20%
Discharges Between 22:00 and 06:00		3.5%	3.7%	3.3%	3.5%	3.1%	4.0%	3.1%	3.5%	3.6%	3.3%	3.7%	3.7%	3.7%	3.7%	>=4%		<4%
Reported Incidents - Total		573	557	533	529	598	623	526	543	819	512	461	501	1110	962	>=550		<550
Reported Incidents - Moderate		187	155	149	145	158	165	114	136	139	127	120	129	84	69	>=150	Between	<100
Reported Incidents - Major		31	26	25	42	29	31	28	17	28	33	34	35	5	5	>=20	Between	<5
Reported Incidents - Catastrophic		0	2	1	0	3	1	4	2	1	1	3	2	0	0	>=1		<1
Never Events		0	0	0	0	0	0	0	1	0	1	0	0	0	0	>=1		<1
Early Warning Trigger Tool - Trust Average		5.13	5.63	5.65	5.27	4.97	5.19	5.54	4.28	4.38	4.41	5.09	6.13			>=5		<5
Written Complaints - Number Received		19	45	17	27	33	24	22	23	28	38	29	27	47	56	>=30		<30
Written Complaints - Number Outstanding (>8 week at month end)		6	9	7	12	8	11	11	5	6	7	7	3	19	10	>=6		<6
CQC Compliance																		
Fracture Neck Of Femur (Best Practice)		41%	52%	71%	54%	78%	81%	67%	28%	37%	30%	30%	n/a	70%	30%	<90%		>=90%
Stroke patients spending 90% of time on a stroke ward		68%	57%	66%	64%	80%	67%	44%	62%	60%	60%	71%	51%	68%	62%	<80%		>=80%
VTE - Risk assessment on admission		92%	92%	92%	92%	90%	91%	90%	82%	89%	90%	89%	90%	91%	89%	<95%		>95%
Choose and Book - % of slot unavailability		17.4%	20.0%	34.7%	21.8%	19.6%	18.6%	16.4%	9.4%	14.7%	20.7%	24.1%	30.1%	18.6%	27.5%	>=10%		<10%
Clinic letters timeliness		91%	95%	100%	86%	95%	95%	73%	68%	95%	91%	82%	86%	89%	84%	<95%		>=95%
Medication errors		15	34	16	20	10	21	8	16	25	16	7	0	25	7	>=20	Between	<15
MONITOR - compliance framework indicators																		
Number of Clostridium Difficile cases - Lapse of care		0	0	0	0	0	0	0	1	1	0	1	1	2	2	>=1		<1
Cancer - Two week wait from referral to date 1st seen	93%	93.6%	95.0%	91.6%	96.4%	98.2%	98.1%	97.9%	96.8%	97.2%	96.4%	94.6%	93.7%	97.1%	94.1%	<93%	Between	>93.5%
Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	93%	95.7%	92.2%	76.9%	95.5%	99.0%	100.0%	98.3%	93.9%	98.9%	96.8%	98.8%	95.5%	97.2%	97.1%	<93%	Between	>93.5%
Cancer - 31-day wait from decision to treat to first treatment	96%	98.6%	98.3%	96.7%	99.4%	98.2%	97.3%	97.6%	96.5%	100.0%	98.0%	98.7%	98.1%	99.1%	98.4%	<96%	Between	>96.5%
Cancer - 31-day wait for second or subsequent treatment - Drug	98%	100.0%	100.0%	97.8%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	<98%	Between	>98.5%
Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	94%	100.0%	100.0%	95.9%	98.3%	100.0%	98.8%	98.4%	98.3%	100.0%	98.4%	95.9%	95.7%	93.8%	95.8%	<94%	Between	>94.5%
Cancer - 31-day wait for second or subsequent treatment - Surgery	94%	93.8%	91.2%	93.3%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	97.1%	96.0%	92.9%	97.0%	94.3%	<94%	Between	>94.5%
Cancer - 62-day wait for first treatment - from 2ww referral	85%	93.9%	87.8%	88.1%	87.4%	87.2%	95.6%	91.0%	87.2%	86.4%	85.2%	95.9%	89.4%	90.9%	92.5%	<85%	Between	>85.5%
Cancer - 62-day wait for first treatment - from consultant screening service referral	90%	100.0%	88.9%	92.3%	100.0%	100.0%	90.0%	100.0%	72.7%	71.4%	91.7%	100.0%	100.0%	100.0%	100.0%	<90%	Between	>90.5%
Referral to treatment waiting times – admitted	90%	76.0%	92.1%	84.0%	77.0%	88.4%	74.5%	77.5%	76.7%	75.0%	76.3%	82.4%	76.5%	83.9%	79.7%	<90%		>=90%
Referral to treatment waiting times – non-admitted	95%	95.2%	95.9%	95.5%	95.4%	95.6%	95.0%	95.6%	95.1%	94.7%	95.8%	95.0%	95.2%	95.8%	95.1%	<95%		>=95%
Referral to treatment - % Incomplete pathways	92%	95.2%	94.5%	94.0%	93.9%	93.3%	92.7%	92.3%	92.0%	92.1%	92.1%	91.3%	91.7%	94.5%	91.5%	<92%		>=92%

SDHFT Performance Report - May 2015

Appendix 1 - Performance report

	Target 2015/16	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	YTD 14/15	YTD 15/16	Red	Amber	Green
A&E - patients seen within 4 hours	95%	84.2%	82.0%	90.6%	93.9%	95.4%	90.4%	83.2%	86.9%	81.0%	88.2%	93.9%	89.8%	83.7%	91.8%	<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		19	17	16	33	17	36	116	123	41	42	186	102	60	288	>=30		<30
Diagnostic tests longer than the 6 week standard		0.6%	0.5%	0.5%	1.0%	0.5%	1.2%	3.2%	3.2%	1.0%	1.0%	4.5%	2.5%	0.9%	3.5%	>=1%		<1%
Mixed sex accomodation breaches of standard (reported on UNIFY)		0	0	0	0	0	2	1	0	1	0	0	0	0	0	>=1		<1
On the day cancellations for elective operations (hospital initiated)		0.8%	1.4%	0.9%	0.8%	0.9%	1.0%	1.5%	1.5%	1.5%	1.6%	0.7%	1.3%	1.4%	1.0%	>=0.8%		<0.8%
Cancelled patients not treated within 28 days of cancellation		1	3	3	2	0	3	5	7	1	2	4	3	4	7	>=4		<4
RTT - percentage of treatment functions achieving 90% RTT (Admitted)		57.1%	76.9%	66.7%	46.7%	73.3%	60.0%	57.1%	56.3%	50.0%	56.3%	56.3%	58.8%	58.1%	57.6%	<80%	Between	>=85%
RTT - percentage of treatment functions achieving 95% RTT (Non-admitted)		64.7%	76.5%	64.7%	70.6%	64.7%	52.9%	58.8%	56.3%	52.9%	70.6%	58.8%	58.8%	73.5%	58.8%	<80%	Between	>=85%
RTT - percentage of treatment functions achieving 92% RTT (Incomplete)		100.0%	94.1%	88.2%	76.5%	76.5%	82.4%	76.5%	70.6%	76.5%	82.4%	76.5%	72.2%	94.1%	74.3%	<80%	Between	>=85%
RTT incomplete pathways > 52 weeks		0	0	0	0	0	0	0	0	0	0	0	0	0	0	>=1		<1
Ambulance handover delays > 30 minutes		88	106	40	24	27	34	56	55	72	34	23	39	135	62	>=75	Between	<50
Ambulance handover delays > 60 minutes		4	4	2	1	0	0	1	0	6	4	0	1	10	1	>=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	>=1		<1
Care Planning Summaries % completed within 24 hours of discharge - Weekday		70.7%	64.6%	71.5%	66.5%	65.5%	62.9%	57.3%	59.8%	45.1%	55.8%	57.0%	56.0%	73.0%	56.5%	<77%		>=77%
Care Planning Summaries % completed within 24 hours of discharge - Weekend		54.2%	38.4%	37.4%	40.7%	41.7%	47.1%	38.8%	40.3%	30.6%	41.0%	34.0%	27.0%	48.5%	30.5%	<60%		>=60%
Data book local indicators not included elsewhere																		
A&E - Total visit time (95th percentile)		06:03	06:13	05:13	04:37	04:00	05:24	06:31	05:55	07:14	05:48	04:35	05:26			>04:00		<=04:00
A&E - Percentage of patients with a visit time of less than or equal to 4 hours		84.2%	82.0%	90.6%	93.9%	95.4%	90.4%	83.2%	86.9%	81.0%	88.2%	93.9%	89.8%	83.7%	91.8%	<95%		>=95%
A&E - Unplanned reattendance rate		4.8%	4.5%	4.9%	5.1%	5.0%	5.0%	5.3%	5.2%	5.5%	5.8%	6.3%	5.7%	4.6%	6.0%	>=5%		<5%
A&E - Percentage of patients who leave without being seen		4.5%	5.9%	3.4%	2.6%	2.4%	2.2%	2.9%	1.9%	3.2%	3.0%	2.5%	2.3%	3.8%	2.4%	>=5%		<5%

REPORT SUMMARY SHEET

Meeting Date:	1st July 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

Strategic Context:
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.

Key Issues/Risks and Recommendations:

The key issues/risks from the paper presented are:

- Continued concern over the number of COSHH incidents occurring across the Trust. H&S Committee are monitoring individual departmental performance and the COSHH group continues to monitor the implementation of the COSHH action plan and compliance.

- Whilst meeting expected performance for P1's in month, an increase in these requests in month for urgent action has resulted in a corresponding drop in performance in responding to P2, P3 and P4 requests.

Recommendations:

- Workstream 5 and Trust Board to monitor and receive assurance on the action plan in place to address COSHH incidents.

Summary of ED Challenge/Discussion:
Significant deterioration in the actual percentage of P3 and P4 reactive work resolved within target – what is the plan to address and what is the level of risk this creates? *There is a plan in place within the estates team to re-profile the workload to achieve this indicator within the next two months. Work orders are risk assessed on receipt, those of P3 and P4 are low priority and therefore low risk. If there is a deterioration they are re-prioritised.*
If we increase our investment in equipment, will demand decrease (what percentage of demand is created by equipment that is overdue for replacement?) *This is currently being investigated.*
Given the increase in P1 Emergency requests, are these escalating due to underlying issues or because the response time for P2 – P4 has increased? *P1's have a defined criteria and are directly related to a failure needing urgent attention, they are related to underlying issues and unrelated to P2, P4 increase. A table tracking the numbers of P1's 2's,3's by month will be added to the performance databook reported to workstream 5 and subsequently on to the Board.*

Internal/External Engagement including Public, Patient and Governor Involvement:
A Governor observer sits on Workstream 5.

Equality and Diversity Implications:
All requirements considered as they apply to the EFM agenda

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

1. South Devon Healthcare exception report for May 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 Board's attention.

The detailed monthly performance table is shown in Appendix A (EFM) and Appendix B (Medical Devices / Women's & Children's services)

The group are asked to note the contents of this report.

Table 1 Changes between April 2015 and May 2015 Scorecard Indicator

Green ✓	Amber !	Red ✘	April 2015 Position	May 2015 Position
Improving Indicators				
1.1e: % of Reactive work resolved within target – Emergency P1 (< 2 Hour)			!	✓
3.2: % of Total tonnage Recycled Waste			!	✓
5.1: Number of RIDDOR Incidents			✘	!
5.4: Non-patient incidents resulting in moderate harm			!	✓
Deteriorating Indicators				
1.1i: % of Reactive work resolved within target – Routine P3 + P4 (<7- 30 Days)			!	✘
3.4: % of Total tonnage of Clinical Non-Burn waste			!	✘
4.1b: % of OUTSTANDING/To Be Done Schedule Service Work Requests (over rolling 3 Year Period)			✓	!
5.3: Non-patient incidents resulting in minor harm			✓	!
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) [42% down to 35.6%]			✘	✘
6.5: % of Compliant Fire Audits			✘	✘

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 (P2 Urgent)	
Performance of this indicator has remained at 88% although the number of requests has increased in month by 25% indicating a trend moving in the right direction. We will continue to review and adjust practices and procedures in the department to continue this trend through amber and on to green.		July 2015
1.1i	1.1i: % of Reactive work resolved within target – Routine P3 + P4 (<7- 30 Days)	
Performance of this indicator has deteriorated from 86% to 74% during May, however in the same period the number of Emergency - P1 requests increased from 89 to 104 with a corresponding improvement in performance from 90% (amber) to 97% (green), staff have been dealing with the P1 requests and have not been able to complete the P3 and P4 requests in time. In addition there has been an increase in the number of requests since the previous month, a proportion of which appear to be attributable to work required in anticipation of a CQC inspection.		Quarter 2 2015- 16
3.4	% of Total tonnage of Clinical Non-Burn waste	
The target for this financial year for clinical waste which is disposed by processing at an Alternative Treatment Plant (ATP) is 18% of the monthly waste total tonnage, at 26.5% for the month of April the RAG rating is Red which shows that this waste stream produced considerably more than was anticipated during the month. This is not seen as a problem at this stage, we will continue to monitor.		Quarter 2
4.1a	% of COMPLETED Scheduled Service Work Requests (in month) **[42% down to 35.6%]**	
Slight downward dip in reported value, this is due to a staff resource being committed to the commissioning of 16 new CTG monitors. Additional staff resources were required due to intermittent device faults with these new monitors and possible out of box failures.		Quarter 2 2015-16
6.5	% of Compliant Fire Audits	
This month 4 local audits were carried out with 1 being non-compliant due to continuing problems with fire doors being wedged open unnecessarily. Staff awareness is constantly being raised at all training sessions and when conducting the audits.		September 2015

Appendix A: Estates and Facilities – KPI's South Devon Healthcare Foundation Trust – May 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	1068												1043				
1.1b	PPM (Estates) % success against plan			100%	89%	90%											100%	90%		R<85%	A85-94%	G>95%
1.1c	Planned Maintenance % called for but not available			0%	0%	0%											0%	0%		R>15%	A15%-6%	G≤5%
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	89	104												68				
1.1e		Emergency – P1	<2 Hour	100%	90%	97%											100%	94%		R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	217	272												244				
1.1g		Urgent – P2	<1- 4 Days	100%	88%	88%											100%	88%		R<90%	A90-94%	G≥95%
1.1h		Routine – P3 + P4	Total Requests	Variable	345	386												366				
1.1i		Routine – P3 + P4	<7- 30 Days	100%	86%	74%											100%	80%		R<85%	A85-89%	G≥90%
1.2	Number of Estates Internal Critical Failures			0	0	0											0	0		R1	-	G0
	Facilities																					
2.1	Compliance **Very High Risk** Cleaning Audit			98%	100%	100%											98%	100%		R<95%	A95-97%	G≥98%
2.2	Compliance **High Risk** Cleaning Audit			95%	98%	99%											95%	99%		R<90%	A90-94%	G≥95%
2.3	Compliance **Significant Risk** Cleaning Audit			85%	99%	99%											85%	99%		R<80%	A80-84%	G≥85%
2.4	Compliance **Low Risk** Cleaning Audit			75%	92%	96%											75%	94%		R<70%	A70-74%	G≥75%
2.5	No. of Environment Health (food hygiene) events			0	0	0											0	0		R1	-	G0
	Waste																					
3.1	Total Tonnage per month all waste streams			157	127	138											157 or Less	132.5		R≥173	A158-172	G≤157
3.2	% of Total tonnage Recycled Waste			31%	30%	43%											31%	36.5%		R≤24%	A25-30%	G≥31%
3.3	% of Total tonnage Landfill Waste			37%	34%	24%											37%	29%		R≥44%	A38-43%	G≤37%
3.4	% of Total tonnage of Clinical Non-Burn waste			18%	19%	26.5%											18%	22.75%		R≥25%	A19-24%	G≤18%

3.5	% of Total tonnage of Clinical Burn waste	11%	12%	13.5%											11%	12.75%		R≥17%	A12-16%	G≤11%
3.6	% of Total tonnage of Clinical Offensive waste	3%	5%	4%											3%	4.5%		R≤1%	A2%	G≥3%
3.7	Number of Waste Audits undertaken per month	10	10	10											10	10		R≤5	A6 - 7	G≥8
3.8	% of Compliant Waste Audits	100%	100%	100%											100%	100%		R<90%	A90-94%	G>95%
3.9	% Compliance of Statutory Waste Audits	100%	100%	100%											100%	100%		R<90%	A90-94%	G>95%
	Health & Safety																			
5.1	Number of RIDDOR Incidents	0	3	2											0	3		R≥3	A1-2	G0
5.2	Number of days lost (due to incidents in month)	65	23	19											65	21		R≥81	A66-80	G≤65
5.3	Non-patient incidents resulting in minor harm	30	24	31											30	28		R≥36	A31-35	G≤30
5.4	Non-patient incidents resulting in moderate harm	1	3	1											1	2		R≥4	A2-3	G≤1
5.5	Number of near misses	16	18	16											16	17		R≤10	A11-15	G≥16
5.6	% of Staff receiving H & S training in month	90%	89%	89%											90%	89%		R<80%	A 80-89%	G≥90%
	Fire																			
6.1	No. of Fires	0	0	0											0	0		R1	-	G0
6.2	Number of fire alarm activations	12	7	4											12	5.5		R>15	A12-15	G<12
6.3	Fire alarm activations attended by the Fire Service	6	3	1											6	2		R>11	A6-11	G<6
6.4	No of Fire Audits undertaken	8	4	4											8	4		R<4	A8 - 4	G>8
6.5	% of Compliant Fire Audits	100%	25%	75%											100%	50%		R<90%	A90-95%	G>95%
6.6	% Fire Safety Risk Assessments (Reform Order) in date	100%	90%	90%											100%	90%		R<90%	A90-95%	G>95%
6.7	% of Staff receiving Fire Safety training in month	90%	82%	83%											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 –May 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	360											Variable	373				
4.1a	% of COMPLETED Scheduled Service Work Requests (In Month)	100%	42%	35.6%											100%	38.8%		R<70%	A71%-79%	G≥80%
4.1b	% of OUTSTANDING/To Be Done Schedule Service Work Requests (<2 Months from Required Date)	100%	76%	74.7%											100%	75.4%		R<60%	A60%-79%	G≥80%
4.1c	% of OUTSTANDING/To Be Done Schedule Service Work Requests (over rolling 3 Year Period)	0%	4%	5.8%											0%	4.9%		R>10%	A5% - 9%	G<5%
4.2a	% of REACTIVE Work Requests, Category Emergency, COMPLETED within **1 Working Day**	100%	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%	100%		R≤80%	A81%-94%	G≥95%
4.2c	% of REACTIVE Work Requests, Category Routine, COMPLETED within **10 Working Days**	100%	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%	90.3%											100%	85.7%		R<60%	A60%-79%	G≥80%
4.3	No. of Devices requested/not found for Scheduled Service	Variable	118	62											Variable	90	For Information only			
4.4	No. of incidents involving Medical devices	4	3	10											4	7		R≥9	A5 - 8	G≤4

Report to:	Trust Board
Date:	June 2015
Report From:	Director of Estates & Commercial Development
Report Title:	Monthly 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 May 2014 to 31st May 2015 (inclusive).

Table 1

TRUST	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	MAR
SDHCFT	51	53	64	62	48	60	57	49	44	45	43	46	50	**671**

There has been an increase in the number of incidents reported in May, for the second month in a row, and a continuing positive trend of near misses or no harm since February. (Chart 1)

Chart 1

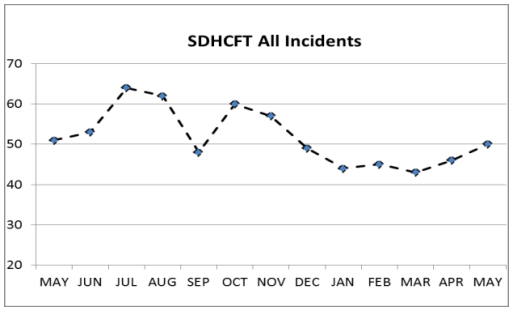


Chart 2

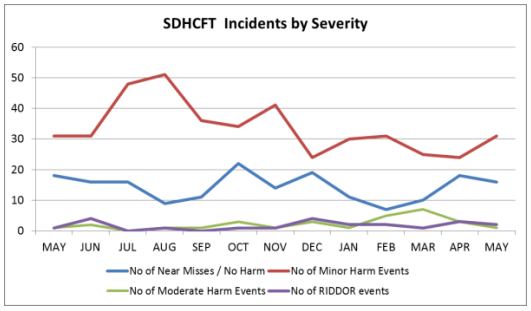


Chart 2 above shows the total monthly incidents by severity for SDHCFT. Two RIDDOR incidents were reported to the HSE in May, both relating to Slips, Trips and Falls. Three RIDDOR's were reported late for April, one because of inaccurate reporting and two where the absence was not confirmed until May.

The highest numbers of incidents reported during May were related to Sharps, closely followed by those relating to Control Of Substances Hazardous to Health (COSHH) (Chart 3). Sharps continue to remain the highest category overall (Chart 4).

Chart 3

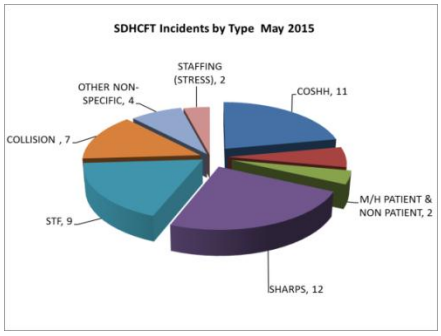
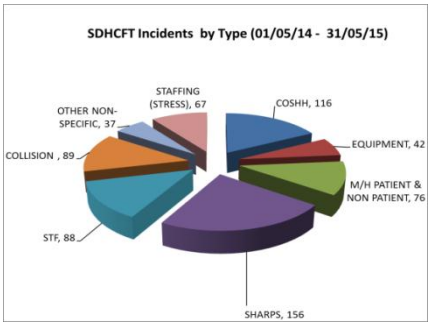


Chart 4



2. Key Issues:

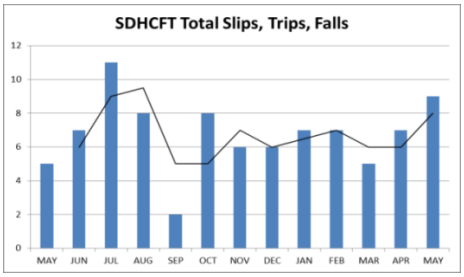
2.1 Days Lost

1059 working days have been lost due to accidents at work, this is equivalent to 15% of our workforce being absent for one day.

2.2 Slips, Trips and Falls (STF)

Chart 5 below shows the level of STF incidents is gradually increasing. There were 9 incidents reported during May 2015. Of these reports, 8 involved employees and 1 was a visitor, and six involved trips on the same level, all of which were preventable accidents and were caused by a general lack of attention.

Chart 5



2.3 COSHH (SDHCFT)

During May COSHH incidents showed an increase compared to April 2015 (Chart 6 below).

Chart 6

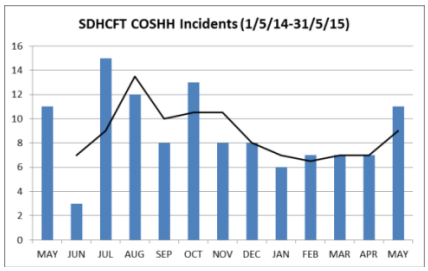


Chart 7

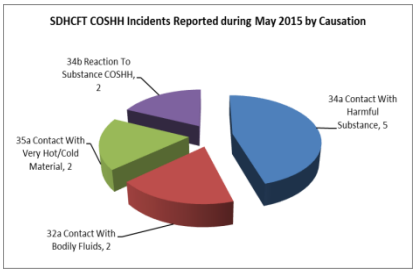


Chart 7 shows the breakdown by department of COSHH incidents reported in May 2015. Chart 7 highlights the breakdown of all reported COSHH incidents in May by causation. The COSHH working party continues to monitor incidents by department and trends and details of any areas of concern reported to the H&S committee.

2.4 Manual Handling

Charts 8 and 9 (below) illustrate the number of reported incidents relating to Manual Handling of Inanimate Objects and Patient Handling over the last 13 months. May showed another slight decrease in both categories.

Chart 8

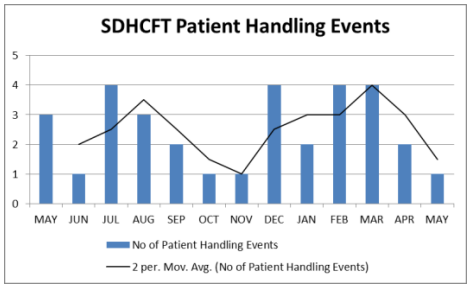
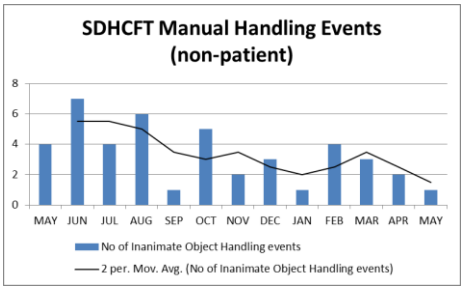


Chart 9



2.4 Sharps

Chart 10 (below) shows the number of reports of sharps incidents on Safeguard following injury over the last thirteen months. During May, there were 8 reports due to poor disposal, 2 non-needlestick and 2 during use of a needle. As shown in Chart 11, of the 12 reports, 7 resulted in minor harm.

From 1st June each sharps incident will now be fully investigated using the new contamination injury investigation form. The health and safety team have met with procurement to ensure the Trust is only purchasing the correct sharps and that relevant information is available to all staff.

Chart 10

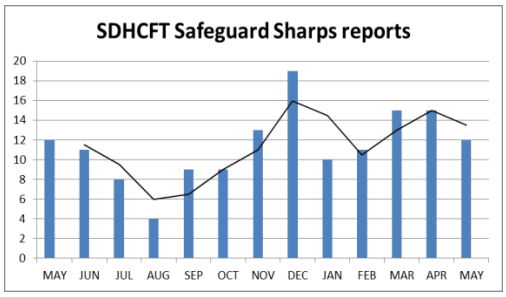
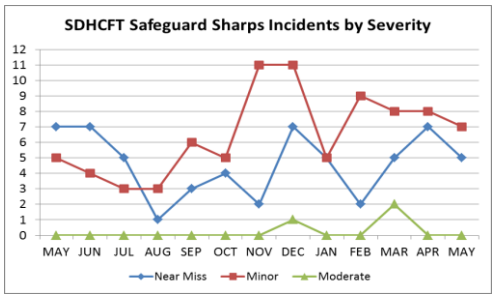


Chart 11



2.5 Stress

As can be seen in Chart 12 there was a slight increase in referrals received by OH for work stress during May 2015. The incidents reported on Safeguard (Chart 13) continue to be minimal.

Chart 12

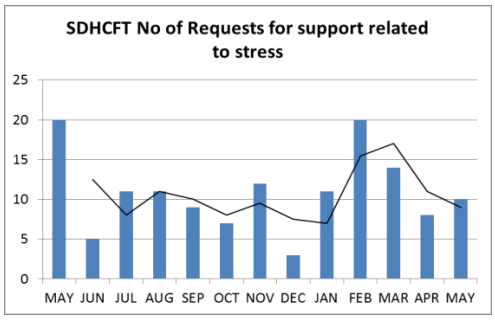
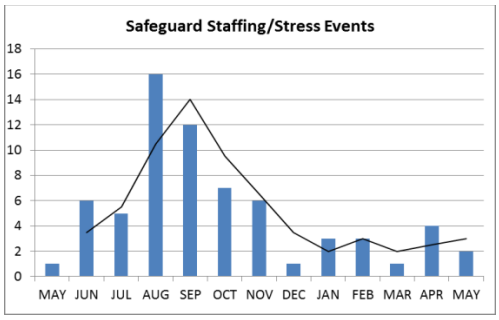


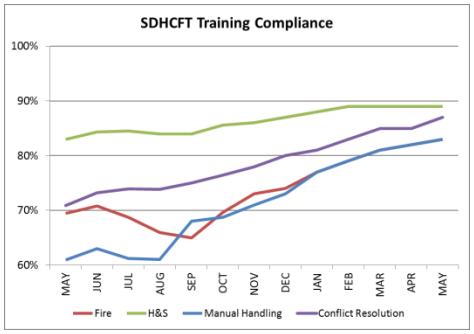
Chart 13



2.6 Training

Chart 14 below shows that the mandatory training figures for SDHCFT still continue to improve and are above 80% for all subjects.

Chart 14



3. Conclusion

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

South Devon Healthcare NHS
NHS Foundation Trust

Board Summary Sheet

Meeting Date:	1 July 2015
Title:	Annual Report of the Audit and Assurance Committee 2014/15
Lead Director:	John Brockwell, Chair of Audit and Assurance
Corporate Objective:	Leadership
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

To present the Annual Report of the Audit and Assurance (A&A) Committee.

Key Issues/Risks and Recommendations:

1. The Board of Directors accepts the attached report.

Summary of ED Challenge/Discussion:

Not applicable as submitted to the Board of Directors by John Brockwell (non-executive director) via the Trust's Audit and Assurance Committee. Director of Finance, Performance and Information was in attendance when the draft annual report was presented to the Committee in May 2015.

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

The content of the report does not directly impact on equality and diversity, public and patient and/or governor involvement. There is a governor observer on the Audit and Assurance Committee.

Equality and Diversity Implications:

None identified.

Board of Directors
Annual Report of the Audit and Assurance Committee 2014/15
Date: 1 July 2015

Main Report

1. Introduction

1.1 The Audit and Assurance Committee ('the Committee') of South Devon Healthcare NHS Foundation Trust ('the Trust') has been established under board delegation. Its terms of reference were updated during the year covered by this report but not changed substantively; they closely follow guidance provided by the Audit Committee Handbook 2011 published by the Department of Health, and by the Healthcare Financial Management Association (HFMA).

1.2 Membership of the Committee comprises the Trust's non-executive directors, with regular attendance by the Trust's Director of Finance, Performance & Information, representatives of its internal and external auditors, the Trust's counter fraud specialist, the Company/Corporate Secretary and, by invitation, the Chairman, other executive directors and other key Trust staff. The Committee has also benefited by the attendance of a representative of the Trust's Council of Governors.

1.3 The Committee has met on five occasions in relation to the year ended 31 March 2015, to consider and discharge its role in scrutinising the operation of the assurance framework of the Trust, and to seek and assess assurance on aspects of the Trust's operations. As one of the senior sub-committees of the board this role is central to the governance of the Trust.

2. Principal areas of review

The work undertaken by the Committee during 2014/15 has included the following:

2.1 **Board Assurance Framework** - the Committee has reviewed and used the assurance framework of the Trust and believes that it is fit for purpose, comprehensive and reliable. Also, that there are no significant areas of duplication or omissions in the systems of governance and the sources of assurance are sufficient to support the boards decisions and declaration. Where appropriate, recommendations have been made to the board regarding the continued development of the assurance framework, and on matters of risk identification and management.

2.2 **Care Quality Commission (CQC) assurance** - whilst the Committee has not directly reviewed the Trust's arrangements for compliance with the registration and continuing requirements of the CQC, the chair of the Committee can attend if required the Trust's Risk and Assurance Integrated Governance Group as an observer. This group seeks and challenges assurance in connection with the Trust's CQC compliance. Further, the Committee has received and considered reports on aspects of compliance with the requirements of the CQC prepared by the Trust's Internal Auditors. These arrangements will continue during 2015/16. There were no formal visits undertaken by the CQC during 2014/15. The foundation trust remains fully compliant with all registration requirements and in respect of the CQC's intelligent monitoring report, which is the CQC's new quality risk profile the Trust remains at band four (on a scale of one to six, with six being the lowest risk) as at 31 March 2015.

2.3 **Risk management and governance arrangements** - during 2014/15, the committee has reviewed the:

- Trust's risk management and governance arrangements;
- Trust's standing orders, standing financial instructions and scheme of delegation;
- undertaken a number of reviews of major areas of activity including the:
  - CQC regulations;
  - integrated care organisation programme;
  - information governance;
  - main accounting system;
  - critical estates functions;
  - service line reporting, management of whistleblowing concerns;
  - doctors revalidation;
  - data quality, capital projects;
  - new clinical interventions authorisation process;
  - safeguarding adults;
  - training of bank staff;
  - incident reporting;
  - information asset owner business continuity and disaster recovery plans (follow-up);
  - Torbay Pharmaceuticals expansion; and
  - banking, cashiering and cash flow management.

All the reviews were conducted by internal audit using a risk-based approach. The minutes of meetings of the Committee are presented at board meetings.

2.4 **Internal audit plan** - the Committee has reviewed and agreed the formulation and content of the Trust's internal audit plan for 2014/15 and 2015/16 to enable assurance over a wide range of topics. It was noted at April's [2015] Committee meeting that the Care Trust had an internal audit plan in place for the year and work was taking place to merge both plans as the Trust moved towards the integrated care organisation and the merged plan would be discussed post integration.

2.5 **External auditor reports/reviews** – the Committee has received and considered reports from its external auditors including:

- International Standards on Auditing (ISA) 260 Report including letter of representation;
- internal audit's processes in line with ISA requirements;
- internal audit plan, which links to the Trust's strategic objectives and CQC outcomes;
- 2014/15 external audit plan and progress reports;
- quality report / continued implementation of reporting using the quality report; and
- review of the design of IT general controls;
- review of financial accounts; and
- review of the arrangements in place to prevent and detect fraud and corruption; no incidences of material fraud were brought to the auditor's attention.

2.6 **Counter fraud** - the Committee has undertaken reviews of the work undertaken by the Trust's local counter fraud specialist, including:

- fraud awareness training for Trust staff;
- counter-fraud plan for 2015/16; and
- results of current fraud investigations as well as any other related matters.

2.7 **Clinical audit** - the Committee reviewed the 2013/14 Annual Report and a 2014/15 six month update. A paper submitted to the Committee in April 2014 set out the obligations of the Audit and Assurance Committee in respect of clinical audit and how the Clinical Audit and Effectiveness team was meeting those obligations. The meeting approved the recommendation that a clinical audit report was brought to the Committee four times a year and this be added to the schedule (February, April, August, October).

2.8 **Follow-up reviews** - the Committee followed up the progress made in the implementation of recommendations from internal audit in relation to:

- tenders and quotes;
- pharmacy subsidiary/ePrescribing;
- IT audit; and
- agency spend.

2.9 **Financial reporting** – the Committee has reviewed the annual accounts and financial statements prior to recommending these to the board, and have reviewed the financial reporting systems and internal controls throughout the year, and considered them to be robust.

2.10 **Committee effectiveness** - the Committee will be reviewing its own effectiveness using feedback from its members and contributors.

2.11 **Regional audit meetings** - the chair or other members of the Committee have participated in the periodic meetings of regional audit committee chairs.

3. Conclusions

3.1 The Committee has reviewed the draft annual governance statement for the Trust for the period 1 April 2014 to 31 March 2015 and considers that the statement is consistent with the Committee's view of the Trust's system of internal control. Accordingly, the Committee supported board approval of the statement.

3.2 The Committee has reviewed and used the Trust's assurance framework, and believes that it is fit for purpose.

3.3 The Committee has considered past self-assessment by the Trust of its compliance with the requirements of the Care Quality Commission and concluded that the self-assessment was consistent with its understanding gained through the assurance framework.

3.4 The Committee has considered the Trust's system of risk management and has concluded that it is adequate as a means of identifying risks and allowing the board to understand the appropriate management of those risks.

3.5 During the year the Board of Directors initiated governance reviews in line with the new Monitor guidance in 2014/15.

3.6 The Committee is not aware of any other significant duplications or omissions in the Trust's systems of governance that have not been adequately resolved.

4. Other matters

4.1 The Committee would like to record its thanks for the contributions that it has received during 2014/15 from its internal and external auditors, counter-fraud specialists, executive directors, the company/corporate secretary, the governors' representative, and for the secretarial support.

John Brockwell
Chair Audit and Assurance Committee
South Devon Healthcare NHS Foundation Trust
27 May 2015