Torbay and South Devon NHS Foundation Trust

TSDFT Board of Directors

Public Board of Directors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital, Torquay, TQ2 7AA

02 December 2015 13:30

AGENDA

1 Apologies - L Burnett
Owner : Chairman

Note

2 Minutes of the Board Meeting held on the 4th November 2015 and Outstanding Actions
Owner : Chairman

Approve

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3 Declaration of Interests
Owner : Chairman

Note

4 Quality, Patient Safety and Experience

4.1 Report of the Chief Nurse
Owner : CN

Information/Assurance

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4.2 Report of the Medical Director
Owner : MD

Discussion/Assurance

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4.3 Research and Development Report
Owner : MD

Information/Assurance

Research and Development.pdf 32

5 Strategy and Vision

5.1 Report of the Chairman
Owner : Chairman

Note

5.2 Report of the Chief Executive
Owner : CE

Discussion/Assurance

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5.3 Public Consultation on the Future of Baytree House Short Breaks Unit for People with Learning Disabilities in Torbay
Owner : COO

Approve

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5.4 ICO Developments
Owner : Chairman

5.4 Child and Adolescent Mental Health Service Report
Owner : COO

Discussion/Assurance

CAMHS.pdf 69

6 Workforce and Organisational Development

6.1 Report of the Interim Director of Human Resources
Owner : IDOD

Information/Assurance

7 Engagement and Partnerships

Note

7.1 Council of Governor Issues
Owner : Chairman

Note

8 Performance

8.1 Monthly Finance and Performance Report
Owner : DoF/DPPNPE/COO

Discussion/Assurance

Performance and Finance Report.pdf 99

8.2 Report of the Director of Estates and Commercial Development

Owner : DECD

Discussion/Assurance

9 Assurance
Owner : Chairman

10 Governors' Question Time
Owner : Chairman

Discussion/Assurance

11 Date of Next Meeting - 1.30 pm, Wednesday 6th January 2016
Owner : Chairman

Note

12 Exclusion of the Public
Owner : Chairman

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE SOUTH DEVON HEALTHCARE FOUNDATION TRUST BOARD MEETING HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE TORBAY HOSPITAL ON WEDNESDAY 4TH NOVEMBER 2015

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mr D Allen	Non-Executive Director
	Mr J Brockwell	Non-Executive Director
	Mr L Burnett	Non-Executive Director
	Mr J Furse	Non-Executive Director
	Mrs S Taylor	Non-Executive Director
	Mr J Welch	Non-Executive Director
	Mrs M McAlinden	Chief Executive
	Mr P Cooper	Director of Finance
	Mrs L Darke	Director of Estates and Commercial Development
	Ms L Davenport	Chief Operating Officer
	Dr J Lowes	Medical Director
	Mr M Ringrose	Interim Director of Human Resources
	Mrs J Viner	Chief Nurse
In Attendance:	Ms K Adams	ICO Champion
	Ms E Austin	ICO Champion
	Mrs C Bamford	Operational Support Manager, Medicine
	Mr L Dodd	Consultant Trauma and Orthopaedic Candidate
	Mrs S Fox	Board Secretary
	Mrs J Gratton	Interim Director of Communications
	Ms J Peachey	ICO Champion
	Ms G Rogers	Swift Project Lead (part)
	Mr R Scott	Corporate Secretary

Mrs C French	Lead Governor	Mr R Allison	Governor
Mr D Brothwood	Governor	Mrs C Carpenter	Governor
Mrs C Day	Governor	Mrs S Gardner-Jones	Governor
Mrs L Hookings	Governor	Mrs A Harvey	Governor
Mrs A Hall	Public Observer		

ACTION

171/11/15 **Apologies**

Apologies were received from the HIS Director, Mrs Lyttle and Councillor Parrott.

172/11/15 **Minutes of the Board Meeting held on the 7th October 2015 and Outstanding Actions**

The minutes were approved as an accurate record of the meeting held on the 7th October 2015.

All actions had been completed apart from the following:

- **Care Planning Summaries (CPS)** – the Medical Director advised that some quality improvement work was taking place to look at CPS to see if they could be simplified by removing some of the data sections. Another way of capturing the data removed from the CPS would need to be identified.

173/11/15 **Declaration of Interests**

Nil.

Quality, Patient Safety and Experience

174/11/15 Report of the Chief Nurse

The Chief Nurse highlighted the following from her report:

a) **Safe Staffing**

Work had taken place to check the Trust's compliance with recent documentation issued by Monitor around safe staffing. The Chief Nurse provided assurance that the Trust was compliant with the recommendations made by Monitor and that robust systems were in place to ensure staff staffing on a daily basis. At present the ratio of registered nurses to patients was 1:8 and she felt this to be the right ratio (at present).

Mr Furse queried what the impact of moving to a 1:9 registered nurse to patient ratio might be and the Chief Nurse said that some work was taking place to assess ward staffing levels, and that the 1:8 ratio might not be correct for all wards. This work would be brought back to the Board once completed.

Mr Furse then asked if flexible contracts were offered to staff to encourage Trust permanent employment rather than via bank or agency. The Chief Nurse said that flexible contracts were offered, for example term time contracts, different shift patterns etc, but that it was a challenge to balance the needs of the service against individual needs. It was noted that staff who were regularly employed via the bank or agency were to be asked if there was anything the Trust could do to enable them to become permanent employees of the Trust.

b) **Monitor Agency Rules**

Monitor had issued guidance around the safe use of agency staff and the Chief Nurse provided assurance that when booking agency staff robust checks were used to ensure any staff used were fully trained and appropriate.

Mr Brockwell asked how the agency staff pricing cap would affect the Trust. The Chief Nurse said that Monitor had not informed the Trust of the approved agencies it could use as none of the agencies currently on the national framework covered the South West. The desire to drive down the cost of agency staff was supported, but the effect of the cap not yet known. The Trust had processes in place to monitor any effect and escalate to Monitor if necessary. Monitor was also aware of the issues that would face the Trust if the main agency used, Thorbury, was not added to the approved list.

c) **Infection Control**

There had been one CDiff in the last month. It was noted that although robust actions plans were in place to manage infections, an external review of the Trust's processes would be taking place to ensure that best practice was being applied.

Mrs Taylor queried the lapses in care and the Chief Nurse explained that there was variation between local Trusts in how the national guidelines were applied and this

Trust had agreed with the CCG how to apply the guidelines. She confirmed that there was only one lapse in care that had a direct correlation to a CDiff infection.

175/11/15 Report of the Medical Director

a) **Medical Equipment**

As previously reported, the Trust used to have a rolling medical equipment replacement programme for items costing over £5,000, which had ceased two years ago due to budgetary constraints. Subsequently equipment was only replaced when broken. Over time potential risks have been identified with this approach including lost opportunities for economies of scale and also aged equipment. For the coming financial year a different approach was being considered by Executives to manage this risk.

b) **Physician Associate**

The Trust is currently sponsoring 5 students via Plymouth University and 4 of them gave a presentation to the Trust on their role last month. It was recognised that the posts would create some tensions in the workforce as they would be working alongside trainee doctors and this would need to be managed to ensure the best use was made of the roles and to ensure teams worked well together. The Trust would be sponsoring a further 10 students as part of the second cohort.

c) **Health Education South West 2015 GMC National Training Survey**

The Board noted the Executive Summary attached to the agenda papers. The Trust continued to be a top performer in the peninsula.

Strategy and Vision

176/11/15 Report of the Chairman

The Chairman reported on the following:

- Ann Wagner, Director of Strategy and Business Development at Airedale Trust had been appointed as the Trust's new Director of Strategy and Improvement following a robust process. It was hoped she would commence in February 2016.

- The Chairman felt that there was a feeling of determined enthusiasm across the new organisation in respect of the ICO.

- The CCG was currently focussing on its current financial problems and this Trust could not make system changes in isolation and would need to understand the impact of the CCGs difficulties whilst moving forward with the changes required by the ICO. There was also a need to ensure the ICO was not inappropriately drawn in to the wider peninsula financial problems.

- It was clear that the ICO clinical model required community engagement and a robust feedback process. The Chairman asked the Board to approve him taking action to engage with the Lead Governor to take this forward through the Council of Governors. This was approved.

- A paper had been circulated to the Board and Governors on the outcome of the CCG proposals for consultation on community hospital bed closures due to winter pressures. The proposals set out proactive action, rather than reactive, which was what happened last year when community beds were closed at very short notice. The feedback was not wholly supportive of the CCG's proposals, but no alternatives were available so the CCG was

proceeding.

177/11/15 Report of the Chief Executive

The Chief Executive highlighted the following from her report:

- The challenges to the Emergency Department 4 hour target continued, and the Chief Executive said she was impressed by the efforts of staff to manage the challenges with staff working very long and difficult hours. Monday of this week was a particularly challenging day and she thanked the Chief Operating Officer and Medical Director who stayed on site until midnight to support staff.

- The meeting noted the updated Executive organisational chart included in the papers which provided information of executive staff in respect of the Trust's leadership and responsibilities and changes to titles.

- Ofsted were currently undertaking an inspection of Torbay Council's Children's Services and the outcome of this would be fed back to the Board once received by the Chief Nurse.

- The Interim Director of Human Resources reported that a ballot was starting the next day in respect of Junior Doctor industrial action. They would be asked if they supported strike action, or action short of strike action. The Trust would work with its Junior Doctors and Consultant staff if any action was taken.

178/11/15 ICO Developments

The Chief Nurse and Chief Operating Officer gave the following presentation:

New Care Model – Intentions

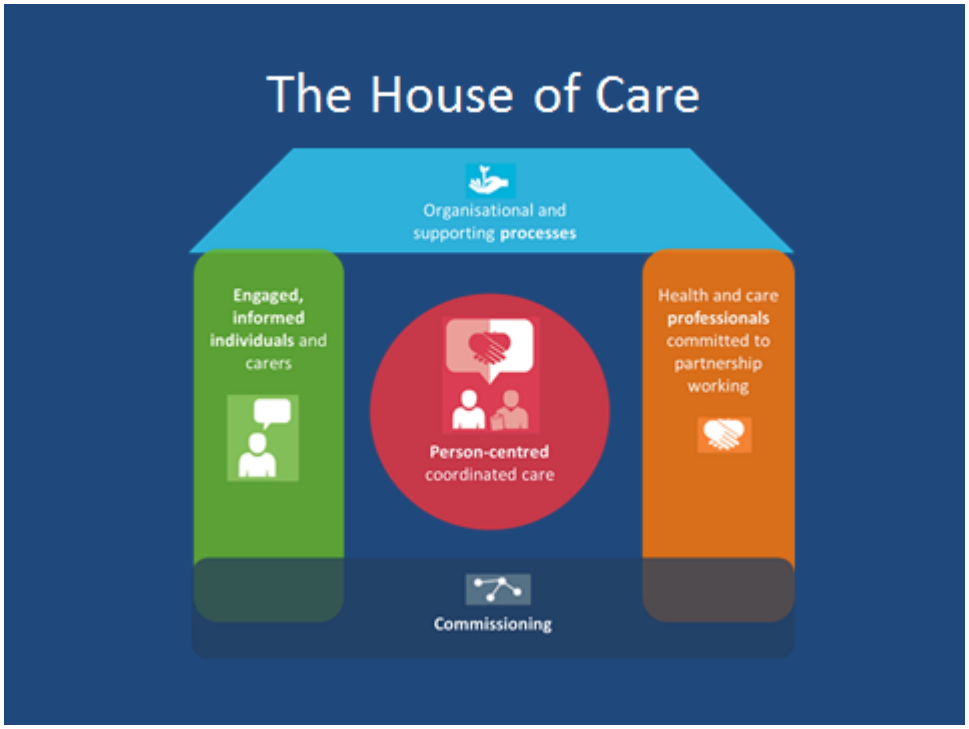
- Improve people's experiences of health and care;
- Support people in improving their wellbeing and in managing their own health;
- Shift the focus of our services from reactive to proactive with preventative interventions at all levels;
- Help to reduce inequalities in health and care;
- Continue to support and develop a motivated, flexible workforce

Through improved quality of services, reduction in duplication and waste and reduced clinical risk we will

- Maintain a financially stable and sustainable health and care system for the long term.

2

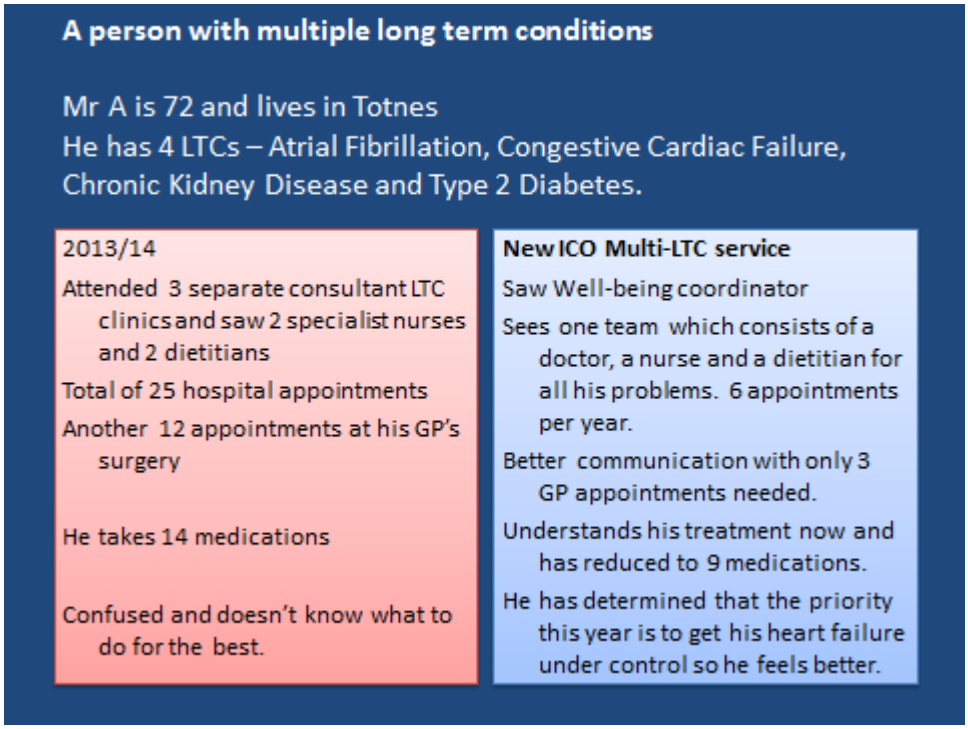
New model of care; the Local Multi-Agency Team (LMAT)

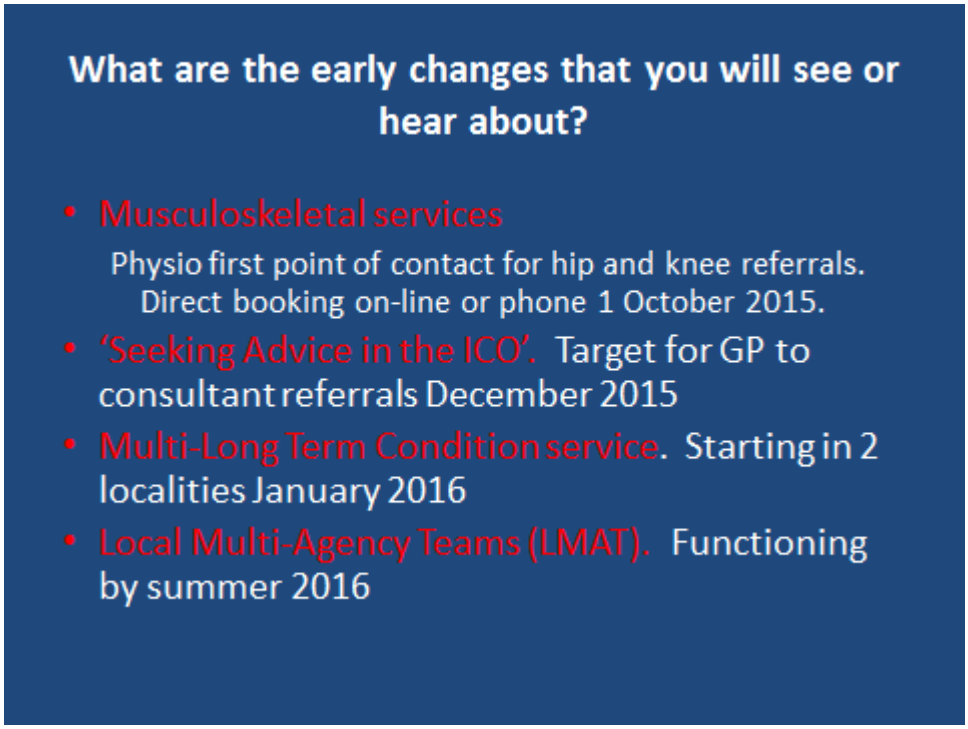


'Projects'

- Frailty Pathway
- Single Point of Contact (SPOC)
- LMATs
- Community hospitals
- Wellbeing (staff & public)
- Market development: domiciliary & voluntary sector
- Multi – LTCs
- Outpatients: Seeking Advice in the ICO
- Outpatients: MSK
- Other outpatient innovations
- Inpatients

No longer ICO 'projects' – the way we all need to work





The Chairman queried how the new pathways would be communicated to patients, and the Chief Operating Officer said that they had not been developed in isolation but with primary care and service users etc. Once a patient had seen a GP and an appropriate pathway had been identified, information on that pathway would be provided.

179/11/15 Proposal to Evaluate Benefits of Integrating Children's Services

The Chief Executive referred to previous Board briefing on the approach from Torbay Council asking the Trust to consider assimilating Children's Social Services into the ICO and the paper included in the agenda set out the background to this proposal. It was consistent with the logic that resulted in the Trust integrating adult health and social care, however due diligence would need to be undertaken before a decision was made in respect of children's services.

If taken on, it would also support the portfolio for the post of Director of Social Care, as this Trust, with Devon and Torbay Councils, had struggled to develop a portfolio for that post and make it attractive to high calibre candidates.

The Board agreed that due diligence process was needed and that the Trust should progress cautiously as it already had a lot of work to do to realise the care model etc.

Mr Furse queried how the Trust would determine which acquisition projects were appropriate to be taken on by the ICO and those that were not, to ensure any future opportunities were properly evaluated. It was noted that nothing was in place at present, but this needed to be considered.

Mrs Taylor asked if the review could also include Devon County Council Social Services and the Chief Executive explained that Devon wished to wait to see how the ICO progressed before formally asking the Trust to take on the Devon element of any of their provision of services.

The Board then formally approved the ICO undertaking a due diligence process around the benefits and risks of bringing Torbay Council's provision of Children's Social Care into Torbay and South Devon NHS Foundation Trust.

Workforce and Organisational Development

180/11/15 Report of the Interim Director of Human Resources

The Interim Director of Human Resources reported on the following:

- He felt that the acquisition process had been completed successfully, without any formal concerns being raised by staff.
- Performance in respect of staff appraisals and mandatory training had dropped, which was to be expected given the recent transaction, but performance did need to improve and the CQC would also expect the Trust to improve its performance.
- As an organisation, the Trust needed to look at alternative ways of filling hard to recruit posts. The Trust already had moved forward with the Assistant Practitioner role and also the Physician Assistant, but it was expected that in the future more new roles would be identified.
- The Trust's Sickness Policy had been reviewed and was found to be robust with good controls. Improvements could be made, however, in respect of adherence to the policy.
- The Master Vendor Medical Agency was in difficulty and at present was not fulfilling its contract.
- Nursing had been included in the national shortage occupation list.
- The success of the Trust's apprenticeships was highlighted, and as the one of the major employers in the area it was felt to be an important role for the Trust.
- The Trust's purpose had been agreed at the Board meeting last month and the Board was now informed that, following consultation by the ICO Champions Group, it was recommended that the NHS Constitution values, with no additions, continued to be adopted by the new organisation:

- Respect and Dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together for patients
- Everyone counts

- The consultation work had also identified a proposed vision for the new organisation:

  'A community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care, we have choice about how our needs are met; only having to tell our story once.'

- Following a consultation and voting process, the following strapline was proposed for the Trust:

  'Working with you, for you'

The Board formally approved the values, vision and strapline for the new organisation.

In respect of planning for the ICO and communications, the Chief Executive asked the ICO Champions if they felt there were things that could have been done better, or whether the process felt right. It was noted that the ICO Champions had found it very useful to be able to speak to staff and ally any concerns they might have in respect of the acquisition process and to also be able to raise concerns on their behalf.

The Chief Executive thanked the ICO Champions for their hard work and input over the last few months.

Engagement and Partnerships

181/11/15 Council of Governor Issues

The Chairman advised that a number Governors were coming to the end of the tenure and would be stepping down. These Governors were very active in their role and the Trust would need to ensure the CoG remained as active and vibrant as at present.

Performance

182/11/15 Monthly Finance and Performance Report

a) **Performance**

The following was noted:

Community

- The Safeguarding Team have had capacity issues due to staff vacancies which had impacted on their ability to hold strategy meetings within the required 7 days. Vacant posts have now been filled and it was hoped that improvements would be made.

- The MIU targets had been met with 100% compliance with the 4 hour wait.

- There had been delayed discharges in community hospitals and also an increase in lengths of stay. It appeared that causes include changes to domiciliary care packages and also capacity in the residential and nursing care sector.

- Timeliness of social care assessments was an issue, with deterioration due to vacancies. Changes in skill mix were taking place to address this issue and improve performance.

- Risk areas within CAMHS had been identified in respect of risks to children waiting for assessment and ongoing treatment packages. The delivery of the Transformation Programme for the service was critical to improve performance.

- There had been an increase in turnover in community social care, possibly due to the recent acquisition, and this needed to be stabilised moving forward.

Acute

- The Trust had faced challenges over the past year in respect of its performance against the Dementia targets. Improvements have been made, but reliance on a paper system has made it difficult. A new IT system had been installed and it was hoped this would make a real difference.

- The Trust's commissioners had highlighted 3 areas of concern including the A&E 4 hour wait for which a formal contract performance notice had been issued. An action plan had been submitted and there was strong cross-system support to implement change.

- The Trust was working with Alamac to help improve emergency performance and they had identified 3 key areas that could improve performance.

- In respect of Emergency performance, Mr Allen suggested that the Trust had a tendency to over-promise in terms of meeting the 95% target, and under-achieve and suggested that marginal gains should be sought and held before seeking the next improvement. The Chief Operating Officer acknowledged this but said that the 95% target was very important to staff, and also in terms of patient experience. She added that the work being undertaken by Alamac had identified small incremental changes which should make marginal and sustainable improvements to performance. The Chairman asked if there was a way to support staff and try to reduce the pressures they were under and the Chief Operating Officer said that work was being undertaking around the on call rota in this respect.

- The Chief Executive said that she was aware the new clinical leadership team in the department had a real enthusiasm to make the improvements to the service. She added that the Executive Directors were considering how implement 7 day working across the Trust and were using learning from Salford in this respect. It was hoped that the Executive Team could start to work across 7 days from mid-December.

- Stroke performance was still not at target and was disappointing given the team had made changes to processes. It was known that some of the issues occurred out of hours.

- The RTT incomplete pathway target had been achieved. There were still some areas of risk, namely Ophthalmology, Trauma and Orthopaedic issues and Cardiology.

- All cancer targets had been met.

- Diagnostic performance was above target, due to CT capacity and additional capacity was being put in place to reduce the backlog.

- A deep dive had been undertaken to understand the reasons for surgery cancelled due to lack of equipment, following a question from Mrs Carpenter at the last meeting. It was found that some surgery had been cancelled due to a flood in theatres affecting equipment. In this last month there had been 4 cancellations due to lack of equipment, 2 were due to equipment failure on the day, one was due to a new piece of equipment being used and another due to the right equipment being ordered, but the wrong equipment being delivered.

- Mr Welch queried the timeliness of social care and CAMHS assessments. He suggested both issues needed to be addressed quickly, so that performance did not deteriorate any further. The Chief Operating Officer said that the CAMHS issue was an issue for the whole system and that the Executive Directors had robustly discussed the service at their meeting earlier in the week. Significant improvements had been made but there was still work to be done. She said she would provide more detailed information on the service and performance at the next meeting. COO

b) Finance

Acute

- Performance was overall in line with plan. Income above plan was offsetting expenditure and non-recurrent CIP offsetting below plan recurrent CIP performance.

Care Trust

- The Care Trust's accounts were still in the process of being finalised and closed down. There was significant movement from month 5 and 6, which would be reported once finalised. These would not affect the consolation of the accounts, but there could be an ongoing issue for the ICO.

183/11/15 Report of the Director of Estates and Commercial Development

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

- The number of violent and aggressive incidents to staff had increased. Assurance was provided that staff were appropriately trained and supported. The incidents were mainly around patients with dementia and patients on Louisa Cary Ward.

- A recent national benchmarking exercise had been undertaken, the results of which were included in the report.

- Cost of cleaning and food had been highlighted and a new service model for facilities management services had been implemented across the community, effective from the 1st November. It would produce some savings, but also provide a sustainable service across the Trust's community hospitals.

- It was noted that he Trust had a maintenance backlog of £45m. This was an improving picture, but did reflect the lack of single rooms in the Trust, as well as equipment issues. A clear estates strategy and investment plan would be

provided to deliver the new model of care which would be risk assessed and prioritised. It would be brought to the Board in March 2016.

- Mr Brockwell asked that this work also included the medical equipment issues raised by the Medical Director earlier in the meeting, and also capital requirements and this was agreed. The Director of Finance added that some of the investment was included in the ICO LFTM. DECD/ DoF

Assurance

184/11/15 Governors' Question Time

- Mrs Harvey asked when the single point of contact system would be rolled out to Teignbridge and South Hams and the Chief Nurse explained that a timeline for this work had not yet been identified.

- Mrs French queried the role of the Partnership Trust in respect of the issues around children services assessments. She also asked that Governors were informed of any Governor Issues discussed in the private section of the Board and finally wished to place on record her thanks to Dr Lowes as the outgoing Medical Director and also Dr Dyer for his work and input to the pre-ICO Governor training sessions.

The Chairman wished to record his thanks and that of the Board to Dr Lowes for his support and guidance whilst Medical Director.

185/11/15 Date of Next Meeting

1.30 pm, Wednesday 2nd December 2015.

Exclusion of the Public

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

ACTION SHEET

BOARD OF DIRECTORS

PUBLIC

4th NOVEMBER 2015

No	Issue	Lead	Progress since last meeting	Matter Arising From
1	Issue of Care Planning Summary performance to be brought to Board	MD	**Quality improvement work taking place to simplify CPS**	7/10/15
2	Detailed performance information in respect of CAMHS to be provided at the next meeting.	COO		4/11/15
3	Capital, Estates, Equipment and Investment plan to be devised.	DCED/ DoF		4/11/15

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	02 December 2015
Title:	Director of Nursing, Professional Practice and Peoples Experience Portfolio Report: 01 Nursing and Midwifery Council (NMC)revalidation of nurses and midwives
Lead Director:	As above
Corporate Objective:	Safest Care
Purpose:	Assurance NMC revalidation

Summary of Key Issues for Trust Board

Strategic Context:
All nurses and midwives within the United Kingdom are required to be registered with the Nursing and Midwifery Council (NMC) in order to practice as a nurse within our country. From April 2016 new regulations will come into force that require every nurse to demonstrate on a three yearly cycle that they are compliant with a number of set parameters in order to achieve revalidation and continue to practice.

Key Issues/Risks
Nurses and midwives nearing the end of their career may choose to finish working as a registered nurse rather than revalidate which could impact on our nursing and midwifery workforce. A comprehensive support process has been developed to mitigate this risk.

Summary of ED Challenge/Discussion:
The Executive Team supports the purchase of an E-portfolio system that will enable staff to gather the required evidence and feedback into their portfolio. This system will also allow line managers and organisational oversight of progress and achievement of revalidation for registrants in our employment. A business case is in development to acquire a system.

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

N/a

Equality and Diversity Implications:

N/a

PUBLIC

Director of Nursing Report

1.0	**Revalidation Update**
1.1	All nurses and midwives within the United Kingdom are required to be registered with the Nursing and Midwifery Council in order to practice as a nurse within our country. In April 2015 the NMC published the revised 'Code: Professional standards of practice and behaviour for nurses and midwives'. The Code has four key sections: • Prioritise people • Practise effectively • Preserve safety • Promote professionalism and trust. The Code contains the professional standards that all registered nurses and midwives must uphold. The introduction of revalidation will give greater confidence to the public, employers and fellow professionals that registrants have clearly demonstrated that they practice safely and effectively throughout their careers. The overarching aims of revalidation are to: • Protect the public and increase public confidence in nurses and midwives • Use practice related feedback to improve the quality and care and service provision • Promote a culture of professionalism and accountability through on-going reflection on the code, and require those on the NMC register to demonstrate they are 'living' these standards. All nurses are currently required to renew their registration every three years and meet current post registration education and practice standards (PREP). The introduction of revalidation will strengthen the process that underpins registration with the NMC and under revalidation nurses and midwives will have to declare and demonstrate through a portfolio that they have met a number of key requirements. These requirements include: • **Practice hours** – to practice a minimum of 450 hours over the three year period. • **Continual professional development (CPD**)- undertake 40 hours of CPD relevant to the individuals scope of practice over three years prior to renewal of registration. 20 of the 40 hours must be participatory learning. • **Practice related feedback** –Over the three years prior to renewal of registration at least five pieces of practice –related feedback are required. Ideally these will come from a variety of sources. • **Reflection and discussion** – Over the three years prior to renewal of registration minimum of five pieces of written reflection on the Code. This includes completing a professional development discussion with another NMC registrant which will cover reflections on the code, continual professional development and practice related feedback. • **Health and character**- a health and character declaration must be completed and the registrant must declare if they have been convicted of any criminal offence or issued with a formal caution over the three years prior to renewal of their registration. • **Professional indemnity arrangement**- Every registrant must complete a declaration to declare that when practising they have indemnity appropriate to their role. For the organisation this is within our group indemnity cover. • **Confirmation from a third party**- The individual who provides the role of confirmer does not have to be a registrant with the NMC and this role will in our organisation be the responsibility of the line manager. Their role is to verify the declarations made in the application Systems currently exist to monitor registration and provide assurance that all nurses registered with NMC are checked by the workforce team. Managers and the employee are alerted if registration cannot be confirmed as being renewed and appropriate action taken. This gives assurance that all nurses employed in the organisation are registered with the NMC. However this is not linked to an appraisal or education function directly.

	There are 1426 nurses and midwives currently employed in the organisation and the numbers due to revalidate each year are 2016/17 = 434; 2017/18 = 485; 2018/19 = 507. The programme of work led by the revalidation group includes • Written correspondence with all registrants • Face to Face group sessions to support registrants meeting the NMC requirements for revalidation. • Ratification of an NMC Revalidation policy • Educational sessions for confirmers from January 2016. • Develop systems and processes to support internal bank staff to revalidate • Identification of the best electronic solution through the procurement process
2.0	**Safer Staffing**
2.1	A number of staff changes at Bovey Tracey Community Hospital have created challenges to maintaining Registered Nurse establishment throughout December. The Senior Nurse and Operations Team have met to develop a mitigation plan that supports Bovey Tracey Hospital. The position will be reviewed weekly to ensure issues are managed promptly but this remains a vulnerable service. The Quality Improvement Group (former WS1) reviewed the latest safer staffing dashboard and Quality Effectiveness and Safety Trigger Tool (QuESTT). The low compliance with ward level appraisal was noted and this has been discussed in the Senior Nurse Strategy Group and ADN meetings. Cheetham Hill ward are currently operating with below establishment levels of Registered Nurses. Skilled Not Registered staff are providing support to maintain safe staffing. Recent recruitment activity will increase the RN numbers and return the ward to established levels. It is anticipated that the recent overseas recruitment will result in a significant reduction in vacancies which should be reflected in the January safe staffing figures. Work is progressing to build on the detailed establishment review undertaken in 2014 to ensure establishments are appropriate to meet patient need using the recognised benchmarking tools.
3.0	**Engagement and Feedback Group (former WS2) notes of the meeting**
3.1	**Attached Appendix A**

Appendix A.

Patient Experience and Community Partnership Committee

Workstream 2

16th October 2015

WCDT Division

Members:	*Jane Viner	Director of Professional Practice, Nursing and experience (Chair)
	A Gary Hotine	HIS Director
	* Jennifer Mills	SDTCCG
	* Lesley Darke	Director if Estates and Commercial Development
	* Pat Harris	Healthwatch Torbay
	*Susan Martin	Associate Director of Innovation and Quality
	A Carol Pearson	Experience and Engagement Lead
	*Cathy Bessent	Deputy Director of Nursing (Engagement and Experience)
	R Katy Heard	Carers Lead
	A Emma McCluskey	Equality and Diversity Lead
	A Sally Taylor	Non-Executive Director
	Louise Waterton	Communication Team
	Cathy Gardner	Head of Operations
	A Paul Procter	Head of Performance

*Denotes present. A apologies sent. R apologies and represented

1. **In attendance**:
   Lindsey Jeffrey - Carers

2. **Apologies**
   Carol Pearson, Sally Taylor, Gary Hotine, Paul Procter, Emma McCluskey

3. **Notes of meeting held on 18st September 2015**
   Notes of the previous meeting were agreed

4. **Matters arising/outstanding/updates**

   Refer to action list for matters arising/ actions

   Actions
   1 x closed
   Surgical division actions have been relayed back to Division for next presentation.

5. **WCDT Division report including Patient Story**

   The Committee had received apologies from the WDDT division who were unable on this occasion to provide a representative to attend. The Committee read though the report provided and the following key points were noted.

- The story provided was the personal account from a young patient who had been an inpatient on Louisa Cary ward at a time when there had been several other patients receiving CAMHS input. The story outlines the impact on the young person's own wellbeing and was thought provoking. During the ensuing discussion the Committee heard that the Trust is working with the CCG to facilitate a more robust pathway for these service users. The Committee agreed how valuable it was to have received direct feedback from a young person using our services. Further update would be sought through the next presentation from the WCDT. **Action ADN WCDT**
- The division is undertaking an engagement and feedback process to shape the future hydrotherapy service for those service users who no longer qualify for NHS commissioned hydrotherapy.
- The physiotherapy service is introducing the Patient Knows Best service as an on online booking system. This is as a result of the feedback received around the difficulties in getting through to book an appointment on the phone.
- FFT – the division highlighted the areas which were achieving the desired response rates and actions taken to improve those. The Committee discussed the various engagement events across the community and HW noted they have planned future events locally in Torbay and the potential for various hospital services to link into these events. The Committee agreed this would be beneficial and would receive information through HW.
- Learning and actions from upheld complaints included the review of OT services in orthopaedic wards and the previously noted review of the hydrotherapy charges. An upheld PHSO case had resulted in a training programme delivered in house in relation to an uncommon condition.
- The division is collating the number of compliments received
- A child with a long term condition who had recently died in the ward is leading to an education update from the Bristol children's hospice.

The committee were appreciative of the report provided by the WCDT division and discussed the reporting format for the EFM division which would not exactly fit the template as it was set out. LD suggested that the clinical divisions identify the top 3 estates/environmental issues which could then be effectively triangulated with EFM division. This action was agreed **Action CP.** The EFM division would continue to provide a quarterly report.

6. Patient Services Quarterly report

The Committee noted the following:

- No significant differences with numbers this quarter, although the graph showing the overall numbers of complaints by quarter is showing a downward trend against an increasing number of discharges. The committee postulated if the 'Take a Quarter' training is the reason for this.
- There did not appear to be an increase in complaints as a result of increased activity. The Committee were reminded that the current data does not correlate the complaint to the episode of care. It was noted that this would be something to be taken forward as part of the procurement for the new Risk and Quality Management System and the implementation of the system for the ICO.
- There is a need to do more to ensure that actions following complaints are captured and followed up. This will be led through the Learning from Complaints group.

7. Risk Register

The Committee reviewed the risk register with the following requirements:

- Update the 'reviewed date' column for all risks
- Include a risk from lack of evidence of learning from complaints
- Consider including FFT and dementia

:

8. **ICO – How can we join the 2 Workstreams together? JV**

- The Committee discussed the current arrangements for the 2 legacy organisations which will merge as we move beyond Day 100. The corresponding community committee meets every 2 months. The Committee agreed that maintaining a monthly meeting in the first instance would be preferable.
  - Devise a monthly report which includes the report of both the acute site and the community service delivery unit. This will initially result in a different format due to the 2 different risk management systems in place.
  - There are already improvement projects underway across the legacy organisations eg Patient Leaders Network with identified projects assigned.

9. **Q2 CQUINs**
   - SM shared the Q2 report. The assessment shows green for 4 of the relevant CQUINs for this Committee.
   - The dementia CQUIN showing as red, requires further work to develop a consistent approach including ward clerking and clinical assessment processes. The work to date has resulted in considerable improvements in performance in the FIND aspect. The onward referral for a positive screen demonstrates compliance.

10. **Healthwatch update**
    - PH outlined the headlines from the rate and review paper. There were a number of adverse reports with regard to waits in A/E.
    - PH also reported on the feedback around domiciliary care providers. CP is aware of this work and the Committee will receive an update at the December meeting. **Action PH/CP**
    - Discharge issues – right information about benefits, care, medication, etc. this could be provided by the 24 hour follow up phone call signposting to appropriate area

11. **Items for information:**
    - **Real Time inpatient experience survey results**
      The group reviewed the results for September. There were no newly identified issues of concern
    - **Friends and Family Test**

12. **From the items on the agenda discussed today what assurance do we have against our CQC outcomes?**

The Patient Experience and Community Partnership Committee is responsible for the following Care Quality Commission Key Lines of Enquiry:

Is it effective?	
E2:	How are people's care and treatment outcomes monitored and how do they compare with other services?

Is it caring?	
C1:	Are people treated with kindness, dignity, respect & compassion? **F&F results support this.**

C2:	Are people who use services and those close to them involved as partners in their care?
C3	Do people who use services and those close to them receive the support they need to cope emotionally with their care treatment or condition? **Real time feedback survey**

Is it responsive?	
R1:	Are services planned to meet the needs of patients? **Discussions regarding Hydrotherapy and Patient Leaders Group.**
R2:	Do services take account of the needs of different people, including those in vulnerable circumstances? **Louisa Carey ward and the care of CAMHS patients**
R3:	Can people access care and treatment in a timely way? **Patient Knows Best solution to the physiotherapy appointment booking problem**
R4:	How are people's concerns and complaints listened and responded to and used to improve the quality of care? **Example in WCDT report and relevant changes to be made in the future.**

Is it well led?	
W1:	Is there a clear vision & credible strategy to deliver good quality? **Patient Leaders Network.**
W2:	Does the governance framework ensure that responsibilities are clear and the quality, performance and risks are understood and managed? **The Risk Register entries demonstrate assessment of risks.**
W4:	How are people who use the services, the public and staff, engaged and involved?
W5:	How are services continuously improved & sustainability ensured? **Experience reports delivered to clinical areas. QI projects**

13. AOB

In connection with a discussion regarding learning and making improvements following an incident or complaint, KJ noted the work previously undertaken through the education department and suggested further conversations with David Alderson. **Action CB**
PH – noted HW were aware of issues around mixed sex accommodation in radiology
SM – outlines a project capturing the impact of the integration change on staff and service users.

Date and time of next meeting 20th November 2015 - 9.30

New / Outstanding action list as of 18th September 2015.

Agenda reference	Person responsible for action	Action required	Date for co Completion
21-08-15. 4	Cathy Bessent Jane Viner	Strategy to be discussed at clinical Divisional Board meetings. Monitoring process for the strategy to be devised. Engagement strategy to be considered for future Trust Board seminar –company secretary to be informed.	Oct 2015
21-08-15. 6	Emma McCluskey Cathy Bessent	Amend E&D risk register to reflect the changes regarding Translation services and additional entry for Accessible Information requirements Amend WS2 register to reflect the changes to the CQUINs, and additional controls in relation to increased reporting required by Monitor.	Completed and Closed
21-08-15. 10	Sam Holden	Share TOR for CCG Engagement committee	Sept 2015
18-09-15 3	Surgical Division	Share action plan from colorectal cancer business meeting	Mar 15
18-09-15 3	Surgical Division	CCU-“ Getting to know you” model- share with the workstream	Mar 15
18-09-15	Surgical division	Include PROMS evaluation in the report for future.	Mar 15
18-09-15	Surgical division	Update on the ITU bereavement group	Mar 15
18-09-15 3	Carol Pearson	Review of EOL contacts for Cheetham Hill	Nov 15
18-09-15 3	Carol Pearson	Change reporting template Quality Account priorities	Nov 15
18-09-15 3	ADNs and Matrons	Review individual wards where FFT response rate is improving and share the learning with their divisions. Ask Forrest ward manager to present.	Nov 15
18-09-15 3	Karen Robertson	Update the workstream about availability of newspapers	Nov 15
18-09-15	AND surgery	Assure the workstream that the 6 week response rate for complaints is achievable	Mar 15
18-09-15	Cathy Bessent	In connection with a discussion regarding learning and making improvements following an incident or complaint, KJ noted the work previously undertaken through the education department and suggested further conversations with David Alderson.	Nov 15

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	2nd December 2015
Title:	Medical Director's Report
Lead Director:	Patient safety, quality and patient experience, Medical Workforce, R&D, Undergraduate and Postgraduate medical education.
Corporate Objective:	Safest Care.
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Junior doctors' Industrial Action.

It is expected that the planned Industrial action (IA) will go ahead after a 98% vote in favour with a high turnout. The dates of the IA are

- 1st December 08.00 to 2nd December 08.00 hrs – 'Christmas day level of cover'
- 8th December 08.00 to 17.00. – all-out strike
- 16th December 08.00 to 17.00 – all-out strike.

'Christmas day level of cover' means that we have the number of junior doctors that would be expected for Christmas day. Although the time of action on 1st – 2nd December is longer than 8th or 16th (including overnight), the impact in some areas is less, particularly in the emergency areas of the hospital.
We are predicting 0-25% of junior doctors being at work on the days of the strike (variable by day of strike).

A contingency plan has been agreed with SDTCCG and communicated to NHS England (23/11/15). It is attached as Appendix 1.
The following table summaries cancelled activity on the days of the strike. Note that outpatient cancellations are indicative as planning continues.

Day\Cancellation	Elective day case surgery	Outpatient appointments
1 December	50	200
8 December	66	200
16 December	60	200
TOTAL	**176**	**600**

Risk assessment and mitigations. The risks of the IA that have been defined are:

1. ***Risk to patient safety***. Senior medical staff will take up the roles that junior doctors usually perform in relation to inpatients and urgent outpatient activity. All senior medical staff have actively engaged with the planning process and cover is in place to ensure patient safety and continuity of essential hospital activity. In order to achieve this cover a substantial proportion of regular activity will need to

be cancelled (once each day of IA is confirmed). Operations and procedures to be cancelled are detailed in Appendix 1. In addition an estimated 600 outpatient appointments will be cancelled and rescheduled.

Priorities for staffing are inpatient wards, emergency operating and other procedures and the Emergency Department, particularly on 8th and 16th December when staffing levels in ED will be lower. Other staff groups are contributing to the response; nurses and AHPs will help to ensure safe care and timely discharge.

Plans have been agreed to ensure continuity of cross-organisational functions such as the Cardiac Arrest Team and Major Incident Plan.

We will declare an Internal Incident and operational control will be in line with the Major incident policy.

We are developing plans to ensure optimum patient flows during the period from 27 November to the last strike day. The response will be across all services within the ICO with support from community hospitals, Intermediate Care and Social Services and support from the CCG and the wider system to ensure that discharge planning and ongoing care contribute to the response.

2. ***Implications of cancellation of activity.*** Cancellation of operations and procedures, and outpatient activity will cause significant inconvenience and anxiety for patients. We have contacted patients as early as possible to reduce distress and apologising for the inconvenience. We will make a public statement explaining the actions of the Trust.

The postponement of clinical activity will put pressure on the Trust's RTT performance. Wherever possible adjustments have been made to operating lists to ensure that procedures continue on the strike days for those at greatest clinical need (including patients with known cancer). Patients who are cancelled will be re-booked as soon as possible, and additional activity will be arranged to recover the position if an adverse effect on RTT performance is predicted.

3. Relationships with Junior Doctors. The Trust is dependent upon an excellent junior doctor workforce who in turn have rated us highly as a training organisation. We have met with the junior doctors' to discuss the IA to express our support for them and to ensure that they understand their responsibilities. As a body they have acted responsibility and constructively in ensuring patient safety.

4. Risk to staff who are working. Our plans to ensure patient safety include consideration of the risk that staff who are working may be in a position where they are at risk. Additional support from nursing and AHP colleagues and additional training and support from IT have been arranged.

5. Concern in the public around safety in the hospital during the strike. There is a possibility that the public alter their behaviour because of concern of safety in our hospitals. We will issue public statements to allay fears.

Coordination of incident response.
An internal incident will be declared and the response will be coordinated on the days of the IA from the Trust control room in conjunction with our partners in the CCG and neighbouring Trusts. Executive support will be provided to clinical teams throughout.
A whole system approach will be needed to ensure safe and timely care. This will include community health and care services. No direct impact of the IA is expected in community services and community hospitals.

Summary of ED Challenge/Discussion:

The Industrial Action will cause significant disruption of usual Trust activity and will cause additional financial pressure on the organisation (full impact to be defined and reported later). The priority is to provide safe and timely care for our patients and we believe our plans will achieve those aims.

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

As above
Equality and Diversity Implications: None expected.

PUBLIC

Unify2 Upload Template
Junior doctors strike - assurance template

Organisation:	RA9	SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST
Period:	23rd November 2015	

Site Name	Site Code	Upload Organisation Data (A tick denotes the sheet is to be uploaded)
Other	RA9XX	✔
Torbay Hospital	RA901	✔

"Child" Organisation RA901 Torbay Hospital

Period 23rd November 2015

Sheet To be Uploaded? Yes

Junior doctors strike - assurance template

Note - you do not need to complete greyed out cells

Return to Control Panel Sheet

0		Please confirm whether you are expecting a significant impact from the industrial action involving junior doctors.		Yes
		If no, please specify?		
		Are you taking mitigating actions to manage/minimise the expected impacts?		Yes
		Are you assured you can run an 'Emergency Care – Christmas Day Model' of service for the period of the industrial action?		Yes
1				
		Which services are you planning to maintain (select one)?		b) Limited elective and emergency care model
		If b, please specify which services you are planning to maintain.		different arrangements for 1 Dec and 8th and 16th December). D
		Of the services you planned to maintain, have any of these changed as a result of the industrial action?		
		If yes, please specify.		
2		Please confirm you have taken each of the following actions to protect the urgent and emergency care pathway:		
		A Creation of bed capacity prior to industrial action taking place		Yes
		B Ensuring no ambulance handover delays		Yes
		C Ensuring flow from emergency department into the rest of the hospital		Yes
		D Any other actions.		Yes
		If D, please specify.		onal IT, training and non-medical support
3		Provide the number of elective procedures that you expect to cancel as a result of industrial action for a) inpatient and b) day case (See table to right)		
		Please confirm whether you will still be able to undertake emergency/lifesaving surgery during the industrial action		Yes
		Is your site a designated major trauma centre?		No
		If yes, please confirm that you have appropriate arrangements in place to maintain a full service during the period of industrial action		
4		What proportion of junior doctors are you expecting to arrive for duty on the day of industrial action, include those scheduled to provide emergency care, as per local plans (select one)?		a) 0-25%
		What proportion of rostered staff actually turned up for duty?		
		Please confirm that your trust human resources department is engaging with local members of the BMA/LNC and requesting information on the number of junior doctors likely to strike		Yes
		Have exemptions been agreed locally?		No
		If yes, please specify.		
		Please confirm that you have agreed local arrangements for the immediate return to work of all appropriate staff in the event a major incident is declared		Yes
5		Please confirm that you have engaged with the consultant body and they will cover shifts that are likely to be affected by the industrial action		Yes
6		Please confirm that actions have been taken in partnership with CCGs and other partner organisations to maximise community support to acute trusts, including the purchase of additional capacity, to help the trust enter the period of industrial action with a positive bed balance		Yes
7		Please confirm that arrangements will be in place for executive oversight, command and control and escalation during the period of industrial action		Yes
		Are you intending to establish an Incident Coordination Centre to support oversight?		Yes
		Please confirm that you have an up to date Incident Response Plan (major incident plan), which includes the ability to call in staff, in line with the NHS England Emergency Preparedness, Resilience and Response Framework and that this plan has been shared with appropriate partner organisations and you have agreed with them arrangements for a multi-agency response		Yes
8		Please confirm you have a plan for the recovery to business as usual following the period of industrial action		Yes
9		Please confirm that you have in place appropriate arrangements for informing patients, carers, relatives and staff regarding the impacts of industrial action		Yes
10		Please confirm that you have in place appropriate arrangements for handling media enquiries		Yes
11		Please provide details of the accountable emergency officer responsible for industrial action who has authorised this submission	Name	LESLEY DARKE
			Role	DIRECTOR OF ESTATES
			Email	lesley.darke@nhs.net
			Telephone	7789744855
12		Please provide details of the Medical Director who supports this submission	Name	DR ROB DYER
			Role	MEDICAL DIRECTOR
			Email	robert.dyer@nhs.net
			Telephone	07718 990073
13		Please provide details of the CCG representative engaged in planning for industrial action	Name	VANESSA DUNN
			Role	TY DIRECTOR OF CORPORATE SERVICES
			Email	vanessa.dunn@nhs.net
			Telephone	07825 027556
14		During this period of industrial action have there been any adverse events reported?		
		If yes, please specify.		

Question 3a

	Inpatient	Daycase
23/11/2015		
24/11/2015		
25/11/2015		
26/11/2015		
27/11/2015		
28/11/2015		
29/11/2015		
30/11/2015		
01/12/2015	14	36
02/12/2015		
03/12/2015		
04/12/2015		
05/12/2015		
06/12/2015		
07/12/2015		
08/12/2015	23	43
09/12/2015		
10/12/2015		
11/12/2015		
12/12/2015		
13/12/2015		
14/12/2015		
15/12/2015		
16/12/2015	16	44
17/12/2015		
18/12/2015		
19/12/2015		
20/12/2015		

Organisation	RA9	SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST
"Child" Organisation	RA9XX	Other
Period	23rd November 2015	
Sheet To be Uploaded?	Yes	

Junior doctors strike - assurance template

Note - you do not need to complete greyed out cells

Return to Control Panel Sheet

0		Please confirm whether you are expecting a significant impact from the industrial action involving junior doctors.	
		If no, please specify?	
		Are you taking mitigating actions to manage/minimise the expected impacts?	
		Are you assured you can run an 'Emergency Care – Christmas Day Model' of service for the period of the industrial action?	
1			
		Which services are you planning to maintain (select one)?	
		If b, please specify which services you are planning to maintain.	
		Of the services you planned to maintain, have any of these changed as a result of the industrial action?	
		If yes, please specify.	
2		Please confirm you have taken each of the following actions to protect the urgent and emergency care pathway:	
		A Creation of bed capacity prior to industrial action taking place	
		B Ensuring no ambulance handover delays	
		C Ensuring flow from emergency department into the rest of the hospital	
		D Any other actions.	
		If D, please specify.	
3		Provide the number of elective procedures that you expect to cancel as a result of industrial action for a) inpatient and b) day case (See table to right)	
		Please confirm whether you will still be able to undertake emergency/lifesaving surgery during the industrial action	
		Is your site a designated major trauma centre?	
		If yes, please confirm that you have appropriate arrangements in place to maintain a full service during the period of industrial action	
4		What proportion of junior doctors are you expecting to arrive for duty on the day of industrial action, include those scheduled to provide emergency care, as per local plans (select one)?	
		What proportion of rostered staff actually turned up for duty?	
		Please confirm that your trust human resources department is engaging with local members of the BMA/LNC and requesting information on the number of junior doctors likely to strike	
		Have exemptions been agreed locally?	
		If yes, please specify.	
		Please confirm that you have agreed local arrangements for the immediate return to work of all appropriate staff in the event a major incident is declared	
5		Please confirm that you have engaged with the consultant body and they will cover shifts that are likely to be affected by the industrial action	
6		Please confirm that actions have been taken in partnership with CCGs and other partner organisations to maximise community support to acute trusts, including the purchase of additional capacity, to help the trust enter the period of industrial action with a positive bed balance	
7		Please confirm that arrangements will be in place for executive oversight, command and control and escalation during the period of industrial action	
		Are you intending to establish an Incident Coordination Centre to support oversight?	
		Please confirm that you have an up to date Incident Response Plan (major incident plan), which includes the ability to call in staff, in line with the NHS England Emergency Preparedness, Resilience and Response Framework and that this plan has been shared with appropriate partner organisations and you have agreed with them arrangements for a multi-agency response	
8		Please confirm you have a plan for the recovery to business as usual following the period of industrial action	
9		Please confirm that you have in place appropriate arrangements for informing patients, carers, relatives and staff regarding the impacts of industrial action	
10		Please confirm that you have in place appropriate arrangements for handling media enquiries	
11	Please provide details of the accountable emergency officer responsible for industrial action who has authorised this submission	**Name**	
		Role	
		Email	
		Telephone	
12	Please provide details of the Medical Director who supports this submission	**Name**	
		Role	
		Email	
		Telephone	
13	Please provide details of the CCG representative engaged in planning for industrial action	**Name**	
		Role	
		Email	
		Telephone	
14		During this period of industrial action have there been any adverse events reported?	
		If yes, please specify.	

Question 3a

	Inpatient	Daycase
23/11/2015		
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19/12/2015		
20/12/2015		

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	December 3rd 2015
Title:	R&D Key Performance Indicators (KPI) report
Lead Director:	Dr Rob Dyer, Medical Director (R&D Executive Lead)
Corporate Objective:	Research & Development (R&D) contributes to the Trusts quality, safety, patient experience, improvement and financial objectives / agendas. This report provides an overview of the Trusts performance and delivery against Government metrics (KPIs) for R&D in the NHS; as part of the National Institute for Health Research (NIHR) / DH Research Strategy and agendas. Details pertain to mid-year status for the current financial year (2015-16) and year end 2014/15.
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

The increased relevance and importance of research means the Government is increasingly keen to monitor; report on and assess our performance. Each NHS organisation has a responsibility to deliver the Governments vision and strategic ambitions. This report forms part of our accountability framework within the current 5 year NIHR NHS R&D contract and supports the following primary contractual obligations:

- DH R&D strategy and Policy
- The NHS Constitution
- The Health & Social Care Act 2012
- The plan for Growth
- Prime Minister Dementia Challenge
- National Institute for Health Research (NIHR) Clinical Research Network (CRN) contract
- Quintiles Prime site contract
- CQC domains and metrics (quality, safety, effectiveness, improvement, well led)

Key Issues/Risks

- Most specialities are research active where possible - which is to be commended.
- The Trusts performance at midyear has started to slip regarding recruitment and number of studies etc, attributed primarily to unprecedented workforce issues within R&D. Work is on-going regarding a restructuring of the R&D workforce & service redesign in response to help improve resilience and business continuity.
- The Trust core NIHR R&D funding has been cut with further cuts expected
- Income generation has dropped slightly mid-year due to lower activity, recruitment and delivery but still higher than pre-2014 levels.
- The Trust has seen improvements to most other metrics (recruiting to time and target, first Patient first visit, approval times, 70 days metric).
- To remain research active we need to remain competitive and therefore need to improve sustainability and consistency of our performance and delivery metrics; as this links to

selection and award of studies (new and repeat business); income generation (potential and actual).

- The increasing operational and financial pressures and demands placed on staff, facilities and services to provide routine everyday clinical services; is leading to an increasing lack of capability and capacity to support R&D activity.
- Fundamentally research is still seen as an 'add on' to the day job, done by a few as time, interest and other pressures allow.
- How research can support and underpin the quality and improvement agendas is not well appreciated by many still across the organisation. More work is needed to demonstrate the added value and benefit as well as impacts and outcomes.
- There is a risk that the economic climate could stem further development. "*When you are squeezed, one thing you can drop back on is research – and that would be a great mistake*." (Prof Jeremy Farrar, Director of the Wellcome Trust, April 2014).

Recommendations:

Continued support for R&D in the Trust – to help ensure R&D is maintained despite the increasingly pressurised service, workforce and economic pressures.

We need to focus our efforts on maximising the benefits from a fully integrated clinical research strategy and improving our ability to compete and perform well. The Board is recommended to:

- Endorse participating in clinical research is in our local interests as an ICO and we have a duty to contribute.
- Research is seen as core business and priority given to improve engagement and embedding of research at all levels.
- Research is integrated more both operationally & strategically at all levels supporting a more systematic, long term development of R&D across the new ICO.
- Endorse development and implementation of a new fully integrated clinical research strategy, for which every staff member is responsible for making a Trust-wide contribution to the research effort.

Summary of ED Challenge/Discussion:

N/A

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

KPIs are one range of measures regarding the Trusts support to help improve the opportunities and engagement of staff, carers, patients and the public in the NHS research agenda. To help improve culture, awareness and understanding as well as participation opportunities and help evaluate and contribute to the evidence base as well as use the latest evidence, treatment and technologies, to provide the highest quality care now and investing in tomorrow's care to help the future and to understand how to focus NHS resources where they will be most effective.

Equality and Diversity Implications:

None – covers all aspects and domains

Torbay and South Devon NHS
NHS Foundation Trust

Board of Directors

Research & Development Report by
Dr Fiona Roberts, R&D Director, November 2015

Purpose:
This report provides a summary regarding the organisation's performance and delivery against national Government metrics (KPIs) for R&D in the NHS. The report provides the mid-year status as well as year-end 2014/15 status for comparison. NHS R&D is contracted separately and sits outside of standard NHS / Trust mainstream dashboard reporting mechanisms; hence separate reporting to the Board. This report is part of our accountability framework within the current 5 year NIHR NHS R&D contract and supports the following primary contractual obligations:

- DH R&D strategy and Policy
  - The NHS Constitution
  - The Health & Social Care Act 2012
  - The plan for Growth
  - Prime Minister Dementia Challenge
- National Institute for Health Research (NIHR) Clinical Research Network (CRN) contract
- Quintiles Prime site contract
- CQC domains and metrics (quality, safety, effectiveness, improvement, well led)

Research & Development - strategic intent:
The Government wants to make health research easier and faster so that research findings can benefit patients more quickly and we can make this country a competitive location for life science industry research.

It is recognised that Healthcare organisations with vibrant programmes of research provide higher quality clinical care and have better outcomes through:

- Improved patient experiences
- Improved safety and quality assurance programmes and practices
- Improved efficiencies (less variations)
- recruit, motivate and retain the best staff
- Early adopters and better access to and use of the latest evidence

Delivering high quality care is critical to the future sustainability of the organisation and essential to keeping costs down and to help achieve the Trusts values and vision: *To ensure we provide high quality, safe health and social care at the right time, in the right place to support the people of Torbay and South Devon to live their lives to the full.*

Government KPIs / National Deliverables: Current NIHR NHS R&D 5 year contract April 2014 – March 2019: the NHS is expected to:

1. Increase access to research / clinical trials to patients and staff.
2. Increase the number of patients offered entry to a research study / clinical trial.
3. Increase the number of patients recruited into a research study / clinical trial.
4. Improve set up and feasibility making research faster and easier.
5. Improved delivery of research to time and to target.
6. Increase the level of life science (commercial) research activity.
7. Promote and Improve engagement in research with staff and patients.
8. Change the ethos and culture to embed research as core business fully integrated into everyday care.
9. Increase the level of Dementia research.
10. Improve and share the clinical and economic benefits through research.

Below – please find summary details and statistics relating to each of these areas:

RAG rating Key to NIHR metrics throughout the report

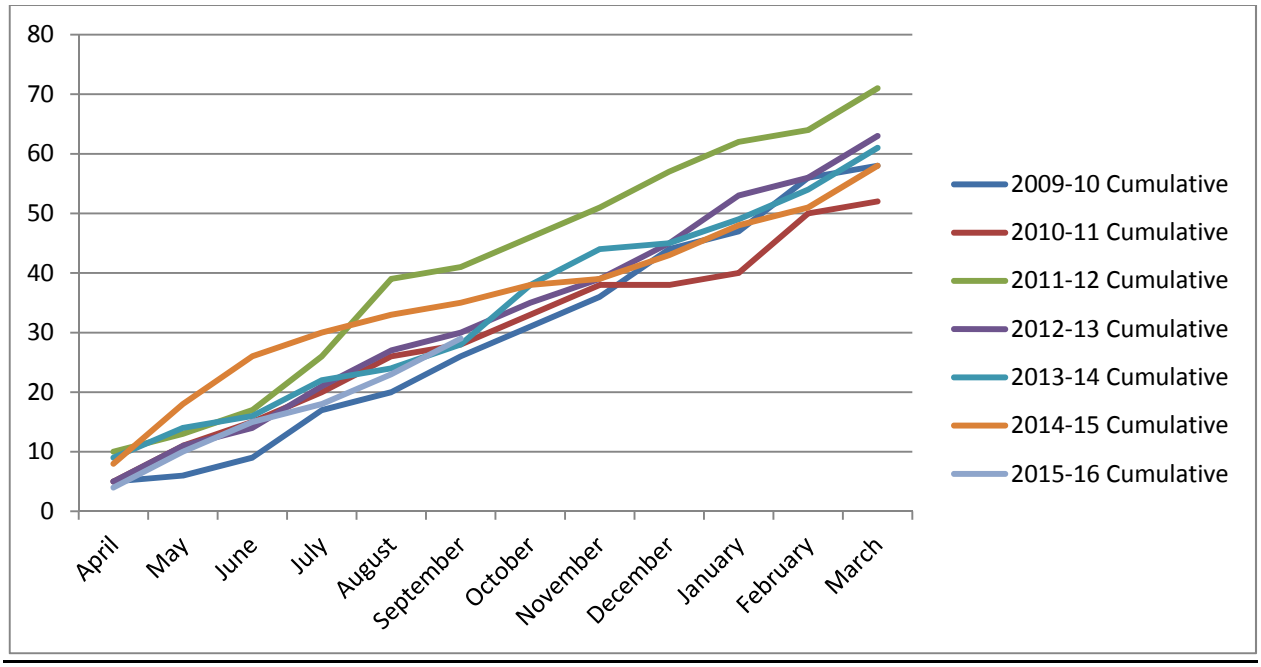
Assessment Criteria - Key	>80%	60-80%	<60%

1. Increase access to research / clinical trials to patients and staff

Potential Studies - Expressions of Interest / new business opportunities: Improved both numbers received and numbers returned with a positive response

	2014/15		2015/16 (Q2)	
	Number received	positive response rates	Number received	positive response rates
Commercial	275	14%	144	27%
Non-commercial	98	47%	50	46%
Total	373		194	

New studies approved: Q2 status - 30 new studies approve; down 17% compared to previous year but on a par with other years – see below



2. Increase the number of patients offered entry to a research study / clinical trial

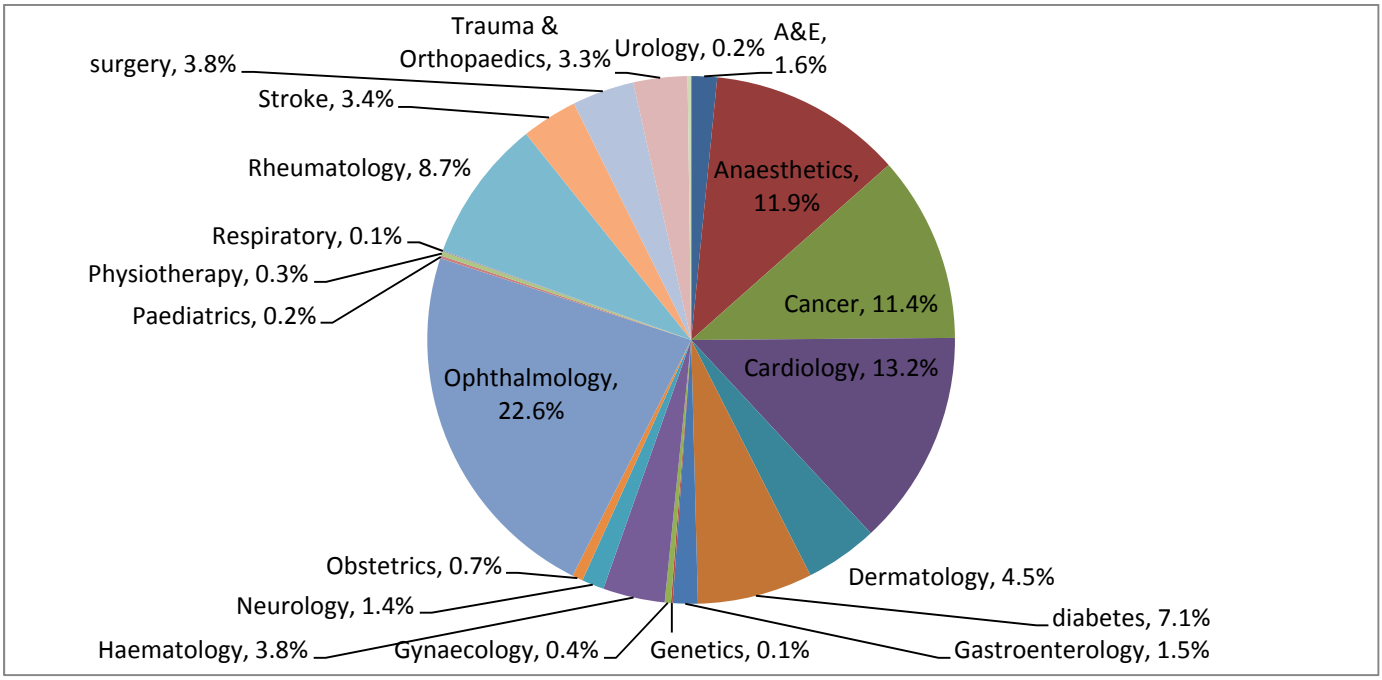
	2014/15	2015/16 (Q2)
Number of participants approached	2093 (1049 at Q2)	840

3. Increase the number of patients recruited into a research study / clinical trial.

Trust NIHR Recruitment

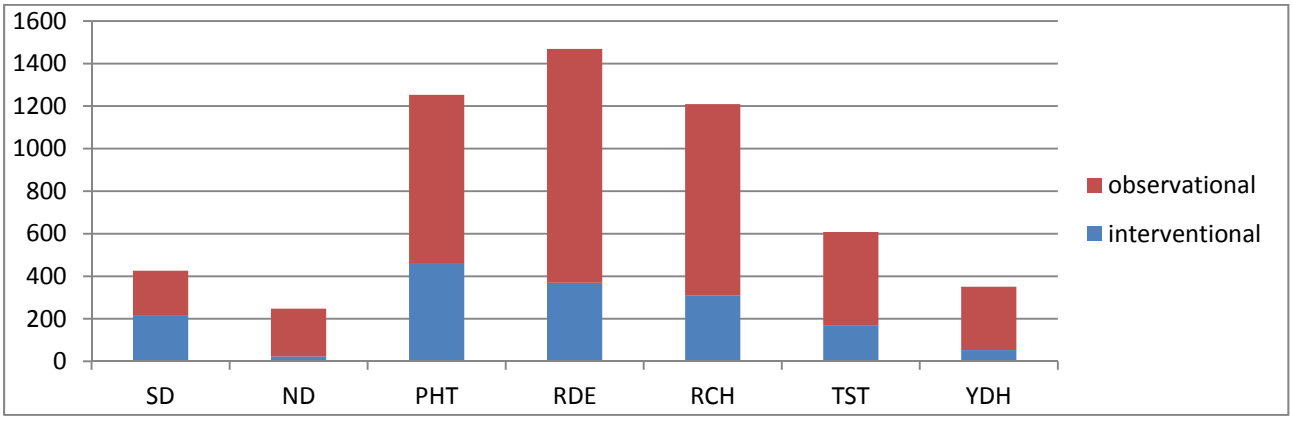
NIHR Objective		2014-15	2015-16 Q2
Proportion (NIHR) of agreed recruitment goal being met (14/15 Target = 1200; 15/16 Target = 1296)		**143% (n=1710)**	**78% (n= 507)**

Recruitment per speciality for 2014/15: The graph below shows recruitment per speciality for 2014/15 showing the diversity across the divisions.



Current status: 2015/16 (Q2): NIHR Recruitment (Raw) – comparison with regional acute NHS organisations

N.B. data from national database, provided by network. Data is not as complete as Trust system due to upload time lag (hence difference in total numbers for SD)



Guardian NIHR League Tables: Extract showing the Trusts performance based on absolute numbers (not adjusted for population); classified per size of organisation for comparison purposes; published on the public website to help showcase and benchmark activity in England.

	NIHR recruiting studies		**NIHR recruitment**	
	Number	Position in class	Total recruited	Position in class
2011/12	94	4/47	1248	14/47
2012/13	97	4/47	1317	10/47
2013/14	96	7/47	1226	11/47
2014/15	95	8/47	1710	14/47

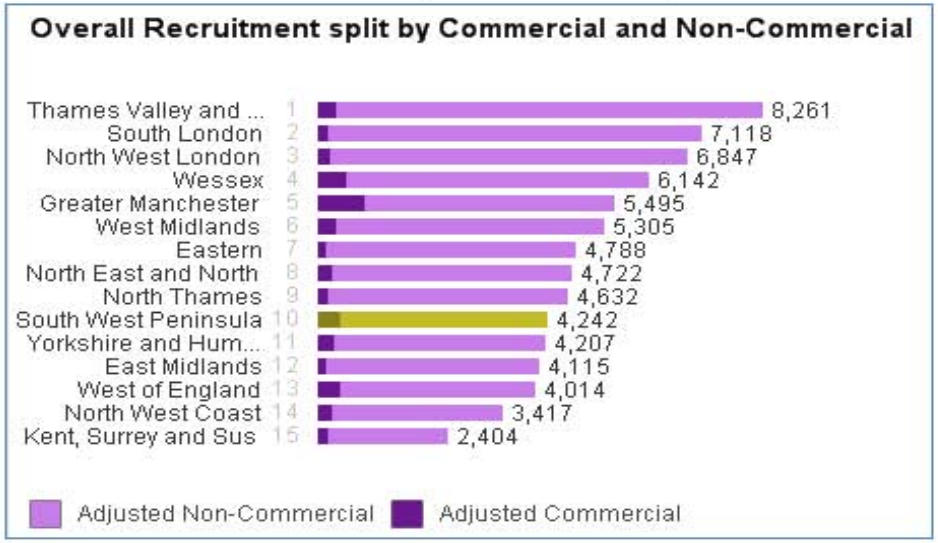
Class = medium sized acute Trust

National NIHR performance: Comparison and benchmarking of the 15 NIHR Clinical Research Networks (CRNs) in England:

National Perspective

Raw Recruitment

Recruitment adjusted to Population



Data from Portfolio ODP – Cut off 02/10/15

4. Improve set up and feasibility making research faster and easier

NIHR Objective	2014-15	2015-16 Q2
% of study-wide governance review completed within 30 calendar days	N/A (no studies)	N/A (no studies)
% of local governance review completed within 30 calendar days	85%	86%
Mean Days taken - local processes completed and NHS permission in 15 calendar days	19 days	13 days
% of local governance review completed within 15 calendar days	65%	76%

5. Improve delivery of research to time and to target

Objective		2014-15	2015-16 Q2
Proportion of NIHR CLOSED studies recruiting to time and target	Commercial	30% (3/10)	40% (4/10)
	Non commercial	35% (11/31)	56% (5/9)
	Total	32% (13/41)	47% (9/19)
Proportion of all NIHR OPEN studies recruiting to time and target	Commercial	46% (12/26)	44% (4/9)
	Non commercial	68% (98/145)	45% (40/89)
	Total	64% (110/171)	45% (44/98)
Proportion of NIHR studies achieving NHS permission to First Patient First Visit (FPFV) within 30 days of approval *(studies recruiting >11 per annum only)*	Commercial	0% (0/3)	0% (0/1)
	Non commercial	61% (8/13)	80% (4/5)
	Total	50% (8/16)	66% (4/6)
Proportion of NIHR interventional studies recruiting their first patient within 70 days of Valid Research Application		29% (7/24)	42% (8/19)

2015/16 (Q2): Benchmarking with other Acute Trusts within the NIHR South West Peninsula Clinical Research Network.

Partner Organisation: NIHR Time to Target (closed studies)	Commercial	Non Commercial	Total
North Devon Healthcare NHS Trust	0% (0/1)	25% (1/4)	20% (1/5)
Plymouth Hospitals NHS Trust	10% (1/10)	42 (5/12)	27% (6/22)
Royal Cornwall Hospitals NHS Trust	63% (5/8)	22% (2/9)	41% (7/17)
Royal Devon & Exeter NHS Foundation Trust	54% (6/11)	80% (8/10)	67% (14/21)
Torbay and South Devon NHS Foundation Trust	40% (4/10)	56% (5/9)	47% (9/19)
Taunton and Somerset NHS Foundation Trust	50% (3/5)	17% (1/6)	36% (4/11)
Yeovil District Hospital NHS Foundation Trust	100% (1/1)	33% (2/6)	43% (3/7)
Cornwall Partnership NHS Foundation Trust	0% (0/1)	100% (1/1)	50% (1/2)
NIHR Clinical Research Network: South West Peninsula (for all organisations, acute, partnership, CCG etc)	**42% (20/47)**	**44% (25/57)**	**43% (45/104)**

Partner Organisation: NIHR First Patient First Visit	Commercial	Non Commercial	Total
North Devon Healthcare NHS Trust	-	75% (3/4)	75% (3/4
Plymouth Hospitals NHS Trust	0% (0/1)	50% (4/8)	44% (4/9)
Royal Cornwall Hospitals NHS Trust	-	37% (3/8)	37% (3/8)
Royal Devon & Exeter NHS Foundation Trust	100% (1/1)	50% (2/4)	60% (3/5)
Torbay and South Devon NHS Foundation Trust	0% (0/1)	80% (4/5)	67% (4/6)
Taunton and Somerset NHS Foundation Trust	-	50% (1/2)	50% (1/2)
Yeovil District Hospital NHS Foundation Trust	-	0% (0/1)	0% (0/1)
NIHR Clinical Research Network: South West Peninsula (for all organisations, acute, partnership, CCG etc)	**33% (1/3)**	**57% (20/35)**	**55% (21/38)**

DH metrics: The Government wishes to see a dramatic and sustained improvement in the performance in providers of NHS services regarding initiating and delivering clinical research; with the aim to increase the number of patients who have the opportunity to participate in research and to enhance the nation's attractiveness as a host for research.

Effective from 2014/15 all NHS providers must report quarterly to the NIHR Central Commissioning Facility and publish on their own public websites performance against the metrics. NIHR funding to providers of NHS services is conditional on meeting benchmarks. This is seen as an incentive and indicator (benchmark) on the local level for efficiency in initiation and delivery of research and to drive improvements locally to achieve the required operational changes. The metrics are:

- The % of closed commercial studies that met the agreed recruitment target (i.e. recruited to time and target).
- The 70 day benchmark (the interval from receipt of a valid research application to recruitment of the first patient to a trial).

Below are benchmarking graphs taken from the latest DH report for 2015/16 (reports are issued quarterly in arrears). Trusts are placed in leagues dependent on the level of activity and then within each league reported as per below:

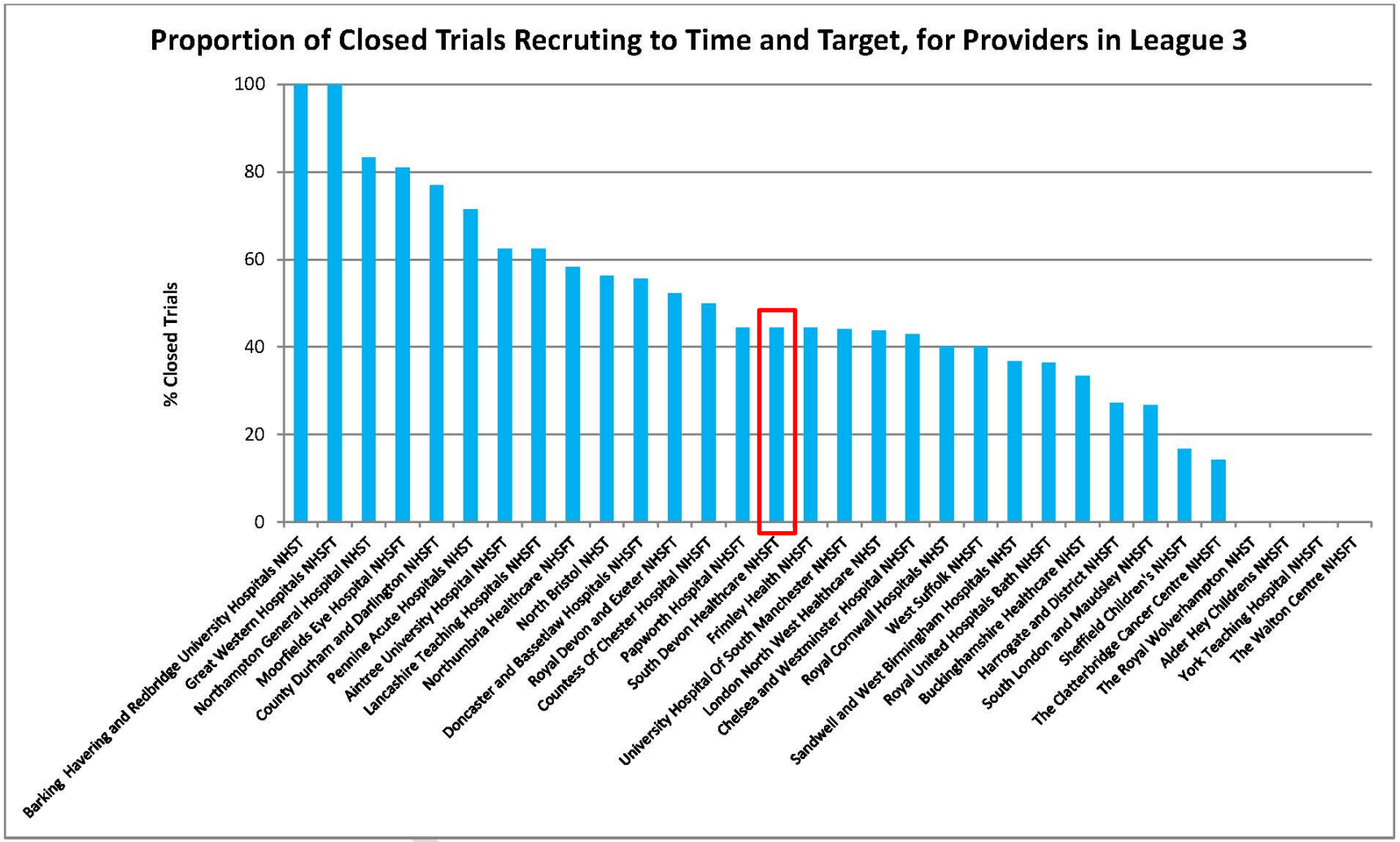


Figure 11 League 3: Proportion of trials recruiting patients to time and target (per provider, % of closed trials NB: Providers where the % of trials recruiting to time and target is N/A were not included in this figure.)

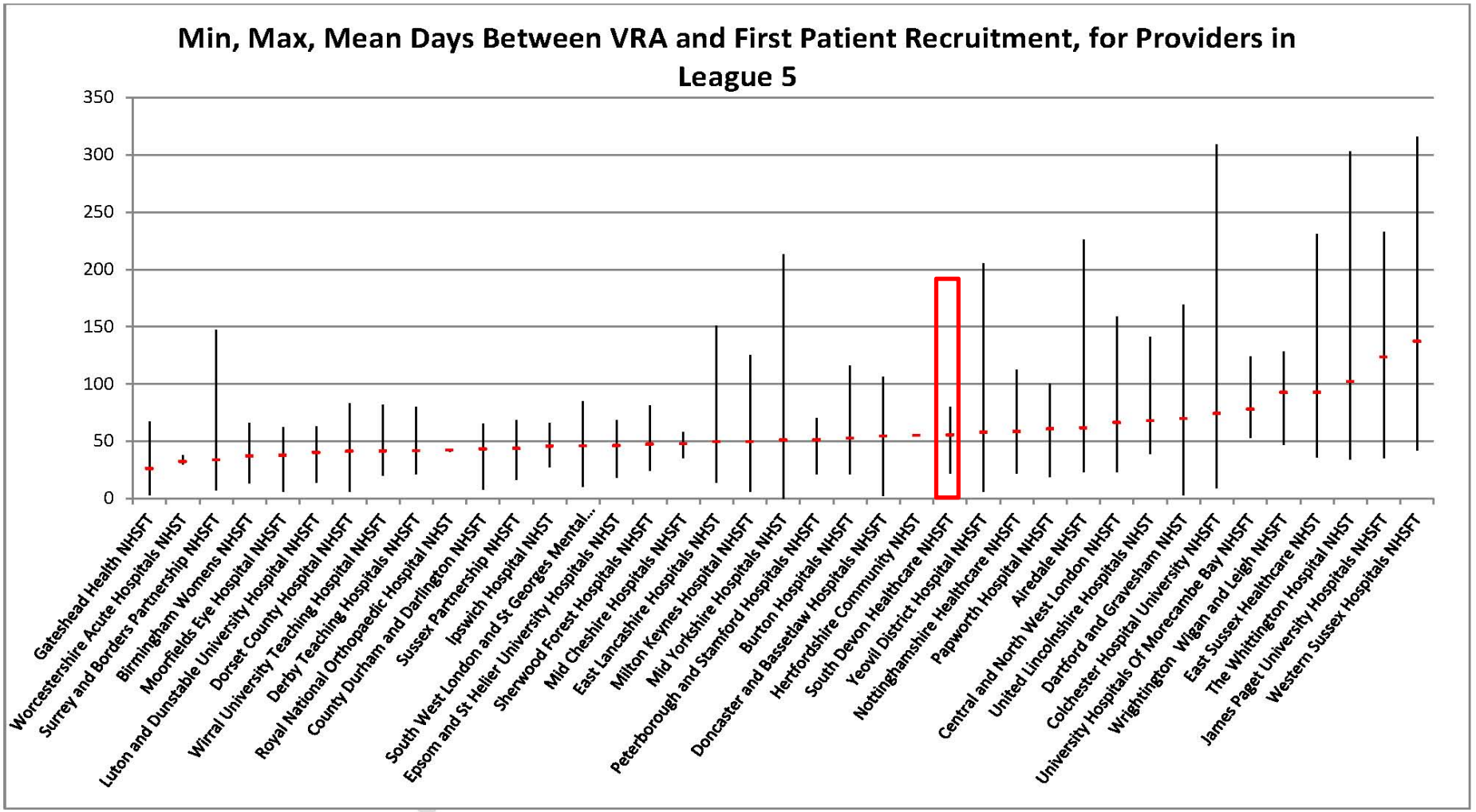


***Figure 5*: League 5: Minimum, mean and maximum number of days between receipt of Valid Research Application and recruitment of first patient, per provider – Adjusted analysis (NB: Providers with no trials recruiting a first patient have not been included in this figure.)**

7. Promote and Improve engagement in research with staff and patients

In line with NIHR strategy focusing on '*Research and Clinical Trials should be seen as an everyday part of the work carried out by the NHS'*; R&D has made concerted efforts to raise the awareness and the profile of research amongst our staff, public and our patients through a series of events:

International Clinical Trials Day (May 20th): Locally activities included:

- A display in Paignton Town Centre, staffed by the R&D teams, on the preceding Saturday: a precursor event held for the first time to raise awareness of the day.
- See examples of clinical trials and what is involved. All the research teams displayed research activity from their specialities, held throughout the ground floor of the Horizon Centre; opened to both staff & public.
- Talks from patients on their experience of research (this was very well received)
- Meet the Torbay Hospital research teams
- A 'Name the Bear' Competition
- Invitation to participate in the 'mock' Chocolate Trial
- New R&D logo stickers - using the winning logo from the children's R&D competition held the previous year.
- An invite to join us for 'Afternoon Tea'

Summary of other events throughout the year included:

- Patient Experience Questionnaire Survey (November 2014); organised by the NIHR's South West Peninsula Clinical Research Network. All clinical trial patients attending NHS organisations in the region were given a questionnaire to complete. A summary of the Trusts results are listed below:
  - High response rate of 75% (128/170)
  - Approximately 90% of patients said that they '*would be happy to take part in another research study'*, that they '*felt valued as a participant in a trial'* & that '*Research should be a normal part of healthcare'* (N.B these figures correlate with the 2014 NIHR national survey)
  - More than 70% said that they *'learnt more about their condition by taking part in the study'*
  - Patients were asked whether there was *'anything about taking part that they particularly liked?*' – we received many comments regarding:
    - '*friendly helpful & welcoming staff'*
    - *'better understanding of my condition'*
    - *'feeling valued & being able to help'*
  - The main issue raised and less favourable feedback centred around difficulties and lack of car parking on site.
  - The 2015 survey is currently in progress throughout November on site and in all SWP:CRN organisations.
- Displays and 'meet and greet' sessions held as part of the Horizon Institute Open day (June 2015) & the Members day (September 2014 & 2015)
- Various posters & banners placed in prominent positions around the hospital.
- R&D has created a new PPI group – linking up with a new CRN regional PPI lead and working party
- Monthly research presentation slots on all Trust Inductions
- Research presentation slot on annual Junior Doctors Induction
- The SWP:CRN has commissioned the Trusts Hiblio team to produce a TV broadcast / film an interview about research and clinical trials with an emphasis on the "Join Dementia Research" initiative.
- The Gallery display; along the main corridor during February, aiming to raise the profile and introduce the R&D staff / teams.
- We have started to develop research team Newsletters.
- Mystery Shopper exercise (Feb/March 2015): Organised by the NIHR's South West Peninsula Clinical Research Network. Patient volunteers were asked to visit the NHS Trusts in the region, unannounced and 'secretly' to complete a survey.

8. Change the ethos and culture to embed research as core business fully integrated into everyday care

Work is on-going. All aspects of this report align to supporting directly and indirectly efforts in this domain. Further details provided in the R&D annual report to the Patient Safety Committee.

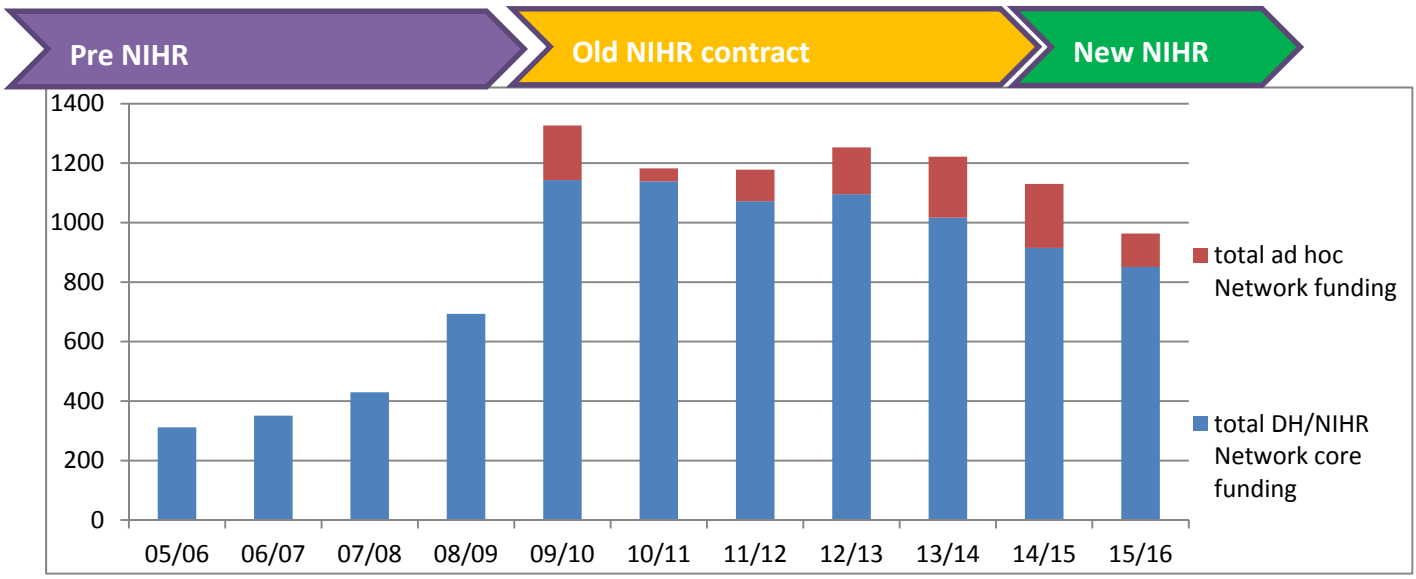
9. Increase the level of Dementia research

- To date the Trust has not been involved in any dementia type research.
- As part of the NIHR national High Level Objective deliverables and linked to the Prime Ministers Dementia Challenge; in collaboration with DPT; a new Dementia Research programme has been established.
- It is envisaged this will links to other initiatives to broaden the scope for developing a wider neurological research portfolio with our neurologists.
- The Trust successfully bid for and was awarded 12 months pump prime funding from the Network (Research Capability Funding) to create a new senior research nurse post to help support and drive this new initiative.
- The Trust has already been accepted for 8 new studies (commercial and non-commercial) to roll out in the New Year. Many others in the pipeline and Torbay is now on the research radar and map for further expressions of interest.

10. Improve and share the clinical and economic benefits through research

NHS R&D Budgets are separate to patient care budgets and commissioned differently to other NHS business via the NIHR.

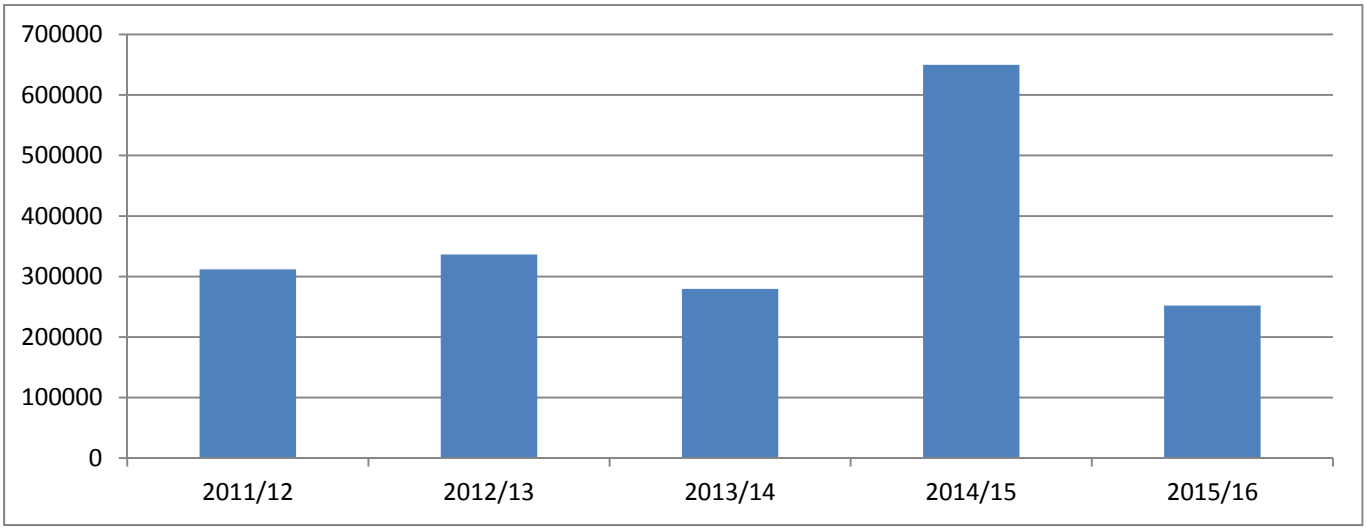
Core funding from the government (NIHR) to manage and deliver the NIHR contract is decreasing. In addition, overall our regional network has not performed relatively as well as other CRN regions (as depicted above). As a consequence, less funding has come to the regional CRN which in turn means less funding to Trusts. In 2014/15 the Trust received an 11% cut in overall core funding and in 2015/16 the Trust received a further 7% cut to core funding. This downward trend is expected to continue and the CRN has advised all partners to plan for at least 5 % cuts year on year for the remainder of the contract .The graph below shows the trend of year on year decrease in core network funding.



NIHR Ad hoc funding: Core funding is topped up through ad hoc network funding) – as shown in red above. NIHR Network Research Capability Funding (RCF) accounts for circa 60% of this ad hoc funding the Trust receives each year to top up funding shortfalls and pump prime new developments. This funding stream will be abolished from 2016/17 onwards.

Trials Income: Primarily links to commercial studies. Trusts are contracted to undertake each research study and payments are made on a per patient pro rata basis. Due to funding changes nationally to research grants non-commercial studies are starting to follow similar patterns where funding is provided per patient pro rata as opposed to block up front. As Government funding decreases, despite robust efforts to manage expenditure, more reliance on trials income is inevitable for a more sustainable and viable future.

Gross Trials Income: Income is down 36% from £252 compared to £364K at Q2 last year, but importantly still an improvements compared to pre 2014.



R&D remains within budget and on target against current budget and business plans for expenditure but down slightly regarding trials income; which is linked to reduced new studies and recruitment activity.

Miscellaneous:

ICO changes:

- There was no equivalent R&D Department or staff in the Care Trust. Research management and governance responsibilities were outsourced and provided by the Royal Devon & Exeter NHS Foundation Trust. This has now transferred to the ICO/Torbay and South Devon Foundation Trust effective from October 1st 2015.
- 15 studies registered and undertaken at the Care Trust were notified and transferred to Torbay and South Devon Foundation Trust from the RD&E; as part of the acquisition. A total of 8 open studies and 7 recently closed studies. We are working through all these studies to add to our records and complete other transfer notices accordingly.
- We have formally notified all research sponsors of all active studies registered regarding the changes and working with them to amend contracts etc.
- All staff issued with current valid Letters of Access and or Honorary Research Contracts via the Research Passport scheme have also been notified and where necessary issued with new updated paperwork to ensure continuation of cover for staff and projects in line with relevant research governance requirements.
- Currently addressing changes to information systems
- NIHR and CRN all notified and have changed their reporting frameworks to account for the change in name and sites now under our management.
- Progress regarding transferring and changes to current studies etc as per governance and regulatory requirements proceeding to plan and on target to complete within the first 6 months of becoming an ICO.

Chief Executive's Business Report
2nd December 2015

Internal

Emergency Department – Performance
There continues to be a high degree of focus on delivery of the four hour target. Alamac is continuing to better understand performance variance and to deliver sustainable improvement. Meeting the target continues to be a challenge and ED performance remains a significant corporate risk with a high degree of Executive action and oversight.

Focus is continuing on the factors that will help us achieve a sustainable performance of patients not having to wait more than four hours. We know that our ability to discharge patients from the acute hospital, once it is medically appropriate, is a key factor and there has been good progress on achieving this. Two examples are:

- Patients who are medically fit for discharge in the acute hospital but whose discharged is delayed, has reduced by 40 per cent from October into November

- We are discharging on average two more patients a day before 11am in November compared to October

There is still a considerable amount of work being focussed on consistency in patients flow throughout the pathway. This includes a greater emphasis on meeting our discharge goals in our acute and community hospitals. The aim of this is to increase our resilience to pressures on days of the week where our admissions exceed our demand, these continue to be Saturday and Sundays.

Junior doctors' strike action
The BMA has announced industrial action on 1, 8 and 16 December. The Medical Director's report sets out the plans in place to ensure safety of all our patients and minimise the effect on patients of the planned industrial action. A decision has been taken to prioritise urgent care and patients who would have been having routine operations on the first planned date have been contacted to inform them that their operation will be cancelled and to ask them to phone to rebook. All operations have been rebooked for another date. This may impact on our future ability to meet RTT targets.

It has now been announced that the government will engage with the BMA through ACAS and we await the outcome of this. However, if industrial action still takes place we are well prepared.

Dawlish Community Hospital – Centre of Excellence for Urgent Care
From 4 January 2016, Dawlish Community Hospital will provide an improved service for the treatment of minor injuries, becoming the area's centre of excellence for urgent care. The service, based at the community hospital's minor injury unit (MIU), will be available 8am to 8pm seven days per week, 365 days per year.

To enable this greater service provision, the existing MIU and x-ray facility at Teignmouth Community Hospital will merge with the MIU at Dawlish Community Hospital to create one top-class facility for the local population. The MIU at Dawlish, run by a team of qualified and experienced nurses, already provides excellent, local treatment for a range of minor injuries and ailments and has all of the state-of-the art equipment needed, including x-ray. The extended opening hours will ensure that local people have convenient, daily access to high quality care closer to home.

Joining the area's two minor injury units is the first phase of the developments and improvements to health and care service taking place across Dawlish and Teignmouth. Earlier this year, South Devon and Torbay Clinical Commissioning Group undertook an extensive 14-week public consultation to consider a number of proposals that would strengthen and secure the long-term future of the two community hospitals in the area.

The plans include establishing Dawlish Community Hospital as the centre for medical inpatient beds for the whole locality and will be the new location for Devon Doctors' out-of-hours service. Teignmouth Community Hospital will become a specialist rehabilitation unit – making the best use of its excellent rehabilitation gym, occupational therapy and physiotherapy suite.

National WOW Award Winners
The national WoW award ceremony was held in London last week and out of three categories our organisation was awarded one of the top prizes for 'Best use of the WoW Awards'.

We were chosen for this award because it was recognised that we have successfully embedded the WOW Awards across the whole organisation and have a positive culture where we live and breathe our Trusts' values and behaviours.

In addition both Cheetham Hill and the Moorland team were shortlisted in their category for 'Outstanding Customer Service teams' but were pipped at the post as outright winners. However out of thousands and thousands of nominations it is an excellent achievement to be recognised for the excellent innovative and creative quality care they provide. I know the Board will wish to record their congratulations to our teams.

Media
The Communications Team is in regular contact with local media to ensure a positive relationship is maintained. A six week campaign has been launched in the Herald Express which includes supplements and double page spreads to positively communicate the story of integration and what it will mean for local people. The

campaign includes interviews with staff and patient stories to demonstrate how integration is already improving the care and lives of local people. The first three editions have already gone to print and are on the Herald Express website.

TV, radio and print media coverage of Trust over the past month includes:

- Baby remembrance weekend
- Teignmouth minor injury unit merging with Dawlish
- Raising awareness for International Day of Medical Physics
- Antibiotic resistance awareness
- Donation from Dawlish WI to support breast care patients
- Junior Doctor planned strike
- Project Search – BBC interviews with current students and student now employed
- Mouth Cancer awareness
- Radio interview MSK pilot
- Supporting Stay Well this Winter campaign
- Encouraging uptake of flu jabs

Chief Executive Leadership Visibility

Internal
Joined Up Board
Disability Awareness Action Group
Critical Care Unit (SPI Walkaround)
Community Team Newton Abbot
Staff Side Meeting
Paignton and Brixham Locality Group
Children's Learning Disability Team
Paediatric Diabetes Nursing Team
Health Visiting and School Nursing Staff, Paignton
Albany Clinic, Newton Abbot
Continuing Care Team

External
Chief Executive Torbay Council
Assistant Director of Children's Services, Torbay Council
Interim Director of Public Health, Torbay Council
Head of Commissioning, Adult Social Care, Torbay Council
Director of Adult Services, Torbay Council
Chief Clinical Officer, CCG
CEO Plymouth Community Healthcare
Northern Ireland Governance Conference
Northern Ireland Confederation
Department of Health Trust Visit
CQC pre-visit briefing
Monitor Relationship Team Visit
Anne-Marie Morris MP

External

CCG Briefing

South Devon and Torbay CCG have issued their second stakeholder briefing (Appendix 1) on Reshaping Community Health Services.

NHS Funding Increase

The government has announced an increase NHS England's budget of £3.8 billion above inflation in 2016/17. In the following years the rises will tail off and by 2020/21, NHS England's budget will stand at £119.6 billion. That equates to a rise of £8.4 billion once inflation is taken into account. Once the £1.8 billion extra given to the NHS this year is taken into account, it means an overall commitment of £10 billion.

The extra money represents a 'front-loading' of the £8.4 billion previously designated by 2021 and will be a start to make the changes necessary to implement the efficiencies required to prevent financial problems this winter, and to take the NHS towards the goal of a seven day service by 2020.This settlement only increases NHS funding by an average of 1.75% per year over the life of this parliament. This is half the historic average annual increase in NHS funding of 3.6%. The 'On the Day' briefing is included in Appendix 2.

Ofsted-style ratings to rank care quality

The Department of Health is introducing Ofsted-style ratings so patients can see how their local area's health service is performing. From next summer all local health groups will be graded from 'outstanding' through to 'inadequate' in a similar system to school inspections. It is intended that the information will enable patients to decide to travel further if the care for a particular service they need is inadequate. The rankings will be given for separate areas such as cancer, dementia, diabetes, mental health, learning disabilities and maternity care.

NHS
South Devon and Torbay
Clinical Commissioning Group

Stakeholder Briefing No 2 – 19 November 2015

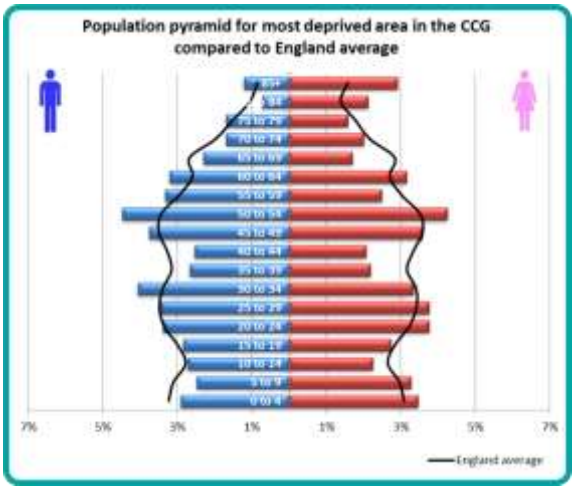
Re-shaping Community Health Services in South Devon and Torbay

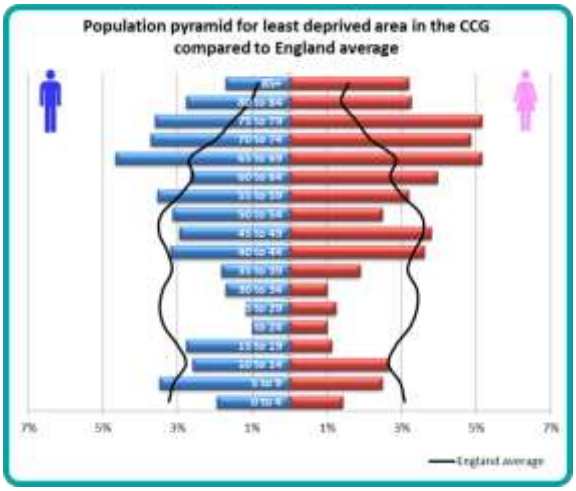
Purpose

This briefing shares information presented to meetings with local people in South Devon and Torbay. These have been discussing the challenges faced by health services in planning to deliver services to a growing population and people with more long term conditions. Our aim is to meet this growing demand by establishing a new model of care.

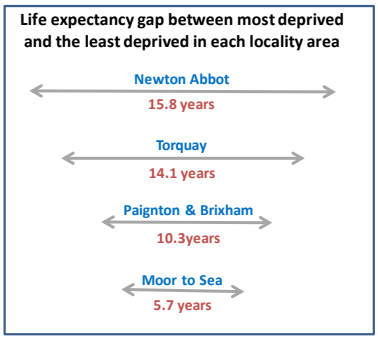
Pressures for change

A range of data is being used to identify the services we need to provide in future and is available by locality on our website, at www.southdevonandtorbayccg.nhs.uk/community-health-services. In comparison to the rest of the country, the population graphs show that overall we have an above England average of people aged over 65 and especially those aged over 85. This is really obvious in our least deprived areas. But a very different profile is apparent when analysing the ages of our most deprived populations where younger people are much more represented. The graphs below show the variations across the CCG area and these population differences need to be considered in our planning. Equivalent graphs for each locality are on our website.





In each of our localities, there are significant differences in life expectancy between our most deprived and least deprived areas as shown in the table opposite as well as in the numbers of people in the under 16 or over 85 age groups. Emergency admissions also vary significantly between these areas. When planning future health services, we need to consider how best to address some of these health inequalities and reduce the gaps in life expectancy.



Demand for services

The table opposite illustrates how the demand for services is likely to increase.

Finance

Financial pressures mean that there is no additional money to deliver these services and so we need to find different, more effective ways of delivering care. The financial pressures relate to both day to day spending and capital investment.

Issues and questions

A recurring theme is the need to find affordable solutions that can be delivered across the area, taking account of the different needs of rural and urban areas. Issues raised include a single point of access for services; having a community hub out of which local services operate; keeping staff; increasing health prevention; transport; and the number of people who are in hospital and who would not need to be, if community services were stronger and available across the area.

Number of patients with disease; known or not known to primary care	Moor to Sea	Newton Abbot	Paignton & Brixham	Torquay
	2015-25 %	2015-25 %	2015-25 %	2015-25 %
Coronary heart disease	19.8	20.5	18.3	17.2
Chronic kidney disease	21.5	21.7	19.4	18.5
People aged 65 and over predicted to have:				
• Type 1 or Type 2 diabetes	20.0	20.5	17.1	16.5
• A longstanding health condition caused by a stroke	25.5	25.7	22.1	21.5
• Dementia	34.5	33.4	30.7	30.7
• Depression	20.3	20.7	17.0	16.5
• Severe depression	25.2	25.3	21.7	21.1
• A longstanding health condition caused by bronchitis and emphysema	21.5	21.9	18.5	17.8
• A moderate or severe visual impairment	29.2	28.7	24.9	24.4
• A moderate or severe, or profound, hearing impairment	31.5	31.0	26.0	25.0

Timeframe for consultation

Our last briefing indicated that we hoped to consult over the winter months. However, more time is needed to capture and explore ideas coming out of the engagement discussions and in particular views on how resources can best be used. These discussions will continue over the coming weeks with consultation therefore not starting until next year.

What's next?

Having previously set out the overall challenges, our aim in future meetings, involving elected representatives as well as people from health, social care, voluntary sector and community organisations, is to discuss the cost of services. By doing so, those attending will be better able to consider with us how resources can be used to fund a new model of care which can deliver services fit for the future.

If you would like further information please go to www.southdevonandtorbayccg.nhs.uk/community-health-services or email us at sdtccg.consultation@nhs.net.

on the day BRIEFING

the association of foundation trusts and trusts NHS providers

COMPREHENSIVE SPENDING REVIEW: 2016- 2020

OVERVIEW

Today the government has published its comprehensive spending review, setting out the budget for each department over the course of this parliament. The Chancellor spoke at the dispatch box for over an hour, outlining a roadmap for public sector funding over the course of this parliament to realise the Government's ambition for Britain to be "the most prosperous and secure of all the major nations of the world 2020".

His speech was couched in the language of investment, support and security – very different from the spending review in 2010 when debt, struggle and uncertainty loomed large.

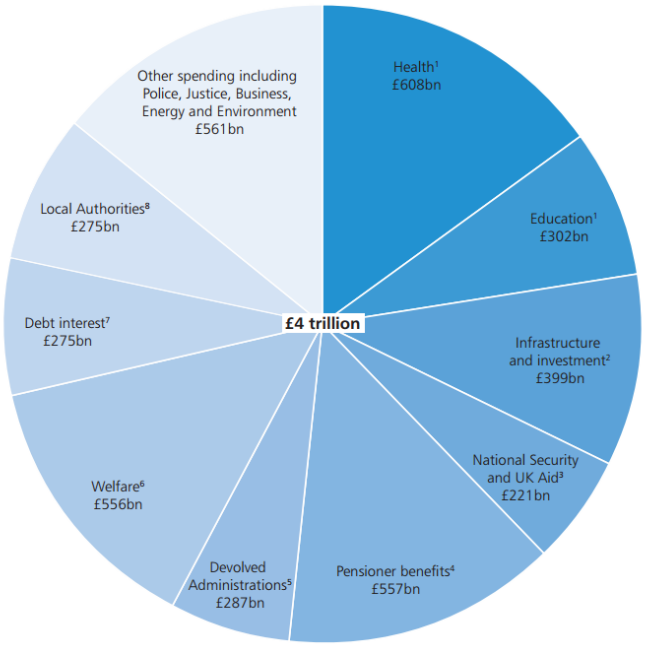
This briefing provides a summary of the review, the implications for the NHS and Department of Health, and includes the press release we issued yesterday in response. There is still a substantial amount of detail which needs to come about what today's announcement means for the NHS, and the implications of the spending review for the 2016/17 national tariff, planning round, contracting round and commissioner allocations. We will be working to provide this detail for members in the coming weeks.

KEY ANNOUNCEMENTS

Macroeconomic headlines

- A fall in government borrowing from £73.5 bn this year aiming to reach a £10.1 bn surplus in 2019/20. The Office for Budget Responsibility (OBR) now forecasts GDP growth of 2.4% in 2015 and 2016, rising to 2.5% in 2017. Public sector net debt is forecast to fall each year in this parliament, reaching 71.3% of GDP in 2020-21.
- A reduction in state spending to 36.5% as a proportion of total output by 2020/21, compared to 45% in 2010
- Cuts across the vast majority of government departments, with some particularly deep: 37% for transport; 29% for communities and local government and 17% for business, innovation and skills
- Protection for selected budgets, including health, education, defence and policing.
- A U-turn on the Government's plan to cut £4.4 billion in tax credits, which will see the Government breach the welfare cap for the first years of this parliament
- A major house building programme in England, including plans to develop 400,000 new homes in England
- An increase in the state pension of £3.35 a week next year

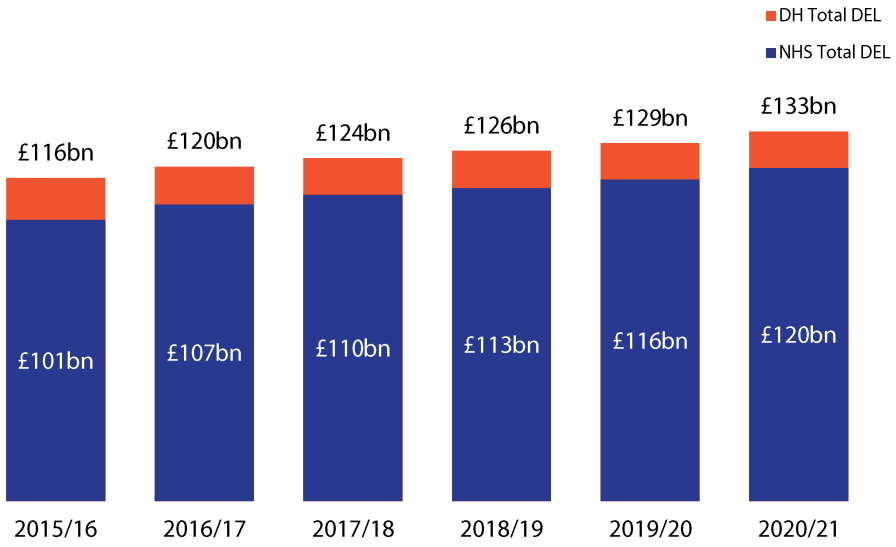
Figure 1: Breakdown of total public sector spending: 2016-17 to 2020-21



Health headlines

- The government has confirmed an extra £10bn in real terms for the NHS by 2020/21 (figure 2). This includes the £2bn already announced for 2015/16 in last year's Autumn Statement). The Treasury highlighted that this "investment will ensure that everyone will be able to access services in hospitals 7 days a week and GP services in the evenings and at the weekend".

FIGURE 2: DEPARTMENT OF HEALTH AND NHS TOTAL DEPARTMENTAL LIMITS 2015/16 – 2020/21



- The £8bn of additional investment has been applied to NHS England's budget only (table 1), with substantial reductions being required from non-NHS health budgets. This will likely lead to around 20-25% cuts in other health spending, for example to:
    - Health Education England (HEE): it is estimated that their budget (currently around £4.9bn) will reduce significantly. Approximately £1.2bn of HEE funding, which currently pays for bursaries for nurse and other allied health professional education, will be removed over this Parliament as a student loans system is introduced for these professions. This action, coupled with the removal of the cap on training places, is expected to lead to an increase of up to 10,000 nurses in training. The budget pressures placed on HEE may lead to freezes in clinical placement fees for medical students and other NHS staff.

    - Care Quality Commission (CQC): it is likely that the budget for the CQC will be significantly impacted by the spending settlement. The CQC is already consulting on proposals to significantly increase its fees, to offset proposed reductions in the grant-in-aid funding it receives from the Government.

    - Department of Health (DH) capital budgets: the capital budget will be frozen at £4.8bn a year over the course of this parliament.

- The £8bn for the NHS has been frontloaded, with a 3.6% real terms increase for 2016/17 (£3.8bn), £1.5bn in 2017/18, followed by a lower growth rate in the next two years followed by a larger rise in 2020/21.

TABLE 1: DEPARTMENT OF HEALTH AND NHS TOTAL DEPARTMENTAL LIMITS 2015/16 – 2020/21

Year	Department of Health		NHS England	
	Department Expenditure Limit (£bn)	Increase in real terms (tbc)	Budget (£bn)	Increase in real terms
2015/16	£116.4		101.3	↑1.9%
2016/17	120.4		106.8	↑3.6%
2017/18	123.5		110.2	↑1.3%
2018/19	126.1		112.7	↑0.4%
2019/20	128.9		115.8	↑0.7%
2020/21	133.1		119.9	↑1.4%

HEALTH HEADLINES

Department of Health budget

- DH's budget will increase from **£116.4bn in 2015/16 to £133.1bn in 2020/21** in cash terms, but this **only represents a £4.5bn real terms increase over this period, an increase of less than 1% a year above inflation.**

- DH will receive £4.8 billion a year for capital expenditure between 2016/17 to 2020/21, which will likely lead to sustained pressures on local capital expenditure from central sources. The chancellor highlight that £500m will be invested in new hospitals including in Cambridge, Brighton and Sandwell, which we assume would be drawn from DH's capital budget.

- The NHS 'ring-fence has been drawn around NHS England's budget only, rather than DH's, which will lead to **substantial reductions in non-NHS health spending of around 20-25%.** For example, of the additional £5.5bn NHS England will receive for 2016/17, health commentators have suggested around £1.5bn will come from the Department of Health's wider budget.

- Limited detail has been published about where reductions in non-NHS health spending will come from, but today's announcements highlight a number of areas:
    - As noted above it is estimated that **Health Education England's budget will be cut by around £1.2bn over the course of the parliament.** The CQC has indicated that they have not heard what the financial implications will be for them but any budget reductions will clearly **have implications for their fee levels and/or the comprehensiveness of their inspection model.**

    - A further reduction to public health (as part of DH's budget), which is discussed in more detail below. This is alongside a 30% reduction in DH direct administration costs over the course of the parliament.

NHS England budget

- NHS England's budget will increase from **£101.3 in 2015/16 to £119.9 in 2021/21**, a 1.5% average annual real terms increase over this period.

- As we highlighted in our press release, it is clear that any additional funding the NHS receives has to be considered alongside growing demand, social care and public health cuts, the costs of returning the provider sector to surplus and managing the increased costs as a result of changes to national insurance contributions. It is clear that the real increase in the NHS's budget is likely to be significantly less than the headline figure as a result of these other factors.

- The £8bn for the NHS has been frontloaded, with a 3.6% real terms increase for 2016/17 (£3.8bn), £1.5bn in 2017/18, followed by a lower growth rate in the next two years followed by a larger rise in 2020/21 (see Figures 3 & 4).

TABLE 2: NHS DEPARTMENTAL EXPENDITURE LIMITS 2015/16 – 2020/21

Year	NHS England	
	Budget (£bn)	Increase in real terms
2015/16	101.3	↑1.9%
2016/17	106.8	↑3.6%
2017/18	110.2	↑1.3%
2018/19	112.7	↑0.4%
2019/20	115.8	↑0.7%
2020/21	119.9	↑1.4%

FIGURE 3: THE PACE AT WHICH THE NHS RECEIVE THE ADDITIONAL £8BN

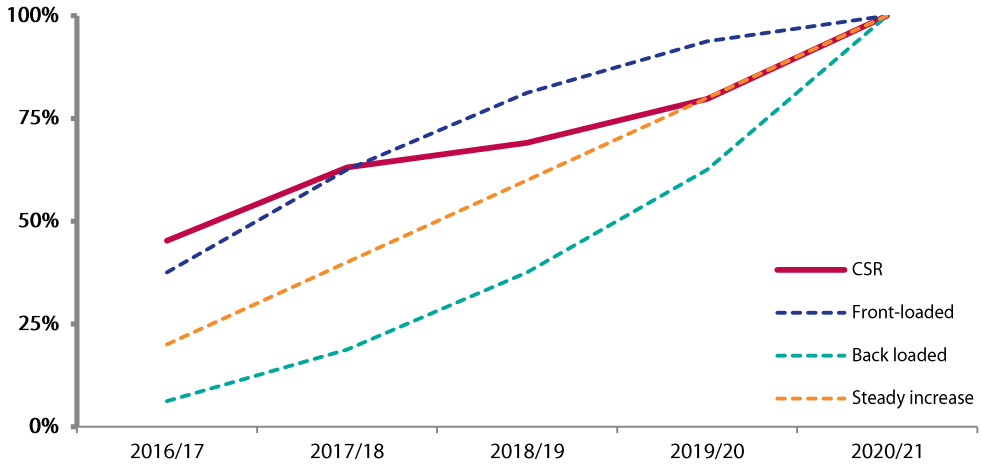
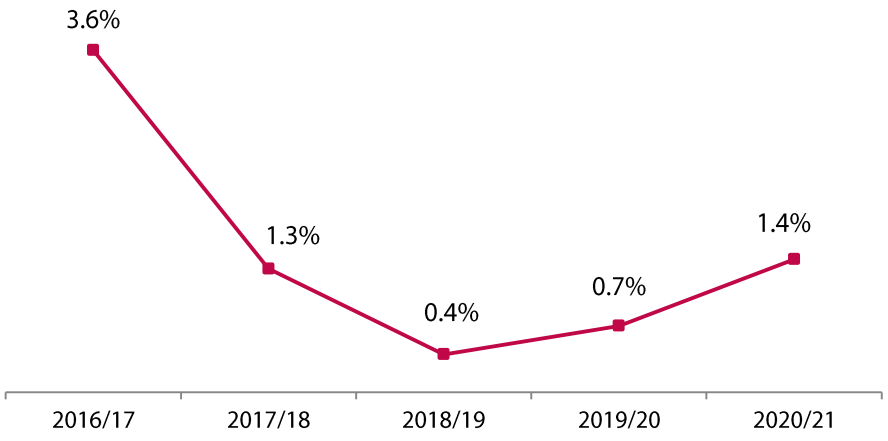


FIGURE 4: REAL TERMS GROWTH IN NHS ENGLAND BUDGET 2016/17 to 2020/21



- The Spending Review confirms that the NHS "has committed to deliver its £22 billion in efficiency savings by 2020-21 to deal with rising demand." It suggests that this will be achieved by:
    - Reducing running costs: the Treasury highlights Lord Carter's review in to operational productivity as key here. The review has found that on average hospitals could save "between 5% and 15% of their expenditure".

- Paying the right price for equipment: we assume this is in part alludes to the work that NHS England is doing to centralise the procurement of high cost devices
- Reducing avoidable hospital admissions
- Improving care quality
- DH plans to sell nearly £2 billion of assets over the next 5 years, in order to release land to build new homes. It is unclear what mechanisms the national bodies have or would employ to encourage providers to do this.

Social Care and Better Care Fund

- The local government grant will reduce by £6.1bn by 2019/20, creating substantial pressures for local authorities. Two revenue streams have been opened up to local authorities:
  - Social care precept: local authorities will be able to levy a social care precept to raise funds for spending on adult social care exclusively through a council tax rise of up to 2%. If every local authority were to do this, it could bring in up to £400m a year (£2bn by 2019/20). Given that there will be a £6bn gap in social care by 2020, this will only go a limited way to closing the gap. Social care commentators have also observed that there are also distributional consequences between local authorities of using this tax, given that it will disadvantage deprived areas with the highest needs for publically funded care.
  - Business rates: the government is allowing local authorities to keep the rates they collect from business, give councils the ability to change business rates and give elected city mayors the power to levy a business rate premium for local infrastructure projects.

- The Better Care Fund (BCF) will be frozen for 2016/17, which means that there will be no mandatory *increase* in the transfer of funds from the NHS to the fund next year. From 2017/18 the fund will be increased through additional funding being made available to local government, worth £1.5 billion by 2019/20. We understand that this additional investment will come from the Department for Communities and Local Government, rather than DH budgets.

- The BCF will also become the mandatory minimum requirement for local health and social care economies to demonstrate that they are moving towards integrated care models. The government would not impose how the NHS and local government move towards integrated care but a number of options should be considered including:
  - Accountable Care Organisations such as the one being formed in Northumberland, to create a single partnership responsible for meeting all health and social care needs
  - Devolution deals with places such as Greater Manchester which is joining up health and social care across a large urban area.
  - Lead Commissioners such as the NHS in North East Lincolnshire which is spending all health and social care funding under a single local plan.

- Taking these policies together, the government suggests that there will be an additional £3.5 billion of support for adult social care by 2019/20.

- The government also reiterated its commitment to implementing the Dilnot proposals from 2020. Additional funding would be made available from 2019/20 to provide preparation for the introduction of a cap on reasonable care costs, and an extension of means testing from April 2020.

Public Health

- The full funding picture for public health is still emerging, as no detail has been published about what cuts will be made to Public Health England. It is hard to imagine there would not be further substantial cuts given how pressurised non-NHS health expenditure will be over the course of this parliament.

- The Government has noted today that 'This spending review finishes the job of reforming the public health system, delivering average annual real terms savings of 3.9 per cent over the next five years.' It has been estimated that total spending on public health will fall from £3.4bn in 2015-16 to £3.1bn in 2020-21.

- Some of the public health funding local authorities receive is administered through the grant arrangements – the ring fence for public health in this arrangement will be maintained for the first two years of the parliament. For the latter years of the parliament, the government will be consulting on options to fully fund local authorities' public health spending from their retained business rates receipts (see above for more information).

- In 2016, the government will be publishing its Childhood Obesity strategy, highlighting the action the government will be taking in this parliament.

Other health announcements

A number of additional announcements have been made in and around the health sector. Some of these are restatements from last year's Autumn Statement for the 2015/16 financial year:

- £600m for mental health talking therapies and crisis care (a commitment initially made in the Autumn Statement for 2015/16)
- £300m a year by 2020 to support the Cancer Taskforce recommendations on earlier GP diagnosis for cancer, including investment in additional staff and diagnostic capacity
- Long term partnerships between the NHS and the private sector will be developed to modernise buildings, equipment and services, and deliver efficiencies, especially where these partnerships support the upgrade of diagnostics capabilities and the development of new models of care, such as Accountable Care Organisations and hospital groups.
- The government will invest £1 bn in new technology over the next 5 years to deliver better connected services for patients and ensure that doctors and nurses have digital access to information. This is less than the £3.3bn to £5.6bn DH was estimated to have asked for in their submission to the Treasury. £10 million has also been announced to expand the Healthcare Innovation Test Bed programme to test digital technologies
- £5 bn in health research and development, including 100,000 Genomes Project, Global Antimicrobial Resistance Innovation fund, and the Ross Fund to combat the most infectious diseases
- £750 million of investment and a new national voluntary contract for GPs to support extended hours and weekend working
- £150 million for a new Dementia Research Institute

- £400 million over an 8 year period in a new 'Science Hub' which will provide world class Public Health England labs at Harlow, Essex and help protect the public from threats such as flu and Ebola
- £500 million will be invested in building new hospitals over Parliament, as noted in the capital funding section above

Devolution

- The Chancellor's spending review and Autumn Statement set out the aim of delivering a "devolution revolution by returning power to the UK's nations, cities and councils and rebalancing our economy, giving people greater control over the decisions that affect their lives"
- On the devolution of health, the Statement stresses that key national services will continue to be nationally mandated, given the government's commitment to "tackling society's health problems, not just treating the symptoms". The government meanwhile will look to devolve greater powers so that local authorities can take preventative action.

- Devolution of powers and responsibilities to local authorities:

    - Uniform business rates to be abolished
    - Local government to keep all revenue by the end of this parliament.
    - Plans to consult on changes to the local government finance system (covered above in the briefing)
    - The government will consult on transferring full responsibility for public health funding to local government, to be funded from their retained business rates receipts
    - Elected mayors will be able to raise business rates to fund specific infrastructure projects supported by the local business community.
    - Local government grant to be phased out entirely over this Parliament.
    - The Temporary Accommodation Management Fee will no longer be paid through the benefits system. Councils will instead receive an additional £10m a year to provide more help to homeless people.
    - Councils to be able to spend 100% of the receipts from their fixed asset receipts (excluding Right to Buy receipts) on the revenue costs of reform projects. More details will be included within the December 2015 Local Government settlement. The Chancellor in his statement said that the government would encourage councils to draw on their reserves, which he stated had increased by nearly £10billion, as they undertake reforms.

- No new devolution deals in England were announced within the statement however it is emphasised that the Department for Communities and Local Government will continue to oversee delivery of devolution deals agreed with city regions and other areas.

- Alongside the Autumn Statement and Spending Review, HM Treasury also published an update on further devolution to the Greater Manchester Combined Authority to demonstrate the commitment from government and Greater Manchester to maximising devolution to Greater Manchester over time.

ANNEX A – PRESS RELEASE

PRESS STATEMENT

24 November 2015

Funding boost is very welcome but significant challenges remain across NHS

Responding to the settlement for the NHS outlined in tomorrow's Comprehensive Spending Review, Chris Hopson, chief executive, NHS Providers, said:

"The government's commitment to £10 billion in extra money for the NHS over the lifetime of this parliament is very welcome. It is also good news that the NHS will receive more of this money in 2016/17 as the Department of Health and NHS England requested. Given the significant pressures on public expenditure and the difficult choices the Government had to make in the spending review, this is a good settlement for the NHS.

"However there are still substantial challenges that the NHS must meet and that this funding must cover. These include meeting the demands of an older population, transforming NHS services, closing the public health gap, absorbing the impact of social care cuts, returning the provider sector to surplus and managing the changes to National Insurance contributions on NHS pensions.

"Our members – NHS trusts and foundation trusts – will want to see how this settlement translates into their detailed budgets but they will, of course, welcome any extra money. There are also important details still to come including how the rest of the Department of Health budget has been treated, and what extra commitments the NHS is now expected to meet at what cost.

"We must also put the settlement in its full context. Every year demand and cost rise in the NHS by 4% but this settlement only increases NHS funding by an average of 1.75% per year, less than half the historic average annual increase in NHS funding of 3.6% . The share of our national wealth spent on health - GDP per head – will also decline further. So, in 2015, the NHS is still in the middle of the longest and deepest financial squeeze in its history."

Ends

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	Board meeting 2nd December 2015
Title:	Public Consultation on the future of Baytree House short breaks unit for people with learning disabilities in Torbay
Lead Director:	Liz Davenport
Corporate Objective:	
Purpose:	Decision to proceed with public consultation as per the attached document

Summary of Key Issues for Trust Board

Strategic Context:

In 2014, the local NHS published its Learning Disability Operational Commissioning Strategy.

The document outlines how the Trust will commission and provide quality support to people with a learning disability and their carers in the future. The strategy sets out why it is necessary to deliver changes in learning disability services in Torbay and examines the types of services which need to be provided now and in the future. It also describes what needs to change locally to modernise services and enhance the lives of people with a learning disability in a challenging financial climate.

The strategy explained that the NHS in due course would no longer be a direct provider of learning disability services and that we would be implementing a change programme in all areas of provision. Successful changes have already occurred in day services, with the creation of the high needs service at Hollacombe.

The Baytree House short breaks service is situated in a large traditional Torbay Victorian Villa. The building is located in Croft Road, Torquay and is owned by Torbay Council and leased to the NHS on a 'peppercorn' basis. Currently Baytree has a maximum capacity of eight beds; however the average occupancy in the last financial year was an average of 3.6 residents per week, with the majority of placements made at the weekends. This gives a 45 per cent occupancy rate. The total cost of running the unit including staffing costs is £509,000 per year.

The structure of the building means that several of the bedrooms are inaccessible for wheelchair users and people with significant physical disabilities. The building also has a number of constraints meaning it cannot be altered, for example ceiling tracking that enables the safe hoisting of people and movement around the premises for people with complex physical needs cannot be installed.

There is also a well evidenced change in the demographics of people with learning disabilities. The numbers of people with profound and multiple disabilities is going up, and although it is good news that many people with a learning disability now enjoy a longer life expectancy it does mean that the service has seen an increase in the physical frailty and mobility problems that are associated with old age. Therefore Baytree is not always the best care setting for individuals with these more complex needs.

Our change programme for people with learning disability has used a “co-design” model. This involved a series of meeting with parents and carers, prior to formal consultation, to seek their views and help shape the proposals that are being put forward I the attached document. The co-design approach has enabled carers, parents and individuals involved have an influence over the type of short break they can access in the future. By working together with carers the Trust believes it can design a range of alternatives that not only give people more choice and control over their chosen short break but ensure quality, reliability and financial sustainability in services. Carers of Baytree users have been invited to these meetings, in addition parents of children and adults in transition and other interested parties attended.

Through co-design, the Trust has discussed new options for short breaks and looked at ways in which carers can use and combine their personal budget allowances to find better-suited alternatives to current provision. This included a session with five independent sector providers of bed based and alternative community based short breaks. The Trust also shared its rationale for change, discussed how the future may work and gave its commitment to support to carers and parents throughout the planning and transition of any change process.

Key Issues/Risks

1. Finding suitable alternatives for carers in the independent sector if Baytree closes.
2. If the unit does not close the financial savings required will not be delivered.
3. Public opposition to closing a long standing service.

Recommendations:

1. To proceed with the public consultation as per the attached document.
2. The Trust is proposing to close Baytree House in April 2016.
3. For all those using Baytree House as a short breaks option, the Trust has given its commitment to ensure improved support and planning for people, to help them use personal budgets to meet their outcomes and manage their money to support a new short break of their choice.

Summary of ED Challenge/Discussion:

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

Torbay and South Devon NHS Foundation Trust is seeking your views from parents and carers of people with learning disabilities about future of Baytree House, its in-house short breaks unit in Torbay.

Equality and Diversity Implications:

This proposed service change impact upon people with learning disabilities and with their carers and families, the relevant impact assessments have been completed.

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Consultation on the future of Baytree House short breaks unit for people with learning disabilities in Torbay

www.torbayandsouthdevon.nhs.uk

Welcome

Torbay and South Devon NHS Foundation Trust is seeking your views on the future of Baytree House, its in-house short breaks unit in Torbay.

This consultation document provides you with the background to the Trusts proposals and why there is a need to change the way that short breaks (respite) are provided to people with a learning disability in Torbay. The consultation will provide you with an opportunity to formally share your views on the proposals.

The Trust wants to make the right decisions for individuals and their carers, whilst also considering the tough choices that need to made in order to ensure services remain fit for purpose, viable and financially sustainable in the future.

Why change is needed?

In 2014, the local NHS published its Learning Disability Operational Commissioning Strategy.

The document outlines how the Trust will commission and provide quality support to people with a learning disability and their carers in the future. The strategy sets out why it is necessary to deliver changes in learning disability services in Torbay. It looks at the types of services which need to be provided now and in the future. It also describes what needs to change locally to modernise services and improve and enhance the lives of people with a learning disability in a challenging financial climate.

The strategy explained that the NHS in due course would no longer be a direct provider of learning disability services and that we would be implementing a change programme in all areas of provision. Successful changes have already occurred in day services, with the creation of the high needs service at Hollacombe.

Last year the NHS also consulted on its policy for short breaks and this has been in place since 1st April 2015. The policy included a new approach to providing eligible carers, with funding for a short break, much more options for the type of break they have. The policy also brought the Trusts approach to short breaks up to date in respect of supporting carer's rights under the Care Act. This is a new piece of government legislation brought in from April 2015 to ensure care and support is more consistent across the country.

Why change is needed for Baytree House?

The Baytree House short breaks service is situated in a large traditional Torbay Victorian Villa. The building is located in Croft Road, central Torquay. The building is

owned by Torbay Council and leased to the NHS on a ‘peppercorn’ basis, meaning the rent is given at a low cost.

Currently Baytree House has a maximum capacity of eight beds, however the average occupancy is approximately between three and four placements. The total cost of running the unit including staffing costs is £509,000 per year.

The structure of the building means that several of the bedrooms are inaccessible for wheelchair users and people with significant physical disabilities. The building also has a number of constraints meaning it cannot be altered, for example ceiling tracking that enables the safe hoisting of people and movement around the premises for people with complex physical needs cannot be installed.

There is also a well evidenced change in the demographics of people with learning disabilities. The numbers of people with profound and multiple disabilities is going up, and although it is good news that many people with a learning disability now enjoy a longer life expectancy it does mean that the service has seen an increase in the physical frailty and mobility problems that are associated with old age. Therefore Baytree House is not always the best care setting for individuals with these more complex needs.

In the last financial year Baytree House had an average occupancy of 3.6 residents per week, with the majority of placements made at the weekends. This gives a 45 percent occupancy rate for short breaks, meaning that per year each bed currently costs approximately £125,000 to run. There has been a downward trend in use over the last four years with a 17 percent reduction in bed occupancy.

With this is mind, we believe change is necessary. We want local services to be the best they can be and meet the commitment set out in the learning disability strategy but in order to do so we must change the way they are provided. By doing so we can create a wider breadth of sustainable services that meet people’s needs, now, and in the future.

Working with you

Our change programme for people with learning disability has used a “co-design” model. This involved a series of meeting with parents and carers, prior to this formal consultation, to seek their views and help shape the proposals that are being put forward in this document. The co-design approach has enabled carers, parents and individuals involved have an influence over the type of short break they can access in the future. By working together with carers the Trust believes it can design a range of alternatives that not only give people more choice and control over their chosen short break but ensure quality, reliability and financial sustainability in services.

Carers of Baytree House users have been invited to these meetings, in addition to carers and parents of children and adults in transition, as well as wider groups of carers of people with a learning disability or interested parties.

Through co-design, the Trust has discussed new options for short breaks and looked at ways in which carers can use and combine their personal budget allowances to find better-suited alternatives to current provision. This included a session with five independent sector providers of bed based and alternative community based short breaks. The providers were able to talk about what services they could offer and carers were able to discuss concerns they may have had about any alternative provision. The Trust also shared its rationale for change, discussed how the future may work and gave its commitment to support to carers and parents throughout the planning and transition of any change process.

In the previous consultation work held in 2012 and our co-design work this year with regard to day services and short breaks, the following themes have emerged from people with learning disabilities and their carers.

- People felt that there should be more choice
- People want to improve community participation, independence and choice
- People and their carers said they needed help accessing those opportunities and using a personal budget
- People said that building based services would still be required for people with the most complex needs
- People also said that new services should be properly monitored quality assured and reliable.

What we are proposing

To create a wider breadth of sustainable services that meet people's needs now and in the future the Trust is proposing to close Baytree House. The Trust will work with carers and individuals to provide alternative short breaks that better meet people's needs.

This means that people would no longer receive short breaks at Baytree House but by combining personal budgets and working with carers, a range high quality, flexible replacement short breaks would still be available. These would be provided by a range of providers from the independent sector, to offer people more choice and control over the type of short break they would like to access.

The Trust is proposing to close Baytree House in April 2016. For all those using Baytree House as a short breaks option, the Trust has given its commitment to ensure improved support and planning for people, to help them use personal

budgets to meet their outcomes and manage their money to support a new short break of their choice.

How to have your say

The consultation will run from Friday 4th December 2015 closing on Friday 5th February 2016. It will run for a total of nine weeks to account for the Christmas break.
You will be able to have your say by completing the consultation questions at the end of this document and returning it to the freepost address or alternatively by going on to our website and completing the electronic form.

We want to provide as many opportunities as possible for parents,carers and people with learning disabilities to understand the proposals and share their views and feedback. As part of this formal consultation, we will give you the opportunity for further face-to-face dialogue. You will be able to book a one to one slot at a consultation surgery on **Tuesday 15th December from 9am- 4pm** with Jo Williams, Assistant Director Adult Social Care and/or Steve Honeywill, Head of Operational Change. This will enable carers and parents to clarify issues and speak confidentially about any further concerns that they were unable to raise or address as part of co-design meetings.

If you are unable to attend a slot at this session you can call 01803 217695 to arrange an alternative time to either meet or talk directly to one of the team via telephone.

All of the feedback from the co-design meetings, surgery session, over the telephone and the consultation will be incorporated into the consultation report for a decision by the NHS Trust Board and Torbay Council Scrutiny.

Consultation questions

The Trust now needs your help. Please share your views with respect to the proposed closure of the short breaks unit at Baytree House and the proposal to provide alternative short breaks. When taking part in the consultation please consider the following:

1. Has the Trust has taken all the facts into account in its proposals and if you think they are fair?
2. Do you have any concerns you may have about any of the proposals outlined in this consultation document, and how these concerns could be reduced?
3. What support you would like if any changes were to go ahead?

The Trust is seeking your views on the following questions. If there is not enough space to write your response please attach additional sheets and these will be included, along with your response.

1. Do you agree with our proposals to close Baytree House and provide alternative bed and community short breaks? Yes ☐ No ☐ Additional comments
2. Do you currently use Baytree House? Yes ☐ No ☐
3. Do you feel you have been able to help shape and influence the proposals by taking part in the co-design process? Yes ☐ No ☐
4. What are the features of a good short break service, in your view? Please list the aspects that matter to you.
5. Are there any unique features about the service provided at Baytree you would like other providers to continue?
6. Are there any aspects of the service at Baytree which you think could be improved?
7. If you have chosen not to use Baytree would you be able to outline the reasons?
8. If have considered other providers, please give us any feedback you have on them.
9. Do you think this proposal is unfair towards any group of people (with regards to their gender, ethnicity, age, religion, disability or sexuality)?

How to respond

You can take part in the formal consultation by post, online, telephone, or attending a surgery session. Any feedback you have already submitted as part of the co-design meetings will still be taken into consideration in the final report.

Please respond to the consultation no later than **Friday 5th February 2016.**

Post: You can submit your formal response by completing the form above and sending via post to:

FAO Steve Honeywill
FREEPOST(RRLE-KHTU-ZGEU)
Torbay and South Devon NHS Foundation Trust
Bay House
Riviera Park
Torquay
TQ2 7TD

Online: You can complete and submit the consultation form via the Trust website www.torbayandsouthdevon.nhs.uk/about-us/news-and-publications/consultations/

Consultation surgery: If you would prefer to speak to someone in person you can book at slot at the consultation surgery on **Tuesday 15th December 2015 from 9am-4pm.** To book a suitable slot please call 01803 217695.

Telephone: To speak to someone via the telephone please call 01803 217695 between 10am-4pm, Monday to Friday, you may not be able to speak to a representative straight away but you will be given a call back by one the team. You can also leave message, requesting a call.

Thank you

Thank you for taking the time to come along to the co-design meetings, read this document, and respond to the consultation. We hope that it gives you a clear understanding of why the Trust is proposing changes to short breaks in Torbay.

Torbay and South Devon NHS Foundation Trust is very proud of the services it runs and we know that you are too. By working together, we can help shape the future of short breaks, ensuring that any alternative provides high quality, sustainable and modern care to you and your loved ones.

All of your comments from the co-design meeting and consultation will feed into the decision making process.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	2nd December 2015
Title:	Child and Adolescent Mental Health Service (CAMHS) Report
Lead Director:	Liz Davenport
Corporate Objective:	Safe care No delays
Purpose:	The purpose of this paper is to brief the Board on the CAMHS service, its service offer, standards, strengths and what it does well, the risks within the service and mitigation and future aspirations.

Summary of Key Issues for Trust Board

Strategic Context:

CAMHS services nationally have seen very little investment and Government priority. The strategic context for the current CAMHS service sits within the 'Future in Mind' document published this year by the Department of Health. There is also a significant lack of in-patient (Tier 4) provision for CAMHS and this has been recognised nationally following an audit completed by NHS England last year. This has created pressure within the service and it is challenged to manage the current waiting times which are in excess of 18 weeks. This is not an unusual picture nationally, although there is limited benchmarking information available. The local CAMHS service has seen an increase in demand for urgent and crisis work by 140% over the last 3 years and has also seen a rise in complexity of the cases referred to them. In addition there has been a rise in routine referrals of 80% over 3 years. This level of increase in demand has been experienced by CAMHS services nationally but for Torbay the rise has been higher. The service is innovative and has an excellent track record of transformation recently being successful in gaining national monies to further develop local services. It also involved young people and families in the design though the 'Have Your Say' group ensuring young people's participation in recruitment processes, website development and mystery shopping.

Key Issues/Risks

The key issues for the CAMHS service is the current level of demand for the service and backlog of people waiting over 18 weeks for treatment. There are robust risk assessment processes in place for the management of this. Lack of a Crisis Intervention service and the service has been successful in obtaining national redesign monies to develop this service locally.

Recommendations:

That action in relation to waiting list pressures and service capacity are addressed through the RTT and Diagnostics Assurance Group and also factored in as part of business planning.
That transformation support for the CAMHS redesign group remains ongoing.
The Board supports the development of the CAMHS service in line with the transformation bid.

Summary of ED Challenge/Discussion:

Discussed performance and current challenges to CAMHS performance at ED meeting on 10 November 2015 and agreed:

- Project management capacity to support transformation programme
- Review of performance standard and improvement plans through the RTT risk and assurance group

Internal/External Engagement including Public, Patient and Governor Involvement: N/a
Equality and Diversity Implications: N/a

01	Service Description
1.1	**Overview** This service provides treatment for children and young people that are registered with a Torbay GP. Torbay Child and Adolescent Mental Health Services (CAMHS) provides a spectrum of services from early intervention through to specialist services, in a cross-section of venues; for example designated GP Practices and Schools, across the bay by a wide range of professionals for children, young people, families and carers between the age of 0 -18 years. The Service works closely with other professions (such as Paediatric staff, health visitors and school nurses) and partner agencies, Devon Partnership Trust and Torbay Council (such as educational psychologists, Social Workers, Inclusion Workers and the education sector including foster carers). This service is delivered in two strands. The primary mental health service (PMHW) is a uni-professional service providing services for children and their families where the child is in difficulty, having a mild to moderate impact on their functioning. This service also provides consultation, training and support to Universal services. The workers are based within designated school community clusters and in reach into designated GP surgeries. This service is currently jointly funded by the CCG and Schools Forum. A specialist service is available for children and families with moderate to severe mental health difficulty, this is a multi-disciplinary team, consisting of Psychiatry, Psychology, Nursing, Psychotherapy and Systemic Therapy working with children and young people and their families/carers with complex and / or enduring mental /emotional health and behavioural problems. The teams work closely with a wide range of other agencies to ensure a comprehensive mental health assessment is undertaken prior to offering a wide range of therapeutic interventions. The range of problems that are treated include anxiety and depression, eating disorders, trauma and psychosis. For many of these children and young people being treated within this service the type of difficulties would include; those with suicidal behaviour, self-harm and risk taking behaviour requiring robust risk management and care planning. It is important to note that the CAMHs service for South Devon is provided by Virgin Care. The Torbay CAMHS service provides urgent assessments within Louisa Carey. If the case is complex and requires additional discharge planning Virgin Care will provide this. In addition if a psychiatric inpatient unit (tier 4) is required for South Devon patients then Virgin Care will facilitate this admission.
1.2	**Bases of Work** The main service is based at the Annex on Newton Road in Torquay. The PMHW are attached to school clusters in Primary and Secondary Schools; Torquay Academy, Barton Hill Academy, Cuthbert Mayne, The Spires, Brixham College and Paignton Academy. There is a psychiatric liaison practitioner who provides daily support to Louisa Carey as well as providing mental health assessments and contributing to discharge planning. The Consultant Psychiatrist also conducts a weekly ward round with paediatric staff on Louisa Carey. There is a practitioner based within Children's Social Care Looked After Children's service. Two practitioners are also based 1 day a week within Children's Social Care Safeguarding and Children In Need (CIN) teams. These practitioners provide direct access to social care staff for consultation and CAMHS assessment for children and young people who are either Looked After or being supported by Children's Social Care. There is a practitioner integrated within the Youth Offending Service providing consultation to professionals and direct CAMHS access for young people within the Youth Offending Service.

There is a Perinatal Infant Mental Health Practitioner who works with the Perinatal Mental Health team within midwifery and is based alongside Health Visiting teams.

There is an Attention Deficit Hyperactivity Disorder (ADHD) Nurse who is co-located within the Community Paediatric team providing assessments to paediatric clinics to aid assessment and diagnosis.

The hours of operation are Monday to Friday 8.00 to 18.00 with clinics operating on a Saturday as required. Our clinical staff are flexible around their times of work on the basis of clinical demand, especially in relation to urgent work.

1.3 **Workforce Summary**

The team comprises of managerial staff, clinical staff from a range of disciplines such as Consultant Psychiatry, Clinical Psychology, Systemic Therapists, Psychotherapist, Nursing, Social Work and Occupational Therapy. The WTE of the team comprises of :

- Management 4.0 WTE (0.6 WTE clinical practice)
- Clinical staff 24.3 WTE (7.0 WTE Primary Mental Health Workers - PMHW)
- Administration/reception 5.54 WTE

The sickness absence rate for the service is 4.17% which is within the 15/16 year to date target of 4.2%.

The rolling turnover up until the end of October is 14.90%, just above the target of 14%.

The current vacancies in the service are:
1.0 WTE Manager
2.0 WTE Clinical staff

Expected leavers
1.5 WTE clinical staff - Dec 2015 – (PMHW)

Expected starters
1.0 WTE Clinical staff Jan 2016
1.0 WTE Clinical staff Feb 2016 (PMHW)

02	Standards against which the service is delivered

2.1 **Key Performance Indicators**

Measure	Apr-15 Actual	May-15 Actual	Jun-15 Actual	Jul-15 Actual	Aug-15 Actual	Sep-15 Actual	Oct-15 Actual
CAMHS - Urgent referrals seen within 1 week (%)	60%	86%	50%	67%	0%	100%	100%
CAMHS - No. waiting > 18 wks for treatment (seen)	8	6	8	6	11	12	1
CAMHS - No. still waiting > 18 wks for treatment (not seen)	19	14	19	27	23	19	21
CAMHS - No. of accepted referrals per month	57	38	32	44	23	38	40
CAMHS - No. treated for the first time per month within 18 weeks	22	18	28	3	10	18	7
CAMHS - % of referrals seen within 18 weeks	73%	75%	78%	33%	48%	60%	88%

2.2 **Clinical Process for prioritising work and managing risk**

The service manages the risk in relation to waiting times by clinical screening. Referrals are screened on a daily basis for urgency using criteria for urgency such as suicidal thoughts, severe depression, eating disorder, psychosis, significant self-harm or significant risk to themselves or others. If these risk factors are highlighted these clients will be seen urgently.

The process includes an assessment using an evidence based CAMHS risk assessment tool and their risk is scored which determines urgency for ongoing work and priority for allocation.

Also of note are the internal waits within the service, for a range of treatment pathways and these are addressed as part of routine practice but will impact on the number of new referrals that can be seen.

2.3 **Quality Standards**

The service has been part of the national Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT). CYP-IAPT was introduced nationally to deliver a service transformation programme for CAMH Services. It was recognised that nationally CAMH Services were not delivering evidence based therapies and CYP-IAPT was introduced to support the transformation of services, with a particular emphasis on training the CAMHS workforce to deliver evidenced based therapies such as Cognitive Behavioural Therapy for Anxiety and Depression. The Service has supported the development of the workforce to improve access for psychological therapies for children and young people in Torbay.

The service uses NICE Guidelines to inform clinical pathways and practice. There are a range of guidelines that are applicable to the service such as Depression, Anxiety, Eating Disorders, Self Harm and Psychosis.
The service has completed baseline audits and is compliant with these.

	As part of CYP-IAPT the service now uses clinical Routine Outcome measures to measure performance on the impact of treatment provided. This means that the service has outcome data for each individual child or young person that has treatment. We benchmark well against the South West region for the implementation of this approach however this will now cease with the inception of the national Minimum Dataset being rolled out nationally in April 2016. Future In Mind (DoH 2015) sets out a set of guidelines and principles in which CAMH Services should transform. This has provided a guideline to help inform the future priorities and developments of our local service. The redesign programme used the principles of this document as part of its development.
03	**Strengths of the service**
3.1	The service is in the second wave of the CYP-IAPT programme and has had a significant transformation over the recent years. This has included training for staff in delivering evidence based psychological therapies, using Routine Outcome Measures and the development of participation programme for children, young people and their families. The participation programme consists of a young people's group and a family forum. Young people and parents contribute to service development and design, staff training and staff recruitment. The service has been successful in rolling out a newly commissioned Primary Mental Health Service to schools which has had a significant impact and improvement on school relationships, schools resilience in supporting children and young people with emotional/mental health concerns as well as offering direct quick access for CAMHS assessment and treatment. The service is flexible to meet the needs within designated clusters and delivers training and consultation to staff in order to up-skill the workforce in supporting children and young people with emotional/mental health concerns. The service has 7 WTE Primary Mental Health Workers working across the Bay. The service is working jointly with Children's Social care to re –design the roles of two social workers previously aligned to the CAMH Service to develop an Edge of Care team that would work with families to reduce children and young people going into care. The service is delivering a new workshop over a period of 5 weeks within the community for parents to help support their child where there are mental health concerns called 'Understanding Your Child's Mental Health'. This has been successful with positive feedback from parents with some no longer requiring support from the service or at a reduced level. The group has also offered parents the opportunity to develop and build on their own resilience within their community. One year ago a multi-agency redesign group was established across significant partners at a senior level. This group was established following a report from an external review, participation groups and staff feedback resulting in a redesign action plan. The plan has been divided into 5 work streams, each led by a senior lead across agencies. This programme of work was shared with the Board at their November meeting as part of Jane Viner's report. This plan placed the organisation in a strong position to bid for the CAMHS Transformation funding available over the next 5 years of up to £1.2 billion nationally. The Service manager has worked jointly with the CCG and the service has been successful in its first round of bids for £1 million over 5 years. The main focus for the bid was funding for improving care pathways for eating disorders, Crisis Intervention team, Neurodevelopmental pathways, Parenting programmes and intensive support for children and young people who are either excluded or on edge of school exclusion. The team in general are hard-working, committed and supportive to future transformation and service re-design. They have been actively involved in the development of the redesign programme and its on-going actions as well as being offered opportunities to suggest innovative ways of working. The service works closely with CCG colleagues and has recently contributed to a Vanguard bid for developing an all age liaison service with DPT.

4.0 Risks to delivery and mitigation plans

Risk	Mitigation	Rating
Increase in emergency presentations and waits over 18 weeks	Comprehensive risk assessment of referrals Implementation of the re design programme 18 week recovery plan in development Use of new NHS England investment via the CCG to set up a 'crisis response' service	8
Increase in Psychiatry caseloads to above the level recommended by the Royal College of Psychiatry	Review of job plans Telephone clinics Waiting list for non-urgent work Weekly reviews of caseload with allocation to key workers where possible All cases risk assessed Shared care with GPs Re- design work	4
Workforce pressures leading to a capacity reduction for clinical and administrative staff.	Embed new ways of working as part of redesign programme 18 week recovery plan articulating workforce requirements Appropriate sickness management in place aligned to policy Creative recruitment strategies Transformation funding	6
Management capacity and its impact on the transformation programme	Recruitment Support from the Operational Development Team Medical support and leadership from Dr Morris Prioritisation of activities	6
Ability to operationally deliver the new Crisis Intervention service	Creative recruitment strategy with HR Early recruitment	4

5.0 Future aspirations and ambitions including the potential that the service may be tendered

5.1 The CAHMS redesign plan placed the organisation in a strong position to bid for the CAMHS Transformation funding available over the next 5 years of up to £1.2 billion nationally. The service manager worked jointly with the CCG and the service has been successful in its first round of bids for £1 million over 5 years. The main focus for the bid was funding for improving care pathways for eating disorders, Crisis Intervention team, Neurodevelopmental pathways, Parenting programmes and intensive support for children and young people who are either excluded or on the edge of school exclusion.

The Transformation plans will have oversight and scrutiny from a regional team yet to be established, holding CCG to account for the delivery of the Transformation Plan. For the forthcoming years there will be a requirement for the CCG to articulate year on how it will mobilise its plans in more detail for each particular year.

The service works closely with CCG colleagues and has recently contributed to a Vanguard bid for developing an all age liaison service with other providers.

On the basis of the development work that the service has been involved with we would want to look at all opportunities and evaluate these on their individual merits.

6.0	**Appendix**
6.1	Commission for health improvement experience of service questionnaire  CHI report Oct 15.pdf
6.2	Current waiting times as of 16/11/15  Awaiting Treatment V2 - 20151116.pdf

COMMISSION FOR HEALTH IMPROVEMENT - EXPERIENCE OF SERVICE QUESTIONNAIRE

TORBAY CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

APRIL - SEPTEMBER 2015

CORINNE FOY

EXPERIENCE OF SERVICE QUESTIONNAIRE

Torbay Child and Adolescent Mental Health Service (CAMHS)

April - September 2015

1. Introduction

The Commission for Health Improvement – Experience of Service Questionnaire (CHI-ESQ) was developed by the Commission for Health Improvement (CHI), now the Care Quality Commission (CQC), the tools was devised from focus groups around issues raised as important in determining satisfaction with services, and then piloted with carers and children using CAMHS . The CHI-ESQ was originally used as an anonymous measure for one off audits of service delivery. It has high face validity but there is no other information on its information on its psychometric properties. The CHI-ESQ consists of 12 items and three free text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments.

The versions consist of:

- Parent/carer CHI-ESQ
- Self report CHI-ESQ 12-11 year olds
- Self report CHI-ESQ for 9-11 year olds

As a member of the CYP-IAPT programme the service has now fully introduced the questionnaires which are given to families to complete at either discharge or every 6 months. This report is based on questionnaires received from the period of April 2015 to September 2015.

2. Results

Each group was given a set of questions which slightly differed from the others, although the main purpose of each question was essentially the same across all three groups (for example, Question 1 was phrased “Did the people who saw you listen to you?” to 9-11 year olds, but “I feel that the people who saw me listened to me” for 12-18 year olds.) Questions for parents and carers occasionally referred to the service received by their children, but also to the support received by the carer / parent themselves.

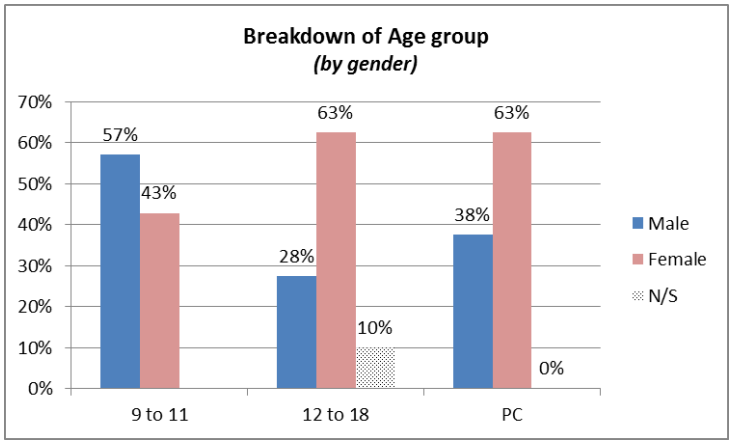
2.1 The Questions

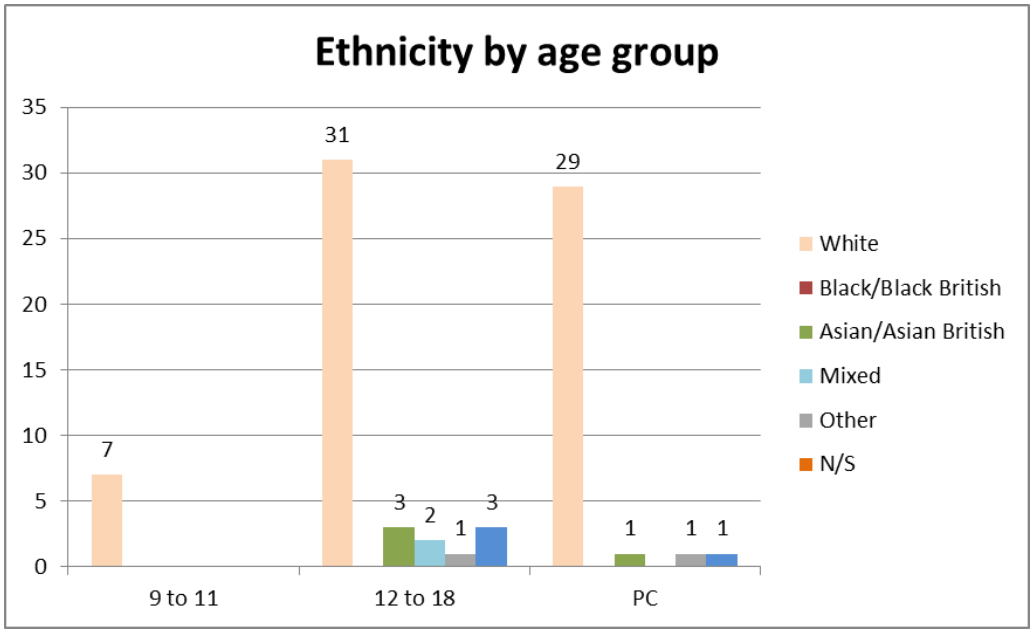
AGE Group 9-11	Age group 12-18	Age group Parent Carer
Did the people who saw you listen to you?	I feel that the people who saw me listened to me	I feel that the people who have seen my child listened to me
Was it easy to talk to people who saw you?	It was easy to talk to the people who saw me	It was easy to talk to the people who have seen my child
How were you treated by the people who saw you?	I was treated well by the people who saw me	I was treated well by the people who have seen my child
Were your views and worries taken seriously?	My views and worries were taken seriously	My views and worries were taken seriously
Do you feel that people here know how to help you?	I feel the people here know how to help me	I feel the people here know how to help with the problem I came for
Were you given enough explanation about the help available here?	I have been given enough explanation about the help available here	I have been given enough explanation about the help available here
Do you feel that the people here are working together to help you	I feel that the people who have seen me are working together to help me	I feel that the people who have seen my child are working together to help with the problem(s)
The facilities here (like the waiting area) are..	The facilities here are comfortable (e.g. waiting area)	The facilities here are comfortable (e.g. waiting area)

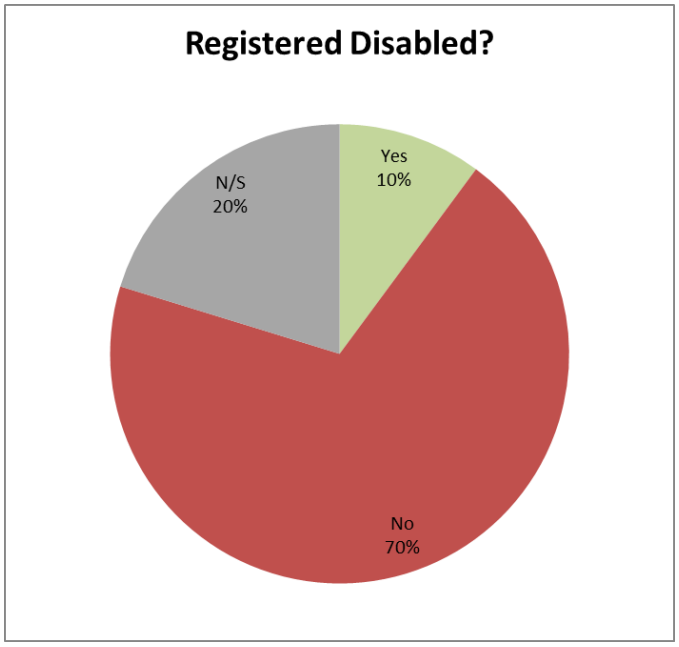
The time of my appointment was..	My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)	The appointments are usually at a convenient time (e.g. don't interfere with work, school)
The place where I had my appointment was..	It is quite easy to get to the place where I have my appointments	It is quite easy to get to the place where the appointments are
If a friend needed this sort of help, should they come here?	If a friend needed this sort of help, I would suggest to them to come here	If a friend needed similar help, I would recommend that he or she come here
Has the help you got here been good?	Overall, the help I have received here is good	Overall, the help I have received here is good
What was really good about your care?	What was really good about your care?	What was really good about your care?
Was there anything you didn't like or anything that needs improving?	Was there anything you didn't like or anything that needs improving?	Was there anything you didn't like or anything that needs improving?
Is there anything else else you want to tell us about the service you received?	Is there anything else you want to tell us about the service you received?	Is there anything else you want to tell us about the service you received?

2.3 Demographics

Age Breakdown	Male	Female	N/S	**Total**
9 to 11	4	3	0	**7**
12 to 18	11	25	4	**40**
PC	12	20	0	**32**
Total	**27**	**48**	**4**	**79**


Breakdown of Age group
(by gender)
70%
60%
50%
40%
30%
20%
10%
0%
57%
43%
63%
28%
10%
63%
38%
0%
9 to 11
12 to 18
PC
Male
Female
N/S

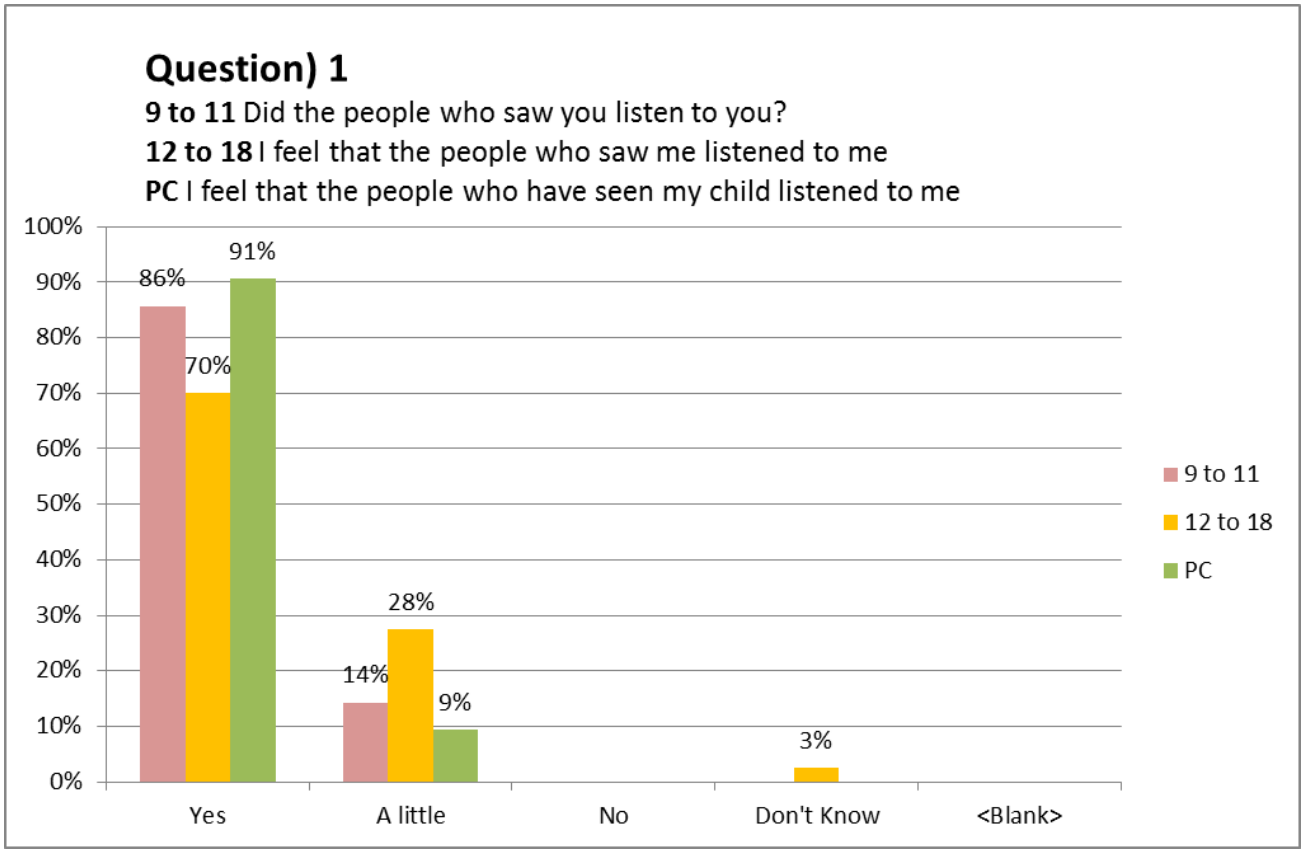

Ethnicity by age group
35
30
25
20
15
10
5
0
7
31
3
2
1
3
29
1
1
1
9 to 11
12 to 18
PC
White
Black/Black British
Asian/Asian British
Mixed
Other
N/S

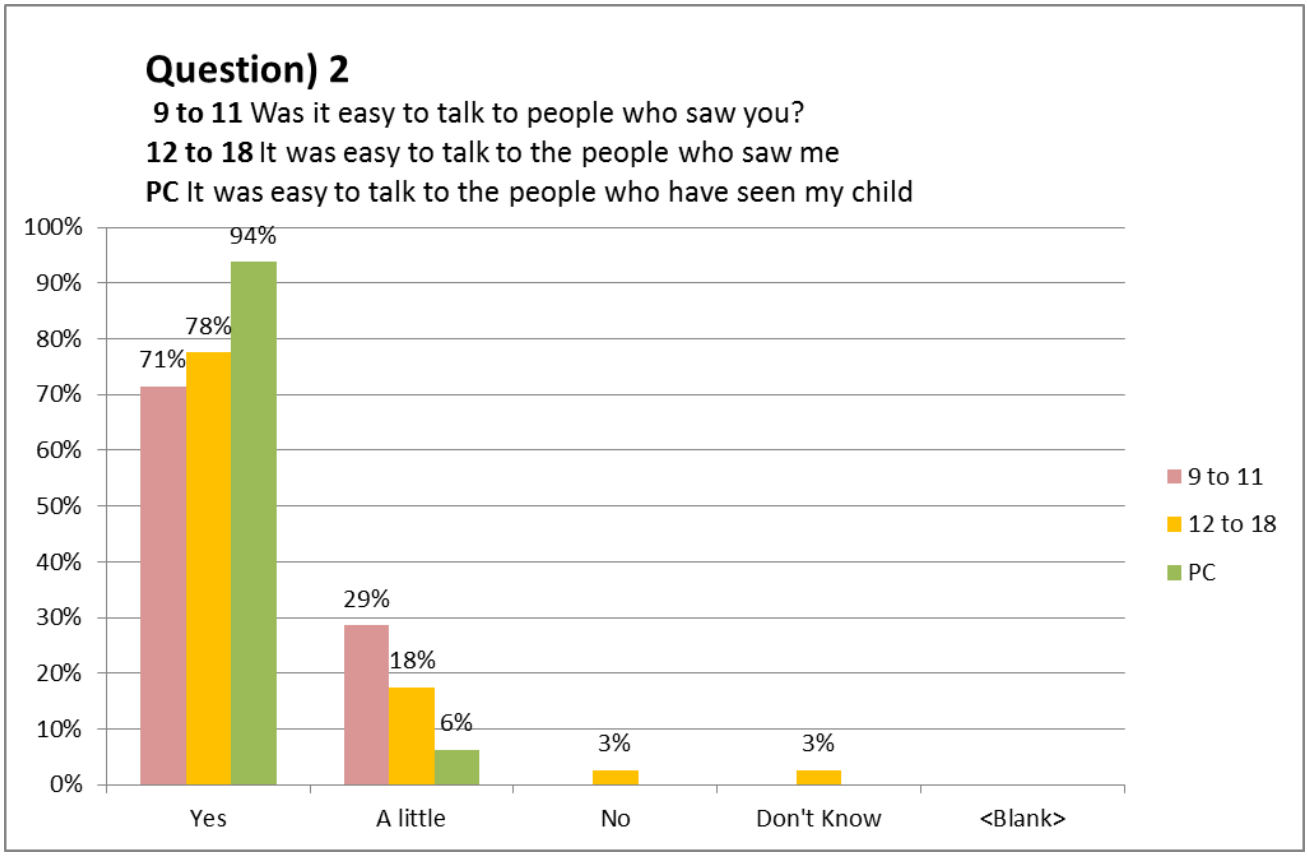

Registered Disabled?
Yes
10%
N/S
20%
No
70%

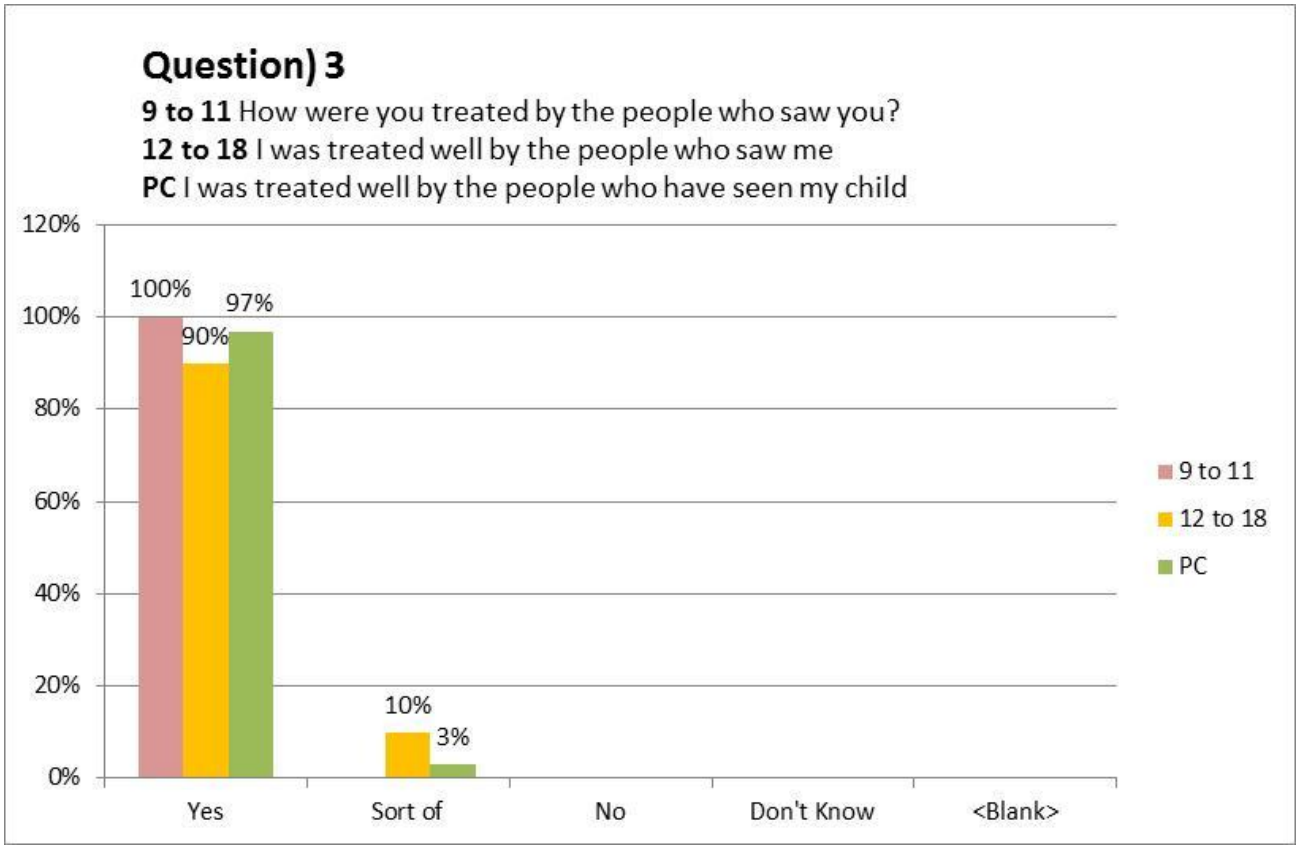
2.4 The Responses

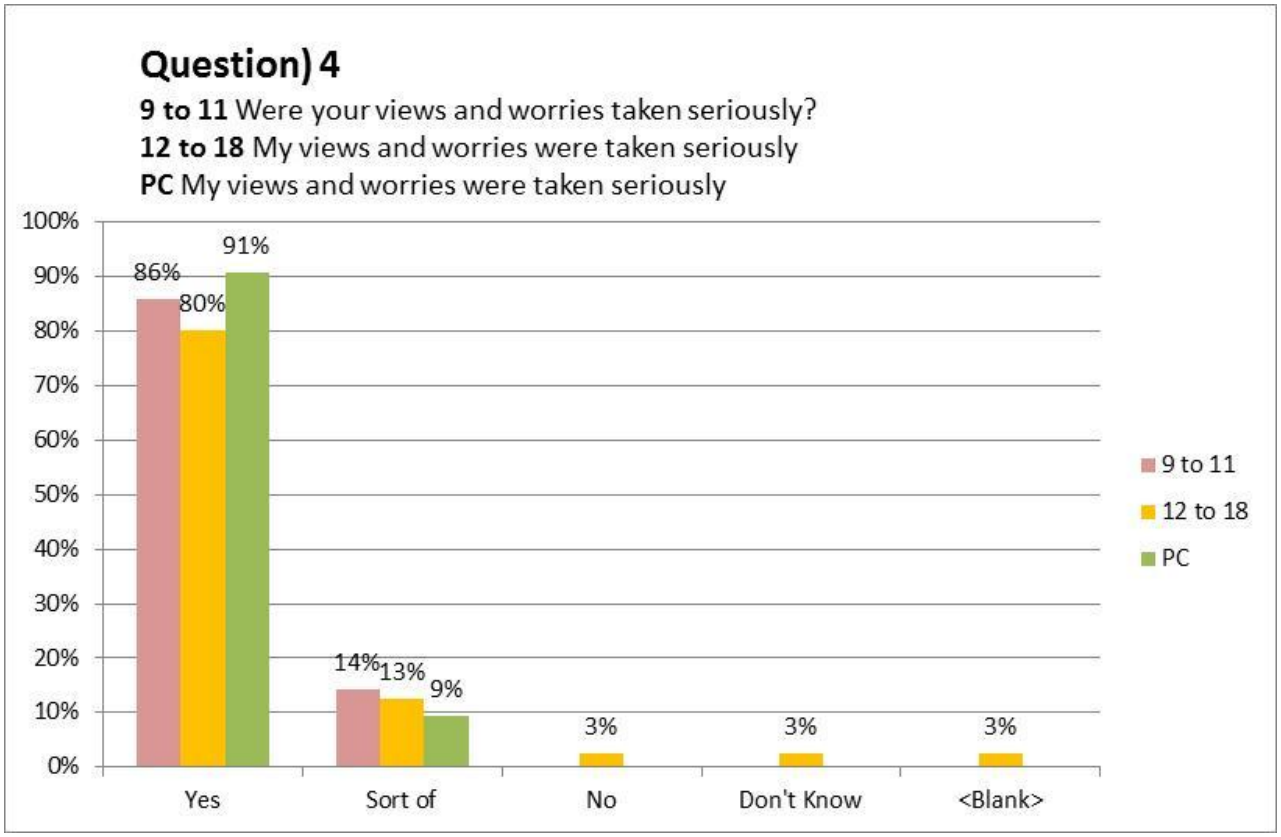
Each question below includes the variations of phraseology used for the different groups. The answers specified are generalised, to accommodate the variation in questions (for example, answers given for the categories PC and 12-18 were "Certainly true", "Partly true", "Not true" – these have been amended to enable them to tie in with the "9-11" questionnaire.)

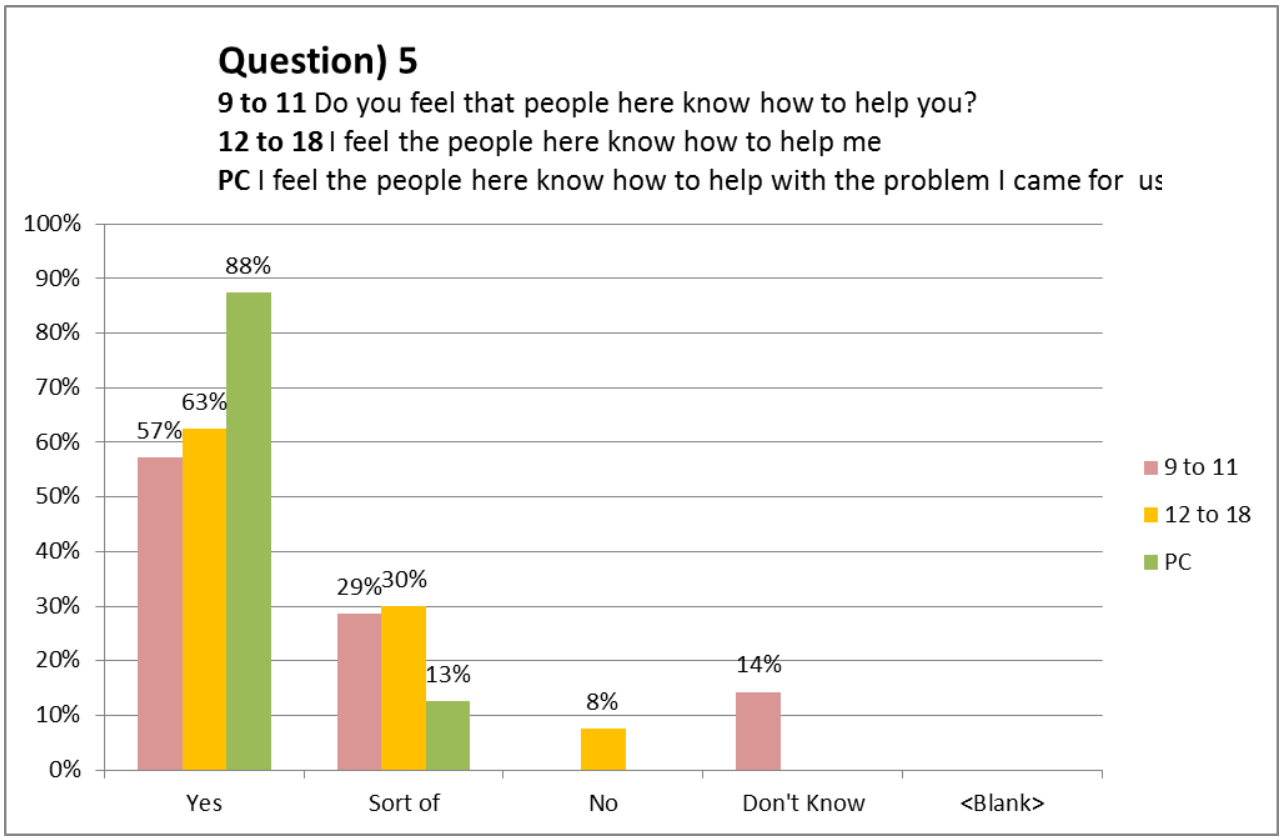
The percentages quoted relate to the number of clients in the specific age groups, e.g. in question 1, 86% of 9 to 11 year olds felt that the person they saw listened to them, as opposed to 70% of 12-18 year olds.

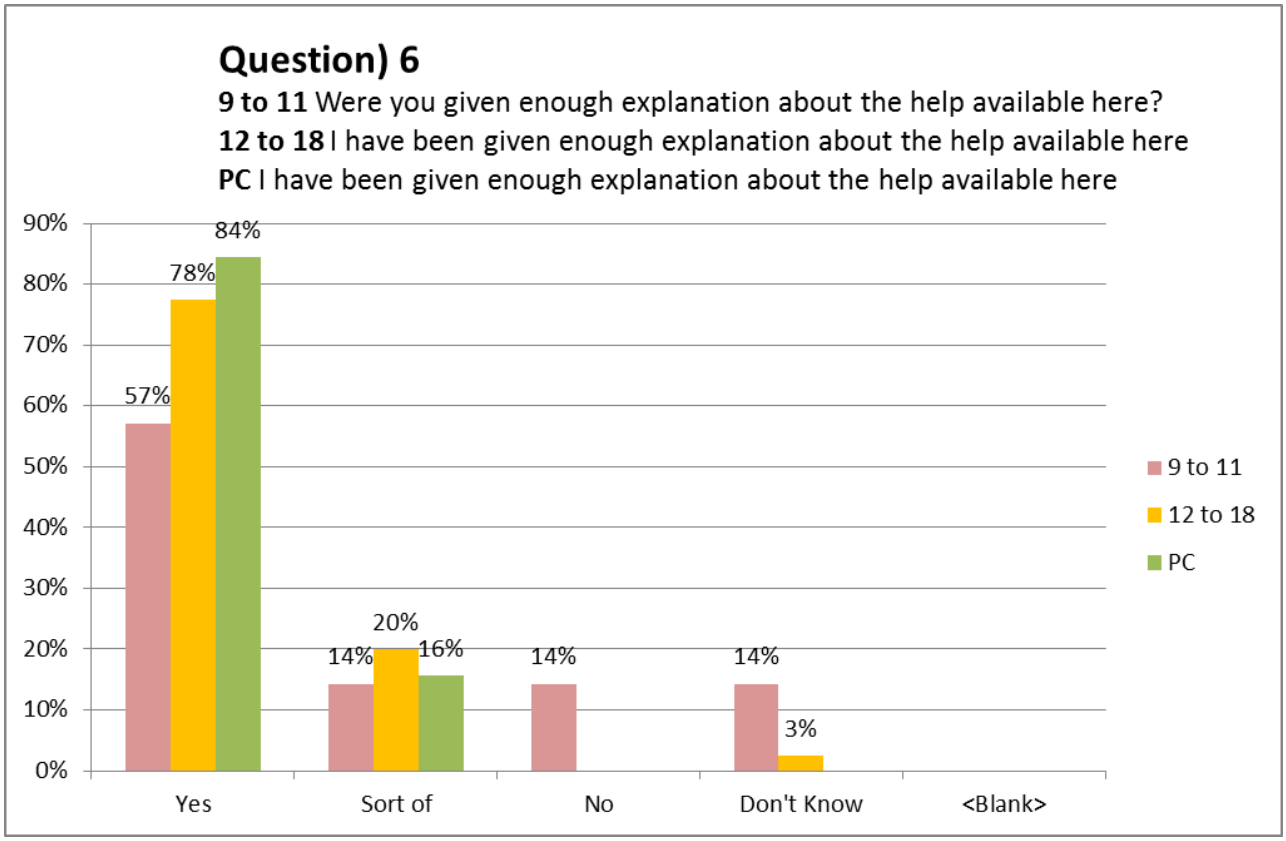


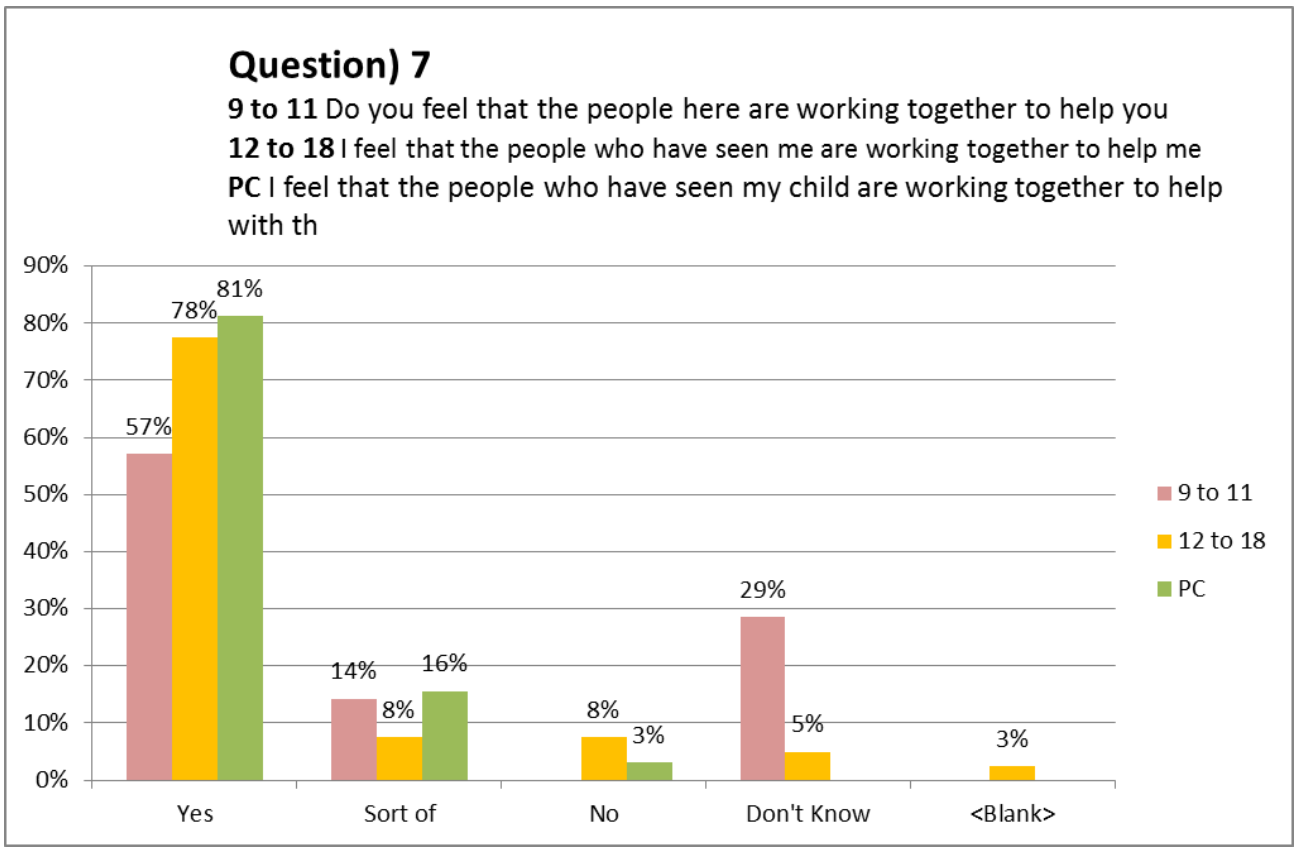

Question) 2
9 to 11 Was it easy to talk to people who saw you?
12 to 18 It was easy to talk to the people who saw me
PC It was easy to talk to the people who have seen my child
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
78%
94%
29%
18%
6%
3%
3%
Yes
A little
No
Don't Know
<Blank>
9 to 11
12 to 18
PC

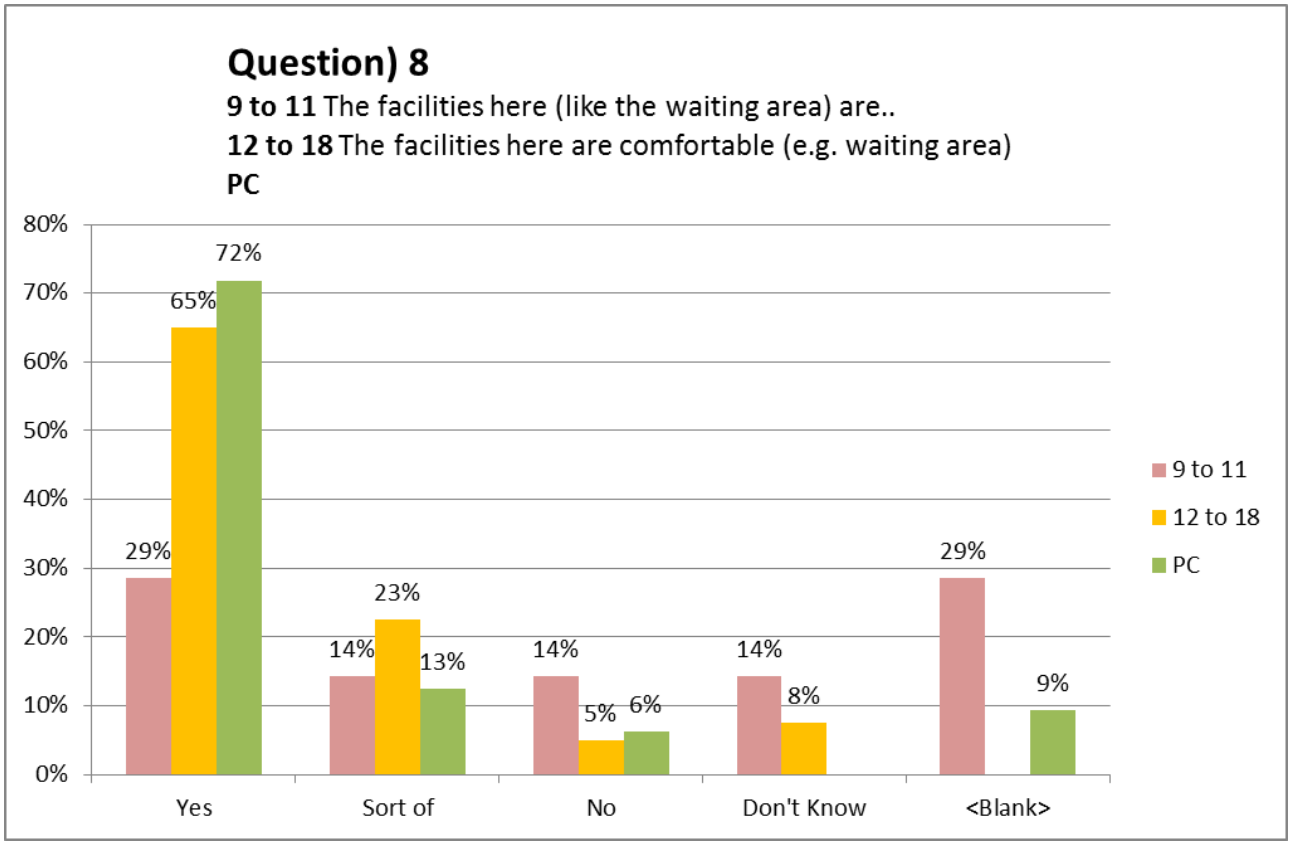

Question) 3
9 to 11 How were you treated by the people who saw you?
12 to 18 I was treated well by the people who saw me
PC I was treated well by the people who have seen my child
120%
100%
80%
60%
40%
20%
0%
100%
90%
97%
10%
3%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC

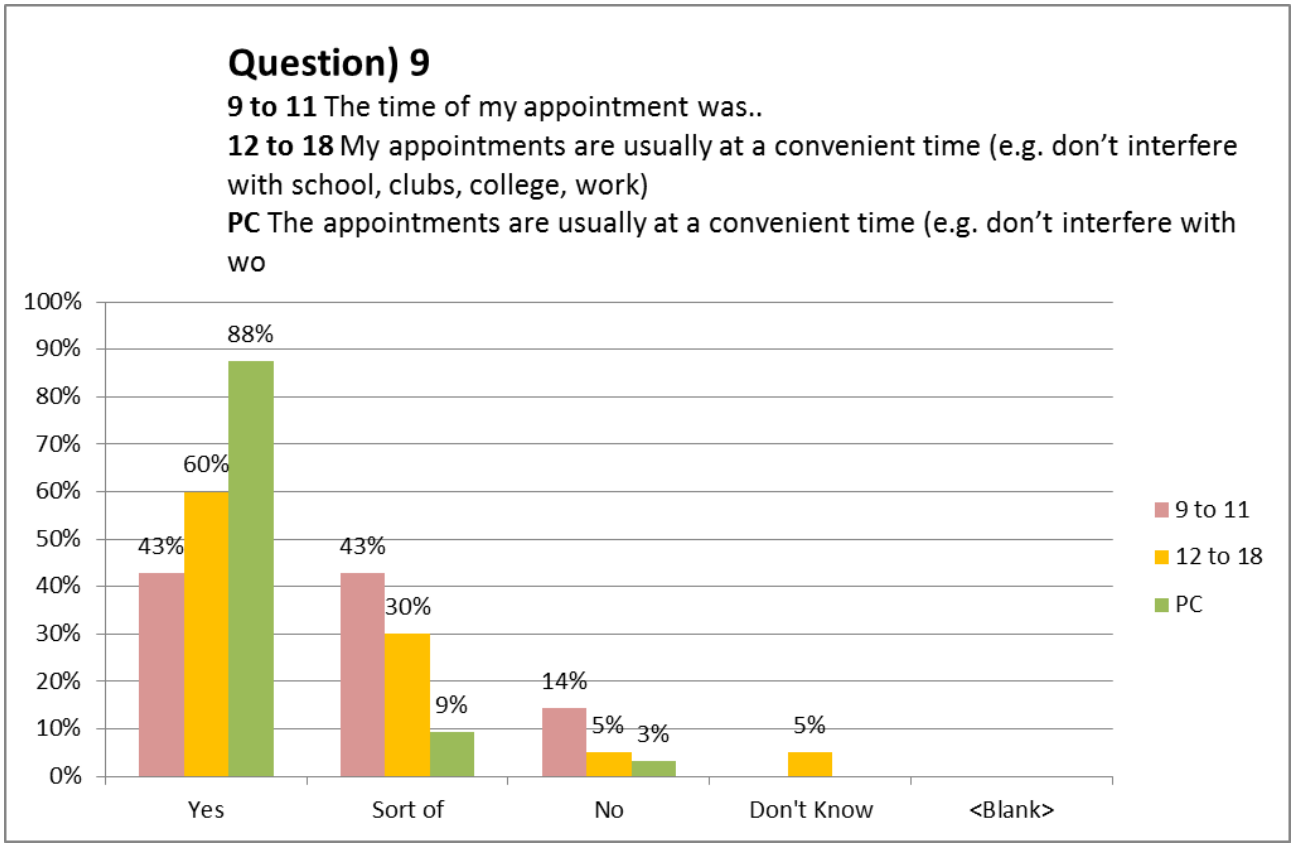

Question) 4
9 to 11 Were your views and worries taken seriously?
12 to 18 My views and worries were taken seriously
PC My views and worries were taken seriously
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
86%
80%
91%
14%
13%
9%
3%
3%
3%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC


Question) 5
9 to 11 Do you feel that people here know how to help you?
12 to 18 I feel the people here know how to help me
PC I feel the people here know how to help with the problem I came for us
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
63%
88%
29%
30%
13%
8%
14%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC


Question) 6
9 to 11 Were you given enough explanation about the help available here?
12 to 18 I have been given enough explanation about the help available here
PC I have been given enough explanation about the help available here
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
78%
84%
14%
20%
16%
14%
14%
3%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC

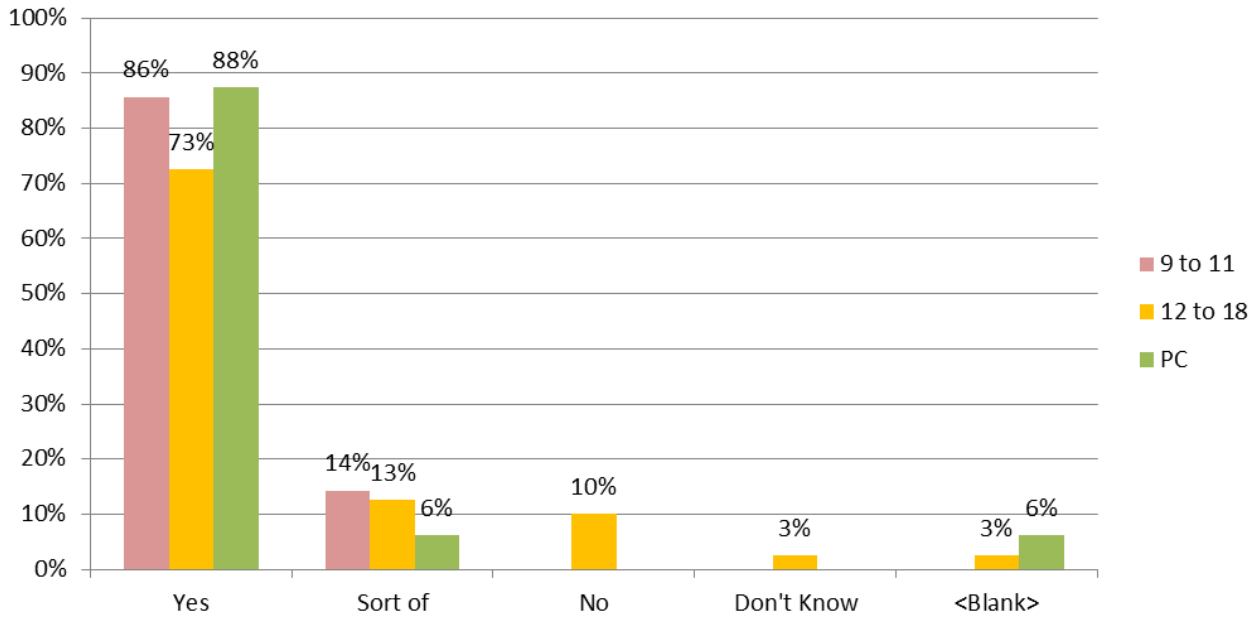

Question) 7
9 to 11 Do you feel that the people here are working together to help you
12 to 18 I feel that the people who have seen me are working together to help me
PC I feel that the people who have seen my child are working together to help with th
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
57%
78%
81%
14%
8%
16%
8%
3%
29%
5%
3%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC


Question) 8
9 to 11 The facilities here (like the waiting area) are..
12 to 18 The facilities here are comfortable (e.g. waiting area)
PC
80%
70%
60%
50%
40%
30%
20%
10%
0%
72%
65%
29%
23%
14%
13%
14%
5%
6%
14%
8%
29%
9%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC


Question) 9
9 to 11 The time of my appointment was..
12 to 18 My appointments are usually at a convenient time (e.g. don't interfere with school, clubs, college, work)
PC The appointments are usually at a convenient time (e.g. don't interfere with wo
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
60%
43%
43%
30%
9%
14%
5%
3%
5%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC

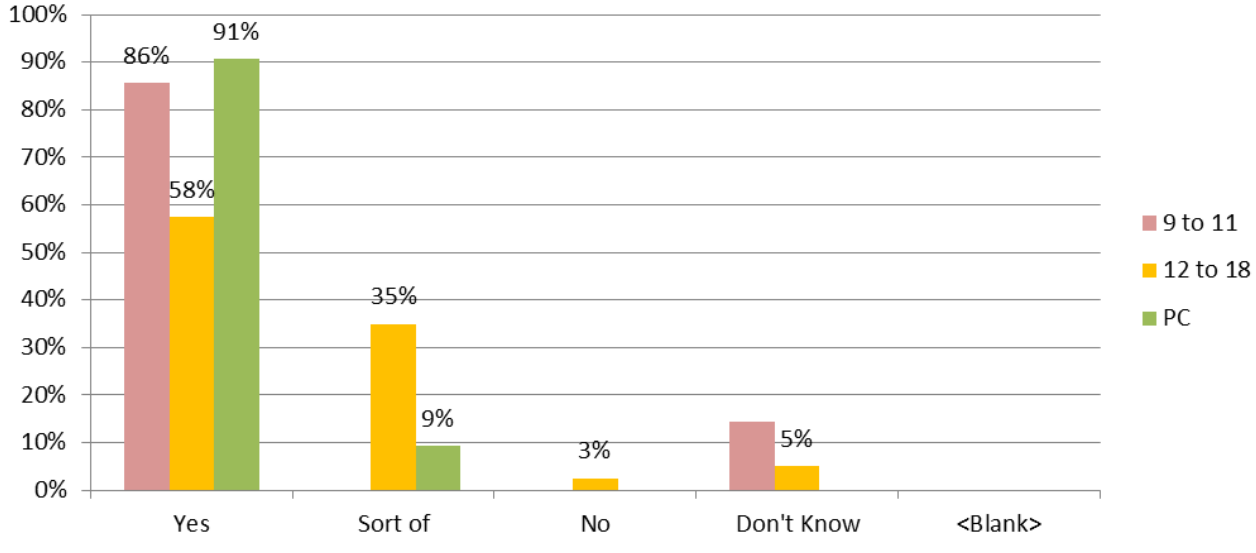
Question) 10

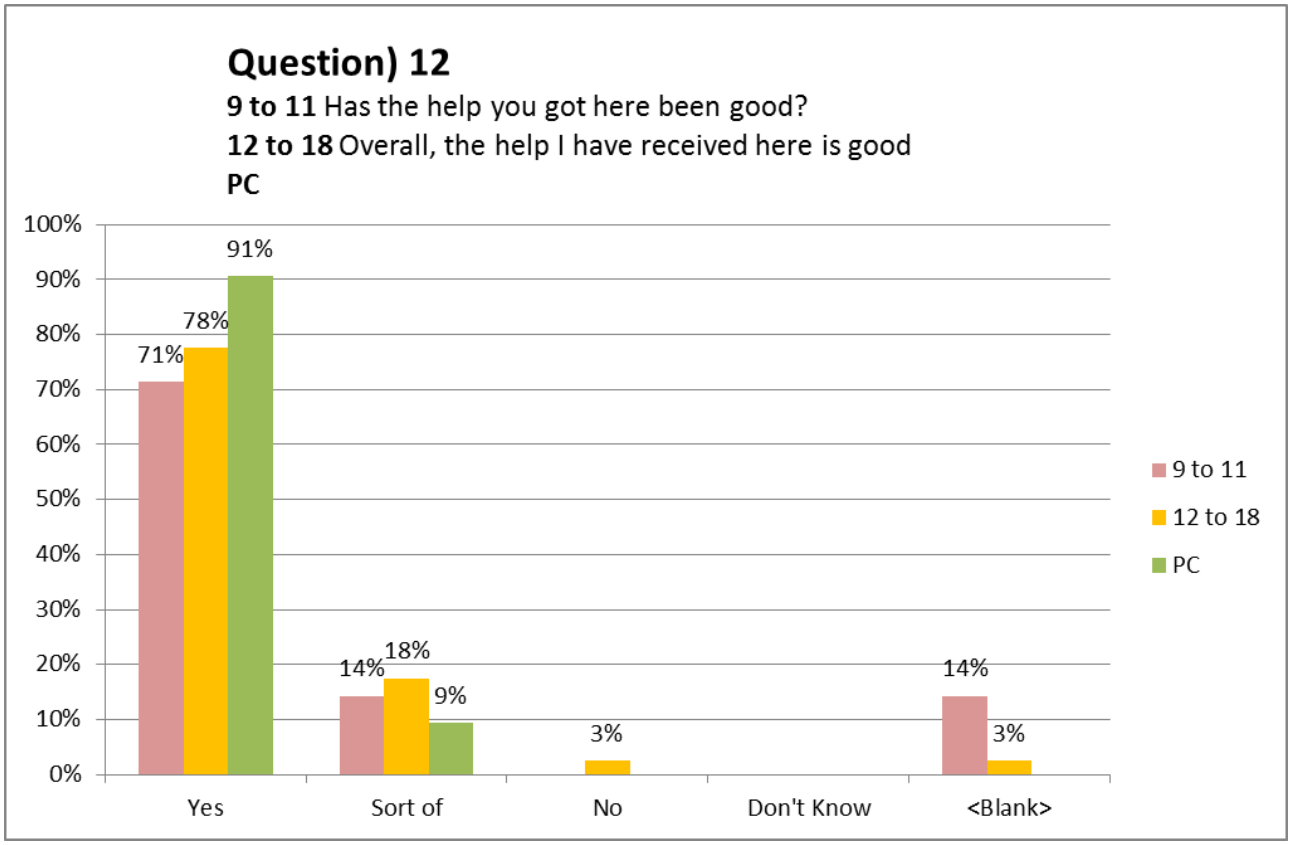
9 to 11 The place whre I had my appointment was..
12 to 18 It is quite easy to get to the place where I have my appointments
PC It is quite easy to get to the place where the appointments are



Question) 11

9 to 11 If a friend needed this sort of help, should they come here?
12 to 18 If a friend needed this sort of help, I would suggest to them to come here
PC If a friend needed similar help, I would recommend that he or she come here




Question) 12
9 to 11 Has the help you got here been good?
12 to 18 Overall, the help I have received here is good
PC
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
71%
78%
91%
14%
18%
9%
3%
14%
3%
Yes
Sort of
No
Don't Know
<Blank>
9 to 11
12 to 18
PC

2.5 The Comments

(Please note that client and staff names have been replaced with "XXX".)

2.5.1 What was really good about your care?

9-11	12-18	PC
I thought that the distraction was a very good idea. Overall I think that it was good having this help. The paper boats and making flowers and Mum being here *xxx was friendly/lively and funny. We got on well.* *Epic* They take care of you and help *Playing with soldiers*	It really helped me to get rid of thoughts that wasn't really true and to prove to myself that I can hold the span between toilet stops. I was able to talk to my worker. *Plenty of appointments so it didn't feel rushed* *I was able to talk about my problem without getting laughed at or feeling like nobody really cared or wanted to listen.* She was there when I needed someone and helped me with the things going round in my head and gave me more options that I needed. *They listened to me lots* Cause I spoke about things It was all very structured and efficient, and I always knew what was happening. *My guy was nice to me.* *The care I had was good because xxx really listened to what I had to say* I was getting the help I needed and listened to me. *Dr xxx*	xxx came every time our appointment was met. She was very patient - and easy to talk to. XXX's fears and worries were taken seriously. Nothing was considered unusual and we weren't made to feel "different" because of the issues we had. It is good XXX was given more time, and that time paid off with XXX's symptoms reducing and some disappearing altogether. XXX is much better at expressing her feelings and needs, and being able to identify them. *Bringing fun out of us all and it was lovely to be able to talk about worries and issues. Many thanks.* *I felt very supported and listened to. I now feel so much better in myself and feel so much closer to both my children and have a better bond with them.* xxx understand my problems *The best element of care on this occasion was the initial appointment with xxx. Then a follow up meeting with (with xxx) while XXX was awaiting for his*

	That all my problems were listened to and I was given the best advice. She made me feel comfortable and I have really warmed to her. She is very down-to-earth and always made me laugh. She's great. Someone to talk to I guess Was listened to and received good advice on what to do when feeling low in situations. Also manage to express it properly instead of bottling up anything. Give me another perspective on things rather than looking at a situation with a funnel vision. I was listened to really well and the care I have received is working very effectively. Everyone helped and listened to me. I felt it was really beneficial. I was well matched with the people I was working with The fact that I was taken seriously and not treated like a child Very understanding and supportive. Personalised care. Flexible appointments. Very encouraging and positive. That I was listened to. xxx saw me at	therapy sessions to begin. Could talk about anything without being judged Everything The fact that XXX is getting better xxx helping my son at school & away from the sterile / frightening environment of the CAMHS building was brilliant - really helped to set him at ease and allowed him to engage more easily. It was helpful that xxx allowed me to join her and XXX in the sessions sometimes. XXX was also happy for this to happen. I was able to discuss any worries relating to XXX wellbeing, in a friendly and relaxed way and I would have been able to contact xxx at any time outside of appointments if the need had arisen. Being listened to Very supportive when my daughter was very low They listened and helped! xxxx listened to the whole family's views and would often refer back to certain points made. At no time did XXX feel that anyone was being

	home. My Mum was able to be with me. It was at home so it was easy to be ready and it felt like I was always safe and comfortable. It also felt I was in control because I could say if it was not working or I wanted to change something. I was listened to and appreciated Making you feel at ease and not being worthless The people here listen to what I have to say and try to help me. I felt that I was heard. My therapist. Nobody, at any point in my life, has been able to soak up my anguish and alleviate my troubles in quite the same way. xxx is funny & interesting, and that doesn't begin to cover it. I will miss her, but am ultimately happy she will be able to help others in the same way. Helped me understand my illness, helped my parents. Allowed me to express my annoyances. Threw this paper. Feel better after normally. They listened to me and	negative or judgemental towards her. xxx was very understanding and compassionate. She had a way of bringing herself down to my child's level enabling her to talk. That people have listened to me about my concerns and worries. Genuinely wanted to help in all ways possible, listened and brought her to the point that she has been discharged and is doing well. Friendly, relaxing atmosphere where I could express my concerns. Xxx understood my concerns and why we had sought help. She supported me and empowered me to make some of the changes needed to help my son. She was direct and got to the heart of the matter quickly. xxx has been brilliant - Supportive & understanding with true empathy for my son. xxx has been patient and understanding. I feel both genuinely care for XXX and his wellbeing. Also, looking at the "whole picture" i.e. siblings / parents XXX felt listened to and the boys were included too. All members of staff helpful

	understand where I was coming from. I felt listened to at the meeting and was more happier than normal because of it. I felt really listened to and like people actually care about me. Very attentive staff who listened to concerns	and were willing to let outside agencies attend sessions for the benefit of the child. People listen to your concerns and are quick to action necessary procedures & remedies. Support is available for the family as a whole leading to a holistic centred approach to care. The sincerity of xxx. Both are extremely helpful in assisting us in our journey. Explaining our situation and listening to us to give us pointers in the right direction. CAMHS have helped my son to manage his anxiety better.

2.5.2 Was there anything you didn't like or anything that needed improving?

9-11	12-18	PC
No The first lady I saw was really difficult to understand. It upset me. The building needs more colour & paintings on the wall. A bit Different toys	No I feel that everything has been improved. Too much paperwork. Didn't like the [smiley face] charts every session. Some of the anger controlling exercises were completely pointless. While I had counselling, xxx made XXX sit with me through every counselling session but it was a problem because I couldn't open up to him fully as I expected like home problems, because she sat in the room so couldn't. So counselling with him didn't really help one bit / was bad counselling - as he didn't ask me if I wanted XXX in the room she just sat every session. We had the latest appointment at 4:30pm but this was not always easy to get to because of work. I think nothing! Was what I needed and got. I felt that the overall process was quite long, so at point when I felt I needed help most my situation was still being evaluated.	Still have a little concern for my kids for the future due to the circumstances from the past. It is a shame that XXX had to see a locum as it would have been more reassuring for her to know she could come back to see xxx if SHE wanted. I felt my son's issues were being over-emphasised at one point he would never hurt his sisters he is very protective of them overall. My behaviour needs to improve along with my parenting skills Lack of continuity between sessions, so felt momentum never established - after the final session, I am left not really knowing how best to continue supporting my son, now that CAMHS involvement has ended. It feels that we now just wait and see if / when the next difficulties may occur to a serious enough degree to seek help. I/We still feel we have no answers about what has triggered XXX anxiety and mood swings

	I feel that my issues were not taken 100% seriously, and were just passed over as minor, and I further felt I could not open up fully. Maybe have her on a Thursday 3 lesson but nothing at all Relationship with my Mum No, everything was perfect. [Illegible], but I understand that people are bust. A bit more adult staff in the waiting area The homework Shorter waiting lists. Better communication while on waiting list Maybe waiting, but I don't much can be done about that. I was promised a letter which I did not get. My session was cut down to 20 mins instead of an hour because they were running late. Why would people with social anxiety want to all sit together or have to look at each other. I feel it was the thing I needed	(which seem more than teenage hormones.) Our initial assessment was very difficult as my son could not understand the accent of the lady assessing him. We all found this very stressful but this was put right by doing a second assessment. More counsellors are needed as the waiting time to get an initial appointment is too long. Possible helpline at weekends, because taking your child to A&E is not always the best thing to do. I think there should be autism-specific help / therapy as CBT is not suitable for ASD clients. Although xxx was very helpful in supporting me to help my son, she was unable to access any therapies to help XXX directly. At times the admin has been a nightmare - wrong appointment times, misinformation and sometimes an "abrupt" attitude on the phone when questioning why mistakes were made. The wait time to see XXX was detrimental to his progression and the inconsistency of the service at the start (locums) broke trust and was damaging.

		The initial waiting time of referral and if a member of staff leaving having to wait again to be allocated to another therapist. The waiting list for assessment. My daughter has been let down by the system as it stands. By taking the forms of people who do not know XXX well enough led to a severe delay in getting CAMHS help thus far. I fear that further delay will only prove negative for XXX.

2.5.3 Is there anything else you want to tell us about the service you received?

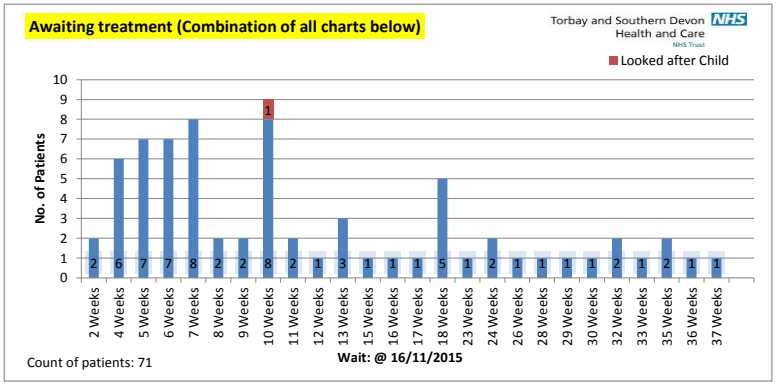
9-11	12-18	PC
I thought that the help I have had is going to help me whilst I am at Churston School It will be good that xxx is based at Brixham College for when I go there later. *I really like it.*	No everything has been good Would have been nice to have had more feedback on the advice that was being given *That I haven't felt suicidal since xxx came and helped.* *I feel that I had been given the opportunity to say certain things and other things had actually been listened to a conclusion would've been reached much quicker.* *I would like the sessions to be at the CAMHS Complex.* The only thing is I just don't like having loads of different people because I don't always like to repeat myself. It has helped me a lot. I have learned a lot about my problems and know how to control it. *No. A bit repetitive.* *Thank you!* *Was happy and really good.* I am truly thankful and appreciate the help I have received First class service	Think there needs to be a continuation of service (maybe less frequently) if it is needed. XXX social worker has recommended XXX has further help but probably not so frequently with one or two behavioural issues still linked to anxiety, it seems a pity that she has to "start again" from her point of view with a new person. It has been very helpful. *I am grateful to have received this care and support as it has help to improve the way I feel greatly. Thank you!!* *xxx engaged wonderfully with my son and also with us. We are pleased that she is based at school and therefore so much more accessible. Thank you.* *I am just happy to know that the service is available to us, should any other worries or issues arise.* Not really The staff were all very helpful and friendly *For the limited resources given to Mental Health you do an amazing job.*

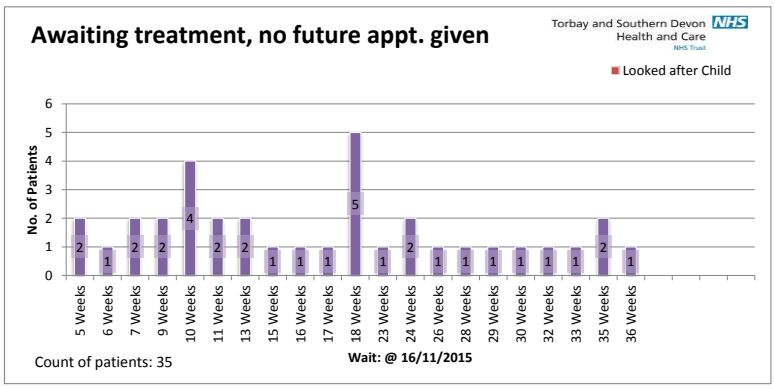
	xxx was very helpful. It has helped me gain confidence that my Mum went on the workshop. Very Helpful Not really Please give CAMHS more money to improve the services. The car park sucks. When I say I should be due a prescription I am, so don't act like I am some kind of dumbass when you check and I'm right. Why should my Mum call up so we can drive here and pick up the prescription when I'm here right now. No just that it was helpful	I was happy with the services but felt communication with my son's school and CAMHS should have been direct rather than having both school and CAMHS needing me to facilitate communications. We have been here for 2 years - really only starting when there was a permanent consultant as before that it was a MESS! In the past 12 months there has been real improvement to CAMHS. You can see it and FEEL it. The parent support group was so important and helpful Reception staff are excellent. xxx. Nothing is too much trouble, they help make this experience more manageable.

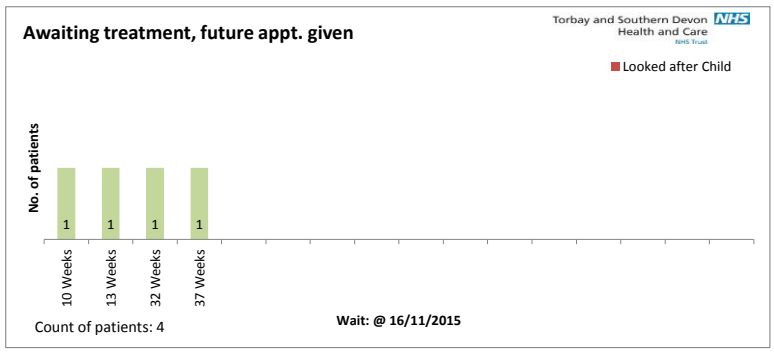
Torbay and Southern Devon Health and Care NHS Trust

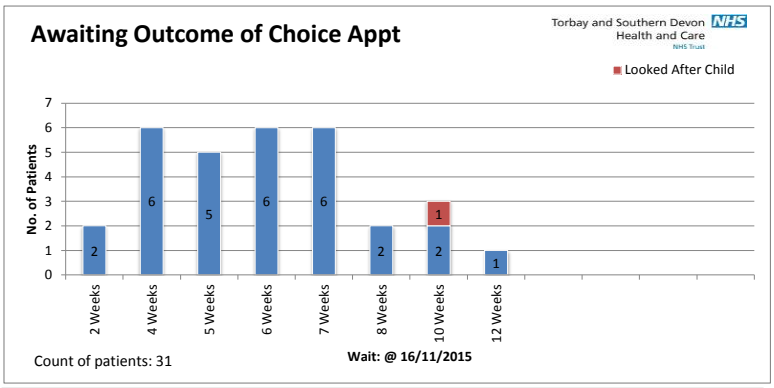
CAMHS Patients waiting times

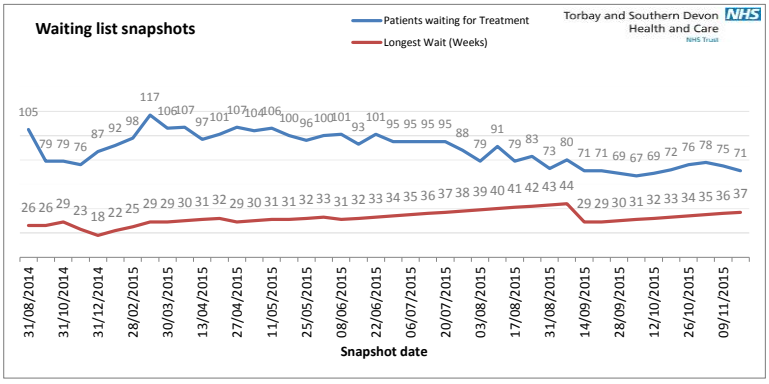
Wait: @ 16/11/2015











Torbay and South Devon NHS
NHS Foundation Trust

Board Performance Report

October 2015

1. Summary & Key Issues

1.1 Service and Quality Standards

- Quality indicators
  - There are no CQC regulatory actions in place.
  - CQC intelligent monitoring remains at 3.
  - C-diff 20 cases with 9 lapse in care identified in period Apr – Oct 2015 increase over previous year.
  - The number of follow up appointments waiting 6 week or more beyond their scheduled to be seen by date is a risk to performance and potential quality of care.

- Monitor Compliance Framework
  - The A+E standard has not been met in October 91.4% combined Acute and MIU performance.
  - The RTT standard for incomplete pathways has not been achieved in October and will be assessed as not meeting standard in the Q3 monitor risk assessment.

- Contractual Framework
  - CQUIN schemes - Feedback on the CCG contract Q2 CQUIN reports identified several areas not meeting agreed milestones, with a potential contractual risk of 78k.

1.2 Financial Performance

- The financial plan has been updated to represent the LTFM of the new organisation. Accounting for the transaction on an absorptin basis gives rise to a significant technical surplus.

- The below table shows the annual plan revised for absorption accounting:

	£'000
Gross Deficit LTFM	7,422
Plus Impairment	500
Plus Asset disposal on transfer	6,028
	13,950
Less Transfer planned under absorption	(43,373)
Total (Surplus)/Deficit	(29,423)

- At EBITDA level, performance for the seven months ended 31st October 2015 remains broadly in line with plan at £3.72m.
  Variances in non- operating costs reflect higher than planned expenditure in completing the transaction, driving the I&E deficit to £4.4m, which is £0.90m above plan.
  The Trust has a £960k deficit in month net of transfer by absorption, and £4.4m year to date, which is behind plan by £0.9m, excluding the gain on transfer.
  Cip delivery remains a significant challenge and is the focus of all budget holders.

- The Trust has delivered a Financial Sustainability rating of 2, which is on plan.

- The cash position is strong at £32.62m reflecting increased working capital achieved through the acquisition.

2. Board Performance Dashboard

Torbay & South Devon NHS FT Performance Report - October 2015

Section 2 - Performance report

FRAMEWORK
Indicators split by buisness unit
Trustwide / Acute indicators

KEY
(P) = Provisional

	Safest Care	No Delays	Experience	Promoting Health	Improved Value	Target 2015/16	Red	Amber	Green	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD 15/16
QUALITY FRAMEWORK																							
Safety Thermometer - % Harm Free - (Acute)	✓		✓			> 95%	<95%		>=95%	98%	99%	99%	98%	98%	99%	97%	100%	98%	98%	97%	97%	98%
Safety Thermometer - % Harm Free - (Community)	✓		✓			> 95%	<95%		>=95%						89%	88%	88%	88%	87%	88%	90%	88%
Pressure Ulcers - Category 3 + 4 - (Acute)	✓		✓			Nil	>=1		<1	1	2	2	2	0	1	1	1	0	0	2	1	6
Pressure Ulcers - Category 3 + 4 - (Community)	✓		✓			Nil	>=1		<1						1	0	0	0	0	0		1
Reported Incidents - Major + Catastrophic - (Acute)	✓		✓			Nil	>=20	Between	<5	0	0	1	3	2	4	1	0	0	0	1	0	6
Reported Incidents - Major + Catastrophic - (Community)	✓		✓			Nil	>=20	Between	<5						0	1	1	0	1	1	1	5
Never Events - (Acute)	✓		✓			Nil	>=1		<1	0	0	1	0	1	0	0	0	1	0	1	0	2
Never Events - (Community)	✓		✓			Nil	>=1		<1						0	0	0	0	0	0	0	0
Written Complaints - Number Received - (Acute)	✓	✓	✓			<30	>=30		<30	18	18	23	28	33	26	23	22	18	18	22	22	151
Written Complaints - Number Received - (Community)	✓	✓	✓			<30	>=30		<30						14	11	17	18	8	11	14	93
(P) - VTE - Risk assessment on admission - (Acute)	✓		✓		✓	>95%	<93%	Between	>95%	91.1%	90.2%	81.6%	89.0%	89.9%	93.4%	94.0%	94.0%	95.2%	95.3%	94.6%	94.8%	94.5%
(P) - VTE - Risk assessment on admission - (Community)	✓		✓		✓	>95%	<93%	Between	>95%						94.3%	95.8%	98.6%	100.0%	93.4%	97.1%	91.7%	95.8%
Medication errors - (Acute)	✓		✓			<15	>=30	Between	<20	45	25	37	330	36	46	42	31	34	34	28	15	230
Medication errors - (Community)	✓		✓			<15	>=30	Between	<20						40	33	32	49	35	26	30	245
HSMR - hospital standardised mortality rate	✓		✓			<100%	>=105%	Between	<100%	98%	103%	108%	90%	91%	111%	110%	86%	99%	106%	100%	88%	
Infection Control - Bed Closures	✓		✓			<100	>=170	Between	<100	252	124	141	156	104	358	955	288	40	68	18	54	1781
Fracture Neck Of Femur Best Practice	✓		✓		✓	>90%	<90%		>=90%	81%	67%	72%	63%	60%	70%	74%	50%	59%	62%	61%	65%	63%
(P) - Stroke patients spending 90% of time on a stroke ward	✓	✓	✓		✓	>80%	<80%		>=80%	67%	44%	62%	60%	60%	73%	54%	70%	68%	65%	61%	68%	66%
CQC Compliance intelligent monitoring score / banding										6	4	4	4	4	4	3	3	3	3	3	3	3
(P) - Dementia - Find - monthly report						>90%	<90%		>=90%	40%	32%	36%	35%	41%	49%	41%	52%	55%	75%	71%	74%	61%
(P) - Dementia - Assess & Investigate - Monthly report						>90%	<90%		>=90%	27%	27%	56%	47%	68%	48%	81%	61%	66%	73%	80%	62%	67%
(P) - Dementia Refer - Monthly report						>90%	<90%		>=90%	83%	100%	95%	100%	96%	100%	100%	100%	100%	100%	100%	96%	99%
Clinic letters timeliness							<80%		>80%	95%	73%	68%	95%	91%	82%	86%	73%	86%	77%	73%	59%	77%
Follow ups past to be seen date						Nil				3062	3247	3112	3096	3115	3294	3577	3745	4020	4570	4873	4731	
MONITOR COMPLIANCE FRAMEWORK																							
Referral to treatment waiting times – admitted - (Acute)		✓	✓			90%	<90%		>=90%	75%	78%	77%	75%	76%	82%	76%	72%	74%	77%	81%	80%	77%
Referral to treatment waiting times – non-admitted - (Acute)		✓	✓			95%	<95%		>=95%	95%	96%	95%	95%	96%	95%	95%	95%	95%	95%	95%	94%	95.0%
Referral to treatment - % Incomplete pathways - (Acute)		✓	✓			92%	<92%		>=92%	93%	92%	92%	92%	92%	91%	92%	91%	92%	92%	92%	91%	91.8%
Number of Clostridium Difficile cases - Lapse of care acute only	✓		✓			Nil	>=2		<2	0	0	1	1	0	1	1	3	1	1	2	0	9
(P) - Cancer - Two week wait from referral to date 1st seen		✓	✓			93%	<93%	Between	>93.5%	98.1%	97.9%	96.8%	97.2%	96.4%	94.8%	94.0%	95.2%	93.0%	94.7%	97.6%	98.3%	95.4%
(P) - Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		✓	✓			93%	<93%	Between	>93.5%	100.0%	98.3%	93.9%	98.9%	96.8%	98.8%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	97.6%
(P) - Cancer - 31-day wait from decision to treat to first treatment		✓	✓			96%	<96%	Between	>96.5%	97.3%	97.6%	96.5%	100.0%	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	97.2%	98.5%
(P) - Cancer - 31-day wait for second or subsequent treatment - Drug		✓	✓			98%	<98%	Between	>98.5%	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
(P) - Cancer - 31-day wait for second or subsequent treatment - Radiotherapy		✓	✓			94%	<94%	Between	>94.5%	98.8%	98.4%	98.3%	100.0%	98.4%	94.1%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.7%
(P) - Cancer - 31-day wait for second or subsequent treatment - Surgery		✓	✓			94%	<94%	Between	>94.5%	96.4%	100.0%	100.0%	100.0%	97.1%	96.4%	93.8%	94.6%	92.9%	95.2%	97.4%	96.7%	95.3%
(P) - Cancer - 62-day wait for first treatment - from 2ww referral		✓	✓			85%	<85%	Between	>85.5%	95.6%	91.0%	87.2%	86.4%	85.2%	96.0%	92.5%	84.3%	93.0%	90.3%	87.8%	84.9%	89.4%
(P) - Cancer - 62-day wait for first treatment - screening		✓	✓			90%	<90%	Between	>90.5%	90.0%	100.0%	72.7%	71.4%	91.7%	100.0%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	97.1%
A&E - patients seen within 4 hours (ICO combined A+E figs from Oct 2015)	✓	✓	✓			95%	<95%		>=95%	90%	83%	87%	81%	88%	94%	90%	91%	91%	80%	90%	91%	89%
CONTRACTUAL FRAMEWORK																							
Diagnostic tests longer than the 6 week standard - (Acute)		✓	✓			<1%	>=1%		<1%	1.2%	3.2%	3.2%	1.0%	1.0%	4.5%	2.5%	1.2%	1.1%	2.6%	2.7%	0.4%	2.2%
Mixed sex accomodation breaches of standard - (Acute)		✓	✓			<1	>=1		<1	2	1	0	1	0	0	0	0	0	0	3	1	4
Care Planning Summaries % completed within 24 hours of discharge - Weekday	✓	✓	✓			>77%	<77%		>=77%	63%	57%	60%	45%	56%	57%	56%	60%	61%	62%	62%	62%	59.9%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	✓	✓	✓			>60%	<60%		>=60%	47%	39%	40%	31%	41%	34%	27%	33%	37%	28%	24%	27%	29.9%
On the day cancellations for elective operations		✓	✓			<0.8%	>=0.8%		<0.8%	0.96%	1.50%	1.55%	1.47%	1.65%	0.72%	1.31%	1.02%	0.71%	0.84%	0.84%	0.98%	0.9%

2. Board Performance Dashboard

Torbay & South Devon NHS FT Performance Report - October 2015

Section 2 - Performance report

FRAMEWORK
Indicators split by buisness unit
Trustwide / Acute indicators

KEY
(P) = Provisional

	Safest Care	No Delays	Experience	Promoting Health	Improved Value	Target 2015/16	Red	Amber	Green	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	YTD 15/16
Cancelled patients not treated within 28 days of cancellation		✓	✓			<4	>=4		<4	3	5	7	1	2	4	2	4	3	2	0	0	15
Ambulance handover delays > 30 minutes	✓	✓	✓			<50	>=75	Between	<50	34	56	55	72	34	23	27	18	68	87	86	73	382
Ambulance handover delays > 60 minutes	✓	✓	✓			<5	>=10	Between	<5	0	1	0	6	4	0	0	0	1	3	2	3	9
A&E - patients seen within 4 hours Type 1 - DGH only	✓	✓	✓			95%	<95%		>=95%	90%	83%	87%	81%	88%	94%	90%	91%	91%	80%	90%	88%	89%
A&E - patients seen within 4 hours community MIU	✓	✓	✓			95%	<95%		>=95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Trolley waits in A+E > 12 hours from decision to admit		✓	✓			Nil	>=1		<1	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Clostridium Difficile cases - Acute	✓		✓												3	4	4	3	2	3	1	20
Number of Clostridium Difficile cases - Community	✓		✓												0	0	1	1	1	0	0	3
Number of Clostridium Difficile cases - lapse in care Community	✓		✓												0	0	0	1	0	0	0	1
COMMUNITY & SOCIAL CARE FRAMEWORK																						
Number of Delayed Discharges			✓			<185	>185		<185						400	508	401	320	403	317	211	2560
Timeliness of Adult Social Care Assessment			✓			75%	>75%		<75%						70%	71%	71%	71%	70%	70%	70%	0%
Clients receiving Self Directed Care				✓		70%	<70%		>70%						89%	92%	92%	93%	93%	93%	93%	0%
Carers Assessments Completed year to date				✓		>40%									7%	11%	19%	18%	24%	27%	32%	0%
Number of Permanent Care Home Placements			✓			<630									649	652	652	646	645	639	645	0
Children with a Child Protection Plan				✓		TBC									160	157	156	161	190	199		
4 Week Smoking Quitters				✓		>50											118					
% OCU in Effective Drug Treatment				✓		>9.3											7%					
% Safeguarding Strategy Meetings within 7 Days				✓		>80%									73%	57%	45%	38%	38%	46%	44%	0%
Bed Occupancy															91%	91%	92%	91%	92%	90%	90%	
CAMHS - % of referrals seen within 18 weeks															73%	75%	78%	33%	48%	60%	88%	
CHANGE FRAMEWORK																						
Number of Emergency Admissions - (Acute)			✓		✓	TBC				2384	2525	2437	2276	2597	2729	2546	2631	2732	2580	2693	2777	18688
Average Length of Stay - Emergency Admissions - (Acute)		✓	✓		✓	TBC				3.57	3.88	3.93	3.81	3.72	3.32	3.43	3.52	3.24	3.25	3.20	3.22	
Hospital Stays > 30 Days - (Acute)		✓	✓		✓	TBC				20	29	25	29	27	24	23	33	27	21	28	17	173
LMAT Population Coverage			✓	✓		TBC																
CORPORATE MANAGEMENT FRAMEWORK																						
Staff Vacancy Rate - (Trustwide)						TBC									n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Staff sickness / Absence - (Trustwide)						TBC									4%	4%	4%	4%	4%	4%	0%	
Appraisal Completeness - (Trustwide)						TBC									84%	85%	86%	86%	86%	84%	80%	
Mandatory Training Compliance - (Trustwide)						TBC									87%	87%	87%	88%	88%	87%	89%	

3. Service & Quality Standards

3.1 Summary

Overview of Performance as identified in the Performance Dashboard

1.0 Quality Framework indicators

These indicators give the board assurance on the quality and safety of care given to patients.
Combining Acute and Community indicators – A number of the quality metrics are separately recorded in both the acute and community setting often using different data collection processes and reporting IT systems. There is a process of validating data collections to enable combined ICO view to be reported at board level, however at this stage the dashboard shows a number of these as separate indicators.

1.1 Performance Highlights

1.1.1 CQC regulation compliance assessment

There are no CQC regulatory concerns being reported. The latest CQC intelligent monitoring report (May 2015) maintains an overall score of 3 with 9 risks identified. Preparations continue for the scheduled CQC site inspection visit in February 2016. The executive team are receiving regular update against the in-house assurance processes and risk logs.

1.1.2 VTE assessment on admission

VTE assessment is reported on a quarterly basis. The standard of 95% is being maintained in October, community performance was 91.7% in October.

1.2 Performance variances

1.2.1 Stroke pathway time spent on a dedicated stroke ward.

The number of patients discharged in October having been admitted with acute stroke spending 90% or more of their hospital stay on the stroke ward did not achieve the standard of 80%.

The October performance is 68%. This is an improved position and is anticipated, following the focus on ring fencing of beds on the stroke ward and review of actions to improve performance against these standards with the clinical team.

1.2.2 Dementia (acute) – The % of patients over 75, admitted as an emergency to hospital and having dementia assessment accurately recorded was 74%, below the target level of 90%. Community was at 88.8%. Further improvement is anticipated, as ward teams and matrons are increasing the direct support to routinely review compliance. The pilot of the "Nerve centre" clinical system is expected to make it easier to record this information and track the status of dementia assessments for qualifying patients

1.2.3 Follow up outpatient appointments waiting times
A number of areas have plans to reduce the number of patients waiting 6 weeks or more beyond their planned review dates for follow up appointments. The at the end of October there were a total of 4731 patients waiting 6 weeks or more beyond the planned to be seen by data with 1378 of these over 18 weeks. Teams are reviewing the longest waiting patients against clinical risk to reprioritise along with plans to increase capacity and manage demand. The data book gives the detailed breakdown of the numbers by specialty. This remains a risk in several areas and is being escalated through the Chief Operating Officer at the regular RTT meetings.

2.0 Monitor Compliance

2.1 The Monitor Annual Plan for 2015/16

Declared risks against the following target indicators:

A+E 4 hour performance – plan to be compliant from the end of Q1
RTT admitted performance – plan to be compliant from the end of Q2. (Note from October 2015 the only RTT standard to be used in the risk assessment is the end of month snapshot of the % of pathways remaining to be treated waiting less than 18 weeks – the target is 92%)

2.2 Q2 update against declared risks :

2.2.1 **4 hour standard for time spent in A+E**

The standard is not achieved in October and remains at variance to our declared Monitor plan. Type 1 performance in October *87.8%, combined with the MIU performance the monthly result is 91.4%.* Improvements in type 1 performance in September (90.24%) have been challenged as a result of several periods of intense pressure on patient flow and resulting delays to meet the 4 hour standard in A+E.
More detail of the action is included in an exception plan template attached to this report.

2.2.3 **RTT incomplete pathway**s

The standard (92%) has not been achieved in October. The table below gives the national reported performance levels.

	<126		>126			
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Incomplete IPDC	Incomplete Outpatients	Grand Total	**% < 18wk**
Urology	213	390	51	3	657	91.78
Plastic Surgery	190	71	23	1	285	91.58
Other	551	3086	150	232	4019	90.50
Cardiology	118	1075	21	105	1319	90.45
Trauma & Orthopaedics	654	1114	116	87	1971	89.70
Ophthalmology	723	834	283	37	1877	82.95
Grand Total	3391	10850	700	607	15548	91.59

Significant risks remain with several specialties

- Upper Gastroenterology
- Colorectal surgery
- Ophthalmology
- Orthopaedics
- Cardiology

Diagnostics is a potential risk due to key workforce changes in the Radiology department although currently remains within target compliance. The Each of these areas has an action plan and a subset of these have been summarised in exception reports of this report.

2.2.4 **C-diff** - There has been one further case of C-diff recorded in the acute setting in October. This brings the year to date total to 20 with 9 confirmed as lapse in care against our target of 18 cases. There has also been a further lapse in care case reported in the community. The Trust has had confirmation from Public Health England that they have not set a standard for the community in the same manner that the acute standard is set for Monitor purposes.

3.0 Contract Framework

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) CQUIN and locally agreed quality indicators that have been included in the contract schedules.

3.1 **Commissioning for Quality and Innovation (CQUIN)**

The CCG have reported back against updates submitted for Q2. Several areas have not met agreed milestones and we have been requested to provide additional supporting information in two other to achieve full sign off.

Schemes not meeting Q2 milestones

- Dementia Find Assess and Refer – Not achieved
- Acute Kidney Injury (AKI) – Partial achieved – 2 or the four milestones achieved.

Schemes where additional information has been requested.

- Nutrition and Hydration – further evidence against actions taken where high risk patients identified through the screening audits.
- Unplanned admissions – Data for Q2 to be updated

It is anticipated that the further evidence requested will be delivered and these two schemes achieve full sign off.

The potential penalty in Q2 for not achieving the two unmet schemes is 78k

Community Delayed discharge

3.2 There was a total of 4,836 bed days available in October with an average of 156 beds open daily. In month, a total of 211 bed days were lost to delays.

The most common reasons for delays in October were 'Care Package in Own Home' (92 days lost; 43.6% of all bed days lost in October), followed by 'Residential Home Placement' (54 days; 25.6%) and 'Patient / Family Choice' (33 days; 15.6%). The Community Hospital Matrons and Zone Managers are working to manage this pressure each month.

3.3 **Child and Adolescent Mental Health (CAMHS)**

The CAMHS service has seen an increase in referrals whilst having a reduction in the clinical rersource to support the service. The waiting time been steadily increasing with waits for new referrals over 18 weeks.

CAMHS currently has 5.7WTE + 1WTE bank staff and a Waiting List of 83 referrals. On average, there are 15 referrals needing treatment per month and the current staffing of 6.7WTE can deal with 9 referrals per month, leaving a deficit of 6 referrals (which will contribute to the existing Waiting List of 83 referrals). CAMHS normally has over 10WTE giving it the capacity to deal with 15 referrals per month. To deal with the Waiting List of 83 referrals needing treatment, CAMHS need additional support of equivalent 5WTE for a full year.

The CAMHS re-design board continues to meet monthly and the CAMHS transformation action plan has been developed with leads allocated across TSDHCT, Torbay Council and CCG. The plan includes a comprehensive breakdown of tasks to ensure the service sees more appropriate children, improves access, works in smarter ways, working with partners including young people, schools, secondary care and children's services and finally building a resilient service

3.2 Further detail on the performance indicators is available in the Trust Quality and Performance Data Book.

4 **Attached to this report**

Appendix 1 - Performance databook

3.1 Board Performance Dashboard - Exception Reports

Performance Standard	Summary	Exception Report
RTT incomplete standard 92%	Exception report for delivery of RTT standard Orthopaedic specialty	
RTT incomplete standard 92%	Exception report for the delivery of the RTT standard for Ophthalmology	
4 hour A+E target	Exception report against the delivery of the 4 hour standard for time spent in ED	
CAMHS	The waiting time for new routine referrals is over 18 weeks	
Dementia assessment	The standard fro asessing patients for Dementia is not being achieved - this is a CQUIN target	

3.2 Escalated Matters – Finance, Performance and Investment Committee

Performance Standard	Summary	Exception Report

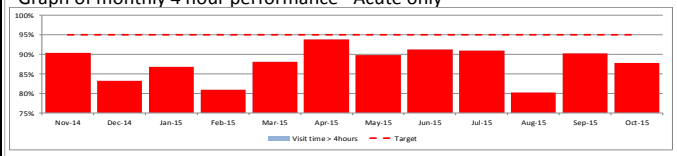
3.3 Escalated Matters – Quality Assurance Committee

Performance Standard	Summary	Exception Report

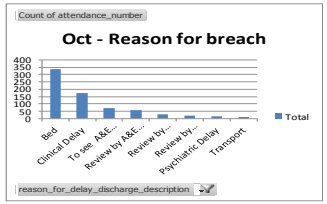
Key Performance Indicator Exception Report	4 hour standard	01 November 2015

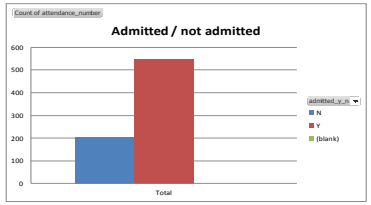
Data Analysis

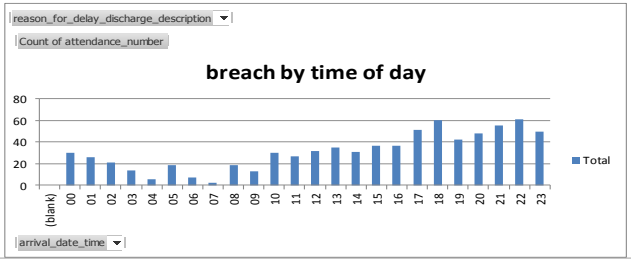
Graph of monthly 4 hour performance - Acute only



October breach analysis







Commentary

The standard is not achieved in October and remains in variance to the declared Monitor plan. Performance in October type 1 is 87.84% and 91.37% including MIU's where 100% compliance is being achieved.

Despite improvements seen in September (90.24%) October has seen several periods of intense pressure on patient flow and resulting delays to meet the 4 hour standard in A+E.

The community wide recovery plan gives details of actions that influence front door assessment capacity as well as system wide initiatives to ensure patient flow is optimised within available resources and bed capacity.

Good progress has been made in the recruitment to senior clinical roles within the Emergency Department as well as other staffing skill mix and shift patterns changes to manage periods of highest demand.

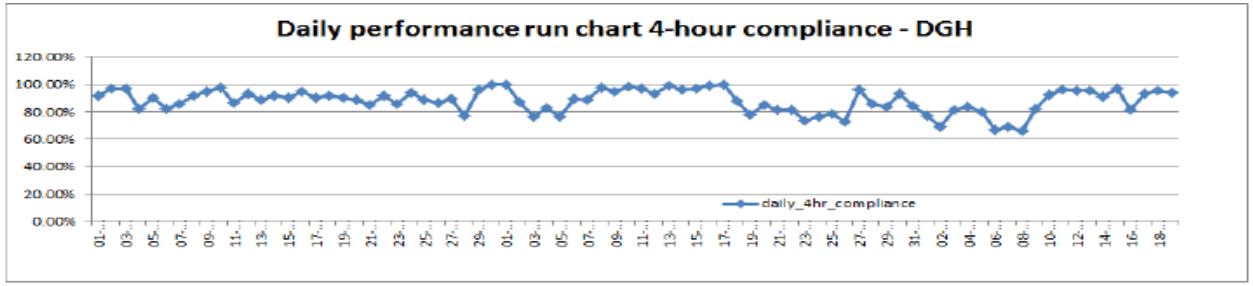
We have now engaged with an independent company (Alamac) to help provide a more robust escalation tool. The data flows and daily escalation calls have commenced and it is anticipated that this will support earlier and more robust escalation across the unscheduled care pathway. In addition Alamac are undertaken a capacity and demand exercise to review bed alignment.

Improvement Plan

No.	Action	Lead	Date
1	Workforce - appointment to Senior Clinical Posts	Clinical Director	Ongoing
2	Workforce - skill mix and shift patern changes	Matron	Ongoing
3	Predictive modelling and escalation response	Head of Operations	Ongoing
4	Timely discharge of medically fit patients and improved access to community based support	Head of Operations	Ongoing
5	Optimising alternative pathways to admission	Head of Operations	Ongoing

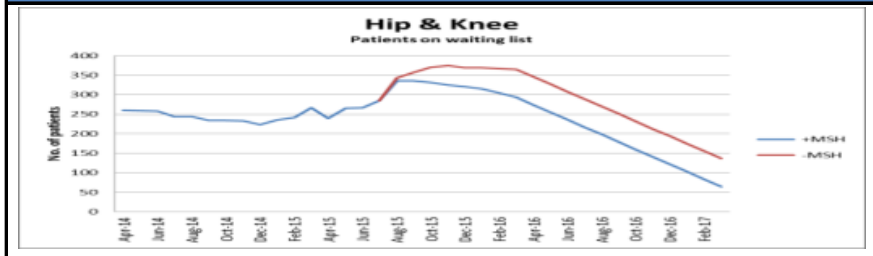
Governance Arrangements

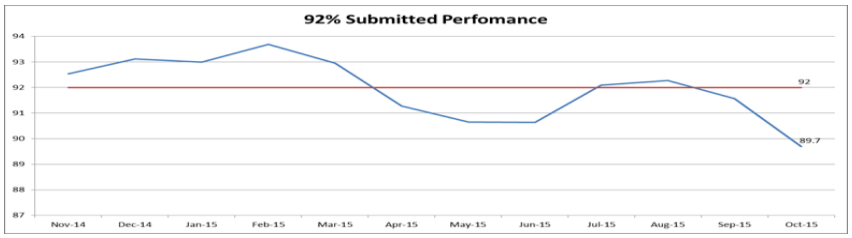
Action Plan exceptions reported through the Trust's Patient Flow Board. Performance Review at Urgent Care Board. System Resilience Group.

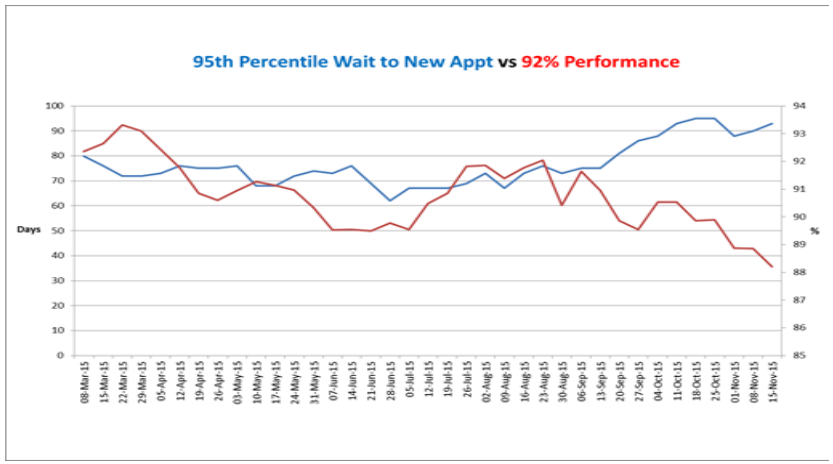


Key Performance Indicator Exception Report	Orthopaedic RTT	November 2015

Data Analysis







Commentary

Orthopaedic overall waiting list is holding 650 - 700. Hip and knee subspecialty has deteriorated by 70 patients - This is a direct result of losing an experienced consultant in June 2015. We have covered most lists but not always by hip and knee surgeons hence the subspecialty increase in waiting times whilst the overall list size remains static.

Improvement Plan

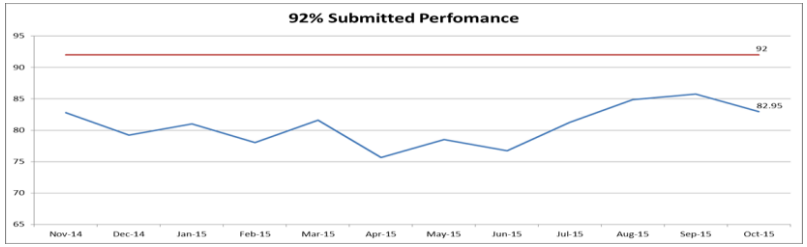
No.	Action	Lead	Date
1	Recruitment to consultant vacancy	Div man	25-Nov
2	Outsourcing of MSH - 15 patients per month until March 2016	Div man	ongoing
3	Increasing numbers per list - A 4 joint or equivalent project has been initiated	Div man	TBC
4	Review of outpatient department activity to free up consultant time for additional lists	Div man	TBC
5	Referral process changes reducing the numbers of patient being added to waiting lists	Div man	Commenced

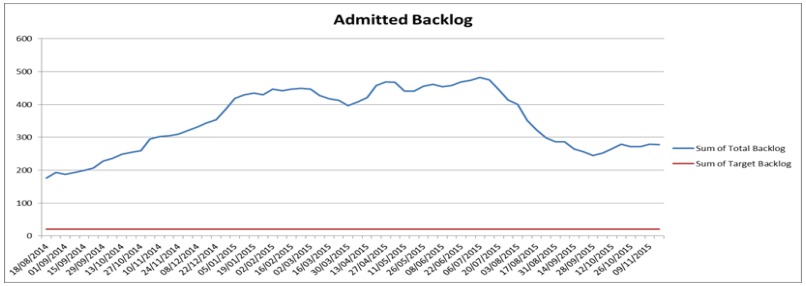
Governance Arrangements

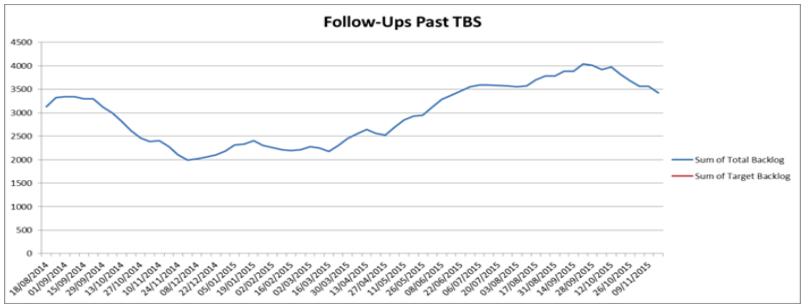
RTT and Diagnostics risk and assurance group and Senior Business Team Meeting reporting to the Executive team

Key Performance Indicator Exception Report	Ophthalmology	October 2015

Data Analysis







Commentary

The incomplete RTT position continues to deteriorate due to shortage of in-house activity for cataract surgery and continued level of referral. New guidelines for cataract surgery introduced in October with the average additions to list per week being the lowest rate all year.
Support from the Vanguard unit has ended, having taken 500 outpatients of the WL between June and October. Until additional capacity is available the waiting list is forecast to increase.

Improvement Plan

No.	Action	Lead	Date
1	Outsourcing	DGM	Ongoing
2	Additional in-house lists	DGM	Ongoing
3	Workforce training & recruitment medical & nursing staff - supporting with Locum	DGM	Jan-16
4	Estates- strategy for new eye theatre	DGM	TBC
5	Increased outpatient capacity	DGM	TBC

Governance Arrangements

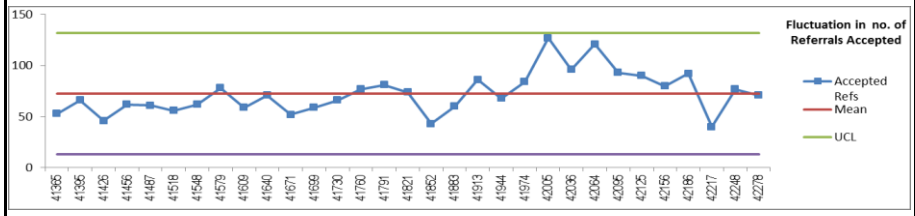
RTT and Diagnostics risk and assurance group and Senior Business Team Meeting reporting to the Executive team

Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	CAMHS	November 2015

Data Analysis

CAMHS referrals



Commentary

The spike in referrals seen in December 14 remains a non recurrent problem for the service. Without this non recurrent problem the service is broadly aligned in terms of demand and capacity.
The service has however been operating with a shortage of clinical staff to cover all the routine referrals as well as the maintenance of existing caseloads, and this has led to a review of the scope and redesign of the CAMHS service.
5 extra staff on top of establishment non recurrently for 1 year will clear the backlog and resolve the problem

Improvement Plan

No.	Action	Lead	Date
1	Prioritising patients based on Risks	DGM	Ongoing
2	Increase the clinical workforce on a temporary basis to address backlog - CCG and national funding being identified	DGM	Ongoing
3	Commissioning of outreach service for out of hours	DGM	Jan-16
4	Transformation board to look at the wider redesign of the CAMHS service	DGM	TBC
5	Increased outpatient capacity	DGM	TBC

Governance Arrangements

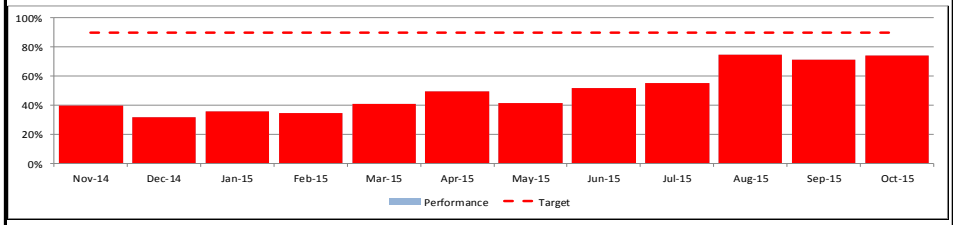
RTT and Diagnostics risk and assurance group and Senior Business Team Meeting reporting to the Executive team

Key Performance Indicator Exception Report	Dementia assessment	November 2015

Data Analysis

Dementia - Find

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Emergency admissions with LoS >3days (75+)	405	437	425	335	304	273	251	224	239	278	283	316
Finding question completed within 72 hours	162	138	153	116	125	135	104	116	132	208	202	235
Performance	40%	32%	36%	35%	41%	49%	41%	52%	55%	75%	71%	74%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Recent improvement towards the achievement of the target 90% has been made however over the last few months no further progress has been seen. This standard is CQUIN target and underachieved in Q2.

Commentary

Dementia assessment in a mandatory standard for all over 75 yrs of age emergency admission to hospital with a hospital stay of over 72 hours.
The performance recorded does not demonstrate the 90% performance standard is being achieved.
The analysis of the issues identifies two main areas of process for for improvement. Firstly the proactive assessment and monitoring of the assessment status of patients admitted to hospital can be improved. Ward matrons are laking the lead with support of ward clerks to identify patients on ward areas where assessments have not been completed. Secondly the transcribing into the clinical planning summary is not picking up all assessment completed. The introduction of the Nerve centre system to be piloted in February 2016 will address this issue

Improvement Plan

No.	Action	Lead	Date
1	Dementia steering group	CQUIn lead	ongoing
2	Care planning summaries	Medical Director	ongoing
3	Matrons engagement	Nursing Director	ongoing
4	Nerve centre - replacement clinical information capture system	I&MT Lead	TBC

Governance Arrangements

This is a CQUIn standard reported through the Exec lead to the Senior Management Team

4. Financial Performance

4.1 Summary of Financial Performance

	Year to Date - Month 7			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Income & Expenditure					
Income	155.02	157.43	2.41	2.02	↑
Operating expenses	(151.00)	(153.70)	(2.70)	(2.03)	↓
EBITDA	**4.02**	**3.72**	**(0.29)**	**(0.00)**	↓
Non-operating revenue	0.22	0.09	(0.13)	(0.06)	↓
Non-operating expenses	(7.77)	(8.24)	(0.47)	(0.20)	↓
Net surplus / (deficit)	**(3.53)**	**(4.43)**	**(0.90)**	**(0.26)**	↓
Gain/(loss) on transfers by absorption	43.37	44.67	1.30		
Surplus / (deficit)	**39.84**	**40.24**	**0.40**		
Cash & Balance Sheet					
Cash Balance	26.17	32.63	6.46	2.22	↑
Capital Expenditure	9.26	8.09	(1.17)	3.61	↓
Loans & leases Drawn down	21.09	25.80	4.71	(0.76)	↑
Key Metrics					
EBITDA Margin	2.6%	2.4%	(0.2%)	(0.0%)	↓
I&E Surplus Margin	(2.3%)	(2.8%)	(0.5%)	(0.2%)	↓
Financial Sustainability Risk Rating measures					
Capital Service Capacity	1	1	0	0	↔
Liquidity	4	4	0	0	↔
I&E Margin	1	1	0	0	↔
I&E Margin variance	4	4	0	0	↔
Overall Financial Sustainability Risk Rating	**2**	**2**	**0**	**0**	↔

The Trust has agreed with Monitor that, following successful completion of the acquisition of Torbay and Southern Devon Health and Care NHS Trust, we will revise our Annual Plan. This will ensure that our plan for the year matches the substance of the final LTFM and reflects the agreed accounting treatment of the acquisition, being by absorption rather than consolidation. This report monitors against that revised plan, which will be submitted to Monitor in December.

At EBITDA level, performance for the seven months ended 31st October 2015 remains broadly in line with plan at £3.72m.

Within this position, both income and expenditure are above plan. Income, at £2.41m above plan, reflects higher than planned healthcare income , mainly in the specialised commissioning and NCA budgets, and other income, which continues to over-perform in line with previous months. Expenditure, at £2.70m above plan, reflects over-spends, principally in pay budgets.

Variances in non- operating costs reflect higher than planned expenditure in completing the transaction, driving the I&E deficit to £900k above plan.

Service Units continue to find recurring CIP delivery a significant challenge, though under-spends are being held non-recurrently limiting impact on the bottom line.

Cash balances are significantly in excess of plan, primarily due to the receipt of funds from Torbay Council in respect of Adult Social Care debt. Capital expenditure below plan, largely on the Critical Care Unit development, has also contributed.

The Financial Sustainabililty Risk Rating, also remains in line with plan at a score of '2'. This will remain suppressed , being capped at a score of '2' until the I&E Margin and Debt Service Capacity improve following delivery of the care model savings programme.

4.1.1 Summary of Financial Performance - Pre and post phasing adjustments

	In Month 7			Year to Date - Month 7		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
LTFM Merger Accounting from 01 April 2015 as submitted to Monitor						
Income	31.20	33.34	2.14	218.50	157.43	(61.07)
Operating expenses	(30.40)	(32.78)	(2.38)	(212.80)	(153.70)	59.10
EBITDA	**0.80**	**0.57**	**(0.23)**	**5.70**	**3.72**	**(1.97)**
Non-operating revenue	0.00	0.01	0.01	0.00	0.09	0.09
Non-operating expenses	(1.50)	(1.53)	(0.03)	(9.70)	(8.24)	1.46
Net surplus / (deficit)	**(0.70)**	**(0.96)**	**(0.25)**	**(4.00)**	**(4.43)**	**(0.43)**
Gain/(loss) on transfers by absorption	0.00	44.67	**44.67**	0.00	44.67	**44.67**
Surplus / (deficit)	**(0.70)**	**43.71**	**44.41**	**(4.00)**	**40.24**	**44.24**
Adjustments to move from Merger to Absorption Accounting plus Phasing Adjustments						
Income	1.28	0.00	(1.28)	(63.48)	0.00	63.48
Operating expenses	(1.03)	0.00	1.03	61.80	0.00	(61.80)
EBITDA	**0.25**	**0.00**	**(0.24)**	**(1.68)**	**0.00**	**1.68**
Non-operating revenue	0.00	0.00	0.00	0.22	0.00	(0.22)
Non-operating expenses	0.15	0.00	(0.15)	1.93	0.00	(1.93)
Net surplus / (deficit)	**0.40**	**0.00**	**(0.39)**	**0.47**	**0.00**	**(0.47)**
Gain/(loss) on transfers by absorption	43.37	(0.00)	**(43.38)**	43.37	44.67	**1.30**
Surplus / (deficit)	**43.77**	**(0.00)**	**(43.78)**	**43.84**	**44.67**	**0.83**
Absorption Accounting plus Phasing Adjustments						
Income	32.48	33.34	0.86	155.02	157.43	2.41
Operating expenses	(31.43)	(32.78)	(1.35)	(151.00)	(153.70)	(2.70)
EBITDA	**1.05**	**0.57**	**(0.48)**	**4.02**	**3.72**	**(0.29)**
Non-operating revenue	0.00	0.01	0.01	0.22	0.09	(0.13)
Non-operating expenses	(1.35)	(1.53)	(0.18)	(7.77)	(8.24)	(0.47)
Net surplus / (deficit)	**(0.30)**	**(0.96)**	**(0.65)**	**(3.53)**	**(4.43)**	**(0.90)**
Gain/(loss) on transfers by absorption	43.37	44.67	**1.30**	43.37	44.67	**1.30**
Surplus / (deficit)	**43.07**	**43.71**	**0.64**	**39.84**	**40.24**	**0.40**

The LTFM supporting the transaction was submitted to Monitor in February 2015. In the intervening perdiod , two key issues have affected the presentation, though not substance of the plan. The basis of accounting for the transaction, as finally confirmed by Monitor and External Audit, is one of'absorption' rather than 'consolidation'. The phasing of the plan will also need to reflect the transaction completed on 1st October 2015, rather than 1st August as reflected in the plan. In resubmitting the 2015/16 plan, these will both be reflected.

These tables describe the movement between the ICO LTFM as submitted to Monitor in February and the revised plan due for submission on 8th December and reflected in this report:

In preparing the accounts on the basis of absportion rather than consolidation:

- We include trading activities of TSD for the six months from the date of acquisition, rather than a full 12 month period as initially reflected in the plan. Significant adjustments to operating income (£63.48m) and operating expenses (£61.68m), being the most obvious manifestation.
- We effectively take ownersip of a significant asset for nil consideration, creating a technical gain on the transfer. This amounts to £43.37m.

The revised presentation will include phasing adjustements to:

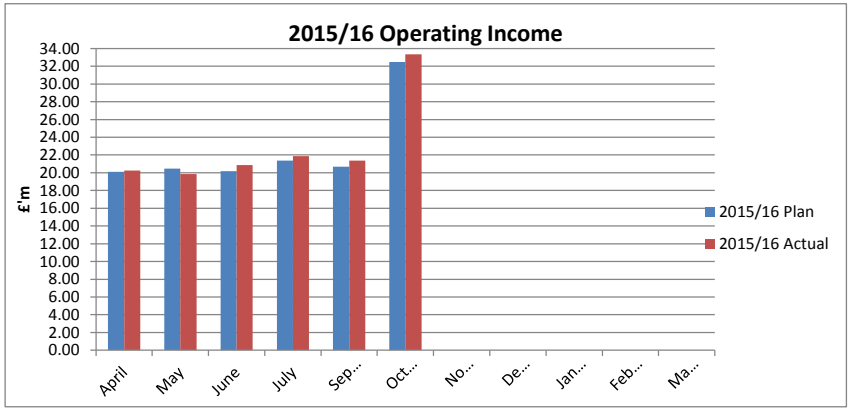
- Reflect actual financial performance to the date of the resubmission;
- Phase synergies, care model savings, investments and transition costs from the 1st October transaction date.

The net impact to October is relatively small, moving the planned surplus (before gain on transfers) from £4.0m to £3.53m.

4.2 Statement of Comprehensive Income

4.2.1 Operating Income

Income by Category	Year to Date - Month 7 Plan £m	Actual £m	Variance £m	Previous Month Variance £m	Change
Healthcare (Acute and Community)	127.19	127.88	0.69	0.76	↔
Social Care	4.00	4.19	0.19		
Other Income	23.83	25.36	1.53	1.26	↑
Total	**155.02**	**157.43**	**2.41**	**2.02**	↑



Income is £2.41m above plan for the period to 31st October 2015.

The key factors driving the healthcare income variance (£0.69m favourable) are as follows:

- Income received from NHS England Specialist Commissioing activities is £0.5m in excess of planned levels. This continues to reflect higher than expected prescriing of high cost, pass through drugs. In October,ance on passed through drug expenditure, at £0.22m accounted for almost all of the £0.26m increase in income.
- The £0.6m favourable variance in income from other Commissioners relates mainly to non-elective NCA income.
- At Service Unit level, there are significant variances, largely driven by the PbR impact of activity levels below plan, principally for our main commissioner, South Devon and Torbay CCG. The operation of the Contract Heads of Terms, with under-performance and penalties being less than the previously advised discount. As a result there is no variance from the net plan for this CCG and, in the analysis by Service Unit, a large and offsetting favourable variance in Central Contract Income.

The key factors driving the other income variance (£1.53m favourable) are as follows:

- R&D Income is below plan by £0.33m
- PMU Income is £0.2m above plan.
- Revenue from non patient services to other bodies continues above planned levels, now at £0.5m;
- Miscellaneous Income has a favourable variance of £0.41m as a result of the Risk Share Agreement. This will be recalculated every month, and will be agreed with Commissioners quarterly.

Healthcare Income - Commissioner Analysis					
South Devon & Torbay CCG	93.99	93.99	0.00	0.00	↔
North, East & West Devon CCG	2.96	2.94	(0.02)	0.03	↓
NHS England - Area Team	3.90	4.04	0.14	0.14	↑
NHS England - Specialist Commissioning	14.32	14.82	0.50	0.24	↑
Other Commissioners	4.65	5.25	0.60	0.35	↑
Sub-Total Acute	**119.82**	**121.04**	**1.22**	**0.76**	↑
South Devon & Torbay CCG (Placed People and CHC)	**7.37**	**6.84**	(0.53)		
Total Acute and Community	**127.19**	**127.88**	**0.69**	**0.76**	↔

Healthcare Income - By Business Unit					
Medical Services	53.58	52.47	(1.11)	(0.23)	↓
Surgical Services	40.59	38.88	(1.71)	(1.50)	↓
Women's, Childrens & Diagnostic Services	26.51	26.54	0.03	(0.18)	↑
Community Services	7.37	6.84	(0.53)		
Non-Clinical Services / Central Contract Income	(0.86)	3.15	4.01	2.67	↑
Total	**127.19**	**127.88**	**0.69**	**0.76**	↔

Improvement Plan

No.	Action	Lead	Date
1	R&D recruiting posts	Fiona Roberts	Ongoing
2	Specialty level plans to recover elective under-performance	Liz Davenport	Ongoing

Governance Arrangements

1	Research & Development Committee / SBMT
2	SBMT / Service Unit performance review meetings

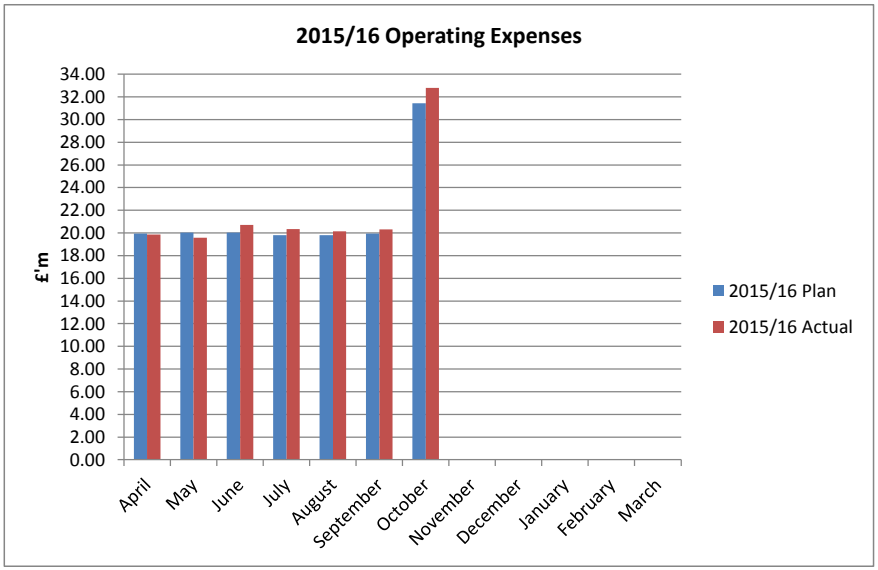
4.2.1 Operating Income (Continued)

	Year to Date - Month 7			Previous Month	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Healthcare Activity - By Setting					
Elective In-Patient Admissions	3,119	2,769	(350)	(344)	↔
Elective Day Case Admission	19,708	19,836	128	588	↓
Urgent & Emergency Admissions	18,884	21,945	3,061	(710)	↑
Out-Patients	225,192	208,504	(16,688)	(14,646)	↓
Community Services					
Total	**266,903**	**253,054**	**(13,849)**	**(15,112)**	↑
Social Care Income					
Torbay Council - ASC Contract income	2.80	2.92	0.12		
Torbay Council - Public Health Income	0.41	0.41	0.00		
Torbay Council - Client Income	0.79	0.86	0.06		
Total	**4.00**	**4.19**	**0.18**		
Other Income					
Non Mandatory/Non protected clinical revenue	0.95	1.05	0.10	0.10	↑
R&D / Education & training revenue	5.23	5.57	0.33	0.33	↑
Site Services	1.06	1.20	0.14	0.09	↑
Revenue from non-patient services to other bodies	5.32	5.87	0.55	0.48	↑
Misc. other operating revenue	11.26	11.68	0.41	0.26	↑
Total	**23.83**	**25.36**	**1.53**	**1.26**	↑

4.2 Statement of Comprehensive Income

4.2.2 Operating Expenditure

	Year to Date - Month 7			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Total Operating Expenses Included in EBITDA					
Employee Expenses	96.43	98.78	(2.35)	(1.76)	↑
Non-Pay Expenses	54.50	54.89	(0.39)	(0.27)	↑
PFI / LIFT Expenses	0.07	0.04	0.03		
Total	**151.00**	**153.71**	**(2.71)**	**(2.03)**	↑



Employee Expenses - By Category					
Medical and Dental staff	27.75	29.01	(1.26)		
Registered nurses, midwives and health visiting staff	21.97	22.98	(1.02)		
Qualified scientific, therapeutic and technical staff	17.53	16.94	0.59		
Support to clinical staff	6.67	7.57	(0.90)		
Managers and infrastructure Support	21.03	22.28	(1.25)		
Harmonisation	1.49	0.00	1.49		
Total	**96.43**	**98.78**	**(2.35)**	**(1.76)**	↑
Employee Expenses - By Type					
Substantive	94.94	91.66	3.29	1.76	↓
Bank	0.24	2.69	(2.45)	(1.07)	↑
Locum	0.13	0.87	(0.74)	(0.67)	↔
Agency	1.12	3.57	(2.45)	(1.77)	↑
Total	**96.43**	**98.78**	**(2.35)**	**(1.76)**	↑

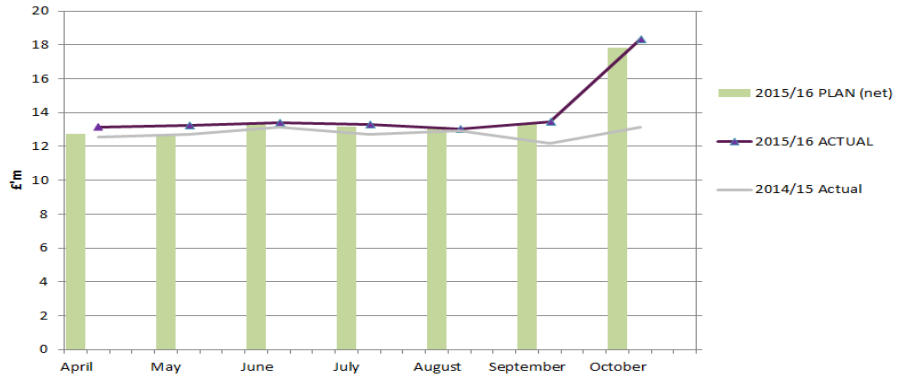
Total Operating Expenditure included in EBITDA has increased by £0.68m relative to budget during October, taking the total variance for the year to £2.71m. Variance in pay budgets continues to be the principal driver of this position.

The key factors driving the employee exepnses variance (£2.35m adverse) are as follows:

- Over-spends continue across all clinical staff groups;
- There is a significant (£3.29m) under-spend on substantive pay budgets. The overall over-spend is, in large part the result of bank and agency staff being used to cover vacancies and absences in the clinical staff group.
- Also contributing is the need, for much of the year to staff escalation capacity, both in the acute and community settings, and the Acute Medical Unit within the acute hospital, largely at agency rates.
- The need to maintain elective capacity in a range of key specialties has driven significant agency expenditure, particularly in medical staffing. This is a combination of coveirng critical vacant posts (e.g. Orthopaedics) and providing additional capacity to address backlog issues (e.g. Ophthalmology).
- As a consequence, the bank and agency budgets continue to over-spend significantly. The rate of expenditure on agency staff increased in October, being some £0.68m in excess of budget.
- A proportion of nursing agency staff over-spend in October relates to the delayed processing of circa £200k of invoices relating to previous periods for theatres.
- These pressures are experienced across all clinical services and are offset by under-spends in non-clinical staff costs.
- The budget set, as part of the integration plan, to invest in the staffing of care model changes has yet to be drawn down. At present the associated budget is aslo off-setting over-spends in clinical staff groups.
- It is the care model changes that these investments deliver that will reduce demands in the acute setting and therefore the over-spends described above. It is critical that these plans move to delivery as soon as possible if the rate of over-spend across pay budgets is to be curbed.
- There has been a significant delay in delivering pay CIPs this year. Plans relied in large part on our ability to reduce bank and agency expenditure, which has proven enormously difficult given the operational pressures experienced across the organisation.

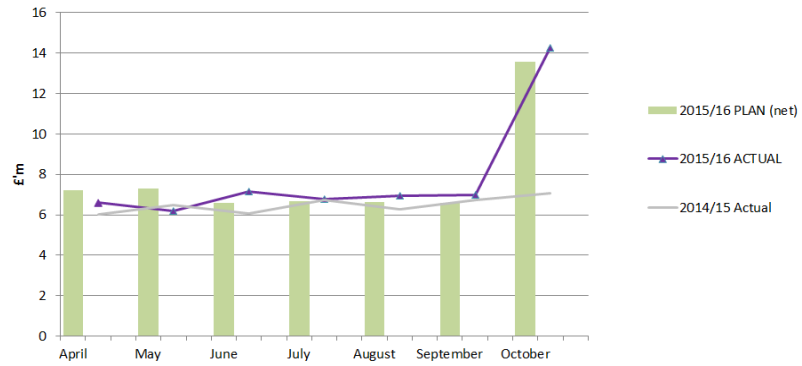
	Year to Date - Month 7			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Employee Expenses - By Service					
Medical Services	21.43	24.13	(2.70)	(2.19)	↑
Surgical Services	23.98	25.46	(1.48)	(1.09)	↑
Women's, Childrens & Diagnostic Services	20.35	20.95	(0.60)	(0.48)	↑
Community Services	3.18	3.55	(0.38)		
Non-Clinical Services	26.01	24.69	1.32	2.00	↓
Harmonisation	1.49	0.00	1.49		
Total	**96.43**	**98.78**	**(2.35)**	**(1.76)**	↑

TOTAL PAY EXPENDITURE - Run Rate 2015/16 : 2014/15



Non Pay Expenses - By Category					
Clinical Supplies	14.50	12.65	1.86	0.29	↓
Drugs All	5.13	6.02	(0.89)	(0.39)	↑
Pass through Blood and Devices	11.05	10.71	0.34	0.67	↑
Non Clinical Supplies	1.10	1.51	(0.41)	(0.33)	↑
Miscellaneous / Other	22.72	24.00	(1.28)	(0.51)	↑
Total	**54.50**	**54.88**	**(0.39)**	**(0.27)**	↑

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



The key factors driving the non-pay exepnses variance (£0.39m adverse) are as follows:

- Clinical supplies continues to be below planned spend levels, relfecting a range of procurement savings delivered throughout the year combined with some volume savings;
- The drugs over-spend is largely the result of over-spends in pass through drugs, and is also reflected in additional specialist commissioning income;
- Bloods and devices and non clinical supplies have seen no material change in the months;
- Over-spending adult social care and continuing healthcare placements are the most significant driving over-spends in other expenditure. Undelivered CIP is reflected in the adverse variance on miscellaneous expenditure.

Improvement Plan

No.	Action	Lead	Date
1	Overseas Nursing Recruitment	Tracey Collins	On-going
2	Management of sickness absence	Martin Ringrose	On-going
3	Enhanced nurse agency control prcesses	Jane Viner	On-going
4	Implementation of agency price cap	Jane Viner	27/11/2015
5	Enhanced budget control prosesses in service units	Liz Davenport	On-going
6	Care model implementation plans	Liz Davenport	On-going
7	MARS scheme	Paul Cooper	30/11/2015
8	Introduction of enhanced performance monitoring	Liz Davenport	01/11/2015
9	Management cost review	Martin Ringrose	01/12/2015
10	Develop recovery plan for adult social care CIP	Liz Davenport	01/01/2016

Governance Arrangements

Quarterly Service Delivery Unit Performance reviews, monthly SBMT review, Service Delivery Units Board meetings.

4.2 Statement of Comprehensive Income

4.2.4 Non Operating Revenue & Expenses

	Year to Date - Month 7			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Non-Operating Expenses / Income					
Donations & Grants	0.12	0.04	(0.08)	(0.06)	↔
Depreciation & Amortisation	(5.76)	(5.17)	0.59	0.48	↔
Impairments	0.00	0.00	0.00	0.00	↔
Restructuring Costs	0.00	(0.69)	(0.69)	(0.69)	↔
Finance Income	0.10	0.05	(0.05)	(0.00)	↔
Gains / Losses on Asset Disposals	0.00	0.00	0.00	0.00	↔
Gains / Losses on Transfers by Absorption	43.37	44.67	1.30	0.00	↑
Interest	(0.68)	(0.85)	(0.17)	(0.01)	↔
Public Dividend Capitals	(1.29)	(1.49)	(0.20)	0.03	↔
PFI Costs	(0.03)	(0.03)	(0.00)	0.00	↔
Income Tax refund	(0.01)	(0.01)	(0.01)	(0.01)	↔
Total	**35.83**	**36.52**	**0.69**	**(0.26)**	↑

The most significant variance is the result of a higher than expected balance sheet value in TSD at 30th September - the result of revaluation of assets of £1.3m - driving a favourable variance in terms of transfers by absorption. This variance remains subject to the audit.

i) Planned Transfer upon absorption:-

	£'000
Opening Balance TSD assets @ 01/04/2015	43,175
Add: Planned Surplus per TDA Annual Plan	198
Sub Total	43,373
ii) Actual Transfer upon absorption:-	44,673
iii) Difference	1,300

iv) Reconciled:-

Reported Deficit	(2,143)
Planned Deficit	1,802
Movement	(341)
PDC Received by TSD	2,000
Indexation Applied (Revaluation)	1,633
	1,292

Depreciation is £0.59m lower than planned levels, reflecting delayed capital expenditure, particularly in relation to Torbay Pharmaceuticals and the Critical Care Unit.

In line with previous reporting, transaction costs of £0.69m have been taklen 'below

4.2 Statement of Comprehensive Income

4.2.5 Cost Improvement Programme

	Annual 2015/16			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Schemes Delivered to Date M1 to M12					
Delivered Schemes : Recurrent	15.20	3.48	11.72		
Delivered Schemes : Non-Recurrent	0.00	4.93	-4.93		
Delivered Schemes : Total	**15.20**	**8.41**	**6.79**		
Full Year Forecast Delivery					
Forecast Schemes : Recurrent	15.20	3.48	11.72		
Forecast Schemes : Non-Recurrent	0.00	6.94	-6.94		
Forecast Schemes : Total	**15.20**	**10.42**	**4.78**		

Forecast Current Year-end position results in a £4.78m year end deficit . As just £3.48m is delivered recurrently, this means £11.72m of the resultant shortfall will carry forward to next financial year, unless further action is taken.

Significant non-recurrent savings are off-setting delayed recurring delivery. Budget setting for 2016/17 will encourage these to be substantiated recurringly wherever possible.

Review of all CIP accouting, particularly in TSD will take place before the Month 8 report is published, to ensure that CIP journals are complete and that all CIP achieved is described as such.

	CIP Target £'000	Risk Rating	Lead
Community Business Unit Schemes	7,755	Red	COO
Medical Business Unit Schemes	2,693	Red	COO
Surgical Business Unit Schemes	2,772	Red	COO
WCDT Business Unit Schemes	1,368	Red	COO
Support Services Business Unit Schemes	2,096	Red	Various

Improvement Plan

No.	Action	Lead	Date
1	Full review the undelivered schemes as part of the 2016/17 Business Planning Process	Paul Cooper	28/02/2016
2	Ensure completeness of CIP processing	Paul Cooper	30/11/2015
3	Focus on transferring rec to non-rec plans	Liz Davenport	Ongoing
4	MARS scheme	Paul Cooper	30/11/2015
5	Enhanced performance monitoring	Liz Davenport	01/11/2015
6	Pathology managed service contract	Liz Davenport	30/11/2015
7	WCD vacancy factor to be made recurrent	Liz Davenport	30/11/2015
8	Process MARs scheme	Paul Cooper	30/11/2015
9	Internal Audit review of delayed delivery	Int. Audit	31/01/2016

Governance Arrangements

Quarterly Service Delivery Unit Performance reviews, monthly SBMT review, Service Delivery Units Board meetings.

4.3 Balance Sheet

	Year to Date - Month 7			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Non-Current Assets					
Intangible Assets	7.11	1.17	(5.94)	(4.20)	↓
Property, Plant & Equipment	183.98	188.20	4.22	1.03	↑
On-Balance Sheet PFI	0.00	0.00	0.00	0.00	↔
Other	2.65	2.44	(0.21)	(0.25)	↔
Total	**193.74**	**191.81**	**(1.93)**	**(3.42)**	↓
Current Assets					
Cash & Cash Equivalents	26.17	32.63	6.46	2.22	↑
Other Current Assets	24.84	24.82	(0.02)	2.36	↓
Total	**51.01**	**57.45**	**6.44**	**4.58**	↑
Total Assets	**244.75**	**249.26**	**4.51**	**1.16**	↑
Current Liabilities					
Loan - DH ITFF	(5.22)	(5.49)	(0.27)	0.08	↑
PFI / LIFT Leases	0.00	0.00	0.00	0.00	↔
Trade and Other Payables	(33.62)	(30.56)	3.06	(2.14)	↓
Other Current Liabilities	(0.55)	(0.53)	0.02	0.04	↔
Total	**(39.39)**	**(36.58)**	**2.81**	**(2.02)**	↓
Net Current Assets / (Liabilities)	**11.62**	**20.87**	**9.25**	**2.56**	↑
Non-Current Liabilities					
Loan - DH ITFF	(58.29)	(59.28)	(0.99)	0.64	↑
PFI / LIFT Leases	(20.23)	(20.79)	(0.56)	0.00	↑
Other Non-Current Liabilities	(4.25)	(3.94)	0.31	(0.05)	↓
Total	**(82.77)**	**(84.01)**	(1.24)	**0.59**	↑
Total Assets Employed	**122.59**	**128.67**	**6.08**	**(0.27)**	↑
Reserves					
Total	**122.59**	**128.66**	**6.07**	**0.02**	↔

Intangible assets are behind planned level, largely due to delayed implementation of the PARIS community information system.

Property, plant and equipment have benefitted from the revalution of the TSD estate completed as part of the close down process.

Cash is higher than plan due to the full draw down of the ITFF £21m working capital loan and receipt of the£3.2m cash advance from Torbay Council in respect of long term client debt.

Other movements in current assets are broadly neutral and the resul of timing differences between cash, and trade debtors and creditors.

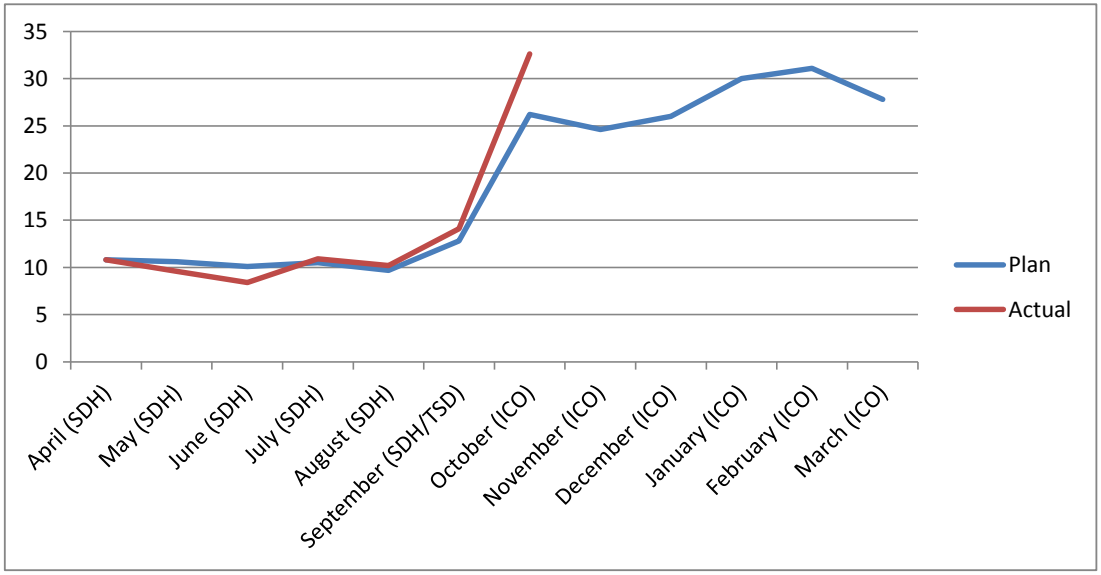
Overall the balnce sheet holds £6.08m of value in excess of the planned.

4.4 Cash Flow Statement

	Year to Date - Month 7			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Opening Cash Balance	**9.04**	**11.26**	**2.22**	**0.51**	↑
Cash Generated From Operations	0.78	0.56	**-0.22**	-0.32	↓
Debtor Movements	1.59	-8.04	**-9.63**	-1.31	↓
Creditor Movements	0.02	6.27	**6.25**	3.55	↑
Capital Expenditure	-2.37	-1.38	**0.99**	0.65	↑
Net Interest	-0.24	-0.12	**0.12**	-0.32	↑
Loan drawndown	15.27	21.98	**6.71**	-0.57	↓
Loan repayment	-0.06	0.00	**0.06**	0.00	↔
Other (PDC Dividend)	2.35	2.84	**0.49**	0.15	↑
Other	-0.22	-0.75	**-0.53**	-0.11	↓
Current Cash Balance	**26.16**	**32.62**	**6.46**	**2.22**	↑

Cash is higher than plan due to the full draw down of the ITFF £21m working capital loan and receipt of the£3.2m cash advance from Torbay Council in respect of long term client debt.

Cash Flow Against Plan (£m):



4.5 Capital

	Year to date			Year end Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Capital Programme	9.26	8.09	1.17	27.19	23.59	3.60
Significant Variances in Planned Expenditure by Scheme						
HIS schemes	0.74	0.55	(0.19)	4.68	3.06	(1.62)
Estates schemes	6.42	5.67	(0.75)	14.21	13.06	(1.15)
Medical Equipment	1.12	1.06	(0.06)	3.83	3.65	(0.18)
Other	0.09	0.06	(0.03)	0.28	0.27	(0.01)
PMU	0.88	0.77	(0.11)	1.83	1.48	(0.35)
Contingency	0.00	0.00	0.00	2.35	2.09	(0.26)
Prior Year schemes	0.00	(0.03)	(0.03)	0.00	(0.03)	(0.03)
Total	**9.25**	**8.08**	**(1.17)**	**27.18**	**23.58**	**(3.60)**

Capital Expenditure £1.1m behind rephased plan (13%), which was prepared with assistance of scheme leads during September 15. This will form basis of Revised Plan that will be submitted to Monitor in December 15.

The year end capital expenditure forecast is £3.6m less than approved plan, of which £2.5m is as a consequence of DoH request to postpone part of capital programme to Qtr 1 of 2016/17.

Reconciliation of approved 2015/16 capital expenditure budget

		£m	£m
i)	Approved budget of Acute - full 12 months		24.99
ii)	Approved full year budget of Community	2.50	
iii)	less: expenditure incurred as at 30th Sept 15	-0.29	
iv)	Budget for Community - 1st Oct 15 to 31st Mar 16		2.20
v)	**Combined ICO capital budget 2015/16**		**27.19**

Governance Arrangements

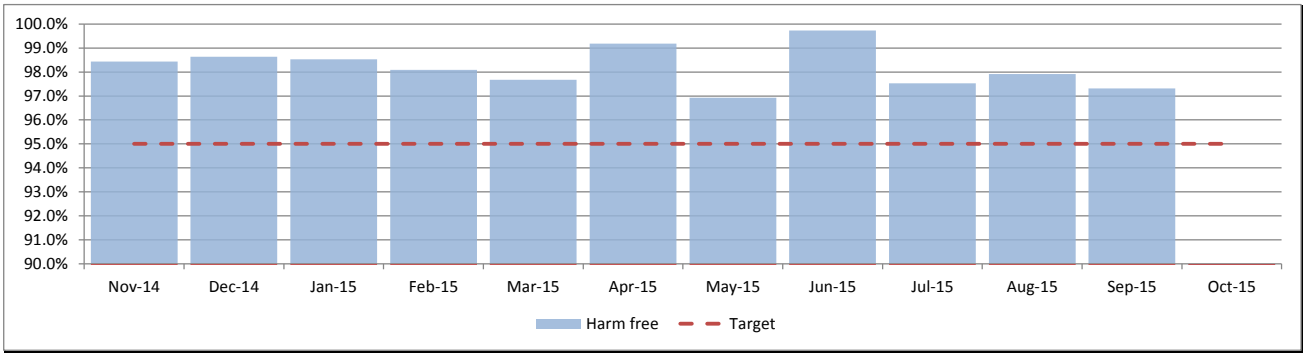
Capital expenditure projects are approved in line with the Trust's Investment policy. The status of each scheme is maintained by the Finance department and reported to the Finance Committee on a monthly basis. The capital prioritisation process takes place at the Senior Buisness Management Team meetings and is overseen by the Trust's Executive Directors. Capital schemes are priortised based upon Risk Scores and Financial payback opportunities.

Performance & Quality Databook

Month 7 October 2015

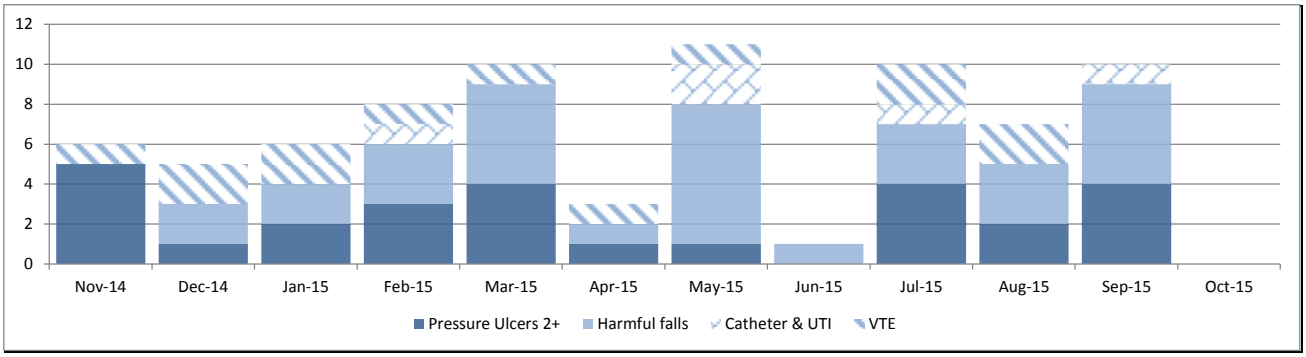
Harm Free - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients	383	367	408	367	387	367	358	377	365	336	372	0
New harms	6	5	6	7	9	3	11	1	9	7	10	0
Harm free	98.4%	98.6%	98.5%	98.1%	97.7%	99.2%	96.9%	99.7%	97.5%	97.9%	97.3%	#DIV/0!
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



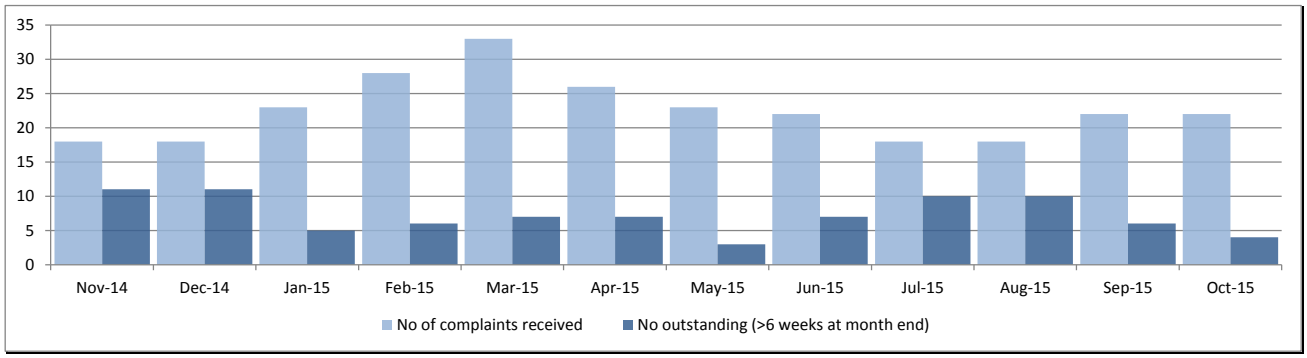
Types of new harm - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
New Harms	6	5	6	7	9	3	11	1	9	7	10	0
Pressure Ulcers 2+	5	1	2	3	4	1	1	0	4	2	4	0
Harmful falls	0	2	2	3	5	1	7	1	3	3	5	0
Catheter & UTI	0	0	0	1	0	0	2	0	1	0	1	0
VTE	1	2	2	1	1	1	1	0	2	2	0	0



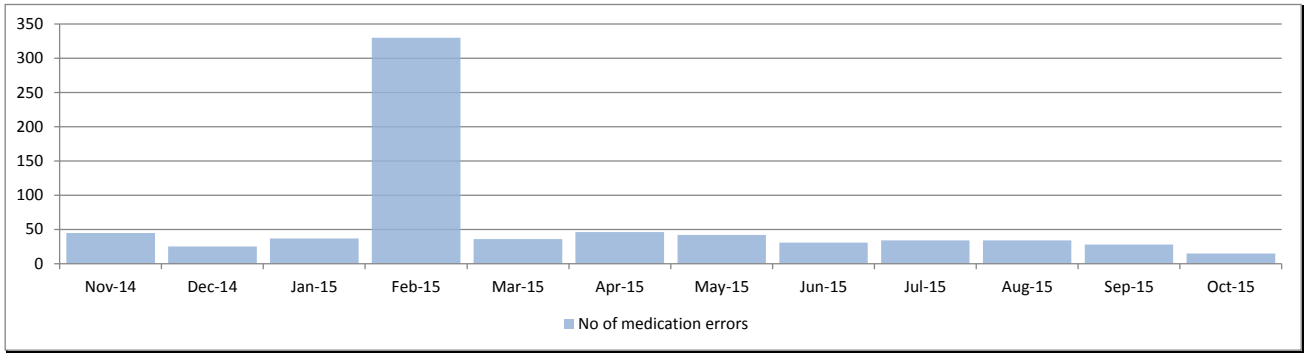
Written complaints - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
No of complaints received	18	18	23	28	33	26	23	22	18	18	22	22
No outstanding (>6 weeks at month end)	11	11	5	6	7	7	3	7	10	10	6	4



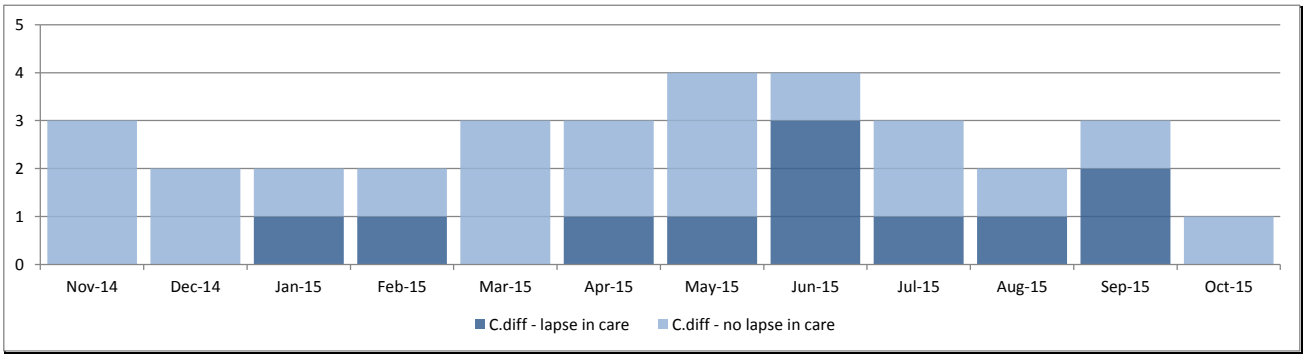
Medication errors - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
No of medication errors	45	25	37	330	36	46	42	31	34	34	28	15



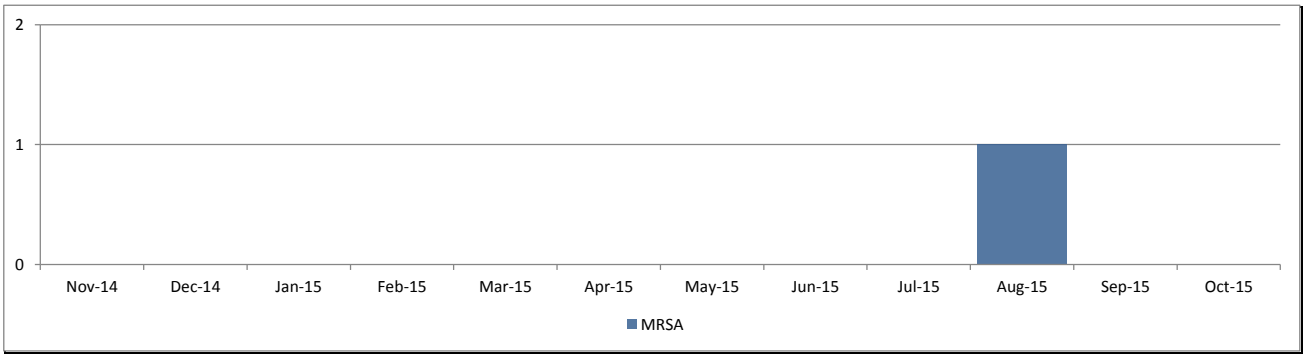
Clostridium difficile

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
C.diff - lapse in care	0	0	1	1	0	1	1	3	1	1	2	0
C.diff - no lapse in care	3	2	1	1	3	2	3	1	2	1	1	1
C.diff - Total	3	2	2	2	3	3	4	4	3	2	3	1



Methicillin-resistant Staphylococcus aureus (MRSA)

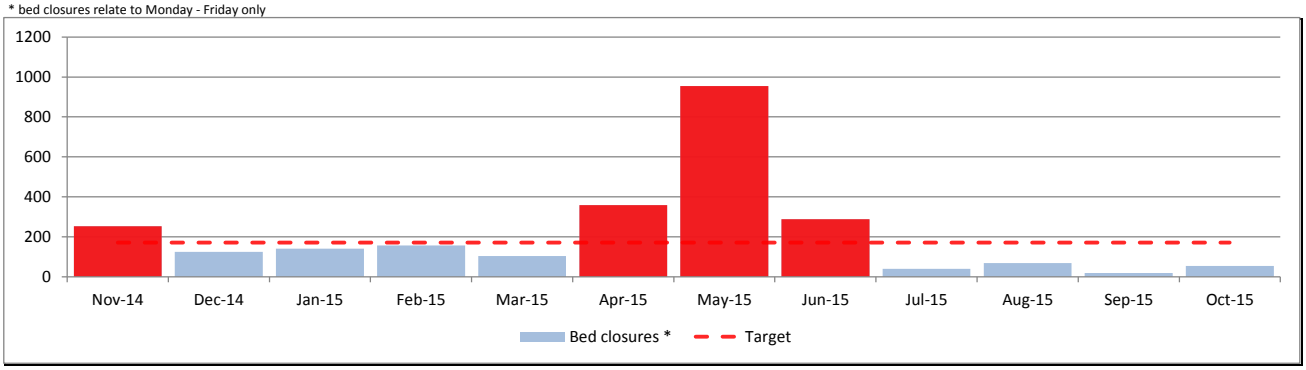
	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
MRSA	0	0	0	0	0	0	0	0	0	1	0	0



Bed closures due to infection control measures

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Bed closures *	252	124	141	156	104	358	955	288	40	68	18	54
Target	171	171	171	171	171	171	171	171	171	171	171	171

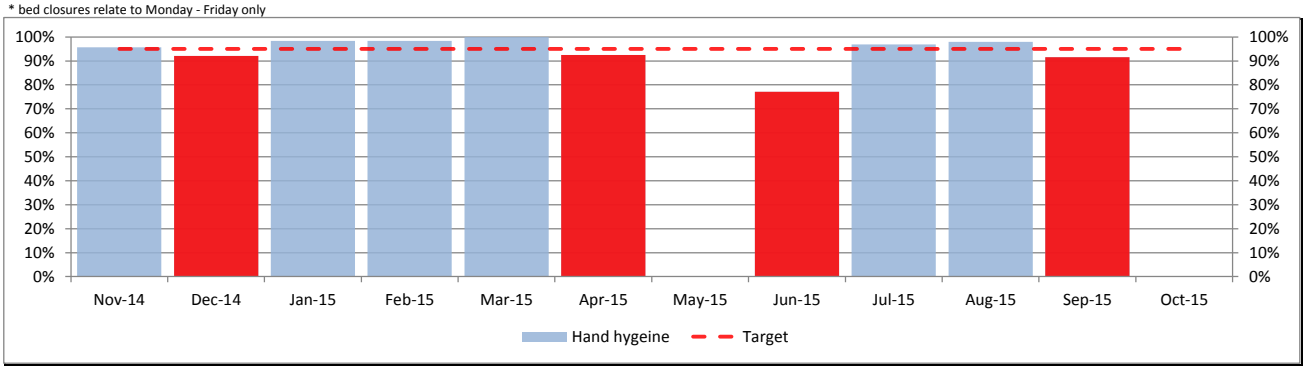
* bed closures relate to Monday - Friday only



Hand Hygiene

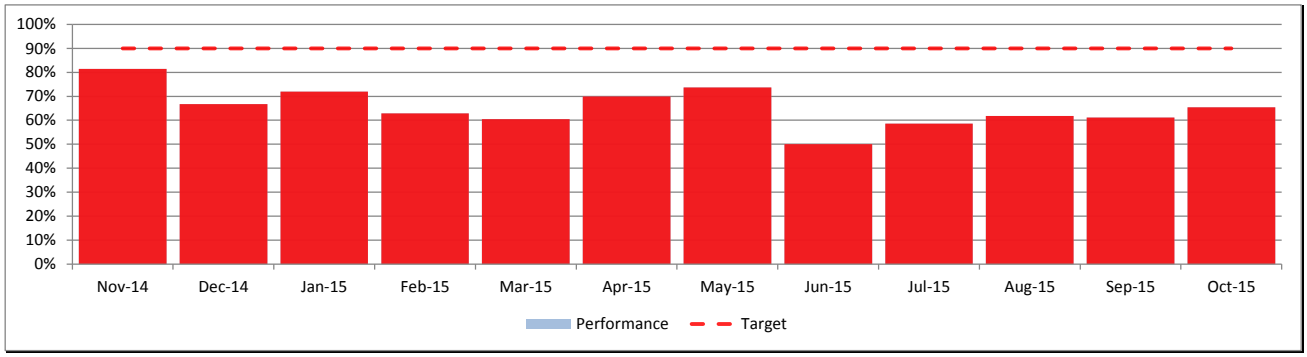
	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Hand hygeine	96%	92%	98%	98%	100%	93%	n/a	77%	97%	98%	92%	#DIV/0!
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

* bed closures relate to Monday - Friday only



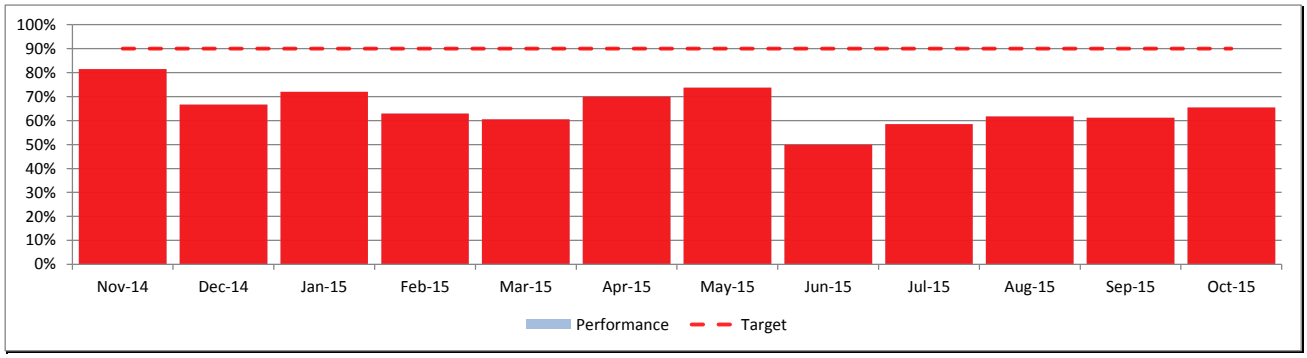
Fracture neck of femur

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients with a fractured neck of femur	27	45	50	35	43	40	38	40	41	34	36	26
Patients achieving best practice tariff	22	30	36	22	26	28	28	20	24	21	22	17
Performance	81%	67%	72%	63%	60%	70%	74%	50%	59%	62%	61%	65%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



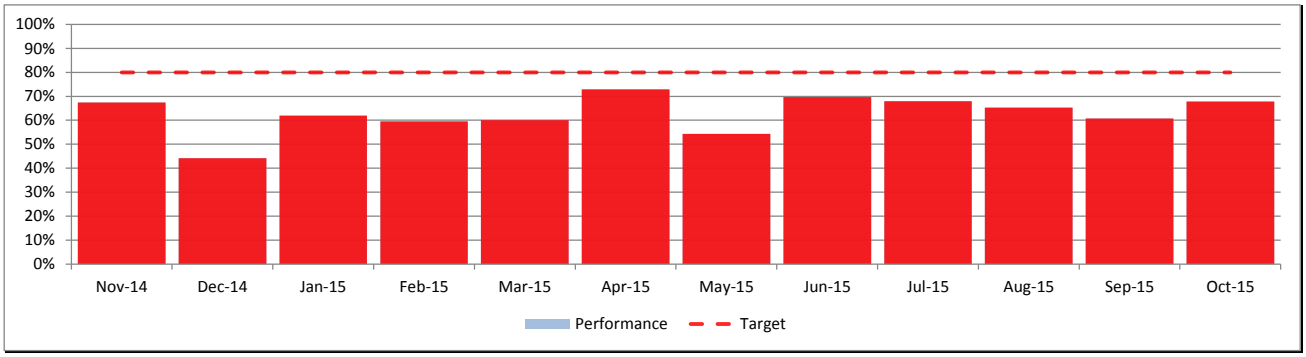
Fracture neck of femur - Admission to surgery less than 36 hours

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
To surgery within 36 hours	22	31	40	23	27	31	33	23	27	26	26	18
To surgery outside 36 hours	5	14	10	12	11	9	5	16	14	8	10	8
Performance	81%	69%	80%	66%	71%	78%	87%	59%	66%	76%	72%	69%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Achieved	81%	69%	80%	66%	71%	78%	87%	59%	66%	76%	72%	69%



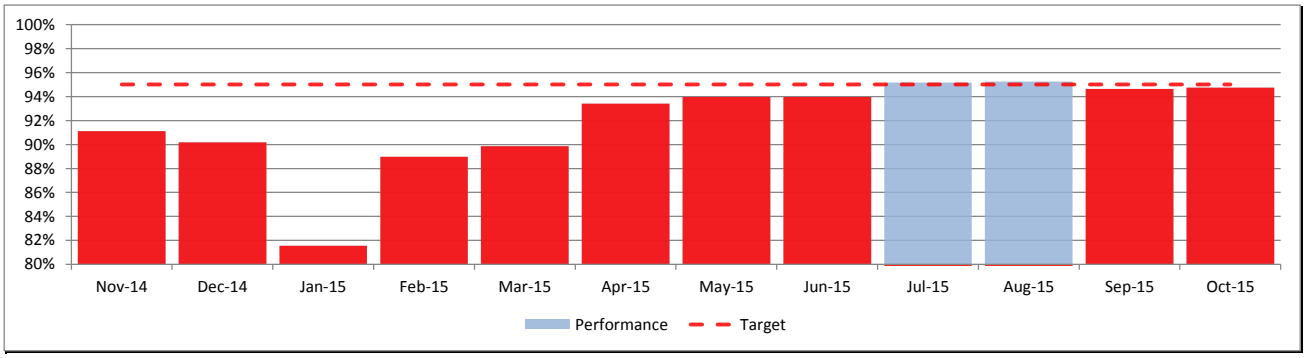
Stroke patients spending 90%+ of their time on a dedicated stroke ward

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients with a stroke diagnosis	46	43	63	42	45	48	46	66	53	46	51	28
Patients spending 90% of time on stroke war	31	19	39	25	27	35	25	46	36	30	31	19
Performance	67%	44%	62%	60%	60%	73%	54%	70%	68%	65%	61%	68%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



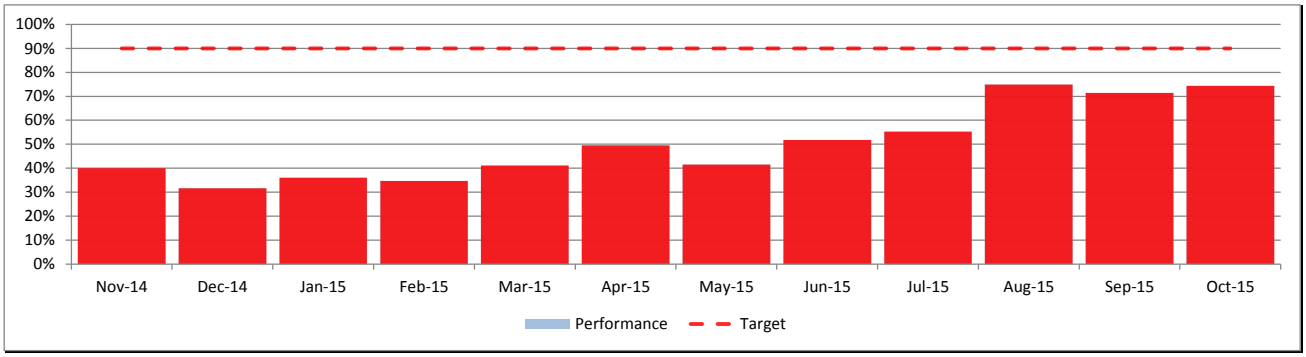
VTE risk assessment on admission - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Adult patients admitted	5397	5501	5871	4758	5984	5940	5334	6076	6257	5803	6266	6101
No risk assessed for VTE using national tool	4918	4961	4788	4233	5377	5549	5013	5709	5955	5528	5930	5781
Performance	91%	90%	82%	89%	90%	93%	94%	94%	95%	95%	95%	95%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Achieved	91%	90%	82%	89%	90%	93%	94%	94%	0%	0%	95%	95%



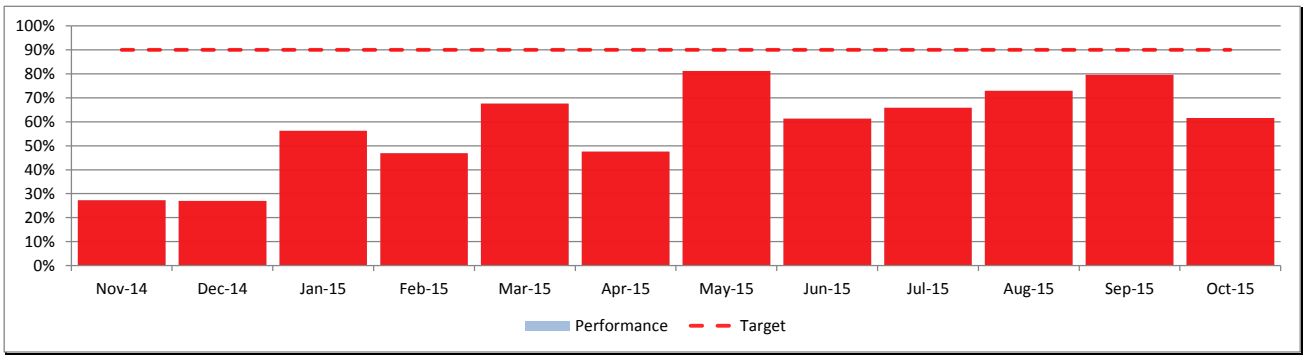
Dementia - Find

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Emergency admissions with LoS >3days (75+)	405	437	425	335	304	273	251	224	239	278	283	316
Finding question completed within 72 hours	162	138	153	116	125	135	104	116	132	208	202	235
Performance	40%	32%	36%	35%	41%	49%	41%	52%	55%	75%	71%	74%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



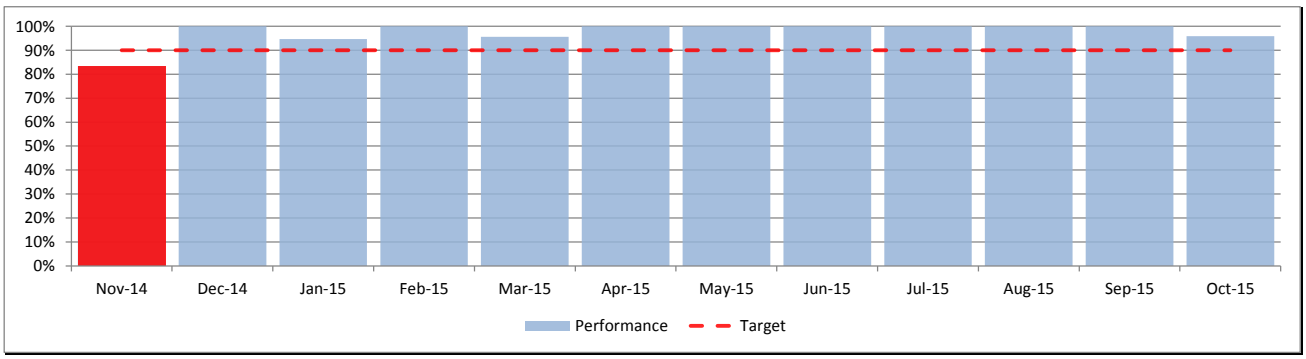
Dementia - Access and Investigate

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
+ve finding question or diagnosed delirium	44	37	48	32	37	40	32	31	38	48	49	65
Diagnostic assessment	12	10	27	15	25	19	26	19	25	35	39	40
Performance	27%	27%	56%	47%	68%	48%	81%	61%	66%	73%	80%	62%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



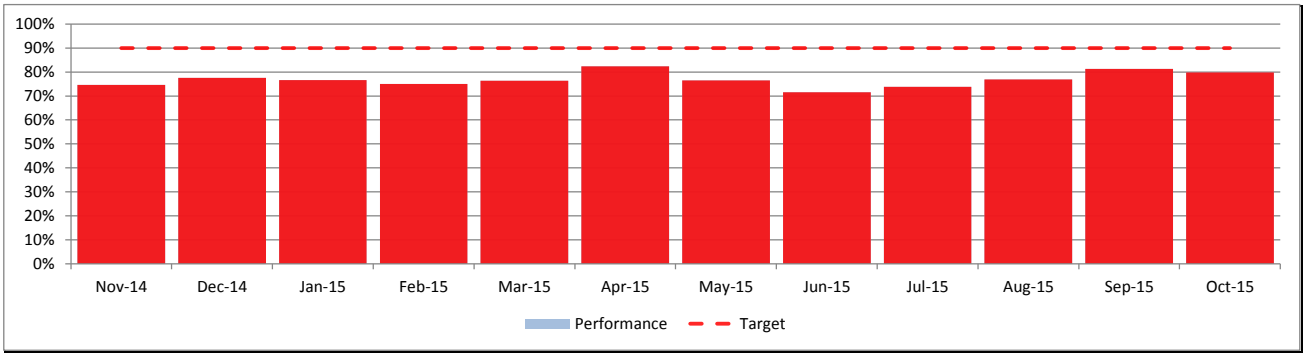
Dementia - Refer

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
+ve / inconclusive result from assessments	6	5	19	13	23	22	23	17	23	24	35	24
With a sufficient plan of care on discharge	5	5	18	13	22	22	23	17	23	24	35	23
Performance	83%	100%	95%	100%	96%	100%	100%	100%	100%	100%	100%	96%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



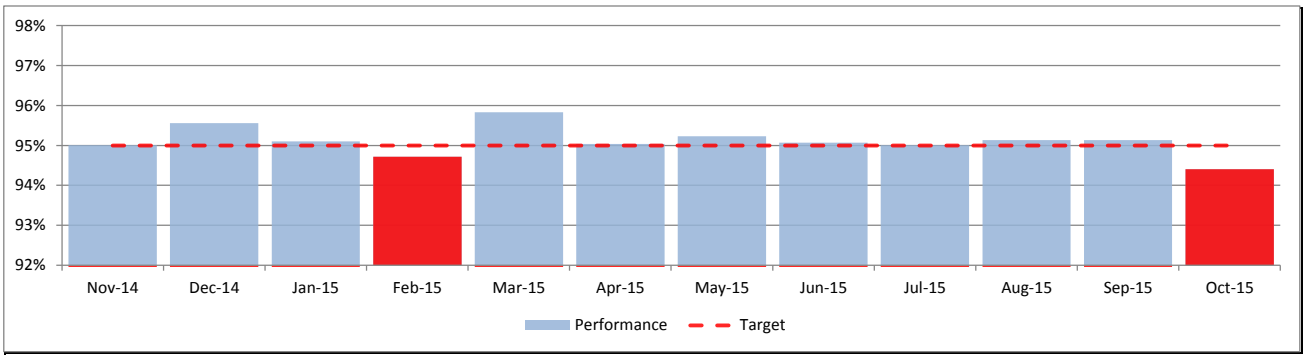
Admitted 18 week referral to treatment - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
RTT admitted clock stops	1269	1263	1495	1473	1570	1438	1246	1587	1594	1459	1616	1367
RTT admitted breaches	323	284	349	368	372	253	293	451	418	338	302	275
Performance	75%	78%	77%	75%	76%	82%	76%	72%	74%	77%	81%	80%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



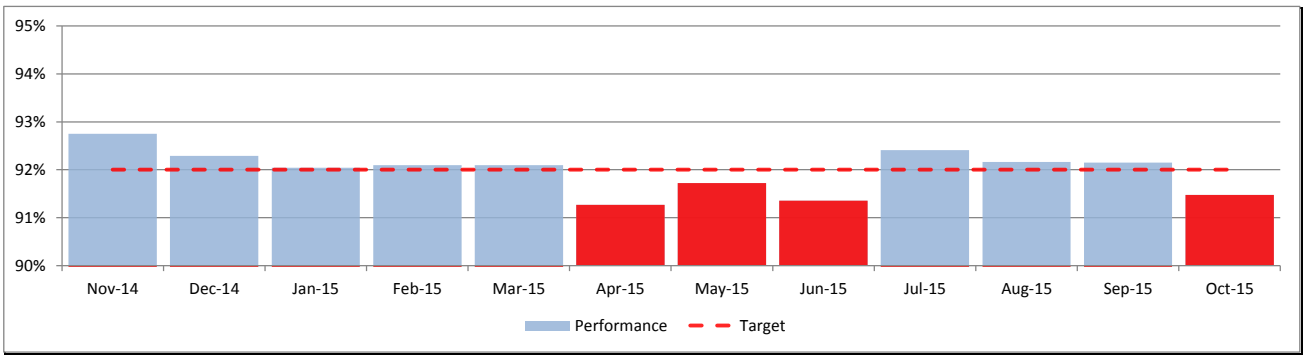
Non-admitted 18 week referral to treatment - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
RTT non-admitted clock stops	5425	5084	5332	5207	5665	5262	4992	5716	6229	4887	5935	6108
RTT non-admitted breaches	271	226	261	275	236	261	238	282	311	238	289	342
Performance	95%	96%	95%	95%	96%	95%	95%	95%	95%	95%	95%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Incomplete 18 week referral to treatment - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
RTT incomplete pathways	15222	15144	15232	14991	15284	15230	15648	15572	17424	17104	16114	15458
RTT incomplete pathway breaches	1104	1168	1212	1185	1208	1330	1295	1346	1323	1341	1265	1318
Performance	93%	92%	92%	92%	92%	91%	92%	91%	92%	92%	92%	91%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%



RTT admitted performance - by specialty

	<126 days	>126 days	Total	Performance
Cardiology	25	4	29	86%
Dermatology	2	0	2	100%
Ear, Nose & Throat (ENT)	82	12	94	87%
Gastroenterology	54	9	63	86%
General Medicine	4	0	4	100%
General Surgery	126	92	218	58%
Geriatric Medicine	0	0	0	n/a
Gynaecology	138	138	276	50%
Neurology	12	0	12	100%
Ophthalmology	117	71	188	62%
Oral Surgery	132	3	135	98%
Plastic Surgery	51	7	58	88%
Rheumatology	51	0	51	100%
Thoracic Medicine	6	0	6	100%
Trauma & Orthopaedics	170	79	249	68%
Urology	64	8	72	89%
Other	58	58	116	50%

RTT non-admitted performance - by specialty

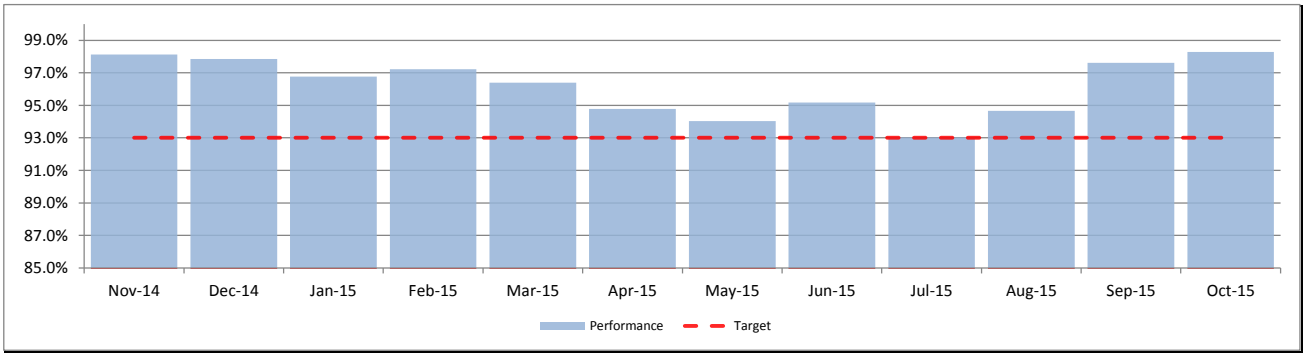
	<126 days	>126 days	Total	Performance
Cardiology	1192	144	1336	89%
Dermatology	939	14	953	99%
Ear, Nose & Throat (ENT)	995	50	1045	95%
Gastroenterology	832	61	893	93%
General Medicine	65	5	70	93%
General Surgery	1386	281	1667	83%
Geriatric Medicine	48	0	48	100%
Gynaecology	620	9	629	99%
Neurology	295	11	306	96%
Ophthalmology	1524	319	1843	83%
Oral Surgery	639	18	657	97%
Plastic Surgery	259	23	282	92%
Rheumatology	280	1	281	100%
Thoracic Medicine	517	39	556	93%
Trauma & Orthopaedics	1732	199	1931	90%
Urology	601	54	655	92%
Other	1872	77	1949	96%

RTT incomplete performance - by specialty

	<126 days	>126 days	Total	Performance
Cardiology	1192	144	1336	89%
Dermatology	939	14	953	99%
Ear, Nose & Throat (ENT)	995	50	1045	95%
Gastroenterology	832	61	893	93%
General Medicine	65	5	70	93%
General Surgery	1386	281	1667	83%
Geriatric Medicine	48	0	48	100%
Gynaecology	620	9	629	99%
Neurology	295	11	306	96%
Ophthalmology	1524	319	1843	83%
Oral Surgery	639	18	657	97%
Plastic Surgery	259	23	282	92%
Rheumatology	280	1	281	100%
Thoracic Medicine	517	39	556	93%
Trauma & Orthopaedics	1732	199	1931	90%
Urology	601	54	655	92%
Other	1872	77	1949	96%

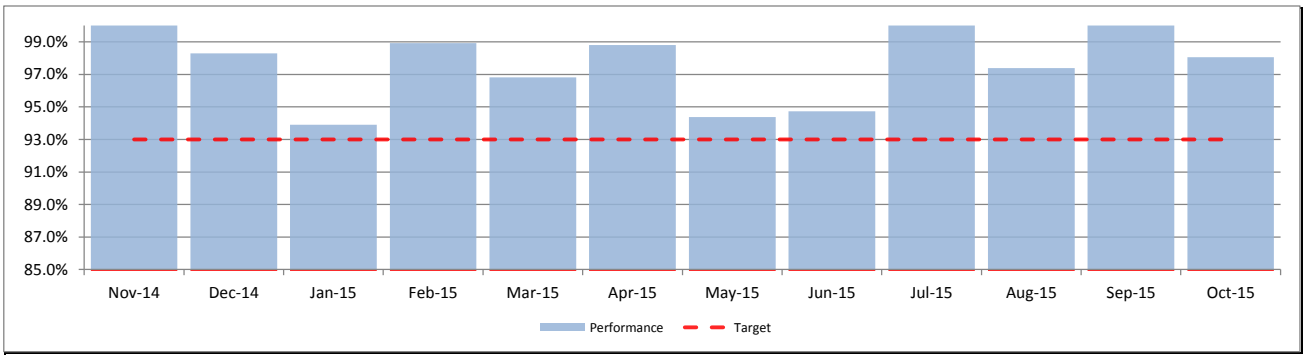
Two Week Wait Referrals - seen within 14 days

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
2ww referrals seen	801	747	680	650	915	746	753	913	903	826	884	878
2ww referral breaches	15	16	22	18	33	39	45	44	63	44	21	15
Performance	98.1%	97.9%	96.8%	97.2%	96.4%	94.8%	94.0%	95.2%	93.0%	94.7%	97.6%	98.3%
Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%



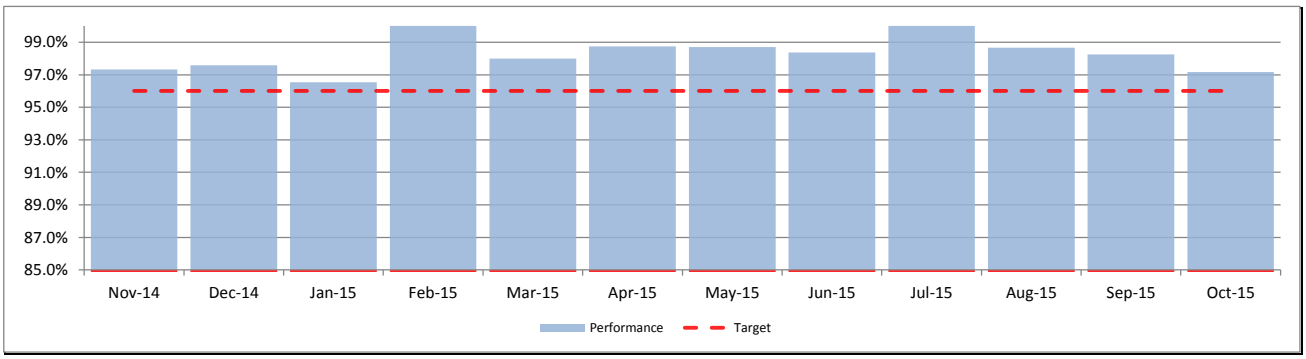
Breast Symptomatic referrals - seen within 14 days

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Breast symptomatic referrals seen	87	117	82	93	94	84	89	114	112	115	90	103
Breast symptomatic referrals breached	0	2	5	1	3	1	5	6	0	3	0	2
Performance	100.0%	98.3%	93.9%	98.9%	96.8%	98.8%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%
Target	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%	93.0%



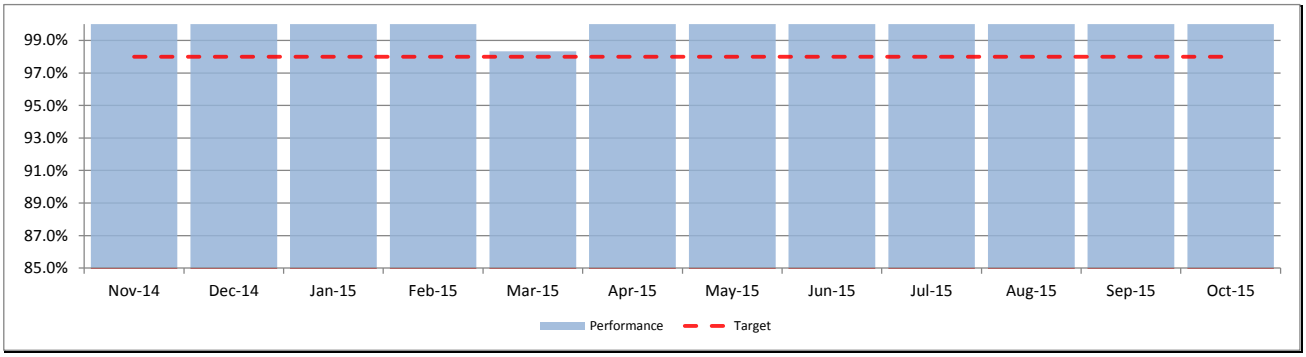
1st treatment - 31 day from decision to treat to treatment

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
1st treatments	150	165	173	131	200	159	155	185	169	149	172	176
31 day 1st treatment breaches	4	4	6	0	4	2	2	3	0	2	3	5
Performance	97.3%	97.6%	96.5%	100.0%	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	97.2%
Target	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%



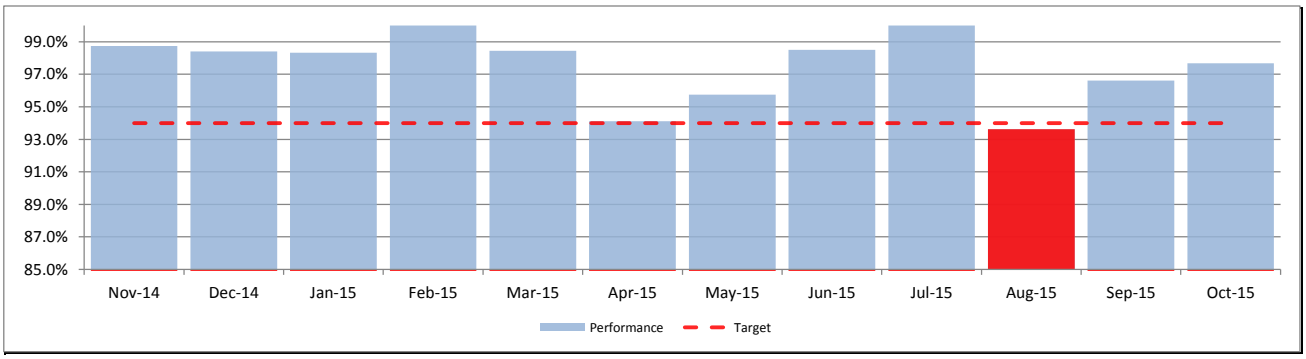
Subsequent treatment - 31 day from decision to treat to treatment - Drug

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Subsequent drug treatments	61	43	54	45	60	45	49	57	48	38	55	52
Subsequent drug breaches	0	0	0	0	1	0	0	0	0	0	0	0
Performance	100.0%	100.0%	100.0%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%



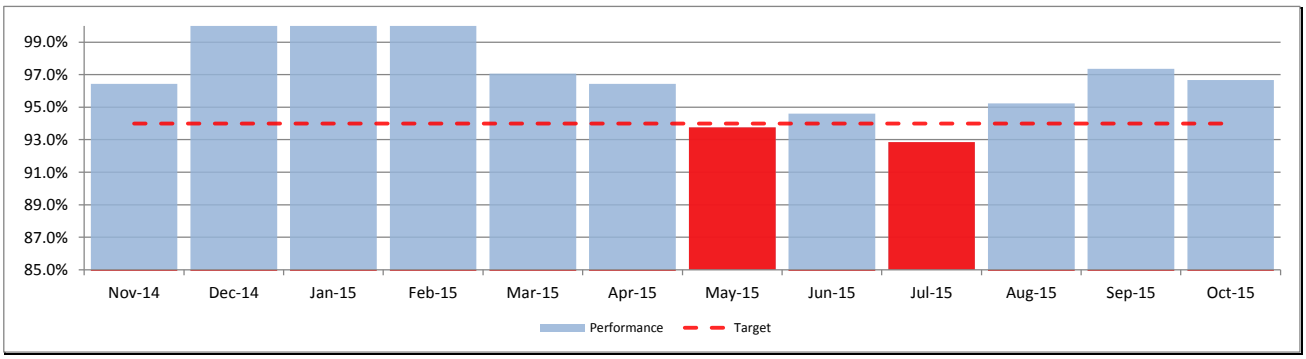
Subsequent treatment - 31 day from decision to treat to treatment - Radiotherapy

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Subsequent radiotherapy treatments	80	63	60	49	64	51	47	67	46	47	59	43
Subsequent radiotherapy breaches	1	1	1	0	1	3	2	1	0	3	2	1
Performance	98.8%	98.4%	98.3%	100.0%	98.4%	94.1%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%
Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%



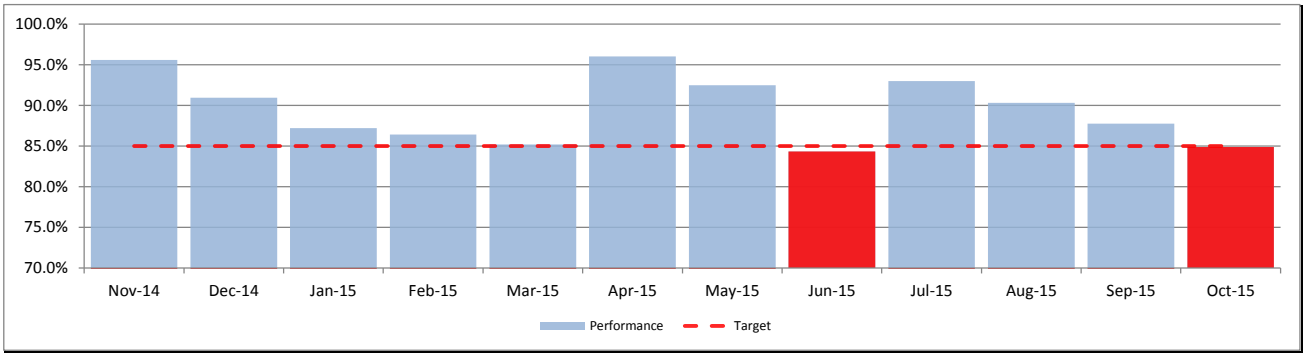
Subsequent treatment - 31 day from decision to treat to treatment - Surgery

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Subsequent surgery treatments	28	34	31	30	34	28	32	37	28	21	38	30
Subsequent surgery breaches	1	0	0	0	1	1	2	2	2	1	1	1
Performance	96.4%	100.0%	100.0%	100.0%	97.1%	96.4%	93.8%	94.6%	92.9%	95.2%	97.4%	96.7%
Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%



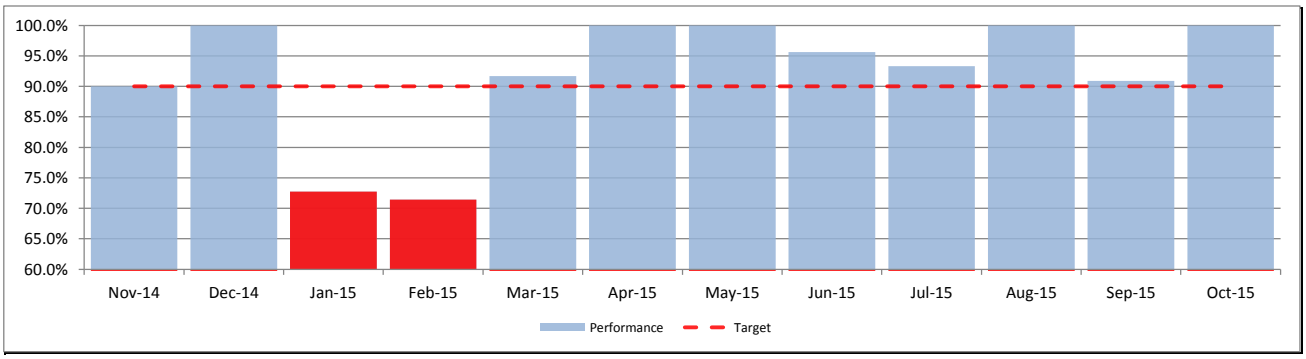
62 day 1st treatment from two week wait referral - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	79.5	99.5	82	62.5	108	75.5	73	92.5	85.5	77.5	98	102.5
62 day 1st treatment breaches	3.5	9	10.5	8.5	16	3	5.5	14.5	6	7.5	12	15.5
Performance	95.6%	91.0%	87.2%	86.4%	85.2%	96.0%	92.5%	**84.3%**	93.0%	90.3%	87.8%	**84.9%**
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



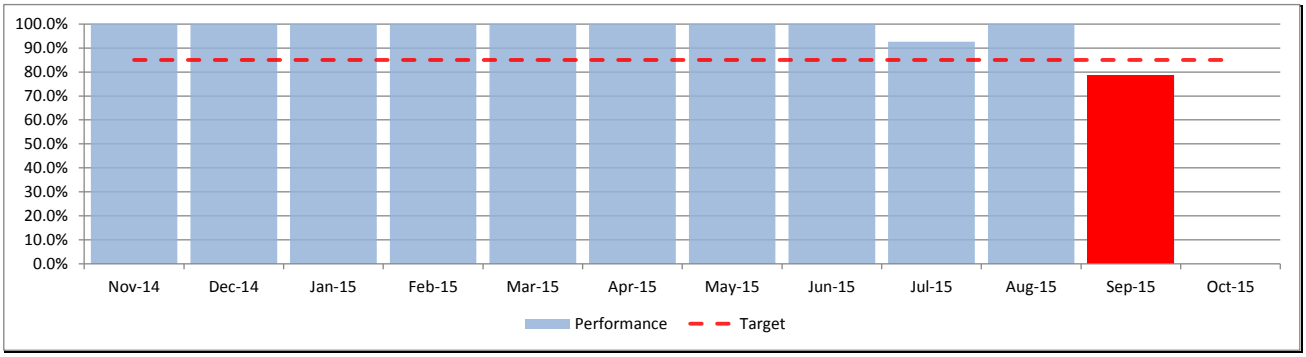
62 day 1st treatment from screening

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	10	3	11	7	12	9.5	11	11.5	7.5	8	11	11
62 day 1st treatment breaches	1	0	3	2	1	0	0	0.5	0.5	0	1	0
Performance	90.0%	100.0%	**72.7%**	**71.4%**	91.7%	100.0%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



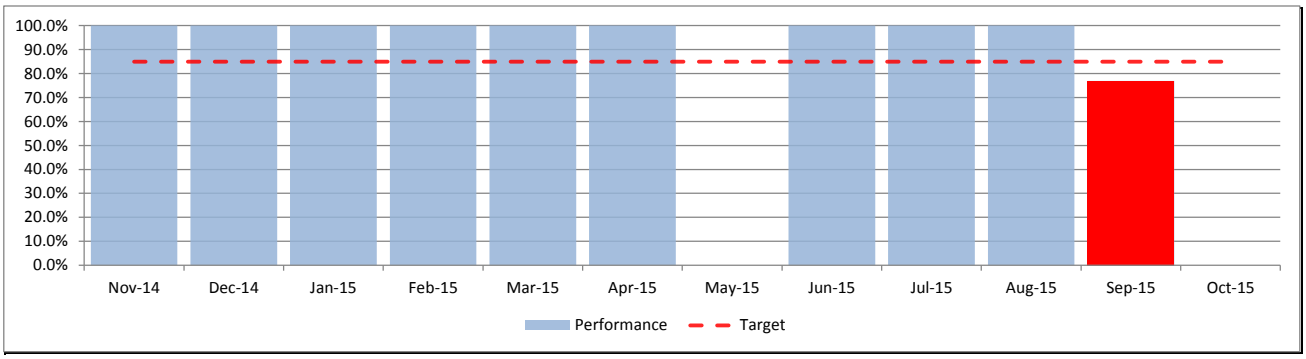
62 day 1st treatment from two week wait referral - BREAST

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	12	12	18	10	10	10	10	9	13.5	10	14	0
62 day 1st treatment breaches	0	0	0	0	0	0	0	0	1	0	3	0
Performance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.6%	100.0%	78.6%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



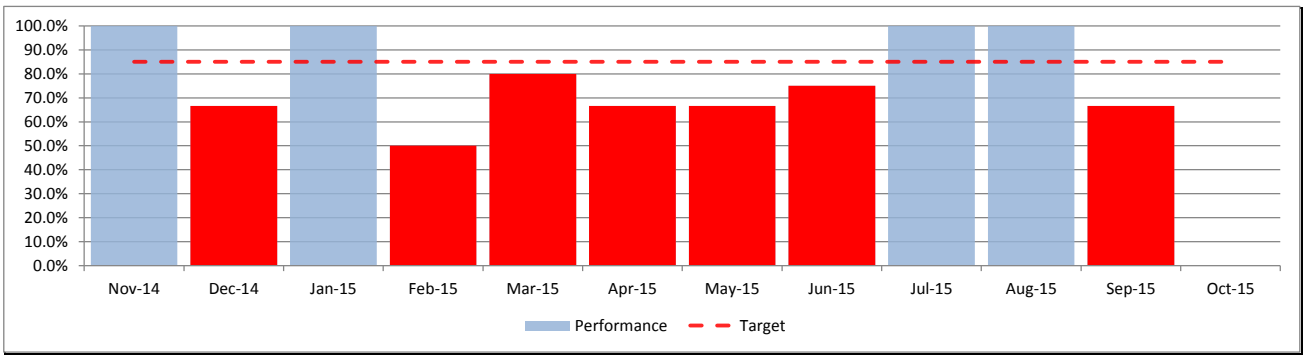
62 day 1st treatment from two week wait referral - GYNAECOLOGY

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	3.5	4.5	1.5	2.5	4	3.5	0	1.5	2	1	6.5	0
62 day 1st treatment breaches	0	0	0	0	0	0	0	0	0	0	1.5	0
Performance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	76.9%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



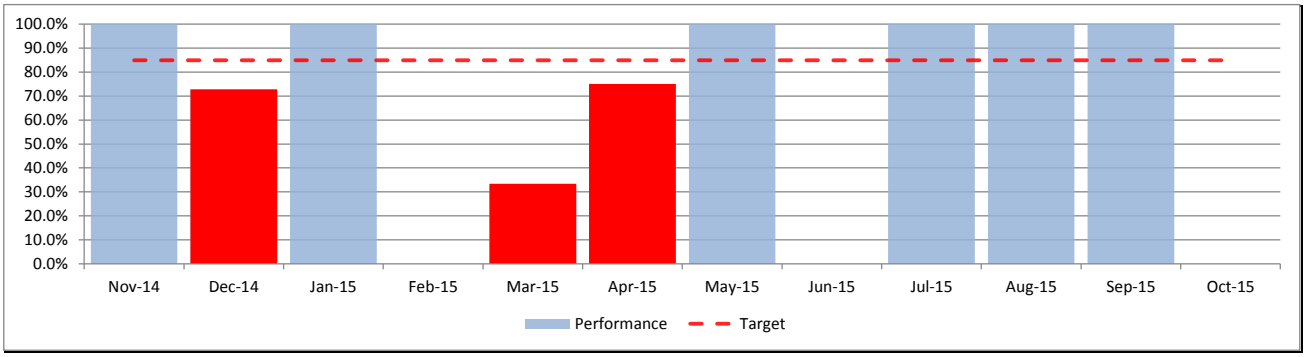
62 day 1st treatment from two week wait referral - HAEMATOLOGY

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	1	3	4	4	5	3	3	4	4	3	3	0
62 day 1st treatment breaches	0	1	0	2	1	1	1	1	0	0	1	0
Performance	100.0%	66.7%	100.0%	50.0%	80.0%	66.7%	66.7%	75.0%	100.0%	100.0%	66.7%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



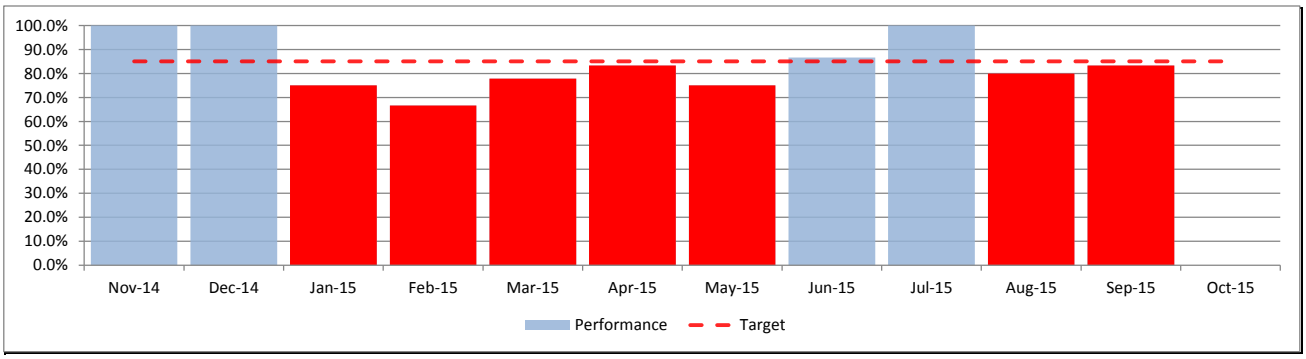
62 day 1st treatment from two week wait referral - HEAD AND NECK

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	1	5.5	1	1	4.5	4	1	4	5.5	2	2	0
62 day 1st treatment breaches	0	1.5	0	1	3	1	0	4	0	0	0	0
Performance	100.0%	**72.7%**	100.0%	**0.0%**	**33.3%**	**75.0%**	100.0%	**0.0%**	100.0%	100.0%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



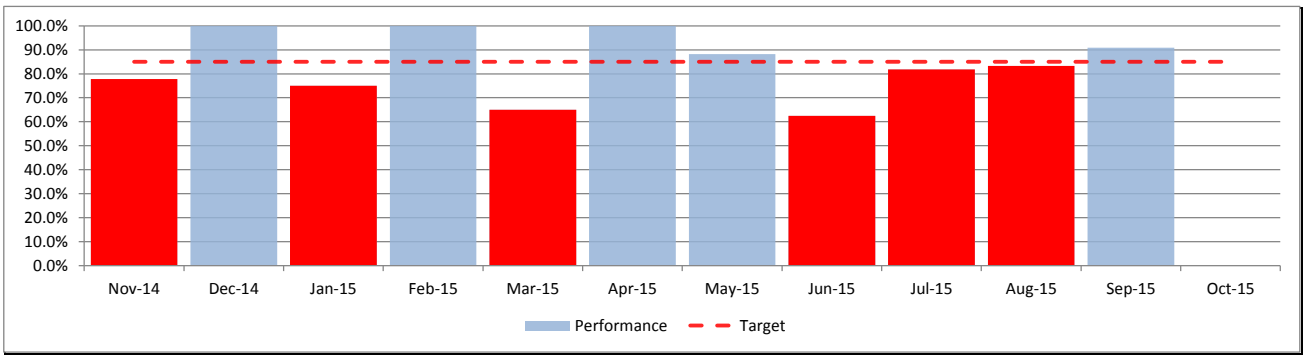
62 day 1st treatment from two week wait referral - LOWER GI

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	10	8	8	3	9	6	4	7.5	7	10	12	0
62 day 1st treatment breaches	0	0	2	1	2	1	1	1	0	2	2	0
Performance	100.0%	100.0%	**75.0%**	**66.7%**	**77.8%**	**83.3%**	**75.0%**	86.7%	100.0%	**80.0%**	**83.3%**	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



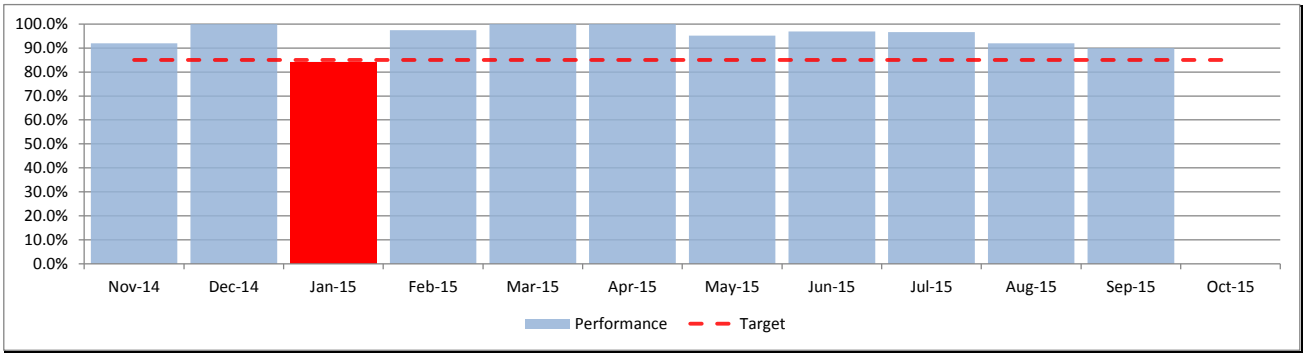
62 day 1st treatment from two week wait referral - LUNG

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	4.5	6	4	4	10	5	8.5	8	5.5	6	5.5	0
62 day 1st treatment breaches	1	0	1	0	3.5	0	1	3	1	1	0.5	0
Performance	**77.8%**	100.0%	**75.0%**	100.0%	**65.0%**	100.0%	88.2%	**62.5%**	**81.8%**	**83.3%**	90.9%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



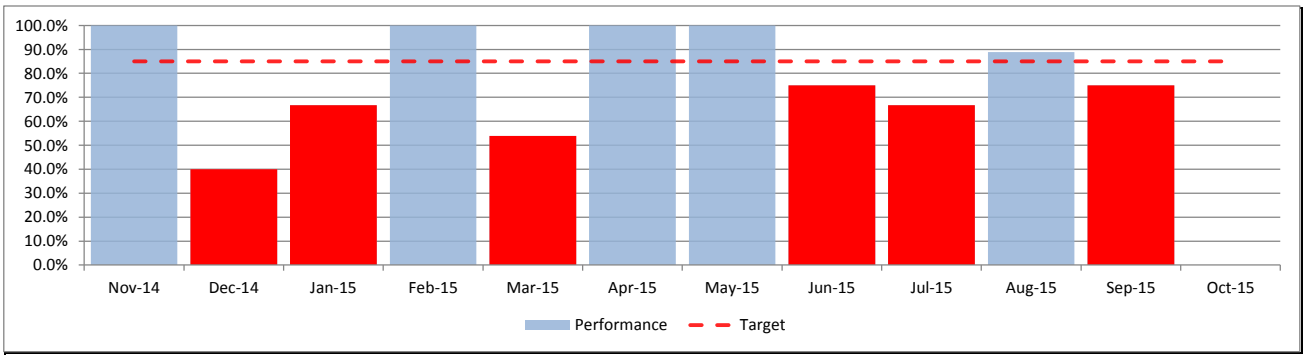
62 day 1st treatment from two week wait referral - SKIN

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	25	24	19	19.5	26	24	21	33	30	25	30	0
62 day 1st treatment breaches	2	0	3	0.5	0	0	1	1	1	2	3	0
Performance	92.0%	100.0%	**84.2%**	97.4%	100.0%	100.0%	95.2%	97.0%	96.7%	92.0%	90.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



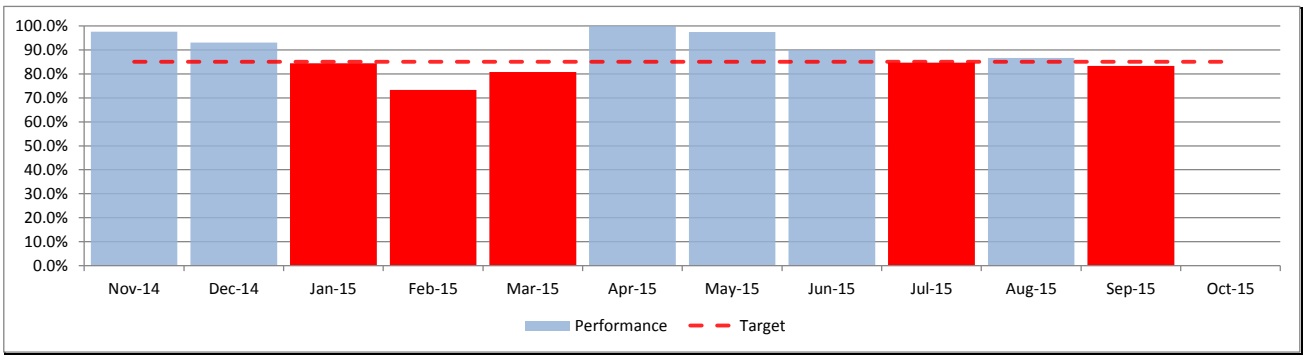
62 day 1st treatment from two week wait referral - UPPER GI

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	1	7.5	3	3	6.5	5	1	4	3	4.5	4	0
62 day 1st treatment breaches	0	4.5	1	0	3	0	0	1	1	0.5	1	0
Performance	100.0%	**40.0%**	**66.7%**	100.0%	**53.8%**	100.0%	100.0%	**75.0%**	**66.7%**	88.9%	**75.0%**	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



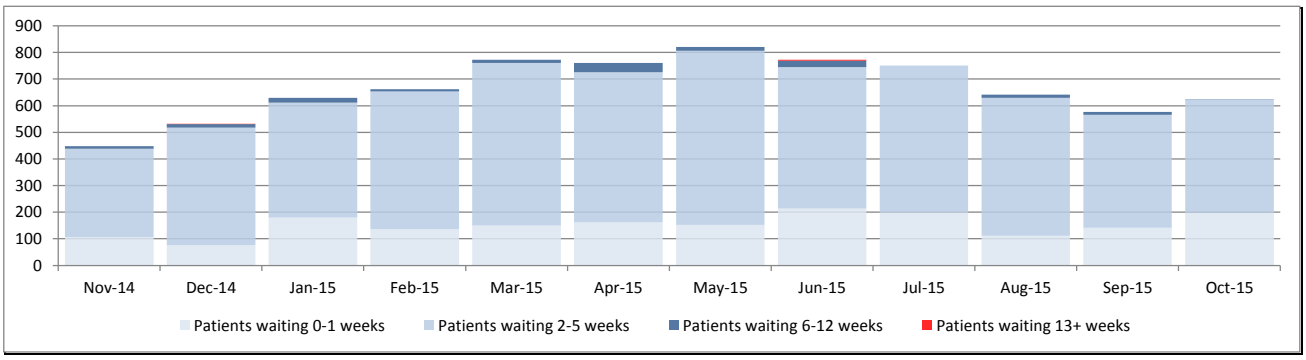
62 day 1st treatment from two week wait referral - UROLOGY

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
62 day 1st treatments	20.5	29	22.5	15	23.5	12	19.5	20	13	15	18	0
62 day 1st treatment breaches	0.5	2	3.5	4	4.5	0	0.5	2	2	2	3	0
Performance	97.6%	93.1%	**84.4%**	**73.3%**	**80.9%**	100.0%	97.4%	90.0%	**84.6%**	86.7%	**83.3%**	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



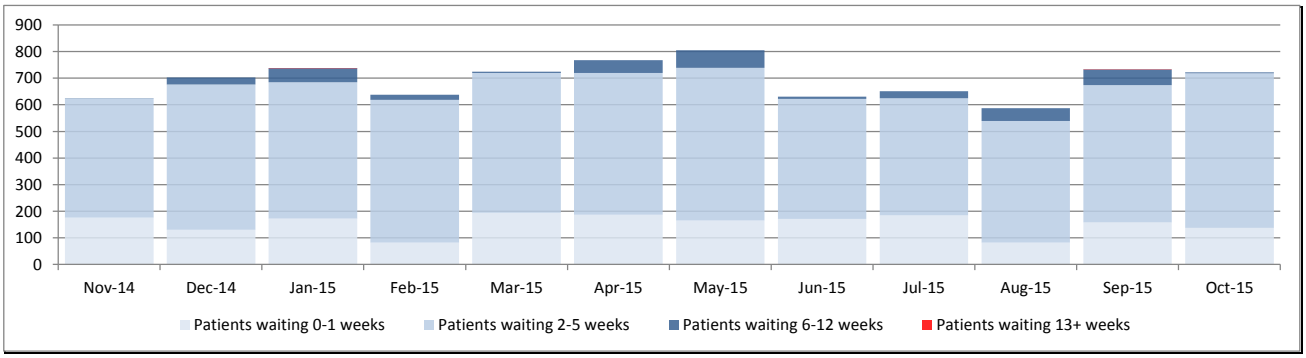
MRI Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	106	76	180	137	150	162	152	213	199	111	142	198
Patients waiting 2-5 weeks	332	442	431	517	610	564	654	532	552	519	424	425
Patients waiting 6-12 weeks	10	13	19	8	13	35	14	24	0	12	10	2
Patients waiting 13+ weeks	0	1	0	0	0	0	0	4	0	0	0	0



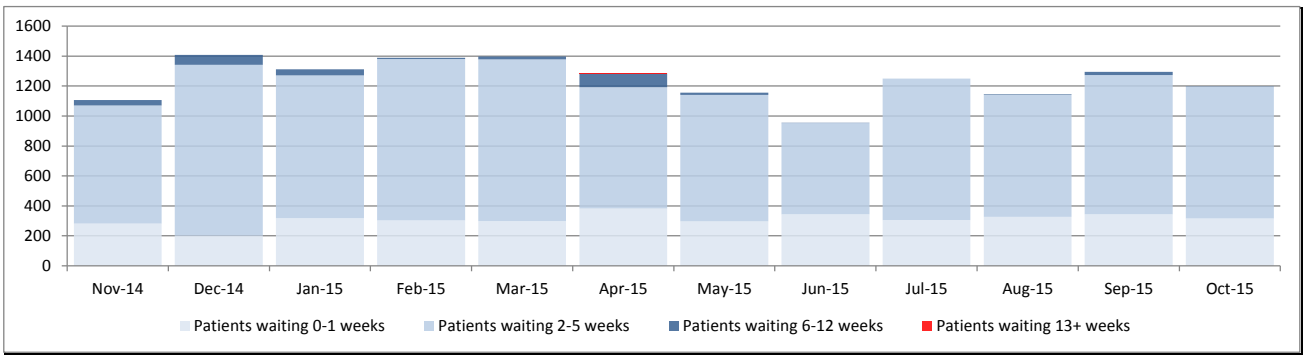
CT Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	176	130	172	82	194	187	165	171	184	82	158	138
Patients waiting 2-5 weeks	447	546	513	537	525	533	574	451	441	457	516	580
Patients waiting 6-12 weeks	2	27	52	19	5	48	66	9	26	48	59	4
Patients waiting 13+ weeks	0	0	1	0	0	0	0	0	0	0	1	0



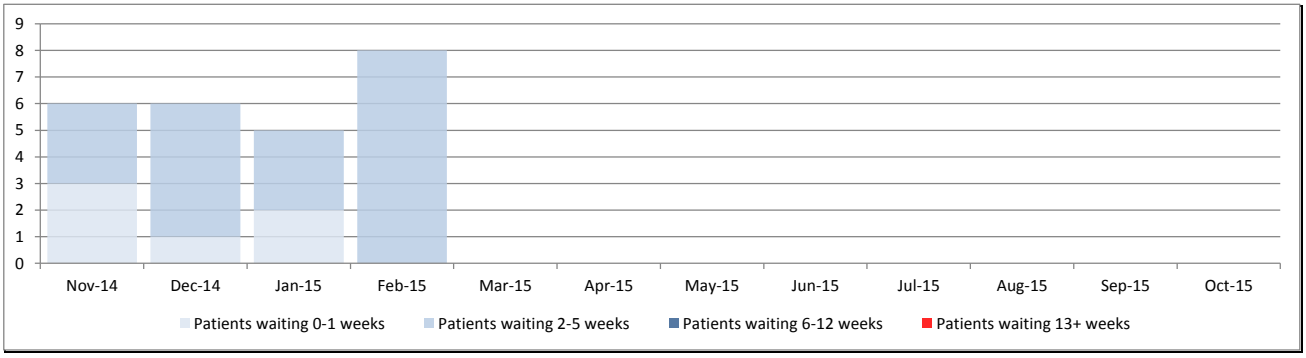
Non-Obstetric Ultrasound Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	281	200	318	304	299	382	296	344	306	327	345	316
Patients waiting 2-5 weeks	790	1143	953	1076	1079	811	846	610	943	814	928	881
Patients waiting 6-12 weeks	36	65	40	9	19	92	15	1	0	5	21	2
Patients waiting 13+ weeks	0	0	0	0	0	1	0	0	0	0	0	0



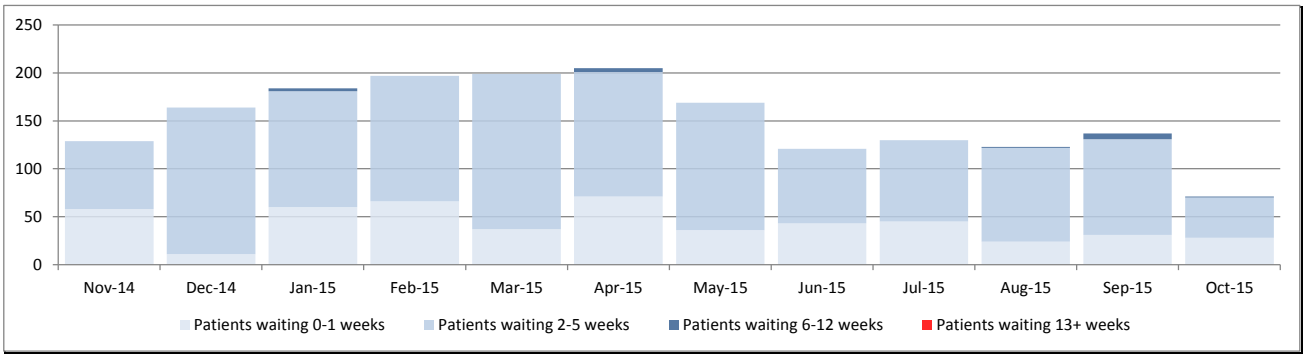
Barium Enema Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	3	1	2	0	0	0	0	0	0	0	0	0
Patients waiting 2-5 weeks	3	5	3	8	0	0	0	0	0	0	0	0
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



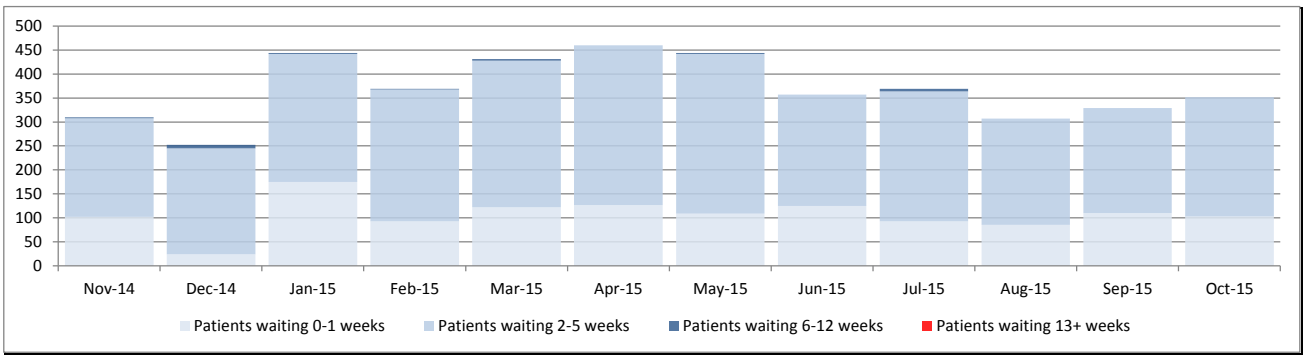
Dexa Scan Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	58	11	60	66	37	71	36	43	45	24	31	28
Patients waiting 2-5 weeks	71	153	121	131	162	130	133	78	85	98	100	42
Patients waiting 6-12 weeks	0	0	3	0	0	4	0	0	0	1	6	1
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



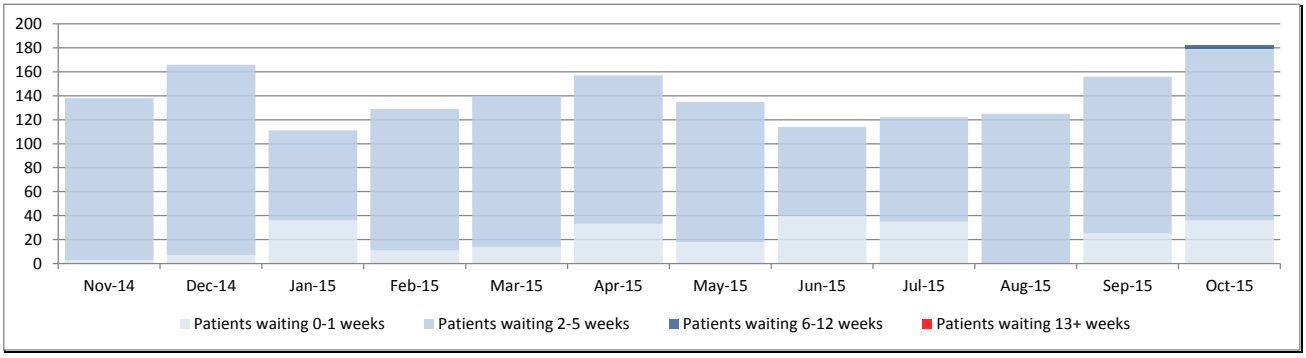
Audiology Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	102	24	175	93	122	127	109	125	93	85	110	103
Patients waiting 2-5 weeks	206	221	267	275	306	333	333	232	271	222	219	249
Patients waiting 6-12 weeks	2	7	2	1	3	0	2	0	5	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



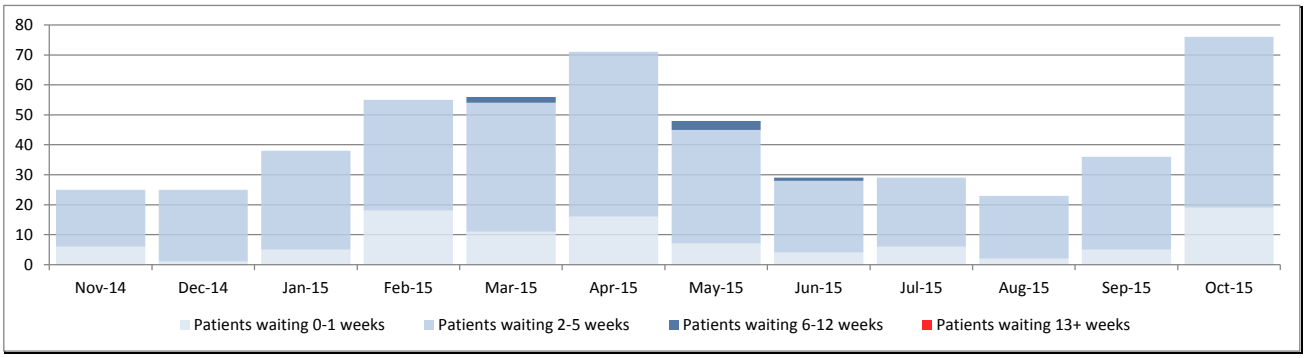
Cardiology (Echocardiology) Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	3	7	36	11	14	33	18	40	35	0	25	36
Patients waiting 2-5 weeks	135	159	75	118	126	124	117	74	87	125	131	143
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	3
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



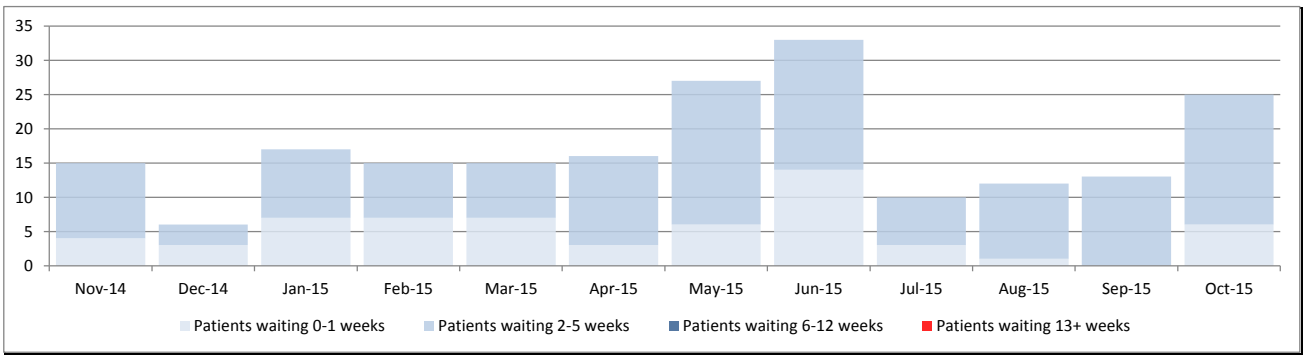
Neurophysiology Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	6	1	5	18	11	16	7	4	6	2	5	19
Patients waiting 2-5 weeks	19	24	33	37	43	55	38	24	23	21	31	57
Patients waiting 6-12 weeks	0	0	0	0	2	0	3	1	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



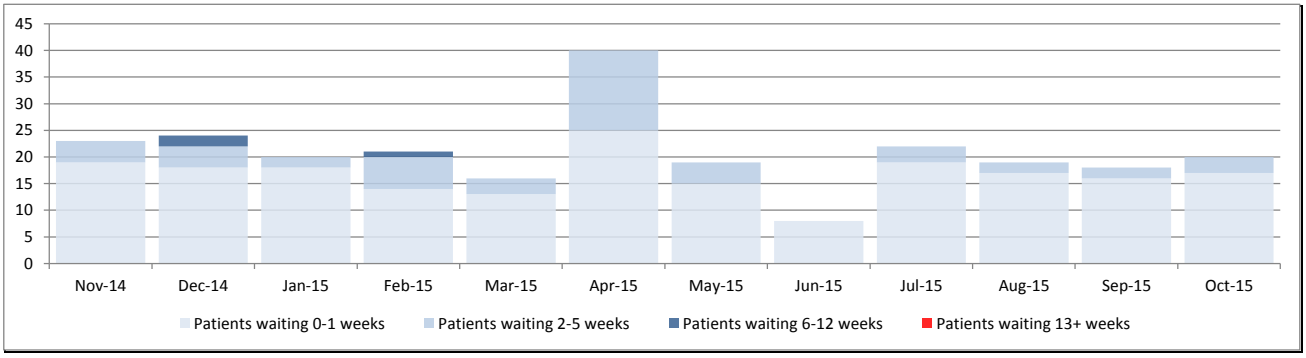
Respiratory Physiology - Sleep Studies

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	4	3	7	7	7	3	6	14	3	1	0	6
Patients waiting 2-5 weeks	11	3	10	8	8	13	21	19	7	11	13	19
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



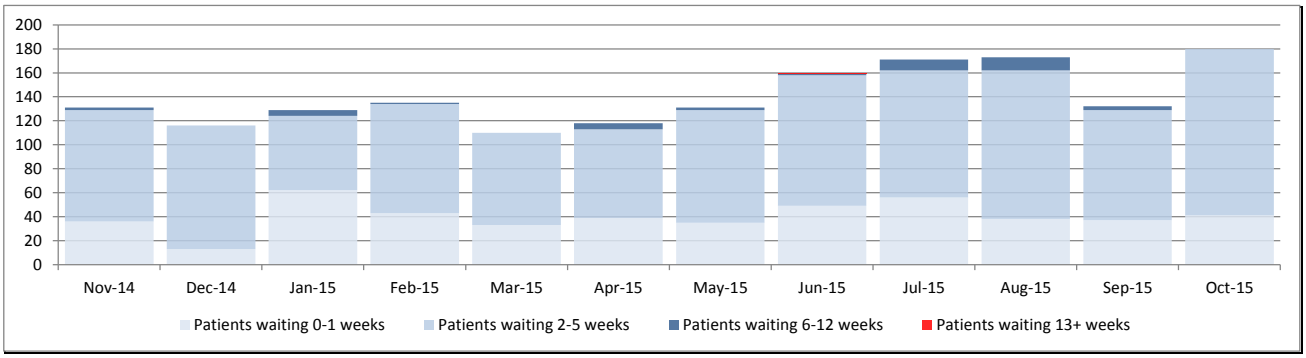
Urodynamics - Pressures & Flows

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	19	18	18	14	13	25	15	8	19	17	16	17
Patients waiting 2-5 weeks	4	4	2	6	3	15	4	0	3	2	2	3
Patients waiting 6-12 weeks	0	2	0	1	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



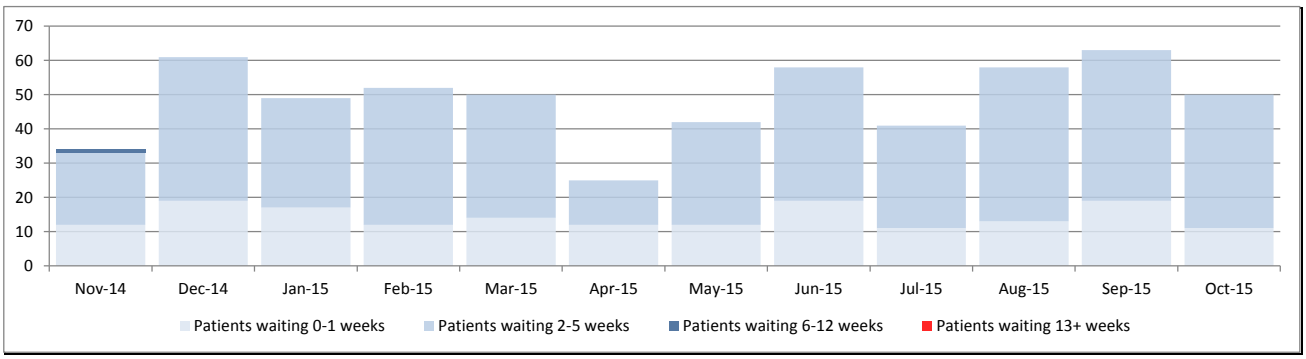
Colonoscopy Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	36	13	62	43	33	39	35	49	56	38	37	41
Patients waiting 2-5 weeks	93	103	62	91	77	74	94	109	106	124	92	139
Patients waiting 6-12 weeks	2	0	5	1	0	5	2	1	9	11	3	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	1	0	0	0	0



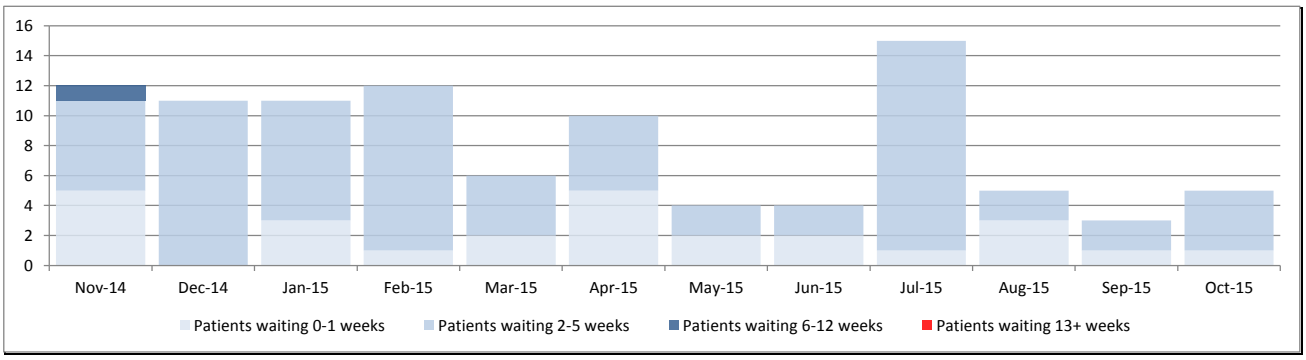
Flexi Sigmoidoscopy Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	12	19	17	12	14	12	12	19	11	13	19	11
Patients waiting 2-5 weeks	21	42	32	40	36	13	30	39	30	45	44	39
Patients waiting 6-12 weeks	1	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



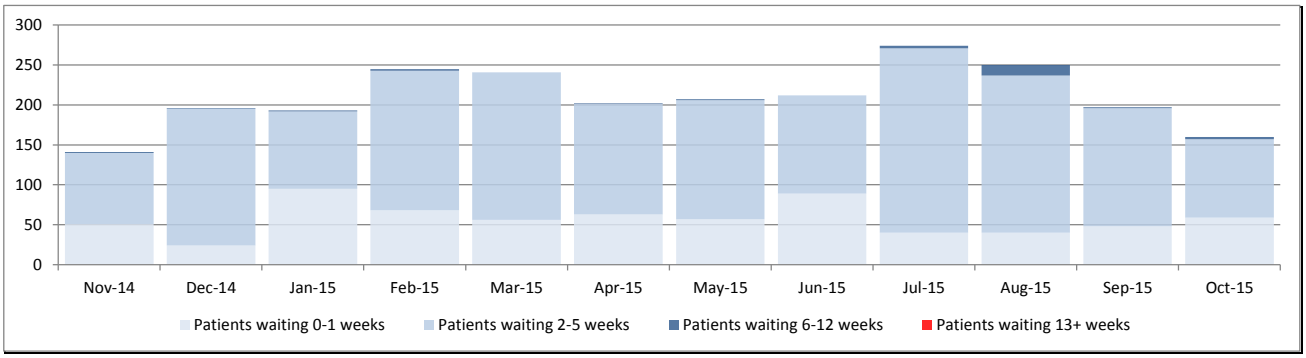
Cystoscopy Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	5	0	3	1	2	5	2	2	1	3	1	1
Patients waiting 2-5 weeks	6	11	8	11	4	5	2	2	14	2	2	4
Patients waiting 6-12 weeks	1	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



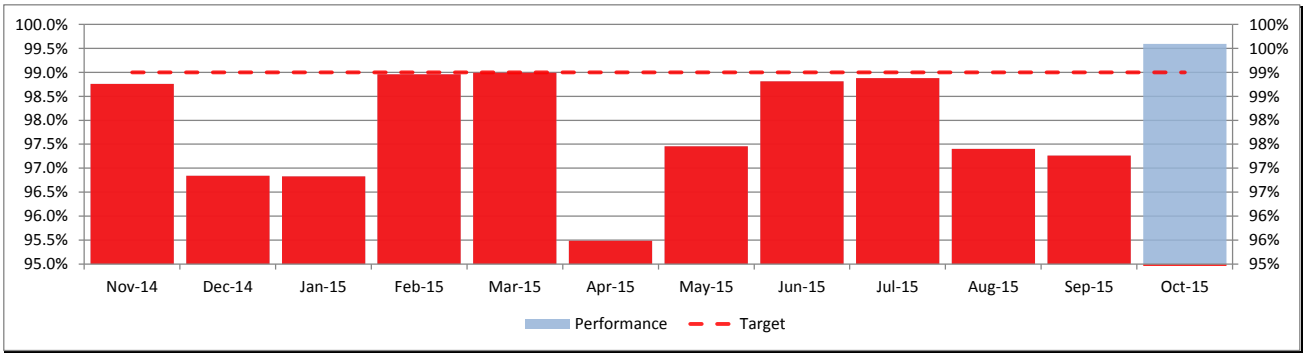
Gastroscopy Waiting Times

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients waiting 0-1 weeks	51	24	95	68	56	63	57	89	40	40	48	59
Patients waiting 2-5 weeks	89	171	97	175	185	138	149	123	231	197	148	98
Patients waiting 6-12 weeks	1	1	1	2	0	1	1	0	3	13	1	3
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



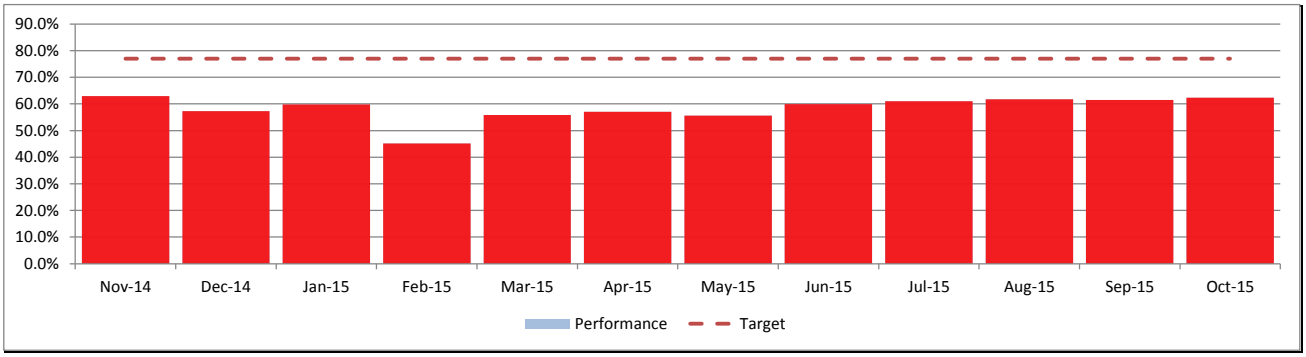
Overall diagnostic position

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Total waits	2902	3670	3880	3927	4158	4123	4007	3455	3834	3470	3688	3667
Total breaches (6+ weeks)	36	116	123	41	42	186	102	41	43	90	101	15
Performance	98.8%	96.8%	96.8%	99.0%	99.0%	95.5%	97.5%	98.8%	98.9%	97.4%	97.3%	99.6%
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%



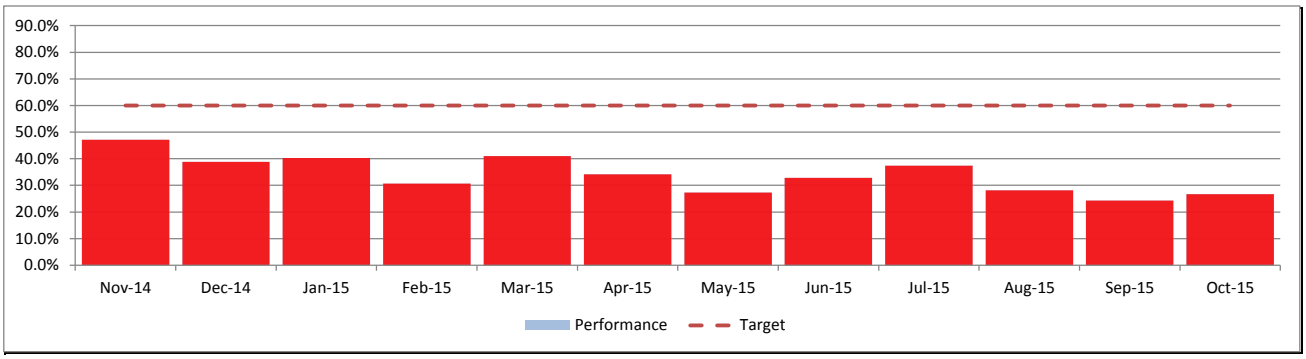
CPS completed within 24 hours - Weekday - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients	1920	2184	2086	1986	2140	2066	1701	1833	1913	1673	1893	1840
CPS completed within 24 hours	1208	1252	1248	896	1194	1179	946	1099	1167	1032	1165	1148
Performance	62.9%	57.3%	59.8%	45.1%	55.8%	57.1%	55.6%	60.0%	61.0%	61.7%	61.5%	62.4%
Target	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%



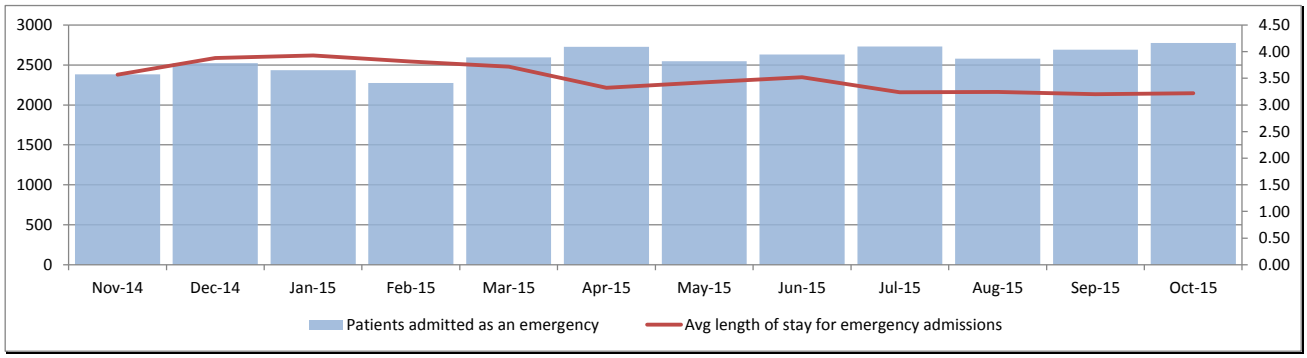
CPS completed within 24 hours - Weekend - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients	601	474	489	470	529	506	524	418	423	565	444	495
CPS completed within 24 hours	283	184	197	144	217	173	143	137	158	159	108	132
Performance	47.1%	38.8%	40.3%	30.6%	41.0%	34.2%	27.3%	32.8%	37.4%	28.1%	24.3%	26.7%
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%



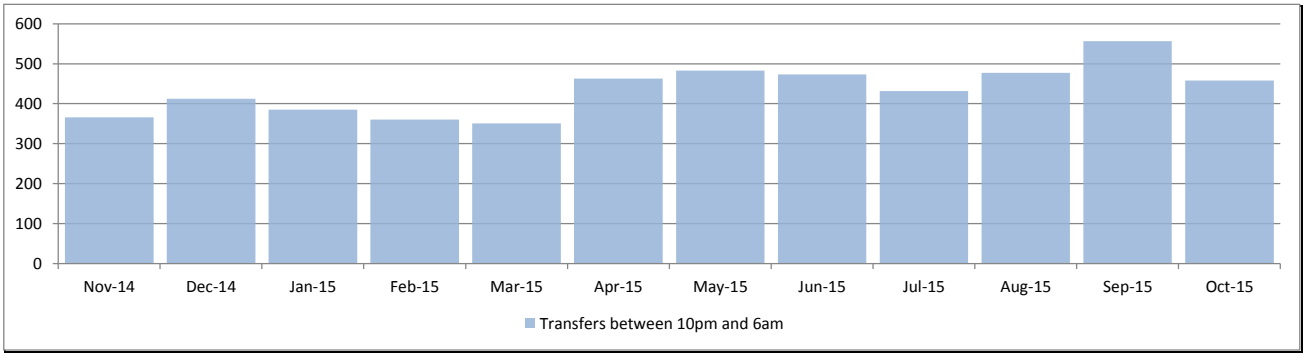
Emergency admissions - Trust Total

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Patients admitted as an emergency	2384	2525	2437	2276	2597	2729	2546	2631	2732	2580	2693	2777
Avg length of stay for emergency admissions	3.57	3.88	3.93	3.81	3.72	3.32	3.43	3.52	3.24	3.25	3.20	3.22



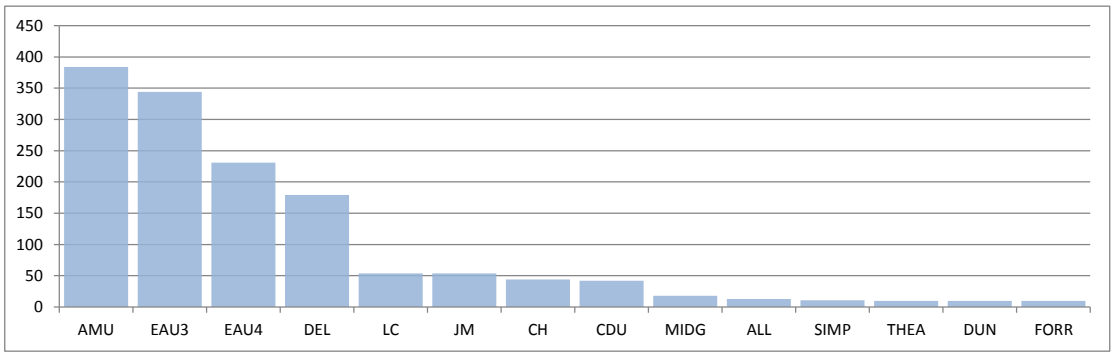
Transfers

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Transfers between 10pm and 6am	366	412	385	360	351	463	483	473	432	477	557	458
Transfers between 10pm and midnight	153	160	158	142	147	169	183	196	173	179	196	184
Transfers between midnight and 2am	92	131	113	107	109	145	153	147	138	141	185	119
Transfers between 2am and 4am	67	58	72	59	56	83	93	79	70	93	113	103
Transfers between 4am and 6am	54	63	42	52	39	66	54	51	51	64	63	52



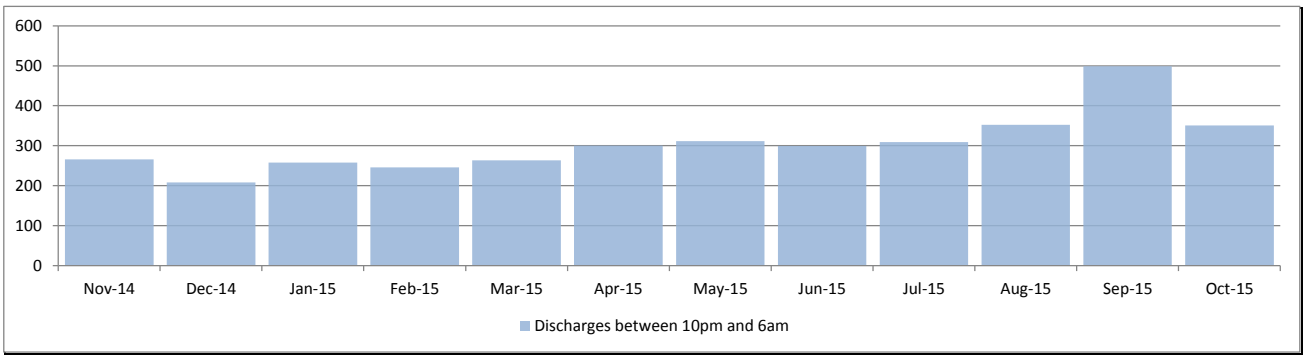
Night time transfers by ward (last 3 months)

Ward	Transfers
AMU	384
EAU3	344
EAU4	231
DEL	179
LC	54
JM	54
CH	44
CDU	42
MIDG	18
ALL	13
SIMP	11
THEA	10
DUN	10
FORR	10



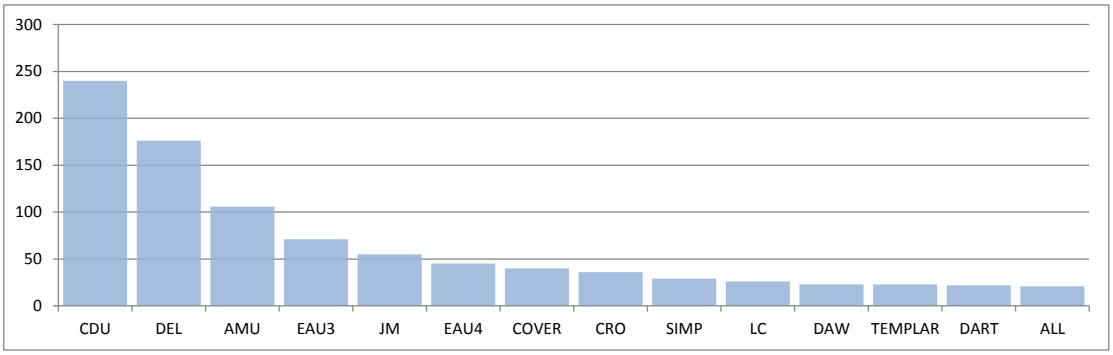
Discharges

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Discharges between 10pm and 6am	266	208	258	246	263	300	311	299	309	352	499	351
Discharges between 10pm and midnight	132	97	115	92	118	142	144	138	149	147	295	162
Discharges between midnight and 2am	70	49	79	79	73	73	87	71	81	103	99	90
Discharges between 2am and 4am	35	39	36	50	39	55	49	60	48	58	56	58
Discharges between 4am and 6am	29	23	28	25	33	30	31	30	31	44	49	41



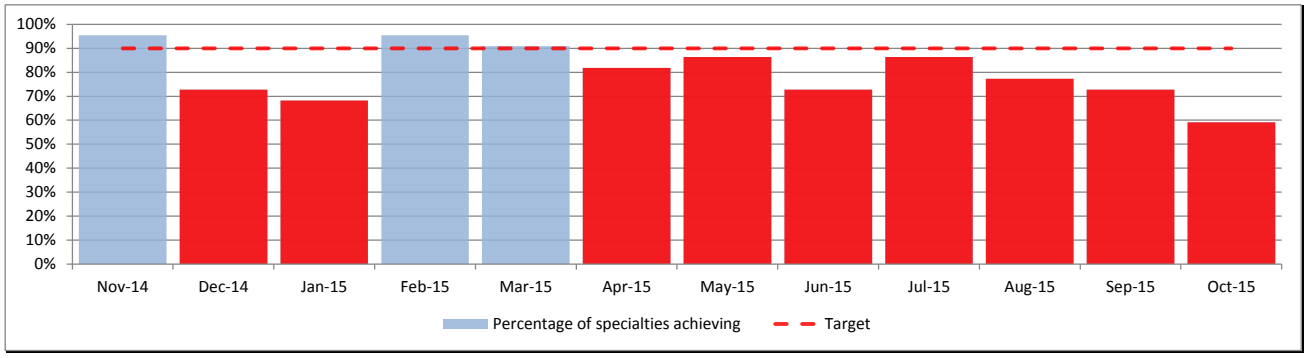
Night time discharges by ward (last 3 months)

Ward	Discharges
CDU	240
DEL	176
AMU	106
EAU3	71
JM	55
EAU4	45
COVER	40
CRO	36
SIMP	29
LC	26
DAW	23
TEMPLAR	23
DART	22
ALL	21



Clinic Letters Timeliness - Dictated Letters Not Typed

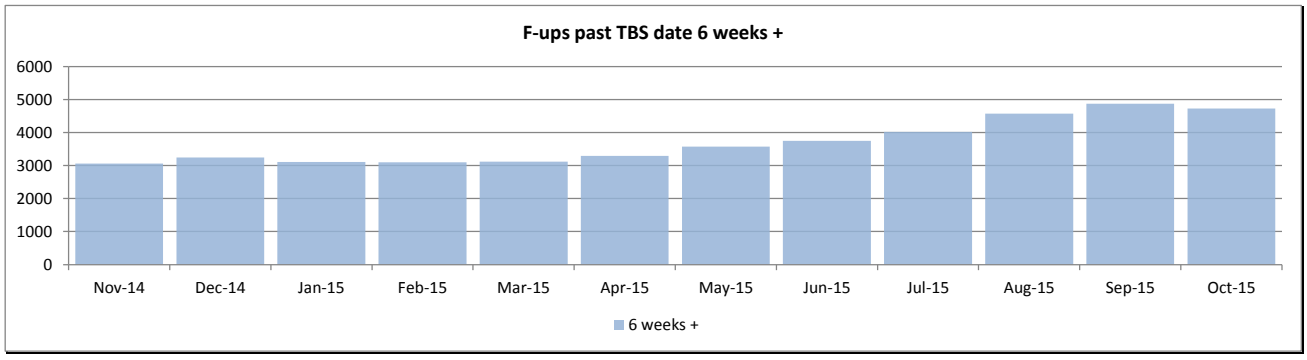
	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Specialties breaching	1	6	7	1	2	4	3	6	3	5	6	9
Percentage of specialties achieving	95%	73%	68%	95%	91%	82%	86%	73%	86%	77%	73%	59%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Follow up appointments past to be seen date

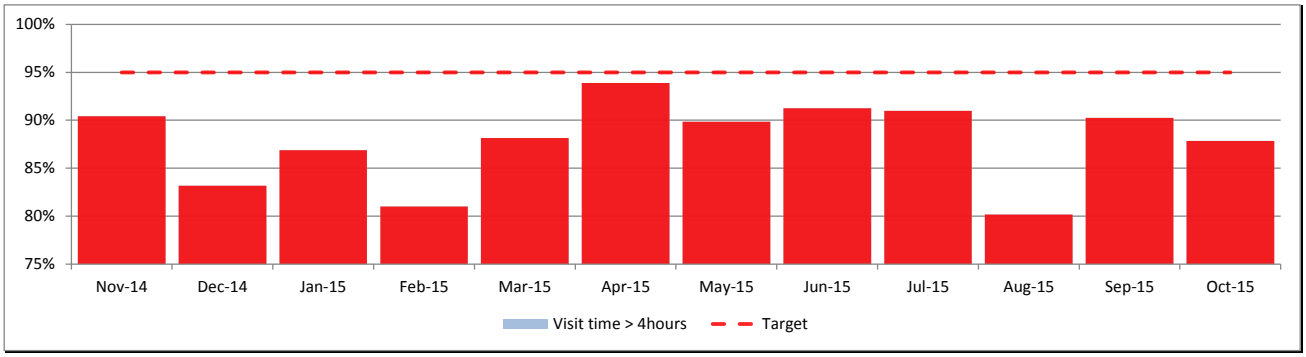
	0-6 Weeks	6-12 Weeks	12-18 Weeks	18 Weeks +	Grand Total
Audiology	14	3	1	0	18
Breast Surgery	35	3	0	0	38
Cardiology	112	57	79	118	366
Colorectal Surgery	53	29	43	76	201
Dermatology	135	76	85	88	384
Diabetic Medicine	78	64	38	34	214
ENT	150	42	79	55	326
Endocrinology	26	16	7	6	55
Gastroenterology	38	15	46	18	117
General Medicine	7	3	24	53	87
Geriatric Medicine	0	0	0	0	0
Gynaecology	90	11	0	0	101
Medical Oncology	0	0	0	1	1
Nephrology	2	0	0	0	2
Neurology	15	15	16	19	65
Ophthalmology	1508	699	842	515	3564
Oral Surgery	51	9	24	3	87
Orthodontics	4	0	0	1	5
Orthoptics	357	43	58	10	468
Paediatrics	225	84	84	153	546
Pain Management	89	53	72	97	311
Plastic Surgery	55	36	8	0	99
Podiatry	0	0	0	0	0
Respiratory Medicine	138	23	31	8	200
Restorative Dentistry	0	2	1	0	3
Rheumatology	357	210	121	23	711
Thoracic Surgery	0	0	0	0	0
Trauma & Orthopaedics	168	43	22	3	236
Upper Gastrointestinal Surgery	19	10	6	13	48
Urology	68	43	67	94	272
Vascular Surgery	0	0	0	0	0
Total	3794	1589	1754	1388	8525

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
0-6 weeks	2713	3039	2805	2812	3309	3307	3781	4105	4211	4068	3886	3794
6-12 weeks	1148	1201	1098	1139	1072	1253	1274	1337	1511	1593	1771	1589
12-18 weeks	1130	1172	1111	976	1046	1044	1196	1344	1420	1761	1778	1754
18 weeks +	784	874	903	981	997	997	1107	1064	1089	1216	1324	1388
6 weeks +	3062	3247	3112	3096	3115	3294	3577	3745	4020	4570	4873	4731



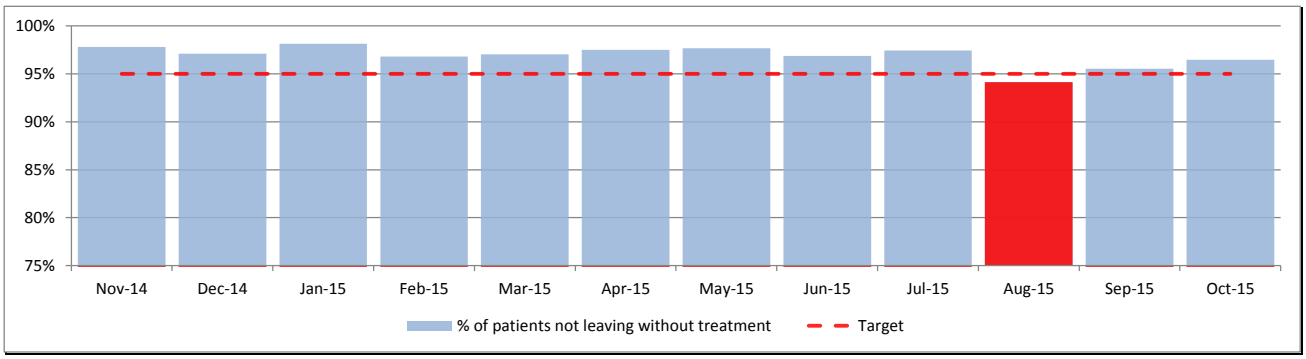
Time spent in A&E

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
A&E attendances	6222	6178	5821	5537	6397	6446	6646	6518	6752	6209	6087	6192
Percentage of patients treated within 4 hours	596	1039	764	1053	758	394	674	571	608	1232	594	753
Visit time > 4hours	90%	83%	87%	81%	88%	94%	90%	91%	91%	80%	90%	88%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Left department without being treated

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
A&E attendances	6222	6178	5821	5537	6397	6446	6646	6518	6752	6209	6087	6192
Percentage of patients treated within 4 hours	136	178	108	177	189	160	154	204	172	365	271	218
% of patients not leaving without treatment	98%	97%	98%	97%	97%	98%	98%	97%	97%	94%	96%	96%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Unplanned re-attendances

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
A&E attendances	6222	6178	5821	5537	6397	6446	6646	6518	6752	6209	6087	6192
Re-attendances	308	329	303	304	370	406	379	335	239	31	51	135
% of unplanned re-attendances	5%	5%	5%	5%	6%	6%	6%	5%	4%	0%	1%	2%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%