Torbay and South Devon NHS Foundation Trust

TSDFT Board of Directors

Public Board of Directors Meeting

Arlington Room, Toorak Hotel, Chestnut Avenue, Torquay, TQ2 5JS

03 February 2016 11:00

AGENDA

1 Apologies

Owner : Chairman

Note

2 User Experience

Note

3 Minutes of the Board Meeting held on the 2nd December 2015 and Outstanding Actions

Owner : Chairman

Approve

4 Declaration of Interests

Owner : Chairman

Note

5 Quality, Patient Safety and Experience

5.1 Report of the Chief Nurse

Owner : CN

Information/Assurance

5.2 Report of the Medical Director

Owner : MD

Discussion/Assurance

5.3 Safety Scorecard

Owner : MD

Information/Assurance

9.2 Report of the Director of Estates and Commercial Development

Owner : DECD

Discussion/Assurance

10 Assurance

Owner : Chairman

10.1 Feedback from Chairs of Board Committees (Finance, Quality Assurance, Charitable Funds and Audit and Assurance Committees)

Owner : Chairs

Discussion/Assurance

11 Governors' Question Time

Owner : Chairman

Discussion/Assurance

12 Date of Next Meeting - 11.00 am, Wednesday 6th April 2016

Owner : Chairman

Note

13 Exclusion of the Public

Owner : Chairman

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST BOARD OF DIRECTORS MEETING HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE TORBAY HOSPITAL ON WEDNESDAY 2ND DECEMBER 2015

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mr D Allen	Non-Executive Director
	Mr J Brockwell	Non-Executive Director
	Mr J Furse	Non-Executive Director
	Mrs J Lyttle	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 R Dyer	Medical Director
	Councillor J Parrott	Torbay Council Representative
	Mr M Ringrose	Interim Director of Human Resources
	Mrs J Viner	Chief Nurse
In Attendance:		
	Mrs S Fox	Board Secretary
	Mrs J Gratton	Interim Director of Communications
	Mr R Scott	Corporate Secretary
	Mrs C Ives	Specialist Registrar
	Mr S Langridge	SPOT Torbay
	Mrs P Roberts	League of Friends
	Mr S Honeywill	Head of Operational Change
	Ms C Foy	Service Manager, CAMHS
	Ms C Williams	Assistant Director, Community Division

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

Before commencing the meeting the Chairman welcomed Dr Dyer to his first meeting as Medical Director.

ACTION

186/12/15 **Apologies**

Apologies were received from Mr Burnett.

187/12/15 **Minutes of the Board Meeting held on the 4th November 2015 and Outstanding Actions**

The minutes were confirmed as an accurate record of the meeting held on the 4th November 2015.

The following actions were noted:

- **Care Planning Summary** – work was continuing to try to simplify the process with some rapid change cycles taking place. It was agreed this would be monitored through the Quality Improvement Group.
- **CAMHS Performance** – a report was included in the agenda for today's meeting.
- **Capital, Estates, Equipment and Investment Plan** – it had been agreed this would be brought to the Board in March 2016 and was being addressed through the business planning process.

188/12/15 **Declarations of Interest**

Mr Allen informed the Board that he had worked with Quintiles as part of the work in respect of clinical trials in the peninsula but no longer undertook any work for them (discussed in the Research and Development report).

Quality, Patient Safety and Experience

189/12/15 Report of the Chief Nurse

The Chief Nurse reported the following:

- **Nurse Revalidation** – work continued on the nurse revalidation process, mirroring the one put in place for medical revalidation. Nurses would be required to demonstrate they met a number of key requirements: practice hours; continual professional development; practice-related feedback; reflection and discussion; health and character; professional indemnity arrangement; and confirmation from a third party. Staff were being supported through the process, especially those who were perhaps close to the end of their career or wishing to work differently and might feel anxious about the revalidation process.
- **Safer Staffing** – it was noted that Bovey Tracey Hospital had been experiencing staffing issues due to a number of staff changes and work had taken place to develop a mitigation plan to support the hospital. The Hospital had a very small cohort of staff so changes in one or two staff members had a significant effect on the Hospital's ability to keep beds open.
- **Engagement and Feedback Group Minutes** – noted.

The Chairman asked if the CQC would wish to review the nursing revalidation process and the Chief Nurse confirmed that they would, but that she felt the Trust was on track to deliver the expectations of the CQC. Mr Furse added that he was pleased to note that the work was being used as an opportunity to embed the process of professional development and learning, and that that it was not just being seen as a 'tick box' exercise.

Mr Furse asked if the staffing issues at Bovey Tracey were a one off or had been present for some time, he also queried the acuity of patients at the hospital. The Chief Nurse said that the hospital had a small number of beds and a small staffing cohort so any changes to staffing had a big impact on the team. In terms of patient

acuity, the hospital took patients with a low dependency. The Chief Operating Officer added that the ICO allowed for staff to be used across the whole Torbay and South Devon area in a more flexible way which would help to add resilience to areas such as Bovey Hospital.

190/12/15 Report of the Medical Director

It was noted that although the Junior Doctors' strike did not take place, there was still the possibility that strikes could happen in the New Year. The plan that had been put in place for the cancelled strikes would be used if this did happen.

The Board noted that junior medical staff contributed to almost half of the Trust's medical workforce and comprised from doctors just out of medical training to doctors with up to 10 years' experience and were a highly skilled group workforce.

In working up the plan for the strike, the Trust identified risks including, most importantly, patient safety; the need to cancel elective activity; the Trust's relationship with the junior doctors; risk to staff who were working on the day of the strike; and the fact that patients might behave in a different way if it was perceived the hospital was not staffed adequately. It was important to note that the junior doctors did not have any issue with the Trust and had worked with the Trust in putting the mitigation plans in place.

Of the estimated 50 elective day case operations cancelled, 27 were actually cancelled. All of the 27 had been rebooked before Christmas, apart from one which was due to patient choice. The overall impact of the strike was still being assessed and understood.

Mr Furse said that, as Chair of the LNC, the approach and attitude of the Junior Doctors in supporting the Trust to help plan for the strike had been very responsible, considered and professional.

Finally, the Medical Director reported that following some staffing difficulties in Paignton Hospital, a robust staffing plan was in place until April of next year. He added that the model used was now being considered for other community hospitals.

191/12/15 Research and Development Report

The Board noted the yearly Research and Development report. It was noted that the Trust had an active and successful research team in place. There had been a reduction in activity in recent years, but it was hoped that additional activity would be realised in future years to provide additional income for the service and Trust. The R&D lead was keen to see R&D embedded into the ICO and support the activity of the Trust and this was seen by the Board as very important.

Mr Welch queried governance of the R&D function and the Medical Director explained that there was a very strong national governance system in place for R&D and that internally governance was through him as Medical Director and to the Board. It was agreed that this issue would be further discussed outside the meeting. MD/JW

Councillor Parrott queried the number of staff in the R&D team and whether they actively pursued grants for research etc. The Medical Director explained that they were a small team and there was a balance between appropriate staff numbers and ensuring enough funding was available to cover the cost of those staff members.

Mr Brockwell suggested the report should have included some examples of successful research outcomes and the Medical Director said he would take this comment back to the R&D lead. MD Mr Allen said that it would helpful if the report also connected to the wider research community, for example the Academic Health Science Network, Horizon Institute, Medical Schools etc and this was noted. He also

suggested that research questions needed to be asked of consultant candidates at interview and it was suggested that this was an area NEDs could focus on in interviews.

The Chief Executive referred to the desire stated in the report to increase the level of dementia research. She said that this was a big opportunity for the Trust as it fitted with the Trust's footprint and local demography and she wished to understand how the Trust could support any bids for funding. She also raised a concern around the level of R&D funding and if it did reduce the Trust could lost valuable research capability. She said she was keen to explore how more funding could be found for R&D including allocating a percentage of E&G income. Councillor Parrott suggested that the Public Health Team and Health and Wellbeing Board be involved in research work to ensure that it was relevant to the local population.

Mr Furse queried consultant SPA time and asked if there was assurance it was used in the correct way and if it was aligned to the Trust's R&D ambitions. The Medical Director said that SPA time was reviewed on an individual basis through consultant appraisals, but not centrally, and agreed this needed to be addressed and would be considered as part of an overall review of how SPA time was used.

The Chief Executive said that she welcomed such a positive debate as she felt that it was important for an organisation the size of the Trust to be seen as an organisation where R&D took place.

Strategy and Vision

192/12/14 Report of the Chairman

The Chairman reported on the following:

- **WoW Award** – the Trust had won a national WoW award for 'Best Use of WoW Awards Scheme'. The Chairman said that the impact on staff when they received an award was very humbling. Mr Furse queried the wording of the scheme 'catching' people doing the right thing, and suggested that it should be 'celebrating'. The Chairman agreed that the wording was not necessarily ideal, and said that this was why he wished to keep the Blue Shields Awards programme as a way of celebrating staff achievements.

- The Board noted that Caroline Dimond had been formally appointed to the role of Director of Public Health.

- **South Devon and Torbay CCG** – it was noted that the CCG was in severe financial difficulties, as was Torbay Council. These difficulties, which were outwith the Trust's control, would impact on the pace and scope of change the Trust and wider system had committed to as an ICO.

- **Operational Pressures** – staff continued to work very hard to manage the Trust's operational pressures and the Chairman wished to acknowledge the dedication of staff during this difficult period.

- **A&E Waiting Times** – progress to improve waiting times and RTT performance was difficult and the Chairman said that the Board needed to ensure the welfare of staff was a priority as they strived to meet targets.

- **Planned Strike** – the Chairman noted the very sensible reaction to the planned strike from staff in the Trust.

- **CCG Board to Board** – the Board to Board with the CCG was taking place on the 5th January and the Chairman said that the Board needed to be prepared for the meeting.

- **Interim Director of Human Resources** – the Board noted that Martin Ringrose had accepted a 6 month extension to his contract, until the end of June 2016.

193/12/15 Report of the Chief Executive

The Board noted the Chief Executive's written report. She added that the Trust had received Monitor's Quarter 2 letter earlier in the week which gave the Trust a 'Green' rating for Governance and a '2' for Financial Stability – in line with plan. The letter did note that the Trust had not met the A&E 4 hour target for 7 quarters, but that Monitor would not be taking action at this time, however did expect the Trust to continue to take robust action to manage the issue.

In respect of the Junior Doctor strike, the Chief Executive wished to commend the preparatory work that had taken place including consultants, junior doctors and other staff groups coming in and working the weekend before the strike to make sure the Trust was in the best position as possible on the day. Although the strike did not take place, the outcome of the weekend work was that the Trust was in a much better position at the start of the week than it had been for some time and learning would be taken from this experience.

194/12/15 Public Consultation on the Future of Baytree House Short Breaks Unit for People with Learning Disabilities in Torbay

The Board noted that the paper included with the agenda sought approval to commence a period of formal consultation in respect of the planned changes to Baytree House.

The Head of Operational change then gave the following briefing:

- This was one of a series of planned changes in learning disability services.
- The proposal was informed by the change and design process which had worked up the proposed model following a series of consultation meetings with service users who would be affected by the proposed changes.
- The need to change the service at Baytree was in part as a result of how families were now using personal budgets, which gave them more flexibility.
- The Trust was working with the independent sector to ensure that alternative services provided the features that service users had said were important to them, including reliability, quality and flexibility.
- Each family affected had a support plan in the independent sector and if Baytree did close, those families would be fully supported to find alternative care. There were around 6-10 families whose care provision was challenging and they would be prioritised in terms of finding alternative care.
- Councillor Parrott endorsed the proposal and stated that, of the 45 families affected, only 2 had contacted him about the process which, he felt, was a testament to how well the change process was being managed.
- Mr Welch raised a concern around objections and asked if the new model of care had been tested with the existing clients to ensure it worked. The Head of Operational Change said that all those affected had been part of the co-design process and that, there were some challenges for around 6-10 families in terms of finding appropriate alternative care and this was being addressed.

- The Interim Director of Human Resources queried the engagement of staff that would be affected by the proposed closure and the Head of Operational Change said that the proposal had been discussed with Staff Side and that he was confident they would be redeployed elsewhere in the Trust.

- Mr Furse queried the transition process and whether it would be enduring. The Head of Operational Change said that it would be an enduring relationship to ensure the correct level of care was in place for the families.

The Board then approved the following:

1. To proceed with the public consultation as detailed in the report.

2. To propose to close Baytree House in April 2016.

3. To give a commitment to those using Baytree House as a short breaks option, 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.

195/12/15 <u>ICO Developments</u>

Already discussed through other items.

196/12/15 <u>Child and Adolescent Mental Health Service Report</u>

Following the request at last month's Board in respect for more detail around CAMHS, the CAMHS Service Manager and Assistant Director, Community Division, gave the following presentation:

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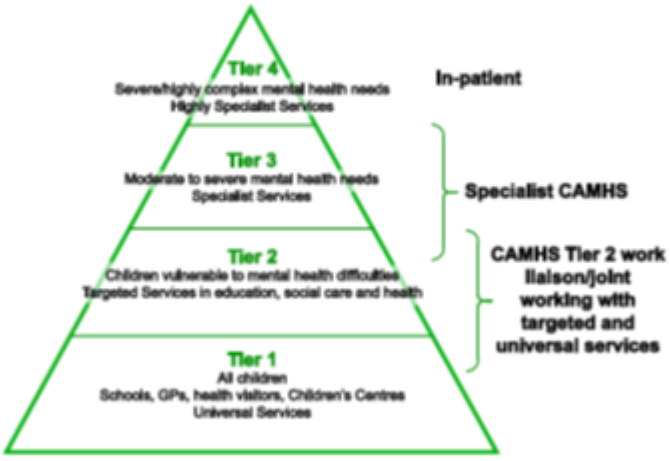
The Concept of CAMHS Services



Torbay and South Devon NHS
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Our Provision

- Tier 2 services – Primary Mental Heath Service
- Tier 3 services – specialist CAMHS
- Tier 4 services – specialist in patient services or specialist national service (not provided by us)
- Workforce
  - 4.0 WTE management (0.6 WTE clinical practice)
  - 24.3 WTE clinical staff
  - 5.54 WTE admin and reception staff

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Service Pressures

- 50% increase in referrals since 2013/14
- Increased urgent and crisis work and patient complexity
- A requirement to balance new referrals and internal waiting times
- Given rise to current waiting list of 19 patients waiting over 18 weeks for treatment and longest wait 37 weeks

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Mitigations & Developments

- Multi agency re-design programme led by Dr Morris
- 'Have Your Say' group and family forum
- CYP – IAPT transformation programme
- PMHW service in Schools
- New community parental workshops
- National transformation monies – 1.2 billion
- Success in bidding for 1 million over 5 years
- Vanguard funding for development of all age psychiatric liaison service

Torbay and South Devon NHS
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Transformation Funding

- Improving pathways for eating disorders
- Crisis Intervention team
- Neurodevelopmental pathways
- Parenting programmes
- Intensive support for children and young people who are excluded or on the edge of exclusion from school

Summary

- Service pressures remain
- Service development and redesign continue
- Multi agency support for making sure that children's and young peoples mental health is everyone's business
- Continue to look for further opportunities as they may arise

The following was then discussed:

- Mr Allen queried whether additional funding would result in less Tier 4 interventions and the Service Manager confirmed that it would – even a short delay in seeing a client could result in deterioration. The Chief Operating Officer added that the Crisis Intervention Team would reduce the number of people who required Louisa Cary Ward as a safe place and would also ensure those people were supported more safely.

- Mr Allen asked what would happen if a Tier 4 admission through Virgin Healthcare, who provided the service outside of Torbay, came to Louisa Cary Ward. It was noted that it was proposed the Crisis Intervention Team would support Virgin Care in accessing Tier 4 care.

- Councillor Parrott said that the Children's Safeguarding Board had taken a close interest in how CAMHS was developing its service and he asked when it was thought the backlog would be cleared. The Assistant Manager said that there were no nationally mandated standards in terms of waiting times, however there was a locally determined standard. She said that they were hopeful the CCG would provide some non-recurrent funding to help clear the backlog because once it was cleared it was known that the service could manage the workload. It was noted that the team prioritised the waiting list to focus on those with the greatest need.

- Councillor Parrott asked if there was any sense of trends moving forward. The Associate Director said that there had been an increase in demand of 11% over the last 5 years, with only a 1% increase in funding and this lack of funding was being challenged nationally.

- Mr Welch queried whether, once the backlog was managed, the team would be able to manage the workload. The Chief Operating Officer said that the modelling work undertaken showed that the service needed 5 full time members of staff to manage the backlog on a short term basis and that once the backlog was cleared the workload could be managed with the substantive workforce.

- The Chief Executive queried the proactive and long term work being undertaken based on the deprivation indices for Torbay as she felt this service was too important to be just 'fire fighting '. She suggested the

Safeguarding and Health and Welling Boards would take an interest in such work. The Assistant Director said that the Redesign Group had already started this work. The Chief Executive acknowledged this and added that the causes and factors needed to be understood and also a focus on children on the point of being excluded from school and at the edge of the care system.

Workforce and Organisational Development

197/12/15 Report of the Interim Director of Human Resources

The Interim Director of Human Resources informed the Board that, in respect of the Junior Doctors' strike and the positivity of the Trust's relationship with the Junior Doctors, he was aware that in other Trusts Junior Doctors would not even sit down and discuss their plans with managerial staff and he commended the local approach. He added that at the heart of the contract negotiations was the desire for 24 hour 7 day working, and what constituted core hours and premium pay, and that a similar set of negotiations for consultant medical staff and agenda for change staff would take place in the future.

Engagement and Partnerships

198/12/15 Council of Governor Issues

The Chairman reminded the Board about the NED recruitment process that would shortly be commencing and also the process to recruit 11 new Governors, as many were coming to the end of their tenure.

Finally, it was noted that the Council of Governors meeting next week would take a slightly different format with the first 30 minutes being led by the Lead Governor without Board members present.

Performance

199/12/15 Monthly Finance and Performance Report

a) **Performance**

The following was noted:

- The community safety thermometer was slightly higher than normal. This was due to pressure ulcers, however work had been taking place and pressure ulcer incidents had reduced by about 80%, but this had not yet played into the dashboard figures.

- Work continued to try to improve the recording of Dementia Find. The Chief Nurse stressed that the question was asked of patients where appropriate, but there were difficulties in transferring the information from paper to an electronic system.

- The Trust's CDiff trajectory was almost back on target. The peak in April was found to be due to an episode of norovirus.

- The Trust had not been able to meet its target in terms of time to arrange Safeguarding Strategy meetings and work was taking place to try to resolve this. A report would be brought to a future Board meeting around the Adult Safeguarding Pathway. Councillor Parrott asked when this issue might be resolved and the Chief Nurse explained that she felt that the target should not only focus on timescales, but also on outcomes and that it needed to be joined up.

- Mr Welch raised a concern in terms of ambulance turnaround times as he understood this had been resolved. The Chief Operating Officer agreed that the Trust had been performing well against this target, however there had been issues in recent weeks partly due to the timings of when patients presented to the Trust, with a clustering of arrivals at certain times. There was a multi-faceted plan to address this issue, including looking at how the patient transport system was used and working with commissioners to flex and develop the contract to provide a more responsive service.

- Mrs Lyttle queried medication errors in the community as she was surprised by the number of errors. The Chief Nurse explained that, as part of a recent audit, staff had been encouraged to submit incident forms and incidents reported could be, for example, the fact that FP10 forms had been found not with the prescriber a form was completed. It was agreed that at a future Board a split of data would be provided to identify major incidents as opposed to near misses etc. CN

- The number of people waiting over 6 weeks for a follow up appointment had increased, partly due to the challenges facing some specialties in terms of RTT compliance. This was an area of concern and work was taking place with clinicians to ensure patients were treated according to need. Feedback had also been received from primary care that the Trust followed-up more patients than required and this was being taken forward.

- Emergency Department performance remained a challenge and the overall position had deteriorated in October and continued into November. Minor Injury Unit performance was very close to 100%, and there was a combined score for the Trust of 91.4%. Work continued to try to understand what was driving the position and what actions could be taken to improve performance. To date, it had been found that the Trust could shorten the time to triage when patients first presented; reduce time to medical assessment and decision; and discharge more quickly. Weekends were also an issue because if the Trust had a low discharge rate at weekends it affected performance for the rest of the week.

- RTT performance against the incomplete pathway was just below the 92% target and this was being driven by Ophthalmology; Trauma and Orthopaedics (due to a gap in capacity with a new consultant having just been appointed); and Cardiology (there had been a growth in delays for patients attending for first or subsequent outpatient appointments. The solution would need to be strategic and a paper would be brought to a future Board meeting). COO

- There had been dip in cancer performance in respect of the 62 day wait and work was taking place to ensure all patients were tracked and performance reflected an increase of patients for breast services via choose and book who were outside the Torbay and South Devon area.

- There had been an improvement in delayed discharges, but the Trust was still outside of target.

- There was an emerging risk in respect of clinical radiology as 2 members of staff were due to go on maternity leave, and mitigating actions were being put in place.

- Mr Brockwell suggested that there were patients who presented to A&E who could be treated at minor injury units if they were made aware of the services available at a MIU. He also said that the Board needed to have an early understanding of how the funding proposals and shortage in adult social care

could affect the Trust.

- Mrs Lyttle queried the Vanguard Unit for Ophthalmology as she understood it would be in place until the backlog had been cleared. The Chief Operating Officer explained that it had gone and this was because the Trust could not secure the right level of locum capacity to staff the unit. Work was taking place internally to try to find ways of delivering the additional capacity.

b) **Finance**

The following was noted:

- The report was presented in line with changes agreed with Monitor and as submitted in the revised annual plan. The transaction took place on the 1st October, however the plan had assumed the 1st August, and secondly the accounts would be presented by absorption not consolidation.

- Performance was broadly in line with plan, with a deficit of £4.3m, but there was some deterioration.

- There was a risk rating of 2, in line with plan.

- CIP recurring savings were significantly behind plan. Work was taking place to put into budgets a permanent CIP target that traditionally had been made up by different one-off non-recurrent savings each year and make this part of routine budget setting. Also several schemes had recently released savings including MARS; Managed Services Contract; Vacancy Factor; and moving microbiology consumables into a managed service, totally around £1.2m of savings.

- Mrs Lyttle queried the effect of pass through drugs and the Director of Finance explained that there was no effect to the Trust, however he would check the wording of the report to ensure this was made clear. DoF

- Mrs Lyttle queried the £200,000 nursing agency staff overspend due to delayed processing of invoices. The Director of Finance said that this should not have happened and had been addressed with the budget holder.

- Many members of the Board expressed their appreciation of the new style of integrated reporting for performance and finance, as it was very easy to understand and highlighted the areas of concern very clearly.

200/12/15 <u>Report of the Director of Estates and Commercial Development</u>

The Board noted that the planning consultation in respect of car parking had been completed and work had started on site. The requirements put in place by the Council would cost the Trust around £500,000. £120,000 of this related to Section 106 and the rest drainage and environmental issues. This was money that could have been spent on patient care.

Discussions were taking place with contractors in respect of the ICU to minimise delays and costs in relation to the hole found by the main entrance. The outcome of these discussions would be known next week.

The process of transferring the ownership of West Devon properties to NHS Property company had commenced.

Assurance

201/12/15 Governors' Question Time

Mrs French said that she would lead a discussion at the Council of Governors next week around how Governors could become more involved in representing the community and suggested that relevant constituency Governors should ensure they attended meetings about Baytree and Bovey Tracey to ensure they were fully informed. She also expressed disappointment that the R&D report had not moved on from last year's report, despite some constructive feedback being given, and also because of the very good work undertaken by the team. Finally, she said that she had been part of the work to develop the colour scheme for the new entrance and suggested it would be helpful for the Board to understand the work taking place around the colour scheme in terms of making it easy for patients with dementia to navigate the hospital. LDk

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

2ND DECEMBER 2015

No	Issue	Lead	Progress since last meeting	Matter Arising From
1.	**Research and Development** – issue of Governance to be discussed.	MD/JW	Discussed with Director of R&D who advised that committee existed previously to provide additional governance. MD to discuss with Board Secretary.	2/12/15
2.	**Research and Development** – suggestion report should have contained some examples of successful research outcomes to be discussed with R&D Lead.	MD	Director of R&D is happy to provide the R&D annual report to the Board if required. This report contains all research	2/12/15
3.	**Performance** – data in respect of medical errors to be presented showing the split between the different levels of errors.	CN		2/12/15
4.	**Performance** – paper to be brought to a future meeting in respect of Cardiology performance.	COO		2/12/15
5.	**Finance** – wording describing the pass through drug transaction to be checked to ensure it explained that the transaction had no financial effect on the Trust's budget.	DoF		2/12/15

REPORT SUMMARY SHEET

Meeting Date:	3rd February 2016
Title:	Chief Nurse Report Infection Prevention and Control Peer Inspection
Lead Director:	Jane Viner- Chief Nurse
Corporate Objective:	Best Experience
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Peer Inspection – Infection Prevention and Control:

In April we experienced an increase the number of Clostridium Difficile Toxin (CDT) positive results. This increase took the Trust above the expected trajectory and led to a sustained increase in total numbers until September when incidence returned to expected levels. To end of December we have reported 23 cases with 10 lapses in care against a target of 18. It is important to stress that typing of these cases shows that they are not related. Each case is subject to a Root Cause Analysis (RCA) investigation that is reviewed externally by our Clinical Commissioning Group. The April spike in cases was discussed with expert colleagues at the regional Infection Control forum and with Public Health England colleagues. A decision was made to seek further assurance via an external peer review.

Dr Nizam Damani, Consultant Microbiologist / infection control specialist, undertook this review over two days in January 2016. The scope of the review included:
Clostridium difficile toxin control measures
Norovirus / other viral gastroenteritis control

Key Issues/Risks:

Verbal feedback on the day suggested no significant issues relating to local practice but a preliminary list of recommendations has indicated areas for focus, these include:

Risk assessments	- process and practice
Audit	– process relating to ward level audit of hand washing compliance and isolation best practice
Information	– accessibility of visitor and staff information
Training	– induction and training of substantive and temporary workforce

The full report is expected in February and will be presented to the Trust Infection Prevention and Control Committee and to the Quality Assurance Committee.

Recommendations:

Note this update and await the full report.

Summary of ED Challenge / Discussion:

Whilst the incidence of Clostridium Difficile has returned to expected levels, monitoring and management requires constant vigilance. The environment and aged estate provides specific challenges that a difficult to mitigate. This includes ward bay design and the increase in bedside equipment that can result in cramped bed spaces. The lack of side rooms across the site that requires careful management and risk assessment to ensure they are used appropriately. Despite these challenges Dr Damani noted examples of excellent infection control practice that helped to mitigate these risks.

A review of the estate is underway to identify opportunities for increasing the complement of side rooms.

Internal/External Engagement including Public, Patient and Governor Involvement: Clinical Commissioning Group Public Health England
Equality and Diversity Implications: Nil.

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	3rd February 2016
Title:	Chief Nurse Report Safe Staffing Update
Lead Director:	Jane Viner- Chief Nurse
Corporate Objective:	Safest Care
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

Safe Staffing update:
Over the last 18 months we have undertaken a comprehensive programme of work to ensure we meet best practice guidance set out by the National Quality Board (2013) and by the National Institute for Health and Care Excellence (NICE) (2014) for safe staffing in acute ward settings. We have reported previously to the Finance Committee and the Board on the methods used to determine safe staffing establishment and actions underway to set and maintain appropriate staffing levels. This includes:

- Shelford Safe Staffing Tools
- Professional Judgement
- Profession body guidance e.g. Royal College of Nursing

In July 2014 we appointed an interim Associate Director of Nursing and a Service Improvement Lead to focus exclusively on this work. In the last six months this investment has enabled detailed examination of the evidence and review of our current position.

Key Issues/Risks:

The summary below sets out our current position and hi-lights wards where further work is being undertaken to restore safe staffing establishment.

This month the group identified five wards (Dunlop / Simpson / Cheetham / Hill / George Earl and Ainslee) appeared to be outside the RCN guidance of 60% Registered and 40% skilled not registered. Meetings have been held between the Chief Nurse, Associate Nurse Directors and Matrons to identify plans to explore and mitigate this position. An action plan will be included in the six month safer staffing report to Board in March

Recommendations:

Note the current position and plan for full report in March.

Summary of ED Challenge / Discussion:

Whilst considerable work has been undertaken to understand acute ward safe staffing, further work should be undertaken to determine how the evidence based methods can be applied to community hospital setting and non-bed based settings.

Internal/External Engagement including Public, Patient and Governor Involvement: Earnst Young review in 2014 provided assurance on the methodology used. The Lord Carter review will inform future work.
Equality and Diversity Implications: Nil

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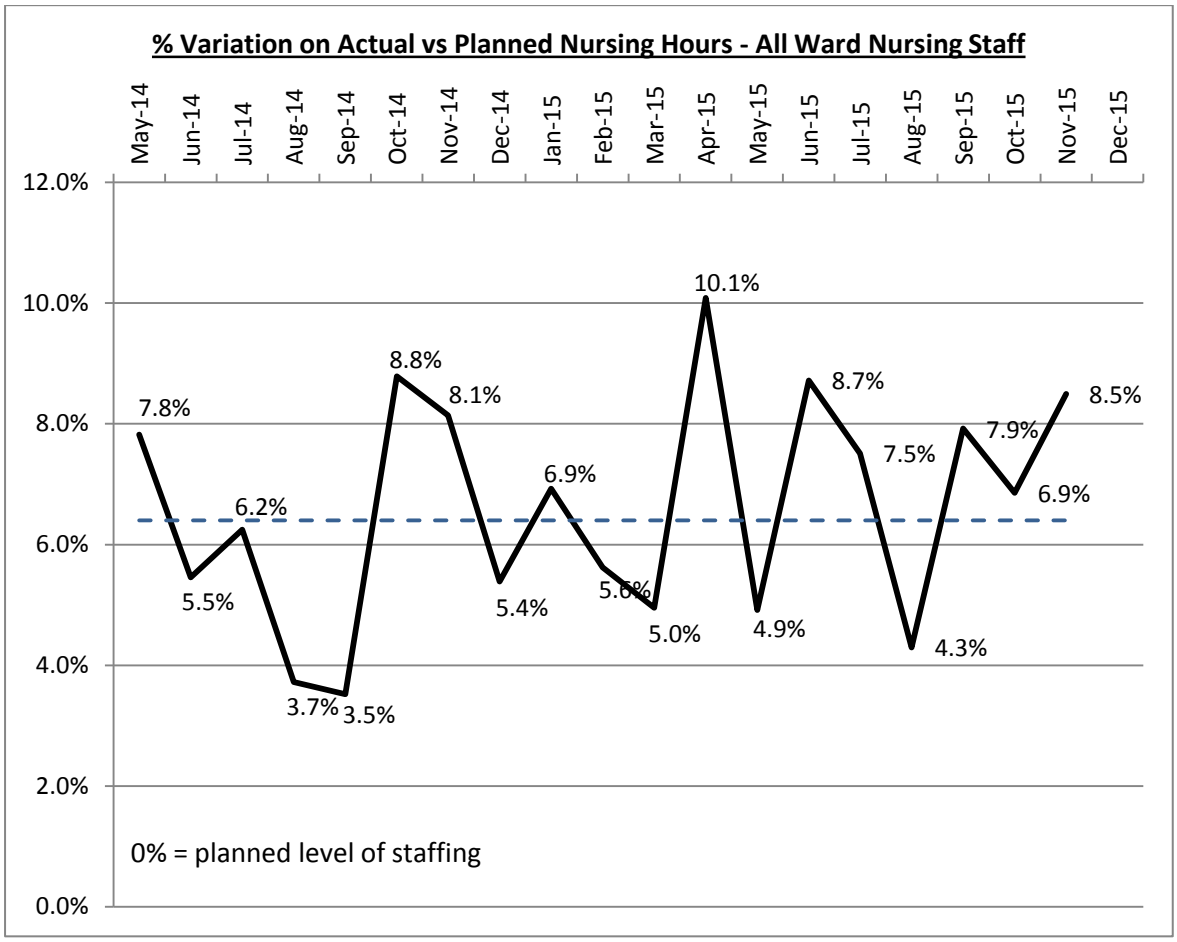
1.0 General Ward Staffing Overview – Acute Hospital Setting

On a monthly basis the number of planned nursing hours (based upon the agreed baseline safe daily staffing numbers for each ward) and actual nursing hours (the total number of nursing hours used each day) for each inpatient ward area is submitted to the national dataset. We analyse this information to assess the variation from planned nursing hours. A positive number equates to an increased number of hours against the planned staffing numbers, and a negative number equates to less nursing hours than planned.

The total number of all actual registered and Care Support Worker nursing hours delivered on the 15 non escalation wards for November 2015 was 8.5% above planned. This is an increase of 1.6 % from the previous month but falls within the normal variation currently exhibited by the Trust.



No areas fell below 20% of the total planned nursing hours

i) Cheetham Hill ward fell below 20% for Registered Nurses, however this was backfilled with Band 4 and Health Care Assistants as it was deemed safe to do so with the patient acuity and dependency at the time.

ii)

2 of the 19 areas required 20% total nursing hours more than planned.

iii) George Earle ward had an increase in health care assistants to cover a shortfall in Registered Nurses and to safely care for a high number of increased dependency patients.

iv) Simpson had an increase in Healthcare Assistants in response to increased dependency of the patients

The Shelford Group's Safer Nursing Care Tool (SNCT) snapshot is undertaken monthly. During November this was undertaken on all of the 12 appropriate wards. This is summarised, along with the individual wards nursing hour's variations and other safety and quality data below. This data is reviewed by the Quality Improvement Group. This month the group identified five wards (Dunlop / Simpson / Cheetham / Hill / George Earl and Ainslee) appeared to be outside the RCN guidance of 60% Registered and 40% skilled not registered.

Meetings have been held between the Chief Nurse, Associate Nurse Directors and Matrons to identify plans to explore and mitigate this position. An action plan will be included in the six month safer staffing report to Board in March.

Nurse Staffing, Safety and Quality Assessments- Acute Setting:

	Nursing Hours			Temporary Staffing		Patient acuity		Safety Indicators			Workforce Indicators	
Ward name	**% Variation RN hours**	**% Variation CSW hours**	**% Variation RN + CSW hours**	**% of actual hours filled by bank**	**% of actual hours filled by agency**	**Agreed Staffing Levels WTE**	**Ward Acuity Assessment (SNCT) WTE**	**Early Warning Trigger Tool Score**	**Total number incidents**	**Number of minor and moderate incidents**	**% Appraisal rate completion (at month end)**	**Variation from last month**
Ainslie	7.3%	11.6%	9.6%	19.0%	0.4%	37.0	43.8	5	15	3	**77.78%**	↑5.56%
Allerton	**-10.0%**	11.8%	**-1.5%**	13.4%	0.0%	42.9	38.9		4	1	**76.19%**	↑9.52%
Cheetham Hill	**-20.8%**	**39.1%**	7.3%	20.0%	2.7%	38.3	43.5	3	22	14	**71.43%**	↑7.14%
Coronary Care	5.5%		7.5%	4.4%	0.0%		Tool inappropriate	2	1	0	**91.30%**	↓4.35%
Cromie	**-2.5%**	**29.4%**	10.3%	14.3%	7.3%	32.9	32.4		21	7	**73.33%**	↓3.14%
Dunlop	**-3.5%**	10.0%	3.9%	12.9%	0.3%	32.0	27.2	0	10	4	**57.14%**	0.00%
EAU3	**-0.4%**	**38.9%**	13.7%	25.5%	2.4%		Tool inappropriate	2	7	3	**92.00%**	↑4%
EAU4	**-5.1%**	**32.8%**	8.5%	9.8%	1.3%		Tool inappropriate	6	3	1	**71.43%**	↑2.46%
Ella Rowcroft	-12.0%	**-8.4%**	-10.5%	8.9%	0.0%	31.5	33.2	4	13	2	**95.24%**	↑20.24%
Forrest	**-9.4%**	11.3%	**-1.1%**	26.3%	5.0%	32.9	30.8		22	4	**76.47%**	↓11.77%
George Earle	-19.1%	**84.5%**	**30.8%**	27.3%	0.5%	35.7	37.5	5	4	0	**56.25%**	↓10.42%
ICU	12.7%		12.7%	4.5%	9.1%		Tool inappropriate		4	1	**76.47%**	↓3.91%
Louisa Cary	16.7%	12.1%	15.0%	8.4%	0.0%		Tool inappropriate		5	0	**86.84%**	↓2.35%
Maternity	**-0.4%**	5.7%	1.0%	0.0%			Tool inappropriate	5	33	16		0.00%
McCallum	**-6.4%**	19.7%	3.5%	13.0%	0.9%	18.9	10.2	14	7	2	**42.86%**	↑4.4%
Midgley	4.6%	**32.9%**	16.1%	24.3%	6.8%	34.8	36.8	8	3	3	**90.00%**	↑5.001%
SCBU	**-9.4%**	-13.8%	-10.7%	18.1%	0.8%		Tool inappropriate		3	0	**66.67%**	0.00%
Simpson	**-3.4%**	**45.0%**	**23.1%**	29.1%	1.6%	38.3	47.9		12	5	**81.25%**	0.00%
Turner	11.5%	**27.6%**	18.8%	17.1%	1.0%	29.0	27.0	4	2	0	**60.00%**	↓12%

Organisational Alert Status

An organisational RAG status is published and shared with our partner organisations on a daily basis which provides an indicator of the operational pressures experienced within the system. This is summarized within this report, as it provides a good proxy indicator of the wider organisational pressures and climate the wards are working within, and which may impact on our staffing decisions.

The alert status for the organisation for the month of November 2015 is summarised in the table below.

SDHFT Alert Status	No Days in Month	% days in Month
Red	18	57%
Amber	8	27%
Green	5	17%

During November additional escalation beds were active for all of the 30 days.

2.0 General Ward Staffing Overview – Community Hospital Setting

Monthly data of staffing levels in our nine Community Hospitals which include 158 inpatient beds is collated and published on our public website including both registered nurses and skilled not registered staff.

On NHS Choices website the number of registered nurses only is published against each Community Hospital.

In November 2015 the average fill rate for both day and night shifts for registered nurses did not fall below 80% or exceed 120% with exception of one ward as set out below.

November 2015 Registered Nurse Safer Staffing

HOSPITAL	SHIFT	FILL RATE	REASON
Teignmouth	Early	73%	Vacancies

The organisation requested to temporarily suspend eight inpatient beds within Brixham hospital reducing the inpatient bed number for twenty to twelve in June 2015. This position continues at present due to difficulty in the provision of medical cover.

During November 2015 fill rates have, for both registered nurses and skilled not registered staff, aligned to the establishment of the hospital wards. The skilled not registered staff on a number of wards has exceeded the 120% due to the complexity of patients' needs and support requirements. A daily escalation report for all hospital wards is completed which reflects the acuity and dependency of patients and facilitates timely adjustments where required. The daily escalation report is also shared across the foot print of the organisation as we work to ensure patient flow across the care pathways.

The monthly staffing data is complemented with information on the other key parameters than demonstrate our performance. This includes incidents, complaints, compliments, mandatory training compliance and appraisals completed within all community hospital wards. (Appendix 1 –November 2015 data)

3.0 Agency/Temporary Staffing Position:

Tight controls of the Nursing agency process continue to be in place with approval of shifts authorised by the Executive Director. This is being monitored closely in line with the weekly reporting to Monitor to ensure requests are matching the data submitted.

Escalation continues to pose a cost pressure in the use of temporary staff and an options appraisal has been submitted for consideration and discussion by the Executive team.

Further discussions are underway with regards to staff incentives / overtime rates and a briefing will be submitted once options have been finalised.

4.0 Vacancy and Recruitment Position:

The remainder of the Spanish nurses recruited in October will be arriving in the Trust at the end of the month. There is also a further recruitment drive to Italy this month with a view to successfully recruit more nurses with the aim to arrive in late February/early March. A separate piece of work is underway to explore recruiting from the Philippines and information gathering and discussions are currently underway with a view to submit a business case by the end of the month.

Nationally there continues to be a challenge recruiting nursing staff and work is underway across the South West to look at working collaboratively and innovatively in meeting the recruitment/workforce challenges.

This month a mapping exercise of healthcare careers will be undertaken to identify gaps, training needs and exploring new ideas to help meet the workforce challenge. This may well cross professional boundaries and identify new innovative roles and ways of working.

Further recruitment has taken place for HCA apprentices for the community hospitals whom will start in February. The aim is to mirror the concept of the pilot in the acute Trust where they will undertake their care certificate and bolster the current establishment to enable substantive staff to special complex patients where required and reduce the need for temporary staffing.

5.0 Revalidation:

The trust is on track for meeting the needs of the first tranche of nurses to go through the revalidation phase. A questions & answers Buzz clip will be filmed at the end of the month for staff to access and a project group has now been identified with regards to purchasing a new electronic E learning, Appraisal and revalidation system for the organisation.

Appendix 1 - Community Hospital Inpatient Wards Safe Nursing Dashboard

November 2015	Ashburton Hospital	Bovey Tracey Hospital	Brixham Hospital	Dartmouth Hospital	Dawlish Hospital	Newton Abbot Hospital- Teign	Newton Abbot Hospital- Templar	Paignton Hospital	Teignmouth Hospital	Totnes Hospital	Hospital Clinic total
Staffing / Training											
WTE Clinical Budget	13.11	14.79	26.12	20.04	23.85	24.03	23.55	31.98	14.24	25.96	217.96
WTE Clinical in post	13.84	12.83	17.28	18.24	16.65	20.53	20.29	28.81	10.69	21.02	180.18
Bank FTE #	2.81	0.64	1.79	1.97	2.57	1.8	2.57	8.95	3.46	7.75	34.13
Agency FTE #	0.48	2.41	0.61	0.12	0.4	1.32	2.98	2.68	0.11	1.48	12.59
Skills Mix (Registered) 1	50%	45%	51%	51%	46%	45%	53%	54%	53%	47%	50%
Skills Mix (Unregistered) 1	50%	55%	49%	49%	54%	55%	47%	46%	47%	53%	50%
Sickness Absence 2	5.81%	4.13%	4.71%	2.80%	1.29%	4.62%	4.62%	4.63%	4.48%	3.28%	4.12%
Appraisal Compliance 3	67%	11%	84%	92%	90%	87%	87%	84%	68%	95%	85%
Avg. Corporate Mandatory Training Compliance 3	94%	83%	96%	90%	94%	94%	94%	95%	86%	95%	92%
Staff Turnover	17%	35%	34%	27%	26%	13%	13%	24%	15%	16%	20%
Complaints	0	0	0	0	0	0	0	0	0	0	0
Compliments	0	0	0	0	0	0	0	0	0	0	0
Activity											
Number of funded beds	10	9	12	16	18	15	20	28	12	18	158
% Bed occupancy	94.0%	96.3%	92.5%	72.5%	92.0%	96.7%	98.4%	96.4%	97.1%	90.4%	92.70%
Avg. Length of stay (days) 4	19	15.9	15	12.1	12.5	17.7	15.1	17	16.9	16	15.2
Patient Transfers from Community Hospital to DGH	1	0	1	0	4	2	1	5	1	0	15
Harm Free Care (Safety Thermometer)	80%	88%	91%	89%	86%	93%	74%	89%	80%	89%	86%
QUESTT (See footnote 5 for levels)	3	6	12	12	1	3	8	8	6	3	
Friends and Family Test(proportion of patients 'extremely likely' and 'likely' to recommend our service)	90%	100%	88%	100%	94%	91%	92%	83%	88%	95%	93%
Incident Harms for Community Hospital Nursing (Patient Related)											
Harm Caused	2	1	5	1	4	6		7	6	1	33
Near Misses	0	0	1	0	1	2		0	1	2	7
No Harm Caused	1	2	5	5	6	7		8	4	2	40
Total	3	3	11	6	11	15		15	11	5	80

REPORT SUMMARY SHEET

Meeting Date:	3rd February 2016
Title:	Experience and Engagement Annual Report – Community and Acute
Lead Director:	Jane Viner- Chief Nurse
Corporate Objective:	Best Experience
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:
The formation of Torbay and South Devon NHS Foundation Trust In October 2015 brought together the two Engagement and Experience Teams into one service. This report reflects the priorities and activities of the two legacy organisations from January 2015 to December 2015. Future reports will reflect the single organisation.

Two recent PHSO reports, 'Breaking Down the Barriers. Older People and Complaints about Healthcare' and 'A Review into the Quality of Complaint Investigations' hi-light the need to engage with those who may find it difficult to raise concerns due to vulnerability, difficulty accessing the process or fear of repercussion and the need for open and transparent organisations. A response to these reports is included.

Key Issues/Risks:
The new organisation continues to use two risk management systems. This risk was flagged during the acquisition process and a mitigation plan was presented to the Trust Development Authority to mitigate the risk. Procurement of a single system is near completion and a single provider has been identified. An implementation plan for a single risk management system has been developed with an implementation date of April 2016.

Key themes from feedback relating to services across the Trust continue to be:

- Noise at night from staff and other patients.
- Communication and information about the plan of care
- Communication and information relating to safe and effective discharge.

Themes emerging from complaints for acute services are:

- Access to services / delays
- Communication and information
- Clinical treatment issues

For community services complaints relate to:

- Access
- Appropriateness
- Staff attitude

Actions relating to these themes are detailed within the report.

Friends and Family responses continue to be a challenge with Trust level response rate below target. Responses received positive. Over the last year a number of changes have been made and whilst improvement has been noted in some areas, this is not consistent across the Trust. The team are currently exploring electronic and web based options as a definitive solution.

Recommendations:

Continue the procurement and implementation of the single Risk Management System. Include actions relating to the above themes in the Trust Quality Strategy priorities Reflect these issues in the Trust Quality Account and CQUIN priorities Procurement of an electronic / web based solution to improve the Friends and Family response rate.
Summary of ED Challenge/Discussion: Triangulation of the significant number of data sources to identify priorities is a challenge. The volume and complexity of external and internal data sources relating to patient experience provides a daily stream of data that requires collation, analysis, management and a response. The resource needed to manage this demand is exceeding current capacity. Increasingly service users are using electronic real time feedback mechanisms e.g. NHS Choices, Spotted in Torbay. Whilst this provides an opportunity to respond immediately to issues raised, the need to monitor these sources creates a capacity and resource issue. We are currently reviewing the Engagement and Experience team structure, functions and processes in response to this rapidly evolving workflow which needs to be real time to move from a focus on the bureaucracy of the process to the outcomes the person needs.
Internal/External Engagement including Public, Patient and Governor Involvement: NED and Governor involvement in the legacy Engagement and Experience Committees which continues in the new committee structure. Governor and stakeholder engagement in setting priorities including service users / CCG / Healthwatch / Carers.
Equality and Diversity Implications: Engagement of services users who are difficult to reach is a priority for 2016/17.

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Trust Board Summary Report
1st December 2014 – 30th November 2015

1.0 Introduction:

This year's annual report encompasses the work by the community and acute service delivery units of the organisation. This report focuses on the key areas of work and is by no means representative of all the on-going work in the organisation. Throughout the report the work of the former Acute Service (SDT) and former Community Service (TSD) are noted with reference to the new Service Delivery Units (formerly divisions) of Medicine, Surgery and Women's, Childrens / Diagnostics together with the new Community Service Delivery Unit.

Understanding how people`s experience influences the services we provide and using that information to make improvements is well established as a key focus for our work and is identified as a core priority in the Trust's Strategic Directions for Best experience.

2.0 Governance:

The former TSD managed this function through the Executive led Experience and Engagement (E&E) committee which met bi-monthly during 2014/15 with the exception of the October meeting. The former SDT managed the function through the Patient Experience and Community Partnerships committee (Work Stream 2) which met monthly with the exception of the June meeting. These committees provided reports and minutes to the respective Trust Boards.

The former TSD E&E Committee prioritised the development and maintenance of partnerships with patients, service users and with key stakeholder groups in the wider community in order to better understand the experience and meet the needs of those who use services. This year, the committee monitored the implementation of Engagement and Experience Strategy performance against the relevant Care Quality Commission (CQC) regulations and reviewed all high level risks.

The former SDT Patient Experience and Community Partnerships Committee (Work stream 2) changed the format of the meetings this year to fully capture the work of the Divisions. Each Division presented a 6 month comprehensive report setting out their work to date and actions in response to user feedback. At every committee meeting the risk register, Friends and Family Test and real time patient experience data is reviewed. Quarterly reports included the Patient Services and CQUIN reports.

Both committees had Non-Executive and Governor Representation along with stakeholders such as the Clinical Commissioning Group (CCG) and Healthwatch. This has enabled a richer discussion of the information presented and that the priorities identified reflect those of with wider community however, whilst there has been some service user attendance, this needs to be strengthened over the coming year.

Throughout last year, the two committees increasingly worked together to share information, agree priorities and align processes. For the future, each Service Delivery Unit (SDU) will be responsible for ensuring service user experience is captured, reported and acted on. This local activity will be supported by the Trust Engagement and Experience team who will collate and analyse information, help prepare reports, share learning and produce Board reports on progress against priorities.

This year has seen the development and ratification of the Experience and Engagement strategy which gives structure and process to the organisation to use the feedback we receive and proactively engage with the public. This will be used as a baseline for the SDUs to report to the new Quality Improvement Group (QIG) and through to the Quality Assurance Committee and the Board.

The engagement and experience team identified 'number of complaints received' and 'complaints closed within 6 weeks' as the service proxy indicators in the Trust Board dashboard. The total number of complaints has remained stable and the number closed within 6 weeks has improved with SDUs working to ensure the timely closure of complaints. Board report indicators will be reviewed in March.

3.0 Identifying priorities from feedback:

3.1 Quality Improvement priorities:

Experience and Engagement feedback informed the local Quality Account priorities:

	Priority	Progress	Origin
1	Improving timeliness of notification to GP`s of a patient's death in hospital	New process in place. Further reduction in GP letter timeliness achieved	Service user feedback
2	Improve bereavement signposting and information	Redesign the service to enhance patient support and information	Service user feedback
3	Support for carers in the discharge process	System of identifying carers on the SWIFT Plus Board. Carer survey undertaken 24 hours following discharge to understand their experience.	Service user / stakeholder feedback
4	Safe Transfers of Care	Work progressing to develop common transfer documentation and risk assessments. Drug chart alignment in progress.	Service user / Stakeholder feedback

3.2 Experience and Engagement feedback also inform the local CQUIN priorities:

	Local priority		
	Bereavement - improve the timeliness of information to GP`s	As above	Complaint feedback
	Bereavement - signposting and information to families	As above	As above
	Identify and improve the top three areas of concern for carers on discharge. Car parking, information, discharge information.	Free car parking for carers in place SWIFT plus used to identify carers Discharge survey complete	Healthwatch Report
	Improve the involvement of carers in the management of medications on admission and at discharge at Torbay Hospital and at our community hospitals.	This work is being monitored through the Carers Steering group which meets bi-monthly.	stakeholders
	To set up a Single Point of Contact for people to access community-based health and social care services in Torbay.	A business case for this project has been written.	Service users / stakeholders

Quality Account priorities are being identified for this year and will include priorities identified from feedback throughout 2015/16. The CCG have taken a different approach to the patient experience CQUIN this year that has involved the same CQUIN being applied to all provider organisations.

- Dementia and Delirium
- Improvement in patient care across the system
  - "Hello my name is."
  - "you said, we did"
  - Patient Leaders network
  - Use of technology

These will be reported in full by April 2016 and at the end of Quarter 2 these were all signed off as on plan.

3.3 CQC Regulations and Key Lines of Enquiry (KLOE):

Both committees reviewed the relevant KLOEs at each meeting to ensure that the work reported on to the committees meet some or all of them. Quality reviews have been ongoing in the acute and community settings to review quality, safety, compassion and effectiveness within practice. Patient feedback is a fundamental aspect of the quality review and helps give a snapshot by utilising questionnaires, face to face contact and telephone consultations and these have numbered 200. Feedback is positive but a number of themes have been identified:

- Noise at night from other patients
- Information about discharge
- Greater menu variety

Action plans are in place to address these. Noise at night from other patients is reflected in the national patient survey comments and in our local surveys.

3.4 National Surveys:

We have taken part in and received reports from the following surveys:

- A&E survey 2014 -published January 2015
- National Inpatient Survey 2014 - published April 2015
- National Children and Young People`s Inpatient / Day Case Survey 2014 – published June 2015
- National Maternity Survey- published December 2015
- National Cancer survey 2015 – in progress

Survey results have been reported to the Board as available. The National Survey regulations this year have been amended so that in the written comments individual staff and departments are named. This has enabled feedback where appropriate and this has been appreciated by both departments and individuals.

There was high praise for care, kindness and competence by hospital staff, some comments about night time care, including noise, mixed comments about the quality of the food and discharge experience. Below is an analysis of all the comments from the National Inpatient Survey.

Key findings from the National Surveys:

A&E 2014:

This survey had a 40% response rate, slightly higher than the national average although the results were slightly worse than the 2012 survey. Overall in all questions we were in the middle 60% when benchmarked against all Trusts. The Trust scored well on two questions:

- pain management
- information on discharge as when to resume normal activities.

Areas for improvement: These were our top three areas of improvement for the department and are shown with the actions that have been taken to improve the service.

Waiting time for triage – the department has a new system to provide 24 hour triage (previously it was unavailable at night)**.** If it becomes evident that the waiting room is becoming very full and the triage nurse is in need of support, another nurse is allocated to triage where possible.

Waiting time to be examined- the department now has rapid assessment areas. All major patients brought in by ambulance are seen in a dedicated space with a dedicated team who can commence immediate investigations and liaise with senior clinicians where necessary.

Information on waiting- this remains difficult to resolve. The department does have an information board but due to the fluctuation of the status of the department it is not always possible to keep up to date. The department are still working to resolve this.

National Inpatient Survey 2014:

The response rate for this survey was 58%, higher than the national average. The results divided the 70 questions into 11 sections which are scored as Green (better than most Trusts), Amber (the same as most Trusts), Red (worse than most Trusts). We have no red rated and 1 green rated section.

Strengths:

- Specialist was given all the necessary patient information by person referring
- People not admitted to a mixed-sex room or bay
- Cleanliness of wards and bathrooms
- Food quality and choice
- Nurses answering questions clearly
- Information about surgery
- Involvement in discharge decisions
- Information to family/friend on discharge
- Patients treated with respect and dignity

Areas for improvement and actions:

In A&E, privacy when being examined – In the short time, during times of escalation the department matron and senior staff endeavour to ensure the privacy of service users but the challenges of the department environment are difficult to overcome. In the medium term, discussion are underway to undertake some redesign of the department.

Waiting time to get a bed on a ward - The feedback from service users and relatives is that communication is key to improving this if there is a delay.

Noise at night from patients and staff - we now include this question in the discharge survey, and ask service users to be specific about the noise they experienced. We review this monthly and each ward get a detailed breakdown. This year has seen environmental changes (e.g. squeaky bin lids) as well as feedback to staff. Explanations regarding the nature of ward activity at night has been provided.

Availability of hand-wash gels - on review of this we do not believe there is a lack of hand gels although there are areas and occasions where gel is not available by direction of the Infection Control Team.

Amount of information given on condition / treatment – part of the Talk Back communication plan.

National Children`s and Day Case Survey 2014:

The results for this survey showed a response rate of 30%, slightly higher than the national average.

There were no areas where we did better than other hospital and one where we were worse. Those in the middle 60% were:

- Patients knew what would happen to them at the hospital
- Patients felt safe on the hospital ward
- Patients liked the food
- Hospital staff talked to patients in a way they could understand
- Someone at the hospital talked to patients about any worries they had
- Someone at the hospital told the patients who they could contact after discharge
- People looking after them listened
- The people looking after them were friendly
- Patients had a good overall experience

Areas for improvement:

Patients had enough privacy when receiving care or treatment – One of the changes made has been the opening of the short stay paediatric unit and means that GP referrals are seen in a dedicated area which has been designed to be more child- friendly.

National Maternity Survey 2015:

This survey has a response rate of 43.5% and the service scored in the top 20% of Trusts for 10 of the questions asked. These included:

- being provided with enough information to help decide on the place of birth
- having contact details of the midwife
- being involved in the decisions made regarding care
- being listened to
- Receiving help and advice in the postnatal period.

Areas for improvement:

- whether the mother and her partner had felt they had been left alone in labour at a time when it worried them
- Being given enough information about their own physical recovery after the birth

An action plan for this survey is currently in progress and includes repeating the questions with local service users real-time to understand the unexpected results relating to being left alone in labour.

3.5 Local Surveys:

There are a number of local surveys conducted, some Trust wide such as the public membership survey which reports to the Trust Board annually and the Real Time Patient Experience Survey. Others are speciality specific and report to the relevant SDU`s. The 2014 public membership survey was distributed to foundation trust public members in September 2014 accompanied by the Trust's Autumn newsletter and summary annual review.

2,990 survey responses were received, a response rate of 26%. Publicly-elected governors from the three public constituencies (Teignbridge, Torbay, South Hams & Plymouth) read all of the responses and working with the Trust developed an improvement plan for 2015/16. The plan contained six areas for improvement to be completed by either 31 December 2015 or 31 March 2016 and was formally agreed by the Council of Governors at their meeting in April 2015. Improve waiting times and communicate delays

- Remove all homemade signs
- Implement 'raising awareness campaign' for all clinical and non-clinical staff of basic 'customer/patient service' expectations
- 70% staff trained in dementia awareness, continue this
- Increase awareness of dementia for service users and visitors
- Promote awareness of alternatives to Accident and Emergency

Governors received an update on the progress against the plan from the Board of Directors in December 2015. A further update will be given to governors at their meeting in April 2016.

The Real Time Patient Experience Survey asks a sample of patients on the day of discharge 21 questions about their care and experience. Below is the overall view of the care received and shows that the majority rated their experience as excellent or very good.

Q21
Overall, how would you rate the care you received?

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Excellent	66	54	78	96	85	85	67	60					591
Very good	24	14	32	41	34	41	29	28					243
Good	2	1	5	3	5	8	5	4					33
Fair	2		1	1				1					5
Poor		1						1					2
Total	**94**	**70**	**116**	**141**	**124**	**134**	**101**	**94**	**0**	**0**	**0**	**0**	**874**
%	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Excellent	70%	77%	67%	68%	69%	63%	66%	64%					68%
Very good	26%	20%	28%	29%	27%	31%	29%	30%					28%
Good	2%	1%	4%	2%	4%	6%	5%	4%					4%
Fair	2%	0%	1%	1%	0%	0%	0%	1%					1%
Poor	0%	1%	0%	0%	0%	0%	0%	1%					0%

The questions asked on the survey are reviewed regularly depending on organisational priority or issues noted via people`s feedback. This year has seen the inclusion and subsequent removal of a short term question to understand the impact of volunteers on our patients, the addition of a question asking if staff introduce themselves and if they know who they are as part of our evidence for the "Hello my name is" campaign and CQUIN. The wards and senior managers receive their information monthly and anything noted on the day is dealt with by either the ward or patient services teams.

3.6 Online feedback:

This year has seen an increase in comments on online forums (NHS Choices, Patient Opinion and Torbay`s Healthwatch rate and review) as well as social media such as Twitter and Facebook. Comments are mainly positive with maternity and paediatric services featuring strongly. Whilst there are a number of comments about difficulties with car parking there are no other strong negative themes emerging. The Patient Services, Feedback and Engagement and Communication teams collaborate proactively to respond as promptly as possible to comments posted online and as part of 2016 we will be reviewing the social media policy and our response times. The online feedback is incorporated into the quarterly patient services report.

3.7 Healthwatch:

Healthwatch Devon and Torbay are invited to attend the E&E Committees and play an active role in the feedback, experience and engagement of the organisation. This year the Patient Services Department have had six contacts from Healthwatch Torbay where members of the public have sought their assistance with concerns about care. All but one of these contacts was already known to the department and active work to resolve the issues had begun the Feedback and Engagement team (Community) had three concerns raised. Where we have enough information to review we have done this otherwise we have just logged the issues for feedback.

Healthwatch Torbay have supported the concept of the Integrated Care Organisation and have worked proactively with the long term condition and frailty leads. They have worked on the design for the new front entrance by seeking the views of the public which has been really helpful in the design. They have been developing their online rate and review feedback centre, which allows the public to rate their experience

with a service publicly online. PALs have been active in responding to public reviews of Torbay Hospital directly online .Plans for 2016 include monthly visits to the hospital to seek the views of the public. Healthwatch Torbay shared their "*Torbay Health-related community services review"* with us. The key finding is that there is not enough information on local community-based health-related services available to the public locally. Three recommendations were made:

- An extensive local marketing campaign is required, particularly in the TQ1 and TQ2 postal areas, to inform residents of the types of community-based health-related services available to them locally
- A review of the current MIU signage should be conducted to ensure that both Paignton and Brixham MIUs are clearly signposted, including in the TQ1 and TQ2 postal areas. Where possible, opening times should also be included.
- A further investigation asking the community exactly how they would like to access community-based health-related services should be conducted.

Healthwatch Devon have shared the findings of their report *"Then what? A report of people leaving hospital"* and was reviewed at the committee in May 2015. Findings showed that most people seemed happy with the care they had received in hospital, and some were full of praise for the staff on the wards however, For some, a really good experience in hospital was spoiled by delays and poor communication during the discharge process. Key recommendations:

- Plans for joining up health and care services need to ensure good co-ordination, communication and timeliness between service providers.
- That plans for joined up health and care services should build in a means of tracking the experience of patients as they move from one service provider or location to another.
- Findings from this report should be used in hospitals for staff training and system improvement
- Since some survey respondents took the view that hospital staff were simply under too much pressure, hospitals should check whether staff share this view.

Getting discharge right remains a high priority and work continues to get this done well and is a priority in the Safe Transfers of Care work. The recommendations in these reports will inform the Quality Account and *CQUIN priorities this year.*

We have provided information to Healthwatch Devon for their review "Putting patients in the Picture" which is due to report in 2016.

4.0 Service Delivery Unit (SDU) improvement priorities:

Over the last year each Division and community service provided reports to the respective E&E committees. This activity has transferred to the new SDU structure and will report to the Quality Improvement Group. As part of the reporting template they report on complaints and learning from complaints, compliments, feedback- including Friends and Family Test, CQC Key Lines Of Enquiry, End of Life Care (where appropriate), plans for the quarter and how they have been engaging with people in the service.

Medical Services SDU:

The Medical SDU`s key areas of focus are:

- Communication and managing and discussing public expectation.
- Development of the Ambulatory Medical Unit

Community Services SDU:

- Improving access to the complaints and feedback service for those our care whatever their location.
- Improving discharge processes and information

Surgical Services SDU:

- Noise at night following the feedback from the Real Time Patient Experience and they will be undergoing further night-time Observations of Care in 2016.
- Continued focus on patient storytelling and supporting the Matron for theatres in the patient engagement work.

Women`s, Children`s, Diagnostic`s and Therapies:

Redesign and clinical management support for the Sexual Health Service
Recruitment of Consultants in Radiology and Histopathology
Child and Adolescence Mental Health Service (CAHMS) as there has been an increased demand for CAHMS based care. An action plan relating to CAMHS has been presented to the Board in December 2015.

The estate and facilities directorate are making improvements to many areas which have received very positive feedback from the public. The new ICU, main entrance and LINAC are key areas of estate improvement in the coming 12 months. Car parking remains an outstanding issue but plans are in place to improve this and the SDU asked members of the public to support them in the design of this improvement.

The first changes are due in December.

- The photographs in the hospital corridors have received a great deal of positive feedback.
- A food satisfaction survey showed 87% of those who responded stated the food was excellent or good. Implementation of menu mark throughout the hospital which means that patients order their food the meal before rather than the day before which has improved the experience as well as reducing waste.
- The PLACE audits undertaken in 2015 showed that all of the hospitals performed above the national average in most of the key assessment areas and, in addition, seven community hospitals (Ashburton, Brixham, Dawlish, Newton Abbot, Paignton, Teignmouth and Torbay) scored above the national average in all five categories. However, the assessments also identified some areas for improvement.

As a result, and as part of the trusts commitment to providing the highest quality of care, over the next 12 months minor improvement works will be carried out including:

- Reviewing seating to ensure various heights of chairs are available, with and without arms
- A review of menus and the availability of ‘finger foods’ as a complete meal choice rather than just snacks
- Addressing, where possible, redecoration, lack of storage and items such as hand rails and blinds
- The ‘dementia friendly environment’ was a new scoring category for this year’s assessments. Whilst all of our hospitals scored well, there are improvements that can be made including clocks with the date and time, signage that includes pictures and text, toilet doors painted in a single distinctive colour and ‘matt’ flooring where possible.

5.0 Service Improvement projects:

Bedside Folders

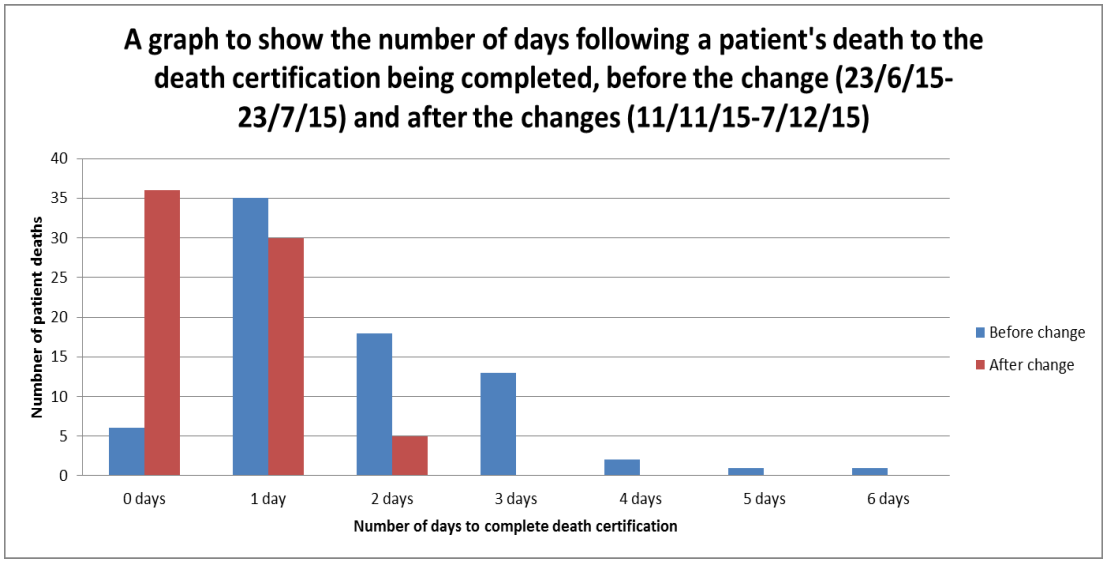
The new updated version of the Bedside Folders for hospital patients was finalised and on the wards in April 2015. This was the result of a lot of input from all staff, local organisations and patients.

Translation and Interpretation

The new policy for Translation and Interpretation services was ratified this year which will lead to a better service for our patients requiring support. We now also have 24 hour support from “Deafinate” who provide our sign language services and we are currently exploring further opportunities to enhance the experience from those who require the service. We are currently tendering for translation services which will ensure there is only one provider for the integrated care organisation.

Bereavement Project

Further to the Quality Account and CQUIN priorities last year the bereavement and patient services office began to see an increase in the time it took relatives to receive the death certificates of their loved one. We noticed an increase in complaints, poor feedback and distressed relatives as well as a negative impact on the Registrar's office and Mortuary capacity. A project group was formed to review and a Horizon Institute project manager supported the project throughout. As a result a new process was designed, an additional member of the bereavement team was recruited and the new process began in November 2015. To date the feedback has been very positive and the graph below demonstrates the difference in time for completion of death certificates. Currently the team are asking for feedback from the Doctors about the new process and will make any changes as this embeds.



Datix implementation:

The Trust is currently using two legacy risk management systems, Safeguard and Datix. The E&E team are nearing the end of a procurement process to implement a single system.

6.0 Complaints, Concerns, Comments and Compliments (acute):

The data on complaints, concerns and compliments are noted below. The Patient Services Team and all staff make every effort in the first instance to resolve the issues.

In the reporting period for this report the acute service received 275 formal complaints. Compared against the number of discharges for the same period (76,866) this shows the formal complaints as 0.36% of the total number of patients discharged. The PHSO Report 'Complaints About Acute Trusts 2014/15' published in September 2015 showed that our activity is in line with other organisations of a similar size.

Table 2 shows the Types of Enquiry received

Type of Enquiry		
	Patient Services	PALs
Complaints	246	13
Concerns	217	234
Comments	69	147
Compliments	230	322
NHS Choices	155	-
MP Enquiry	18	-
Repeat contact following complaint response (2nd 3rd 4th)	22	-
Advice & Information	94	622
Other-includes duplicate	40	

response, out of time and sent in error		
Total	**1091**	**1338**
	2429	

Table 3 below shows the categories of the feedback received matched against the Corporate Objectives for 1st Dec 20014 – 31st Nov 2015. This year the focus on Compliments has been reflected in the reporting.

Corporate Objective	Category:	Compliments	Complaints Concerns Comments	PALS
NO DELAYS	Appt Delay/cancelled OP		42	61
	Access to services	1	81	142
	Appt Delay/ Cancelled IP		28	29
Total		**1**	**151**	**232**
Theme total (%)			**16%**	**23%**
PATIENT EXPERIENCE	Attitude of Staff (to include privacy and dignity and discrimination)	11	96	56
	Communication/Info	2	133	113
	Adm/Discharge/ Transfer		48	37
	Bereavement (PALS)			16
	General Info -to include personal records, transport, hotel services, benefits advice and property & expenses, Automated phone	3	36	201
	Carers (PALS)			1
	Complaints Handling (SDHCFT & other Orgs) Community Services		11	11
	Care and compassion	292	48	18
	Dementia			1
	Learning disabilities		1	1
	Friends and Family Test			5
	Miscellaneous Compliments	68		
Total		**376**	**373**	**462**
Theme total (%)		**68%**	**40%**	**46%**
SAFER CARE	Clinical treatment (to include infection control, failure to follow procedure and consent to treatment, End of Life, Code of openness)	176	364	237
	Eq'mt /Premises/ Access		28	27
	Safeguarding (to include neglect/abuse or financial	1	6	5
	Policy/commercial decisions/ Information Governance/Human Resources		4	10
Total		**177**	**402**	**279**
Theme total (%)		**31%**	**43%**	**28%**
OTHER			10	42

Total		**0**	**10**	**41**
Theme total (%)			**1%**	**4%**
Total		**554**	**936**	**1014**

The key areas to note are the “No Delays” for access to services which highlights some of the delays our patients have been experiencing and under “Patient Experience” communication remains a key issue that people tells us about as well as concerns about attitude of staff.

Support Empower Advocate Promote (SEAP advocacy):

As a result of the feedback the key actions to the complaints process have been to risk rate the complaints and when appropriate convene an early meeting with key members of staff. This has proved very useful in planning the complaint investigation process and liaising with the complainant. SEAP, the Health advocacy service has worked with the Trust this year and have held monthly “drop-ins” in the hospital. The feedback from SEAP from these has been very positive with most people keen to tell them of positive experiences of care. The complaints policy is currently under review to encompass the ICO. The Trust`s Learning from Complaints group meets bi-monthly.

Public Health Services Ombudsman (PHSO):

The Parliamentary and Health Service Ombudsman (PHSO) have considered 13 cases this year. 8 were not upheld and 3 were partially upheld with remedy and action plans, all of which have been completed.

The PHSO felt that the Trust had missed an electrolyte imbalance and not treated appropriately. An order communications system which has a mandatory electronic acknowledgement of test results as they are received should resolve the situation when abnormal blood test results are not noted.

The lack of a completed TEP (Treatment Escalation Plan) was also noted by the PHSO and the following changes made:

- ✓ Nursing handover documentation records patients’ resuscitation status and if a TEP has been completed.
- ✓ A member of the junior medical staff is working on a quality improvement project which includes using a board round sticker within the medical notes to record the multi-disciplinary board round conversation regarding TEP. It is anticipated that this will act as a prompt for all staff to ask the question regarding TEP which will improve communication with patients, their families and completion of TEP forms in a timelier manner with palliative care discussions when appropriate.
- ✓ The Trust End of Life group recognise that the completion of TEP forms is as an area requiring improvement. Membership of this group includes Consultant representation who recently discussed TEP forms at the Medical Unit Committee meeting.

The resuscitation group Consultant lead is writing a policy aimed at making the adoption of TEP forms more robust across the trust. A teaching programme is also being finalised to highlight TEPs and to teach staff how to complete TEP forms e.g. what forms of words to use.

2 cases remain with the PHSO for consideration

Changes as a result of specific complaints:

Complaint centred on the fact that the patient did not receive her medication correctly whilst on the ward. The actions included:

- When a doctor is prescribing medications at least two sources of information should be used to confirm all medications are prescribed and correct. This has been discussed with staff involved following this incident.

- Once the medicine reconciliation has been completed by the pharmacy department the staff caring for the patient will be notified to minimise any delay in the medications being signed by a doctor. The pharmacy department are receiving training about the specific drug.
- The management of patients receiving this drug has been discussed at the trust medical clinical governance meeting which is attended by consultant, medical and nursing staff. The aim of the meeting is to look at clinical incidents, identify any learning and actions to prevent them from occurring again.
- The pharmacy department have requested an alert to be added on the computer to identify patients who are receiving this drug. The alert system is used to identify any concerns when a patient is admitted to the hospital. This would immediately alert the doctor if a patient is receiving a vital medication.
- A patient complained that changes were made to her planned operation just before she was due in theatre. As a result the surgical admissions unit has reviewed their processes whereby no pre-medications are given until the surgeon has reviewed the notes and completed their final pre-operative talks with patients.
- A patient complained that they had suffered a rare complication of surgery which they were not aware of. As a result the patient information leaflet is to be amended and will include information about the rare possibility of the side effect.
- Complaint where the insertion of urethral catheter damaged the bladder of a patient with a pre-existing condition. The clinical teams have modified practice, so that in a similar set of circumstances, an alternative product will be used. A protocol has been devised and training provided.

Compliments:

This year we have focussed on compliments, learning from them and the impact compliments have on the workforce. A concentrated effort to record the number of compliments has been made this year - 554 compared with 417 in 2014. It is recognised that this is probably still only a very small proportion of the total compliments. A pilot has been set up in December 2015 with the Maternity department who have started to collate compliments using a simple chart.

The ICO Network, staff bulletin and website continue to display compliments for both the acute Trust and Community in order to help staff understand how their roles can make a real difference to patient care.

The Case study: *"What are the effects of patient compliments on hospital staff"?* has been led by the Experience and Engagement Facilitator. This pivotal work has been supported by NHS England and they want to use the work as a National Case Study with a Toolkit to support the study.

Patient Advice and Liaison Service (PALs):

PALs continue to help *"unstick"* people during their hospital journey. It is very often relatives rather than the patient who contact the service and increasingly staff point people towards PALS.

Although it is difficult to identify clear trends there have been a couple of areas that are of note: the difficulty for some people being able to park causes huge distress and frustration which has led to late attendance or even non-attendance. There has been an increase in the number of Child Health enquiries regarding waiting times for special needs assessment and behavioural concerns.

The service continues to be contacted by bereaved relatives who simply need to understand what happened to their loved one. Clinical staff are very responsive to such requests and these meetings although sad and sometimes distressing, are extremely worthwhile.

PALs have led and developed the "Take a Quarter" training which aims to help staff deal with any concerns as they arise. It has been well received and 450 staff have received training this year. Although staff instinctively know what to do in these situations they are empowered by reinforcement of the principles of "customer care" giving them the confidence to try and resolve issues at the point of delivery.

7.0 Community Service Delivery Unit 2015/16:

This year has seen the development of a new 5 step complaints process which includes all the required investigation templates in one pack and mirrors the incident reporting investigation procedure. This process has been trialled with both Health and Social Care complaints and positive feedback has been received about the quality of the final response letter to the complainant. It also enables the Quality and Experience Team to store centrally evidence of the investigation completed. The effectiveness of communication has increased as the Quality and Experience Team have attended various forums to present the new 5 step complaints process and to promote the team's objectives. These forums include: the All Manager's Meeting, Hospital Matron's Meeting, Assistant Director's Group Meeting and the Community Nurse Lead's Meeting. There has also been some opportunity to meet services in their own locality, although the team resource is a limiting factor.

The Quality and Experience Team form an integral part of the peer Clinical Quality Review Team (CQAT) which inspects services on a monthly basis. The aim of these inspections is to provide assurance to the Board that community services are providing high quality health and care services supported by systems and processes that enable the service to be consistent at all times. There is still some work to do to formally design and deliver a programme of quality and experience visits to all services.

The number of patient stories captured and shared has not increased significantly, although this does remain a priority for the Quality and Experience Team. Compliments are shared every week in the Staff Bulletin and there is a monthly learning report that is included in the Community Dashboard report.

Internal Audit:

As part of the 2015/16 Internal Audit Plan as agreed by the Audit and Assurance Committee, a follow-up review of the 2013/14 complaints audit was agreed. The overall objective of this review was to provide assurance to the Audit and Assurance Committee that the processes in place for the management of action plans arising from complaints, and the dissemination of learning gained from complaints are adequate.

The outcome of the audit was that the overall assurance opinion on the design and operation of controls was Green in accordance with the definition, "No control weaknesses were identified or the work found some low impact weaknesses in the design and/or operation of controls which, if addressed would improve overall control. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the objectives of the system. The conclusion is that the design and/or operation of the key controls is sound".

Good Practice:

- Action plans are created as appropriate, and in cases where they are not required, specific detail of the reason why an action plan is not required is recorded.
- A Data Integrity Report is run on a monthly basis to identify incomplete or incorrect entries within the Datix system.
- Follow-ups and communication were taking place regularly and fully detailed and evidenced within the Progress Notes section of Datix.
- The majority of action plans for closed complaints on Datix appear to be recorded as complete.
- The majority of complaints appear to be reviewed for learning.
- The introduction of the Response Letter Quality Review Checklist will help to ensure that final response letters are appropriate and consistent.

Areas for Further Action:

The monitoring of the completion of action plans is inconsistent and the Datix entry fields could be updated for further clarity.

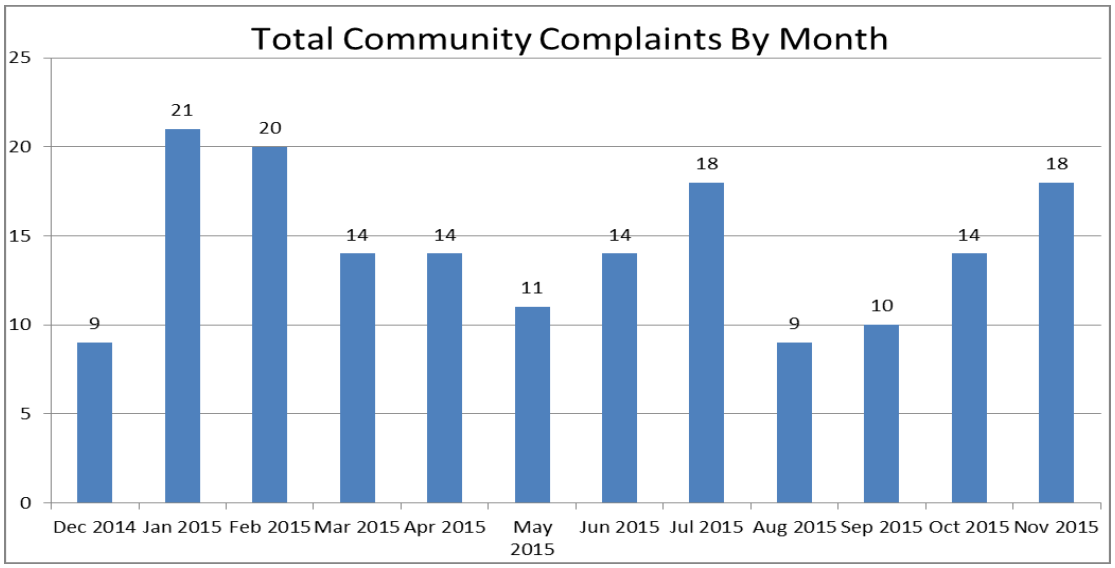
- Formal reporting and escalation of incomplete or outstanding action plans appears to be minimal.

- The “Actual completion date” and “Action plan completed in full date” details within action plans were not always consistent with the dates recorded on Datix.
- Learning identified and recorded within action plans was not always consistently transferred from on the action plan to the Datix entry.
- The sharing of any identified learning is not clearly recorded within Datix.
- The recommendation from the previous year’s audit report was marked off as complete, yet half of the actions were not resolved.
- Since the formal introduction of the Response Letter Quality Review Checklist in late April 2015, only approximately 50% of the complaints for which final responses were issued held evidence of completion of the checklist within the Datix entry. Whilst the checklists were completed for a further 25% of the Complaints, these were not uploaded onto Datix.

There have been improvements made to ensure that any identified learning is clearly recorded on Datix. It is also now recorded where and when this learning has been shared. There is now a formal procedure in place for escalating when action plans have not been completed or when actions have not been completed by the agreed deadline. The new 5 step complaints process has also enabled the Quality and Experience Team to ensure that all root causes have associated actions and that these actions are appropriate for the learning identified.

Complaints- There were 274 received during the year. However 102 of these were logged and “rejected”, the most common reason for rejecting complaints was due to the complaint being for another provider. Of the complaints received, 172 complaints were investigated by community services.

TSD / SDU	**01.12.14 – 30.11.15**
Complaints	172
Compliments	218
MP/Councillor Enquires	33
Pals	117
Concerns	90
Comments	63
Rejected contacts- e.g. for other providers	126
Total	**819**



Themes from Complaints – community:

Each complaint is categorised (from the service user's point of view) - what were we providing and what was it about our delivery that was unsatisfactory.

	Availability, Non-Delivery	Eligibility	Accessibility	Timeliness, Delays	Appropriateness	Effectiveness	Attitude of Staff	Competence, Negligence	Hygiene, Infection Control	Procedures, Standards	Privacy, Dignity, Respect	Communication	Total
Care	2	0	7	1	20	5	7	2	0	0	1	3	48
Treatment	4	3	6	1	15	0	5	4	1	0	0	0	39
Assessment	3	2	3	2	15	1	4	0	0	1	0	2	33
Appointment	2	0	4	0	1	0	2	0	0	0	0	2	11
Non-Clinical Support	2	0	0	0	3	0	1	0	0	0	0	3	9
Equipment	0	0	1	2	4	0	1	0	0	0	0	0	8
Discharge	0	0	0	1	5	0	0	0	0	1	0	0	7
Diagnosis	0	0	0	0	1	1	0	1	0	1	0	0	4
Premises	0	0	0	0	0	0	0	0	1	1	0	1	3
Personal Welfare	0	0	0	0	1	1	0	1	0	0	0	0	3
Record Management	0	0	0	0	1	1	0	1	0	0	0	0	3
Referral	0	0	0	0	1	0	1	0	0	0	0	0	2
Corporate	0	0	0	0	0	0	0	0	0	1	0	0	1
Admission	0	0	0	0	0	0	0	1	0	0	0	0	1
Total	13	5	21	7	67	9	21	10	2	5	1	11	172

Appropriateness - Care, treatment and assessment remain the top three issues most complained about, particularly with regard to appropriateness of the service provided.

Accessibility of services - has been complained about more in this period than in the last annual report, which may indicate pressure on services. However, complaints about competence, negligence have reduced significantly in this period.

Attitude of staff – often relates to inadequate / poor communication but also rudeness.

In the reporting period there have been 19 complaints relating the Continuing Healthcare Team, which is significant. The Continuing Healthcare Team state that there are over two hundred cases of previously unassessed periods of care waiting to be reviewed. Each case has to be thoroughly reviewed for the period requested which can be, in some cases, a number of years and have varying levels of complexity. It is therefore very difficult to put a timescale on completion of each case but staff are working toward completion in every case. NHS England have recently advised all CCGs that they have brought the date for completion of all initial assessments, for previously unassessed cases, forward to 31 September 2016. The Trust is in on-going discussions with the CCG on the options available to them to manage the retrospective workload in light of this revised timescale.

There have also been some complaints relating to the process issues and learning from these complaints has been shared locally.

Cases Referred to the Local Government and Parliamentary and Health Service Ombudsman

There were 7 cases referred to the Ombudsman during this year. Of these 3 were "partly upheld" by the Ombudsman, 2 were "not upheld" and 2 are still being investigated. There have not been any cases

referred to the Ombudsman since July 2015 which may indicate an improvement in the complaint responses.

Recent PHSO Publication:

Arising from a number of national high profile patient safety and experience incidents, the process and effectiveness of complaints handling and learning has received significant attention and review. Hard Truths, The Journey of Putting Patients First was released in 2014 and included the recommendations of the Clwyd/ Hart review of the complaints process. The PHSO has recently released two reports which build on earlier recommendations; these are reviewed below with an outline of recommended actions for this Trust which will form part of the work plan for the Learning from Complaints group.

Breaking Down the Barriers. Older People and Complaints about Healthcare (PHSO)

The report notes that older people are more likely to access health care services as they enter later life, yet are more reluctant to complain, or do not know how to. The UK population is ageing; nationally around 1:10 people will age 75 or over by 2030 and there is likely to be a doubling of numbers of those over 85 years of age. Locally, we know we are ahead of the national curve. Despite being the greatest users of health and social care, the evidence set out in the report suggests that older people are less likely to complain if they receive a poor service. The PHSO noted that only a quarter of complaints received by them were from those aged 65 or over. There are broader issues affecting older people's likelihood or ability to raise a complaint i.e., large numbers of older people live alone and may not have anyone to support them in making a complaint, older people are more likely to have ongoing health needs and express concern about the impact of making a complaint on their on-going care needs.
The key issues raised in the report are that Older People:

- Do not know how to complain or who to complain to, and that organisations may signpost people to use communication channels they are unfamiliar with eg on line. The report also reflects that older people may be receiving care from both health and social care services which may be a further complicating factor when making a complaint.
- Do not want to make a fuss and are worried about what will happen if they do.
- Do not think that making a compliant will make a difference.
- Are not offered support to make their complaint.

The report concludes with 4 recommendations for provider organisations

1. Organisations need to make everyone who uses their services aware of how to complain
2. Organisations should point people towards the help available to help them in making a complaint
3. Organisations should make it clear that future care will not be compromised if they do complain.
4. Organisations should measure how well they are doing this. The document 'My Expectations for raising concerns and complaints' is referenced as a tool to aid this.

Clearly the age profile of the population the Trust serves renders this report highly relevant, although the recommendations above would be applicable to users of services. The Trust position and actions against the 4 recommendations are shown in the table below and will be presented to, and be overseen by the Trust Learning from Complaints Group. The governance for monitoring progress against the recommendations will sit with the Quality Assurance Committee via the Quality Improvement Group.

Trust position and actions

PHSO Recommendation	Current position	Action	Who
Organisations need to make everyone who uses their services aware of how to complain	The Trust web site provides information on how to complain. The leaflets 'We want to know what you think' are available in clinical areas. There are posters in clinical areas which signpost service	Review the current information and update where necessary to include this recommendation. Further work is needed to ensure that issues raised	Engagement and Feedback team by March 2016. Engagement and Feedback lead with

	users to the complaints process. The 'Take a Quarter' training is designed to facilitate early identification of service user concern and to address the issue in real time with the patient. Feedback mechanisms from Healthwatch and SEAP are incorporated into the Engagement group and Learning form Complaints. The CCG feedback and engagement lead also works with the Engagement group.	through engagement activity is recorded and informs the wider learning. Foster closer working relationships with Healthwatch, linking to organisational priorities.	DDoN during Q1 2016/17 Engagement group Q1
Point people to the support available to help make a complaint	Trust information includes PALS contact details and points people to the SEAP service. The 'Take a Quarter' training provided through the E&F team facilitates rapid and local resolution of problems.	Learning from Complaints group to consider how volunteers could assist, for example in targeting areas where the most vulnerable older people receive care.	Learning from Complaints group to discuss at February meeting. Develop a test of change model by April 2016.
Clarify that future care will not be compromised if a complaint is made.	The We Want to Know what you think leaflet does cover this point, however, the person has probably already made contact by this time.	Review the written information and material provided through the Take a Quarter training.	E&E team in February meeting.
Measure the effectiveness of the above using the *My Expectations* framework.	The Trust has limited feedback from people who have used the complaints process. This is an area already under consideration as the community and acute E&F teams develop unified processes.	Review the *My Expectations* framework to agree additional effectiveness monitoring arrangements.	Learning from Complaints meeting in February 2016.

A Review into the Quality of Complaint Investigations (PHSO):

This report follows a review of the quality of complaint investigations in the NHS, noting that when things go wrong people want to understand what happened and what action is being taken to prevent the same thing happening to others. The report sets out the PHSO expectation that organisations take complaints seriously and that whether or not there has been a serious patient safety incident, organisations should undertake a thorough investigation. The report reviewed 150 complaint investigations where avoidable harm or death was alleged, and surveyed complaints managers to add further information.
The findings of the review were that:

- Investigation processes are not consistent, reliable or good enough.
- Staff do not feel adequately supported in their investigatory role
- There are missed opportunities for learning

The report calls for the Independent Patient Safety Investigation Service (IPSIS) to improve how the role of complaints investigators can be better recognised and supported, and that investigations are carried out consistently and to a high standard. Learning across whole organisations needs to improve. For the

purposes of this briefing, the Trust position and preliminary actions against the report findings as outlined below.

PHSO Issue	Current Position	Action	Who
Complaint investigation process is not consistent, reliable or good enough.	Complaint and serious incident investigations are managed by the SDUs. The Associate Directors of Nursing (ADN) are responsible for allocating an investigator, usually the clinical governance coordinator where the incident is serious. For other complaints the specialty matron/lead is tasked to undertake an investigation. Recording of the investigation detail has been variable across the SDUs. This renders scrutiny of the quality of the investigation difficult and has already been raised as an improvement need. There is a close working relationship between the complaints and incident reporting teams and cross referencing of processes where a complaint is received and an incident investigation is already underway. The ADNs complete a critical incident report in the event a complaint raises a previously unknown safety incident. The central complaints team check the Risk Management System for an incident form on receipt of a complaint. Where a complaint is being managed as a critical incident, serious and catastrophic cases are subject to greater scrutiny and external oversight. These are also reported through to the Serious Adverse Event group. The SDUs ensure that the Duty of Candour obligation is carried out and that ToR for serious incident investigations include questions from the patient or family.	To set out the format and process for complaint investigations across the organisation. To evaluate training requirements for those who undertake the investigator role.	Learning from Complaints Group and Deputy Director of Nursing with Patient Safety Lead by April 2016. Patient Safety Lead, E&F lead with SDUs by end Q1 2016.
Staff do not feel adequately supported in their investigatory role	The allocation of a complaint investigator is the responsibility of the ADN who uses discretion as to who should investigate the complaint. Where the complaint is being investigated as a serious incident, this usually rests with a matron and the SDU clinical governance coordinators. The ADNs receive update reports on the progress of the complaint response and intervene where the investigator requires assistance. The E&F central team monitor the agreed response time and provide alerts to the DDoN where there are delays. Escalation to the	As above, review training requirements for staff who are assigned the investigator role. Further review the cross working and coordination of incident and complaints investigations.	As above Deputy DoN with E&F manager and Patient Safety Lead by end Q1 2016.

	AMD/MD is undertaken where appropriate.		
There are missed opportunities for learning	Serious incidents where significant harm has been caused are part of the SDU governance processes, and are also reviewed by the Learning from Serious Adverse Event Group. The learning from complaints which have not reached the serious incident threshold is less quantifiable. For example, the senior sisters share the outcomes of complaint investigations, and the ADNs share learning from their investigations via the Learning from Complaints Group. The need to capture local learning for the benefit of the whole organisation has been identified as an improvement need. In terms of incident investigation, local organisations, through the CQUIN mechanism, have been working together to identify smarter ways of working to achieve robust investigations and cross organisational learning. The CQUIN group has also considered how the Human Factors approach can be incorporated into investigations. The Trust HR work is also beginning to inform in house education programmes and ways of working.	As part of the review of the complaint investigation process, a more detailed record of complaint actions and learning is required. The Learning from Complaints Group will be tasked with developing a process and for providing the SDUs with a clear governance route for monitoring actions.	Learning from Complaints Group by April 2016.

Friends and Family Test:

Acute

The Friends and Family Test (FFT) for inpatients and A&E was removed from the National CQUINs in April 2015 and became part of the standard contract. At this point the ongoing responsibility for delivery of the FFT was devolved to the Service Delivery Units with reporting to the Engagement and Experience Committee. The response rates over the period have remained low, particularly in A&E. Volunteers have been encouraging patients to complete these. The inpatient wards have a range of response rates and we have been reviewing process where response rate is high and looking to replicate. The feedback from those that complete the FFT is very positive (average 92% of responders are extremely likely or likely to recommend the Trust) and the results are shared with the clinical areas monthly and poster displays are updated regularly.

The four gateways for Maternity patients continue and we continue to see less feedback after the final gateway (10 days after birth). Again the feedback is mainly positive. Any FFT feedback where the responder leaves contact details, we respond directly to them.

From April 2015 we have been asking all Outpatients, Day Surgery attendees and Patient Transport the FFT question. We have informed the Department of Health that our long term cancer patients receiving ongoing treatment found the repeated request to complete the FFT question distressing; this was found nationally and has been changed.

Friends and Family in the Community Service Delivery Unit

Additions to services required to request feedback as a mandatory requirement came into force on 1 April 2015. The services that are now included are: community inpatient services, community nursing services (district nursing services, community matrons and end of life care), rehabilitation and therapy services (physiotherapy, occupational therapy, podiatry and speech and language therapy), specialist services (community dental, specialist dentistry) and other community healthcare services (Minor Injury Units, Child and Adolescent Mental Health Services and Older Peoples Mental Health services, Public Health).

The Friends and Family Test Questionnaire results are logged centrally on Datix® and are extracted and uploaded to NHS England on a monthly basis. The overall results are published on the Trust public website on a monthly basis.

All areas with public-facing areas are required to display posters of their results if 5 or more responses obtained and for services without public facing areas, results have been published on the Trust's Social Media.

There has been much work done to encourage services to access their own data, especially the rich qualitative data. The Quality and Experience Team regularly visit community teams in their own locality to promote the Friends and Family initiative, to work with services to consider the variety of implementation methods and to ensure they are confident with accessing their results. The data is now cleansed on a monthly basis to ensure that any errors are amended.

Other developments are the Friends and Family Test Questionnaire was rolled out to Adult Social Care in November 2015, and an Asphasia Friendly version of the Friends and Family Test is currently being tested by patients. The percentage of people who were either "likely" or "extremely likely" to recommend the service they received has been consistently over 96% between April and November2015.

April 2015	98% (590 responses)
May 2015	97% (693 responses)
June 2015	96% (832 responses)
July 2015	97% (619 responses)
August 2015	97% (674 responses)
September 2015	97% (824 responses)
October 2015	99% (409 responses)
November 2015	96% (720 responses)

Engagement work.

The engagement work this year has included:

- Focus groups for patients about their experience of theatre and recovery. This is currently being led by the Matron for theatres and will be reported through the SDU and the Engagement Group.
- The new Overseas Visitors policy is being reviewed to ensure the Trust applies the legislation correctly and the working party is involving an overseas visitor to ensure the policy and information as useful as possible.
- Maternity strategy development and new Maternity Services Liaison Committee (maternity voices). This has been in collaboration with the CCG and the venues for the new meetings will take place across the Bay.
- The CCG have led work around the mental health crisis team and liaison psychiatry as there has been feedback from patients and staff particularly in ED

- Urgent care strategy and Vanguard
- The design and development of the new main entrance has included feedback and engagement from the public.
- We have been keen to involve the public in junior doctor training and communication. A new leaflet and poster is currently in development with support of the public.
- Carers evaluators

9.0 Looking forward 2016/17:

The key areas for the Integrated Care Organisation for 2016 will be to fully understand the patient and service-user pathways across the new organisation and then to review their experience.

We will review all the ways which we receive feedback and align our process to give a clear picture. The Friends and Family Test processes will be reviewed and aligned.

Experience and Engagement activity will be reported to the Quality Improvement Group, and the newly formed Engagement group will consider and prioritise the engagement work as well as supporting all areas of the organisation to be able to engage with users of our services meaningfully.

The acute and community feedback and engagement teams are working collaboratively, and will co-locate in the near future. The new risk management system will support the full understanding of all the activity of the organisation and will support the facility for all staff to be able to log concerns and comments locally.

The new complaints policy is currently in development.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	3rd February 2016
Title:	Report of the Medical Director
Lead Director:	Medical Director
Corporate Objective:	Safer Care
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

- A twenty four hour junior doctors' strike took place on 12 January 2015. Careful contingency planning was successful in avoiding risk and harm for patients. The further planned 2 day strike was postponed.
- A high level of pressure remains within the emergency system due to 'winter pressures' which increases the additional risk of safely managing any further industrial action by our Junior Doctors.
-

Key Issues/Risks

- A second 'all-out' strike is planned for 10th February 2016.
- Clinical risk is higher on this date because of withdrawal of junior doctor emergency cover.
- There will be impact on current progress towards achievement of RTT in Q4.

Recommendations:

- Careful contingency planning is in progress.
- The Board should be assured that the hospital will be safe for the period of the strike, though to achieve that safety there will be significant disruption of planned care for patients.
- A short, medium and long-term review of Urgent care processes and pathways has been initiated and will report to Flow Board.

Summary of ED Challenge/Discussion:

To maintain safe care during the period of a second strike and at a time of great pressure in our emergency system, the relative priorities of emergency and planned care are being considered.

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

Contingency planning has been support by SD&TCCG. A communications strategy has been developed with detailed communication to the public.

Significant engagement with clinical staff has been led by the Medical Director to ensure plans are in place for safe care.

Equality and Diversity Implications:

Nil

REPORT OF THE MEDICAL DIRECTOR

3RD FEBRUARY 2016

Junior Doctors' Industrial Action 12th January 2016.

The industrial action (IA) around the new junior doctors' contract that was planned to take place on 1st December 2015 was cancelled with only 12 hours' notice. Some disruption was inevitable because of the short notice of cancellation though this was kept to a minimum. The majority of the activity was recovered and cancelled patients who wished to be were re-booked before Christmas.

The planned IA was called again by the British Medical Association (BMA) with 7 days' notice for 12th January 2016. The contingency plan agreed in November was put into action with adjustment relating to activity in the hospital. Planned in-patient surgical activity was low because of expected high levels of emergency medical activity through and after the Christmas and New Year period. A greater level of risk to safety was identified compared to the original strike day but with reduced level of disruption to planned surgical and other day-case activity.

Once again detailed communication with the public and all other stakeholders was undertaken of the Trust's plans to ensure business continuity and safety of patients within the hospital with the support of the CCG. The Medical Director, Director of Human Resources and Chief Executive attended a meeting of junior doctors. Good relationships with the junior doctors were maintained throughout.

The first strike took place on 12th January with a walk out of doctors not rostered to be undertaking emergency care. Greater than ninety percent of junior doctors took part in the strike. Plans to focus consultant and other senior doctor activity in emergency care and on wards were successful. Additional activity was provided within some community hospitals. Other staff groups contributed to an excellent whole organisation response. No adverse incidents relating to patient care were reported. 5 inpatient and 9 day-case procedures were cancelled. Approximately 200 outpatient appointments were rescheduled.

A number of positive effects of the re-focusing of consultant activity were reported. Nursing staff reported appreciation of the presence of senior medical staff on wards. Consultants reported a greater appreciation of the duties of junior doctors. Most significant was the beneficial effect on discharge. The total number of discharges in the day was higher than average with double the number of patients going home early in the day. We know that this has beneficial effects on patient flow. The increased availability of beds supported a recovery from a period of great pressure and poor performance against the 4-hour A&E target. Of note is a 30% reduction in usual Emergency Department attendance and emergency admissions on the day of the strike suggesting a change in General Practice and patient behaviour, although an increase was experienced in the following days after the strike.

Discussion has taken place at divisional level and at cross-organisational on the experience of the day and the learning derived. Though it is clear that we cannot provide the same level of senior medical input to the wards under normal circumstances because of other clinical responsibilities, there is an urgent need to learn from the strike day in order to improve our response to winter pressures, and in particular how that senior presence supported more timely discharge and a reduction in patients in hospital over 10 days.

A 48-hour strike was planned for 26th and 27th January but was cancelled a week in advance. There was no disruption of patient care on this occasion. An outstanding date for an 'all-out' strike between 8am and 5pm on 10th February is pending. A meeting to plan mitigating actions will take place on 3rd February. Greater disruption to planned care than on 12th January is likely as senior medical staff will be needed to provide all levels of emergency and inpatient care. Plans are in place to provide safe and timely care for

patients who need to use the hospital on that day and communication with the public and stakeholders to explain that the hospital it safe will be repeated.

Plans to reduce the impact of the strike will include measures to optimise discharge of patients who can be cared for in other settings or in their own homes. This is part of the ongoing response to high pressure in our emergency system and is a whole system response. Our ability to influence other parts of the system has been enhanced by being an Integrated Care Organisation but the situation remains very challenging.

Pressure on our Urgent Care System.

Like all urgent care systems we experience operational difficulties due to winter pressures every year. This is due to a combination of increasing numbers of patients admitted to our hospitals, increasing acuity and delays in discharge, particularly over the Christmas and New Year period.

Since early December we have been experiencing severe disruption of activity. There is always more than one reason for this but in the main it has been due to high numbers of patients with extended lengths of stay (10 days +), a low level of discharge early in the day, and delayed discharges exceeding our target of 13 or less. While numbers of admissions have not risen, there is evidence of increased acuity and complexity of patients and increase in length of stay. In some cases this is due to acuity, in others to delays to onward movement due to delays in care packages or other needs. There is some evidence of delays in packages of care but also evidence that the care home market is no longer providing the capacity that is needed, particularly for patients with more complex needs or who are at end of life.

Across the whole health and care system we make decisions to optimise patient flow. This is coordination at least 4 times a day through our control room. Through December and January we have had to make decisions in the interest of patient safety that have had an adverse impact on patient experience and on performance against the 4-hour target. We have put additional measures in place to ensure patient safety and we have not seen an increase in incident reporting or complaints. However we have been under pressure from the Clinical Commissioning Group and Monitor to improve our 4 hour performance, currently below 80% average, and have taken part in a 4-way meeting with the CCG, Monitor and NHS England on 29th January.

Performance was significantly improved during the 24-hour strike. This was achieved by focusing senior medical staff activity on urgent and inpatient activity but also through efforts of other staff groups. We cannot achieve this level of activity easily on a regular basis without adverse effect on other clinical performance, resulting in deterioration against targets but also increasing clinical risk in other areas. Our senior medical staff, particularly those most responsible for urgent care performance, are under unusual pressure at present with absent colleagues through sickness or unexpected resignations and difficulties in recruitment which reflect the national position.

We have agreed as an Executive that maintaining safety and experience of patients admitted as an emergency is our number one priority. Recovery of performance against the 4-hour target will follow actions that we take to improve safety.

We have instituted a review of urgent care processes reporting to Flow Board and led by the Medical Director and Chief Operating Officer. This review will consider all care pathways, human and physical resources that we have across the organisation that will improve performance. We have already identified short term measures to produce early improvement in performance and will examine opportunities for medium and longer term options as a matter of urgency, completing the review and reporting to Flow Board in April 2016. We will provide a progress report to the Board against this aim on a monthly basis.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	3rd February 2016
Title:	Safety Scorecard
Lead Director:	Medical Director
Corporate Objective:	Safe Care
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

An assessment of level of Patient Safety derived from incident reports and various patient safety metrics against national quality markers and targets.

Key Issues/Risks

Mortality data is within expected range.

Post Operative Sepsis was identified erroneously as outside the expected norm due to incorrect coding.

There has been a small increase in CDT Numbers due to increased surveillance and with a reduction in severity.

Medication errors remain higher than desirable.

Summary of ED Challenge/Discussion:

A detailed report on governance processes relating to deaths in our organisation should be brought to Quality Improvement Group (QIG), action plan agreed and reported to Quality Assurance Committee (QAC) with actions and enhanced monitoring as required.

Peer Review on Infection Prevention and Control commissioned, visit undertaken in early January and report will be received in February.

A detailed report on Medication Errors will be presented at QIG in February 2016.

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

There is CCG and Governor oversight at the Quality Improvement Group.

Equality and Diversity Implications:

Nil

Safety Score Card No. 36

Background & Introduction

The indicators for this score card have been collated from a variety of data sources using defined methodology. The sources include Trust data, Dr Foster, and data collected initially as part of the NHS South West Quality and Safety Improvement programme. The data in the appendices has in the main been displayed as run charts. The report is generated by the Safer Care Group, which reports through Quality Improvement Group and Quality Assurance Committee to the board.

Data & Graphs – Run Charts

A number of the run charts used are taken from data the Trust enters into the Institute for Health Improvement Extranet site, and this site does not allow for best fit trend lines to be added.

The run charts used by the IHI are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to go wrong.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of a process starting to go wrong.

Table 1: South Devon Healthcare NHS Foundation Trust
Safety Score Card No 36.

Safety Indicator		Data Source	Target
Score Card Overview			Page 4
Hospital Standardise Mortality Rate Summary Hospital-level Mortality (Appendix 1)	Mortality	Dr Foster 2013/14 benchmark Year DH SHMI data	≤90 Due to rebasing by Dr Foster
Unadjusted Mortality rate (Appendix 2)		SPI/HNS SW Safety Programme	≤2%
Dr Foster Patient Safety Dashboard (Appendix 3)		Dr Foster	Indicators all in the positive
Trust wide hand washing compliance (Appendix 4)	Infection Control	SPI/HNS SW Safety Programme from trust data	95% compliance by staff groups
MRSA bacteraemia Days Between (Appendix 5)		Trust data	Zero post 48 hours MRSA's
C Diff Number (Appendix 6)		Trust data	10% reduction from 2008-09 levels
Patient Incidents (Appendix 7)	Patient Incident	Trust Safeguard system	
Major & Catastrophic Incidents (Appendix 8)		SPI/NHS SW Safety Programme from trust data	10% reduction from 2008-09 levels
Falls Rate (Appendix 9)		Trust Safeguard system	Rate of ≤4
Pressure Ulcers Data (Appendix 10)		Trust Safeguard system	10% Reduction in pressure ulcers
Medicines - Missed Doses & Medicines Reconciliation (Appendix 11)		Trust wide monthly audit	95% compliance
Cardiac Arrest Calls (12)		Trust wide monthly audit	50% reduction against baseline
Global Trigger Tool (13		Three monthly Audit	Rate less than 50
Safety Thermometer (Appendix 14)	Assurance	DH point prevalence monthly audit tool measuring harm free care	95% or high SDHCFT Harm Free Care
Never Events (Appendix 15)		Trust Safeguard system	Zero
Addendum For Information		Dr Foster commissioned report on SDHCFT's mortality position dated 6th November 2015	

Overview:

The Safety Score Card (SSC) is now being generated on a quarterly basis, as many of the metrics are stable and are included in the more frequently produced monthly Board Quality and Safety Report. Should this change, then the frequency of the report will be amended accordingly.

The score card has now been defined into four areas, outlined as below, and a brief comment has been included in this overview section.

Mortality
The Dr Foster mortality metrics have now been rebased, i.e. the way Dr Foster creates the average, the 100 rate line, becomes harder to achieve as all trusts improve their performance. When this happens, prior data will change and sometimes in the negative.

The HSMR position remains within the expected range providing assurance that mortality across the organisation is as expected based on our case-mix.

In response to the concerns over excess mortality at Southern Health NHS Foundation Trust in 2015, we are required to submit a return to NHS England by 31 January 2016, describing the governance that is in place to review deaths and ascertain to what extent deaths were avoidable.

Infection Control
The data is showing an increase in CDT numbers as against target. This needs to be observed via the monthly Performance and Quality Data book. A Peer Review of Infection Control systems and processes has been commissioned and will be reported to the Board through the Chief Nurse report.

Patient Incident Data
Patient incident data remains stable in both reportable numbers and harm rates.

Falls per month are showing a reduction in recent months and a winter falls campaign has been launched in December 2015.

Grade 3 & 4 pressure ulcers are showing a reduction, as are the Grades 1 – 2 pressure ulcers. This brings us in line with peer acute organisations.

Missed medication doses are showing a continued reduction but Medicines reconciliation has deteriorated as a result of a change to reporting based on medicines reconciliation taking place in the first 24 hours of an admission. Further work is being done to improved performance and will be reported through the Quality Improvement Group.

Cardiac arrests are reducing over time. This is the result of sustained service improvement activity focussing on Trustwide implementation of the National Early Warning Score, early recognition and treatment of peri-arrest and implementation of Treatment Escalation plans.

Assurance Data
Safety Thermometer - All data is within the target range for each metric.
Mortality Data – external report from Dr Foster data within expected range

Appendix 1
This metric looks at the two main standardised mortality tools:
Hospital Standardised Mortality Rate (HSMR) and
Summary Hospital Mortality Index (SHMI)
(Data obtained from Dr Foster)

Morbidity and Mortality reviews take place in all specialist departments and in all community hospitals. In community hospitals all deaths are reviewed using software designed with the support of the South West Academic Health Sciences Network. Recurring themes are identified and change in care pathways has been undertaken with that learning.
The Director of Patient Safety will lead on the establishment of a Mortality Surveillance Group to provide assurance that robust investigation of avoidable deaths is undertaken and to ensure that learning is shared across the organisation when suboptimal care has been identified relating to any death. This review will include assurance around 'duty of candour'.

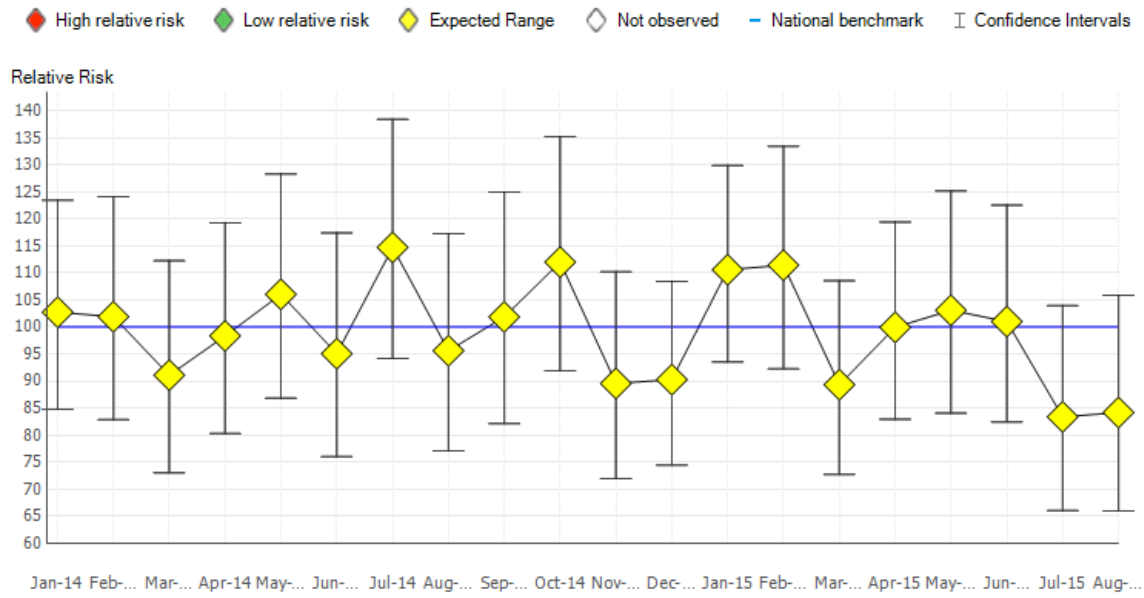
The Dr Foster mortality data, as shown below, are taken from the *newly rebased* benchmark data year **2014/15, unless stated**. This may mean a number of data points are different from previously produced score cards as they were based on a prior data year.

Traditionally, the rebasing is undertaken every year to make it harder to achieve the 100 average line as individual Trusts improve performance.

1. Hospital Standardised Mortality Rate (HSMR) basket of 56

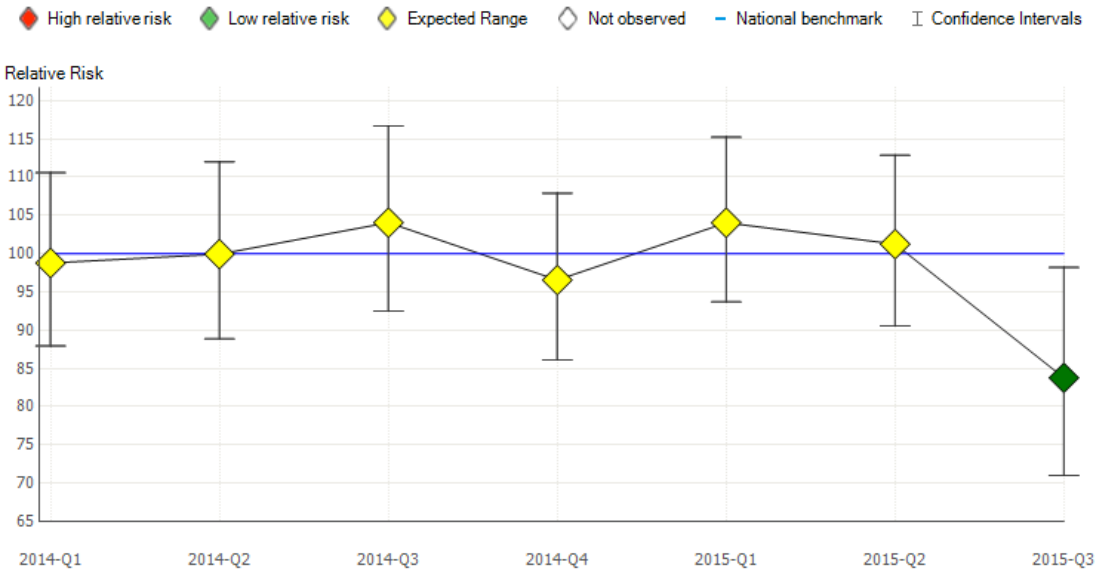
The average HSMR for all UK hospitals is a rate of 100. A rate above 100 with a *high relative risk* may signify a concern and needs to be investigated.

HSMR from Jan 14 – Aug 15



Our latest data point, August, is showing a low relative risk of 84.19, and the long term trend for all the data points (as above) are within the expected range

The next chart highlights Trend by Quarter, specifically Quarter 1 2014 to Q3 2015 using the 2014/15 baseline data set



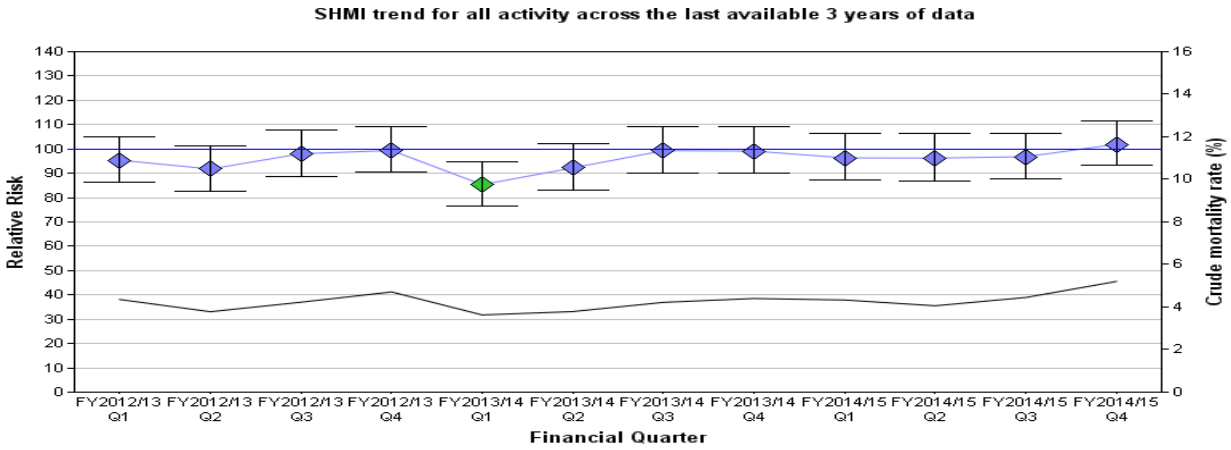
The run chart demonstrates the data points are within the expected range.

2. Summary Hospital Mortality Index

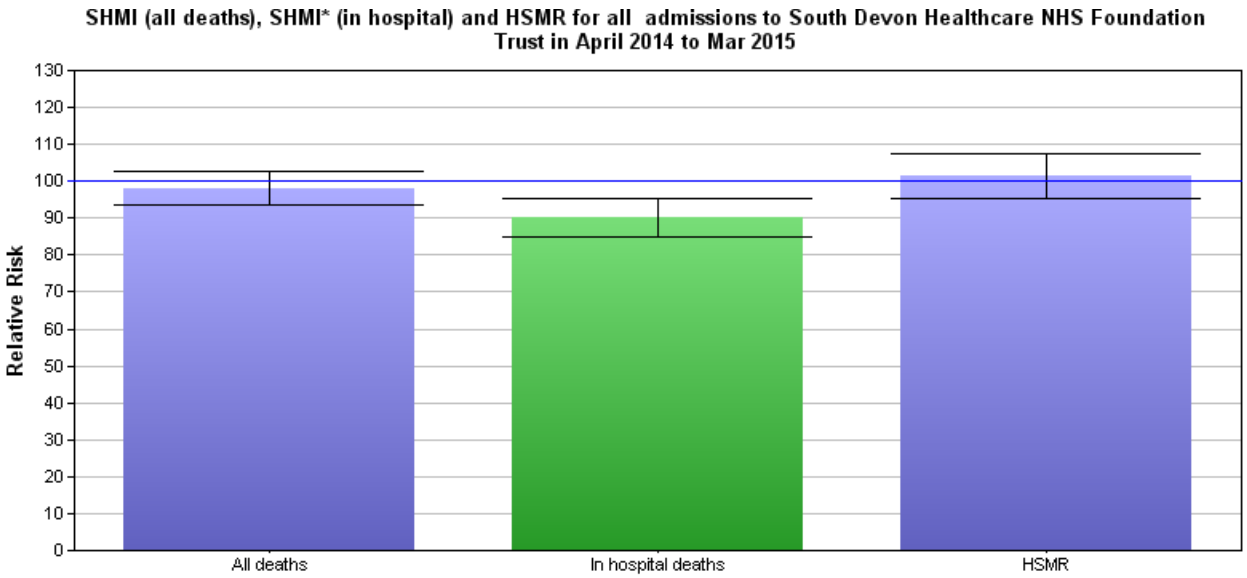
The Department of Health's Summary Hospital Mortality Index (SHMI) is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is retrospective; therefore, please note *the following data is from April 2014 - Mar 2015*

The latest released data sets are as below; **please note** these data periods will be different from the dates used on Dr Foster's HSMR.

The first chart highlights SHMI by quarter, again with all data points within the expected range

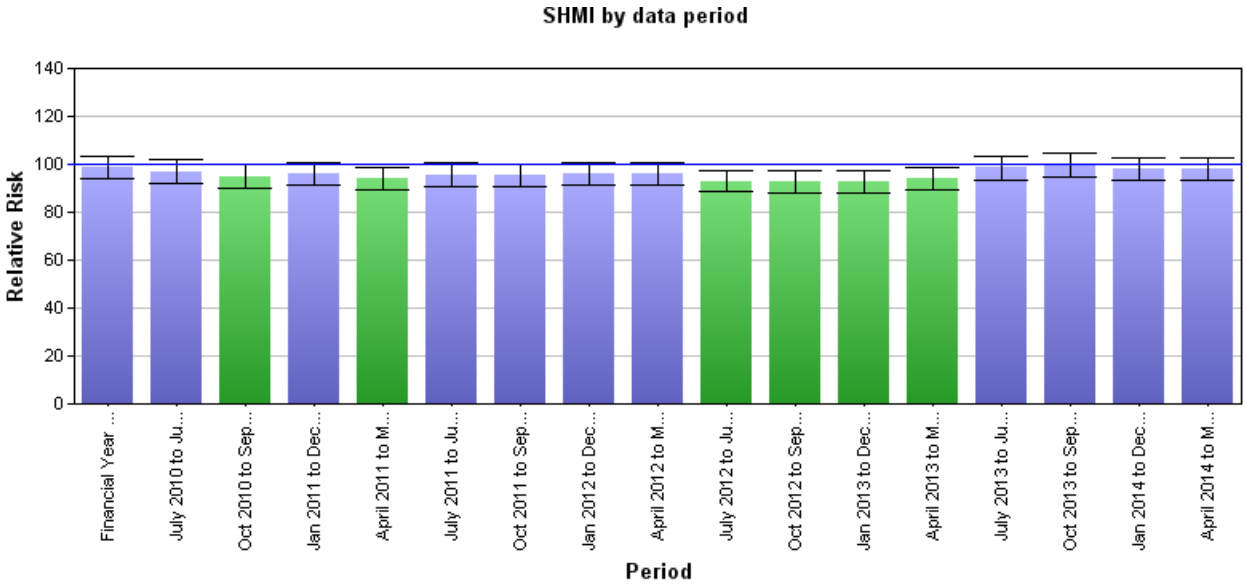


SHMI all deaths, SHMI in hospital deaths and HSMR



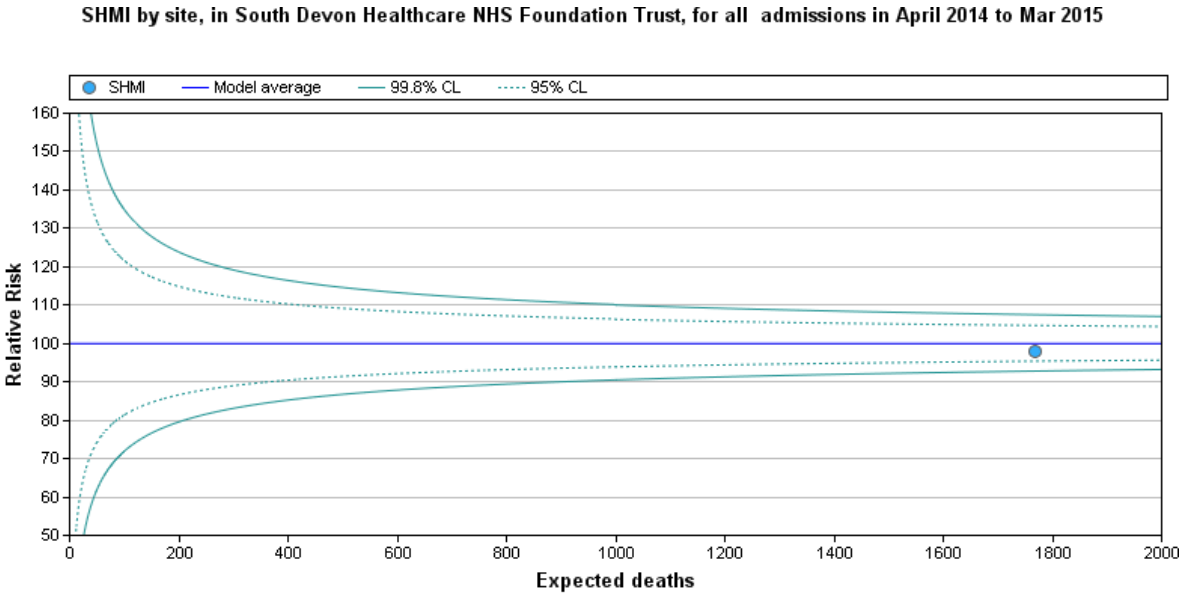
The above chart records all SHMI deaths, deaths in hospital as well as a comparison with HSMR for the time period April 2014 – Mar 2015. All are within expected range and with the in-hospital deaths at a low relative risk.

The following chart records SHMI by a range of data periods

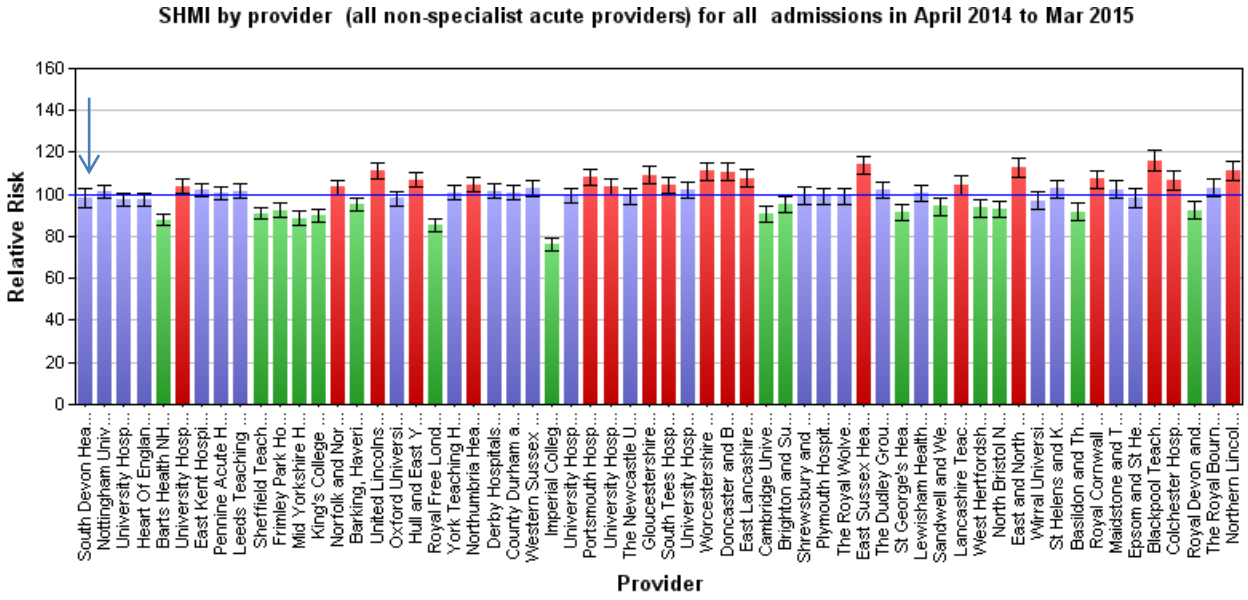


This chart (above) allows a look back at SHMI by quarter, showing mortality as being consistently below the 100 average over a 4 year period.

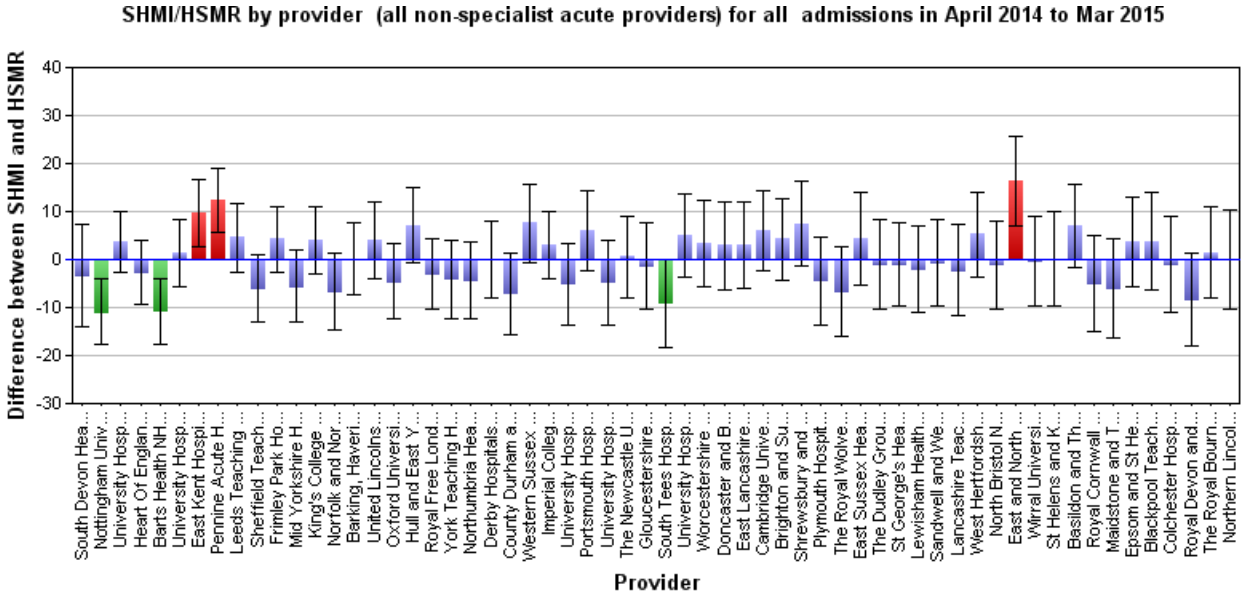
The third chart (as below) plots the SHMI mortality for the time period April 2014 - Mar 2015 against expected deaths, again showing SDHCFT performing within the expected range.



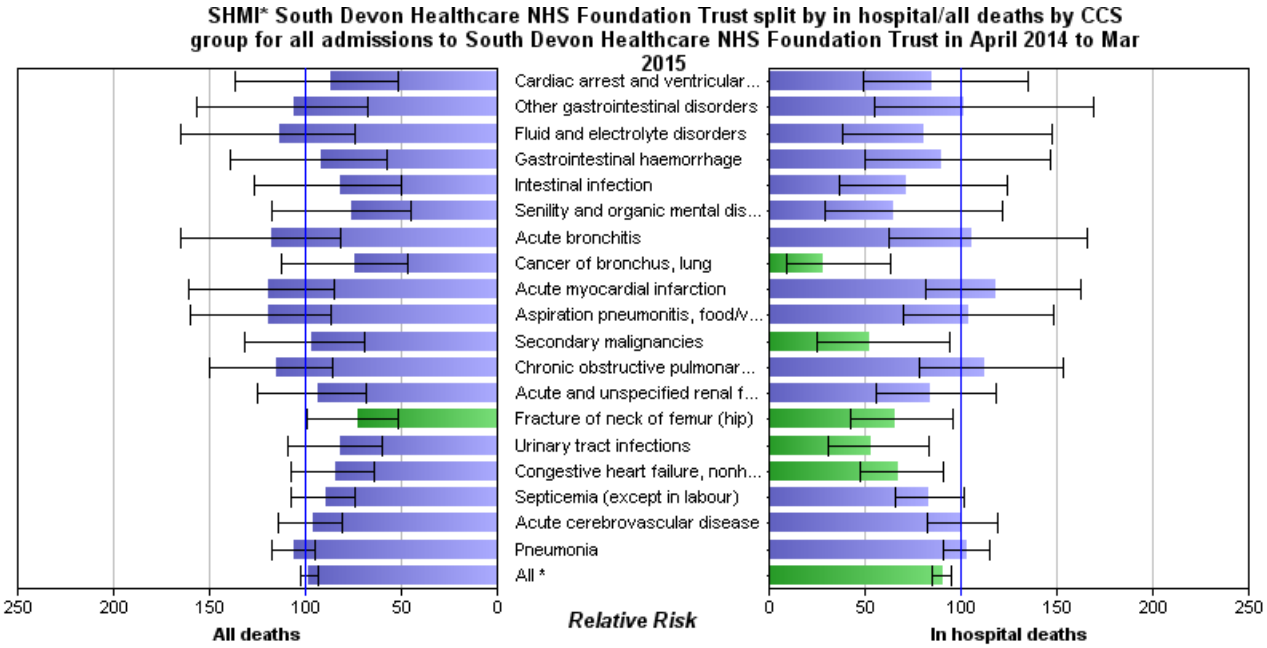
The next chart highlights the position of similar sized trusts within England for the period April 2014 – Mar 2015 and allows a comparison against these organisations.



The penultimate chart displays the differential +/- between the two different classification systems for mortality, i.e. HSMI and HSMR. SDHCFT's differential is very minor when compared across the other non-specialist acute provider organisations. SDHCFT's shows little variation between the two which is the preferred position.



The final chart allows a comparison of the mortality clinical classification software (CCS) groups for in hospital and all deaths (i.e. within 30 days post discharge). None are flagging red and all are within normal limits or green, performing better than the norm.



Appendix 2
Unadjusted death rate (%) (SPI AH02)

Percentage Unadjusted Mortality (UM)

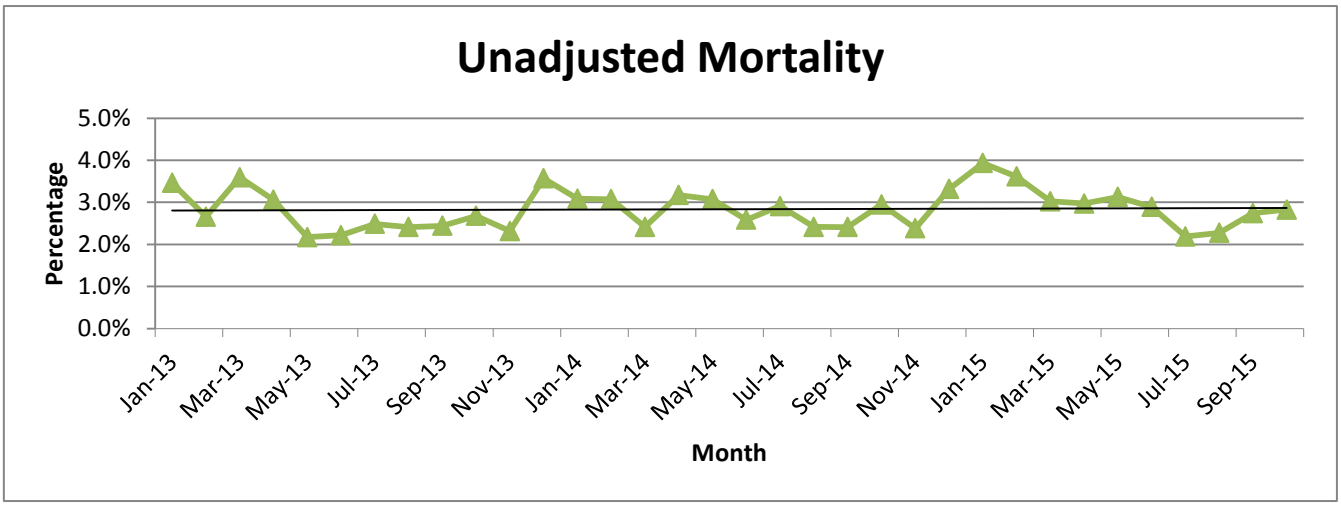
This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).

Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).

Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

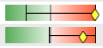
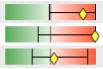
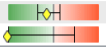
The unadjusted mortality has to be viewed along with the more in-depth analysis provided by HSMR and SHMI.



The winter period recorded a rise in the number of deaths, particularly in Jan 15 and then has returned to its normal variance. The winter hasn't transposed over negatively into the HSMR, which is remaining within normal limits. More data points will need to be observed looking for any trend or shift in the data.

Appendix 3
Dr Foster Patient Safety Dashboard

These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which is based on procedure codes used in the NHS.

Indicator	Volume	Observed	Expected	Observed Rate/K	Expected Rate/K	Relative Risk	
Deaths in low-risk diagnosis groups*	26,314	22	16.0	0.8	0.6	138	
Decubitus Ulcer	7,291	323	350.8	44.3	48.1	92	
Deaths after Surgery	430	36	36.5	83.7	84.8	99	
Infections associated with central line*	11,698	1	0.6	0.1	0.1	161	
Postoperative hip fracture*	21,099	3	1.3	0.1	0.1	229	
Postoperative Haemorrhage or Haematoma	18,680	15	8.6	0.8	0.5	175	
Postoperative Physiologic and Metabolic Derangement*	16,037	4	1.5	0.2	0.1	271	
Postoperative respiratory failure	14,706	14	12.7	1.0	0.9	110	
Postoperative pulmonary embolism or deep vein thrombosis	18,854	34	37.4	1.8	2.0	91	
Postoperative sepsis	539	10	4.4	18.6	8.3	225	
Postoperative wound dehiscence*	756	0	0.7	0.0	0.9	0	
Accidental puncture or laceration	58,883	64	71.4	1.1	1.2	90	
Obstetric trauma - vaginal delivery with instrument*	265	21	22.2	79.2	84.0	94	
Obstetric trauma - vaginal delivery without instrument*	1,334	47	53.5	35.2	40.1	88	
Obstetric trauma - caesarean delivery*	590	0	2.5	0.0	4.2	0	

* For Indicators marked with an asterisk expected values are derived from the national average crude rate and are not casemix adjusted

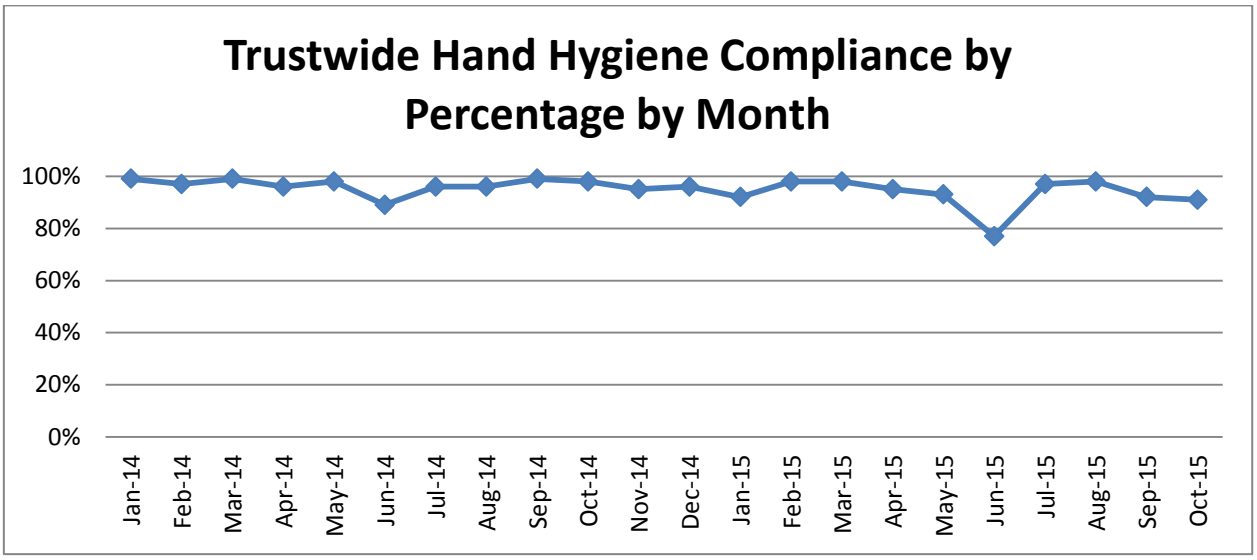
Of the 15 indicators above, the relative risks of post-operative sepsis is currently flagging outside of the expected norm. This was investigated and a verbal report presented to Quality Improvement Group in on 8th December 2015. The numbers in this cohort were small; the expected number was 4 and observed was 10. When notes were reviewed 4 patients had been coded incorrectly and when this was taken into account the risk was back within the expected range. Continued close monitoring will be performed.

Appendix 4
Hand washing compliance

Determine the numerator: the total number of patient encounters in the sample where appropriate hand hygiene was conducted.

Determine the denominator: the total number of patients in the sample.

Calculate the percent compliance with hand hygiene by dividing the numerator by the denominator and then multiplying the resulting proportion by 100.

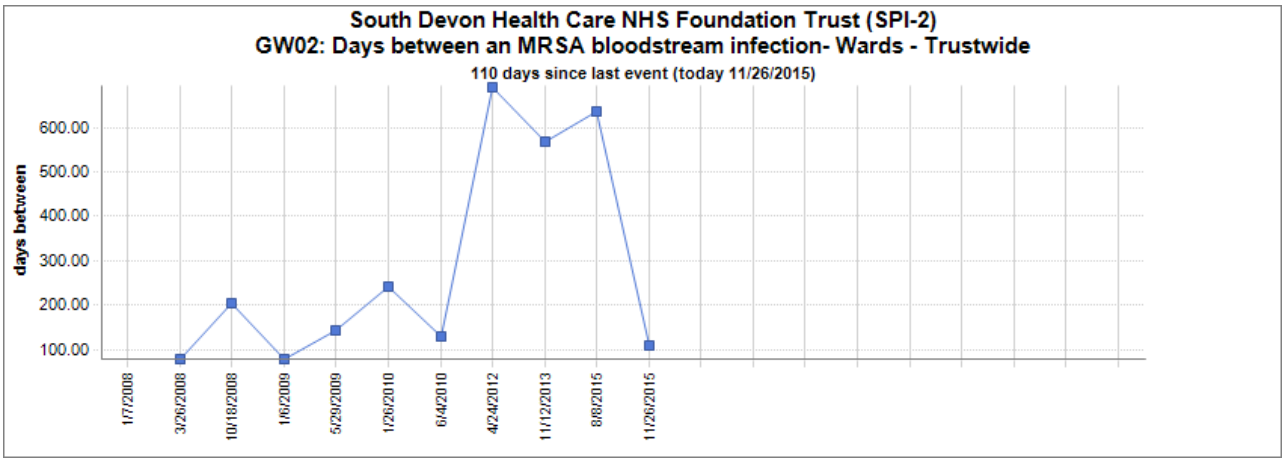


Commentary

Maintaining awareness of this important aspect of good infection control practice is crucial. Education is ongoing from Infection Control using the WHO Five Moments and posters highlighting the five moments for hygiene have been displayed around the hospital. All audit results are shared with the area at the time of the audit and any issues discussed. Any recommendations from the Peer Review on this area of practice will be actioned.

Appendix 5

Days between an MRSA bacteraemia (SPI)



This measure is a cumulative count of the number of days that have gone by with no in hospital MRSA bacteraemia being reported.

Every time an MRSA bacteraemia occurs the count is started over again.

The current count stands at 110 days. The longest count has stood at 633 days.

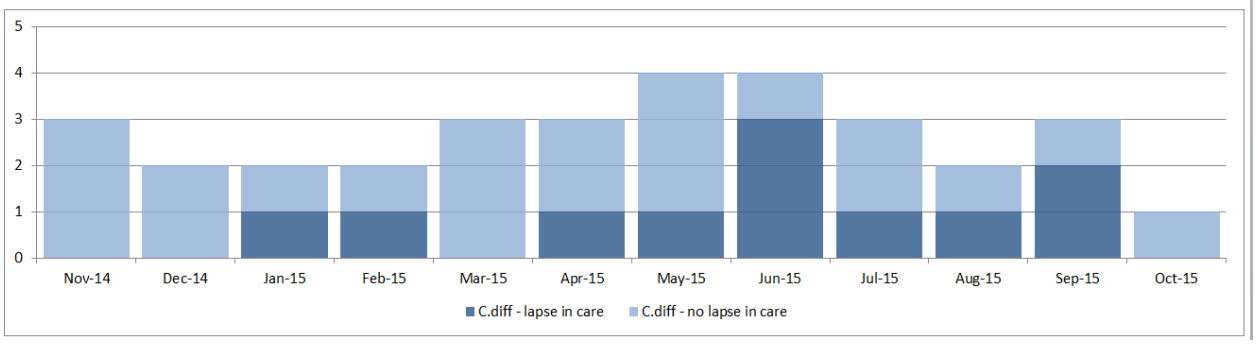
This reflects the national reduction in MRSA bacteraemia.

Appendix 6
Clostridium Difficile toxin detection rate
(Number of new infections -Trust data)

This chart highlights the number of confirmed CDT case each month and is expressed as a number in this chart.

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



Commentary

All CDiff cases are subjected to a root cause analysis and presented at the Serious Adverse Events (SAE) Group.

The infection control team when analysing the investigations also now code each case into *lapse of care* or *no lapse of care* and this is identifiable on the chart.

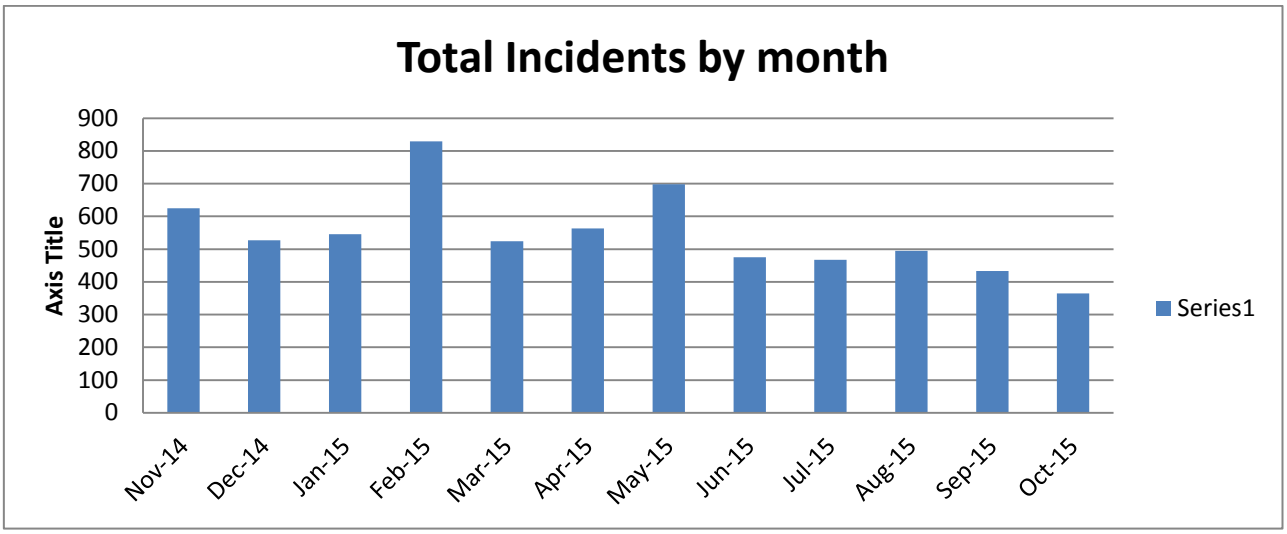
The Peer Review will inform any necessary actions in relation to this level of incidence.

Appendix 7
Total Number of Trust Wide Patient Incidents by Month

This metric is a simple count of the number of incidents reported by month.
An organisation with a healthy safety culture encourages incident reporting and uses this data to target safety improvements within its various governance structures.

SDHCFT's reporting is remaining in a healthy position. The last data month is prone to data lag.

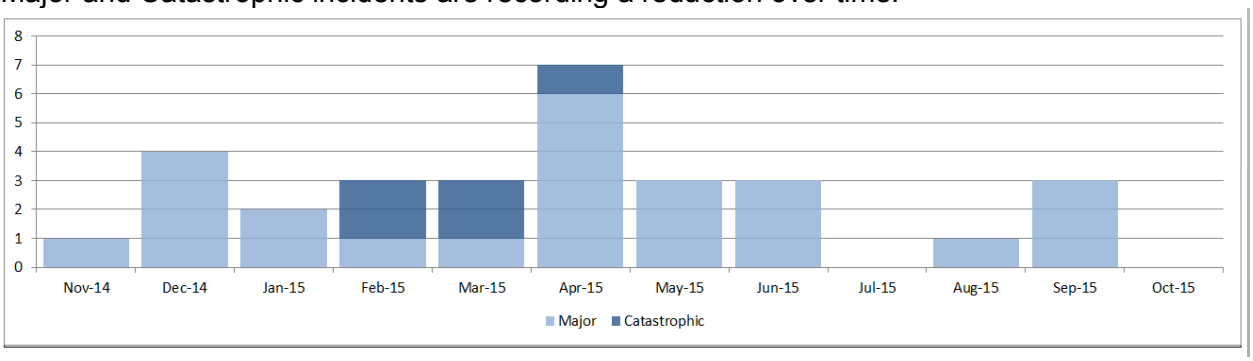
In February and May, Pharmacy recorded any intervention led or undertaken by them when dealing with medications or prescriptions. This was done to create a reliable baseline to aid their improvement work, hence the data spikes.



A detailed investigation of medication incidents has been undertaken by the Clinical Director of Pharmacy and will be presented at Quality Improvement Group and Quality Assurance Committee in February 2016.

Appendix 8
The total number of Moderate Major and Catastrophic incidents reported by month through the Safeguard Incident reporting system

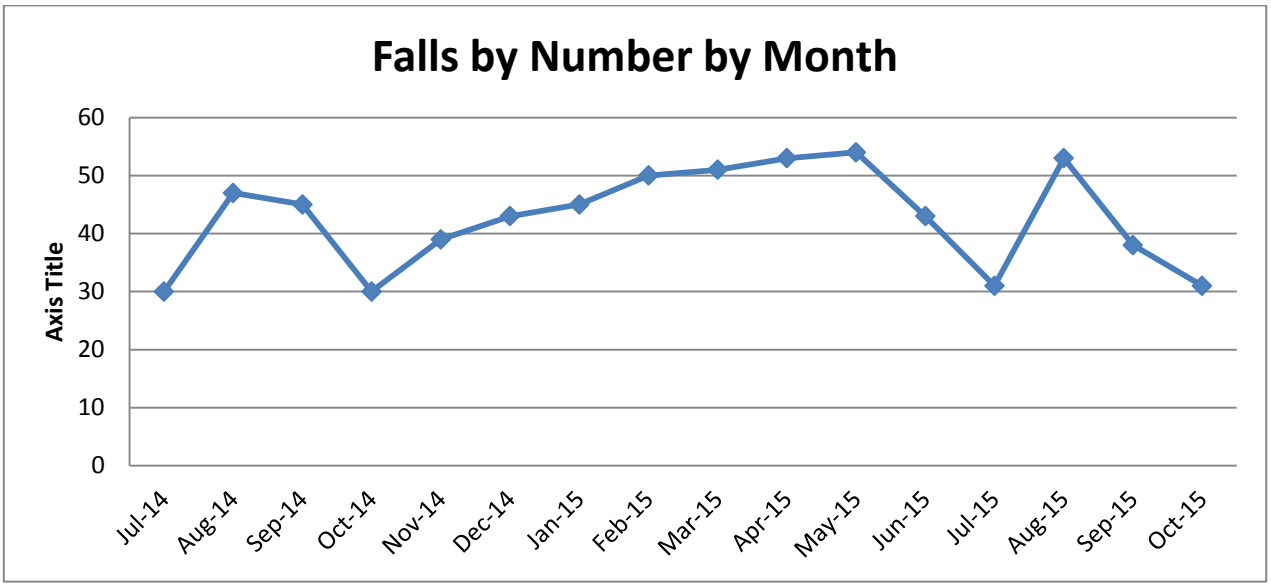
Major and Catastrophic incidents are recording a reduction over time.



All major and catastrophic incidents are presented to the Serious Adverse Events Group, complete with an investigation, root cause analysis and action plan, which is logged and monitored. Major incidents are infrequent and there are no trends discernible.

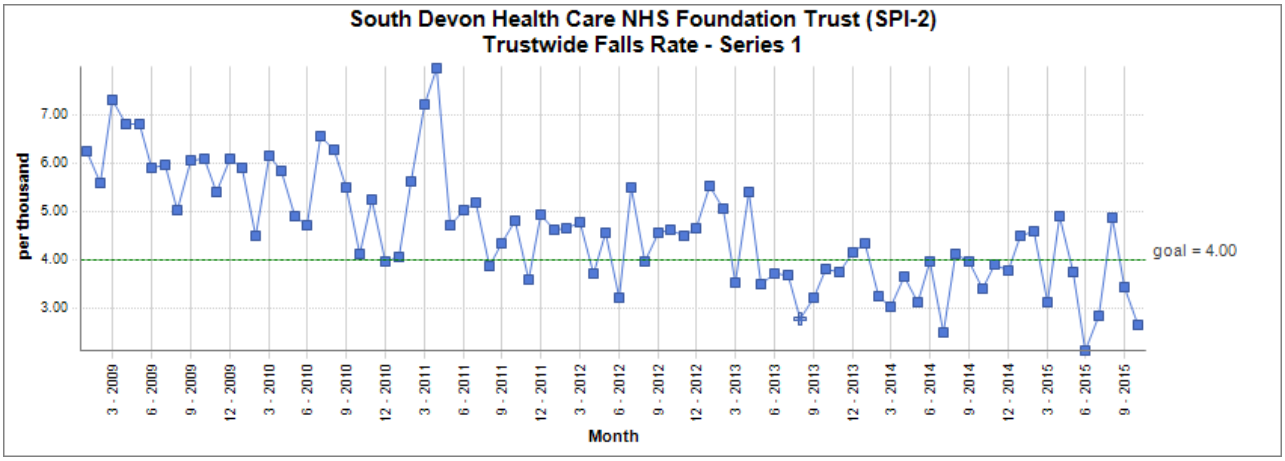
Appendix 9
In Hospital Falls

The below charts record the in-hospital falls number, rate and harm rate

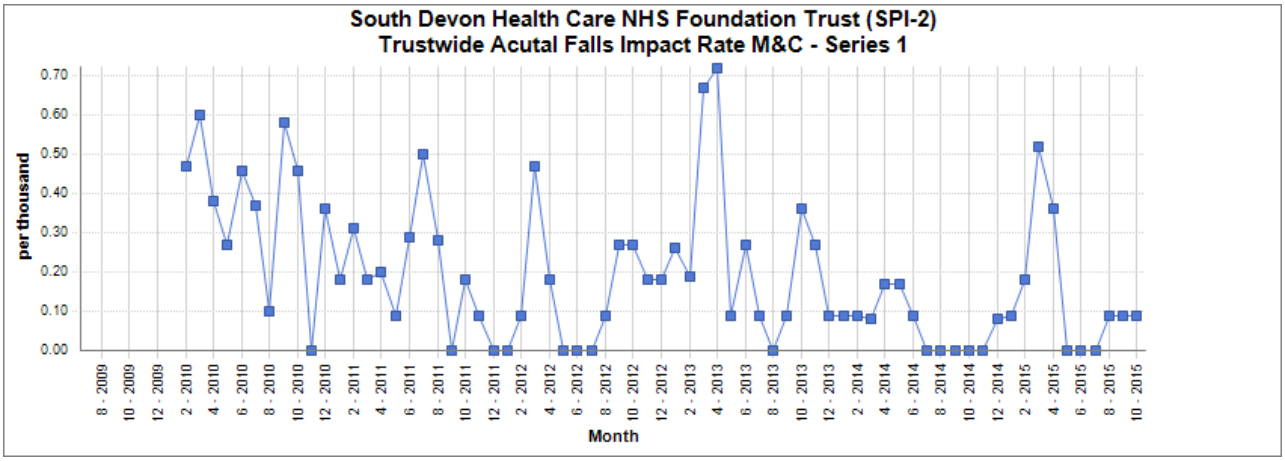


The above chart indicates a trend in the data, i.e. 5 data points consecutively rising and this non-random pattern needs to be observed and understood. A report has previously been sent to the Patient Safety Committee and presentation given to SMG. The latest data points are downwards and this needs to be observed over time.

The falls rate per 1000 occupied bed days reflects the above trend but has recently reduced below the target rate



The final chart records the harm rate as expressed per thousand occupied bed days which for the last two data points is recording a low rate after rising over the winter Q4 period.



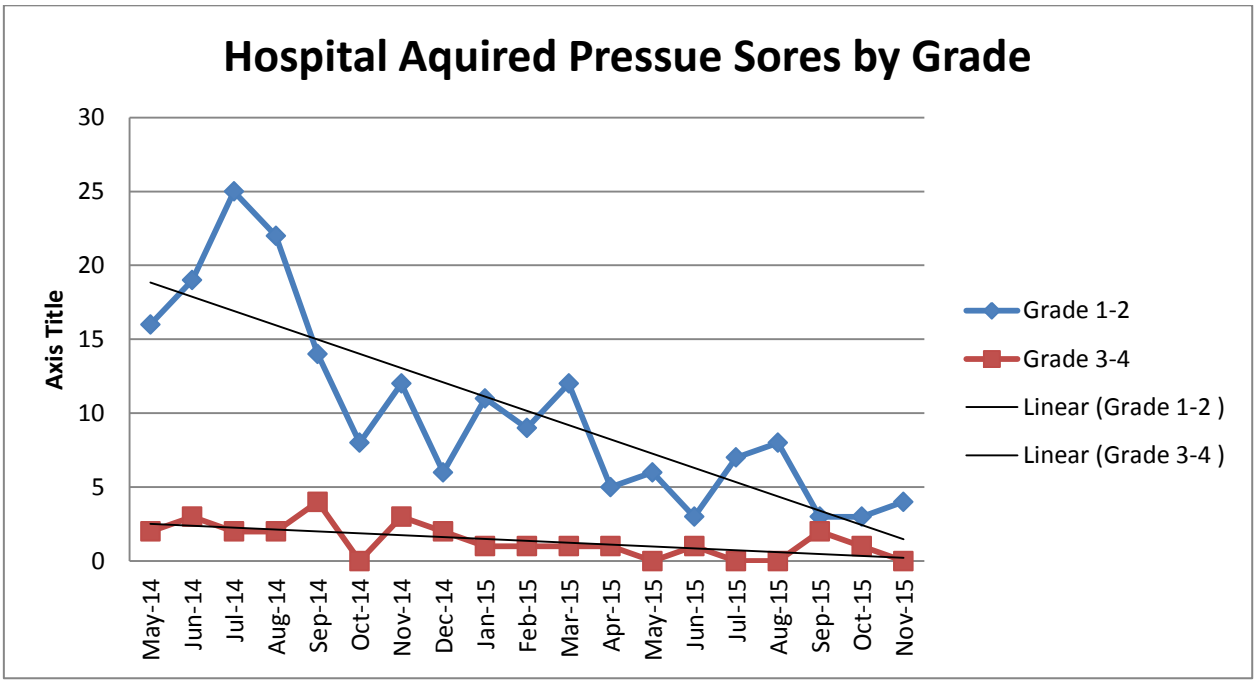
The falls committee reviews this data, agree actions and monitors compliance on a quarterly basis.

Appendix 10
Pressure Ulcers

The prevention of avoidable pressure ulcers (PU) is a key priority for the Trust and the measurement is based on the reduction in numbers of patients who develop a Grade 2, 3 or 4 PU during an inpatient stay. All pressure ulcers are graded based on the categories as outlined by the European Pressure Ulcer Scale.

The Trust has actively been encouraging the reporting of all pressure ulcers that occur. Historically Grade 1 and Grade 2 pressure ulcers may not have been accurately reported and through educational work and the use of pictorial grading guides, reporting has improved. It is essential to gain an accurate picture of PU prevalence in order to take effective action to eradicate them from our health system.

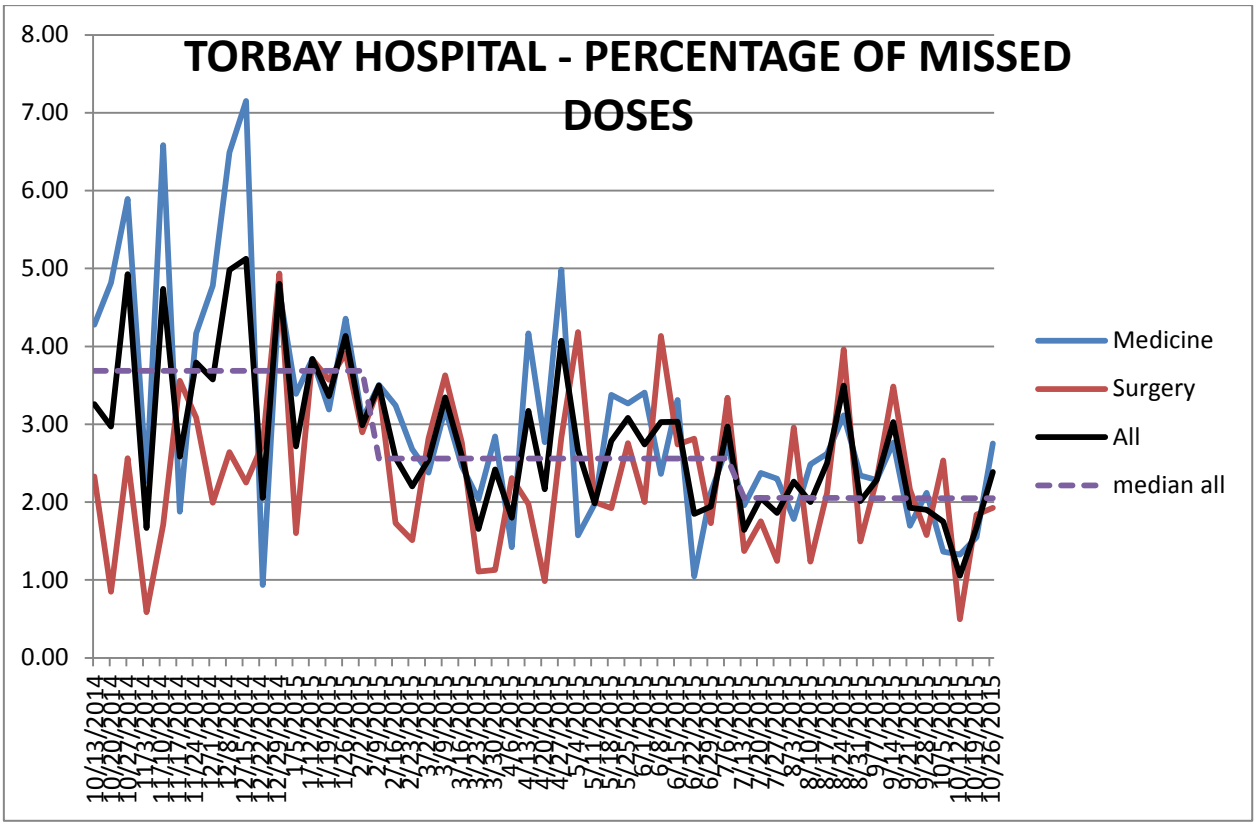
The more serious Grade 3 – 4 pressure ulcers, whilst historically low have recorded zero for the past quarter. Much work is being undertaken in the Pressure Ulcer Prevention (PUP) project which is now being rolled out to other wards under a buddy system; a ward that has been through the programme helps the new ward implement the bundle measures and improvement tools.



This reduction in Grade 3 - 4 is also replicated in the reported Grade 1 -2 pressure ulcers and this trend then being seen Trustwide which is to be encouraged.

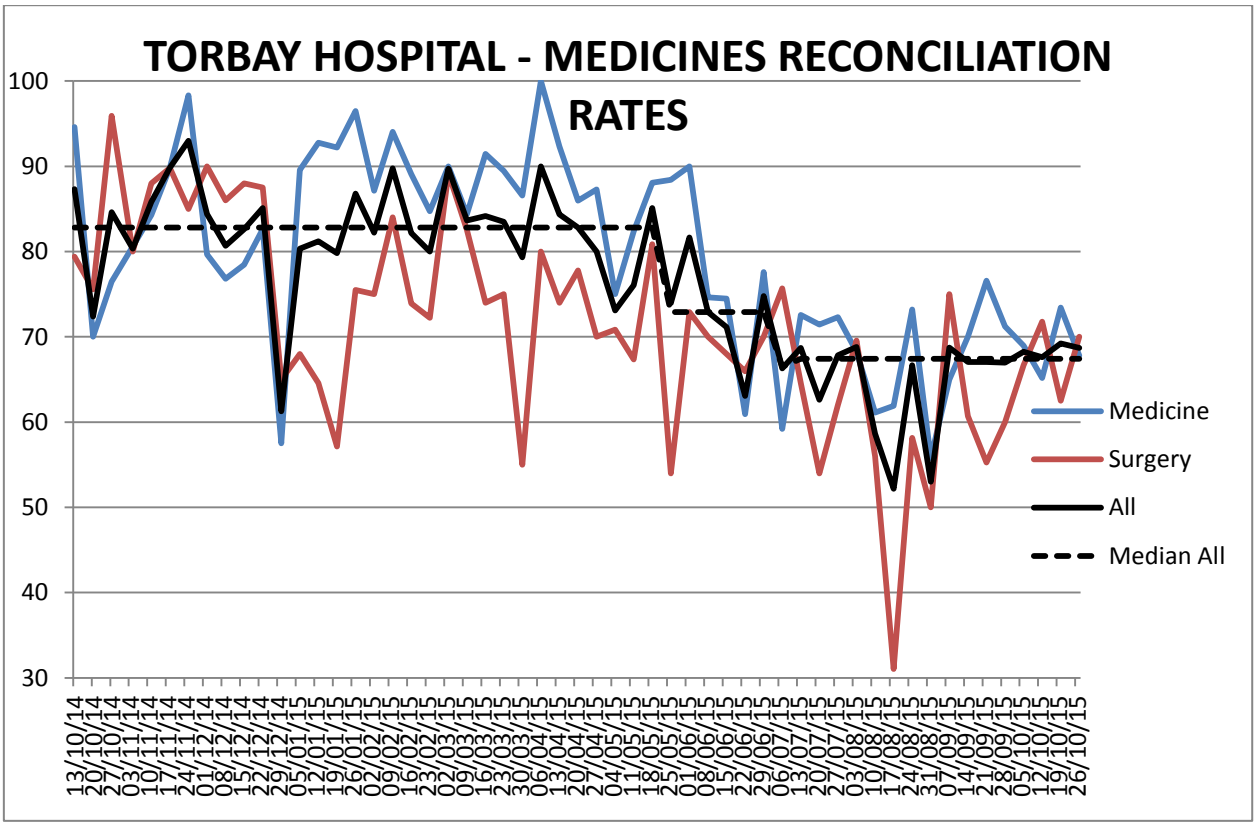
Appendix 11
Medication Missed Doses

These data are collected from a review of a random selection of ten charts performed by a pharmacist on every ward in the hospital. The pharmacist counts the number of prescribed medications and notes in a 24 hour period how many missed doses have occurred, thus producing a percentage compliance figure.



The aim is for 95 % compliance or less than a 5% failure rate. Progress to date has been encouraging, and maintained. Current performance is stable at 2% which compares well with peer organisations.

The penultimate chart highlights Trustwide medicines reconciliation, i.e. the process of obtaining an up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes deletions and additions.

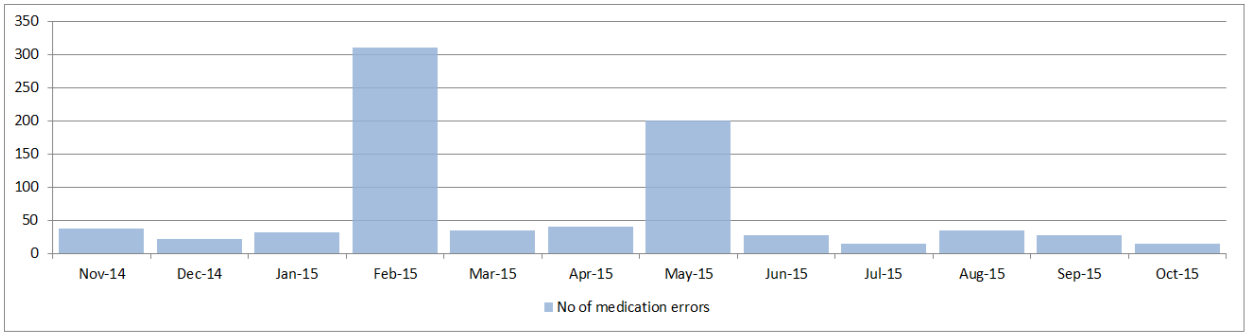


The meds reconciliation figure has decreased from a relatively high position due to a change in the data gathering methodology. Pharmacy, to ensure enhanced compliance, are now applying the Meds Rec within 24 hours of hospital admission to all weekend admissions. This has resulted in the change and improvement work in is progress to return the process to a 95+ reliability level.

The final chart records medication incidents from the incident reporting system by number. The two data spikes are from a pharmacy data gathering exercise using the incident system to as a means to capture data

Medication errors - Trust Total

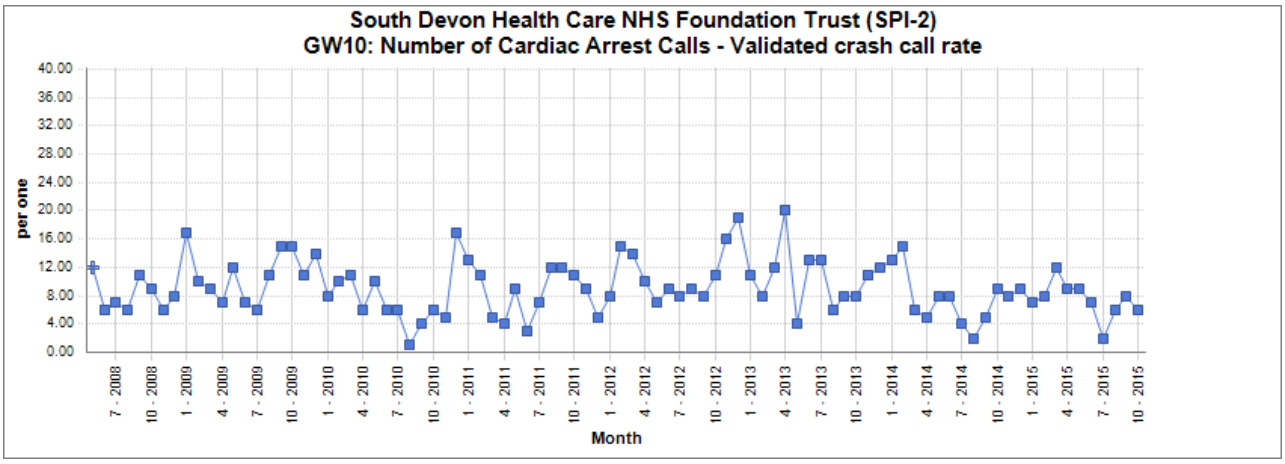
	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
No of medication errors	38	22	32	310	34	40	201	27	15	34	28	15



Appendix 12
Cardiac Arrest Calls

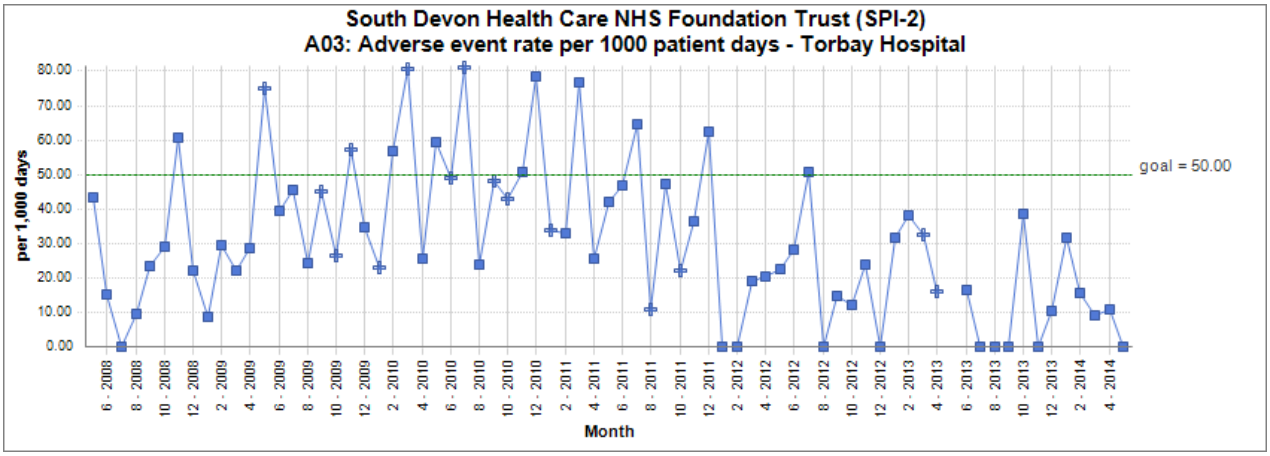
The data is generated from the number of cardiac arrest calls made each month and as reliability is sustained with accurately completed patient observation charts and supported by calls to the ICU outreach team the number of cardiac arrests should fall.

Cardiac Arrest Calls by Month



The Resus team are working to reduce the number of Pulseless Electrical Activity (PEA) arrests and a new review proforma is being tested to help achieve this. Cardiac arrests continue to trend downwards.

Appendix 12
Adverse event rate per 10000 bed days measured using the Global Trigger Tool (GTT)



Commentary

This measure is obtained from reviews of random clinical records performed using the global trigger tool by a team of experienced reviewers. The tool is a tried and tested means of looking for adverse events that may have occurred during an inpatient stay that might contribute to patient harm. A low rate is good and we have set ourselves a best in class target of less than 50 as a goal. Since August 2012 we have achieved levels of harm below that target level.
The majority of harm found (since 2008) using the GTT is of a temporary nature, recorded in categories E and F (Legend as below).

Cumulative Event Description and Severity Totals	E	F	G	H	I	Tot
	60	22	1	0	0	84

Legend Category Codes E - I

E Contributed or resulted in temporary harm to the patient & required intervention

F Contributed or resulted in temporary harm to the patient & required initial or prolonged hospitalisation

G Contributed or resulted in permanent harm

H Required intervention to sustain life

I Contributed to patients death

The most frequently occurring harm event, since 2008, are in the E category and are re-admissions. These currently numbering 41 of the 84 recorded events; pressure ulcers have recorded 5 and falls 7. This will now be audited on a 3 monthly basis starting again in Dec 2015 and will audit from April 2015.

Appendix 14
Department of Health's (DH) Safety Thermometer

The NHS Safety Thermometer (ST) is a tool used for measuring patient safety and was developed by the NHS Information Centre (NHS IC).

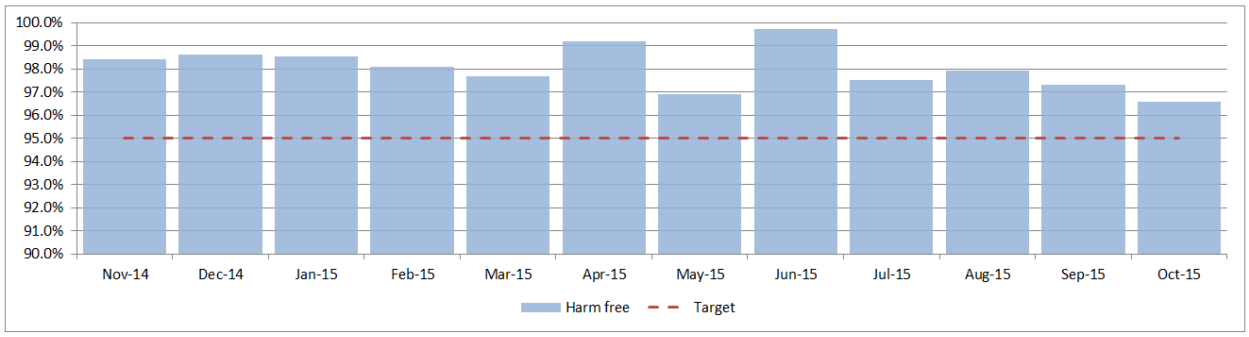
The ST provides a quick and simple method for surveying patient harms under the four headings of falls, catheter infections, pressure ulcers and venous thromboembolic events (VTE).

All patients are surveyed on *one* specific day every month and the data records if any harm, as outlined above, has occurred. The audit, therefore, provides a score for the hospital based on harm free care.

The Trust's percentage of patient harm free care has remained constantly high and stable. Data to September 2015 is for SDHFT. The latest month, is for the new organisation hence the increase in patients sampled. Total harm free is running at 96.6%

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	985
New harms	6	5	6	7	9	3	11	1	9	7	10	34
Harm free	98.4%	98.6%	98.5%	98.1%	97.7%	99.2%	96.9%	99.7%	97.5%	97.9%	97.3%	96.6%
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%



Appendix 15
Never Events List 2015/16

A Never Event (NE) as defined by the National Patient Safety Agency (NPSA 2010) as a 'serious, largely preventable patient safety incident that should not occur if the available preventable measures had been implemented by healthcare providers'.

The below are the latest Department of Health's (DH) expanded 'Never Event' list. The list has now been decreased from 25 to 14 events, one of which is only applicable to Mental Health Trusts.

In 2015 the Trust has recorded four such events, two in Ophthalmology, one in Obstetrics and one in Theatre; in all cases the patients did not suffer any immediate physical harm and investigations and changes have been implemented.

Data Jan 2015 – 5th Nov 2015 source Safeguard

	Description	
1.	Wrong site surgery	1
2.	Wrong implant / prosthesis	1
3.	Retained foreign object post-operation	2
4.	Death or severe harm as a result of wrongly prepared high-risk injectable medication	0
5.	Death or severe harm as a result of maladministration of potassium-containing solutions	0
6.	Wrong route administration of chemotherapy	0
7.	Death or severe harm as a result of wrong route administration of oral/enteral treatment	0
8.	Death or severe harm as a result of intravenous administration of epidural medication	0
9.	Death or severe harm as a result of maladministration of insulin	0
10.	Death or severe harm as a result of overdose of midazolam during conscious sedation	0
11.	Death or severe harm as a result of opioid overdose of an opioid-naïve patient	0
12.	Inappropriate administration of daily oral methotrexate	0
13.	Suicide using non-collapsible rails - Mental Health Trusts Only	0
14.	Escape of a transferred prisoner - Mental Health Trusts Only	0
15.	Death or severe harm as a result of a fall from an unrestricted window	0
16.	Death or severe harm as a result of entrapment in bedrails	0
17.	Death or severe harm as a result of the inadvertent transfusion of ABO-incompatible blood components	0
18.	Death or severe harm as a result of inadvertent transplantation of ABO or HLA-incompatible	0

	organs	
19.	Death or severe harm as a result of a misplaced naso- or oro-gastric tube	0
20.	Death or severe harm as a result of the administration of the wrong gas	0
21.	Death or severe harm as a result of failure to monitor and respond to oxygen saturation	0
22.	Death or severe harm as a result of intravascular air embolism	0
23.	Death or severe harm as a result of misidentification of patient	0
24.	Death or severe harm as a result of a patient being scalded	0
25.	Maternal death due to post-partum haemorrhage after elective caesarean section	0

CEO BOARD REPORT - February 2016
Internal

Progressing the Planning Guidance for 16/17
Following the discussions at the Board to Board meeting with the CCG, the Executive Team have continued to work with the CCG to agree the Service Transformation Plan footprint required to be submitted by 29 January 2016. At the System Resilience Group in January, agreement was reached with other partners to submit a response reflecting the following consensus:

That the footprint for the majority of services should be the population of Torbay and South Devon, reflecting our focus on integration of local health and social care provision, but that for very specialist services a larger population footprint was appropriate and that the CCG and providers within TSD would participate at that larger population level to ensure effective service configuration of very specialist services.

A further opportunity was identified in the Planning Guidance, inviting expressions of interest in trialling the reinvention of the acute medical model in small district general hospitals. We will be submitting an expression of interest by 29th January 2016.

Emergency Department Performance
On Monday 11 January the Trust recorded performance for the day of 55 per cent. This was flagged by Monitor as the worst performance of all acute Trusts in England. In response to this Monitor contacted the Chief Operating Officer asking for a written response to a series of questions to inform a discussion with the Monitor Senior Team and a routine performance review conference call with the Department of Health. The written response was submitted on Wednesday 13 January and was followed up by a phone call with the Regional Director and her team on Thursday 14 January. The written response is attached for your information.

Performance improved in week from the dip on Monday 11 with performance on Tuesday 12 standing at 82 per cent and 97.7 per cent on Wednesday 14 January 2016. This in part reflected the consultant level presence on the wards on the day of the Junior Doctor strike (12 January) which resulted in 'earlier in the day' decision making and a reduction in the number of patients in hospital over 10 days. A joint letter from the myself, the Medical Director, Chief Nurse and Chief Operating Officer was issued to all staff to thank them for their efforts on the day of the strike and to encourage them to share their views and learning for improvement from their experience. The Medical Director is leading this work, and a number of priority actions were agreed at the January Flow Board. Unfortunately the improvement has not been sustained due to bed pressures and the January average performance remains below 80 per cent at the date of writing this report.

We have submitted an action plan to Monitor and NHS England and a meeting is arranged with them and the CCG on Friday 29 January to provide further assurance of the actions we are taking to improve flow throughout our hospital and beyond, across the whole health and care system.

National Issues – Could it happen here?
A recently published report into the tragic death of a one-year old child in Cornwall in December 2014 from sepsis has once again raised questions around training and awareness in the diagnosis and treatment of this life-threatening condition. Sadly, this case is similar to the death of Sam Morrish who died at Torbay Hospital in 2010.

Several learning reviews were undertaken and an ombudsman investigation highlighted failings across the whole health system. As a result, the Trust took part in a substantial learning and awareness campaign led by NHS England during 2014. This included piloting a revised clinical tool and reinforcing the importance of the 'golden hour' for commencing treatment of sepsis. We are awaiting a further Ombudsman's report on the management of the family's complaint.

Vanguard funding for current financial year

The joint work undertaken across our health and social care community to develop our Urgent and Emergency Care Vanguard new care model has been rewarded with news this week of more than £1million national funding to the CCG in the current financial year.

This money will be used by the CCG to accelerate the Vanguard programme and follows our pre- Christmas bid for funds to support the five core workstreams: self-care; 111 and integrated urgent care services; urgent care centres; shared records; and mental health support across all aspects of the Vanguard. In line with our urgent care strategy, the Vanguard's vision is that "people with urgent but non-life-threatening needs will be treated by a highly responsive service, as close to home as possible, allowing emergency departments to concentrate on serious and life-threatening conditions to maximise chance of patient survival and recovery".

In addition to receiving this funding boost, the CCG led draft bid for funding for the next financial year, submitted earlier this month, has been praised for its clarity in setting out what we are doing, how we going to do it, what it will cost and how it maps to national strategies. Further work is taking place to refine our bid ahead of the 8 February deadline for final submission, and it is anticipated we will get more Vanguard funding for next year.

Delivering the right quality outcomes within the resources available

The NHS Improvement organisation and the Care Quality Commission jointly wrote to all NHS trusts to share the early outcomes of their recent discussions to identify how the two organisations can work together to support providers to deliver excellent quality and achieve financial balance. NHS Improvement and CQC have set out their strategic statement of intent which acknowledges that consistent and unified messaging, guidance and measures of success will need to be developed to support this going forward. This will include engagement with trusts through a consultation on the CQC's future strategy and a single new regulatory framework for providers.

Community Services Transformation

South Devon and Torbay Clinical Commissioning Group submitted an update about Community Services Reconfiguration to the meeting of the Devon Health and Wellbeing Scrutiny Committee on 20 January 2016. The paper summarised the engagement work carried out to date and progress in developing plans for services in future – including changes to services in Coastal Locality. Future updates will be posted at www.southdevonandtorbayccg.nhs.uk/community-health-services.

Directors and I have attended a series of local engagement events in January organised by the CCG to meet with local stakeholders and discuss the proposals for local services. Interested representatives from local councils, GPs, voluntary groups including League of Friends and Patient Participation Groups, and the wider health and social care community, as well as those who have expressed an interest in being involved attended.

Dates and locations of meetings:

	Jan 16
Ashburton	7
Bovey Tracey/Chudleigh	12
Brixham	14
Dartmouth	13
Paignton	14
Torquay	12

The feedback from this engagement will continue to inform the CCG's proposals for public consultation on the future configuration of Community Hospitals.

Care home sector

Torre House, a Torquay care home, is to close by the end of March. It currently has 18 residents and 27 staff and provides specialist residential dementia and nursing care. We are leading the project team to find alternative accommodation that provides the right care for each of the 18 residents. More strategically, we are working with Torbay Council, CCG commissioners, the independent sector residential and community providers and the local community voluntary sector to make sure we have the appropriate model of residential and nursing home care to meet our local needs. An updated Commissioner market position statement is due to be available by April 2016 which will inform this work.

Ofsted report on children's services in Torbay

On 5 January 2016, Ofsted released its report of Safeguarding and Looked after Children Services in Torbay following an inspection in October and November last year. The inspection concluded that safeguarding arrangements for children who need help and protection in Torbay are 'inadequate'. Due to this result leadership, management and governance have also been graded as 'inadequate'. Services for looked after children, adoption and care leavers have all been graded as 'requires improvement'. I have been asked to be a member of the Children's Improvement Board established to oversee the plans to address the findings of the OFSTED report. The Board has also approved a 'due diligence' joint process with Torbay Council to assess the appropriateness of integrating children's services within our Trust, and inspectors felt that this would provide a potential long term and robust solution for children's services in Torbay. Department for Education (DfE) has appointed a Commissioner to stress test this process. I have had initial contact with the Commissioner who has advised that he will be producing a report on the due diligence process by early May for submission to DfE.

National accreditation for Endoscopy

The Trust's endoscopy service has been fully accredited by JAG (Joint Advisory Group in GI Endoscopy) for reaching and maintaining a number of national standards. JAG is an independent national assessor of endoscopy units and shares information with the CQC on areas including clinical quality, patient experience and workforce training.

The service provided by the endoscopy team has continued to develop, with a particular emphasis on improving privacy and dignity; public and patient areas now clearly separated, additional discharge rooms for private conversations and more toilet facilities. Patients have a greater choice over appointment times through the

introduction of a new booking process and the pre-assessment service has been streamlined with the majority of appointments now done via telephone.

This success is the result of the clinical, administrative and managerial teams working closely together to improve the Endoscopy service for patients. On behalf of the Board, I would like to congratulate all involved on this wonderful achievement.

Chief Executive Leadership Visibility

Internal	External
Community Palliative Care Team ED Consultant Meeting Palliative Care Acute Team Bereavement Team Obstetrics & Gynaecology Team Meeting Baytree House Staff Side Medicine CD Team Meeting ENT CD Team Meeting John Parkes Unit	Cllr Jackie Stockman Mr Geoff Walker, St Kilda's Visit to St Kilda's to meet staff Dartmouth Stakeholder Engagement Meeting SW Chief Executives Chief Executive HealthWatch Devon Judith Dean – Success Regime Lead, NEW Devon South Devon and Torbay LMC Cllr Nick Bye, Torbay Council Ageing Well Programme Board Children's Improvement Board Paignton Hospital for LoF CCU Cheque Presentation Chair Brixham Hospital LoF

Media highlights

- Publication of the final issue of our six week series with the **Herald Express** setting out the difference our integrated care organisation will make
- **Radio One**'s **Newsbeat** programme followed one of our junior doctors on shift in ED over a busy weekend
- **Devon Life** ran a feature on our ED consultant, Chris Manlow
- Our initiative to provide free parking for carers was featured on BBC One's **The One Show**
- Jane Gidman, Lead for Non-Medical Workforce Professional Development, and Assistant Nursing Practitioner Nadine Wills were interviewed about our innovative assistant practitioner scheme for **The Guardian** nursing supplement (due out 24/02/16)
- Our **Weekend Diagnosis** column in the Herald Express highlighted the positive feedback we received in the national maternity services report.

External

New Chair of South West Academic Health Science Network (SW AHSN)

Dr Alastair Riddell has joined the South West Academic Health Science Network (SW AHSN) as permanent Chair of the Board of Directors. Alastair is a medical doctor and brings over 30 years' experience in the pharmaceutical, life science and biotech industries as a corporate leader, researcher and entrepreneur. He is currently on the Board of three biotechnology companies based in the USA and Netherlands all concerned with drug development. He has previously been CEO and Chairman of successful spin outs from Oxford and Cambridge Universities after years of directing clinical trials of novel drugs for serious hospital based illnesses.

Outgoing interim Chair, Richard Devereux Phillips is to stay on as a Non-Executive Member of the Board of the SW AHSN at Alastair's request.

Devon Studio School league tables
Devon Studio School has been ranked 21 out of 22 schools in Torbay in national league tables published by the Department of Education this month. Only 24% of students achieved five or more GCSEs at grades A*-C. We take students on work placements and host the campus on our estate. Two of our directors are on the board of governors and will be involved in planning to tackle the challenges the school is facing.

Devon Partnership NHS Trust CQC report
The Care Quality Commission (CQC) published its report into the care and treatment provided by Devon Partnership NHS Trust on Monday 18 January 2016. Overall, the organisation's rating was 'requires improvement'. However, seventy per cent of the ratings awarded by the CQC were 'good' and one of them was 'outstanding' and DPT is confident that it has continued to make progress since the CQC visit last summer. A fuller stakeholder briefing was issued via email to board members.

LGA Corporate Peer Challenge
Torbay Council invited the Local Government Association (LGA) to carry out a Corporate Peer Challenge to explore the wide range of opportunities and significant challenges the council faces. Following the four day visit in November and December last year the independent report containing the review's findings has now been published www.torbay.gov.uk/cpc and will be presented to Full Council for consideration on Wednesday 3 February.

Positive findings were highlighted with stakeholders and partners featuring strongly in the report. It was recognised that there is "a range of existing progressive and inspiring partnerships, notably in health and social care integration" and that "admirable core values for its managerial leadership and staff" had been put in place.

There are also a number of key recommendations which include establishing joint priorities for the Bay and find the most effective ways to offer value for money services which matter the most to Torbay residents. One of the key actions is to develop and agree with key partners a long term, high level, strategic vision for Torbay for the next 20 years.

NHS Improvement
(Monitor and the NHS Trust Development Authority)

Wellington House
133-155 Waterloo Road
London
SE1 8UG

020 3747 0000

15 January 2016

Letter to: CEOs Trusts and Foundation Trusts
Finance Directors Trusts and Foundation Trusts
Medical Directors Trusts and Foundation Trusts
Directors of Nursing Trusts and Foundation Trusts

Dear Colleague,

We are all aware that the NHS, and providers specifically, have been under great pressure as we seek to improve quality outcomes for patients within the financial resources available. However, the size of this year's provider sector deficit makes it clear that, collectively, we need to focus more on financial rigour as one of the routes to excellent quality.

We recognise that both our organisations – NHS Improvement and the CQC – have an important role in enabling every trust to deliver that balance. We also recognise that how we do our work, the signals we send and how we work together, are an important influence on whether you can deliver that balance or not.

We have therefore been discussing between ourselves, and with senior provider colleagues, what more we can do to help and support you and we wanted to share the early outcomes of that work. 'Early outcomes' because, at this point, this is a strategic statement of intent and we want you to tell us what we have to do differently to secure the right finance/quality balance that we all need.

Success is delivering the right quality outcomes within the resources available

We want to start off by being clear that, from our perspective, quality and financial objectives cannot trump one another. We know that, in the past, there was a perception that delivering financial targets was more important than delivering the right quality outcomes; and that, more recently, improving quality was more important than staying in financial surplus.

We want to clearly and unequivocally state, with the full support of our other arms' length body colleagues, that your task as provider leaders is to deliver the right quality outcomes within the resources available.

That is how we will both measure success and that is how the NHS Improvement regulatory framework and the CQC inspection regime will be framed going forward. Some changes will be needed to make this happen in exactly the way we now want.

We will involve you in how we make those changes – for example through the consultations that we will shortly be launching on the CQC's future strategy and a single new NHS Improvement regulatory framework for providers.

CQC and NHS Improvement working together on a single national framework

We recognise that it is particularly important that you get a single clear, consistent message from both of us on this issue. There has been a perception in the past that our organisations have had greater focuses on different sides of the quality/finance balance, potentially creating unhelpful mixed messages.

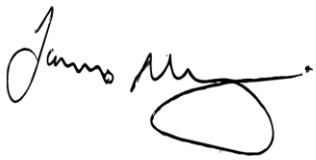
So, we will jointly design the approach the CQC will use to assess trusts' use of resources. We are also looking at how the CQC can use the financial data NHS Improvement holds and use the expertise of NHS Improvement staff in reaching its judgements on use of resources. Similarly, as NHS Improvement develops its view of the role of quality in the new, single, provider regulatory framework, we will do this jointly with the CQC and NHS England. We will also be sharing revised National Quality Board staffing guidance and a new metric looking at care hours per patient day that we will both use in looking at how trusts manage staffing resources.

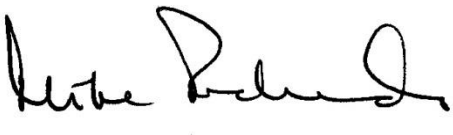
In practical terms, we want regulators and commissioners to rely on each other's work, rather than duplicating effort, and we want to create a single unified framework with a single way of measuring success that we all use. We want this to bring greater clarity and consistency and reduce the regulatory burden, as you have asked for.

NHS Improvement and CQC working together on turnarounds

One of NHS Improvement's early priorities will be to work with organisations with large deficits to help them return to surplus. There is an incorrect assumption that this can only be done at the expense of quality. So we will, again, be working together closely so that we can all be sure that, even in the trusts facing some of the biggest financial challenges, it is possible to balance finance and quality.

We hope this gives you a clear statement of our joint intent – success is delivering the right quality outcomes within the resources available – and how we want to translate that intent into the way we work in future. Please provide us with any comments you have on this letter and tell us what more we can do – our email addresses are below. It would help if you used "JOINT NHSI/CQC LETTER" as the subject of any email you send us.





Jim Mackey
Chief Executive
NHS Improvement
Jim.Mackey@monitor.gov.uk

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission
Mike.Richards@cqc.org.uk

Subject: LGA Corporate Peer Challenge - Torbay

Partners

On Behalf of Steve Parrock, Executive Director Torbay Council

Dear all,

As you will be aware Torbay Council invited the Local Government Association (LGA) to carry out a Corporate Peer Challenge to explore the wide range of opportunities and significant challenges the council faces. Following the four day visit in November and December last year the independent report containing the review's findings has now been released www.torbay.gov.uk/cpc and will be presented to Full Council for consideration on Wednesday 3 February.

The Peer Team highlighted positive findings and offered recommendations on how the council can move forward. Our stakeholders and partners feature strongly in this report and I'd like to thank you all for taking time out of your busy days to contribute to this process.

In summary, the Corporate Peer Challenge found that Torbay Council is viable now and can be in the future if it addresses some core issues. The council has a good understanding of Torbay's challenges, which is "translated into clear priorities for action for the council and its partners". The Peer Team recognised that there is "a range of existing progressive and inspiring partnerships, notably in health and social care integration" and that "admirable core values for its managerial leadership and staff" had been put in place. The report says the council has done well to make the savings required in the last five years.

There are also a number of key recommendations. These include developing and promoting a longer term, sustainable, strategic vision for the next 10-20 years in Torbay that is agreed with key stakeholders. The council needs to deliver upon its Children's Services five year plan. It should also improve its "purposeful political engagement with partners" and address governance working practices.

The Peer Challenge Team concludes that we must let go of any idea that the council might not be viable – we are and can be in the future. The council must be bold, work with its stakeholders and put Torbay on the map on a regional and national stage.

Our partners are fundamental to Torbay's future success and this is highlighted in the Corporate Peer Challenge report. As well as recognising the range of progressive partnerships, it also highlights that many of our external partners understand the council's problems and want to help, but would like a clearer sense of direction and want to feel more empowered.

Addressing these issues is something that we will be prioritising through a new action plan, which is currently being finalised. We want to engage with you much more effectively for the benefit of Torbay.

Together we need to establish our joint priorities for the bay and find the most effective ways of working together so we can offer value for money services which matter the most to our residents.

One of the key actions we will be taking is to develop and agree with our key partners a long term, high level, strategic vision for Torbay for the next 20 years. You will be a key part of this, so we can create a clear, joined up plan for the whole of Torbay to help us all achieve our ambitions.

I hope that you will continue to provide your support, ideas, enthusiasm and expertise so we can build on the successful partnerships we have already created.

Best wishes

Steve Parrock
Executive Director, Torbay Council

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	3 February
Title:	Chief Operating Officer's report – Public Board
Lead Director:	Liz Davenport, COO
Corporate Objective:	To update the Board on developments that is within the responsibility of the Chief Operating Officer
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

1. Provide an update on Care Model development and implementation progress since formation of ICO
2. Provide an update to the Board on the clinical services review

Key Issues/Risks and Recommendations:

To provide assurance to the Foundation Trust Board of progress on the above key areas of operational activity

To note the Risks and Issues identified in relation to the clinical services review :-

- Capacity to deliver change at pace
- Clinical engagement
- Implications for recruitment in the future
- NEW Devon success regime and review of specialist services that will be peninsula wide

Summary of ED Challenge/Discussion:

- Pace of Change
- Impact of Financial Position of CCG and ICO

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

- Senior Business Management Group

Equality and Diversity Implications:

The issues raised will include or provide assurance about our equality and diversity work and our involvement work.

Meeting of the Board of Directors

Public Board

3 February 2016

Chief Operating Officer update

1. **Purpose**

   To update the Board on progress in 2 key operational areas:

   - Care model implementation
   - Clinical services review

2. **Provenance**

   The report has been informed by:

   - Minutes and reports from the care model operational and executive groups
   - Purpose statement and notes from the Clinical Services review group
   - Briefings to the Executive Team

3. **Care Model update**

   The Trust is in the implementation phase of the care model working with partner organisations to drive the delivery of the prescribed service changes. Accountability for delivery sits with operations with each of the Service Delivery Units taking a lead for implementing changes that sit within their service areas. The plans that support delivery will be incorporated into the Business plan priorities.

   Delivery of the programme is governed through the Care Model Operational group chaired by the Chief Operating Officer with Executive oversight from the CCG and Trust through the Care Model Executive. It is this group that directs resources as required in line with agreed plans. The Transformation team provides project management capacity and capability and monitors progress against project plans. The Horizon Institute quality improvement team are enablers supporting teams to identify and implement changes.

   Progress to date

   On 1 October the services that were provided within the former Torbay and Southern Devon Health and Care Trust were incorporated into the new organisation as they were previously organised (lift and shift). A senior leadership team was established with the appointment of the triumvirate leadership team and governance arrangements were established in line with the new ICO governance reporting structure.

   Although we are yet to deliver some of the structural changes that will underpin delivery in the future we have already seen a number of benefits being achieved from the close working arrangements that have developed between teams these include:

   - Reduction in the number of delayed discharges supported by a single team ethos having established in the control room aimed at improving flow and compliance with the 4 hour wait target
   - Strategic agreement to develop an integrated pathway for people requiring neurological rehab in the community increasing capacity for suspected stroke on

the acute hospital site, with plans to engage the clinical leadership in the planning of this change in the New Year.

- Flexible use of workforce enabling community services to be maintained through periods of reduced staffing
- MAAT and THORT Teams working with the out of hours nursing services to provide 24/7 services enabling more people to be treated at home without prolonged stays in hospital.

An initial set of proposals have been developed setting out a revised delivery structure for the organisation and a programme of engagement sessions have commenced with staff to inform the final version of the structure. It is anticipated that subject to the appropriate period of consultation that the implementation will start from April 2016.

Care model changes

Community Hospitals and Local Multi- agency Teams (LMATS)

The Community Services Transformation Group (CSTG) has received and approved a proposal for the design and delivery of community services which will be based around a 'hub and spoke' model within each of the localities. The final CCG proposals on the future configuration of Community Hospitals and MIUs will be made early in 2016 and be subject to public consultation.

In each of the localities there will be a single hub which will be the central base for more specialised services within that locality, with teams working out of these bases to provide services across the locality. The 'spokes' will be the more local groupings of GP Practices at sub locality level supported by those ICO staff most closely aligned to primary care (community nurses, community matrons, health visitors etc).

The CCG have mandated that the re-configuration of services within each of these localities must be delivered within the current level of investment, and as a minimum, must secure the savings and reinvestment aligned to the changes in community hospitals set out in the ICO LTFM. The LMATs are intended to deliver the agreed range of functions through standardisation of service model to an integrated multi-disciplinary team, enabling improved efficiency by removing the multiple team working arrangements and current layering of services.

It should be noted that the individual localities are piloting a number of elements of the new care model including Single Point of Contact. The next step in this approach will be to extend the model of intermediate care and to ensure an integrated approach with the MAAT Team in the Moor to Sea locality.

It is hoped that the locality offer will also include the strengthening of the Urgent Care response with the implementation of 2 Urgent Care centres one in Newton Abbott and the second on the Torbay Hospital site supported through and initially funded by the Vanguard programme. These are due to come on line from 1 June 2016.

Single point of coordination

The initial pilots have concluded and evaluated and a recommendation to implement a single telephone contact point backed up with a standard set of operating procedures within localities has been approved by the Care Model Operational Group. Work has commenced to confirm the provider of this service.

MSK pathway changes

In response to a successful pilot of the revised pathway for the Hip and Knee MSK pathway it was agreed to roll out this service across all localities. This has already resulted in changes to the number of people being referred to the Orthopaedic Team and a reduction in the numbers listed for surgery. The Care Model Delivery group has subsequently approved proposals to extend the service to include foot and ankle and spinal pathways.

Multi- long term conditions

The management of people with long term conditions is central to our model. Recruitment to the team that will be leading our approach to the management of long term conditions is underway with clinics due to commence in March 2016. This service will be embedded within the LMAT and have close linkages with activities aimed at admission avoidance and End of Life care when needed. The MultiLTC service will have a strengths-based focus, with support for self-management and including assistive technologies.

Seeking advice in the ICO

A successful pilot in neurology has resulted in an agreement to roll out the programme that allows GPs to seek advice rather than the default being a decision to refer into specialist services. The roll out will commence in February 2016 with the majority of specialty services ready to go live and others following soon after.

New ways of working

As described earlier, the LMATs will be working differently starting with our approach to assessing the needs of people using our services and how their care needs are met. This change is intended to give greater freedom for people to decide how their care needs are met including the opportunity to access support from voluntary and independent sector providers. To facilitate the development of this approach the Trust has developed a partnership with the voluntary sector through one of the two umbrella voluntary sector organisations - the Torbay Community Development Trust - to introduce ‘My Support Broker’, a charitable organisation which has a national reputation for enabling person centred planning and use of direct payments and personal health budgets.

Preventative strategy

A new approach to prevention, self-care and well-being has been agreed with Public Health, the Councils and the CCG. The intention is to build a preventative approach

into everything we do and to ensure that our preventative strategy crosses all sectors of the population. The new approach will be woven throughout the new operational structure of the ICO and will be supported by training in supporting self-care for health and care professionals, techniques such as motivational interviewing and shared decision-making, and the best use of the new well-being coordinator role. A cross-organisational Prevention Board is in place and there are plans to operationalise in April 2016.

Working with the Voluntary Sector

A new, more structured, approach to working with the Voluntary sector has been agreed. This will allow us to make the best use of the support that we get and can develop from the voluntary sector. The steering group will meet in January.

4. Clinical services review

The Trust and CCG have established a working group with the intent to review the configuration of clinical services in response to:

- Increasing financial challenge
- Risks to the sustainability of key clinical services
- Specialised commissioning intentions review
- Outcome of reviews completed by the Clinical Networks
- Data including information from the Atlas of variation in Healthcare

The group is jointly chaired by the Director of Commissioning and Transformation at the CCG and the Chief Operating Officer in the Trust.

The group is well supported by clinicians from primary care and the acute and community services and commissioning and operational managers. Work has commenced in areas where specialist commissioning and clinical networks have indicated reconfiguration of services may support the sustainability of key clinical services including vascular, stroke and cardio vascular services.

Risks and issues

There are a number of factors that will impact on timely delivery of these changes which include:

- Capacity to deliver change at pace.
- Clinical engagement
- Implications for recruitment in the future
- NEW Devon success regime and review of specialist services that will be peninsula wide

5. Recommendation

To note the content of the report

Liz Davenport

Chief Operating Officer

29 January 2016

REPORT SUMMARY SHEET

Meeting Date:	3 February 2016
Title:	Workforce and OD report
Lead Director:	Martin Ringrose, Interim Director of Human Resources
Corporate Objective:	Safest Care/Promoting health/Personal, fair and diverse/Delivering improved value
Purpose:	**Information/Assurance**

Summary of Key Issues for Trust Board

Strategic Context:

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group/Workstream 4.
- To provide the Board with assurance on workforce and organisational development issues.

Key Issues/Risks:

Staff Friends and Family for Q1 and 2 is reported in Section 7.2 and results indicate that the Trust is above the national average for recommendation of work and care.

Recruitment of Freedom to Speak Up Guardians is underway and has generated a high level of applications, with appointments to be made by the end of the month.

A decrease in Appraisal compliance rate from an average of 82% to 78% in December against a Trust target of 90% or above. The service areas with particularly low level of compliance are identified in Appendix C and actions taken are set out in Section 4.3.

Mandatory training is compliant against target in 7 of the 9 key modules, amber in Information Governance and Infection Control training.

Sickness absence continues a downward trend, reducing to 4.04% in November and increasingly slightly to 4.27% in December against a target of 4.15% or less.

Vacancy factor relative to other Trusts remains low, at 7.53% in December excluding temporary workforce and is 0.83% including temporary workforce. A Strategic Recruitment and Retention Group has been set up to consider initiatives that will facilitate trust wide recruitment issues, Section 7.7.1 refers. A range of temporary staffing initiatives are being introduced to mitigate the difficulties recruiting to nursing posts across the trust, Section 7.7.1 refers. Medical recruitment remains a challenge in key areas as reported in Section 7.6.3.

Details of the full set of workforce metrics included in the report and details of any that are outside of the agreed target range are included in section 4 of this report.

Risks

Monitor's Agency Capped Rates are due to reduce further on 1st February 2016. The use of framework only agencies will be extended to all staff groups including doctors. Work to inform the risk assessment on this issue is on-going – section 7.8.2 refers.

Clinical supervision in Acute Ward areas is flagged as a significant risk and an action plan is in place, Section 10.3 refers.

There is a risk to the Occupational Health Service as a consequence of the retirement of the Occupational Health Consultant Section 8.1 refers.

Recommendations:

The Board is asked consider and discuss the assurance provided by the contents of this report.

Summary of ED Challenge/Discussion

Average sickness rate is good, but masks 'hot spots' identified in Appendix 3, need assurance on targeted action to address.

Nursing vacancy rates need to be reported separately, and Overseas Recruitment initiative approved.

Initiatives to increase proportion of Bank v'a Agency to meet flexible workforce requirements agreed and detailed in Section 7.7

Will the recruitment plans fill vacancies quickly enough to reduce agency spend in line with the financial recovery plan?

Are the actions proposed, in terms of increasing numbers of staff signing onto the nursing bank, sufficient enough to tempt staff away from agencies?

Should the Trust pay beyond 'flat rate' for part time nurses working beyond their contracted hours?

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

Governor Observer on Workforce and Organisational Development Group (Workstream 4)

Equality and Diversity Implications:

None.

PUBLIC

Board of Directors
Workforce and Organisational Development Directorate
4th November 2015

1.0 Purpose and Content of the Report

1.1 Report Purpose

- To update the Board on the activity and plans of the Workforce and Organisational Development (OD) Directorate as reported and assured by the Workforce and Organisational Development Group (Workstream 4).
- To provide the Board with assurance on workforce and organisational development issues.

1.2 Report Content

- A summary of the workforce and OD corporate objectives for 2015/2016 and plans for 2016/2017.
- A summary of progress on key performance indicators. These performance indicators are included in the Trusts monthly workforce and OD scorecards in the appendices and include key targets and monthly trends.
- Detail on actions and initiatives linked to the objectives and key performance indicators.

2.0 Workforce and OD Corporate Objectives

2.1 Objectives 2015/2016

The Directorate agreed the following overarching objectives for 2015/2016 and this report to the Board includes progress towards achievement of each of them.

2.1.1 Workforce Plan

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

2.1.2 Leadership and Culture

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

2.1.3 Friends and Family Test for Staff

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

2.1.4 Sickness Absence Management

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

2.1.5 Mandatory Training

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

2.2 Objectives 2016/2017

This Board has approved four long term strategic objectives as follows and as detailed in paragraph 11.2 below:

- Sale Quality Care and Best Experience
- Improved wellbeing through partnership
- Valuing our workforce
- Well led

As agreed at the last Board meeting and in common with each Directorate the Workforce and OD Directorate will agree a set of annual objectives which relates to these 4 long term objectives. Once agreed the 2016/2017 objectives will be included in the Workforce and OD Directorate report to the Board.

3.0 CQC Inspection

3.1 The Directorate has been preparing for the February 2016 CQC Inspection. This has enabled us to seek assurance that existing processes are being followed and will be maintained. Where any gaps have been identified processes are being updated and implemented. We have achieved this via the following actions.

3.1.2 The usual reports to monitor key workforce metrics for December 2015 are included in this report (see section 4 below). These metrics are significant in respect of the inspection as the same metrics broken down by Directorate, Division and Department has been shared with the CQC as part of their preparation.

3.1.3 A comprehensive comparison of current position against each KLOE in respect of Well-led which specifically relate to Workforce and OD has been undertaken and on-going actions identified for implementation.

3.1.4 A workforce and OD assurance checklist has been sent to all managers, included in the staff bulletin and is included in the ICON CQC web page. This checklist is designed for managers to assure themselves that they and their staff are compliant with Trust Workforce and OD issues that are likely to be subject to inspection.

3.1.5 The Directorate itself has been preparing itself for inspection by ensuring its own staff understand expectations in respect of the inspection by a series of communications and meetings including a CQC Inspection quiz.

4. Progress on Key Performance Indicators

4.1 Key Performance Indicators for TSDFT

Following the creation of the ICO there is now one set of workforce and OD metrics and targets. The targets and thresholds have previously been agreed by the Workforce and OD Group and are reflected in the RAG ratings of the metric reports.

At their last meeting the Workforce and OD Group ratified a further change to the target for mandatory training compliance. The original target was for each of the key modules to be at 90% compliance from November 2015, with the exception of Information Governance which has a target of 95%. It was subsequently agreed that this should be staged with a target of 85% from November 2015 and 90% from April 2016.

4.2 Workforce and OD Metrics Reports

The following reports to monitor key workforce ad OD metrics for December 2015 are included.

- Appendix A – Workforce and OD Scorecard – Organisational month by month metrics for the last year to show trends.
- Appendix B – Key Metrics by Business Unit – Metrics month by month for the 3 Business Units for the current financial year to show trends. Those included are sickness absence, staff appraisal and mandatory training.
- Appendix C – Summary of key metrics by Business Unit, Division/Department for November 2015. Those included are sickness absence, staff appraisal and mandatory training.

Any of the key performance indicators that were outside of the agreed target range in September 2015 are highlighted in this section of the report.

4.3 Staff Appraisals

The appraisal compliance rate for December 2015 was 78%. Over the course of the last year the average is 82%. As can be seen in appendix A 78% represents a small increase from the previous month but not to the levels previously achieved. Actions to improve compliance have included further messages to managers and in the staff bulletin, messages to staff that have not been appraised asking them to seek completion and as part of the divisional performance management process. This is in addition to monthly reports to managers providing RAG ratings of those appraised, those not appraised and those about to become non-compliant.

4.4 Mandatory Training

Of the nine key modules seven were rated green and two were rated amber in December 2015. Overall the combined average compliance was 90%.

4.5 Sickness Absence

The sickness absence rate reduced to 4.04% in November 2015 this is in accordance with a downward trend. The rate in December 2014 was 4.27%. This is a very satisfactory trend and of course represents a significant saving.

4.6 Vacancy Factor

The vacancy factor was 7.53% in December 2015. The vacancy factor is calculated by dividing the WTE vacancies by the WTE funded establishment. If the temporary workforce (bank and agency) plus additional hours are taken into account the residual vacancy factor is 0.83%. The table below shows this position by WTE and percentage.

Funded Establishment WTE	In-Post (WTE Contracted)	Vacancies WTE	Vacancy Factor % excl temp workforce and add hours	Bank (WTE Worked)	Agency (WTE Worked)	Other Variance (add hours, sickness etc.)	Under/Over (-) Funded WTE	Vacancy Factor % inc temp workforce and add hours
5,524.46	5,108.62	415.84	7.53%	243.61	124.20	2.37	45.67	0.83%

5. Workforce Plan

5.1 Integrated Workforce Strategy

As reported in the last Workforce and OD report to the Board the Workforce Redesign Network has been formed to steer and coordinate delivery of the Integrated Workforce Strategy. A workforce planning template for managers to complete as part of the business planning process has been developed. The template enables workforce challenges to be identified and the solutions included in the Integrated Workforce Strategy implemented. The outcomes will be consolidated to provide a Trust wide picture and to ensure the strategy is implemented and delivers the required solutions. The areas managers have been asked to provide feedback on are as follows:

- Current and future service description & workforce profile
- Workforce changes/challenges (growth/contraction/realignment) immediate, 2/3 years, next 3 years
- Continuous Improvement Programme (CIP) Savings required
- Transformation considerations 'Redesigning the Workforce'
- Partnership Working – Aligning the Workforce to work with Partner Agencies
- Staff Morale and Job Satisfaction
- Most significant risks and Issues to highlight

Meetings were held before Christmas with each of the Business Units to discuss delivery of the process with them.

At the same time as the above a number of workstreams are undertaking activity to deliver new and redesigned roles including:

- The transformation team developing alternative and more holistic roles to work as part of the Local Multi-Agency Teams.
- The Medical Staffing Review Group co-ordinating the training and placements for Associate Physicians.
- The Medical Staffing Review Group planning for an increase in Trust Fellows to support vacant medical posts.
- Nursing workforce planning to recruit apprentice posts to work through the planned career pathway and become registered nurses.

5.2. System Wide Workforce Planning Group

It is recognised that to achieve a fully integrated workforce the Trust needs to work closely with its partner organisations. Working with the CCG a Workforce Planning Group which covers the footprint of the entire area has been formed. The participating organisations are:

- Torbay CCG
- Torbay and South Devon NHS Foundation Trust
- Representatives from the local GP Community
- Devon Partnership Trust
- A variety of Voluntary Groups
- South West Ambulance Trust
- Health Education South West

The key purpose of the group is to produce either Workforce or Education initiatives which could not be instigated by any one single Employer. There are a variety of opportunities being considered such as:

- Employing Nurses who rotate between the trust and Primary Care.
- This Trust providing training for GP Practice Staff and Voluntary Sector Staff.

It is not the intention of the Group to produce a system wide Workforce plan although this may happen in the future. The Group has only just been established and updates will be provided to the Workforce and OD Group and the Board as developments occur.

5.3 Education Commissioning Demand Forecast

As previously reported the annual Education Commissioning Demand Forecast exercise has been completed. Health Education England has not yet produced their 2016 workforce plan. However recommendations to increase training numbers in the following staff groups by Health Education South West are progressing:

- Nursing Adult
- Nursing – Mental Health
- Nursing – LD
- Physiotherapy
- Clinical psychology
- IAPT
- Pharmacy Pre-reg

Meetings with the training providers are taking place to agree placements for trainees for 2016/2017. Increased numbers of trainees means we are asking managers to do all they can to support as many placements as possible. This does represent a considerable commitment by teams already supporting significant numbers of placements. However the potential advantage is that those trainees that come to us for placements are more likely to wish to continue their career with us.

6.0 Pay and Pensions

6.1 Weekly Payroll

In accordance with the agreement to provide a weekly payroll for bank only workers (see paragraph 7.9.1 below "Initiatives in the use of Bank and Agency Staff") a project team from payroll, temporary staffing, finance and workforce information are developing a project plan to deliver the service. The aim is to provide the service from the start of April 2016 and the project plan will identify how that can be achieved.

6.2 Staff Expenses System

As previously reported the Trust currently uses the electronic Software Europe system for staff to claim expenses. It had always been intended to roll out the same system for those staff that transferred from TSDHCT to what is now TSDFT once the ESR systems were merged. However there is now a national plan for an expenses system to be available free of charge on ESR. Details of this have now been issued which will enable the Trust to consider moving all staff to the ESR system or just those who those have just transferred from TSDHCT. The Trust contract with Software Europe lasts until September 2018 at a cost of £8K per annum.

6.3 Pensions Auto-enrolment

In accordance with the auto-enrolment regulations the Trust is required to assess and re-enrol eligible staff into an occupation pension scheme every 3 years. This applies to all staff that, more than 12 months before our chosen re-enrolment date have opted out, ceased membership or decided to make contributions that are below the minimum required by the scheme. The Workforce and OD Group have agreed the re-enrolment date of the 30.09.2016. This will only affect a very small number of staff.

6.4 National Insurance Changes

From the 01.04.2016 National Insurance contributions for those staff in an occupational pension scheme will not be reduced. Currently there is a lower rate of National Insurance for those in an occupational pension scheme. This will result in an overall reduction in pay for many of our staff.

6.5 Pensions Tax Allowances

The life time tax allowance and annual tax allowance for pensions are reducing from the 06.04.2016. The reduction in these allowances could lead to a tax charge for an increased number of high earning staff. A letter was sent to all staff earning over £100,000 pensionable pay advising of this change. Further communication is planned for February.

7.0 Human Resources

7.1 Managing Sickness Absence

Long term sickness absence which for the purpose of reporting relates to periods of absence of 20 days or more, makes up the larger proportion of absence overall. It currently stands at 63.25% while the proportion of absence which is classed as short term stands at 36.75%. This is a fairly consistent split with little variation over time. However, there are of course significant variations at cost centre level.
The top three reasons for absence are:

- Anxiety/Stress/Depression (17.60%)
- Musculoskeletal problems (17.40%)
- Cold/Cough/Flu (12.99%)

It is important to note that the category around ‘anxiety/stress’ does not break down further to whether this is work related or non work related. The workforce figures act as an indicator that there may be an issue to address and then HR supports managers to examine more closely what lies behind the figures and then, if necessary, plan remedial action.

The HR Department continues to support managers in the management of sickness absence by the use of direct support, drop in sessions and ad hoc training sessions. In addition, a short Buzz TV Video has recently been filmed featuring a HR Manager and a Matron answering questions on the management of short term sickness absence. The video, which will be released in February is aimed at both managers and staff and is designed to highlight the impact of sickness absence on the service and the means by which it is managed. Following release of this a further video is planned to look at the issues involved in the management of long term sickness absence.

The above initiatives link in strongly with the need to ensure a uniform approach by managers in managing sickness and for staff to understand why and how it is managed. For information in the third quarter HR Advisors were involved in the issuing of 20 formal warnings in respect of the management of short term sickness absence. In addition there were many more involvements in informal and formal reviews which didn't result in the issue of formal warnings.

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

7.2.1 National findings

The national findings for the Staff Friends and Family Test (FFT) are as detailed below. In both quarters the Trust have performed above the national average for recommendation of work and care.

	% staff extremely likely or likely to recommend SDHCFT to friends and family if they needed care/treatment	% staff extremely likely or likely to recommend SDHCFT to friends and family as a place to work.
Q1 (April – June)		
Medical Services Division	92	77
Corporate Services, Public Health and Professional Practice	85	72
National average	**79**	**63**
Q2 (July-Sept)		
Surgical Services Division	87	69
Community Hospitals	92	81
National Average	**79**	**62**

7.2.2 Local findings

Local findings have been provided to the Division's at specialty level, where available. The findings include; the quantative data; the comments report for recommendation of work and care; and a summary report which identifies common themes. Managers are asked to ensure the findings are shared with staff, together with any resulting action plans.

The Staff FFT went live in Quarter 3 within the month of December in Women's, Children's, Diagnostics and Therapies.

It is planned that within quarter 4 the final directorates will be surveyed within the month of February and will include; Corporate Services (Acute), continuing Health-Medical and Community Services.

7.3 Staff Experience CQUIN 2015/16

As previously reported the staff experience CQUIN aims to improve overall staff experience through the establishment of a Multi-Agency Staff Experience Network (MASEN).

As part of this CQUIN we continue to implement the Staff Survey action plan which has been developed to improve those areas identified for development within 2014 NHS Staff Survey. Early indicators from the 2015 NHS Staff Survey raw data report suggest that improvements have been made in the majority of these areas.

We also continue to progress the three 'Always events' (see below) – 'see something, say something', 'hello my name is' and 'you said, we did'.

The Quarter 2 CQUIN report was submitted on 31st October 2015 and reported a green RAG rating – 'Project on plan'. This was supported by the commissioners. The Quarter 3 CQUIN report will be submitted at the end of January and will report a green RAG status.

7.3.1 See something, say something

'See something, say something' is our local initiative designed to encourage and support all staff in raising genuine concerns at the earliest opportunity.

The initiative was developed in response to the findings from the NHS Staff Survey 2014 and the Freedom to Speak Up Report.

A number of actions have been taken to support the introduction of the 'see something, say something' initiative including;

- The Chairman was identified as the figurehead for the initiative which he launched at the Wellbeing event in September 2015 which was followed up by an Executive blog in October.
- Posters have been distributed to wards/departments for display in back of house areas. Information leaflets have been designed and issued to all staff.
- The initiative has been communicated in the Staff Bulletin and Board reports and is being incorporated into the Induction process and handbook for staff.
- An intranet page has been developed and includes details of the initiative, communication materials and frequently asked questions.
- The initiative is included as part of the Workforce Assurance Checklist issued to managers as part of the CQC preparation.

In December, a recruitment campaign has commenced for the appointment of up to five Freedom to Speak Up Guardians. The prime role of the Guardian is to act in a genuinely independent and impartial capacity to support staff that raise concerns. The Guardian will ensure that the voice of front line staff is heard at a senior level by reporting common themes to the Board on a regular basis. The closing date for applications was the 15th January 2015, with interviews on the 29th January 2015. Mairead McAlinden, Chief Executive and John Brockwell Non-Executive Director will appoint to the Guardian role.

A diagrammatical representation of the 'See something, Say something' initiative is displayed in Appendix D.

7.3.2 You said, we did

'You said, we did' is an initiative designed to communicate actions that have been taken as a result of staff feedback. Actions taken include;

- The HR Director has been identified as the figure head for the initiative and has completed an executive blog detailing what we have planned.
- The initiative together with departmental examples were publicised at the Wellbeing event and continue to be published on the web page. The web page also includes a template poster which enables managers to display local actions taken as a result of staff feedback.
- The initiative continues to be communicated through Board and Divisional reports and is being incorporated into the Induction process.

- Additional questions focusing upon integration have been designed for inclusion in this year's staff survey.
- The initiative is included as part of the Workforce Assurance Checklist issued to managers as part of the CQC preparation.

7.3.3 Hello my name is

'Hello my name is' is an initiative to encourage staff to introduce themselves to patients/visitors and colleagues. This work is being undertaken in partnership with the Patient Experience team as 'hello my name is' is also a patient experience CQUIN. Communications and the Horizon Institute are also supporting this CQUIN. Actions taken include;

- Introduction at the Wellbeing Event by the Trust Chairman.
- Design and publication of 'hello my name is' posters of the Chairman and Executive team and inclusion of 'hello me name is' leaflet, with payslips.
- Increasing number of staff using 'Hello my name is' logo on e-mails and on-going use at meetings, training, events etc.
- Executive blogs start with 'Hello my name is'.
- Junior Doctors issued with yellow 'Hello my name is' badges.

7.4 NHS Staff Survey 2015

The fieldwork for the 2015 NHS Staff Survey commenced in the week of 12th October and closed in early December. The final response rate for Torbay and South Devon NHS Foundation Trust is 46%. The national mean response rate for all Trusts using Quality Health as their survey provider was 42%.

The Trust has received some raw data on the findings but is expected to receive the NHS England benchmark reports in the week commencing 8th February 2016. The reports will be under embargo until the official publication date on 23rd February 2016.

Work is currently being undertaken to where possible make comparisons using raw data between the 2015 survey and the two Trusts surveys in 2014.

7.5 Employee Relations Cases

The table below shows the number of Employee Relations cases at Torbay & South Devon NHS Foundation Trust that entered a formal policy over the period October 2015 to December 2015.

Type of Case	Total for Quarter Oct-Dec2015
Disciplinary	**8**
Grievance	**3**
Sickness Warnings	**20**
Performance Management	**3**
Unacceptable Behaviour	**1**
Whistleblowing	**0**
Suspensions	**0**
Employment Tribunal Claims	**0**

The figures above represent where formal warnings have been issued during the relevant period. In addition the following activities are taking place concurrently:

- Active investigations that may lead to disciplinary meetings being invoked and subsequently to formal warnings being issued.
- Management of long term sickness cases that require regular reviews
- Management of short term sickness absence reviews where no warnings are issued
- Support to organisational change projects involving consultation sessions and management of redeployment

These figures now provide the benchmark for trend analysis in future reports.

7.6 Recruitment

7.6.1 Strategic Recruitment and Retention Group

A trust wide recruitment and retention group has been set up to consider issues arising in the following areas:

- Recruitment and recruitment processes
- Succession planning and role redesign
- Agency and Temporary Staffing
- Workforce retention

The group held its first meeting in December 2015. It was agreed that there would be four sub-groups reporting to the main group with a remit to take forward key issues in each of the above mentioned areas. Each group will be led by a member of the workforce division with approximately 4-6 members of staff in each group that will take forward key pieces of work on a task and finish basis. The sub-groups will meet every three weeks and report back to the main group which will meet six weekly.

Minutes from both groups and progress reports will be presented to The Workforce and OD Group.

7.6.2 Language requirements for EU nurses and midwives

The new language requirements for Economic European Area (EEA) trained nurses and midwives joining the Nursing and Midwifery Council (NMC) register came into effect on the 18th January 2016.

Designed to strengthen public protection, the new controls mean that nurses and midwives will be asked to demonstrate that they have the necessary knowledge of English to practice safely in the UK. Key changes to the requirements are:

- EEA nurses and midwives will be asked to prove that they have sufficient evidence of English language skills. If a nurse or a midwife is unable to demonstrate these requirements, he or she will be asked to complete an English language assessment.
- Nurses and midwives who have already completed one of the NMC's pre-registration courses will automatically meet the new requirements.
- New legislation will also give the NMC powers to investigate a nurse or midwife whose fitness to practice has been called into question over their ability to communicate effectively in English.

To work as a registered nurse with the Trust all individuals are required to be registered with the NMC, evidenced by a Personal Identification Number (PIN). The nurse must meet the new requirements to obtain a PIN and therefore would not be employed by the Trust in a Registered Nurse role until they are registered. Checks to ensure a Registered Nurse is on the NMC Register with an up to date PIN are made as part of the recruitment process.

7.6.3 Medical Recruitment

The last couple of months have seen some successful appointments across the Trust, this includes; a locum Consultant Neurologist to cover a member of staff who is on a career break, and replacement consultant posts for Trauma and Orthopaedics, Paediatrics and an Acute Physician. The Trust has also been successful in appointing 2 replacement Specialty Doctors in Paediatrics.

The Trust is still struggling to recruit to two vacant Specialty Doctor posts in A&E and to two Consultant posts in Stroke. The specialties are considering alternatives routes for recruitment.

Current medical vacancies are detailed in the table below:

Grade	Specialty	Status
Consultant (new post)	Histopathology	Out to advert (been trying to recruit since April 2015)
Consultant (new posts)	Radiology- Interventional	Currently out to advert with a closing date of 11 Feb
Consultant (replacement)	Occupational Health	Currently out to advert with no closing date
Consultant (new post)	Oncology	Post closed and interviews set for 20 Jan
Consultant (replacement)	Urology	Out to advert with a closing date of 4 Feb
Consultant (replacement)	Gastroenterology	Out to advert with a closing date of 20 Jan
Consultant (replacement x2)	Stroke	Out to advert (long term vacancy since Mar 2015)
Specialty Doctor (vacant post x2)	Emergency	Out to advert (long term vacancy since Apr 2015)

7.7 Temporary Staffing

7.7.1 Initiatives in the use of Bank and Agency Staff

The level of Bank and Agency Usage is constantly under review. Clearly with an intention to both decrease the level of overall usage of temporary labour and secondly to increase the proportion of Bank as opposed to Agency. It should be noted that the Trust relative to other Trusts is a very good performer both in the overall usage of temporary labour and secondly the proportion of Bank to Agency (see paragraph 4.6 above and 7.7.3 below).

Notwithstanding the above as a consequence of three related issues as follows

- The Government cap on Agency rates
- The requirement to use only certain Agencies
- The major increase in rates applied by Newcross Agency. Newcross has until now being a major supplier of Agency Staff to the Trust.

The Trust has instigated a further review of the usage of Agency Staff. This review has not been completed but never the less a number of initiatives have been agreed and ratified by the Workforce and OD Group as follows

- The provision of weekly pay to staff who are Bank employees only. Staff who have substantive contracts with the Trust but also work on the bank will still be paid monthly as experience from elsewhere would suggest that tax problems occur when the same member of staff receives both weekly and monthly pay.
- Full time staff to be offered on a consistent basis overtime rates to work additional hour rather than use the Bank.
- Part time Staff to be offered additional hours at plain time rates up to 37.5 hours a week and thereafter overtime rates rather than use Bank.
- Paying Bank Staff on a higher incremental point and ensuring that Bank Staff who have substantive contracts are paid at their substantive pay point for Bank work.
- The payment of travel expenses when appropriate.
- The introduction of a reliability payment
- The introduction of a recommend a friend scheme.
- Formal permission with centralised backup to Managers to over recruit certain members of Staff.

Other initiatives are under consideration including setting up our own Agency. Three potential initiatives which have not been approved are as follows:

- The payment of overtime rates to part time Staff before they work a maximum of 37.5 hours
- Late availability payments
- Increasing the basic rate of pay for Bank Staff to close the gap between Bank and Agency rates.

The Board will be updated with progress.

7.7.2 Monitor framework arrangements and price caps for agency staff

Monitor first introduced price caps for agency staff on 23rd November 2015 and a further reduction will be in place from the 1st February 2016. The price caps were implemented in order to reduce maximum rates for agency staff and help Trusts to achieve savings.

The Trust has been working with local agencies to achieve the price caps introduced by Monitor but have not been successful with all placements, with some agencies refusing to support these new rules. Monitor has stated that they are working with framework agencies and are taking the following actions to change this:

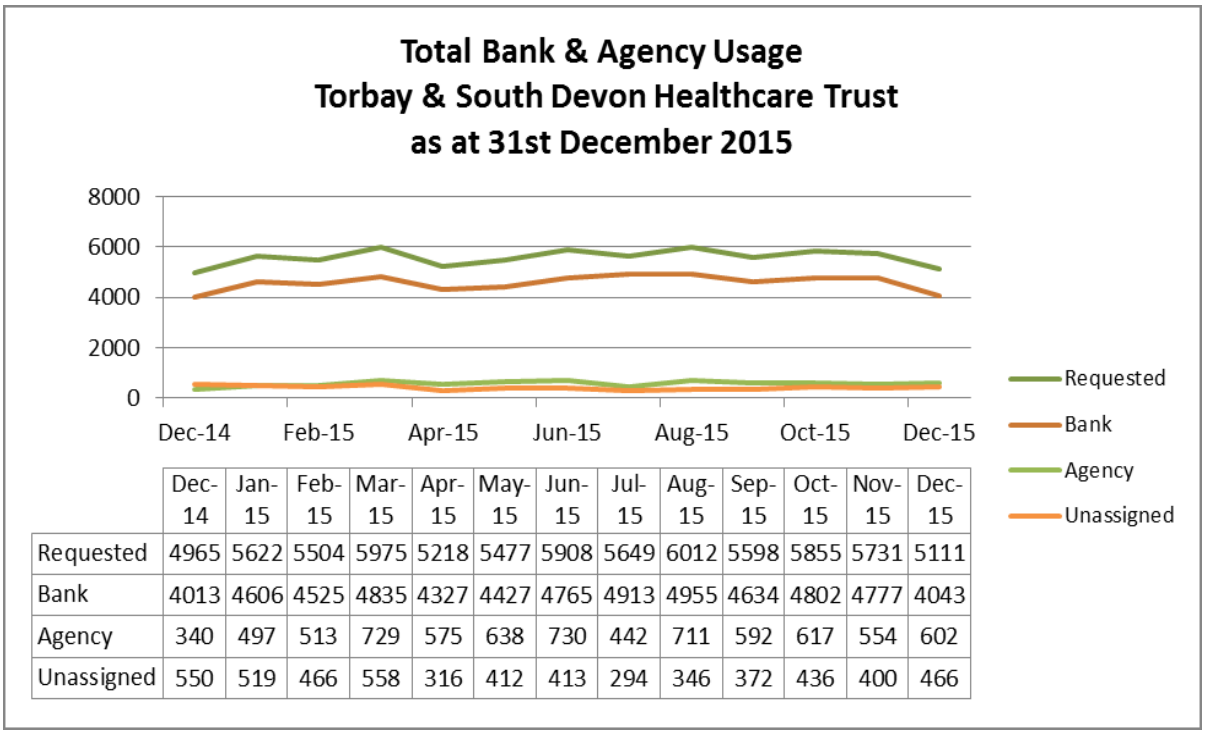
- They will extend the requirement that Trusts procure only through approved frameworks to doctors and other staff, as well as nurses. This will take effect from 1 April 2016. They will only approve frameworks that commit to the further steps below.
- Framework suppliers will have to renegotiate with agencies or retender to ensure that all their prices are at or below the rates set by NHS Improvement. This process will take several months to conclude (beyond 1 April). In the meantime, all approved framework owners must strongly support the price caps.

- At the appropriate point, they will change the way the price caps are expressed so that NHS Improvement defines the amount that the *worker* receives – at a level equivalent to standard NHS terms and conditions.
- Frameworks will embed a requirement that agencies conform to the pay rates set by NHS Improvement. Agencies will bid to be on-framework on the basis of their agency fee, which will then be fixed, and in compliance with our terms.
- We also intend to take steps to eliminate the practice of agency workers using personal services companies to avoid taxes.

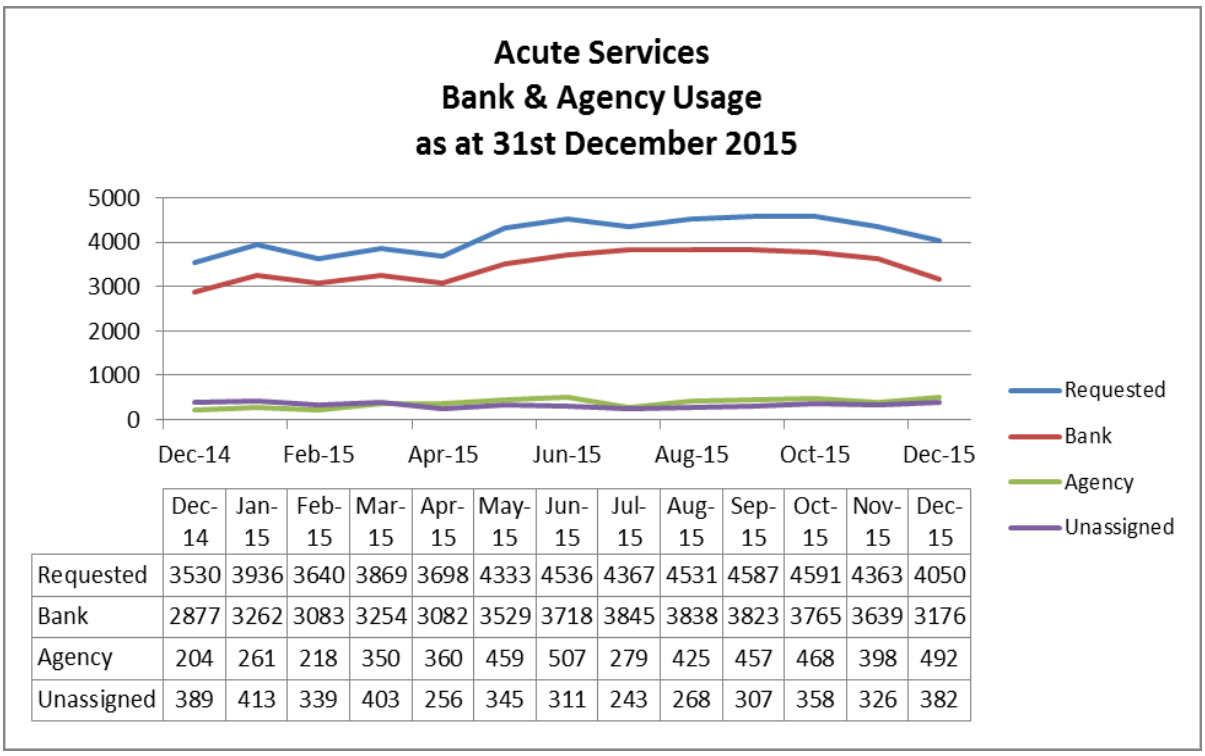
The Trust will be taking steps to prepare for these changes, including reflecting on contractual conditions such as timescales associated with transfer fees

7.7.3 Activity

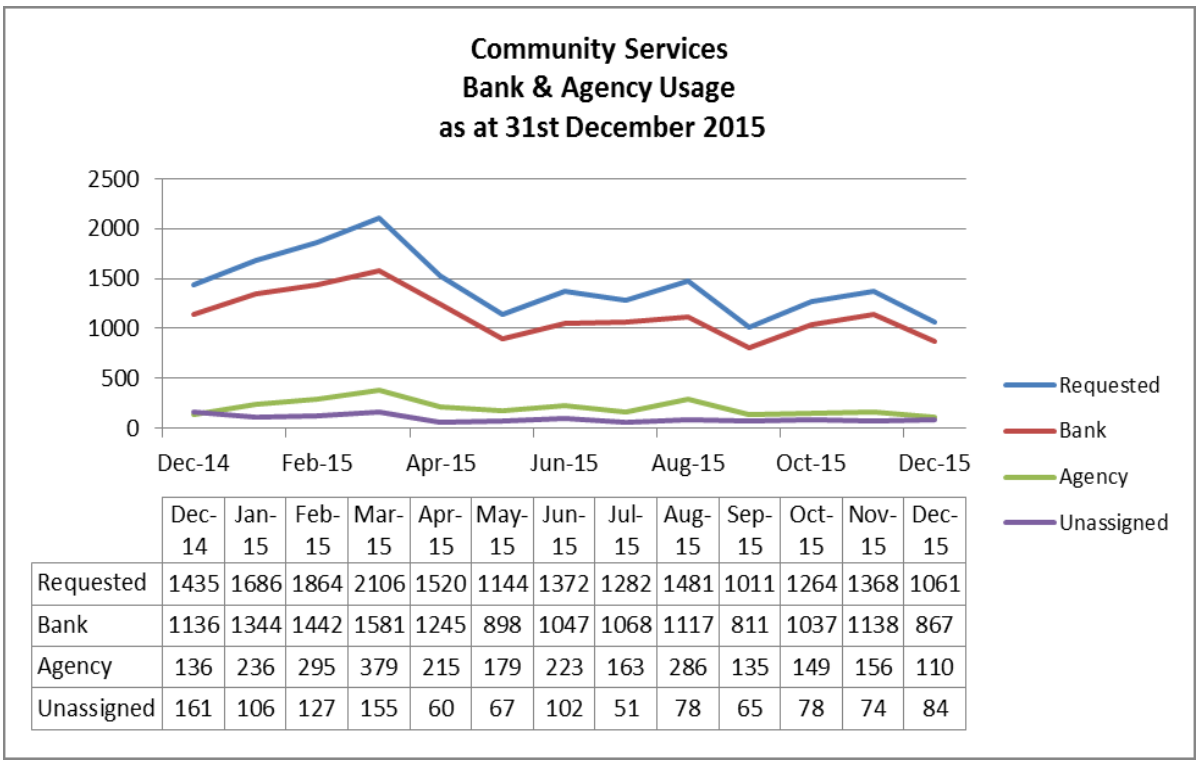
The Temporary Staffing Team continues to strive to fill the demand for shifts within both organisations. In December 2015 the Temporary Staffing Team was able to fill 91% (5111) of the shifts through a combination of bank (79.1%) and agency (11.7%).



	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Requested	4965	5622	5504	5975	5218	5477	5908	5649	6012	5598	5855	5731	5111
Bank	4013	4606	4525	4835	4327	4427	4765	4913	4955	4634	4802	4777	4043
Agency	340	497	513	729	575	638	730	442	711	592	617	554	602
Unassigned	550	519	466	558	316	412	413	294	346	372	436	400	466



	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Requested	3530	3936	3640	3869	3698	4333	4536	4367	4531	4587	4591	4363	4050
Bank	2877	3262	3083	3254	3082	3529	3718	3845	3838	3823	3765	3639	3176
Agency	204	261	218	350	360	459	507	279	425	457	468	398	492
Unassigned	389	413	339	403	256	345	311	243	268	307	358	326	382



	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Requested	1435	1686	1864	2106	1520	1144	1372	1282	1481	1011	1264	1368	1061
Bank	1136	1344	1442	1581	1245	898	1047	1068	1117	811	1037	1138	867
Agency	136	236	295	379	215	179	223	163	286	135	149	156	110
Unassigned	161	106	127	155	60	67	102	51	78	65	78	74	84

7.7.4 Medical Agency

The Trust has undertaken an incumbent review of all current medical agency bookings and has succeeded in reducing some of the current bookings to fall within the monitor capped rates. The Trust is working hard to negotiate with local agencies for all new bookings to be within the capped rates set by Monitor. Current usage is included in the table below:

Grade	Specialty	Reason for booking	Monitor Rates
Consultant	Acute Physician	Long term vacancy	No
Consultant	Dermatology	Long term vacancy	No
Consultant	Emergency	Long term vacancy	Yes

Consultant	Stroke	Long term vacancy	No
Registrar	General Surgery	Gap in the rota	No
Registrar	Obs & Gynae	Gap in the rota	Yes
Registrar x2	Paediatrics	Gap in the rota	Yes
Registrar x2	Ophthalmology	Gap in the rota	Yes
Registrar	Trauma & Orthopaedics	Gap in the rota	Yes

All new bookings and extensions to current agency bookings require authorisation from the MD or On-call Exec; this process has been updated to include authorisation for bookings above the

8.0 Occupational Health

8.1 Service Provision

The Occupational Health Consultant retired at the end of November 2015. A range of actions have been undertaken to try and cover this role without success.

We are currently working to progress locum cover through an agency which effectively means we will exceed the capped payment rates in the short term.

Meanwhile we are reviewing the longer term options available to include, exploring service provision from an external provider. The two providers we have met with are IMASS and Optima. IMASS currently provide a service for Torbay Council and Optima provide a service for SWAST. IMASS have little experience with NHS clients and Optima have contracts with several NHS trusts. We have had favourable feedback from users of both services.

External service provision will require a formal procurement exercise so our aim is to secure a short term twelve month service provision arrangement. We are currently talking to Optima about this type of arrangement so that we use agency cover as a last resort.

9.0 Workforce and OD Systems

9.1 ICO Project Plan

As previously reported the Trust continues to operate with two Electronic Staff Record (ESR) systems for one Trust. Our agreed merge slot is February 2016 which will mean from the start of the financial year we will have one ESR for the Trust. Following this the information we provide will be more reflective of the emerging organisational structure and more useful to managers.
The project plan to deliver the merge of the ESR systems is complex and will require significant input from the Workforce and Payroll Team.

9.2 ESR Input

The Trust has been operating with a variety of forms for ESR input. New electronic starters, change of circumstance and termination forms for the whole Trust have now been implemented. As well as being more manageable for managers it will provide a clear audit trail and support the journey to a paperless Trust. The electronic forms are available on ICON and will eliminate all paper forms and the need to send by email. Any forms submitted using old formats will be received until the end of March 2016 only.

9.3 Nurse Revalidation

The procurement of a nurse revalidation system has become subject to the wider decision in respect of a linked Learning Management System. Comparison between a system called Totara and ESR's own OLM is currently taking place with a view to an early decision.

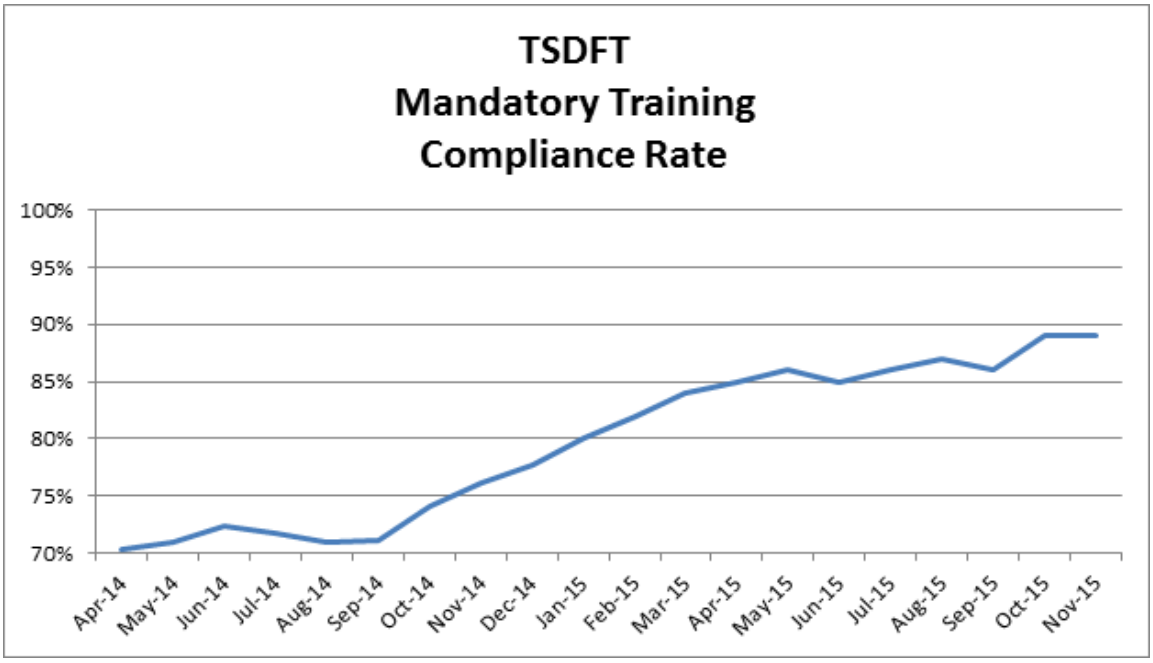
9.4 Annual Employment Declaration Form

The Workforce and OD Committee have agreed a new form and process to ensure compliance with NHS employment checks and standards and Trust policies. This compliance takes place when an employee is recruited. To monitor any changes to an individual's circumstances that may impact on their employment or be a safeguarding issue an annual employment declaration has been developed. All staff will be required to complete this with their manager at the same time as their appraisal and the form and messages to managers and staff will shortly be issued. ESR will be updated to show those staff that have completed the declaration.

For Executive Directors an additional requirement has been added to ensure they comply with the fit and proper persons test. Each Executive Director will be required to complete this immediately and then at their annual appraisal.

10.0 Education and Development

10.1 Mandatory Training



Hotel services within the acute setting remain the biggest area for concentrated support. Bespoke sessions are still being provided that include out of hours together with the management team for the area writing individually to their staff highlighting their non-compliance.

Safeguarding Adults and Children level 1 are available via hiblio and e-learning and are being promoted as such by the mandatory training team who are supporting departments. Additional training sessions for level 2 are being undertaken to address the increased number of staff that have to now undertake this level.

Safeguarding Children Level 3

Due to changes in the Safeguarding Board requirements there has been a significant increase in the number of staff requiring Levels 2 and 3 training.

Additional training sessions for level 2 are being undertaken to address the increased number of staff that have to now undertake this level with a plan to but a business case forward for additional training support.

A training needs analysis conducted by Phillippa Hiles, Safeguarding Lead, has identified approximately 500 people across the ICO that require Level 3 training. This has to be delivered in a multi-agency format and is commissioned from Torbay Council. A rolling programme of training approximately 150 staff per year for the next 3 years has been put in place with underpinning finances agreed with the Education Directorate.

10.2 Medical Education

10.2.1 HESW Postgraduate Medicine Contract Visit 16th December

The annual contract meeting between the Trust and HESW Peninsula Postgraduate Medical Education team took place on the 16th December. HESW were represented by the Dean, Prof Martin Beaman, Associate Dean for Quality, Dr Martin Davis and Quality Manager Ms Jane Bunce. The purpose of the meeting was to review the quality data pertaining to the provision of postgraduate medical education in the Trust and ensure that the action plan to address identified issues is progressing. Nationally the Peninsula performs well and Torbay and South Devon is the top performing Trust in the region and this was highlighted in the meeting. Dr Rob Dyer, Medical Director and Mairead McAlinden attended the meeting and were able to give an overview of the ICO and potential training opportunities this presents. A full summary of the meeting will be prepared for circulation.

10.2.2 Undergraduate Year 5 Programme

Following the dissolution of the joint medical school meetings are on-going with Exeter and Plymouth in order to prepare for the first joint Year 5 in 2018. The Trust has expressed the need to keep processes and assessments as aligned as possible in order to reduce the burden on departments hosting students. One particular area is the dual recognition of training that tutors undergo in order to undertake student assessments. Further meetings are planned to continue refining the detail and in particular these will focus on establishing robust IT links with the schools for the transmission of student information and potentially teaching sessions.

10.2.3 Medical Workforce developments

The next Medical Workforce Review Group is scheduled to meet on January 6th. The focus of discussion will be an update on a review of the Hospital @ Night cover, potential role of Physicians Associates and progressing the career development of SAS doctors. The output of the MWRG helps feed into the Workforce Redesign Network with the aim of developing system wide workforce planning across the medical, nursing and AHP professions.

The first cohort of eight Physicians Associate students join the Trust on 4th January. Following a week of induction they will commence a year of clinical rotations through a number of placements including general practice. The focus of the year will be to gain experience in acute assessment skills and exposure to commonly presenting medical and surgical conditions building up to taking their national exam in Jan 2017. Following this the five PA's the Trust has sponsored through training will join clinical services as part of their multi-disciplinary teams. This allocation will

be based on service workforce development plans submitted as part of the business planning cycle. The second cohort of six sponsored students commence their academic course at the University of Plymouth in January with their clinical placements commencing January 2017 and graduating in 2018.

10.3 Professional Practice

10.3.1 Clinical Supervision

As mentioned in the previous report a review has been undertaken to establish the number of clinical staff receiving clinical supervision (CS). The Table below indicates the overall picture across the whole Trust.

Acute ward areas	21%
Emergency Department	50%
Community Hospitals	100%
Community Nurses	78%
Maternity	100%
AHP and Social work	100%

Conclusions

- The data this year was collected by telephone or face to face conversations, and analysed manually. Responses were obtained from 56 clinical areas across the Trust.
- Acute hospital ward areas were least likely to access CS.
- Midwives and AHPs were most likely to access CS.
- The majority of respondents that were receiving supervision felt that it was very useful.
- Many areas understood the benefits of CS and many supported one another with informal and undocumented CS. However, time and staffing appeared to be the main barriers to access.
- The comments received demonstrated that CS is undertaken in a number of ways. Many clinical teams appear to use staff handover and meetings to ensure CS occurs.
- There is an improvement in the recording of CS and the templates provided appear to be used in many areas.
- Developing CS in the workplace has resource, cost, and time implications that managers need to be aware of. The commitment and support of management, leaders and key members of staff is essential in the planning if CS is to have a beneficial impact on clinical staff and their patients

Action
An action plan in response to the findings is in place and is being driven the Clinical Placement Lead.

	Action	To be achieved by
1.	Liaise with senior managers and directors to look at what can be done to encourage a wider uptake of CS	March 2016
2.	To create a team of CS facilitators to facilitate supervision, provide motivation, information and support to encourage supervision uptake.	February 2016
3.	Offer CS at senior lead meetings so that benefits and CS structure can be realised, experienced and cascaded to other teams.	April 2016
4.	Run local CS information and training sessions.	July 2016
5.	Further develop the webpage and encourage teams to visit for updates and tips.	March 2016
6.	Support teams to achieve CS, particularly where there is poor uptake.	July 2016

10.4 Vocational Training

10.4.1 Apprenticeships

Health Education England (HEE) have now set a national target of that 6% of the workforce should be apprentices. Despite an increase over the last two years we are currently at 1.7% as an organisation. HEE will be undertaking an audit in early 2016 and our Lead for Vocational Training will be setting an action plan in response.

There are a number of benefits for having apprentices within the organisation who not only bring with them enthusiasm and a keenness to learn but financially there are benefits too as we only pay 75% of the salary.

11.0 Organisational Development (OD)

11.1 OD Plan

11.1.2 Values

Following the suggestion from the ICO Champion Group a number of workshops were held across the organisation during November and December with the purpose of asking staff to create the narrative for each of the values. From this process four suggestions for each value were taken to the ICO Champion Group (who also contributed) for them to decide on the final narrative. These value descriptions have now been signed off by the Executive Team.

The Communications Team have refreshed our organisational values diagram in accordance with NHS palate guidelines as seen below. All staff will have received a leaflet attached to their December wage slip that contains not only the values but the vision, strapline and purpose.

Sticky labels have been created and are available through the intranet for staff to place on the backs of their ID badges, an initiative that started with staff within the community.

During February a number of activities are happening to increase the visibility of the values which will include:

- The strapline and values diagram being placed on all corporate policies and paperwork.
- Once the values narratives have been signed of there will also be posters placed across the whole organisation together with banners within reception areas.

11.2 Long Terms Strategic Objectives

The Board has approved 4 long term Strategic Objectives as follows:

- Sale Quality Care and Best Experience
- Improved wellbeing through partnership
- Valuing our workforce
- Well led

The intention is that each Director will agree with the CEO a set of Annual objectives which relates to these 4 long term objectives. Each Director will publish his/her Annual objectives and by a cascade system when an individual member of staff's appraisal is undertaken a set of objectives will be agreed with him/her which relate to the Directors objective. In this way all Staff will be able to see how their work relates to the work of the Trust.

11.3 Leadership Visibility

A number of visits were undertaken by members of the executive team during November and December across the community, a rolling programme will follow to become business as usual.

11.4 Shadowing and Buddying

This had been suggested from staff in the ICO engagement sessions and by the ICO Champions as a way of creating a better understanding of the organisation and the services and roles within in it to address perceptions and promote an open culture.

Two ICO Champions have now piloted a process. They found the experience really useful and learnt a lot about a different service. They could see huge benefits in staff taking part particularly in areas where services are being re-designed and could be used in such a way to reduce the perceived barriers and misunderstandings of roles and services.

11.5 Team Talk

Team Talk is the name by which team meetings will be referred to from within the organisation. A guidance document has been created so support the importance of team meetings and offer template examples for agendas and content highlighting the importance and requirement of holding team meetings. Within the document it also promotes “time to reflect” to promote “Do it right, do it better, do it differently”.

The Director for Workforce and OD will be presenting the guidance document at All Managers on 25 January and it will be cascaded to the membership of that meeting. Team Talk will also be the topic for the Executive Blog during February.

11.6 Introduction to Management for New Line Managers

During January a two part Introduction to Management for new line manager’s programme was delivered. This included specific policies and procedures that are necessary to know and understand ranging from HR, Finance and Health and Safety together with topics regarding difficult conversations and feedback. This will now be delivered throughout the year.

11.7 New model of Care

OD are working with the ICO Care Model Lead in the supporting of the teams within the LMAT with a view to having an implementation plan of interventions and delivery to commence during February.

TSDFT Workforce and OD Scorecard 2015/2016 **Appendix A**

Dec-15

Indicator and (Target)	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Bank/Agency Spend Total	£7,556,792	£8,090,180	£8,900,611	£9,589,122	£737,624	£1,590,091	£2,498,486	£3,388,102	£4,383,581	£5,430,808	£6,718,244	£7,918,436	£9,059,507
Bank Monthly	£299,997	£280,678	£392,172	£319,911	£321,918	£394,001	£366,133	£375,545	£451,147	£373,237	£522,045	£644,746	£544,710
Agency Monthly	£485,234	£252,710	£418,259	£368,600	£415,706	£458,466	£542,262	£514,071	£544,332	£673,990	£765,391	£555,446	£596,361
Staff Headcount Number	4256	4274	4268	4255	4255	4255	4262	4256	4262	4276	6089	6078	6057
Staff Establishment WTE					3866.41	3872.03	3819.94	3844.10	3855.00	3887.31	5506.99	5527.21	5524.46
Staff in Post WTE					3615.57	3599.98	3597.75	3594.88	3682.92	3638.56	5144.64	5153.82	5108.62
Cumulative Vacancies WTE					250.84	272.05	222.19	249.22	172.08	248.75	362.35	373.39	415.84
Vacancy Factor (excl temp workforce and add hours) (4% or below)					6.49%	7.03%	5.82%	6.48%	4.46%	6.40%	6.58%	6.76%	7.53%
Bank Usage (WTE)	133.13	125.20	173.34	154.08	144.73	172.97	155.70	165.76	204.57	166.33	185.09	223.51	243.61
Agency Usage (WTE)	27.66	50.15	24.53	57.37	58.51	81.36	65.74	47.38	44.60	92.58	53.87	98.78	124.20
Additional Hours/Reduced Hours (-) (WTE)					-6.84	-16.23	3.75	6.07	-78.25	-28.72	3.82	42.85	2.37
Vacancy Factor (inc temp workforce and add hours) (4% or below)					1.41%	0.88%	-0.08%	0.78%	0.03%	0.48%	2.17%	0.15%	0.83%
Starters (Exc Junior Doctors)	23.7	35.5	26.7	21.5	20.1	19.9	16.5	24.3	32.4	48.3	70.0	59.9	23.9
Leavers (Exc Junior Doctors)	23.6	24.5	32.0	42.2	26.2	32.5	21.3	36.3	36.3	41.8	54.5	68.1	45.9
Staff Turnover Rate % (Between 10% - 14%)	11.45%	10.94%	10.96%	10.80%	10.78%	12.80%	11.00%	11.17%	11.05%	11.09%	12.79%	12.97%	13.15%
Sickness Absence Rate % (4.15% or less)	4.27%	4.21%	4.26%	4.23%	4.19%	4.18%	4.16%	4.13%	4.12%	4.12%	4.07%	4.04%	
Bradford Score % over 250 Points	12.10%	11.86%	12.41%	12.54%	12.53%	12.76%	12.38%	12.53%	12.23%	12.20%	11.62%	11.69%	
Sickness Cost	£4,362,063	£4,328,006	£4,356,680	£4,325,483	£4,288,033	£4,269,085	£4,223,943	£4,184,439	£4,172,131	£4,172,955	£6,058,810	£6,075,432	
Skill Mix (Registered/Non-registered)	54/46	54/46	54/46	53/47	54/46	54/46	54/46	54/46	54/46	54/46	55/45	55/45	55/45
Staff appraised in last year (90% or above)	83%	82%	83%	82%	83%	83%	84%	85%	85%	83%	80%	77%	78%
Age Profile - % of staff over 55 years of age	20.0%	20.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	22.0%	22.0%	22.0%

Training and Development - Percentage of staff compliant

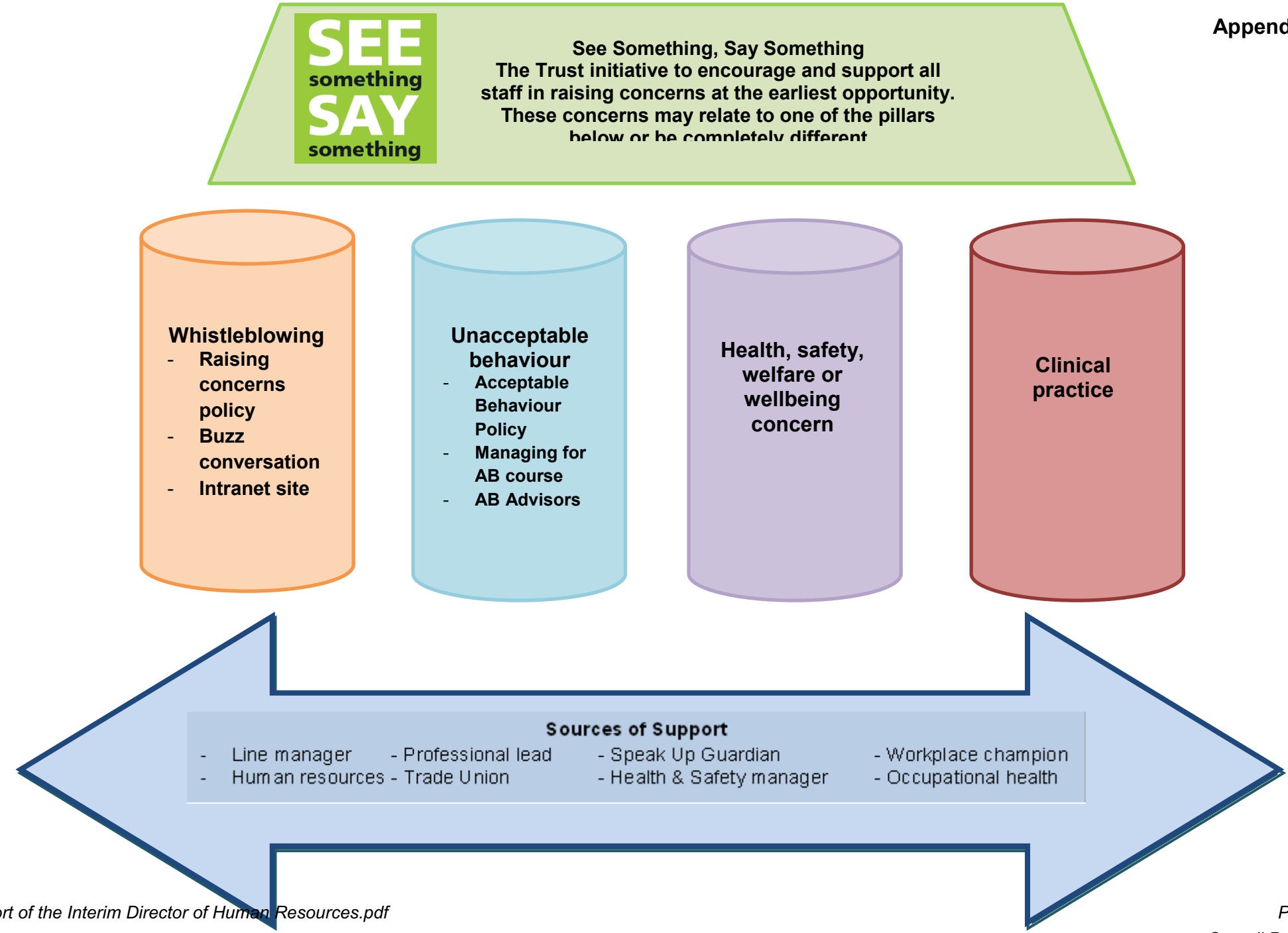
Information Governance Training (95% or above)	81%	83%	79%	85%	85%	85%	84%	85%	87%	87%	91%	90%	90%
Fire Training (85% or above)	74%	77%	79%	81%	82%	83%	83%	83%	84%	84%	85%	84%	86%
Child Protection L1 (90% or above)	77%	78%	81%	85%	85%	86%	86%	86%	87%	87%	92%	92%	93%
Infection Control (85% or above)	71%	76%	77%	79%	81%	81%	80%	81%	82%	82%	84%	83%	85%
Equality & Diversity (85% or above)	81%	83%	86%	88%	89%	90%	90%	90%	91%	90%	91%	92%	93%
Conflict Resolution (85% or above)	80%	81%	83%	85%	85%	87%	88%	87%	89%	87%	90%	91%	92%
Health & Safety (85% or above)	87%	88%	89%	89%	89%	88%	88%	87%	88%	86%	88%	88%	89%
Manual Handling (85% or above)	73%	77%	79%	81%	82%	83%	82%	83%	84%	84%	86%	86%	88%
Safeguarding Adults L1 (90% or above)	76%	78%	81%	85%	86%	87%	88%	88%	88%	88%	93%	93%	94%
Average Compliance	**78%**	**80%**	**82%**	**84%**	**85%**	**86%**	**85%**	**86%**	**87%**	**86%**	**89%**	**89%**	**90%**

Appendix B

OUTTURN	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Vacancy Factor % (excl temp workforce and add hours) - All ICO Staff	6.49%	7.03%	5.82%	6.48%	4.46%	6.40%	6.58%	6.76%	7.53%			
Vacancy Factor % (inc temp workforce and add hours) - All ICO Staff	1.41%	0.88%	-0.08%	0.78%	0.03%	0.48%	2.17%	0.15%	0.83%			
Sickness Absence - All ICO Staff	4.26%	4.28%	4.19%	4.16%	4.15%	4.12%	4.07%	4.04%				
Community BU Total	4.77%	5.01%	4.67%	4.54%	4.50%	4.53%	4.38%	4.43%				
Medicine BU Total	3.85%	3.87%	3.79%	3.75%	3.80%	3.85%	3.84%	3.83%				
Surgery BU Total	4.40%	4.41%	4.45%	4.47%	4.40%	4.36%	4.26%	4.19%				
WCD BU Total	3.64%	3.59%	3.57%	3.53%	3.46%	3.41%	3.27%	3.26%				
Staff Appraisals - All ICO Staff	84%	84%	86%	86%	86%	84%	80%	77%	78%			
Community BU Total	84%	86%	89%	89%	86%	86%	83%	80%	85%			
Medicine BU Total	84%	83%	86%	87%	86%	86%	81%	80%	76%			
Surgery BU Total	83%	82%	84%	86%	90%	89%	88%	85%	86%			
WCD BU Total	81%	84%	86%	85%	85%	79%	81%	80%	87%			
Mandatory Training - % Completion of 9 competencies - All ICO Staff	87%	87%	87%	88%	88%	87%	89%	89%	90%			
Community BU Total	93%	93%	91%	92%	92%	91%	92%	92%	93%			
Medicine BU Total	83%	84%	84%	83%	86%	85%	85%	85%	85%			
Surgery BU Total	85%	86%	86%	86%	87%	86%	87%	87%	88%			
WCD BU Total	90%	90%	90%	90%	90%	89%	89%	89%	89%			

				Appendix C	
TSDFT	**Sickness**	**Appraisal**	**Training (Average)**	**Staff**	**FTE**
Division/Directorate	Nov-15	Dec-15	Dec-15	Dec-15	Dec-15
CHARITABLE FUNDS DIVISION	1.57%	84%	90.20%	33	19.83
Dir - Chief Executive	0.00%	86%	93.95%	9	8.04
Dir - Education & Development	2.68%	82%	90.11%	71	67.80
Dir - Finance, Performance & Information	4.10%	74%	90.12%	277	246.90
Dir - Medical Director	0.00%	100%	100.00%	2	1.35
Dir - Nursing & Quality	2.91%	85%	89.39%	44	37.73
Dir - Operations	4.31%	62%	84.26%	95	83.39
Dir - Pharmacy Services	4.33%	51%	91.32%	86	73.42
Dir - Workforce	5.61%	67%	92.59%	72	60.60
CORPORATE SERVICES DIVISION	4.01%	70%	89.73%	656	579.22
Dir - Estates & Facilities	4.77%	56%	98.15%	54	52.57
Dir - Hotel Services	8.19%	42%	79.49%	372	280.05
ESTATES & FACILITIES MANAGEMENT DIVISION	7.63%	44%	81.85%	426	332.63
Dir - Cancer Services - Medicine	5.91%	63%	84.02%	185	159.05
Dir - Care of the Elderly - Medicine	5.07%	84%	78.36%	139	123.38
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	3.44%	68%	88.25%	35	28.62
Dir - Emergency Services	3.92%	89%	89.12%	241	202.52
Dir - Gastoenterology/Endocrinology- Medicine	4.21%	62%	83.45%	110	96.32
Dir - General Medicine	6.30%	83%	86.94%	73	63.87
Dir - Heart & Lung- Medicine	5.06%	74%	83.93%	200	170.62
MEDICAL SERVICES DIVISION	4.89%	76%	84.75%	983	844.40
PHARMACY DIVISION (Manufacturing)	1.62%	68%	89.93%	117	109.19
RESEARCH & DEVELOPMENT DIVISION	4.66%	74%	88.01%	40	31.83
Dir - Breast Care	0.50%	92%	94.93%	47	36.87
Dir - General Surgery	5.22%	84%	83.36%	264	221.39
Dir - Head & Neck	1.97%	82%	90.67%	100	74.12
Dir - Ophthalmology	2.39%	96%	88.36%	105	89.39
Dir - Surgical Division	7.23%	98%	94.16%	75	68.53
Dir - Theatres, Anaesthetics and ICU	3.99%	79%	87.83%	400	356.58
Dir - Trauma and Orthopaedics	3.63%	94%	88.22%	166	142.91
SURGICAL SERVICES DIVISION	4.02%	86%	87.85%	1157	989.79
Dir - Child Health	3.40%	91%	87.36%	153	124.35
Dir - Lab Medicine	2.82%	84%	84.59%	121	105.47
Dir - Obs & Gynae	3.22%	84%	90.16%	215	172.73
Dir - Radiology & Imaging	3.74%	87%	90.87%	129	112.10
Dir - Sexual Health	2.76%	68%	89.44%	40	30.55
Dir - Therapies	3.87%	90%	88.18%	215	177.53
Dir - Women's, Children's and Diagnostics	4.43%	96%	95.93%	30	29.19
WOMEN'S, CHILDREN'S & DIAG' DIVISION	3.45%	87%	88.72%	903	751.93

545 Dir - 24/7 Nursing/Rapid Response (SD)	1.85%	52%	94.75%	36	30.82
545 Dir - Dawlish & Teignmouth Zone (SD)	2.54%	97%	98.20%	37	30.45
545 Dir - Moorland Zone (SD)	0.78%	75%	96.83%	21	16.74
545 Dir - Newton Abbot Zone (SD)	7.66%	76%	90.57%	33	26.99
545 Dir - Other (Teignbridge) (SD)	1.09%	90%	96.57%	55	42.86
545 Dir - Totnes & Dartmouth Zone (SD)	0.87%	84%	95.77%	34	29.08
545 Div - Community Services - Southern Devon	2.45%	81%	95.53%	216	176.94
545 Dir - Baywide Services	5.28%	81%	94.45%	44	37.87
545 Dir - BEST	7.61%	82%	91.97%	18	13.44
545 Dir - Brixham Zone	5.07%	88%	87.74%	59	46.96
545 Dir - MSK	2.55%	94%	93.54%	39	29.76
545 Dir - Older Peoples Mental Health	7.12%	70%	86.87%	11	7.67
545 Dir - Other Social Care	7.61%	93%	94.29%	35	31.49
545 Dir - Paignton Zone	2.80%	88%	91.90%	106	91.24
545 Dir - Torbay Community Support	0.66%	85%	97.53%	27	25.08
545 Dir - Torquay Zone	6.94%	69%	90.24%	147	126.20
545 Div - Community Services - Torbay	5.06%	82%	91.63%	486	409.69
545 Div - Continuing Healthcare	4.78%	50%	90.95%	27	24.41
545 Dir - Board & Headquarters	11.75%	64%	98.52%	15	13.85
545 Dir - Finance & Corporate Services	1.20%	71%	90.20%	51	48.35
545 Dir - HR & Training	0.00%	79%	96.67%	30	26.81
545 Dir - Operations Support	1.16%	93%	91.11%	50	46.88
545 Div - Corporate Services	2.03%	79%	92.70%	146	135.89
545 Dir - Ashburton Hospital	1.74%	89%	93.24%	23	17.63
545 Dir - Bovey Tracey Hospital	4.60%	100%	78.89%	20	16.60
545 Dir - Brixham Hospital	0.92%	83%	96.41%	34	26.59
545 Dir - Dartmouth Hospital	0.08%	96%	93.79%	34	26.79
545 Dir - Dawlish Hospital	4.70%	100%	97.12%	27	22.39
545 Dir - MIU Services	11.50%	77%	90.74%	30	25.18
545 Dir - Newton Abbot Hospital	4.12%	89%	90.69%	111	93.23
545 Dir - Paignton Hospital	8.76%	89%	93.03%	59	45.49
545 Dir - Teignmouth Hospital	1.07%	88%	90.12%	44	32.29
545 Dir - Totnes Hospital	3.31%	95%	95.56%	44	34.42
545 Div - Hospital Services	4.26%	90%	92.16%	426	340.60
545 Div - Medical	6.63%	80%	94.65%	27	22.80
545 Dir - Allied Health Professionals	1.88%	100%	96.90%	75	61.23
545 Dir - Professional Practice	2.51%	93%	91.85%	81	67.73
545 Div - Professional Practice	2.21%	96%	94.27%	156	128.97
545 Dir - Health Visiting & School Nursing	2.96%	77%	90.67%	106	81.33
545 Dir - PH Provider Services	7.81%	97%	93.62%	94	78.77
545 Div - Public Health	5.32%	86%	92.06%	200	160.10
545 Dir - Independent Sector (Mental Health)	2.19%	38%	95.56%	10	9.32
545 Dir - Inhouse Services LD	3.89%	88%	93.98%	48	34.99
545 Div - Torbay Social Care Specific	3.55%	80%	94.26%	58	44.31
	4.25%	**78%**	89.92%	**6057**	**5102.52**


SEE
something
SAY
something
See Something, Say Something
The Trust initiative to encourage and support all staff in raising concerns at the earliest opportunity. These concerns may relate to one of the pillars below or be completely different
Whistleblowing
- Raising concerns policy
- Buzz conversation
- Intranet site
Unacceptable behaviour
- Acceptable Behaviour Policy
- Managing for AB course
- AB Advisors
Health, safety, welfare or wellbeing concern
Clinical practice
Sources of Support
- Line manager
- Human resources
- Professional lead
- Trade Union
- Speak Up Guardian
- Health & Safety manager
- Workplace champion
- Occupational health

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	3 February 2016
Title:	Finance & Performance Report
Lead Director:	Director of Finance Chief Operating Officer Chief Nurse
Corporate Objective:	All
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The Finance and Performance report describes delivery of the objectives, drawn from the Trust's longer term strategy, targeted for delivery in the current year.

Key Issues/Risks

The main body of the report describes exceptions against the agreed standards, including:

- Four hour emergency performance
- Elective referral to treatment time standards
- Financial performance, including the delivery of the continuous improvement programme.

Recommendations:

The Board are asked to note the report and the actions planned to improve performance.

Summary of ED Challenge/Discussion:

The Executive Team have, following discussion:

- Agreed immediate escalation actions alongside the development of a wider structural plan, considering staffing and bed configuration, that will better support the sustainable delivery of the 4 hour Emergency Care Standard.

- Agreed a range of recovery actions to improve the financial position, sensitive to the above, and with the intent of delivering a result closer to that originally set out in the Long Term Financial Model supporting the establishment of the Integrated Care Organisation.

-

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

There has been wide scale internal engagement through the operational and performance management processes.

Equality and Diversity Implications:

None specifically identified.

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Board Performance Report

December 2015

1. Summary & Key Issues

1.1 Service and Quality Standards

- Quality indicators
  - There are no CQC regulatory concerns being reported. The latest Intelligent monitoring report (May 2015) maintains an overall score of 3 with 9 risks identified.
  - Stroke – Although improved from 60% to 73% during the calendar year, the 90% of time being spent on a stroke unit is not being achieved. Release of the most recent stroke audit data also identified the time to ward as a priority for improvement.
  - The timeliness of clinic letters has deteriorated.

- Monitor Compliance Framework
  - 4 hour standard not met in December. Contract performance notice issued in October. The remedial action plan is showing several actions not delivered with the CCG withholding 2% of contract value against undelivered actions.
  - RTT incomplete pathways not met in December. Contract performance notice issued. Remedial Action Plan (RAP) submitted and monitoring arrangement in place. The original RAP and improvement trajectory to achieve the 92% standard by end of Q4 has been reviewed and considered too high risk to provide confidence.
  - Cancer standards. All cancer targets achieved in December and overall in Q3. Risks against compliance in Q4 have been raised.

- Contractual Framework
  - Waiting times for diagnostic tests did not meet the standard by 0.1% in December. The key actions are recruitment to radiologist posts and maternity cover along with capacity from outsourcing support in key areas of reporting, CT and ultrasound. There is significant pressure on the workforce in January which puts this standard at significant risk. Mitigating actions are being taken.
  - Care Planning summary timeliness remains a challenge with 55% meeting the 24 hour standard during weekdays.

1.2 Financial Performance

- This report monitors against the revised Annual Plan agreed and submitted to Monitor on 18th December 2015 following the acquisition of Torbay and Southern Devon Health and Care NHS Trust. This was prepared on the basis of actuals for the first eight months, and therefore variances month 8 are reported as zero.

- The revised plan has increased the deficit position by £1.5M after risk share contributions from Commissioners. South Devon and Torbay CCG have an affordability gap with the original planned contractual values. The risk share contribution will increase the CCG funding requirement from an already challenged position. The Trust has developed additional recovery measures to try and improve this position.

- At EBITDA level, performance for the nine months ended 31st December 2015 is broadly in line with the revised plan at £4.4m.

- The year to date I&E deficit of £6.9m is in line with the revised plan.

- The Trust has a £1.1m deficit in month excluding the gain from the transfer by absorption, but after risk share income has been applied.

- CIP delivery remains a significant challenge and is the focus of all budget holders.

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

- Cash balances are lower than plan by over £4m due to working capital movement offset by lower than planned Capital expenditure.

- The year end forecast for capital expenditure now totals £19.4m which is in line with revised plan.

- Agency Registered Nursing spend to date is running at 6.9% in month, 6.8% year to date, against a cap of 4%.

Torbay & South Devon NHS FT Performance Report - December 2015

Appendix 1 - 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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD 15/16
QUALITY FRAMEWORK																							
Safety Thermometer - % Harm Free - (Acute)	✓		✓			> 95%	<95%		>=95%	99%	98%	98%	99%	97%	100%	98%	98%	97%	95%	98%	99%	98%
Safety Thermometer - % Harm Free - (Community)	✓		✓			> 95%	<95%		>=95%				89%	88%	88%	88%	87%	88%	90%	87%	86%	88%
Pressure Ulcers - Category 3 + 4 - (Acute)	✓		✓			Nil	>=1		<1	2	2	0	1	1	1	0	2	2	1	0	0	8
Pressure Ulcers - Category 3 + 4 - (Community) 1 month arrears	✓		✓			Nil	>=1		<1				1	0	0	0	0	0	0	0		1
Reported Incidents - Major + Catastrophic - (Acute)	✓		✓			Nil	>=20	Between	<5	1	3	2	4	1	0	0	0	1	0	0	0	6
Reported Incidents - Major + Catastrophic - (Community)	✓		✓			Nil	>=20	Between	<5				0	1	1	0	1	1	1	0	0	5
Never Events - (Acute)	✓		✓			Nil	>=1		<1	1	0	1	0	0	0	1	0	1	0	0	0	2
Never Events - (Community)	✓		✓			Nil	>=1		<1				0	0	0	0	0	0	0	0	0	0
Written Complaints - Number Received - (Acute)	✓	✓	✓			<30	>=30		<30	23	28	33	26	23	22	18	18	22	22	24	18	193
Complaints - Number Received - (Community) - includes written and telephone	✓	✓	✓			<30	>=30		<30				14	11	17	18	8	11	14	18	14	93
(P) - VTE - Risk assessment on admission - (Acute)	✓		✓		✓	>95%	<93%	Between	>95%	81.6%	89.0%	89.9%	93.4%	94.0%	94.0%	95.2%	95.3%	94.6%	95.1%	94.6%	94.0%	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%	100.0%	100.0%	95.8%
Medication errors - (Acute)	✓		✓			<15	>=30	Between	<20	32	310	34	41	207	28	29	33	33	34	34	9	448
Medication errors - (Community)	✓		✓			<15	>=30	Between	<20				40	33	32	49	35	26	30	23	25	245
HSMR - hospital standardised mortality rate	✓		✓			<100%	>=105%	Between	<100%	108%	90%	91%	111%	110%	86%	99%	106%	103%	92%	83%	85%	
Infection Control - Bed Closures - (Acute)	✓		✓			<100	>=170	Between	<100	141	156	104	358	955	288	40	68	18	54	92	36	1909
Proportion of Wards Compliant with Safer Staffing Levels	✓		✓			>90%																
Fracture Neck Of Femur Best Practice	✓		✓		✓	>90%	<90%		>=90%	72%	63%	60%	70%	74%	50%	59%	62%	61%	64%	71%	76%	65%
(P) - Stroke patients spending 90% of time on a stroke ward - 72hr cohort from Nov-1	✓	✓	✓		✓	>80%	<80%		>=80%	62%	60%	60%	73%	54%	70%	68%	65%	62%	67%	67%	73%	67%
CQC Compliance intelligent monitoring score / banding										4	4	4	4	3	3	3	3	3	3	3	3	3
(P) - Dementia - Find - monthly report						>90%	<90%		>=90%	36%	35%	41%	49%	41%	52%	55%	75%	71%	74%	74%	66%	63%
(P) - Dementia - Assess & Investigate - Monthly report						>90%	<90%		>=90%	56%	47%	68%	48%	81%	61%	66%	73%	80%	62%	57%	64%	66%
(P) - Dementia Refer - Monthly report						>90%	<90%		>=90%	95%	100%	96%	100%	100%	100%	100%	100%	100%	96%	100%	93%	99%
Clinic letters timeliness - % specialties within 4 working days							<80%		>80%	68%	95%	91%	82%	86%	73%	86%	77%	73%	59%	59%	73%	74%
Follow ups past to be seen date						Nil				3112	3096	3115	3294	3577	3745	4020	4570	4873	4731	4542	5090	
MONITOR COMPLIANCE FRAMEWORK																						
Referral to treatment waiting times – admitted - (Acute)		✓	✓			90%	<90%		>=90%	77%	75%	76%	82%	76%	72%	74%	77%	81%	80%	75%	73%	77%
Referral to treatment waiting times – non-admitted - (Acute)		✓	✓			95%	<95%		>=95%	95%	95%	96%	95%	95%	95%	95%	95%	95%	94%	93%	93%	94.6%
Referral to treatment - % Incomplete pathways - (Acute)		✓	✓			92%	<92%		>=92%	92%	92%	92%	91%	92%	91%	92%	92%	92%	91%	91%	91%	91.6%
Number of Clostridium Difficile cases - Lapse of care - (Acute)	✓		✓			Nil	>=2		<2	1	1	0	1	1	3	1	1	2	0	0	1	10
(P) - Cancer - Two week wait from referral to date 1st seen		✓	✓			93%	<93%	Between	>93.5%	96.8%	97.2%	96.4%	94.8%	94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.6%	95.9%
(P) - Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		✓	✓			93%	<93%	Between	>93.5%	93.9%	98.9%	96.8%	98.8%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	97.2%
(P) - Cancer - 31-day wait from decision to treat to first treatment		✓	✓			96%	<96%	Between	>96.5%	96.5%	100.0%	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	98.5%
(P) - Cancer - 31-day wait for second or subsequent treatment - Drug		✓	✓			98%	<98%	Between	>98.5%	100.0%	100.0%	98.3%	100.0%	100.0%	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%	98.3%	100.0%	98.4%	94.1%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%	96.9%
(P) - Cancer - 31-day wait for second or subsequent treatment - Surgery		✓	✓			94%	<94%	Between	>94.5%	100.0%	100.0%	97.1%	96.4%	93.8%	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	95.8%	95.0%
(P) - Cancer - 62-day wait for first treatment - from 2ww referral		✓	✓			85%	<85%	Between	>85.5%	87.2%	86.4%	85.2%	96.0%	92.5%	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.4%	89.4%
(P) - Cancer - 62-day wait for first treatment - screening		✓	✓			90%	<90%	Between	>90.5%	72.7%	71.4%	91.7%	100.0%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	93.8%	95.8%
A&E - patients seen within 4 hours (ICO combined A&E figs from Oct 2015)	✓	✓	✓			95%	<95%		>=95%	87%	81%	88%	94%	90%	91%	82%	80%	90%	91%	88%	85%	88%
CONTRACTUAL FRAMEWORK																						
Diagnostic tests longer than the 6 week standard - (Acute)		✓	✓			<1%	>=1%		<1%	3.2%	1.0%	1.0%	4.5%	2.5%	1.2%	1.1%	2.6%	2.7%	0.4%	0.8%	1.1%	1.9%

Torbay & South Devon NHS FT Performance Report - December 2015

Appendix 1 - Performance report

FRAMEWORK	KEY
Indicators split by buisness unit	(P) = Provisional
Trustwide / Acute indicators	

	Safest Care	No Delays	Experience	Promoting Health	Improved Value	Target 2015/16	Red	Amber	Green	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD 15/16
Mixed sex accomodation breaches of standard - (Acute)		✓	✓			<1	>=1		<1	0	1	0	0	0	0	0	0	3	1	0	0	4
Care Planning Summaries % completed within 24 hours of discharge - Weekday	✓	✓	✓			>77%	<77%		>=77%	60%	45%	56%	57%	56%	60%	61%	62%	62%	62%	62%	55%	59.5%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	✓	✓	✓			>60%	<60%		>=60%	40%	31%	41%	34%	27%	33%	37%	28%	24%	27%	30%	24%	29.4%
On the day cancellations for elective operations		✓	✓			<0.8%	>=0.8%		<0.8%	1.55%	1.47%	1.65%	0.72%	1.31%	1.02%	0.71%	0.84%	0.84%	0.98%	0.96%	1.37%	1.0%
Cancelled patients not treated within 28 days of cancellation		✓	✓			<4	>=4		<4	7	1	2	4	2	4	3	2	0	0	2	3	20
Ambulance handover delays > 30 minutes	✓	✓	✓			<50	>=75	Between	<50	55	72	34	23	27	18	68	87	86	42	103	75	529

Torbay & South Devon NHS FT Performance Report - December 2015

Appendix 1 - 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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	YTD 15/16
Ambulance handover delays > 30 minutes	✓	✓	✓			<50	>=75	Between	<50	55	72	34	23	27	18	68	87	86	42	103	75	529
Ambulance handover delays > 60 minutes	✓	✓	✓			<5	>=10	Between	<5	0	6	4	0	0	0	1	3	2	2	2	5	15
A&E - patients seen within 4 hours DGH only	✓	✓	✓				<95%		>=95%	87%	81%	88%	94%	90%	91%	82%	80%	90%	88%	83%	80%	87%
A&E - patients seen within 4 hours community MIU	✓	✓	✓				<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	3	1	4
Number of Clostridium Difficile cases - (Acute)							>=3		<3				3	4	4	3	2	3	1	2	1	23
Number of Clostridium Difficile cases - (Community)							>=1		<1				0	0	1	1	1	0	0	0	0	3
Number of Clostridium Difficile cases - Lapse of care - (Community)							>=1		<1				0	0	0	1	0	0	0	0	0	1
COMMUNITY & SOCIAL CARE FRAMEWORK																						
Number of Delayed Discharges			✓			<185	>185		<185				400	508	401	320	403	317	211	467	327	3354
Timeliness of Adult Social Care Assessment			✓			75%	>75%		<75%				70%	71%	71%	71%	70%	70%	70%	71%	67%	0%
Clients receiving Self Directed Care				✓		70%	<70%		>70%				89%	92%	92%	93%	93%	93%	93%	93%	93%	0%
Carers Assessments Completed year to date				✓		>40%							7%	11%	19%	18%	24%	27%	32%	36%	38%	0%
Number of Permanent Care Home Placements			✓			<630							649	652	652	646	645	639	645	630	636	0
Children with a Child Protection Plan				✓		TBC							160	157	156	161	190	199	216	216	0	
4 Week Smoking Quitters				✓		>50									118			231				
% OCU in Effective Drug Treatment				✓		>9.3									7%			6%				
% Safeguarding Strategy Meetings within 7 Days				✓		>80%							73%	57%	45%	38%	38%	46%	44%	44%	41%	0%
Bed Occupancy													91%	91%	91%	91%	92%	91%	92%	90%	90%	
CAMHS - % of referrals seen within 18 weeks													75%	75%	75%	75%	78%	33%	48%	60%	88%	
CHANGE FRAMEWORK																						
Number of Emergency Admissions - (Acute)			✓		✓	TBC				2437	2276	2597	2729	2546	2631	2732	2580	2694	2776	2760	2706	24154
Average Length of Stay - Emergency Admissions - (Acute)		✓	✓		✓	TBC				3.93	3.81	3.72	3.32	3.43	3.52	3.24	3.25	3.20	3.22	3.41	3.54	
Hospital Stays > 30 Days - (Acute)		✓	✓		✓	TBC				25	29	27	24	23	33	27	21	28	17	18	21	212
LMAT Population Coverage			✓	✓		TBC																
CORPORATE MANAGEMENT FRAMEWORK																						
Staff Vacancy Rate - (Trustwide)						<4%	>6%	Between	<4%				n/a	n/a	n/a	n/a	n/a	n/a	6.58%	6.76%	7.53%	
Staff sickness / Absence - (Trustwide) 1 month arrears						<4%	>5%	Between	<4%				4.26%	4.28%	4.19%	4.16%	4.15%	4.12%	4.07%	4.04%	n/a	
Appraisal Completeness - (Trustwide)						>90%	<80%	Between	>90%				83.80%	84.48%	85.67%	86.17%	86.26%	84.30%	80.37%	77.00%	78.00%	
Mandatory Training Compliance - (Trustwide)						>85%	<80%	Between	>85%				86.94%	87.44%	87.30%	87.66%	88.16%	87.32%	88.77%	88.86%	89.92%	

3. Service & Quality Standards

3.0 Summary of Performance dashboard "highlights and Performance variances"

Overview of Performance as identified in the Performance Dashboard

3.0 Quality Framework indicators

3.1 CQC regulation compliance assessment

There are no CQC regulatory concerns being reported. The latest 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. Stage 1 and 2 provider information requests completed on schedule with initial data packs now received for validation and sign off. The executive team receive regular updates against the in-house preparations and against risk logs.

3.2 Fractured neck of femur time to theatre

The time to theatre for patients presenting with a fractured neck of femur remains a challenge. Increased trauma theatre sessions are required and this is part of the orthopaedic business plan.

3.3 Stroke time spent on a stroke unit part of SSNAP domain 2 – stroke unit key indicator compliance

The indicator used to measure the time spent on a stroke ward for December has been updated to reflect the SSNAP patient centred analysis and represent the ICO whole pathway of care which includes 'Teign' ward at Newton Abbot Hospital.

The time spent on a stroke ward indicator is part of the wider Domain 2 of the SSNAP audit and has shown a 10% improvement since the renewed focus on stroke bed ring fencing. The latest SSNAP audit data released covers the period June to September 2015. The SSNAP audit has become the nationally recognised benchmark for measuring stroke pathway and stroke unit performance.

The latest SSNAP report shows improvement is required against Domain 2 with a score of E, the lowest performing band for stroke services. Improvement is also required against two other areas, the time to scan and delivery of specialist assessments both scoring D.

The SSNAP Domain 2 score comprises 3 indicators:

1. Time from clock start (ambulance) to stroke unit admission – Target 4 hours
2. Median time from clock start to arrival on the stroke unit
3. % of time spent on a stroke ward – target 80% of patient spending 90% or more of their total stay on the stroke ward.

Against Domain 2 of the audit the percentage of time spent on a stroke ward has improved and is meeting the target standard, however the time to admit to stroke ward within 4 hours is shown as the greater challenge. The National median being 3hrs 28mins against the local median time of 4 hours 54 mins with 37% of patients achieving the 4 hour standard.

The creation of the ambulatory care pathways and the Acute Medical Unit has changed the pathway for a number of patients who can now bypass A+E department and move directly to the medical emergency team for assessment. An audit of stroke pathways is now being carried out to identify how this change may be impacting on the time taken to admit patients directly to the stroke ward as well as root cause analysis to inform the wider action plan. The action plan based on the audit will be prepared in February and will set out the identified challenges and actions for overall Domain 2 performance improvement. This approach has been agreed with commissioners. It is noted that the clinical indicators and outcomes remain good with an overall score of C being achieved placing the trust just below the National median score as describe in the scoring distribution summary below

Patient-centred Total Key Indicator levels:
A - 51 teams (25%)
B - 54 teams (26%)
C - 43 teams (21%)
D - 51 teams (25%)
E - 7 teams (3%)

Patient-centred KI levels:		
Patient-centred Domain levels:	1) Scanning	D
	2) Stroke unit	E
	3) Thrombolysis	C
	4) Specialist Assessments	D
	5) Occupational therapy	A
	6) Physiotherapy	A
	7) Speech and Language therapy	B
	8) MDT working	C
	9) Standards by discharge	B
	10) Discharge processes	A
Patient-centred KI level	Patient-centred Total KI level	C
	Patient-centred Total KI score	68
Patient-centred SSNAP level	Patient-centred SSNAP level (after adjustments)	C
	Patient-centred SSNAP score	68

Domain 2 key indicator analysis

	Torbay Hospital	*Torbay Hospital*	*Torbay Hospital*	*Torbay Hospital*	***National July-Sep 2015***		
The item references show where to find more detail on national and your results in the other sections of the report	***Oct-Dec 2014***	***Jan-Mar 2015***	***Apr-June 2015***	***July-Sep 2015***	Median	Lower Qtl	Upper Qtl
2. Stroke unit key indicators See technical information for how calculated							
2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start							
2.1A Patient centred Item reference: G7.18	***33.8***	***27.2***	***37.9***	***36.7***	*62.4*	*50*	*72.9*
2.1B Team centred Item reference: H7.18	***32.9***	***27.1***	***37.9***	***36.7***	*62.1*	*47.9*	*73.1*
2.2 Median time between clock start and arrival on stroke unit (hours:mins)							
2.2A Patient centred Item reference: G7.4	***5:07***	***5:33***	***4:45***	***4:54***	*3:26*	*2:47*	*3:54*
2.2B Team centred Item reference: H7.4	***5:17***	***5:33***	***4:45***	***4:54***	*3:34*	*2:58*	*4:00*
2.3 Proportion of patients who spent at least 90% of their stay on stroke unit							
2.3A Patient centred (proportion of stay across all inpatient teams) Item reference: J8.11	***81.3***	***75.7***	***78.3***	***87.3***	*88.2*	*80.3*	*93*
2.3B Team centred (proportion of stay under your team whilst an inpatient) Item reference: K32.11	***71.9***	***74.3***	***75.8***	***77.8***	*89.3*	*81.1*	*93.7*

3.4 VTE risk assessment on admission to hospital

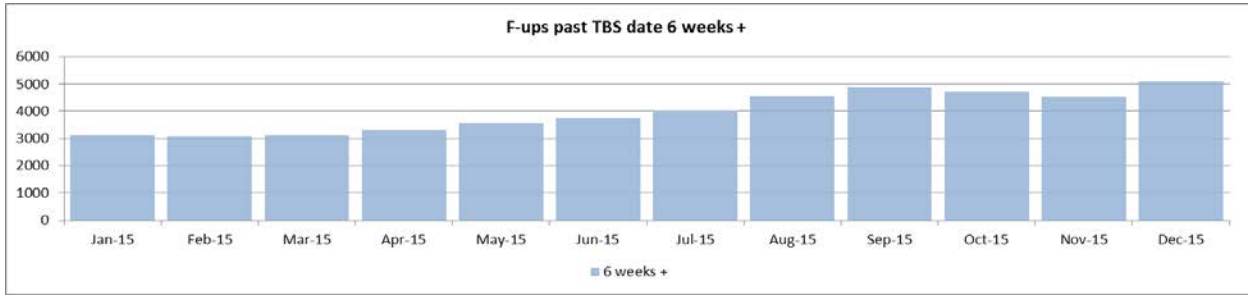
The percentage of patients reported as receiving VTE risk assessment on admission to Hospital is below the standard of 95% in December with 94% being reported. The audit process to review clinical records is in place to retrospectively record any assessments carried out but not recorded in the patients care planning summary. The forecast is that on completion of this audit the standard of 95% will be achieved for Q3.

3.5 Completion of Dementia find assessment on admission to hospital

The standard of completing a dementia assessment for all patients admitted to hospital over 75 years old is not being achieved. A nurse led approach is being trialled that seems to be improving performance in surgical wards. This will be evaluated with potential to roll out to other areas with 66% being reported against the target of 90%.

3.6 Follow up appointments passed their to be seen by date

The number of patients waiting for a follow up appointment of over 6 weeks past the intended 'to be seen' by date has increased.



The numbers against each specialty are routinely monitored through the RTT meetings. The service delivery units have been asked to provide assurance that clinical priority patients are being reviewed and seen if not discharged. The actions are to increase overall capacity to see these patients, work with clinical teams to ensure appropriate timelines are followed and where possible patients discharged back to primary care.

4.0 Monitor Compliance Framework

4.1 The Monitor Annual Plan for 2015/16

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

1. A+E 4 hour performance – plan to be compliant from the end of Q1
2. 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%)

4.2 December update against declared risks

4.2.1 4 hour standard for time spent in A&E

The standard of 95% is not achieved in December and remains at variance to our declared Monitor plan. The ICO performance which combines the Torbay Hospital (type 1 dept.) and the community MIU activity is 85.35%. Torbay Hospital performance on its own is 79.72% against the target of 95%. The community minor injury units achieved 99.96% with one recorded breach of the 4 hour standard.

Summary of A+E performance for December

Arrival /Week Commencing/Month Commencing Date	ICO Attendances	ICO 4 Hour Breaches	ICO 4 Hour Breach % (Target 95%)	ED Attendances	ED 4 Hour Breaches	ED 4 Hour Breach % (Target 95%)	MIU Attendances	MIU 4 Hour Breaches	MIU 4 Hour Breach % (Target 95%)
01-Dec-2015	8,135	1,192	85.35 %	5,874	1,191	79.72 %	2,261	1	99.96 %

In response to the Contract Performance Notice issued in October regarding the 4 hour performance a remedial action plan has been agreed. This is being monitored through the biweekly action plan and performance review meeting. Contract sanction of 2% of service line income has been indicated against each unmet milestone, to a maximum of 10% in any month. This is currently being shown as offset against contract discount in line with the Risk Share Agreement.

The CCG's assessment of remedial action plan milestones due to be delivered by end of December identifies five actions as not delivered. The Trust are responding to this formal contract notice received on 11th January within the contractual timescale of 20 working days with further evidence and operational context to the delivery of these actions.

Patient flow which is critical for managing A+E waiting times has been a challenge during December with escalation wards open during this period and continued difficulties in accessing non acute settings and packages of care. The post bank holiday pressures from delayed discharges have been a significant challenge. Performance in January will see little or no improvement with reported performance to the 18th of January for the combined ICO being 82.19%. The constraints to patient flow manifested themselves on Monday 11th January with a performance of 50%, however there has been a steady improvement since this time with the trust moving from a Red to Amber escalation status.

4.2.2 RTT incomplete pathways

The standard (92%) has not been achieved in December. The table below shows the reported performance level of 91% and includes analysis of all specialties not achieving the standard:

	<126		>126			
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Incomplete IPDC	Incomplete Outpatients	Grand Total	% < 18wk
Pain Management	191	286	32	12	521	91.55
Gastroenterology	412	315	25	49	801	90.76
Plastic Surgery	151	67	23	5	246	88.62
Trauma & Orthopaedics	648	950	132	111	1841	86.80
Colorectal Surgery	78	334	29	61	502	82.07
Ophthalmology	718	858	357	34	1967	80.12
Clinical Neuro-Physiology		41		14	55	74.55
Upper Gastrointestinal Surgery	146	218	114	27	505	72.08
Grand Total	3363	11141	811	623	15938	91.00

The commissioners have raised a contract performance notice in relation to the underperformance against the delivery of the incomplete RTT standard. The remedial action plan submitted to this notice has been assessed as providing insufficient assurance of delivery by the 31st March 2016. Consequently the CCG issued a further contract notice of 'failure to agree a remedial action plan' on 18th January, indicating an intention to withhold 2% of contract value, should a remedial action plan demonstrating delivery by 31st of March not be received by 28th of January. The Trust is considering its response to this communication and will keep board members informed of progress.

All plans are reviewed at the biweekly RTT and diagnostics assurance meeting chaired by the chief operating officer (COO) and the CCG commissioning lead in attendance.

4.2.3 Clostridium Difficile (c-diff)

One new case of c-diff is reported in December. This brings the cumulative total for the year to 23 cases with 10 being confirmed as the result of lapses in care. The community had no new cases of C-diff in December.

4.2.4 Cancer standards

All Cancer standards have been met in December 2015 and for Quarter 3. This will be reported in the Monitor risk assessment.

Looking ahead into Quarter 4 there are risks being identified against the 31day to first treatment, subsequent radiotherapy treatment and subsequent surgery treatments.

In December, a number of pathways had been deferred through patient choice, and will breach target in January. Subsequent surgery for the skin pathway is the most significant risk with treatment times extending. The Dermatology team are looking at options to provide additional treatment capacity. Several additional lists have already been planned however further capacity is still required to manage the number of patents requiring treatment in the period.

Other challenges presenting in Q4 on overall capacity will be managing leave over the half term and early part of the Easter holiday period.

	October 2015	November 2015	December 2015	3rd Quarter Total			
	%	%	%	Target	No. Seen	Breached	%
14day 2ww ref	98.1%	97.3%	97.6%	93.0%	2640	62	97.7%
14day Br Symp	98.1%	93.6%	97.8%	93.0%	352	12	96.6%
31day 1st trt	96.6%	98.7%	98.8%	96.0%	499	10	98.0%
31day sub drug	100.0%	100.0%	100.0%	98.0%	146	0	100.0%
31day sub Rads	97.7%	96.4%	100.0%	94.0%	141	3	97.9%
31day sub Surg	96.8%	92.3%	96.0%	94.0%	95	5	94.7%
31day sub Other	100.0%	100.0%	100.0%	-	63	0	100.0%
62day 2ww ref	86.5%	88.2%	89.0%	85.0%	257.5	31.5	87.8%
62day Screening	100.0%	90.5%	100.0%	90.0%	36.5	1	97.3%
62day Upgrade	100.0%	93.3%	100.0%	-	19	0.5	97.4%

5.0 Contract Framework

5.1 Commissioning for Quality and Innovation (CQUIN)

The CQUIN assessment for Q3 will be submitted to commissioners in January. There are no further risks being identified to the Board. In Q2, the final assessment confirmed underachievement in two CQUIN schemes, Dementia and Acute Kidney Injury with an indicated contract adjustment value of £78k in the period to 30th September.

5.2 Diagnostic tests waiting over 6 weeks

The performance against the 6 week standard was not met in December with 1.1% (43 patients), waiting beyond 6 weeks at the month end. There remain capacity pressures particularly in CT and ultrasound . Recruitment to vacant radiologist posts and maternity cover is the current challenge in radiology. Immediate plans include outsourcing for scan reporting to release radiologist time, along with mobile CT capacity and sonographer sessions. In December, other areas with patient waiting over 6 week included Audiology and Dexa scanning, a review of waiting times and capacity in these areas is being undertaken.

12 hour Trolley wait in A+E

In December, one patient is reported as having waited over 12 hours in the emergency department from decision to admit to actual admission to a ward bed. This was due to no beds being available and the hospital being fully escalated. This has been reported to the CCG and an exception report completed.

Cancelled operations

In December, the number of elective operations cancelled on the day of admission exceeded the national standard of 0.8% with 1.3% (41 patients) of patients cancelled on the day of surgery. Staff sickness on the day in plastic surgery accounted for 13 of these cancellations and an emergency retinal patient meant the cancellation of a cataract list. Three of the cancelled patients were not readmitted within 28 days.

6.0 **Community and Social Care Framework**

The Community Quality and performance dashboards have been reviewed and there are no exceptions being escalated for reporting this month.

7.0 **Attached to this report**

Appendix 1 - Performance M9 databook

3.1 Board Performance Dashboard - Exception Reports

Performance Standard	Summary	Exception Report
RTT incomplete standard 92%	Following the issue of a Contract Performance Notice (CPN) a trajectory of improvement to achieve 92% by end of Q4 was developed and submitted to commissioners. The Remedial action Plan submitted has been assessed as providing insufficient assurance of delivery by 31st March. The exception report sets out further detail.	
4 hour A+E target	The remedial action plan has been agreed – Performance remains below 95%. Several of the agreed milestones have not been met.	

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

Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	4 hour standard	December 2015

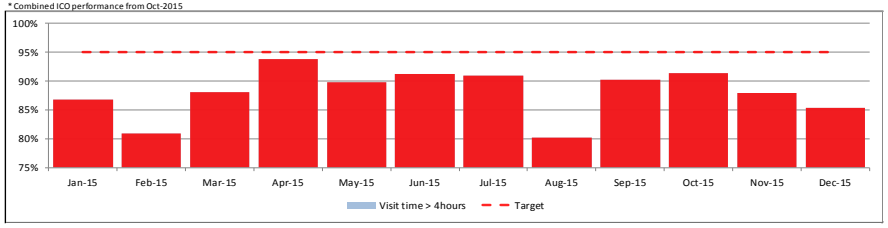
Data Analysis

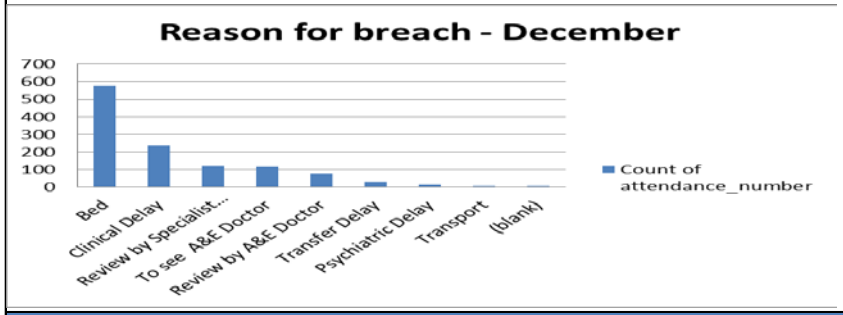
Graph of monthly 4 hour performance

Time spent in A&E

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
A&E attendances	5821	5537	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135
Percentage of patients treated within 4 hours	764	1053	758	394	674	571	608	1232	594	753	1020	1192
Visit time > 4hours	87%	81%	88%	94%	90%	91%	91%	80%	90%	91%	88%	85%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

* Combined ICO performance from Oct-2015





Commentary

The standard is not achieved in December and remains in variance to the declared Monitor plan. Performance in December type 1 is 79.72% (last month 83.27%) and including MIU's 85.35% (last month 87.93%). The community MIU's achieved 100%

The remedial action plan has been agreed and is being reviewed biweekly at the Performance and action plan review meeting.

Several area s of good progress has been made including the successful 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.

There are several areas however that are not achieving agreed milestones. The CCG are viewing these as a potential breach of the contract terms for delivering improved performance with financial sanctions being identified against the unmet actions.

External support continues from Alamac. Alamac have commenced a capacity and demand exercise to review bed capacity and alignment .

Severe operational pressures were experienced in the second week of january with all non urgent elective surgery being cancelled and additional beds being opened at Newton Abbot Hospital. The poor performance triggered an exception report being required by Monitor setting out the pressures and responces taken over this period.

Improvement Plan

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

Governance Arrangements

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

Torbay and South Devon NHS
NHS Foundation Trust

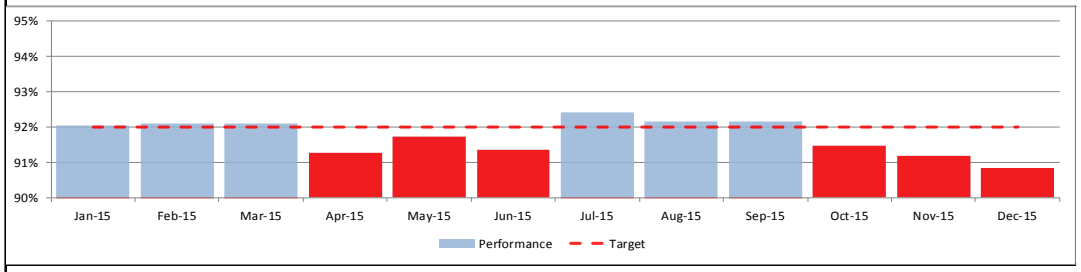
Key Performance Indicator Exception Report	RTT incomplete standard	December 2015

Data Analysis

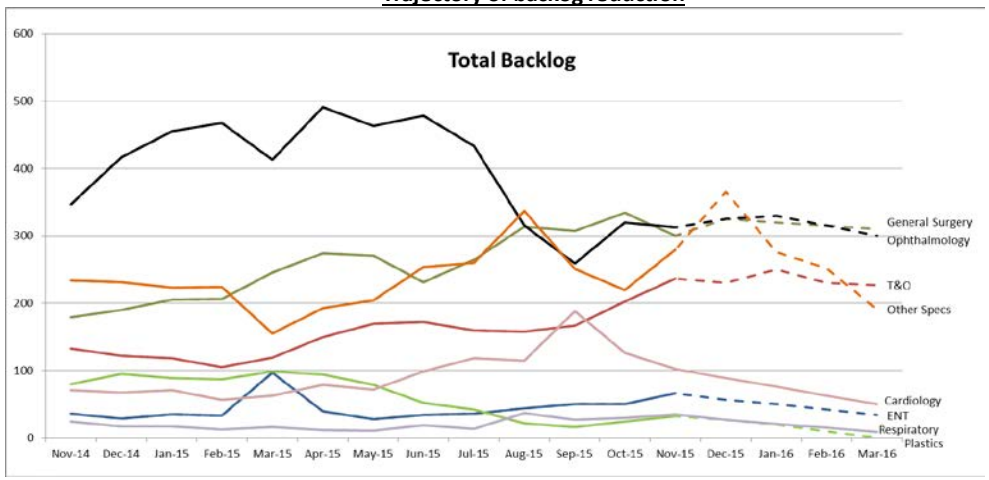
Monthly performance summary

Incomplete 18 week referral to treatment - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
RTT incomplete pathways	15232	14991	15284	15230	15648	15572	17424	17104	16114	15458	15464	15965
RTT incomplete pathway breaches	1212	1185	1208	1330	1295	1346	1323	1341	1265	1318	1364	1462
Performance	92%	92%	92%	91%	92%	91%	92%	92%	92%	91%	91%	91%
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%



Trajectory of backog reduction



Commentary

The overall RTT standard for incomplete pathways in not meeting the 92% target.

The remedial Action Plan (RAP) submitted has been assessed by the CCG on 18th January as not providing sufficient assurance against delivery by 31st March 2016.

Progress aganst actions developed for the submitted RAP are being monitored and updated for COO and SDU managers to review at each of the biweekly RTT assurance meetings chaired by the COO and with CCG commissioning in attendance.

Outsourcing is a key part of the plan for several specialties however to date the opportunities identified with the CCG and RTT PMO have not delivered any additional capacity.

Improvement Plan

No.	Action	Lead	Date
1	All specialities to complete actions set out in Remedial action plan	SDU managers	Jan 16
2	Financial consequences of actions to be reviewed and signed of by exec team	Exec team	jan16
3	Aditional outsourcing opportunities are being explored	SDU managers	Jan 16
4	Clinical engagement to support delivery of additional capacity	Exec team / SDU managers	Jan 16

Governance Arrangements

Bi weekly RTT performance and assurance meetings - Commissioners have been invited to join these meetings

4. Financial Performance

4.1 Summary of Financial Performance

	Year to Date - Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Income & Expenditure					
Income	221.97	221.71	(0.26)	0.00	↓
Operating expenses	(217.52)	(217.28)	0.23	0.00	↓
EBITDA	**4.46**	**4.43**	**(0.02)**	**0.00**	↓
Non-operating revenue	0.18	0.19	0.01	0.00	↑
Non-operating expenses	(11.61)	(11.58)	0.03	0.00	↓
Net surplus / (deficit)	**(6.98)**	**(6.97)**	**0.01**	**0.00**	↔
Gain/(loss) on transfers by absorption	37.40	42.46	5.06		
Surplus / (deficit)	**30.42**	**35.49**	**5.07**		
Cash & Balance Sheet					
Cash Balance	32.98	28.62	(4.36)	0.00	↓
Capital Expenditure	10.78	10.11	(0.67)	0.00	↓
Loans & leases Drawn down	26.78	26.77	(0.01)	0.00	↔
Key Metrics					
EBITDA Margin	2.0%	2.0%	(0.0%)	0.0%	↔
I&E Surplus Margin	(3.1%)	(3.1%)	0.0%	(0.0%)	↔
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 agreed with Monitor that following successful completion of the acquisition of Torbay and Southern Devon Health and Care NHS Trust, the Annual Plan would be revised. This has now been completed and submitted to Monitor on 18th December based on actual spend to month 8, with forecasted spend between month 9 to the end of the financial year . The plan 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 this revised plan.

At EBITDA level, performance for the nine months ended 31st December 2015 is £4.43m which is broadly in line with plan of £4.46m by £0.02m.

Within this position, income is slightly behind plan by £0.26m. Expenditure is £0.23m less than plan plan which is mainly due to small underspends on non pay items. Employee costs are broadly in line with plan.

Under the terms of risk share agreement income includes an additional £1.3m to reflect the contribution expected from commissioning organisations based on the year to date variance against original plan, net of transfer by absorption.

Variances in non-operating costs are also broadly in line with plan, showing a marginal favourable variance e of £0.03m.

Service Units continue to find recurring CIP delivery a significant challenge, though under-spends have been held non-recurrently limiting impact on the bottom line. This too is becoming more challenging.

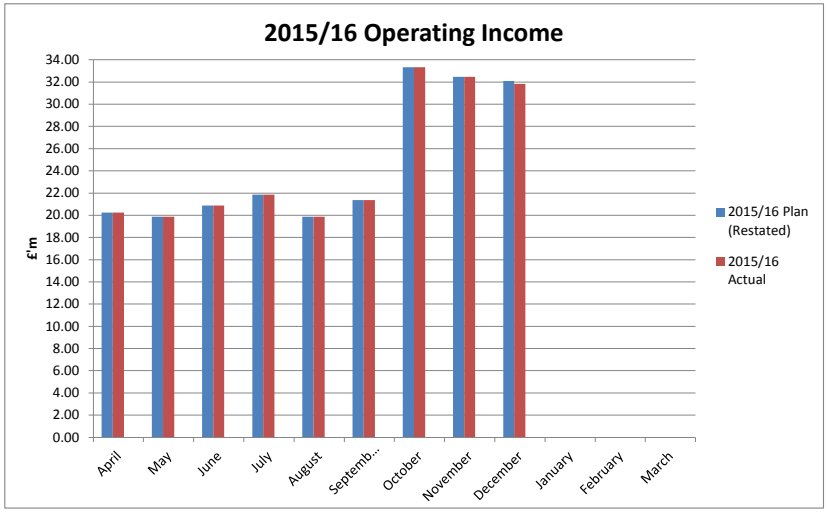
Cash balances are lower than plan by over £4m mainly due to working capital movement (higher Debtor and lower Creditor than plan) offset by lower than planned Capital expenditure.

The Financial Sustainability Risk Rating, 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.

4.2 Statement of Comprehensive Income

4.2.1 Operating Income

Income by Category	Year to Date - Month 9 Plan £m	Year to Date - Month 9 Actual £m	Year to Date - Month 9 Variance £m	Previous Month Variance £m	Change
Healthcare (Acute and Community)	175.58	175.75	0.16	0.00	↑
Social Care	13.36	13.40	0.04	0.00	↑
Other Income	33.03	32.57	(0.46)	0.00	↓
Total	**221.97**	**221.71**	**(0.26)**	**0.00**	↓



- Income is £0.26 behind plan for the period to 31st December 2015.
- There are no material issues driving the healthcare income variance (£0.08m favourable) following the rebasing of the Monitor Income plan.
- Social care income is marginally above plan with no material variances
- Other income is £0.26m behind plan. There has been higher than expected income in Non Mandatory / Non Protected Clinical Revenue (£0.18m) offset by lower than planned income in Non-Patient services to Other Bodies, and Miscellaneous other income.

Healthcare Income - Commissioner Analysis					
South Devon & Torbay Clinical Commissioning Group	121.40	121.55	0.15	0.00	↑
North, East & West Devon Clinical Commissioning Group	3.79	3.78	(0.01)	0.00	↓
NHS England - Area Team	5.23	5.13	(0.10)	0.00	↓
NHS England - Specialist Commissioning	19.95	19.49	(0.46)	0.00	↓
Other Commissioners	5.71	6.30	0.59	0.00	↑
Sub-Total Acute	**156.08**	**156.25**	**0.17**	**0.00**	↑
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	19.21	19.20	(0.00)	0.00	↔
Other Commissioners	0.30	0.30	0.00	0.00	↔
Total Acute and Community	**175.58**	**175.75**	**0.17**	**0.00**	↑

Healthcare Income - By Business Unit					
Medical Services	68.72	66.04	(2.67)	0.00	↓
Surgical Services	54.64	52.18	(2.46)	0.00	↓
Women's, Childrens & Diagnostic Services	31.45	31.64	0.19	0.00	↑
Community Services	19.51	19.50	(0.00)	0.00	↔
Non-Clinical Services / Central Contract Income	1.27	6.39	5.12	0.00	↑
Total	**175.58**	**175.75**	**0.17**	**0.00**	↑

Improvement Plan

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

Governance Arrangements

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

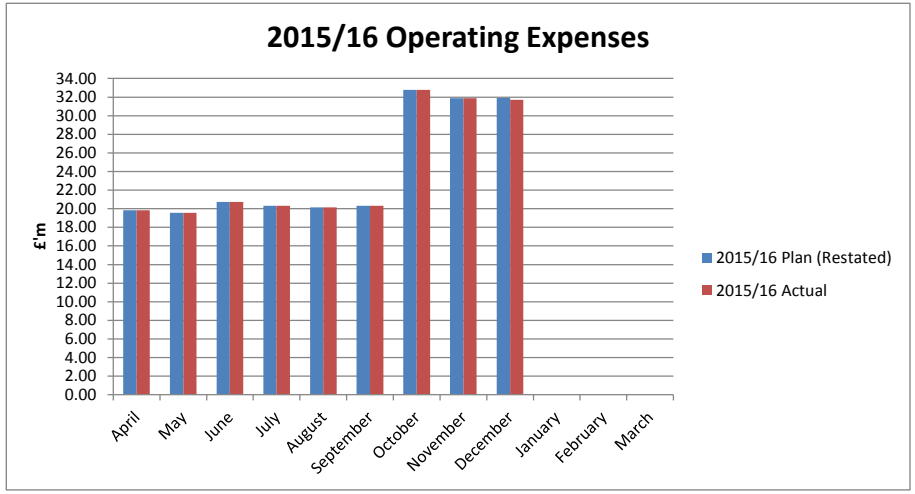
4.2.1 Operating Income (Continued)

	Year to Date - Month 9			Previous Month	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Healthcare Activity - By Setting					
	Activity	Activity	Activity	Activity	
Elective In-Patient Admissions	3,961	3,459	(502)	86	↓
Elective Day Case Admission	25,364	25,156	(208)	(445)	↑
Urgent & Emergency Admissions	85,501	85,331	(170)	(258)	↑
Out-Patients	357,791	332,544	(25,247)	(21,497)	↓
Total	**472,617**	**446,490**	**(26,127)**	**(22,114)**	↓
Social Care Income					
Torbay Council - ASC Contract income	9.74	9.81	0.07	0.00	↑
Torbay Council - Public Health Income	1.24	1.24	0.00	0.00	↔
Torbay Council - Client Income	2.38	2.35	(0.03)	0.00	↓
Total	**13.36**	**13.40**	**0.04**	**0.00**	↑
Other Income					
Non Mandatory/Non protected clinical revenue	1.71	1.88	0.18	0.00	↑
R&D / Education & training revenue	7.07	7.00	(0.07)	0.00	↓
Site Services	1.54	1.56	0.02	0.00	↑
Revenue from non-patient services to other bodies	7.23	6.93	(0.30)	0.00	↓
Misc. other operating revenue	15.48	15.19	(0.29)	0.00	↓
Total	**33.03**	**32.57**	**(0.46)**	**0.00**	↓

4.2 Statement of Comprehensive Income

4.2.2 Operating Expenditure

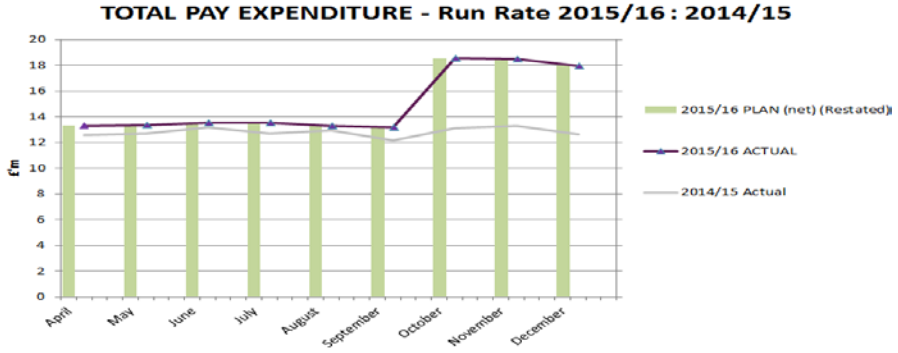
	Year to Date - Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Total Operating Expenses Included in EBITDA					
Employee Expenses	135.25	135.27	(0.02)	0.00	↑
Non-Pay Expenses	82.05	81.83	0.21	0.00	↓
PFI / LIFT Expenses	0.22	0.19	0.04	0.00	↓
Total	**217.52**	**217.28**	**0.23**	**0.00**	↓



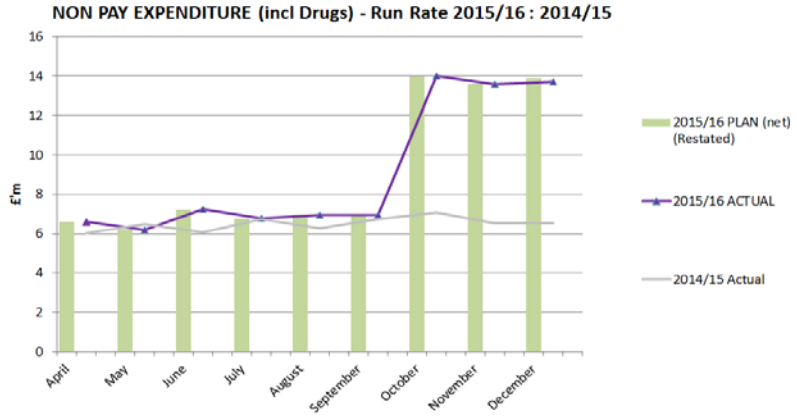
- Total Operating Expenditure included in EBITDA is £0.23m less than planned. The improvement in the variance from the previous month is due to the revision of the Annual Plan and re alignment of pay and non pay budgets.
- Pay is marginally overspent against the revised plan by £0.02m which is comprised of an underspend on substantive posts offset by overspends mainly in agency costs. In month 9 there has however been a reduction in pay cost of approximately £0.5m from the previous months which is mainly due to the MARs leavers, and a reduction in bank costs. Agency expenditure remains at the same level as the previous month.
- Pay costs continue to be reviewed and monitored for cost driven by the staffing requirements of escalation capacity, both in the acute hospital and community settings, and the requirement to cover absence, vacant posts and to address back log issues. In order to reduce demands in the acute setting it is critical that the care model plans take effect as soon as possible and have an impact on this position. CIP delivery in year has been delayed also due to the inability to reduce bank and agency costs
- The Monitor Agency cap for registered nursing spend is 4%. The spend in month is 6.9% giving a year to date position of 6.8%. Monthly and cumulative data can be seen on the attached Agency Cap Appendix.

Employee Expenses - By Category					
Medical and Dental staff	37.61	37.39	0.23	0.00	↓
Registered nurses, midwives and health visiting staff	32.22	32.40	(0.18)	0.00	↑
Qualified scientific, therapeutic and technical staff	23.66	23.73	(0.07)	0.00	↑
Support to clinical staff	10.61	10.60	0.01	0.00	↓
Managers and infrastructure Support	31.15	31.15	0.00	0.00	↔
Total	**135.25**	**135.27**	**(0.02)**	**0.00**	↑
Employee Expenses - By Type					
Substantive	126.03	125.53	0.51	0.00	↓
Bank	3.56	3.99	(0.43)	0.00	↑
Locum	1.07	1.09	(0.01)	0.00	↑
Agency	4.58	4.66	(0.08)	0.00	↑
Total	**135.25**	**135.27**	**(0.02)**	**0.00**	↑

	Year to Date - Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Employee Expenses - By Service					
Medical Services	31.23	31.25	(0.02)	0.00	↑
Surgical Services	32.94	34.01	(1.07)	0.00	↑
Women's, Childrens & Diagnostic Services	26.79	25.68	1.11	0.00	↓
Community Services	10.74	10.60	0.14	0.00	↓
Non-Clinical Services + Harmonisation	33.55	33.72	(0.17)	0.00	↑
Total	**135.25**	**135.27**	**(0.02)**	**0.00**	↑



Non Pay Expenses - By Category					
Clinical Supplies	16.48	16.68	(0.20)	0.00	↑
Drugs All	8.11	7.84	0.27	0.00	↓
Pass through Blood and Devices	13.86	14.03	(0.17)	0.00	↑
Non Clinical Supplies	2.01	2.02	(0.01)	0.00	↑
Miscellaneous / Other	41.59	41.26	0.33	0.00	↓
Total	**82.05**	**81.83**	**0.21**	**0.00**	↓



Overall the non-pay expenses variance is £0.21m favourable against plan. This comprises of:-

- Clinical supplies are marginally overspent against plan by £0.02m, spend in month 9 is broadly the same as the previous month.
- The drugs are under spent against plan by £0.27m. This includes high cost drugs, and the and pass through drugs are reflected in additional specialist commissioning income.
- Bloods and devices and non clinical supplies spend has moved marginally and are overspent against plan by £0.18m
- Miscellaneous expenditure, Adult social care and continuing healthcare placements are underspent against plan by £0.33m.

Improvement Plan

No.	Action	Lead	Date
1	Overseas Nursing Recruitment planned	Tracey Collins	On-going
2	Management of sickness absence	Martin Ringrose	On-going
3	Enhanced nurse agency control processes	Jane Viner	On-going
4	Implementation of agency price cap	Jane Viner	On-going
5	Enhanced budget control processes in service units	Liz Davenport	On-going
6	Care model implementation plans	Liz Davenport	On-going
7	MARS scheme	Paul Cooper	Complete
8	Introduction of enhanced performance monitoring	Liz Davenport	On-going
9	Management cost review	Martin Ringrose	01/12/2015
10	Develop recovery plan for adult social care CIP	Liz Davenport	01/01/2016
11	Control totals to drive down discretionary spend	Rod Muskett	23/12/2015

Governance Arrangements

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

Torbay and South Devon NHS Foundation Trust
Agency Nursing Information
Financial Year 2015/16

Combined (ICO) -Target Agency Cap submitted		Actual April	Actual May	Actual June	Actual July	Plan/Actual August	Plan September	Plan October	Plan November	Plan December	Plan January	Plan February	Plan March	Total FY 2015-16	Outturn M1-M4	Plan M5-M6	Plan M7-M12
Registered nurses, midwives and health visiting staff, agency	£m	(0.221)	(0.294)	(0.300)	(0.275)	(0.288)	(0.224)	(0.192)	(0.190)	(0.178)	(0.207)	(0.215)	(0.212)	(2.795)	(1.090)	(0.511)	(1.193)
Registered nurses, midwives and health visiting staff, total (inc agency)	£m	(4.699)	(4.701)	(4.530)	(4.408)	(4.420)	(4.509)	(4.526)	(4.539)	(4.537)	(4.583)	(4.609)	(4.616)	(54.676)	(18.338)	(8.929)	(27.409)
Nursing agency costs as % of total nursing costs	%	4.7%	6.3%	6.6%	6.2%	6.5%	5.0%	4.2%	4.2%	3.9%	4.5%	4.7%	4.6%	5.1%	5.9%	5.7%	4.4%

Actuals		Actual SDH April	Actual SDH May	Actual SDH June	Actual SDH July	Actual SDH August	Actual SDH September	Actual ICO October	Actual ICO November	Actual ICO December	ICO January	ICO February	ICO March	Total FY 2015-16	Outturn M1-M4	Actual M5-M6	Actual YTD M7-M12
Registered nurses, midwives and health visiting staff, agency	£m	(0.150)	(0.233)	(0.247)	(0.200)	(0.229)	(0.196)	(0.299)	(0.310)	(0.325)				(2.189)	(0.830)	(0.425)	(0.934)
Registered nurses, midwives and health visiting staff, total (inc agency)	£m	(3.022)	(3.066)	(3.137)	(3.043)	(3.075)	(3.036)	(4.605)	(4.698)	(4.718)				(32.400)	(12.268)	(6.111)	(14.021)
Nursing agency costs as % of total nursing costs	%	5.0%	7.6%	7.9%	6.6%	7.4%	6.5%	6.5%	6.6%	6.9%	#DIV/0!	#DIV/0!	#DIV/0!	6.8%	6.8%	7.0%	6.7%

4.2 Statement of Comprehensive Income

4.2.4 Non Operating Revenue & Expenses

	Year to Date - Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Non-Operating Expenses					
Donations & Grants	0.11	0.11	0.01	0.00	↔
Depreciation & Amortisation	(6.94)	(6.89)	0.06	0.00	↑
Impairments	0.00	0.00	0.00	0.00	↔
Restructuring Costs	(1.43)	(1.43)	0.00	0.00	↔
Finance Income	0.07	0.08	0.00	0.00	↔
Gains / (Losses) on Asset Disposals	0.00	0.00	0.00	0.00	↔
Gains / (Losses) on Transfers by Absorption	37.40	42.46	5.06	0.00	↑
Interest	(1.35)	(1.20)	0.15	0.00	↓
Public Dividend Capitals	(1.79)	(1.79)	(0.00)	0.00	↔
PFI Costs	(0.08)	(0.26)	(0.18)	0.00	↑
Income Tax refund	(0.02)	(0.02)	0.00	0.00	↔
Total	**25.97**	**31.06**	**5.10**	**0.00**	↑

- In line with previous reporting, transaction costs of £1.43m have been excluded from Monitor risk rating calculation.
- The forecast for non operating expenses is based on the revised plan for the Integrated Care Organisation (ICO) submitted to Monitor on 18th December 2015 under absorption accounting methodology.
- The favourable variance of £5.06m relates to a delay in the transfer of assets within the South Hams area to NHS Property Company; this is due to transact within quarter 4.

4.2 Statement of Comprehensive Income

4.2.5 Cost Improvement Programme (Based on full year for both Trusts)

	Year to Date - at Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Schemes Delivered to Date M1 to M12					
Delivered Schemes : Recurrent	15.20	2.90	12.30	12.00	↑
Delivered Schemes : Non-Recurrent	0.00	6.60	-6.60	-5.90	↑
Delivered Schemes : Total	**15.20**	**9.50**	**5.70**	6.10	↓
Full Year Forecast Delivery					
Forecast Schemes : Recurrent	15.20	3.20	12.00	12.00	↔
Forecast Schemes : Non-Recurrent	0.00	8.40	-8.40	-7.80	↑
Forecast Schemes : Total	**15.20**	**11.60**	**3.60**	4.20	↓

	CIP Target £'000	Risk Rating	Lead
Community Business Unit Schemes	6,271	Green	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	2,096	Red	Various
	15,200		

The analysis shown is based on Merger Accounting and shows the CIP position for both organisations between Month 1 and 12, 2015/16. (This position excludes Integration and Care model savings).

The forecast current year-end position results in a £3.6m year-end deficit. However, as just £3.2m of the £15.2m target is delivered recurrently, a £12.0m shortfall will carry forward into the next financial yr.

Back office full year synergies savings of £412k have been achieved against a target of £800k. Care model savings target of £1.5m is being covered by the unspent Transition Funding, therefore this Fund is reducing permanently.

Improvement Plan

No.	Action	Lead	Date
1	Full review the undelivered schemes as part	Paul Cooper	28/02/2016
2	Ensure completeness of CIP processing	Paul Cooper	Ongoing
3	Focus on transferring rec to non-rec plans	Liz Davenport	Ongoing
4	MARS Scheme	Paul Cooper	Complete
5	Enhanced performance monitoring	Liz Davenport	Ongoing
6	Pathology managed service contract	Liz Davenport	Ongoing
7	WCD vacancy factor to be made recurrent	Liz Davenport	Complete
8	Internal Audit review of delayed delivery	Int. Audit	31/01/2016
9	Monthly Finance Director review with Service Delivery Units exploring current and additional cost reduction opportunities	Paul Cooper	Monthly

Governance Arrangements

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

4.3 Balance Sheet

	Year to Date - Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Non-Current Assets					
Intangible Assets	5.25	1.09	(4.16)	0.00	↓
Property, Plant & Equipment	157.68	166.09	8.41	0.00	↑
On-Balance Sheet PFI	20.41	20.40	(0.01)	0.00	↓
Other	2.33	2.49	0.16	0.00	↑
Total	**185.68**	**190.07**	**4.39**	0.00	↑
Current Assets					
Cash & Cash Equivalents	32.98	28.62	(4.36)	0.00	↓
Other Current Assets	22.96	26.26	3.30	0.00	↑
Total	**55.94**	**54.88**	**(1.05)**	0.00	↓
Total Assets	**241.61**	**244.95**	**3.34**	0.00	↑
Current Liabilities					
Loan - DH ITFF	(5.68)	(5.53)	0.15	0.00	↓
PFI / LIFT Leases	(0.61)	(0.72)	(0.11)	0.00	↑
Trade and Other Payables	(31.55)	(29.58)	1.97	0.00	↓
Other Current Liabilities	(0.51)	(0.63)	(0.12)	0.00	↑
Total	**(38.35)**	**(36.45)**	**1.90**	0.00	↓
Net Current assets/(liabilities)	**17.59**	**18.43**	**0.84**	0.00	↓
Non-Current Liabilities					
Loan - DH ITFF	(59.80)	(59.95)	(0.14)	0.00	
PFI / LIFT Leases	(20.69)	(20.70)	(0.02)	0.00	
Other Non-Current Liabilities	(3.94)	(3.95)	(0.01)	0.00	
Total	**(84.43)**	**(84.59)**	(0.16)	0.00	
Total Assets Employed	**118.83**	**123.91**	**5.07**	0.00	
Reserves					
Total	**118.83**	**123.91**	**5.07**	0.00	

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

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

Cash balances are lower than plan at over £4m mainly due to working capital movement (higher Debtor and lower Creditor than plan) offset by lower than planned Capital expenditure.

Movements in current assets relate to NHS Trade and Other Debtors . Current liabilities movement relate to Trade payable and Capital creditors.

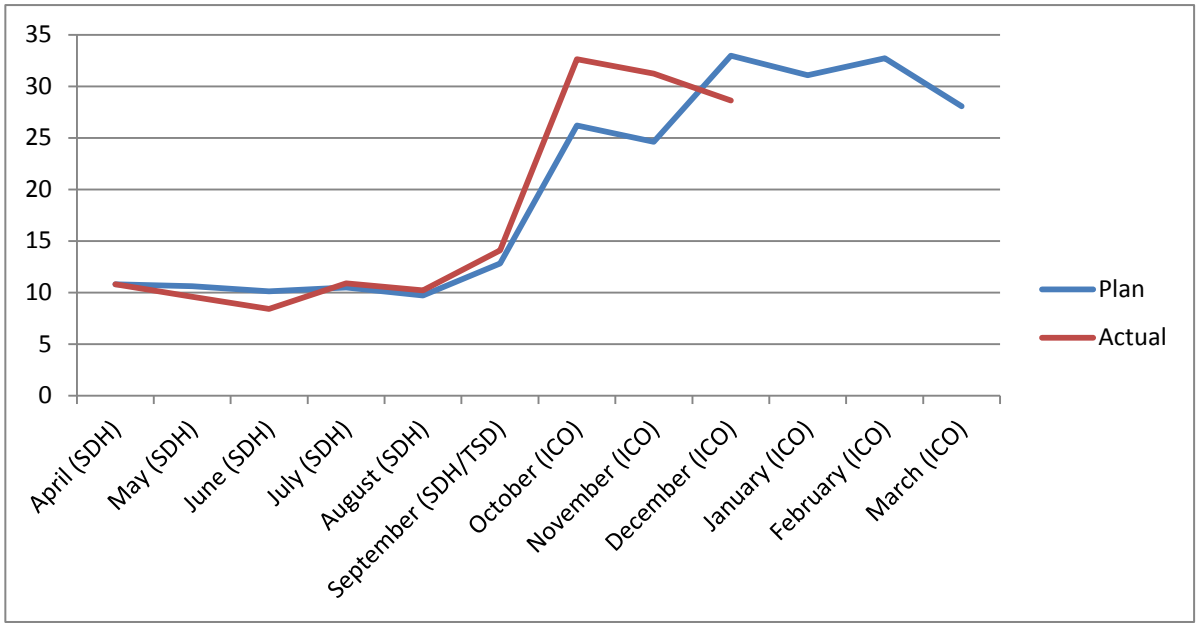
Overall the balance sheet holds £5.07m of value in excess of that planned.

4.4 Cash Flow Statement

	Year to Date - Month 9			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Opening Cash Balance	**31.24**	**31.24**	**0.00**	0.00	↔
Cash Generated From Operations	(0.60)	0.09	**0.70**	0.00	↑
Debtor Movements	12.95	(0.54)	**(13.49)**	0.00	↓
Creditor Movements	(9.25)	(0.98)	**8.27**	0.00	↑
Capital Expenditure	(2.22)	(1.46)	**0.76**	0.00	↑
Net Interest	(0.58)	(0.26)	**0.32**	0.00	↑
Loan drawndown	0.99	0.98	(0.01)	0.00	↓
Loan repayment	(0.27)	(0.27)	0.00	0.00	↔
Other (PDC Dividend)	0.00	0.00	**0.00**	0.00	↔
Other	0.73	(0.18)	**(0.91)**	0.00	↓
Current Cash Balance	**32.98**	**28.62**	**(4.36)**	0.00	↓

Cash balances are lower than plan at over £4m mainly due to working capital movement (higher Debtor and lower Creditor than plan) offset by lower than planned Capital expenditure.

Cash Flow Against Plan (£m):



4.5 Capital

	Year to date - Based upon Revised Annual Plan (Dec 15)			Year end Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Forecast £m	Variance £m
Capital Programme	10.78	10.11	(0.67)	19.42	19.42	0.00

Significant Variances in Planned Expenditure by Scheme:

HIS schemes	0.97	0.72	(0.25)	2.72	2.72	0.00
Estates schemes	7.39	7.06	(0.33)	11.08	11.08	0.00
Medical Equipment	1.13	1.07	(0.06)	3.65	3.65	0.00
Other	0.20	0.20	0.00	0.30	0.30	0.00
PMU	1.10	1.11	0.01	1.48	1.48	0.00
Contingency	0.04	0.00	(0.04)	0.24	0.24	0.00
Prior Year schemes	(0.05)	(0.05)	0.00	(0.05)	(0.05)	0.00
Total	**10.78**	**10.11**	**(0.67)**	**19.42**	**19.42**	**0.00**

As reported in month 8, Capital Expenditure was significantly behind the phased budget incorporated into the initial Annual Planning assumptions.

A revised Annual Plan for 2015/16 was submitted to Monitor in December 2015.

This has reduce the planned capital expenditure value from £27.19m to £19.42m

Governance Arrangements

Capital expenditure projects are approved in line with the Trust's Investment policy. The capital prioritisation process takes place at the Senior Business Management Team meetings and is overseen by the Trust's Executive Directors. Capital schemes are prioritised based upon Risk Scores and Financial payback opportunities.

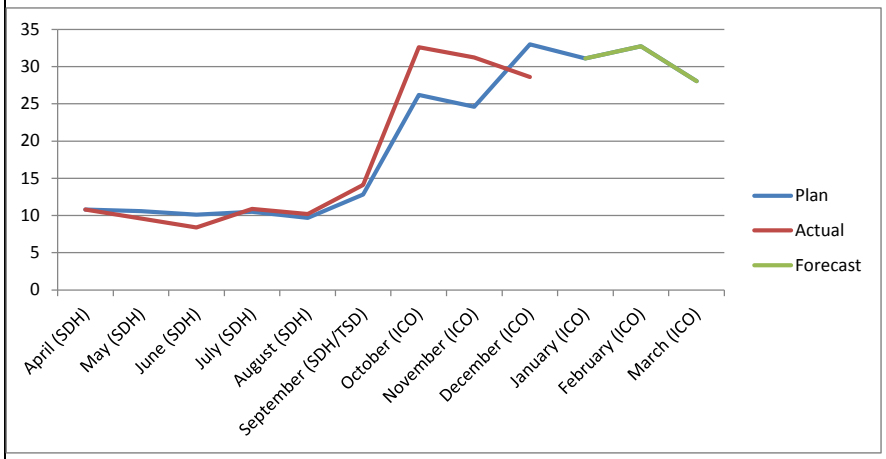
4.6 Forecast

	Current Month			Previous Month	
	Plan £m	Forecast £m	Variance £m	Variance £m	Change
Income & Expenditure					
Income	318.8	318.8	0.00	0	↔
Operating expenses	(313.2)	(313.2)	0.00	0	↔
EBITDA	**5.6**	**5.6**	0.00	0	↔
Non-operating revenue	37.4	37.4	0.00	0	↔
Non-operating expenses	(15.0)	(15.0)	0.00	0	↔
Net surplus / (deficit)	28.0	28.0	0.00	0	↔
Net surplus/(deficit) net of Gain on Absorption	(16.7)	(16.7)	0.00	0	↔
Operating surplus (deficit)	(8.9)	(8.9)	0.00	0	↔
Cash Flow					
Opening Cash Balance 2014/15 -SDH	**12.1**	**12.1**	0.0		
Cash Generated From Operations	4.2	4.2	0.0	0	↔
Debtor Movements	3.5	3.5	0.0	0	↔
Creditor Movements	2.1	2.1	0.0	0	↔
Capital Expenditure	-19.6	-19.6	0.0	0	↔
Net Interest	-2.3	-2.3	0.0	0	↔
Loan drawndown	31.8	31.8	0.0	0	↔
Loan repayment	-4.4	-4.4	0.0	0	↔
Other (PDC Dividend)	-2.2	-2.2	0.0	0	↔
Cash Transferred from TSD	2.8	2.8	0.0	0	↔
Current Cash Balance 2015/16 -ICO	**28.0**	**28.0**	0.0	0	↔

The forecast for I&E is based on the revised plan for the Integrated Care Organisation (ICO) submitted to Monitor on 18th December 2015 under absorption accounting methodology.

It is showing zero variance this month as it is assumed that the year end results will be in line with the revised plan.

Cash Flow Forecast £m:

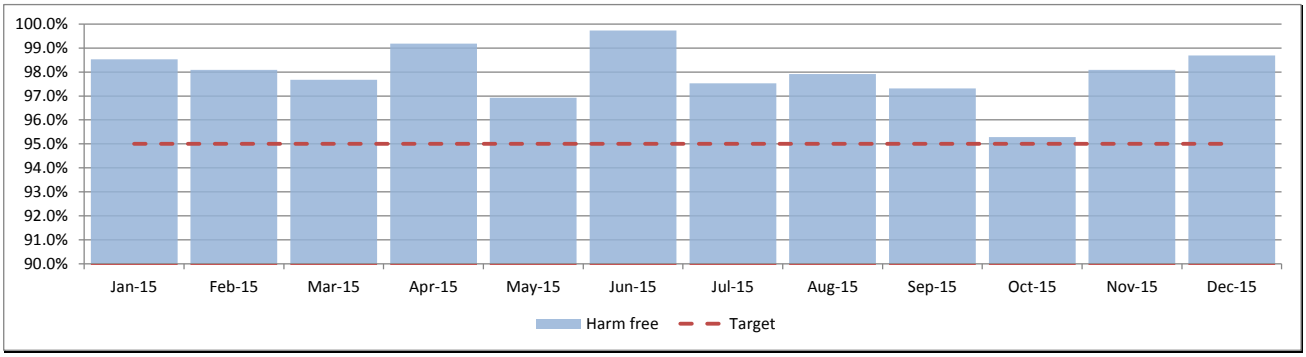


Performance & Quality Databook

Month 9 December 2015

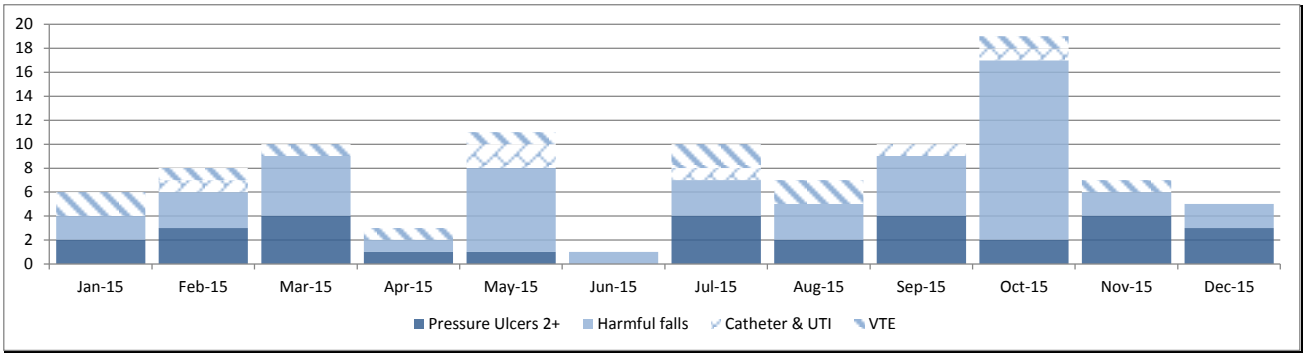
Harm Free - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients	408	367	387	367	358	377	365	336	372	360	366	382
New harms	6	7	9	3	11	1	9	7	10	17	7	5
Harm free	98.5%	98.1%	97.7%	99.2%	96.9%	99.7%	97.5%	97.9%	97.3%	95.3%	98.1%	98.7%
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

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
New Harms	6	7	9	3	11	1	9	7	10	17	7	5
Pressure Ulcers 2+	2	3	4	1	1	0	4	2	4	2	4	3
Harmful falls	2	3	5	1	7	1	3	3	5	15	2	2
Catheter & UTI	0	1	0	0	2	0	1	0	1	1	0	0
VTE	2	1	1	1	1	0	2	2	0	1	1	0



This is a combined report on Safety Thermometer
In Nov 2015, 1044 patients took part in the survey.

SDHCFT harm free care for this month remains very high this month at 97%, below is the harm profile
- 9 Grade 3 - 4 pressure sore. Location: 8 of which are in the community, 1 in the acute hospital.
- 16 Grade 2 pressure sores: Location 8 community 3 Acute 5 Community Hospitals.
- 7 falls: 3 low harm & 4 moderate: Location of Moderates 2 Community 2 Community Hospital
- 8 Catheter acquired infections: Location 7 Community 1 Acute
- 1 VTE Location: Acute

Overview of Organisational ST Safety Work

- The Pressure Ulcer Project is now well established across all care sectors, which will utilise a buddy ward system to aid the learning and sharing from prior wards that have participated in the programme.

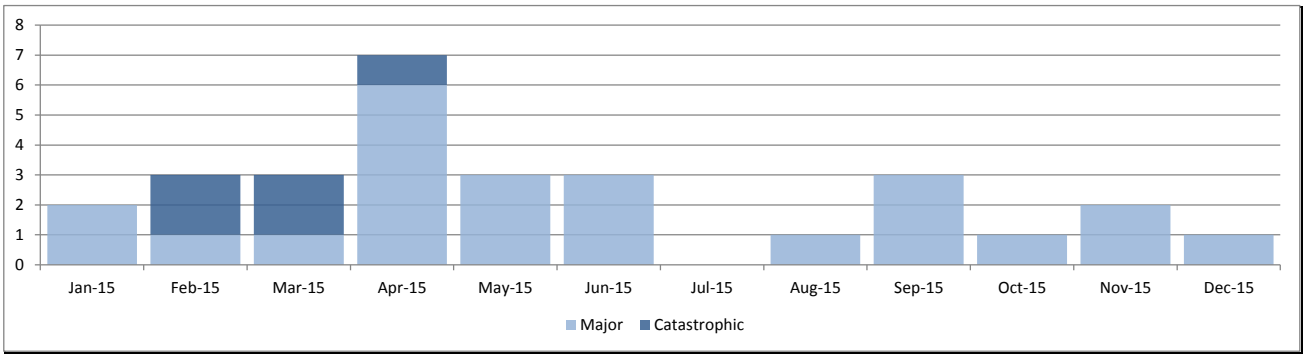
- SWARM continues to be used should a serious pressure ulcer develop. This involves a meeting of the ward manager, matron, TVN as soon after the event as possible to gather information as to why the event occurred.

- All VTE events are investigated and the structure and people are now fully in place for this to happen. Feedback following the RCA is given to the clinicians.

- The Falls team are reviewing process and policy in terms of Hi Lo beds and merging the Communities and Hospitals policies into one document with a view to simplifying documentation. All falls are looked into and any trends and patterns are shared with the wards and falls committee for further sharing and learning.

Incidents recorded on Safeguard

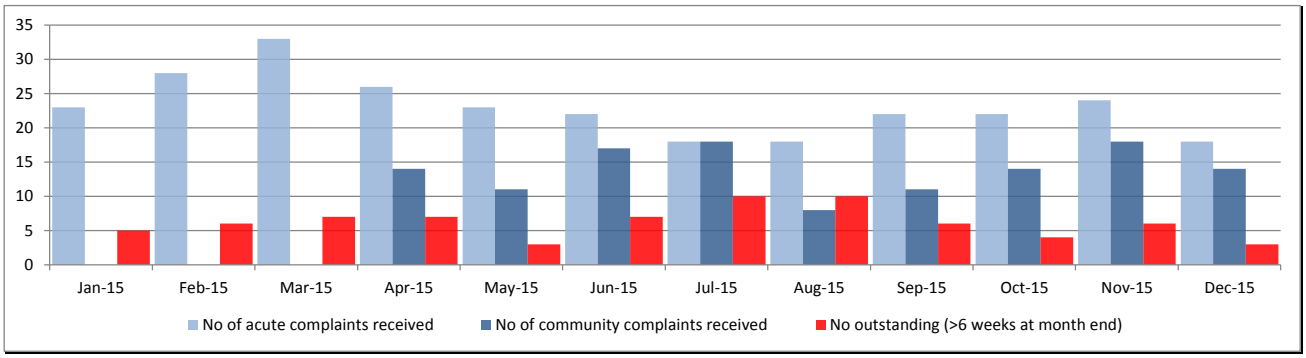
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Near miss	102	172	74	77	104	63	85	57	67	56	44	48
Near miss - major	3	8	7	13	15	7	3	5	4	3	6	11
No harm	223	406	234	227	349	202	202	222	207	226	225	130
Insignificant	61	67	44	45	42	42	30	44	44	38	22	28
Minor	133	141	127	145	163	139	130	148	118	133	110	100
Moderate	19	29	33	44	22	19	25	27	24	22	15	6
Major	2	1	1	6	3	3	0	1	3	1	2	1
Catastrophic	0	2	2	1	0	0	0	0	0	0	0	0
(blank)	0	0	0	6	2	1	1	1	1	0	0	0
Total	543	826	522	564	700	476	476	505	468	479	424	324



Incident reporting remains consistent in November and December. An ICO view of incident data combining safeguard and Datex reporting systems is being developed.

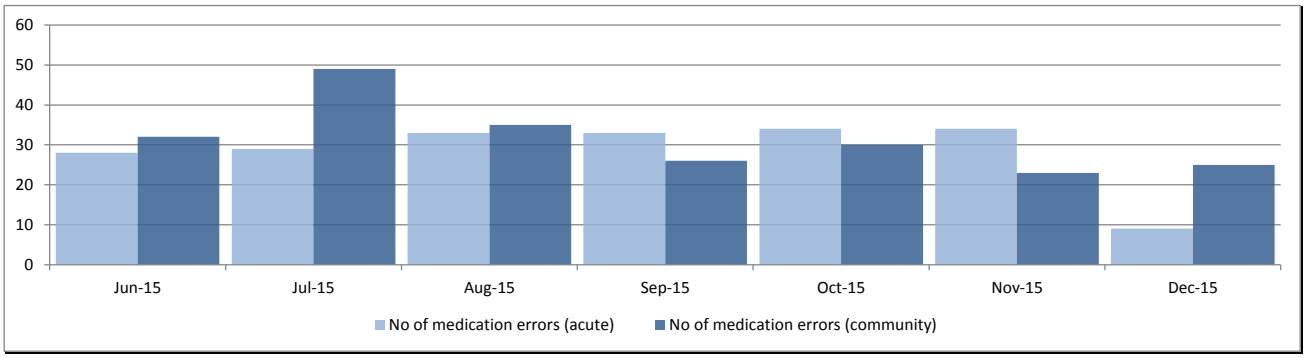
Written complaints - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
No of acute complaints received	23	28	33	26	23	22	18	18	22	22	24	18
No of community complaints received				14	11	17	18	8	11	14	18	14
No outstanding (>6 weeks at month end)	5	6	7	7	3	7	10	10	6	4	6	3



Medication errors - Trust Total

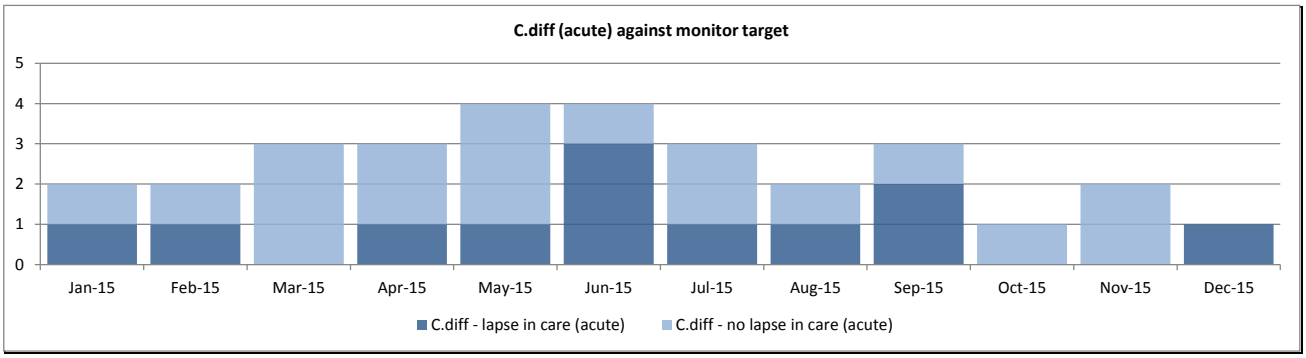
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
No of medication errors (acute)	32	310	34	41	207	28	29	33	33	34	34	9
No of medication errors (community)				40	33	32	49	35	26	30	23	25



Slight dip in reported medication incidents in December, this needs to observed over the next few months looking for trends or shifts in the data.

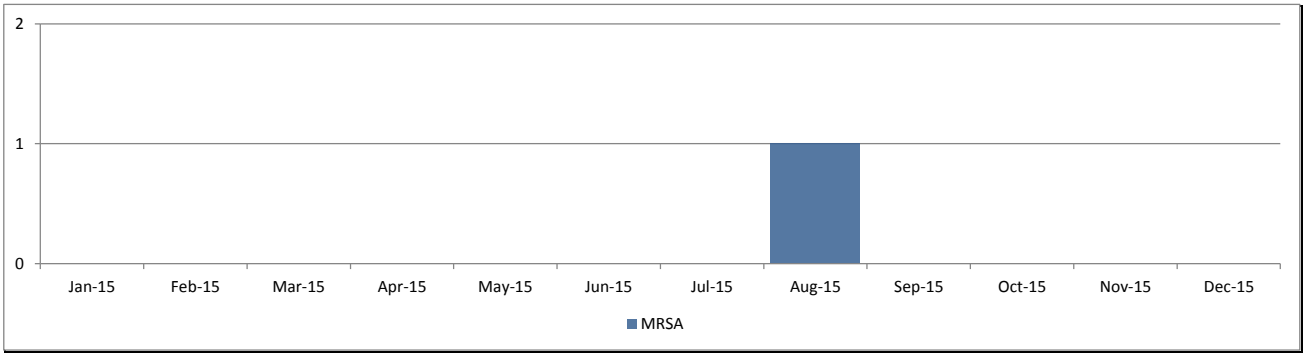
Clostridium difficile

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
C.diff - lapse in care (acute)	1	1	0	1	1	3	1	1	2	0	0	1
C.diff - no lapse in care (acute)	1	1	3	2	3	1	2	1	1	1	2	0
C.diff - Total (acute)	2	2	3	3	4	4	3	2	3	1	2	1
C.diff - lapse in care (community)	n/a	n/a	n/a	0	0	0	1	0	0	0	0	0
C.diff - no lapse in care (community)	n/a	n/a	n/a	0	0	1	0	1	0	0	0	0
C.diff - Total (community)	n/a	n/a	n/a	0	0	1	1	1	0	0	0	0



Methicillin-resistant Staphylococcus aureus (MRSA) - (acute)

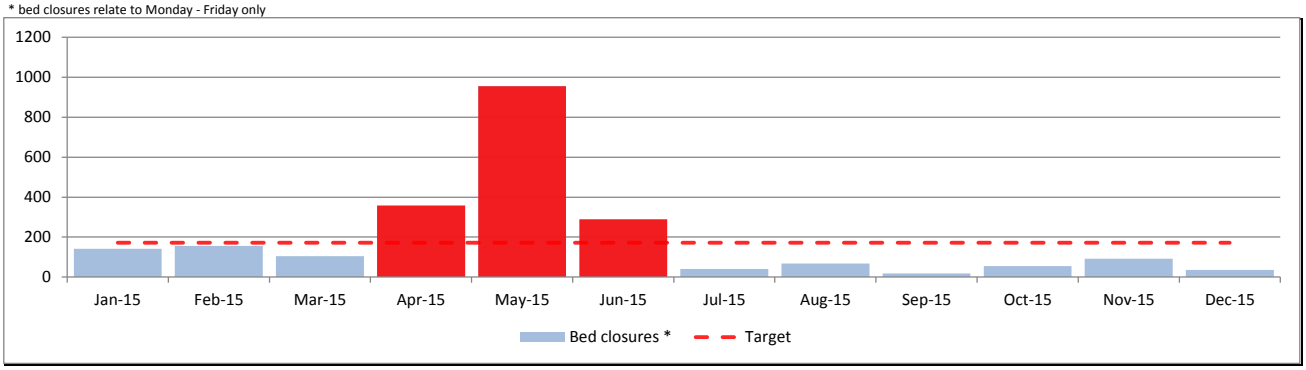
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
MRSA	0	0	0	0	0	0	0	1	0	0	0	0



Bed closures due to infection control measures - (Acute)

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Bed closures *	141	156	104	358	955	288	40	68	18	54	92	36
Target	171	171	171	171	171	171	171	171	171	171	171	171

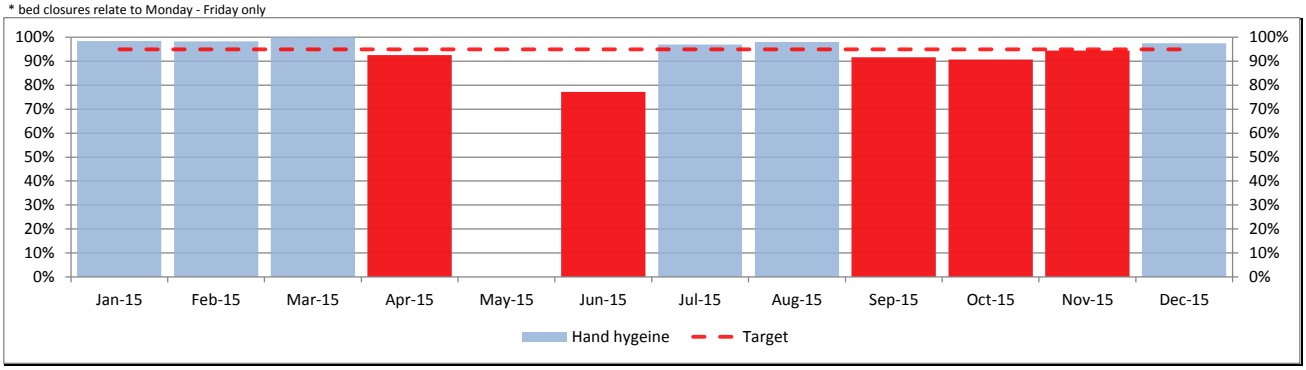
* bed closures relate to Monday - Friday only



Hand Hygiene - (Acute)

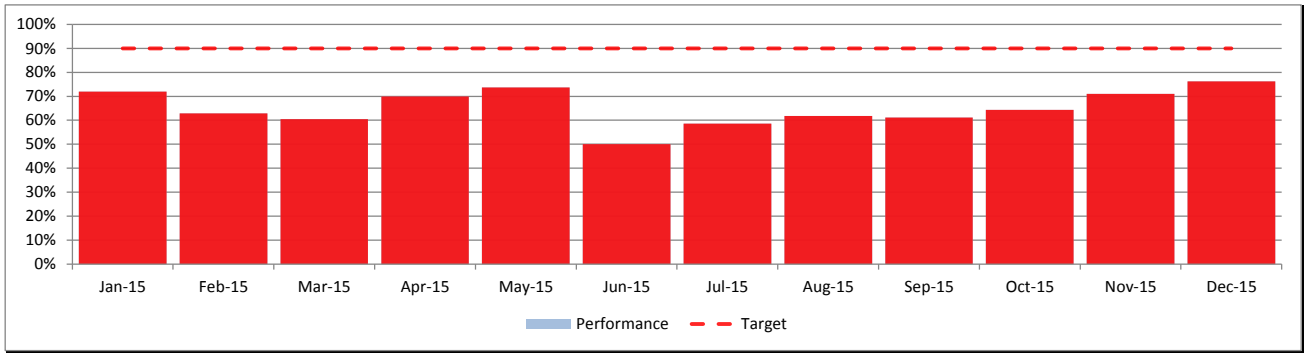
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Hand hygeine	98%	98%	100%	93%	n/a	77%	97%	98%	92%	91%	94%	97%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

* bed closures relate to Monday - Friday only



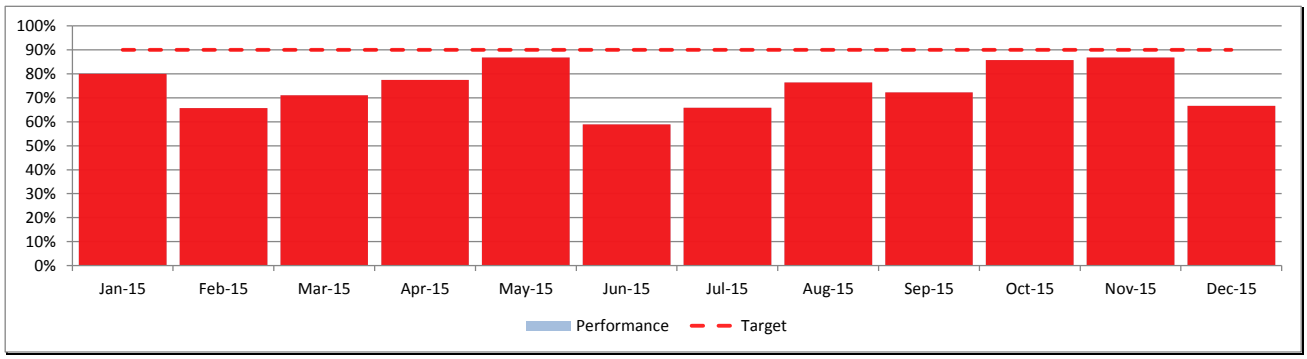
Fracture neck of femur

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients with a fractured neck of femur	50	35	43	40	38	40	41	34	36	28	38	42
Patients achieving best practice tariff	36	22	26	28	28	20	24	21	22	18	27	32
Performance	72%	63%	60%	70%	74%	50%	59%	62%	61%	64%	71%	76%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



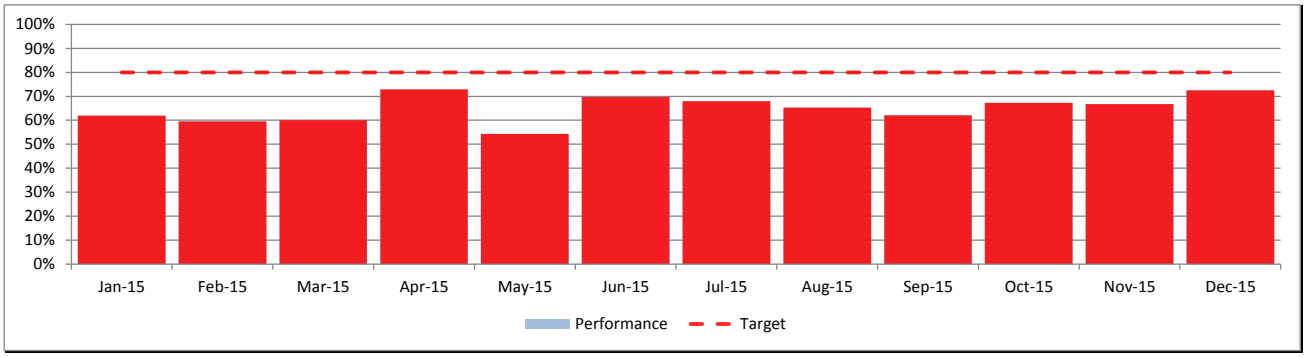
Fracture neck of femur - Admission to surgery less than 36 hours

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
To surgery within 36 hours	40	23	27	31	33	23	27	26	26	24	33	28
To surgery outside 36 hours	10	12	11	9	5	16	14	8	10	4	5	14
Performance	80%	66%	71%	78%	87%	59%	66%	76%	72%	86%	87%	67%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



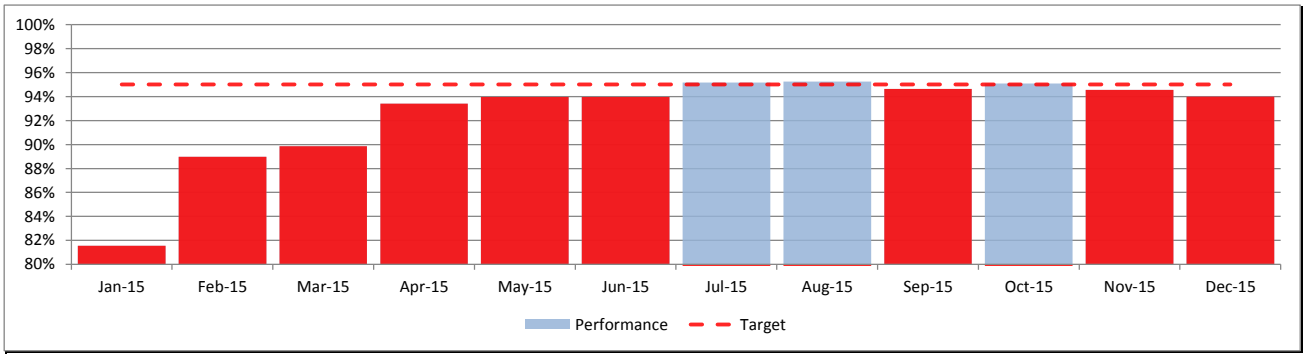
Stroke patients spending 90%+ of their time on a dedicated stroke ward

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients with a stroke diagnosis	63	42	45	48	46	66	53	46	50	58	48	40
Patients spending 90% of time on stroke war	39	25	27	35	25	46	36	30	31	39	32	29
Performance	62%	60%	60%	73%	54%	70%	68%	65%	62%	67%	67%	73%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



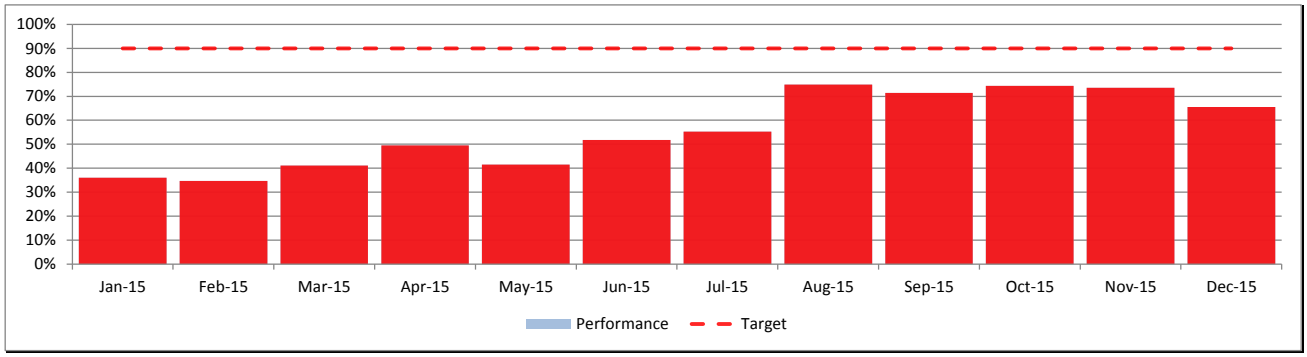
VTE risk assessment on admission - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Adult patients admitted	5871	4758	5984	5940	5334	6076	6257	5803	6266	5967	5821	5577
No risk assessed for VTE using national tool	4788	4233	5377	5549	5013	5709	5955	5528	5930	5674	5505	5243
Performance	82%	89%	90%	93%	94%	94%	95%	95%	95%	95%	95%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Achieved	82%	89%	90%	93%	94%	94%	0%	0%	95%	0%	95%	94%



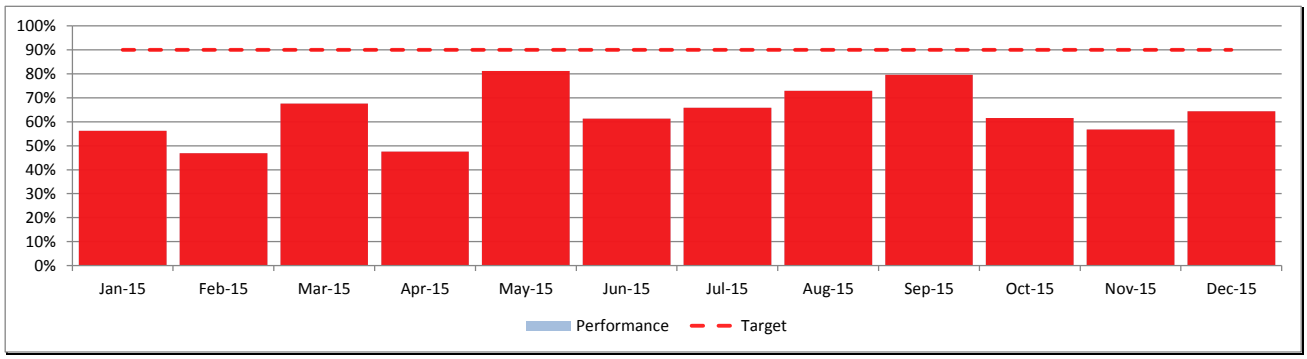
Dementia - Find

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Emergency admissions with LoS >3days (75+)	425	335	304	273	251	224	239	278	283	316	306	348
Finding question completed within 72 hours	153	116	125	135	104	116	132	208	202	235	225	228
Performance	36%	35%	41%	49%	41%	52%	55%	75%	71%	74%	74%	66%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



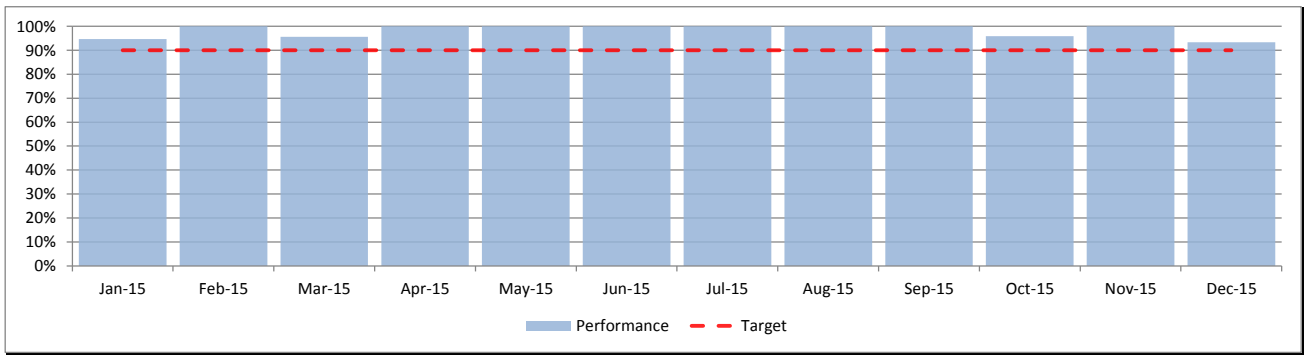
Dementia - Access and Investigate

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
+ve finding question or diagnosed delirium	48	32	37	40	32	31	38	48	49	65	44	59
Diagnostic assessment	27	15	25	19	26	19	25	35	39	40	25	38
Performance	56%	47%	68%	48%	81%	61%	66%	73%	80%	62%	57%	64%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



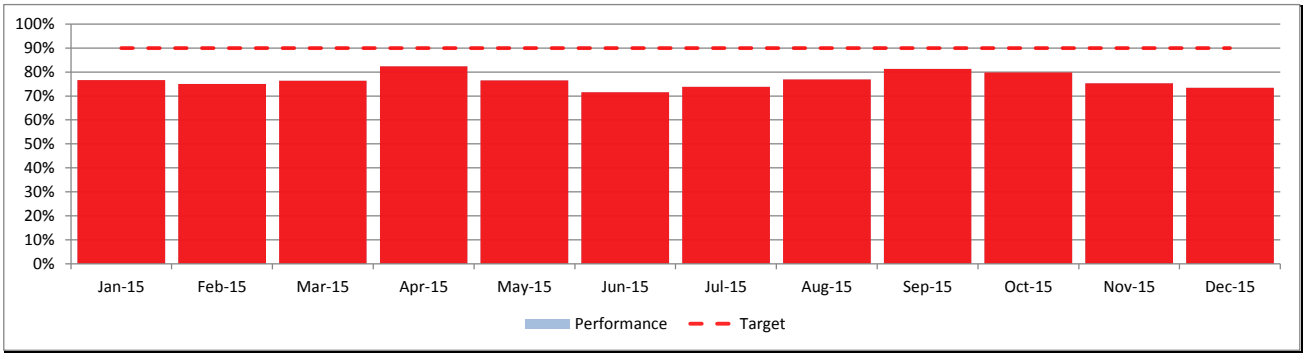
Dementia - Refer

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
+ve / inconclusive result from assessments	19	13	23	22	23	17	23	24	35	24	23	30
With a sufficient plan of care on discharge	18	13	22	22	23	17	23	24	35	23	23	28
Performance	95%	100%	96%	100%	100%	100%	100%	100%	100%	96%	100%	93%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



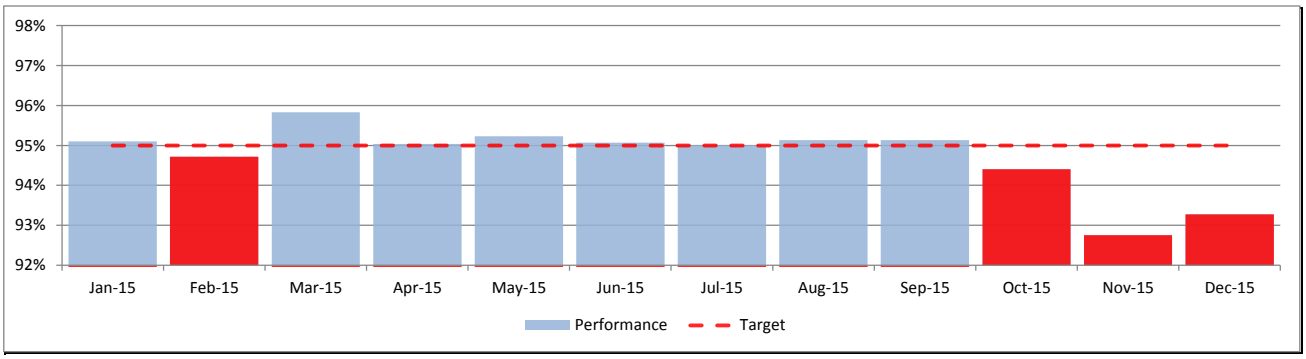
Admitted 18 week referral to treatment - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
RTT admitted clock stops	1495	1473	1570	1438	1246	1587	1594	1459	1616	1367	1365	1261
RTT admitted breaches	349	368	372	253	293	451	418	338	302	275	337	336
Performance	77%	75%	76%	82%	76%	72%	74%	77%	81%	80%	75%	73%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



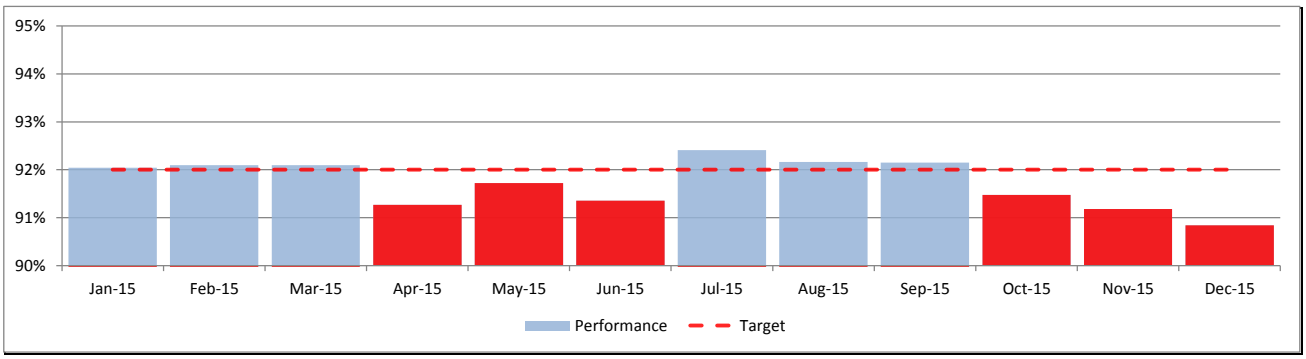
Non-admitted 18 week referral to treatment - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
RTT non-admitted clock stops	5332	5207	5665	5262	4992	5716	6229	4887	5935	6108	5326	4699
RTT non-admitted breaches	261	275	236	261	238	282	311	238	289	342	386	316
Performance	95%	95%	96%	95%	95%	95%	95%	95%	95%	94%	93%	93%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Incomplete 18 week referral to treatment - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
RTT incomplete pathways	15232	14991	15284	15230	15648	15572	17424	17104	16114	15458	15464	15965
RTT incomplete pathway breaches	1212	1185	1208	1330	1295	1346	1323	1341	1265	1318	1364	1462
Performance	92%	92%	92%	91%	92%	91%	92%	92%	92%	91%	91%	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	22	8	30	73%
Dermatology	5	0	5	100%
Ear, Nose & Throat (ENT)	64	15	79	81%
Gastroenterology	80	4	84	95%
General Medicine	2	0	2	100%
General Surgery	119	43	162	73%
Geriatric Medicine	0	0	0	n/a
Gynaecology	96	2	98	98%
Neurology	4	1	5	80%
Ophthalmology	83	96	179	46%
Oral Surgery	74	5	79	94%
Plastic Surgery	71	25	96	74%
Rheumatology	22	0	22	100%
Thoracic Medicine	2	0	2	100%
Trauma & Orthopaedics	159	103	262	61%
Urology	63	21	84	75%
Other	59	13	72	82%
Total	925	336	1261	73%

RTT non-admitted performance - by specialty

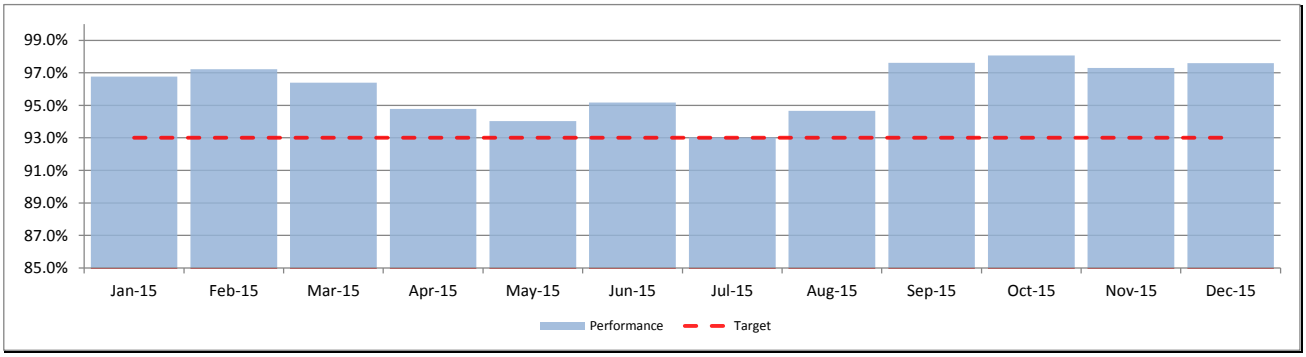
	<126 days	>126 days	Total	Performance
Cardiology	137	33	170	81%
Dermatology	427	4	431	99%
Ear, Nose & Throat (ENT)	324	18	342	95%
Gastroenterology	277	30	307	90%
General Medicine	114	0	114	100%
General Surgery	554	64	618	90%
Geriatric Medicine	21	0	21	100%
Gynaecology	457	2	459	100%
Neurology	106	5	111	95%
Ophthalmology	402	29	431	93%
Oral Surgery	167	3	170	98%
Plastic Surgery	9	2	11	82%
Rheumatology	202	0	202	100%
Thoracic Medicine	56	15	71	79%
Trauma & Orthopaedics	306	45	351	87%
Urology	181	5	186	97%
Other	624	47	671	93%
Total	4364	302	4666	94%

RTT incomplete performance - by specialty

	<126 days	>126 days	Total	Performance
Cardiology	1452	114	1566	93%
Dermatology	870	15	885	98%
Ear, Nose & Throat (ENT)	943	68	1011	93%
Gastroenterology	727	77	804	90%
General Medicine	74	2	76	97%
General Surgery	1264	247	1511	84%
Geriatric Medicine	45	0	45	100%
Gynaecology	674	11	685	98%
Neurology	273	15	288	95%
Ophthalmology	1547	391	1938	80%
Oral Surgery	750	21	771	97%
Plastic Surgery	217	28	245	89%
Rheumatology	301	1	302	100%
Thoracic Medicine	634	36	670	95%
Trauma & Orthopaedics	1604	243	1847	87%
Urology	653	61	714	91%
Other	2039	99	2138	95%
Total	14067	1429	15496	91%

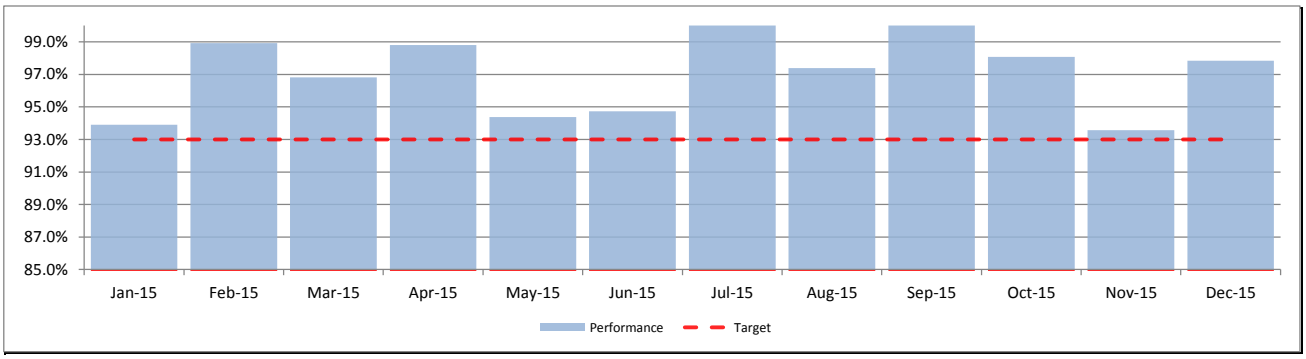
Two Week Wait Referrals - seen within 14 days

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
2ww referrals seen	680	650	915	746	753	913	903	826	884	879	889	872
2ww referral breaches	22	18	33	39	45	44	63	44	21	17	24	21
Performance	96.8%	97.2%	96.4%	94.8%	94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.6%
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%



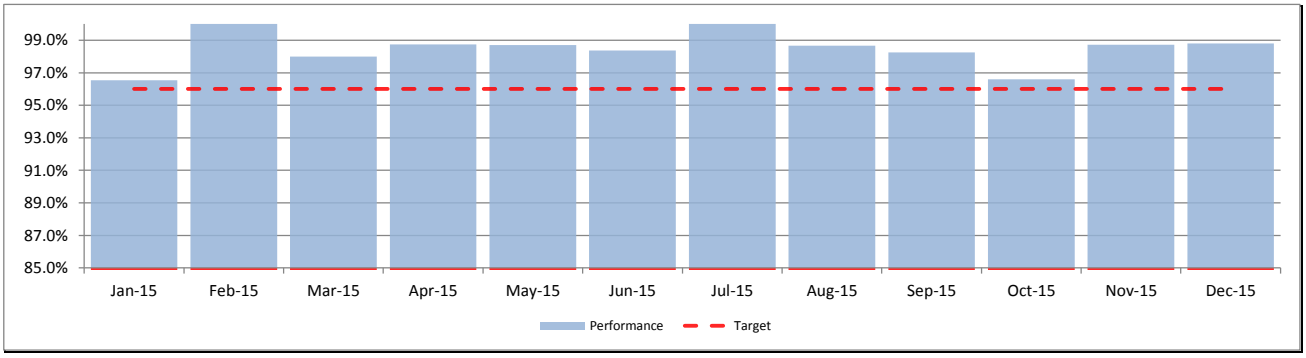
Breast Symptomatic referrals - seen within 14 days

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Breast symptomatic referrals seen	82	93	94	84	89	114	112	115	90	104	109	139
Breast symptomatic referrals breached	5	1	3	1	5	6	0	3	0	2	7	3
Performance	93.9%	98.9%	96.8%	98.8%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%
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%



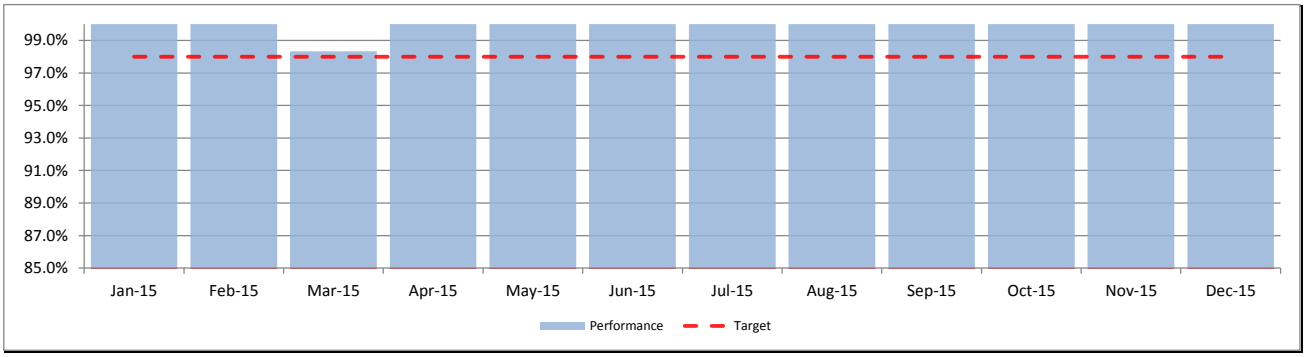
1st treatment - 31 day from decision to treat to treatment

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
1st treatments	173	131	200	159	155	185	169	149	172	176	156	166
31 day 1st treatment breaches	6	0	4	2	2	3	0	2	3	6	2	2
Performance	96.5%	100.0%	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%
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%



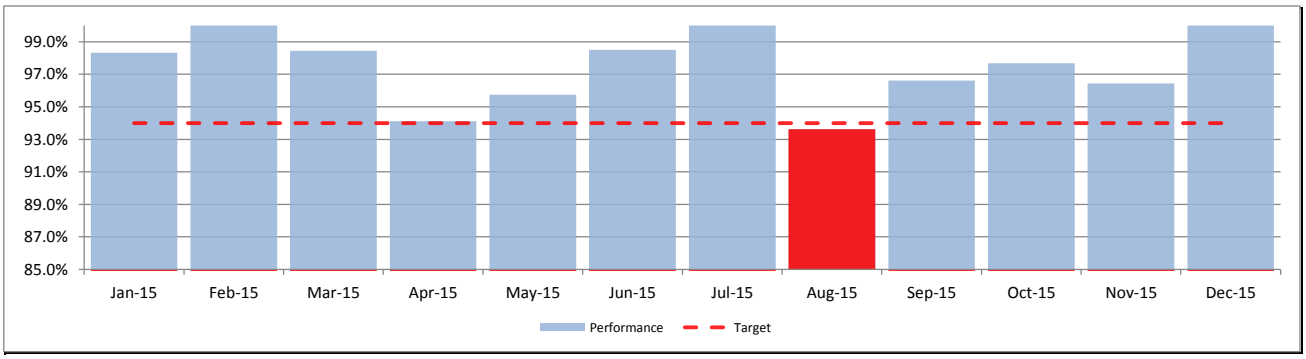
Subsequent treatment - 31 day from decision to treat to treatment - Drug

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



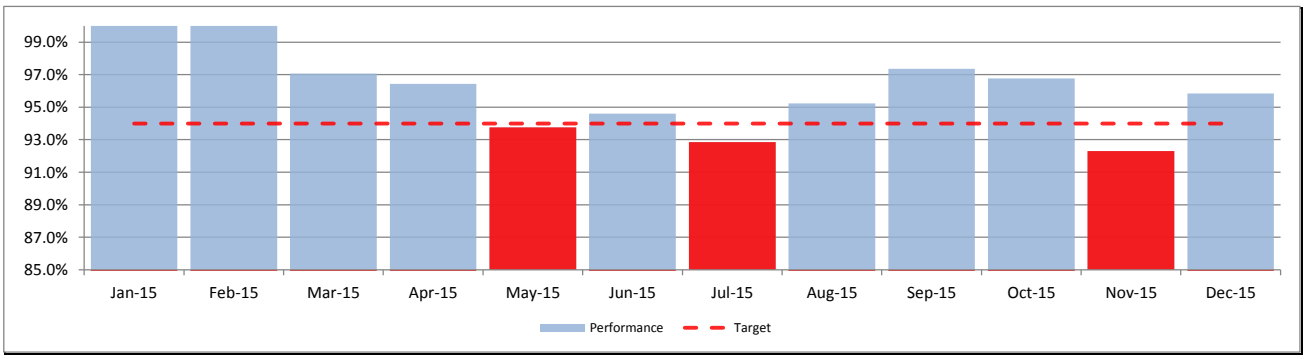
Subsequent treatment - 31 day from decision to treat to treatment - Radiotherapy

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Subsequent radiotherapy treatments	60	49	64	51	47	67	46	47	59	43	56	42
Subsequent radiotherapy breaches	1	0	1	3	2	1	0	3	2	1	2	0
Performance	98.3%	100.0%	98.4%	94.1%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%
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%



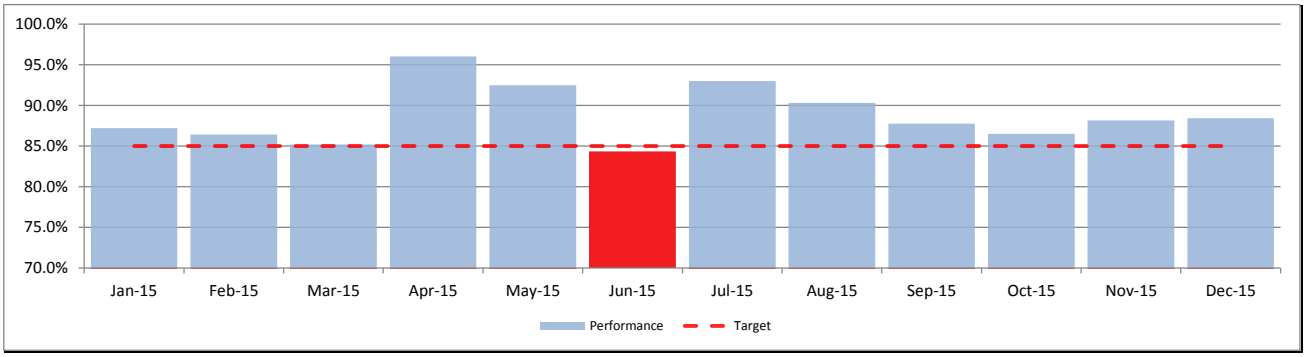
Subsequent treatment - 31 day from decision to treat to treatment - Surgery

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Subsequent surgery treatments	31	30	34	28	32	37	28	21	38	31	39	24
Subsequent surgery breaches	0	0	1	1	2	2	2	1	1	1	3	1
Performance	100.0%	100.0%	97.1%	96.4%	93.8%	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	95.8%
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%



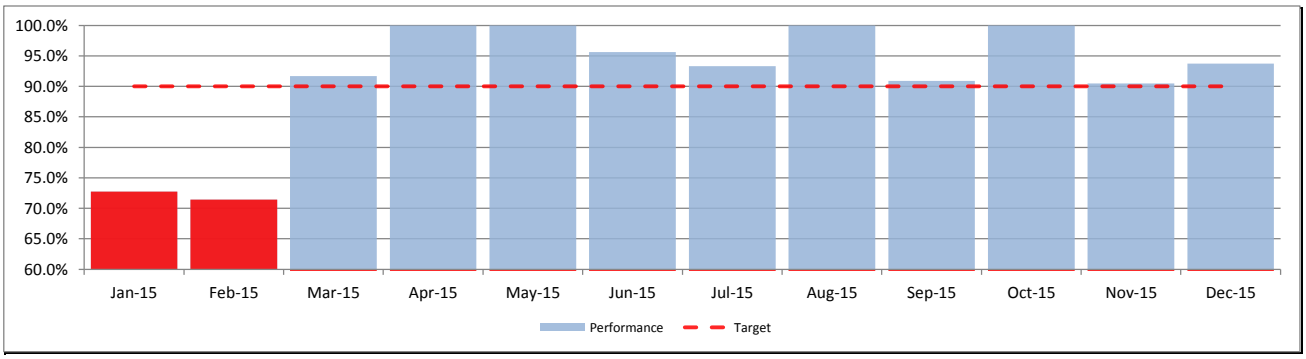
62 day 1st treatment from two week wait referral - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	82	62.5	108	75.5	73	92.5	85.5	77.5	98	100	76	82
62 day 1st treatment breaches	10.5	8.5	16	3	5.5	14.5	6	7.5	12	13.5	9	9.5
Performance	87.2%	86.4%	85.2%	96.0%	92.5%	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.4%
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%



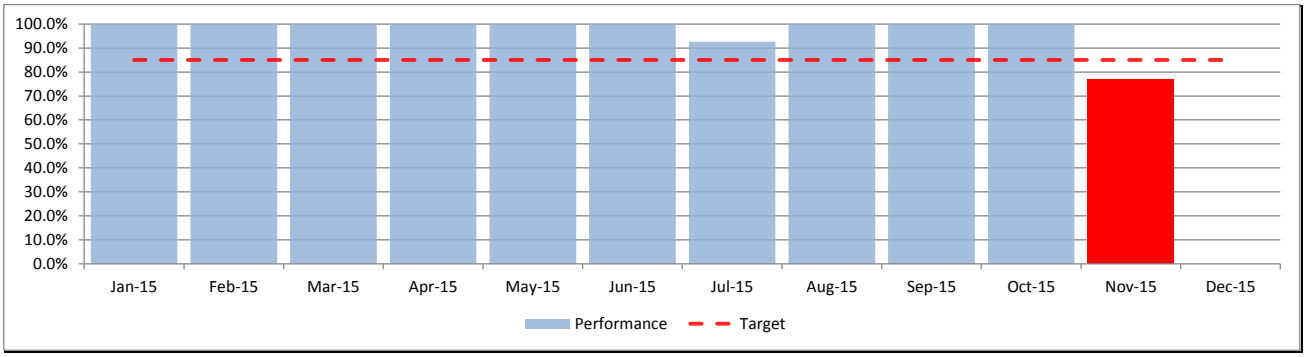
62 day 1st treatment from screening

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	11	7	12	9.5	11	11.5	7.5	8	11	11	10.5	16
62 day 1st treatment breaches	3	2	1	0	0	0.5	0.5	0	1	0	1	1
Performance	72.7%	71.4%	91.7%	100.0%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	93.8%
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%



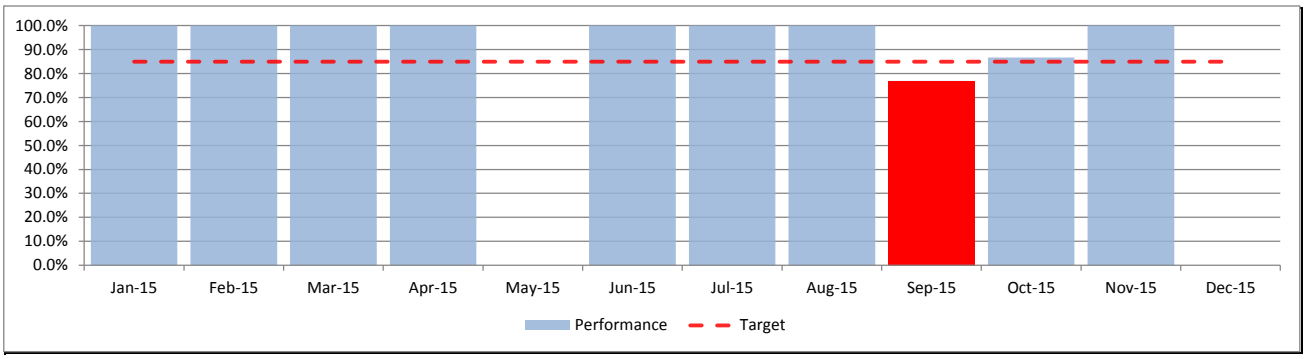
62 day 1st treatment from two week wait referral - BREAST

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	18	10	10	10	10	9	13.5	10	14	8	13	0
62 day 1st treatment breaches	0	0	0	0	0	0	1	0	0	0	3	0
Performance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	92.6%	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%



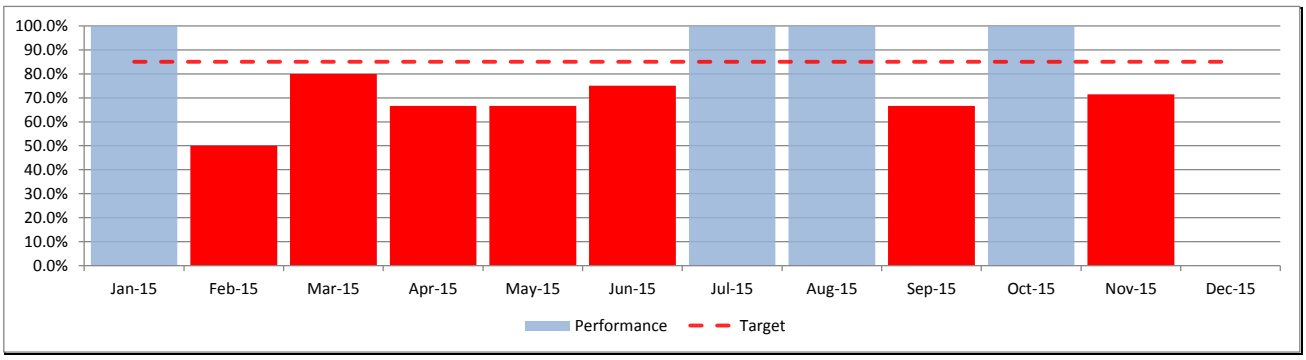
62 day 1st treatment from two week wait referral - GYNAECOLOGY

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	1.5	2.5	4	3.5	0	1.5	2	1	6.5	7.5	5	0
62 day 1st treatment breaches	0	0	0	0	0	0	0	0	1.5	1	0	0
Performance	100.0%	100.0%	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	76.9%	86.7%	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%



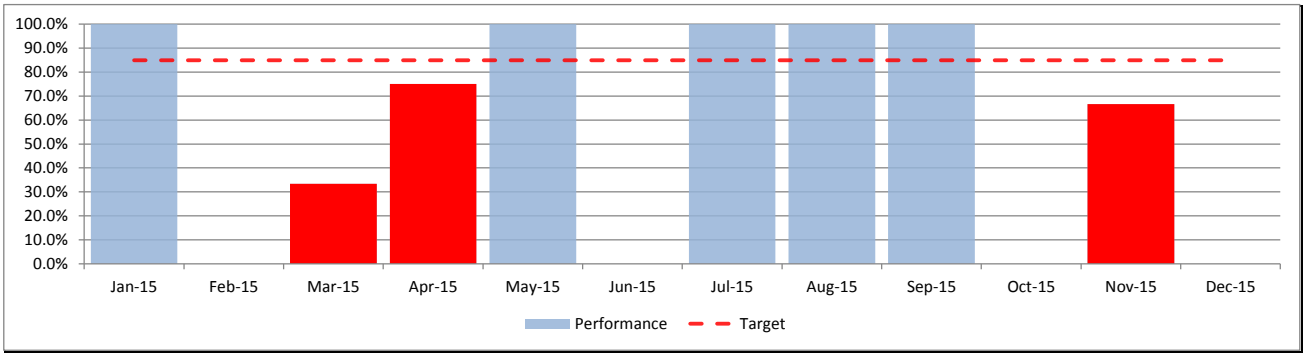
62 day 1st treatment from two week wait referral - HAEMATOLOGY

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	4	4	5	3	3	4	4	3	3	2	7	0
62 day 1st treatment breaches	0	2	1	1	1	1	0	0	1	0	2	0
Performance	100.0%	50.0%	80.0%	66.7%	66.7%	75.0%	100.0%	100.0%	66.7%	100.0%	71.4%	#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%



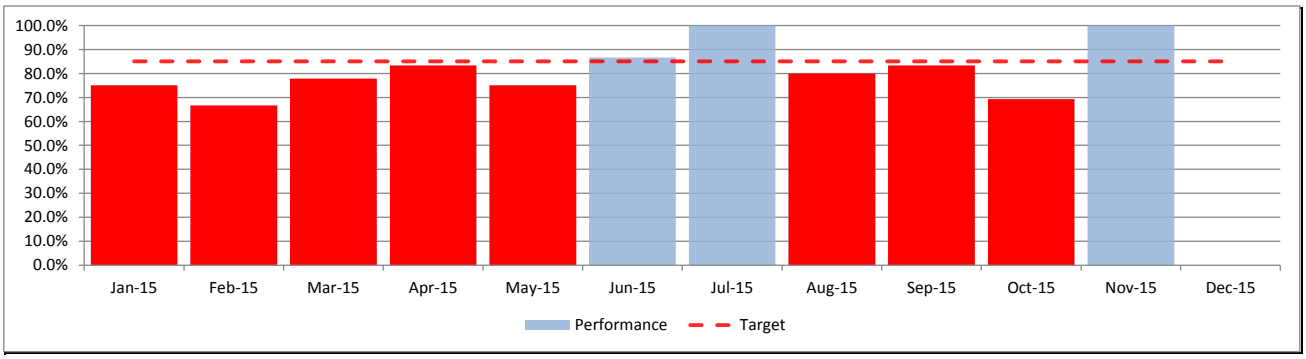
62 day 1st treatment from two week wait referral - HEAD AND NECK

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	1	1	4.5	4	1	4	5.5	2	2	0.5	3	0
62 day 1st treatment breaches	0	1	3	1	0	4	0	0	0	0.5	1	0
Performance	100.0%	**0.0%**	**33.3%**	**75.0%**	100.0%	**0.0%**	100.0%	100.0%	100.0%	**0.0%**	**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%



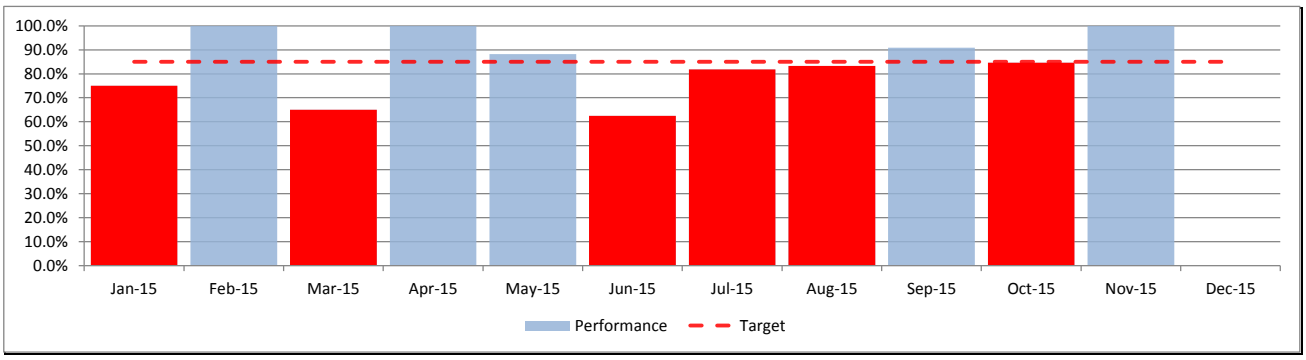
62 day 1st treatment from two week wait referral - LOWER GI

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	8	3	9	6	4	7.5	7	10	12	13	1	0
62 day 1st treatment breaches	2	1	2	1	1	1	0	2	2	4	0	0
Performance	**75.0%**	**66.7%**	**77.8%**	**83.3%**	**75.0%**	86.7%	100.0%	**80.0%**	**83.3%**	**69.2%**	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%



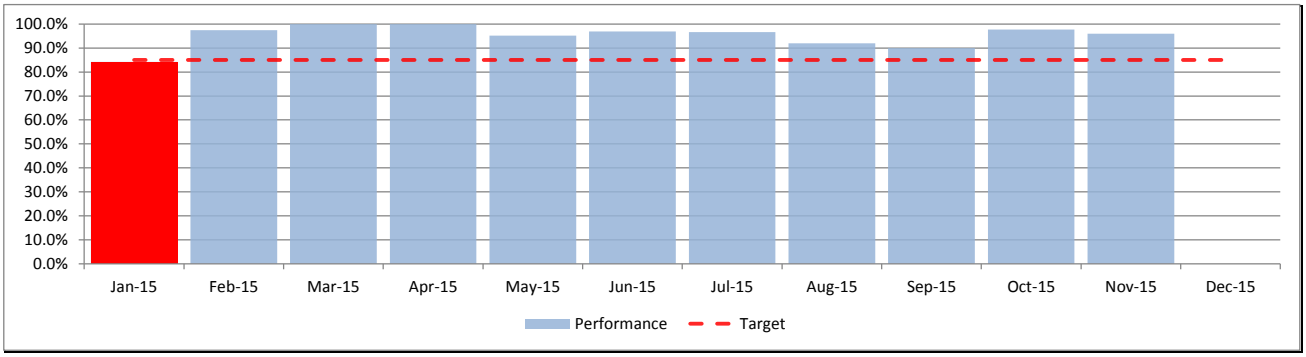
62 day 1st treatment from two week wait referral - LUNG

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	4	4	10	5	8.5	8	5.5	6	5.5	13	6	0
62 day 1st treatment breaches	1	0	3.5	0	1	3	1	1	0.5	2	0	0
Performance	**75.0%**	100.0%	**65.0%**	100.0%	88.2%	**62.5%**	**81.8%**	**83.3%**	90.9%	**84.6%**	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%



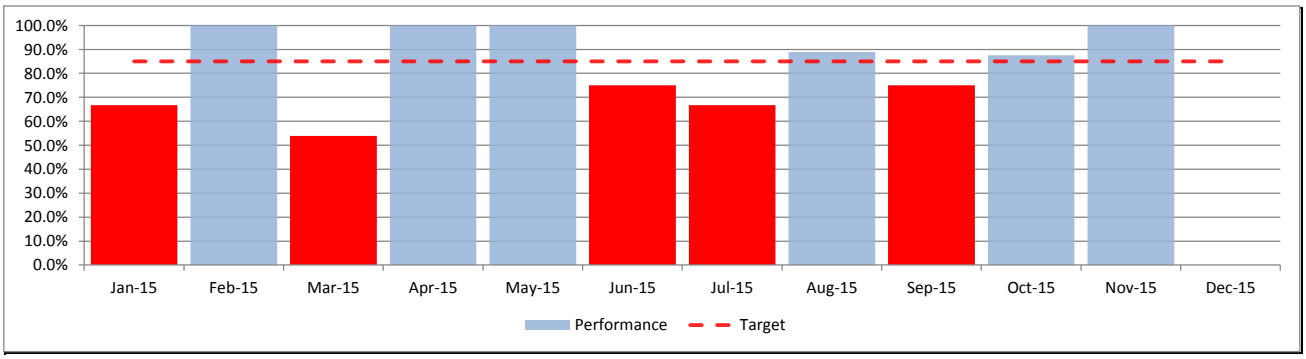
62 day 1st treatment from two week wait referral - SKIN

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	19	19.5	26	24	21	33	30	25	30	22.5	25	0
62 day 1st treatment breaches	3	0.5	0	0	1	1	1	2	3	0.5	1	0
Performance	84.2%	97.4%	100.0%	100.0%	95.2%	97.0%	96.7%	92.0%	90.0%	97.8%	96.0%	#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%



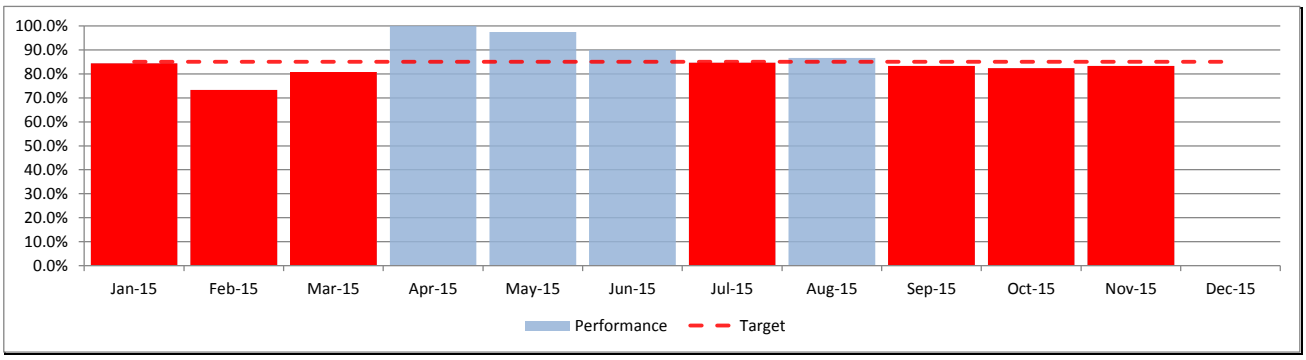
62 day 1st treatment from two week wait referral - UPPER GI

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	3	3	6.5	5	1	4	3	4.5	4	8	2	0
62 day 1st treatment breaches	1	0	3	0	0	1	1	0.5	1	1	0	0
Performance	66.7%	100.0%	53.8%	100.0%	100.0%	75.0%	66.7%	88.9%	75.0%	87.5%	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%



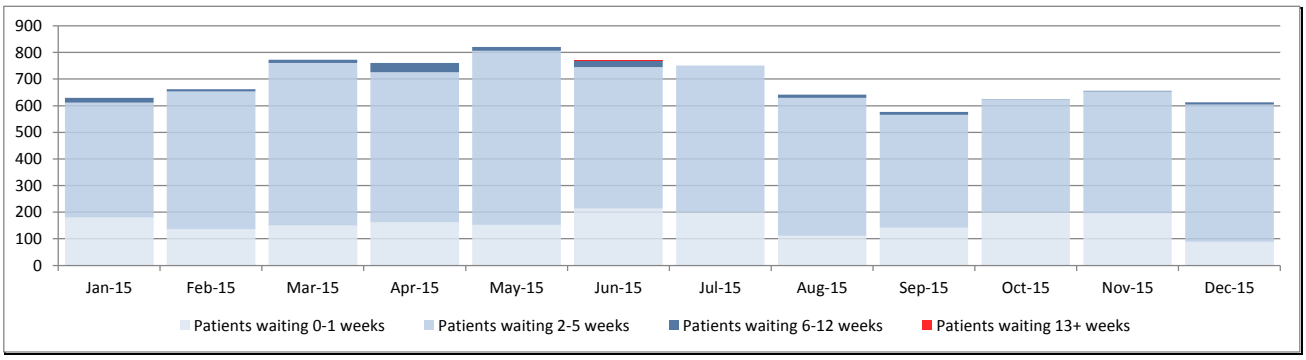
62 day 1st treatment from two week wait referral - UROLOGY

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
62 day 1st treatments	22.5	15	23.5	12	19.5	20	13	15	18	25.5	12	0
62 day 1st treatment breaches	3.5	4	4.5	0	0.5	2	2	2	3	4.5	2	0
Performance	84.4%	73.3%	80.9%	100.0%	97.4%	90.0%	84.6%	86.7%	83.3%	82.4%	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%



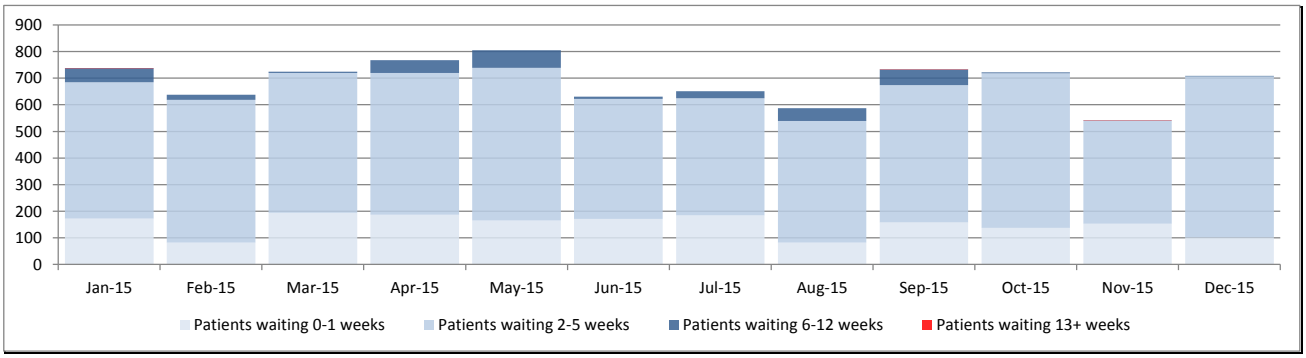
MRI Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	180	137	150	162	152	213	199	111	142	198	195	89
Patients waiting 2-5 weeks	431	517	610	564	654	532	552	519	424	425	459	515
Patients waiting 6-12 weeks	19	8	13	35	14	24	0	12	10	2	2	9
Patients waiting 13+ weeks	0	0	0	0	0	4	0	0	0	0	0	0



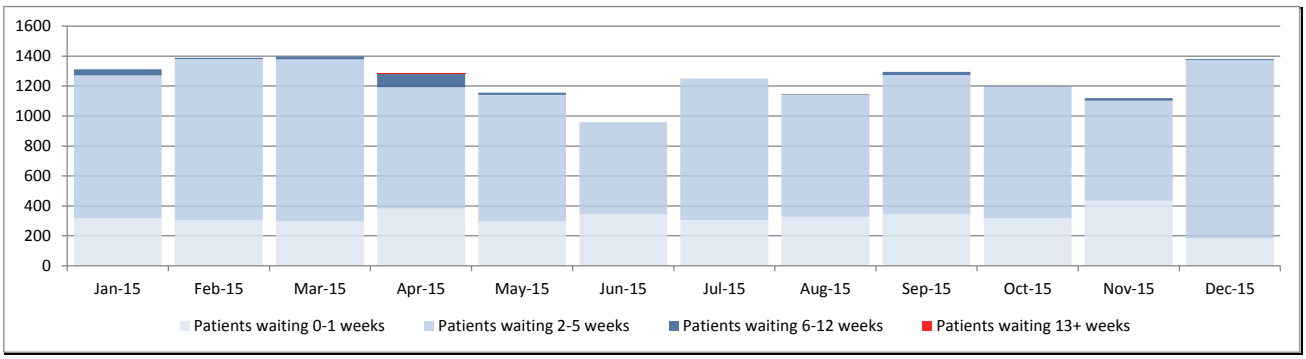
CT Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	172	82	194	187	165	171	184	82	158	138	153	102
Patients waiting 2-5 weeks	513	537	525	533	574	451	441	457	516	580	387	604
Patients waiting 6-12 weeks	52	19	5	48	66	9	26	48	59	4	1	2
Patients waiting 13+ weeks	1	0	0	0	0	0	0	0	1	0	1	0



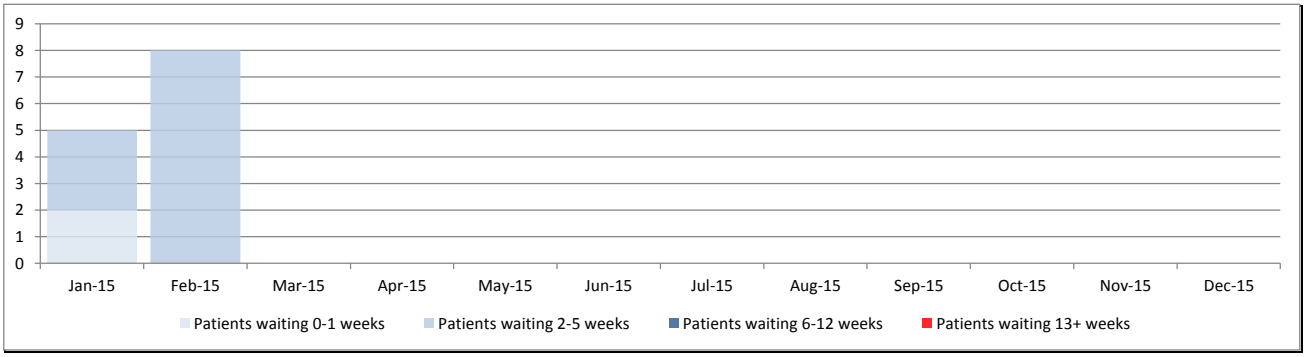
Non-Obstetric Ultrasound Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	318	304	299	382	296	344	306	327	345	316	434	184
Patients waiting 2-5 weeks	953	1076	1079	811	846	610	943	814	928	881	668	1191
Patients waiting 6-12 weeks	40	9	19	92	15	1	0	5	21	2	17	5
Patients waiting 13+ weeks	0	0	0	1	0	0	0	0	0	0	0	0



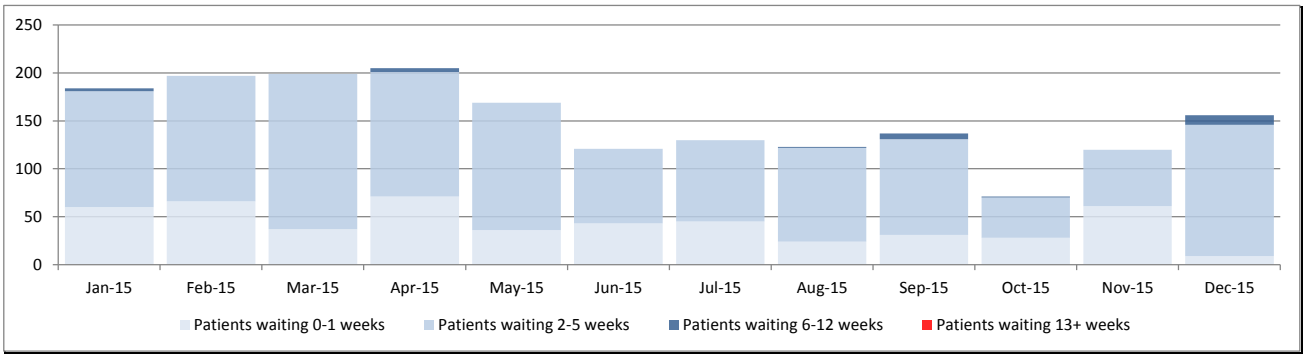
Barium Enema Waiting Times

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



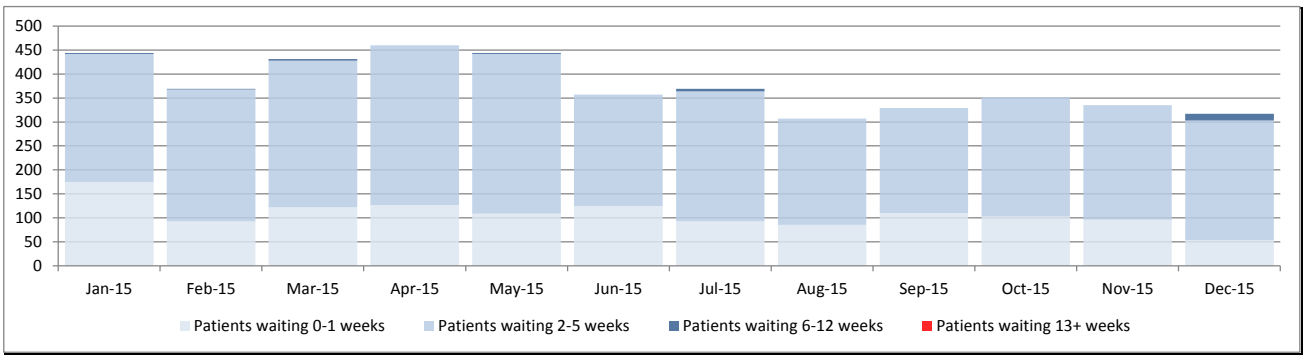
Dexa Scan Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	60	66	37	71	36	43	45	24	31	28	61	9
Patients waiting 2-5 weeks	121	131	162	130	133	78	85	98	100	42	59	137
Patients waiting 6-12 weeks	3	0	0	4	0	0	0	1	6	1	0	10
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



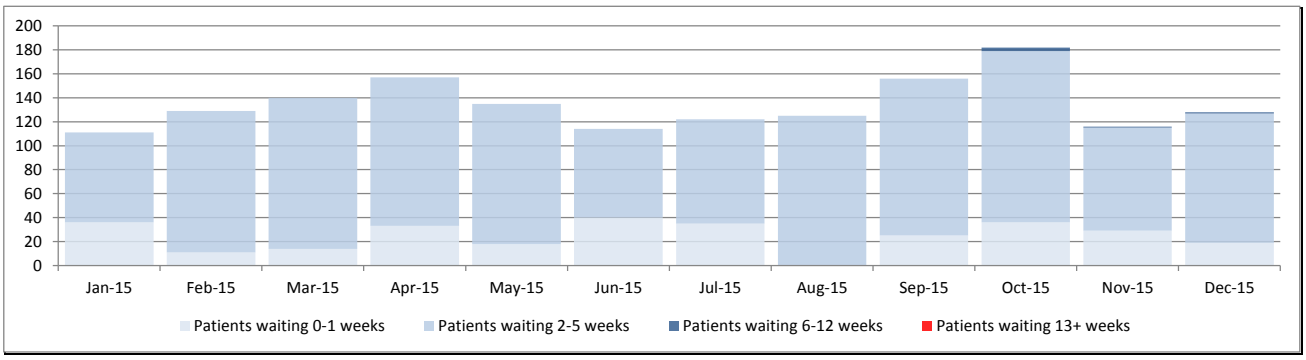
Audiology Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	175	93	122	127	109	125	93	85	110	103	96	53
Patients waiting 2-5 weeks	267	275	306	333	333	232	271	222	219	249	239	250
Patients waiting 6-12 weeks	2	1	3	0	2	0	5	0	0	0	0	14
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



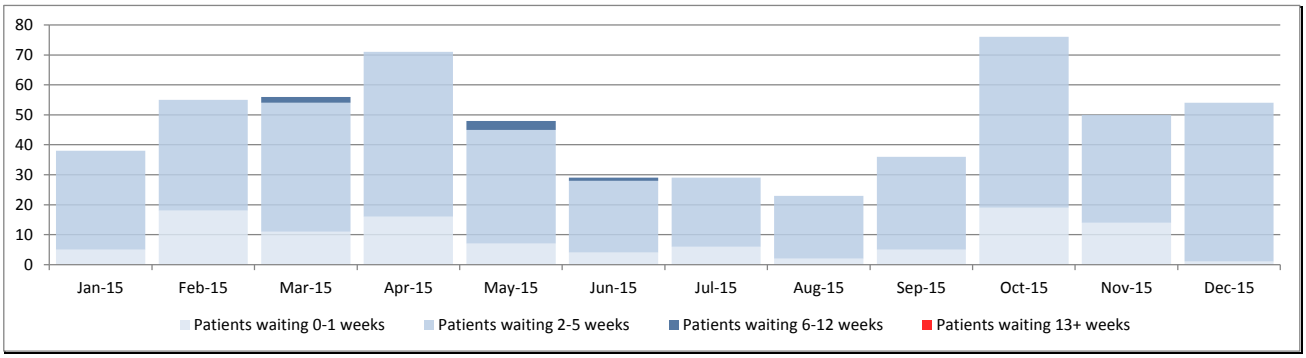
Cardiology (Echocardiology) Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	36	11	14	33	18	40	35	0	25	36	29	19
Patients waiting 2-5 weeks	75	118	126	124	117	74	87	125	131	143	86	108
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	3	1	1
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



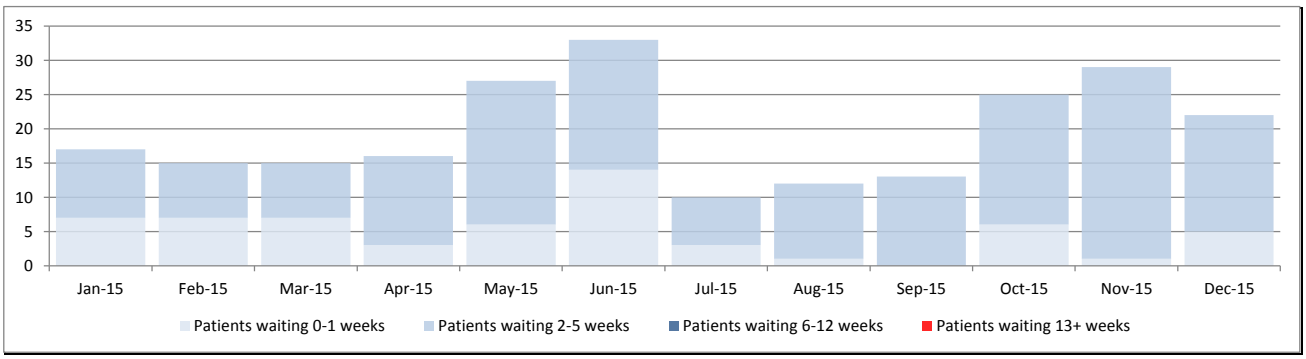
Neurophysiology Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	5	18	11	16	7	4	6	2	5	19	14	1
Patients waiting 2-5 weeks	33	37	43	55	38	24	23	21	31	57	36	53
Patients waiting 6-12 weeks	0	0	2	0	3	1	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



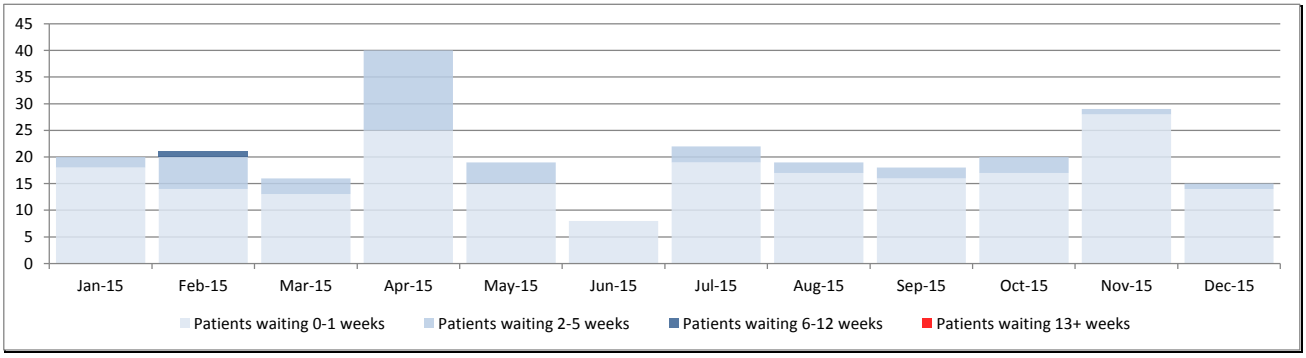
Respiratory Physiology - Sleep Studies

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	7	7	7	3	6	14	3	1	0	6	1	5
Patients waiting 2-5 weeks	10	8	8	13	21	19	7	11	13	19	28	17
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



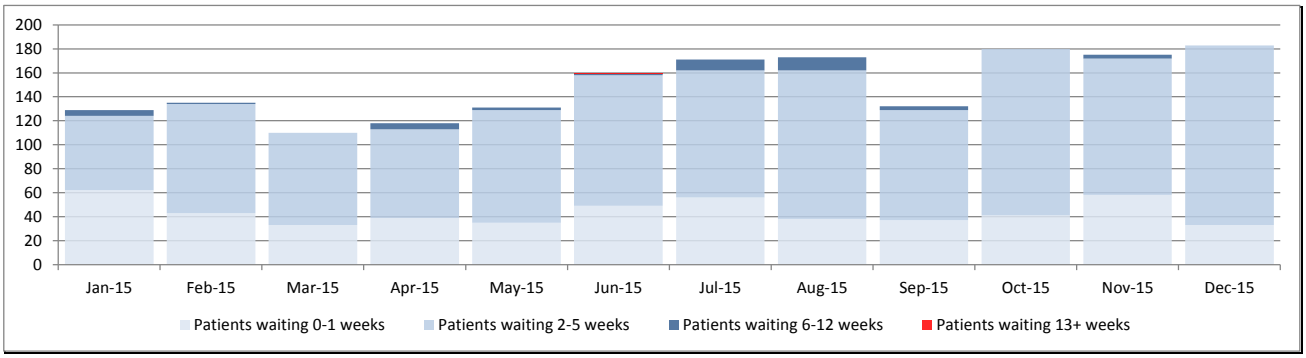
Urodynamics - Pressures & Flows

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	18	14	13	25	15	8	19	17	16	17	28	14
Patients waiting 2-5 weeks	2	6	3	15	4	0	3	2	2	3	1	1
Patients waiting 6-12 weeks	0	1	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



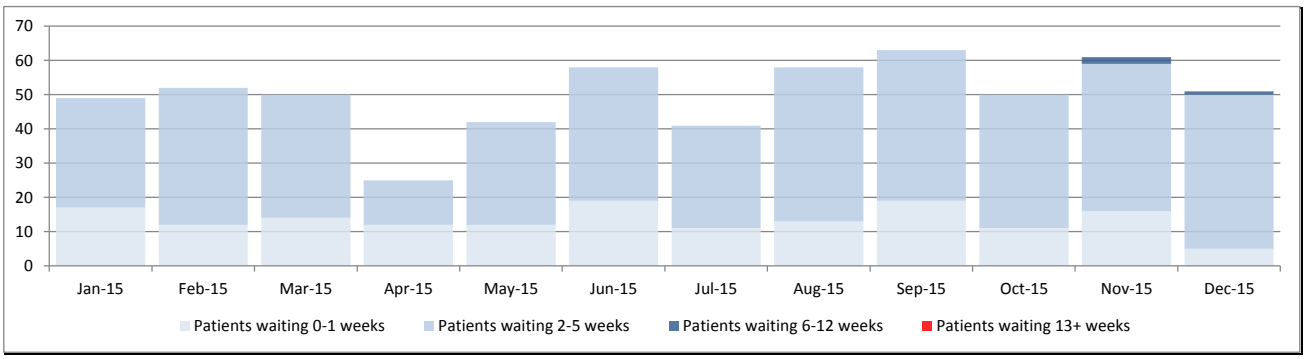
Colonoscopy Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	62	43	33	39	35	49	56	38	37	41	58	33
Patients waiting 2-5 weeks	62	91	77	74	94	109	106	124	92	139	114	150
Patients waiting 6-12 weeks	5	1	0	5	2	1	9	11	3	0	3	0
Patients waiting 13+ weeks	0	0	0	0	0	1	0	0	0	0	0	0



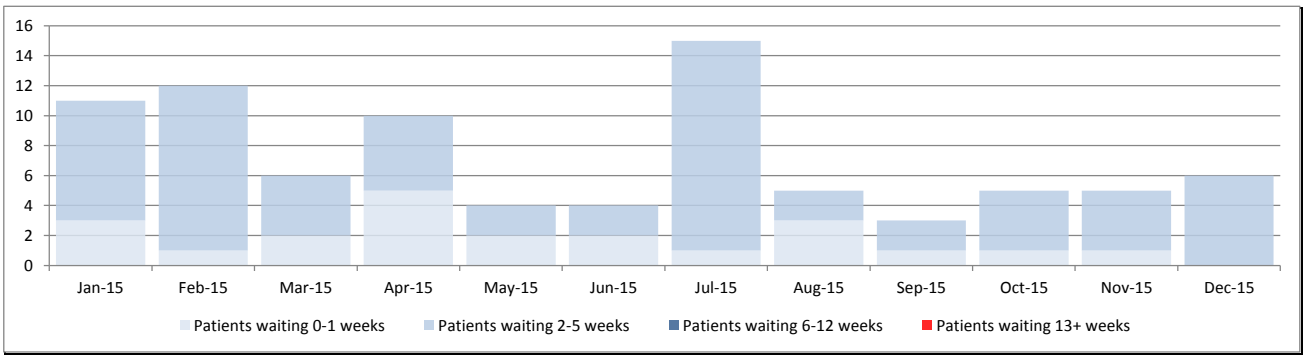
Flexi Sigmoidoscopy Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	17	12	14	12	12	19	11	13	19	11	16	5
Patients waiting 2-5 weeks	32	40	36	13	30	39	30	45	44	39	43	45
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	2	1
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



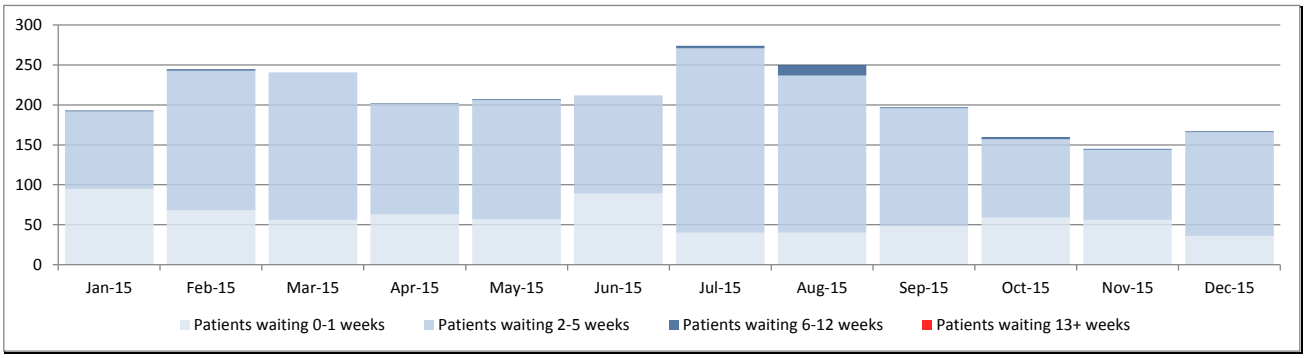
Cystoscopy Waiting Times

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



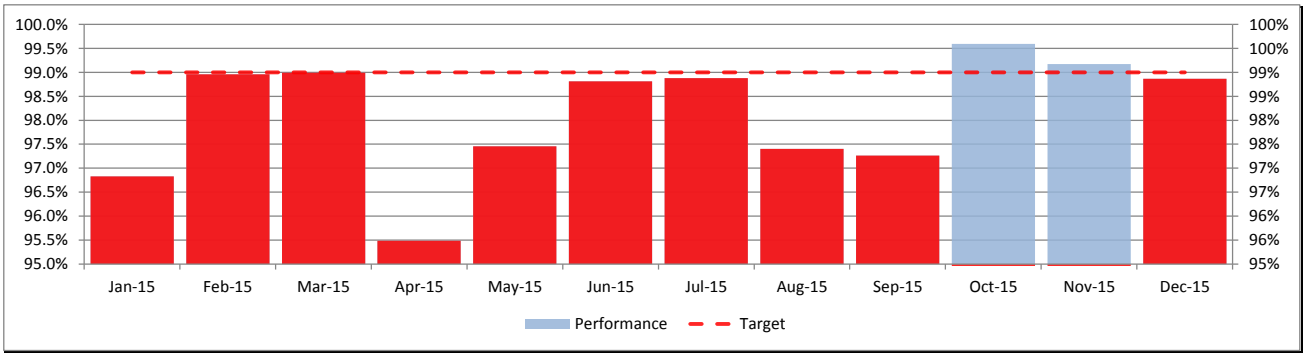
Gastroscopy Waiting Times

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients waiting 0-1 weeks	95	68	56	63	57	89	40	40	48	59	56	36
Patients waiting 2-5 weeks	97	175	185	138	149	123	231	197	148	98	88	130
Patients waiting 6-12 weeks	1	2	0	1	1	0	3	13	1	3	1	1
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



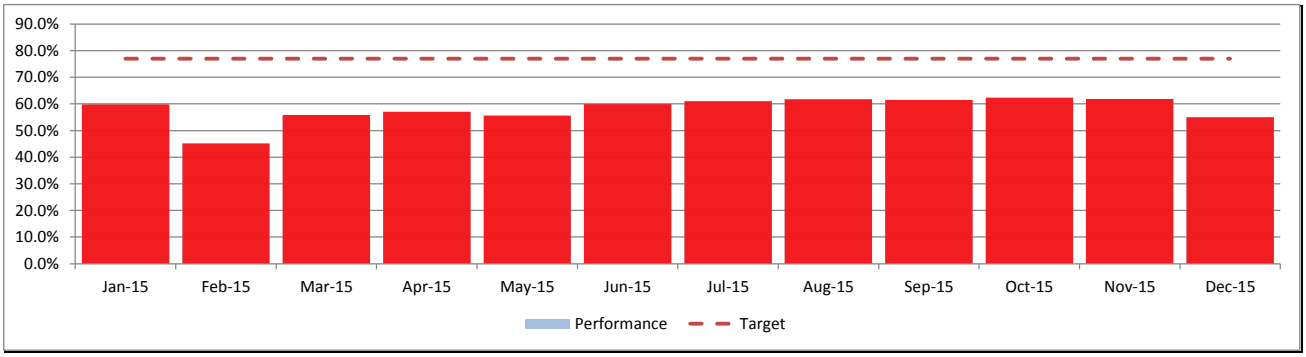
Overall diagnostic position

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Total waits	3880	3927	4158	4123	4007	3455	3834	3470	3688	3667	3382	3800
Total breaches (6+ weeks)	123	41	42	186	102	41	43	90	101	15	28	43
Performance	96.8%	99.0%	99.0%	95.5%	97.5%	98.8%	98.9%	97.4%	97.3%	99.6%	99.2%	98.9%
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%



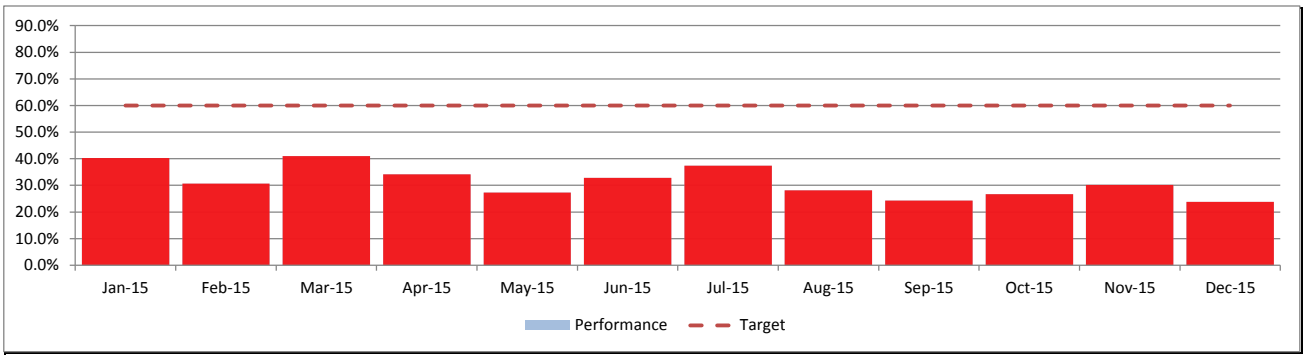
CPS completed within 24 hours - Weekday - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients	2086	1986	2140	2066	1701	1833	1913	1673	1893	1840	1831	1863
CPS completed within 24 hours	1248	896	1194	1179	946	1099	1167	1032	1165	1148	1132	1025
Performance	59.8%	45.1%	55.8%	57.1%	55.6%	60.0%	61.0%	61.7%	61.5%	62.4%	61.8%	55.0%
Target	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%



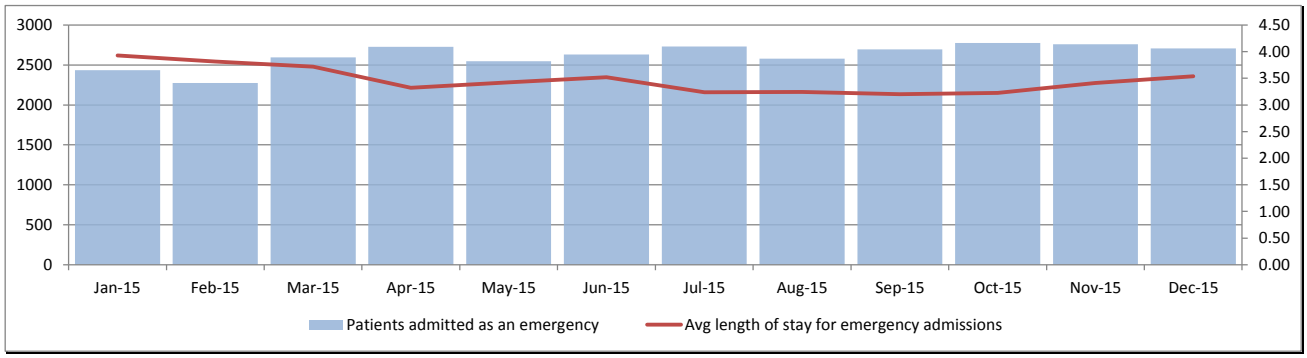
CPS completed within 24 hours - Weekend - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients	489	470	529	506	524	418	423	565	444	495	444	390
CPS completed within 24 hours	197	144	217	173	143	137	158	159	108	132	134	93
Performance	40.3%	30.6%	41.0%	34.2%	27.3%	32.8%	37.4%	28.1%	24.3%	26.7%	30.2%	23.8%
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%



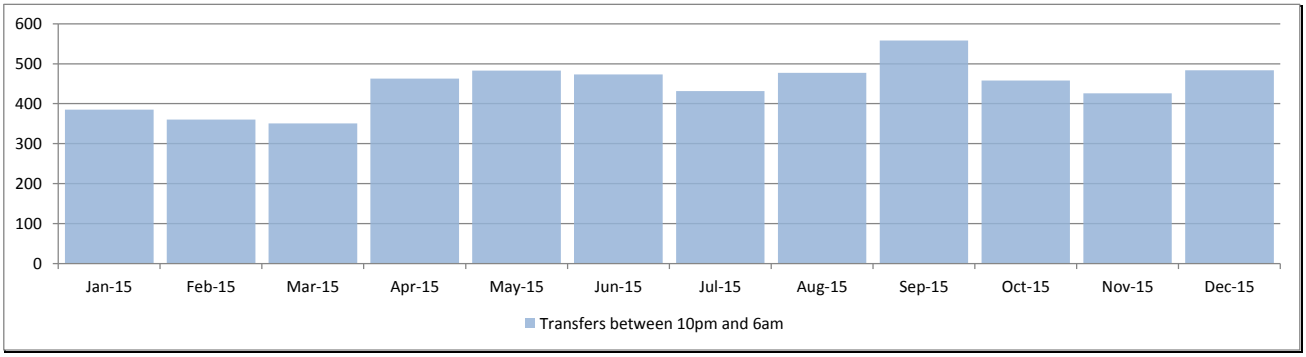
Emergency admissions - Trust Total

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Patients admitted as an emergency	2437	2276	2597	2729	2546	2631	2732	2580	2694	2776	2760	2706
Avg length of stay for emergency admissions	3.93	3.81	3.72	3.32	3.43	3.52	3.24	3.25	3.20	3.22	3.41	3.54



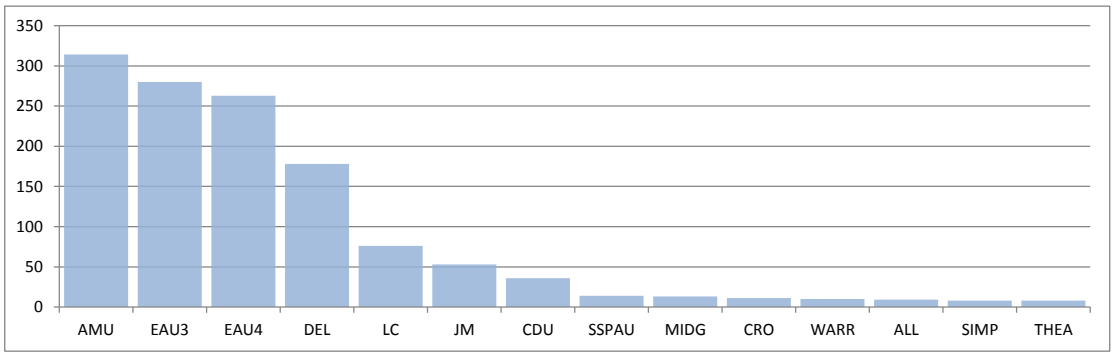
Transfers

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Transfers between 10pm and 6am	385	360	351	463	483	473	432	477	558	458	426	484
Transfers between 10pm and midnight	158	142	147	169	183	196	173	179	197	184	174	181
Transfers between midnight and 2am	113	107	109	145	153	147	138	141	185	119	113	159
Transfers between 2am and 4am	72	59	56	83	93	79	70	93	113	103	78	77
Transfers between 4am and 6am	42	52	39	66	54	51	51	64	63	52	61	67



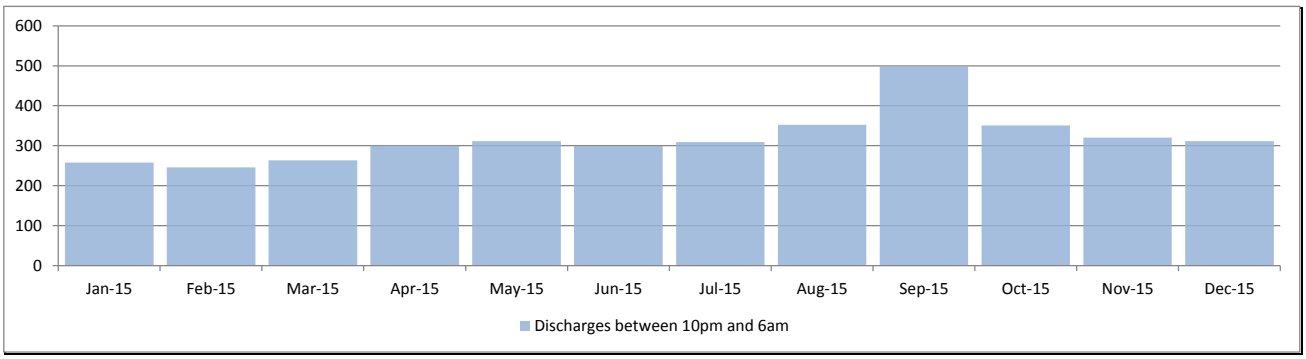
Night time transfers by ward (last 3 months)

Ward	Transfers
AMU	314
EAU3	280
EAU4	263
DEL	178
LC	76
JM	53
CDU	36
SSPAU	14
MIDG	13
CRO	11
WARR	10
ALL	9
SIMP	8
THEA	8



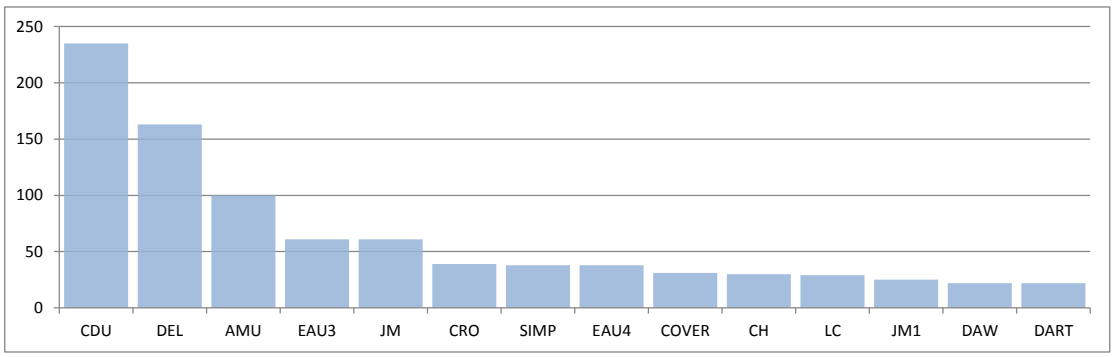
Discharges

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Discharges between 10pm and 6am	258	246	263	300	311	299	309	352	499	351	320	311
Discharges between 10pm and midnight	115	92	118	142	144	138	149	147	295	162	137	132
Discharges between midnight and 2am	79	79	73	73	87	71	81	103	99	90	96	87
Discharges between 2am and 4am	36	50	39	55	49	60	48	58	56	58	45	50
Discharges between 4am and 6am	28	25	33	30	31	30	31	44	49	41	42	42



Night time discharges by ward (last 3 months)

Ward	Discharges
CDU	235
DEL	163
AMU	100
EAU3	61
JM	61
CRO	39
SIMP	38
EAU4	38
COVER	31
CH	30
LC	29
JM1	25
DAW	22
DART	22



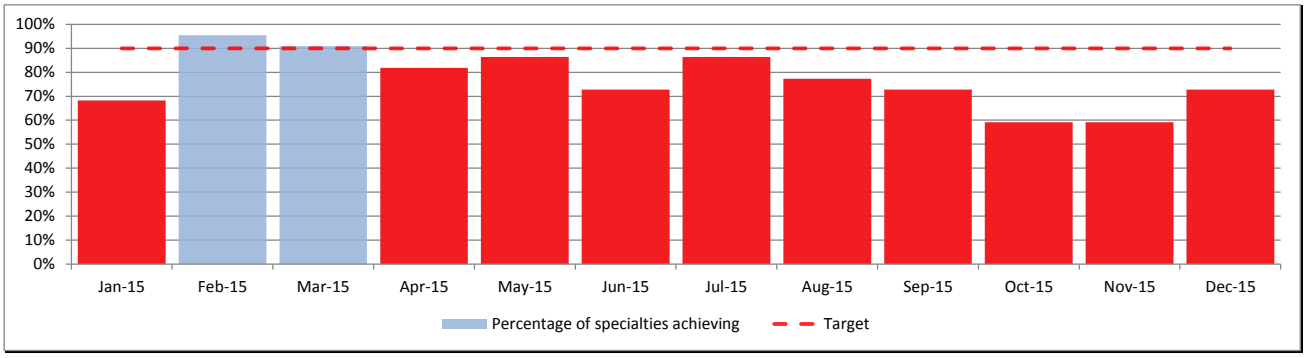
Night time discharges commentary

Higher number of night-time discharges are to be expected from emergency assessment units and maternity areas

The CDU and AMU are newly introduced clinical areas where patients receive extended assessment and operate 24 /7

Clinic Letters Timeliness - Dictated Letters Not Typed

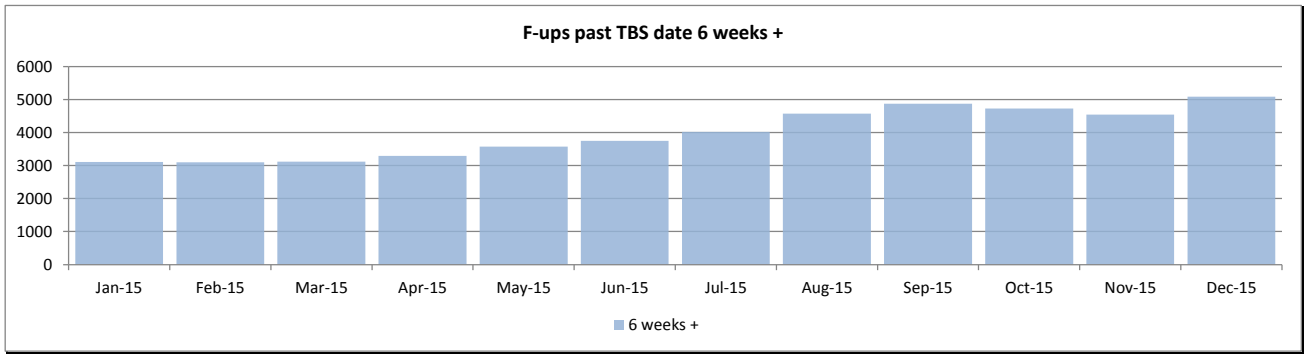
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Specialties breaching	7	1	2	4	3	6	3	5	6	9	9	6
Percentage of specialties achieving	68%	95%	91%	82%	86%	73%	86%	77%	73%	59%	59%	73%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Follow up appointments past to be seen date

	0-6 Weeks	6-12 Weeks	12-18 Weeks	18 Weeks +	Grand Total
Audiology	70	15	12	1	98
Breast Surgery	47	7	2	0	56
Cardiology	100	56	57	132	345
Colorectal Surgery	37	11	23	19	90
Dermatology	202	96	64	104	466
Diabetic Medicine	77	44	38	18	177
ENT	197	40	61	119	417
Endocrinology	33	13	1	1	48
Gastroenterology	22	17	27	46	112
General Medicine	9	4	5	10	28
Geriatric Medicine	17	0	0	0	17
Gynaecology	78	10	4	0	92
Medical Oncology	0	0	0	1	1
Nephrology	32	0	0	0	32
Neurology	27	11	5	14	57
Ophthalmology	1871	773	881	666	4191
Oral Surgery	69	17	10	5	101
Orthodontics	4	0	0	0	4
Orthoptics	276	74	93	29	472
Paediatrics	221	96	85	129	531
Pain Management	66	27	32	48	173
Plastic Surgery	38	24	36	0	98
Podiatry	0	0	0	0	0
Respiratory Medicine	104	53	31	3	191
Restorative Dentistry	0	0	0	0	0
Rheumatology	378	234	307	86	1005
Thoracic Surgery	0	0	0	0	0
Trauma & Orthopaedics	124	32	7	1	164
Upper Gastrointestinal Surgery	38	15	13	5	71
Urology	58	28	42	120	248
Vascular Surgery	0	0	0	0	0
Total	4195	1697	1836	1557	9285

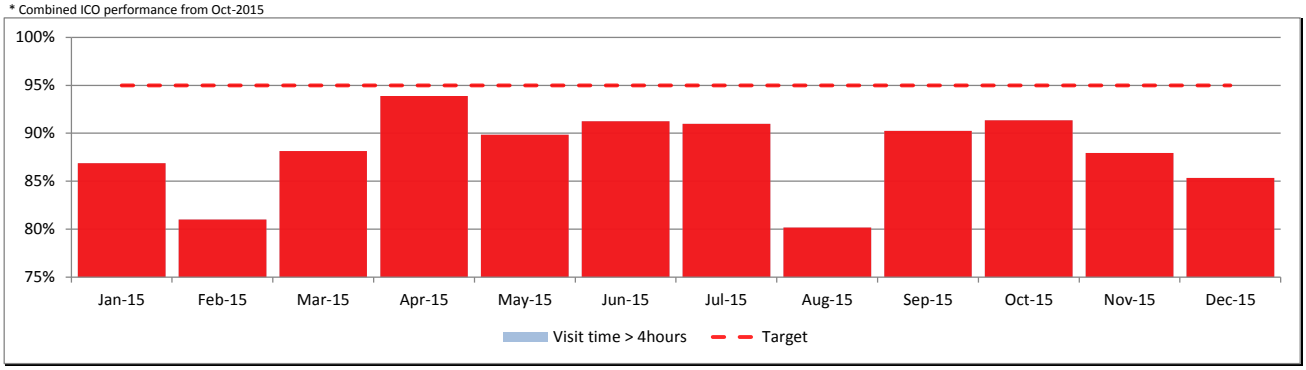
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
0-6 weeks	2805	2812	3309	3307	3781	4105	4211	4068	3886	3794	3556	4195
6-12 weeks	1098	1139	1072	1253	1274	1337	1511	1593	1771	1589	1546	1697
12-18 weeks	1111	976	1046	1044	1196	1344	1420	1761	1778	1754	1608	1836
18 weeks +	903	981	997	997	1107	1064	1089	1216	1324	1388	1388	1557
6 weeks +	3112	3096	3115	3294	3577	3745	4020	4570	4873	4731	4542	5090



Time spent in A&E

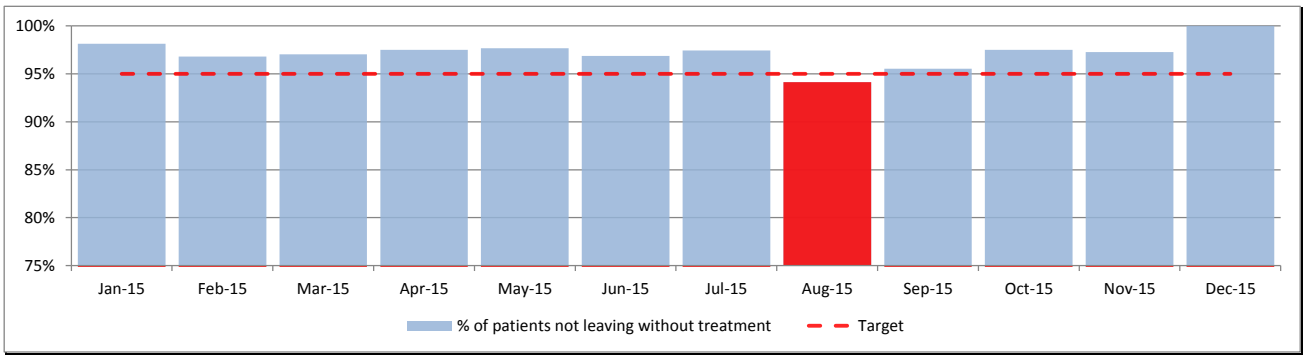
	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
A&E attendances	5821	5537	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135
Percentage of patients treated within 4 hours	764	1053	758	394	674	571	608	1232	594	753	1020	1192
Visit time > 4hours	87%	81%	88%	94%	90%	91%	91%	80%	90%	91%	88%	85%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

* Combined ICO performance from Oct-2015



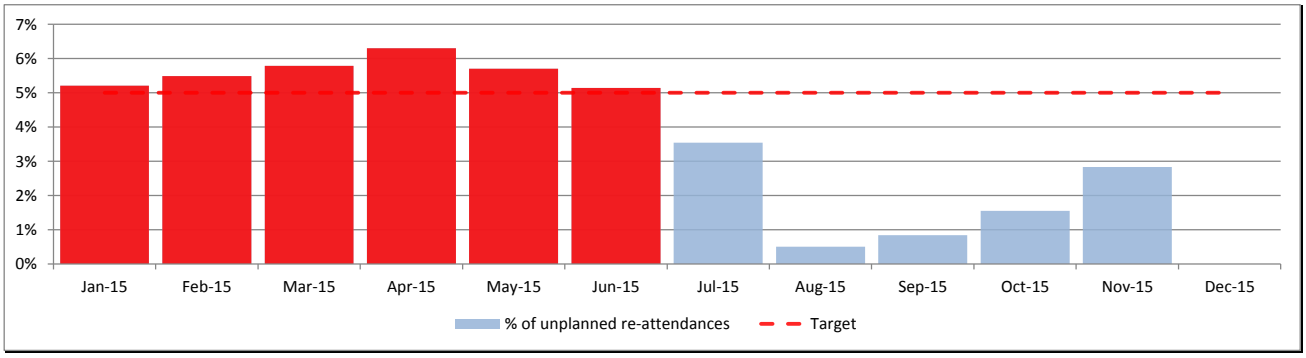
Left department without being treated -Type 1 only

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
A&E attendances	5821	5537	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135
Percentage of patients treated within 4 hours	108	177	189	160	154	204	172	365	271	218	230	0
% of patients not leaving without treatment	98%	97%	97%	98%	98%	97%	97%	94%	96%	97%	97%	100%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Unplanned re-attendances -Type 1 only

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
A&E attendances	5821	5537	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135
Re-attendances	303	304	370	406	379	335	239	31	51	135	239	0
% of unplanned re-attendances	5%	5%	6%	6%	6%	5%	4%	0%	1%	2%	3%	0%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%



Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	Trust Board 3rd February 2016
Title:	Estates and Facilities Management, Medical Devices and Health and Safety Key Performance Indicators: Exception report for November and December 2015.
Lead Director:	Director of Estates and Commercial Development
Corporate Objective:	1. Safest care; 3 Best experience; 6. Delivering improved value
Purpose:	Information/Assurance

Summary of Key Issues for Trust Board

Strategic Context:
Compliance with Acts, National standards, and Regulatory Frameworks e.g. CQC, in relation to Estates and Facilities Management, The Environment, Health and Safety, and Medical Equipment. Strategic Development of the Estate and Capital Investment requirements.

There has been a reduction in Health and Safety incidents across the Trust for November and December and improving performance across all the reported areas. COSHH incidents have significantly reduced month on month from 14 in September to 1 in December as a result of the work plan led by the COSHH group and the PMU.

Key Issues/Risks

- The sustained number of estates critical internal failures since August continues to be of concern and is a representation of the level of significant risk in the estate. One in November and two in December
- Both the community Estates maintenance provider and the Trust team are finding the urgent estates response target a challenge. An action plan is in place for both providers with a view to an improvement in performance by the end of March 2016.
- The anticipated improvement trajectory in the Medical Devices performance indicator has been hampered by the loss of a staff member in this small team.
- Compliance of fire safety audits remains a challenge, in the main due to door wedges in the operational areas. A communications strategy has been developed and implemented including a new BuZZ video, to improve staff awareness and improve performance.

Recommendations:

The Trust Board is asked to consider and discuss the assurance provided within this report.

Summary of ED Challenge/Discussion:
The downward trend in incidents was welcomed, reflecting the improvement focus on this area of risk.
The capacity in relation to medical devices was discussed, and the level of risk to patient safety requested in relation to the 7 incidents reported in Acute dashboard, if considered significant then permission to increase capacity in short term. Assurance was received that the staffing gap had been addressed.
An organisation with a healthy health and safety culture would be expected to be reporting a minimum number of near misses. This explained why a low number of near misses is RAG rated RED on the dashboard, low reporting numbers would be of concern if sustained.
Indicator 6.5 Compliant Fire Audits, discussion on how can we emphasis the message about

wedging fire doors open through line management accountabilities and safety walkarounds/Board walkarounds
Internal/External Engagement including Public, Patient and Governor Involvement: Governor sits on the Capital Infrastructure and Environment Group (CIEG) – (previously workstream 5).
Equality and Diversity Implications: The Disability Awareness Action Group (DAAG) considers and is involved in all EFM development proposals.

Report to: Trust Board

Date: January 2015

Report From: Director of Estates & Commercial Development

Report Title: Estates and Facilities Management, Medical Devices and Health and Safety Key Performance Indicators: Exception report

1. EFM and Performance report for November and December 2015

Table 1 below identifies performance changes between months for November and December and table 2 any area of concern for the attention of the Board, with appropriate explanation and action to a resolution. In order to achieve consistency over a twelve month reporting period (April to March) performance will continue to be reported under the headings acute setting and community setting summarised in one combined report but with two separate performance tables (Appendix 1 and 2).

Table 1 Changes between November 2015 and December 2015 Scorecard Indicator

Green ✓	Amber !	Red ✘

Setting	Improving Indicators	November 2015 Position	December 2015 Position
Acute	1.1c: Planned Maintenance request access denied.	!	✓
Acute	1.1e: % of Estates Reactive work resolved within target – 2 hours (Emergency)[95% decrease to 94%]	!	✓
Acute	1.1i:Estates % of Reactive work resolved within target – Routine P3 + P4 (<7- 30 Days)	!	✓
Acute	5.1: Number of RIDDOR Incidents	!	✓
Community	5.1: Number of RIDDOR Incidents	!	✓
Acute	5.4: Non-patient incidents resulting in moderate harm	!	✓
Community	5.5: Number of near misses	!	✓
Community	6.5: % of Compliant Fire Audits	✘	✓
	Deteriorating Indicators		

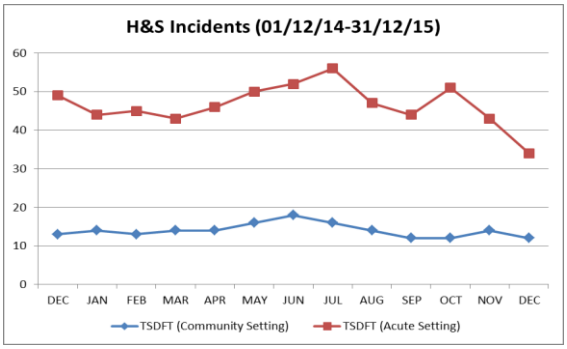
Community	1.1b: PPM (Estates) % success against plan	✓	!
Acute	6.2: Number of fire alarm activations	✓	!
Community	6.4: No of Fire Audits undertaken	✓	!
Acute	6.6: % Fire Safety Risk Assessments (Reform Order) in date	✓	!
Community	6.6: % Fire Safety Audits (Reform Order) in date	✓	✘
Acute	5.5: Number of near misses (low numbers)	!	✘
	Red Rated Indicators with no change		
Acute	1.1g: % of Estates Reactive work resolved within target - <1-4 Days (Routine)	✘	✘
Community	1.1g: % of Estates Reactive work resolved within target - <1-4 Days (Urgent)	✘	✘
Acute	1.2: Number of Estates Internal Critical Failures	✘	✘
Acute	4.1a:Medical Electronics % of COMPLETED Scheduled Service Work Requests (in month)	✘	✘
Community	4.1a:Medical Electronics % of COMPLETED Scheduled Service Work Requests (in month)	✘	✘
Acute	6.5: % of Compliant Fire Audits	✘	✘

	Areas with Specific Cause for Concern		**Timeline for improvement**
Acute	1.1g	% of Estates Reactive work resolved within target - <1-4 Days (Urgent)[85% decrease to 84%]	
	Performance of this indicator has dropped from 85% to 84% over the Christmas period. Work is in hand to review the working practices so that it meets the 7/7 needs of the organisation. Focus will be on improving the performance of this indicator.		Quarter 4 2015- 16
Community	1.1g	% of Estates Reactive work resolved within target - <1-4 Days (Urgent)[81% decrease to 80%]	
	The Trust has called the community Maintenance Contractor to a meeting in early February and an action plan will be developed and implemented to improve the performance on this standard.		Quarter 4 2015- 16
Acute	1.2	Number of Estates Internal Critical Failures	
	1 event in November, 2 events in December 2015. A joint failed on the boiler house water feed which caused 20 tons of water to be lost, other joints have subsequently been checked where possible. Complete loss of heating to the Day Surgery Unit due to an age related failure of a vibration coupling. The coupling was replaced and heating restored with minimal loss of services. As a result we have instigated a site wide programme to replace all flexible couplings.		
Acute	4.1a	% of COMPLETED Medical Devices Scheduled Service Work Requests (in month) ***[53.8% to 44.6%]***	
Community	4.1a	% of COMPLETED Medical Devices Scheduled Service Work Requests (in month) **[64.72 down to 36.36%]**	
	. The improvement trajectory is slower than anticipated on this indicator due to workforce issues, which will be resolved by June. Three factors have contributed to underperforming with planned maintenance: 1) The reduced available working hours for the month of December has been challenging due to staffing availability. 2) Increased staffing requirements for technical support to medical device procurement projects; 3) Increased staff requirements for technical support with action to resolve medical device safety issues.		August 2016
Acute	6.5	% of Compliant Fire Audits	

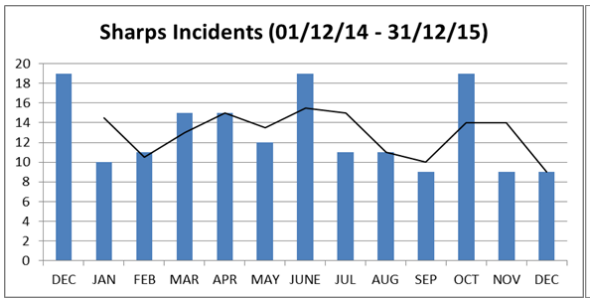
	This month 3 local audits were carried out with 66% being compliant, again the failure is due to staff wedging fire doors open unnecessarily. A reminder has sent to all staff via the staff bulletin not to wedge fire doors open. A short BUZZ presentation on the issue of fire doors has been recorded and is available via ICON.		Quarter 4 2015-16
Community	6.6	% Fire Safety Audits (Reform Order) in date	
	The number of compliant Fire Safety Risk Assessments has fallen to 85%. This was related to e technical issue that has now been resolved. Performance will return to standard in February resolved.		February 2016

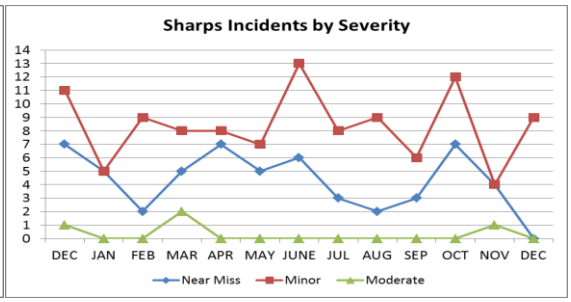
2. Overview of Health and Safety and exception report

The Trust continues to see a downward trend of numbers of incidents across both settings, with no serious (RIDDOR) or moderate incidents reported in November or December.



The significant reduction in the number of COSHH incidents since September 2015 reflects the outcomes of the good work being led by the COSHH group and safer handling of substances hazardous to health. Training numbers have increased across the board for December, fire, H&S, manual handling and conflict resolution are over 80% for the acute setting and over 85% for the community setting. Security incidents in both settings reduced in December. The improvement of controls in place around the management of sharps across the Trust, including the investigation of all sharps incidents, is resulting in a gradual decrease in the number of sharps incidents reported.





Whilst numbers have reduced for December the number of slips trips and falls shows a slightly increasing trend. The reduction in non-patient handling events continues whist the number of patient handling events remains fairly constant. Slips trips and falls and patient handling events and sharps will remain a focus of sustained attention by the Clinical and non-clinical subgroups the Health and Safety Committee and the Capital Infrastructure and Environment Group.

3. Recommendations

The Trust Board is asked to consider and discuss the assurance provided within this report

Appendix 1: Estates and Facilities – KPI's Torbay and South Devon Foundation Trust – Acute Setting – December 2015

	Area			Target	Monthly Performance												Current year to date (Complete Months)			Risk Threshold		
	Description			Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	Status	RAG Thresholds		
	Estates																					
1.1a	Number of PPM items planned per month			Variable	1017	1068	1132	1113	1199	1087	1159	1118	834					1081				
1.1b	PPM (Estates) % success against plan			100%	89%	90%	88%	88%	88%	90%	84%	87%	85%				100%	88%		R<85%	A85-94%	G>95%
1.1c	Planned Maintenance request access denied.			0	0	0	0	0	0	0	0	4	0				0	0		R≥5	A3-4	G≤2
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	89	104	117	106	133	83	92	124	118					107				
1.1e		Emergency – P1	<2 Hour	100%	96%	97%	98%	95%	98%	98%	95%	94%	98%				100%	97%		R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	314	272	332	311	313	331	405	381	303					329				
1.1g		Urgent – P2	<1- 4 Days	100%	85%	88%	90%	95%	92%	91%	80%	85%	84%				100%	88%		R<90%	A90-94%	G≥95%
1.1h		Routine – P3 + P4	Total Requests	Variable	483	386	484	524	420	486	386	421	282					431				
1.1i		Routine – P3 + P4	<7- 30 Days	100%	86%	74%	75%	69%	73%	78%	90%	88%	95%				100%	79%		R<85%	A85-89%	G≥90%
1.2	Number of Estates Internal Critical Failures			0	0	0	3	0	3	2	2	1	2				0	2		R1	-	G0
	Facilities																					
2.1	Compliance **Very High Risk** Cleaning Audit			98%	100%	100%	99%	99%	100%	99%	100%	99%	100%				98%	100%		R<95%	A95-97%	G≥98%
2.2	Compliance **High Risk** Cleaning Audit			95%	98%	99%	97%	98%	98%	99%	98%	100%	99%				95%	98%		R<90%	A90-94%	G≥95%
2.3	Compliance **Significant Risk** Cleaning Audit			85%	99%	99%	99%	99%	99%	99%	99%	99%	99%				85%	99%		R<80%	A80-84%	G≥85%
2.4	Compliance **Low Risk** Cleaning Audit			75%	92%	96%	97%	99%	99%	99%	99%	99%	99%				75%	98%		R<70%	A70-74%	G≥75%
2.5	No. of Environment Health (food hygiene) events			0	0	0	0	0	0	0	0	0	0				0	0		R1	-	G0
	Waste																					
3.1	Total Tonnage per month all waste streams			157	127	138	148	126	116	119	151	154	154				≤157	136		R≥173	A158-172	G≤157
3.2	% of Total tonnage Recycled Waste			31%	30%	43%	43%	33%	25%	33%	42%	44%	37%				31%	37%		R≤24%	A25-30%	G≥31%
3.3	% of Total tonnage Landfill Waste			37%	34%	24%	26%	33%	38%	32%	28%	25%	31%				37%	30%		R≥44%	A38-43%	G≤37%
3.4	% of Total tonnage of Clinical Non-Burn waste			18%	19%	26.5%	17%	18%	21%	19%	16%	17%	18%				18%	18%		R≥25%	A19-24%	G≤18%
3.5	% of Total tonnage of Clinical Burn waste			11%	12%	13.5%	10%	12%	12%	11%	10%	10%	10%				11%	11%		R≥17%	A12-16%	G≤11%
3.6	% of Total tonnage of Clinical Offensive waste			3%	5%	4%	4%	4%	4%	5%	4%	4%	4%				3%	4%		R≤1%	A2%	G≥3%
3.7	Number of Waste Audits undertaken per month			10	10	10	10	10	10	10	10	10	10				10	10		R≤5	A6 - 7	G≥8
3.8	% of Compliant Waste Audits			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%		R<90%	A90-94%	G>95%
3.9	% Compliance of Statutory Waste Audits			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%		R<90%	A90-94%	G>95%

	Health & Safety																		
5.1	Number of RIDDOR Incidents	0	3	2	3	0	3	3	0	1	0				0	2		R≥3	A1-2	G0
5.2	Number of days lost (due to incidents in month)	65	23	21	42	5	30	215	6	0	20				65	40		R≥81	A66-80	G≤65
5.3	Non-patient incidents resulting in minor harm	30	24	31	30	28	30	25	32	28	28				30	28		R≥36	A31-35	G≤30
5.4	Non-patient incidents resulting in moderate harm	1	3	1	5	1	3	1	2	2	0				1	2		R≥4	A2-3	G≤1
5.5	Number of near misses	16	18	16	14	27	12	16	17	12	6				16	15		R≤10	A11-15	G≥16
5.6	% of Staff receiving H & S training in month	*85%	89%	89%	88%	87%	88%	86%	86%	86%	86%				85%	87%		R<80%	A 80-85%	G≥85%
	Fire																			
6.1	No. of Fires	0	0	0	0	0	1	0	0	0	0				0	0.11		R1	-	G0
6.2	Number of fire alarm activations	12	7	4	8	5	7	6	13	12	14				12	8.44		R>15	A12-15	G<12
6.3	Fire alarm activations attended by the Fire Service	6	3	1	2	1	3	2	3	0	2				6	2		R>11	A6-11	G<6
6.4	No of Fire Audits undertaken	6	4	4	6	5	5	6	5	6	3				6	5		R<3	A5 - 3	G>6
6.5	% of Compliant Fire Audits	100%	25%	75%	100%	100%	80%	0%	80%	67%	66%				100%	66%		R<90%	A90-95%	G>95%
6.6	% Fire Safety Risk Assessments (Reform Order) in date	100%	90%	90%	90%	90%	95%	95%	95%	95%	90%				100%	92%		R<90%	A90-95%	G>95%
6.7	% of Staff receiving Fire Safety training in month	*85%	82%	83%	83%	83%	84%	84%	83%	81%	83%				85%	83%		R<80%	A 80-85%	G>85%

* Please note that with effect from November it was agreed to reduce the Training Target from 90% to 85% for Health and Safety and Fire Training.

Appendix 1: Medical Devices / Women, Children, Diagnostics & Therapies Division – KPI's Torbay and South Devon Foundation Trust – Acute Setting – December 2015

	Area	Target	Monthly Performance												Current year to date (Complete Months)			Risk Threshold		
	Description	Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	Status	RAG Thresholds		
	Medical Devices																			
4.1	No of devices for Schedule Service (in month)	Variable	385	360	559	297	242	503	457	493	482				Variable	420				
4.1a	% of COMPLETED Scheduled Service Work Requests (In Month)	100%	42%	35.6%	50.6%	57.9%	50.4%	38.8%	65%	53.8%	44.6%				100%	48.7%		R<70%	A71%-79%	G≥80%
4.1b	% of OUTSTANDING/To Be Done Schedule Service Work Requests (<2 Months from Required Date)	100%	76%	74.7%	81.6%	75.1%	47.4%	37.9%	71.4%	82.2%	87.2%				100%	70.4%		R<60%	A60%-79%	G≥80%
4.1c	% of OUTSTANDING/To Be Done Schedule Service Work Requests (over rolling 3 Year Period)	0%	4%	5.8%	6.4%	5.5%	6.2%	2.6%	2.46%	2.35%	2.56%				0%	4.2%		R>10%	A5% -9%	G<5%
4.2a	% of REACTIVE Work Requests, Category Emergency, COMPLETED within 1 Working Day	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%		R<85%	A85-94%	G≥95%
4.2b	% of REACTIVE Work Requests, Category Urgent, COMPLETED within 3 Working Days	100%	100%	100%	100%	100%	99.4%	98.1%	99.1%	98.1%	98.9%				100%	99.3%		R≤80%	A81%-94%	G≥95%
4.2c	% of REACTIVE Work Requests, Category Routine, COMPLETED within 10 Working Days	100%	100%	100%	100%	100%	97.5%	98.5%	99.5%	99.6%	99.0%				100%	99.2%		R<80%	A81%-89%	G≥90%
4.2d	% of OUTSTANDING/ To Be Done Reactive Work Requests(<3 Months from Required By date)	100%	81%	90.3%	94.6%	97.64	97.9%	97.1%	95%	100%	100%				100%	94.8%		R<60%	A60%-79%	G≥80%
4.3	No. of Devices requested/not found for Scheduled Service	Variable	118	62	58	40	15	84	60	142	176				Variable	84	For Information only			
4.4	No. of incidents involving Medical devices	4	3	10	10	4	6	8	2	5	7				4	6		R≥9	A5 - 8	G≤4

Torbay and South Devon NHS
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Appendix 2 : Estates and Facilities – KPI's Torbay & South Devon Foundation Trust – Community Setting – December 2015

	Area			Target	Monthly Performance												Current year to date (Complete Months)			Risk Threshold		
	Description			Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	Status	RAG Thresholds		
	Estates																					
1.1a	Number of PPM items planned per month			Variable	242	235	269	260	274	297	301	155	126					240				
1.1b	PPM (Estates) % success against plan			100%	93%	89%	97%	98%	95%	88%	97%	95%	92%				100%	94%		R<85%	A85-94%	G>95%
1.1c	Planned Maintenance request access denied			0	0	0	0	1	0	0	0	0	0				0	0		R≥5	A3-4	G≤2
1.1d	% of Reactive work resolved within target	Emergency – P1	Total Requests	Variable	7	16	20	11	25	12	10	24	18					16				
1.1e		Emergency – P1	<2 Hour	100%	93%	75%	100%	100%	100%	92%	100%	100%	100%				100%	96%		R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	61	49	51	69	62	67	65	59	55					60				
1.1g		Urgent – P2	<1- 4 Days	100%	98%	88%	90%	96%	87%	94%	89%	81%	80%				100%	89%		R<90%	A90-94%	G≥95%
1.1h		Routine – P3 + P4	Total Requests	Variable	156	157	140	161	94	100	94	103	103					123				
1.1i		Routine – P3 + P4	<7- 30 Days	100%	96%	78%	96%	89%	88%	86%	95%	92%	93%				100%	91%		R<85%	A85-89%	G≥90%
1.2	Number of Estates Internal Critical Failures			0	0	0	0	0	0	0	2	0	0				0	0		R1	-	G0
	Facilities																					
2.1	Compliance Very High Risk Cleaning Audit			98%	100%	100%	100%	100%	100%	100%	100%	100%	100%				98%	100%		R<95%	A95-97%	G≥98%
2.2	Compliance High Risk Cleaning Audit			95%	99%	99%	99%	99%	99%	98%	99%	98%	98%				95%	99%		R<90%	A90-94%	G≥95%
2.3	Compliance Significant Risk Cleaning Audit			85%	99%	99%	98%	98%	99%	99%	100%	93%	98%				85%	98%		R<80%	A80-84%	G≥85%
2.4	Compliance Low Risk Cleaning Audit			75%	99%	96%	100%	96%	96%	96%	100%	95%	91%				75%	97%		R<70%	A70-74%	G≥75%
2.5	No. of Environment Health (food hygiene) events			0	0	0	0	0	0	0	0	0	0				0	0		R1	-	G0
	Waste																					
3.1	Total Tonnage per month all waste streams			35.1	37.32	35.97	38.94	37.91	33.94	35.51	35.63	37.81	39.58				35.1	36.96		R≥41	A36-40	G≤35
3.2	% of Total tonnage Recycled Waste			31.34%	25.94%	27.44%	31.59%	30.42%	30.76%	29.82%	34.34%	35.84%	39.34%				31.34%	31.72%		R≤25%	A25-30.9%	G≥31%
3.3	% of Total tonnage Landfill Waste			39.89%	46.73%	46.73%	42.01%	42.76%	44.46%	44.16%	42.18%	40.07%	40.53%				39.89%	43.31%		R≥44%	A40-43.9%	G≤39.9%
3.4	% of Total tonnage of Clinical Non-Burn waste			9.97%	8.28%	9.73%	10.14%	8.49%	9.34%	8.36%	7.76%	8.15%	6.87%				9.97%	8.57%		R≥13%	A<8.9%	G9-12.9%
3.5	% of Total tonnage of Clinical Burn waste			1.71%	1.69%	1.47%	1.57%	1.98%	1.44%	1.86%	1.57%	1.61%	1.26%				1.71%	1.61%		R≥3%	A2-2.9%	G≤1.99%
3.6	% of Total tonnage of Clinical Offensive waste			17.09%	17.36%	14.62%	14.69%	16.35%	14.00%	15.8%	14.14%	14.33%	12.00%				17.09%	14.81%		R≥18%	A<14.9%	G15-17.9%
3.7	Number of Waste Audits undertaken per month			6	6	9	6	6	6	6	4	14	6				6	7		R≤4	A5	G≥6
3.8	% of Compliant Waste Audits			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%		R<90%	A90-94%	G>95%
3.9	% Compliance of Statutory Waste Audits			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%		R<90%	A90-94%	G>95%

	Health & Safety																		
5.1	Number of RIDDOR Incidents	0	1	1	1	0	2	1	0	1	0				0	1		R≥3	A1-2	G0
5.2	Number of days lost (due to incidents in month)	60	87	19	14	0	0	47	0	1	0				60	19		R≥76	A61-75	G≤60
5.3	Non-patient incidents resulting in minor harm	8	11	9	11	9	10	7	9	8	7				8	9		R≥16	A9-15	G≤8
5.4	Non-patient incidents resulting in moderate harm	1	1	1	3	1	0	2	1	1	0				1	1		R≥4	A2-3	G≤1
5.5	Number of near misses	5	0	5	3	6	2	2	2	4	5				5	3		R≤2	A3-4	G≥5
5.6	% of Staff receiving H & S training in month	85%	94%	94%	94%	94%	93%	90%	89%	90%	92%				85%	93%		R<80%	A 80-89%	G≥90%
	Fire																			
6.1	No. of Fires	0	0	0	0	0	0	0	0	0	0				0	0		R1	-	G0
6.2	Number of fire alarm activations	12	1	0	0	1	0	1	2	0	1				12	0.7		R>15	A12-15	G<12
6.3	Fire alarm activations attended by the Fire Service	6	0	0	0	0	0	0	2	0	1				6	0		R>11	A6-11	G<6
6.4	No of Fire Audits undertaken	8	5	8	5	5	5	11	5	8	6				8	6.4		R<4	A8-4	G>8
6.5	% of Compliant Fire Audits	100%	100%	100%	100%	100%	100%	100%	80%	63%	100%				100%	94%		R<90%	A90-95%	G>95%
6.6	% Fire Safety Risk Assessments (Reform Order) in date	100%	100%	95%	100%	100%	100%	100%	100%	100%	85%				100%	98%		R<90%	A90-95%	G>96%
6.7	% of Staff receiving Fire Safety training in month	85%	89%	90%	89%	90%	88%	87%	87%	88%	88%				85%	88%		R<80%	A 80-85%	G>85%

* Please note that with effect from November it was agreed to reduce the Training Target from 90% to 85% for Health and Safety and Fire Training.

Appendix 2: Medical Devices / Women, Children, Diagnostics & Therapies Division – KPI's Torbay & South Devon Foundation Trust – Community Setting – December 2015

	Area	Target	Monthly Performance												Current year to date (Complete Months)			Risk Threshold		
	Description	Monthly	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Target	Yr Avg	Status	RAG Thresholds		
	Medical Devices																			
4.1	No of devices for Schedule Service (in month)	Variable	48	154	70	135	106	82	207	31	44				Variable	97				
4.1a	% of COMPLETED Scheduled Service Work Requests (In Month)	100%	58%	54.8%	57.14%	69.89%	45.28%	47.56%	63.77%	64.72%	36.36%				100%	55.3%		R<70%	A71%-79%	G≥80%
4.1b	% of OUTSTANDING/To Be Done Schedule Service Work Requests (<2 Months from Required Date)	100%	73%	82.4%	87.50%	92.9%	90.08%	87.50%	98.7%	86.5%	90.00%				100%	87.6%		R<60%	A60%-79%	G≥80%
4.1c	% of OUTSTANDING/To Be Done Schedule Service Work Requests (over rolling 3 Year Period)	0%	1.1%	1.5%	1.4%%	2.43%	5.02%	3.11%	3.05%	3.06%	0.88%				0%	2.4%		R>10%	A5% -9%	G<5%
4.2a	% of REACTIVE Work Requests, Category Emergency, COMPLETED within 1 Working Day	100%	No data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data				100%	No data	N/A	R<85%	A85-94%	G≥95%
4.2b	% of REACTIVE Work Requests, Category Urgent, COMPLETED within 3 Working Days	100%	100%	100%	100%	100%	100%	100%	94.4%	94.1%	100%				100%	98.7%		R≤80%	A81%-94%	G≥95%
4.2c	% of REACTIVE Work Requests, Category Routine, COMPLETED within 10 Working Days	100%	100%	100%	100%	100%	97.6%	100%	100%	96.8%	98.90%				100%	99.3%		R<80%	A81%-89%	G≥90%
4.2d	% of OUTSTANDING/ To Be Done Reactive Work Requests(<3 Months from Required By date)	100%	70%	84.6%	81.8%	100%	100%	100%	100%	100%	100%				100%	92.9%		R<60%	A60%-79%	G≥80%
4.3	No. of Devices requested/not found for Scheduled Service	Variable	16	52	22	21	10	13	16	9	16				Variable	19				
4.4	No. of incidents involving Medical devices	2	0	0	3	0	0	0	2	0	0				2	1		R≥5	A3 - 4	G≤2

Torbay and South Devon NHS
NHS Foundation Trust

Report of Finance Committee Chair to TSDFT Board of Directors

Meeting date:	26 January 2016
Report by + date:	Les Burnett, 26 January 2016
This report is for: *(please select one box)*	Information ☐ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☒ 3: Valuing our workforce ☒ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐ + Freedom of Information Act exemption [*insert exemption if private box used*]

Key issue(s) to highlight to the Board:

Trust still facing extreme financial pressures, however, performance for nine months broadly in line with revised plan.

Continuous Improvement Programme (CIP) - still major problems in delivery

Agency spend significantly in excess of cap

Service and quality indicators:

- Stroke, 90 per cent time being spent on stroke unit – not being achieved
- 4 hour standard not met in December
- Referral to treatment incomplete pathways not met in December
- Cancer targets achieved but concerns over quarter four

First draft of 2016/17 Annual Plan presented at the meeting – will review in detail at February meeting.

ICT strategy reviewed.

Key Decision(s) Made:

Having regard to the Trust's precarious financial position, requirement that in future, all business cases presented which require investment must be able to demonstrate they will generate at least an equivalent financial saving/benefit to the Trust.

Subject to certain clarification approved the implementation of overseas nursing recruitment.

Recommendation(s):

1. The Committee will only discuss/approve papers where they are sent out in advance of the meeting, so members have the necessary time to fully consider. Approval cannot be expected if papers are simply presented at the meeting.

Name: Les Burnett (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting date:	15 December / 26 January 2016
Report by + date:	David Allen, 26 January 2016
This report is for: *(please select one box)*	Information ☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐ + Freedom of Information Act exemption [*insert exemption if private box used*]

Key issue(s) to highlight to the Board:

The Quality Assurance Committee (QAC) met formally for the first time on 15 December 2015 and informally for an inquorate discussion on 26 January 2016. We intend to meet monthly for six months or so and then every other month. We are not an operational group; our role is to assure ourselves, Audit and Assurance Committee and the Board that we have robust systems and processes in place to ensure the quality and safety of users of our services. In addition to the knowledge and experience of the senior executives and three non-executive directors who sit on the Committee, we will take reports, inter alia, from the Quality Improvement Group, Serious Adverse Events Group and Clinical Audit. We will develop a dashboard of key performance indicators with comparator information. We would welcome a Governor observer of our deliberations. We recognise that capability and culture are important contributors to high quality and safety and will pay particular attention to liaising on workforce issues. We intend to consider strategic issues impacting on quality e.g. working with other local providers to create more resilient, sustainable services with critical mass.

At each of our meetings we have considered "hot topics" e.g. Emergency Department pressures, difficulties in filling vacancies in certain specialties, the junior doctors industrial dispute and the forthcoming Care Quality Commission inspection.

Subject to Board approval we hope to finalise our terms of reference in February but, in essence, we aim to be the repository of sufficient confidence to enable the Board to take assurance from us and the route by which, in general, quality and safety issues reach the Board table.

Key Decision(s) Made: None as yet

Recommendation(s): None on this occasion

Name: David Allen (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

Report of Charitable Funds Committee Chair to TSDFT Board of Directors

Meeting date:	24 November 2015
Report by + date:	Jacqui Lyttle, 28 January 2016
This report is for: *(please select one box)*	Information ☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☐ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐ + Freedom of Information Act exemption [*insert exemption if private box used*]

Key issue(s) to highlight to the Board:

That the charitable fund portfolio remains within the expected range of return on investment.

That the balances on some budgets have remained largely unchanged for some divisions/departments for a number of months, with a small number of funds having no expenditure charged to them for more than 18 months.

There appears to have been a slow down on the use of charitable funds in line with the need to reduce exchequer expenditure.

Key Decision(s) Made:

To undertake a systematic review of all of the funds to explore possible opportunities for budget merger or re-categorisation to general funds.

That budget holders be sent as part of their monthly budget packs:
- Information on the purposes of their account.
- A reminder of the Trust's duty of care to expend the funds in line with the terms and wishes of individual funds.
- A statement reaffirming that the use of Trust funds does not have the same Continuous Improvement Programme (CIP) restrictions as revenue expenditure.
- That we should proactively encourage service delivery unit/departments to access funds and use them to improve patient/service user/client services.

Recommendation(s):

1. To actively communicate to all charitable fund budget holders to seek out opportunities to spend their available funds and to seek permission to realise investment gains to support larger projects.

2. That the release and transfer of unrealised gains be considered by the Board for non-restricted funds.

Name: Jacqui Lyttle (Committee Chair)

Torbay and South Devon NHS
NHS Foundation Trust

Report of Audit and Assurance Committee Chair to TSDFT Board of Directors

Meeting date:	6 January 2016
Report by + date:	John Brockwell, 27 January 2016
This report is for: *(please select one box)*	Information ☒ Decision ☐
Link to the Trust's strategic objectives: *(please select one or more boxes as appropriate)*	1: Safe, quality care and best experience ☒ 2: Improved wellbeing through partnership ☐ 3: Valuing our workforce ☐ 4: Well led ☒
Public or Private *(please select one box)*	Public ☒ or Private ☐ + Freedom of Information Act exemption [*insert exemption if private box used*]

Key issue(s) to highlight to the Board:

This was an additional meeting convened primarily to review the initial external audit report on the Care Trust closure of accounts prior to integration. Unfortunately, a serious road accident prevented Grant Thornton getting to the meeting. Further, the Committee wished to gain assurance in all key areas given the new governance committee structure.

1. Quality Assurance

   Historically, topics such as Clinical Audit & Patient Safety had been standing items on the Audit and Assurance Committee agenda, but have now transferred to the new Quality Assurance Committee. Various sub groups reporting on different aspects of quality to the Committee would provide assurance.

2. Finance and Risk Assurance

   Need to ensure that following integrated care organisation (ICO) set up that all Care Trust major risks and post acquisition adjustments are identified from the legacy document, included in the closing six-month final accounts and transferred to the ICO financial systems and Board Assurance Framework.

   Financial challenges are evident particularly in continuous improvement programme and controls on agency expenditure.

3. Counter Fraud

   Internal Audit informed the meeting of a new offence introduced following Mid-Staffs, relating to the provision of false/misleading information by Care Providers, with the potential for Board members as Responsible Officers to face prosecution.

4. Internal Audit (IA)

   IA and the Company Secretary are reviewing which Committee within the new governance structure should initially receive and monitor published IA reports.

   Pleased to note that actions on outstanding IA report recommendations are well under control.

   IA gave professional briefing on recent cyber security guidelines. Most issues were already known to the Trust and already in hand.

Key Decision(s) & Recommendations Made:

1. Quality Assurance

   Following the first meeting of the new Quality Committee (QC) it was agreed that it is important to ensure that robust governance is maintained and duplication avoided as the quality assurance role transferred from A & A to QC. Assurance would be provided to A & A by means of 6 monthly reports from QC Chair. The position to be reviewed following receipt by the A & A of first report.

2. Internal Audit

   In order to streamline governance processes, discussions are on-going between IA and Company Secretary as to which Committee within the new Governance Structure should initially receive and monitor published IA reports. The Audit Committee would receive a summary from IA except where major concerns were identified when full reports should be presented.

3. Finance

   Finance Director liaising with External Audit on Care Trust closure accounts.

   Given the enlarged Trust post integration the Company Secretary will aim to shorten the annual report and accounts for 2015/16. The Committee has also requested early sight of the draft annual report and quality report for 2015/16.

4. Cyber Security

   In view of current global levels of cyber fraud, the Committee have requested a report from the new IM&T Group to provide assurance in this area.

Name: John Brockwell (Committee Chair)