Torbay and South Devon NHS Foundation Trust

TSDFT Board of Directors

Public Board of Directors

Anna Dart Lecture Theatre, Horizon Centre, Torbay Hospital

06 April 2016 10:45

AGENDA

1 Apologies

Owner : Chairman

Note

2 Recipient Experience

Note

3 Minutes of the Board Meeting held on the 3rd February and 2nd March 2016 and Outstanding Actions

Owner : Chairman

Approve

4 Declaration of Interests

Owner : Chairman

Note

5 Strategy and Vision

5.1 Report of the Chairman

Owner : Chairman

Information/Assurance

5.2 Report of the Chief Executive

Owner : CE

Information/Assurance

5.3 Report of the Director of Strategy and Improvement

Owner : DSI

Information

5.4 Annual Plan

Owner : DoF

Approve

5.5 St Kildas

Owner : COO

Approve

5.6 Coastal Team - Work Showcase

Owner : COO

Information

5.7 Terms of Reference - Children's Services Board

Owner : DoF

Note

5.8 EDMS Business Case

Owner : DoF

Approve

6 Quality, Patient Safety and Expereince

6.1 CQC Update

Owner : CE

Assurance

6.2 Report of the Chief Nurse

Owner : CN

Note

6.3 Report of the Medical Director

Discussion/Assurance

9.2 Report of the Director of Estates and Commercial Development

Owner : DECD

Discussion/Assurance

9.3 Report of the Chief Operating Officer/Care Model Update

Owner : COO

Note

10 Assurance

Owner : Chairman

10.1 Feedback from Chairs of Board Committees

Owner : Chairs

Discussion/Assurance

10.2 Amendment to Scheme of Delegation

Owner : DoF

Approve

10.3 Approval of Banking Arrangements - Health and Care Videos LLP

Owner : DoF

Approve

11 Governors' Question Time

Owner : Chairman

Discussion/Assurance

12 Date of Next Meeting - 3.00 pm, Wednesday 25th May 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, TORBAY HOSPITAL ON WEDNESDAY 2ND MARCH 2016

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mr D Allen	Non-Executive Director
	Mr L Burnett	Non-Executive Director
	Mr J Furse	Non-Executive Director
	Mrs J Lyttle	Non-Executive Director
	Mrs S Taylor	Non-Executive Director
	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
	Mr M Ringrose	Interim Director of Human Resources
	Mrs J Viner	Chief Nurse
	Mrs A Wagner	Director of Strategy and Improvement
In Attendance:	Mrs D Butler	Assistant Director for Operations – ICO Care Model
	Mrs S Fox	Board Secretary
	Mrs J Gratton	Head of Communications
	Mrs P Harris	HealthWatch Torbay
	Dr S Manton	Associate Director – Community Health and Social Care
	Mr R Scott	Corporate Secretary
	Mrs L Sims	Communications Manager
	Mrs M Trist	Corporate Governance Manager
	Ms C Williams	Associate Director for Social Care

Mrs C French	Lead Governor	Mrs A Hall	Governor
Mrs B Inger	Governor	Mr P Welch	Governor

The Chairman commenced the meeting, which was being held to discuss the future of Baytree House, by thanking everyone for attending and outlining a running order for the session.

ACTION

19/03/16 **Apologies**

Apologies were received from Councillor Parrott.

20/03/16 **Report on the Consultation on the Future of Baytree House short breaks unit for people with learning disabilities in Torbay**

Torbay and South Devon NHS Foundation Trust is now responsible for the delivery of all services originally provided by Torbay and Southern Devon Health and Care Trust and South Devon Healthcare Foundation Trust. This included services for

people with learning disabilities in Torbay. In 2014 an Operational Commissioning Strategy for Learning Disabilities was agreed locally. Underpinning this strategy was a commitment to personalisation and a choice from a diverse market place. There was also a clear statement of intent that rather than directly providing learning disability services, the NHS would commission services on people's behalf and co-ordinate the provision of information and support planning either directly or through third parties. It was within the context of this Operational Commissioning Strategy, and associated change programme, as well as a number of other key strategic factors that this closure proposal has developed.

The Chief Executive explained that as a Board they wished to resolve the uncertainty that currently existed in respect of the proposed changes to Baytree and that the paper set out recommendations for the future delivery of care. She said that changes in much valued services such as those provided by Baytree were never easy and that the Trust had worked hard to try to create the best solution for people with learning disabilities and their carers. She reflected the work had been undertaken to develop the proposals and stated her appreciation of the high level of positive engagement from all stakeholders.

The Chief Operating Officer summarised that the Board, at its meeting in December 2015, received a set of proposals and approved a period of formal consultation on those proposals, which commenced on the 4th December 2015 and closed on the 5th February 2016. The proposals were set in the context of the operational commissioning strategy developed in 2014, specifically the proposal to move from NHS provision of services and for the Trust to take on a commissioning role for those services, rather than direct provision.

The Associate Director (Dr Sonja Manton) then gave the following summary of the paper:

- The public consultation lasted for 13 weeks and included feedback via paper; telephone; email; one-to-one, co-design, and HealthWatch facilitated meetings.

- Carers had been continually engaged during the consultation process.

- The papers presented to the Board contained the verbatim feedback received from carers.

- Of the 39 families who used Baytree, 21 had responded through the consultation feedback mechanism. None of the responses supported the proposal to close Baytree. Apart from four, they also had not felt able to influence the proposal despite the co-design work that had taken place.

- A social media campaign had been set up and had gained over 1,000 signatures voicing opposition to the proposed closure.

- Baytree was a service that was highly valued by its users and users and families were concerned that alternatives would not meet the needs of users.

- On Monday, at its Overview and Scrutiny Committee, Torbay Council confirmed that they were assured due process had been followed in terms of the consultation process.

- The was a recommendation to the Board today that if the decision was made to close Baytree, a transition period until the 30th June be put in place to allow the necessary arrangements to be made, including providers having the confidence to invest in their business to provide the services required by users.

- If approved, the Overview and Scrutiny Committee had asked for an update to be provided at their meeting on the 18th May to provide assurance that users and their families were able to secure alternative services by the 30th June.

- It was acknowledged that the closure proposal was not supported by users and their families, however the Board's role was to ensure that the statutory obligation to meet the needs of users was met and to find ways to provide for that need, there was no legal obligation to provide a service in-house.

- Baytree did not provide financial value for money as it was under-utilised.

- Five potential providers had been identified, care would not necessarily be like for like however the main issue was whether appropriate services could be provided in the required timescale.

- If approved, the time until the 30th June would be used to complete all care assessments and for users to have the opportunity to transfer to suitable alternative provision.

- The recommendation was therefore made to the Trust Board to close Baytree House and to source alternative providers in the independent sector and to work with social care commissioners to support the transition to those providers between now and the 30th June 2016. Monitoring of the transition would take place through Torbay Council's Overview and Scrutiny Committee.

The representative from Torbay HealthWatch (Mrs Pat Harris) was invited to speak. She said that they had become involved in the consultation after it had commenced, and would ask that they were involved at the start of any future consultations. She said that Baytree families, at the start of the process did not feel listened to and that there had been a lot of concern around the facts and that there should be clarity and no jargon used if any other consultations took place. The also needed to be clarity around for whom the service was being provided – users had not been part of the consultation.

The Chairman responded and said that the Trust had just started on its journey to deliver the ICO and that any learning from this consultation must be used in any future consultations.

The Chairman then invited Mr Helmore, on behalf of the Baytree Users Group, to speak. His letter to the Board of Directors was included in the papers as one of the attachments.

Mr Helmore thanked the Board for an opportunity to speak. He said that the service provided by Baytree for its users was 'great' however he acknowledged that it was likely the Trust would approve its closure. He expressed concern around the transition period as it could take people with learning disabilities up to 18 months to be fully comfortable in a new environment. He welcomed the proposal to allow for a transition period until 30th June, but did feel it was still too short a time period to allow families and users to identify and move to a new provider. He was also very concerned that families might be 'left in limbo' if they were not able to source an alternative provider. Mr Helmore said that, at present, he could not be assured there were sufficient providers on the market with enough spare bed capacity. He was aware that some providers were not yet operational, but that of those he had visited, or had seen plans for service provision, he did not feel the service being provided was suitable for all current users, as they required a 'homely' rather than clinical facility. The users did not require any medical based services, they had moderate learning disability needs. He added that he had not yet seen some of the new

faculties up and running, so might be assured once he had visited them. Mr Helmore closed by asking that if the decision was made to close Baytree, an extended transitional period was put in place, to give the users a longer period of time to move to new providers. He also wished to place on record the support and engagement provided by the Head of Operational Change.

The Chairman then invited the Director of Adult Services for Torbay Council (Mrs Caroline Taylor) to speak and she provided formal feedback to the Board that the Council's Overview and Scrutiny Committee were assured that a robust and correct consultation process had taken place and that the proposed changes were in line with national policy to allow individuals to have support that was specific to their needs. She added that this proposal was one in a range of changes to realise this aim. It was noted that, although he could not be present, Councillor Parrott had informed the Chairman that he was in support of the recommendations contained within the Baytree report.

The Board then had opportunity to discuss and debate the proposal, as follows:

- Mr Welch queried how the Trust would support users during the transition period. Dr Manton explained that there would be engagement via the support planning service – take up had been slow to start with, but had picked up. This facility would help families to discuss what a care plan would look like so that suitable care could be identified. Once alternatives had been identified, families would be supported in visiting those providers including users being accompanied by their existing carers and being introduced to new teams etc, ensuring any emergency needs were met, and undertaking more than the statutory requirement for annual reviews. There would also be access to a social work team, if required.

- Mr Furse asked how the decision had been made that the 30th June was an appropriate date to close the service. Dr Manton said that it was what was considered a reasonable time period and that dialogue with alternative providers suggested they could have services up and running by that time. The Chief Executive added that once a decision was made to close a facility, it was inevitable that staff would start to look for alternative employment and that the service could very quickly become more difficult to provide. The Interim Director of Human Resources echoed this view and added that staff only had to give four weeks' notice to leave their employment and he felt the end of June was an acceptable timeframe.

- Mr Burnett said that, as a Non-Executive Director, he was persuaded by the financial and strategic reasons to close the unit, but added that he was impressed by the comments made by families of the impact the closure would have on them and asked if there was anything else the Trust could do to ease the transition. The Chairman suggested that the recommendations be amended so that recommendation 'c' had the following sentence added '*implementation is conditional on this being achieved*' (ie, satisfactory provision).

- Dr Manton added that the current service would be flexed as much as it could to ease the transition process including staff accompanying users to new facilities and to keep the user and families at the centre of the transitional period and provide as much continuity as possible.

- Mr Furse asked for assurance that the financial benefits of the closure would be realised and the Director of Finance confirmed that they would.

The Chairman then asked the Board to vote, by a show of hands, on the recommendations, with the proposed addition:

a) Baytree House should in due course close and the short break beds nights should alternatively be sourced in the independent sector.

b) A transitional period to 30th June 2016 occurs before the decision to close is implemented.

c) Adult Social Care Commissioners, in partnership with the Support Planning Services, are tasked urgently over the next four months to work closely with provider to develop and secure satisfactory provision. Implementation is conditional on this being achieved.

d) The Board consider their monitoring requirements. Board receive a written update with respect to progress if the decision is made to close the unit and secondly that the Learning Disability Partnership Board also take an appropriate role monitoring quality and outcome of placements in the independent sector. In operational terms the Community Service Business Unit will manage and be accountable for the completion of Baytree House change programme and all the associated activity. Torbay Council Overview and Scrutiny Committee will set their own follow up requirements.

The Board unanimously approved all recommendations.

Chairman Update

The Chairman informed the Board that the Trust's Anaesthetics Department had been formally recognised with Anaesthetic Clinical Services Accreditation (ACAS) from February. It was one of only seven in the country.

A brief update on the missing doctor, Rose Polge, was provided. The Medical Director updated that she had not yet been found, and advised that support provided to Rose before she disappeared had been appropriate. When Rose disappeared she had made firm plans around what she was planning to do, so her disappearance had been a great shock. He said that ongoing support was being provided to staff and that a short service had been held in the Chapel for Rose earlier in the day and a Book of Remembrance was available for staff to write down their thoughts, which would be passed to her family. He and the Chief Executive were meeting with Rose's family on Friday 11th March.

He confirmed that the Trust was looking at the overall support it provided to junior doctors, to ascertain if any improvements could be made to that support, in the context that the Trust was always one of the best performers in terms of feedback from junior doctors and the support they received.

The Chairman informed Governors that the Trust had received a letter from the CQC raising concerns in respect of Emergency Department performance to which the Trust had to respond by 6.00 pm this evening. The letter was not a surprise and was welcomed by the Trust as a lever to improve performance. The Trust already had a plan in place to improve performance which had been agreed with the Trust's Commissioners, and it was hoped this would give the CQC the assurance it required that the Trust was doing all it could to improve performance.

Mrs French asked if this meant the Trust was in special measures and the Chief Executive said that it did not, but that future action by our commissioner and regulators would depend on the quality of the Trust's response to the CQC's letter and delivery of the action plan. It did also mean that the Trust would need to make changes in a much shorter timescale that originally planned.

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).

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
BOARD OF DIRECTORS MEETING
HELD AT THE TOORAK HOTEL, TORQUAY
ON WEDNESDAY 3RD FEBRUARY 2016

PUBLIC

Present:	Sir Richard Ibbotson	Chairman
	Mr D Allen	Non-Executive Director
	Mr L Burnett	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
	Mrs A Wagner	Director of Strategy and Improvement
In Attendance:	Mrs S Fox	Board Secretary
	Mr R Scott	Corporate Secretary
	Mrs J McCall	Director of Audit
	Mr N Timmins	CQC

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

Before commencing the meeting the Chairman welcomed Mrs Wagner to her first meeting as Director of Strategy and Improvement. He also noted that several Governors were close to the end of their tenure and wished to place on record his thanks and said that their contribution would be formally noted at the Trust's Blue Shield Awards which were taking place in March.

ACTION

01/02/16 **Apologies**

There were no apologies.

02/02/16 **User Experience**

The Trust's Deputy Director of Nursing presented a User Experience story concerning a gentleman whose wife had died in the Trust following admission from a nursing home. She was very poorly, although while in the Trust did have periods of improvement before she sadly died. The husband had waited 18 months to contact the Trust with concerns about his wife's care. These were about how rapidly she deteriorated; not having an opportunity to participate in finding suitable

accommodation for her had she been able to be discharged from hospital; and concern that the medication she had been prescribed was linked to her deterioration. The hospital notes were very clear that communication with him had taken place, however it was very sad that he had waited 18 months to contact the Trust with his concerns. His wife's lead clinician met with him and was able to ally his concerns, but it was a point of learning for the Trust around ensuring patient's families understood why medication was being administered and were clear about a patient's prognosis if they were close to end of life. The Bereavement Office also now included a card in the Bereavement Pack so that families are encouraged to contact the office if they wished to follow anything up after a death. In addition, there had been problems with the timely issuing of death certificates which had now been resolved by a team-led redesign.

Mr Parrott asked whether, as patients presented with more complex conditions, the questions asked in respect of patients who had died were becoming more complicated and the Deputy Director of Nursing confirmed that they were and that the End of Life Group, which worked across the pathway, ensured the end of life pathway was optimised accordingly.

Mr Allen commended the work that had been undertaken to improve the timeless of the production of death certificates, which had been an issue of concern for the Trust.

03/02/16 **Minutes of the Meeting held on the 2nd December 2015**

The minutes were approved as an accurate record of the meeting held on the 2nd December 2015.

Quality, Patient Safety and Experience

04/02/16 Infection Prevention and Control Peer Inspection

The Chief Nurse highlighted the following from her report:

- The Trust had been experiencing higher than expected numbers of CDiff and in early 2015 engaged with the CCG; Public Health England, and Peninsula network which led to a number of actions to improve performance.
- The Trust had experienced 23 outbreaks of CDiff with 10 lapses in care, one of which was reportable to NHSE associated with causing CDiff.
- Incidence was now back to that expected for the time of year.
- An expert in infection control had recently visited the Trust to provide peer group input to practices and the verbal feedback, while reassuring about many aspects of the Infection Prevention and Control service, advised that the Trust needed to look at some of its processes. For example hand hygiene monitoring should increase the number of observations. Infection prevention and control information presented on wards and in clinical settings would also be updated. The report also included information on training compliance and areas the team would be focusing on the in the future. A formal report on the peer review would be received in the near future.
- Mrs Lyttle reported that she was now aligned to the Infection Protection and Control team and had met with staff and was attending the quarterly Infection Control meetings. She said that team had found the Peer Review visit very positive and beneficial.

- Councillor Parrott asked whether a target of zero CDiff was achievable and the Chief Nurse said that it was not, but that an appropriate de minimus number should be set. She added that many people in the community carried CDiff and might not become ill with it when admitted to hospital if managed correctly.

05/02/16 Safe Staffing Update

The Board noted the following:

- A number of tools were used to assess and provide assurance on the appropriateness of Trust's nurse staffing numbers.

- It was known that there was a direct link between appraisals and staff feeling valued and supported, and work was taking place to improve the number of appraisals undertaken.

- There had been a drift in skill mix on some wards and work was taking place to identify the correct skill mix for each ward.

- Teignmouth Hospital was in the process of changing its model of care which had resulted staff being concerned about their future and staffing issues, but this was being managed.

- The Chairman asked if the national targets for agency staffing was having an impact and the Chief Nurse said that it was, but that she personally supported it and it also made the Trust challenge the use of any agency staff.

- Mr Brockwell queried the table detailing nursing hours and the fluctuations in figures on a monthly basis. The Chief Nurse said that getting up to date data was a challenge and she also wanted to produce trend data that covered a longer period of time to show a more consistent picture.

- Mr Brockwell then queried whether the information obtained through Quality and Safety Walkarounds was triangulated with other data collected and the Chief Nurse said that in the coming year the walkarounds would be focussing on specific issues so that the Executive team could understand the issues affecting the data scores.

- Mr Welch raised appraisal performance as he felt that there was no reason why it should not be 100%. The Chief Nurse agreed and said that actions were being taken to improve performance with assistance from Human Resources. The Interim Director of Human Resources added that there had not been a downturn in appraisals when the two organisations integrated, which was positive, but accepted that a more robust process needed to be in place.

- Mr Parrott queried the downward trend in appraisal performance for some of the hospital's wards from the previous month and suggested it would be better if the report showed trends across a longer time period and this was acknowledged.

- The Chief Executive assured the Board that action was taken on a daily basis to ensure the Trust was safely staffed in all areas while managing high demand, especially in terms of the Emergency Pathway. Executives were now also on site at weekends during their on-call week.

- In terms of managing the Emergency Pathway it was noted that the Trust had implemented a new IT system, Symphony, which provided real time information on patients' vital signs and the Alamac Kit Bag which provided

details of performance against key metrics for patient flow at any given time. A performance improvement plan for the Emergency Department was also in place and had been shared with NHSE.

- Mr Furse queried the balance between ensuring safe staffing and allowing for cover for things such as sickness, annual leave etc, and the need to work within a constrained financial envelope. The Chief Nurse referred to the CIP project progressing this work and said that staff had taken ownership of the challenge to ensure staff staffing was provided within the financial envelope available – and that staff were used flexibly to cover the areas of greatest need.

- It was noted that the Trust would shortly be trying to recruit nurses from the Philippines to reduce the need to use agency staff, however it would be much better if the Trust was able to train and recruit staff locality. The importance of the Apprentice Programme was also noted.

06/02/16 Experience and Engagement Annual Report

The Chief Nurse highlighted the following:

- The report detailed patient experience and engagement over the last year.

- At present the new organisation used two risk management systems which had been used in the two legacy organisations. A move to a single system would take place in April 2016.

- One of the biggest issues raised by patients was noise at night and from investigation at lot of this appeared to be from other patients rather than staff, for example those with cognitive impairment or dementia, but also those using social media for example. A lot of work had taken place to try to mitigate this including provision of ear plugs and eye masks, use of soft shoes and also trying to create a 'night time' feel on wards.

- Collection of user experience was also an issue, as many now used digital media as well as paper, and how to collect and respond to this diversity of inputs in a timely fashion was being investigated.

- It was noted that a consultant at the Trust was keen to bring an initiative from another Trust where a group similar to the Serious Adverse Events Sub-Group looked at things that had gone well, or better than expected, to learn and transfer that learning across the Trust.

07/02/16 Report of the Medical Director

The Medical Director reported on the following:

- There was a junior doctors' strike planned for the 10th February; this was not an all-out strike, but a 24 hour strike with emergency cover provided.

- Action was being taken to mitigate the effect of the strike and learning was being taken from the first strike in terms of how different working practices affected flow etc, to see if more permanent changes could be made to the system. Mr Allen supported this and suggested Royal Colleges needed to consider where senior decision-making could be delegated. He added that the Secretary of State might chose to impose the Junior Doctor contract which could have implications for the Trust. The Medical Director said that the Trust did have processes in place to support nurse discharge and this happened for patients on a clear pathway (usually surgical patients). It was not so embedded for medical patients as they frequently varied from the

expected pathway. He added there was more work for the Trust to do in this area.

- It was noted that on the day of the last junior doctor strike 30% less patients attended the Emergency Department and there were 30% less referrals from GP. It was noted, however, that it was likely some people did not come to the Trust as they felt it might be unsafe during the strike and that the Trust did experience increased demand and treated some very sick people the next day.

- The multi-factoral issues affecting flow in the hospital were noted, including lack of appropriate and timely care in the community etc.

- Mr Furse asked if there was data showing how many patients only just missed the 4 hour mark and the Chief Operating Officer said that they knew exactly how many patients were seen and at what time. The main cohort of patients who were not admitted were seen in about 2 hours and 20 minutes. The main issue was those patients who remained in the department for long periods of time awaiting admission, and flow issues meant they could not be moved to where they needed to be.

08/02/16 Safety Scorecard

The Scorecard was noted, in particular the mortality data which showed the Trust's mortality levels were within the expected range and had reduced against peer average in the last two quarters. The Chief Executive highlighted the importance of the Dr Foster mortality data as an external assurance. The Medical Director informed the Board that he would be reviewing the Scorecard and the data it presented.

Strategy and Vision

09/02/16 Report of the Chairman

The Chairman reported on the following:

- He had attended the first meeting of the IM&T Group last week and he flagged up a decision made by the group that information would not be unnecessarily repeated in other meetings and he felt this was a positive way to work and commended it to the Board.

- The interview date for the Director of Human Resources was in the process of being finalised, and once appointed would mean the Board had a substantive complement of Executives.

- Thanks were given to those Governors who had volunteered to guide members of the CQC party around the Trust during their inspection.

- Teignmouth and Dawlish Hospitals and integrated teams were moving at pace to deliver the changes to the ICO Care Model and he felt the positive no nonsense attitude with which this had been achieved should be quoted as an exemplar.

10/02/16 Report of the Chief Executive

The Chief Executive briefed the Board on the following:

- The Chief Executive was engaging with the Lead Governor in terms of communication with Governors and her Chief Executive's report was being reviewing by the Lead Governor to assess if this meets their needs. PA to CE

- She had given her Chief Executive's presentation to the CQC earlier in the week and would circulate it to the Board and Governors for information.

- Nine Freedom to Speak Guardians had been appointed – this Trust was the first in the South West to appoint to this role.

- In December the NHS was issued with planning guidance for 2016/2017 to 2020/21. The guidance, authored by the 6 national NHS bodies, set out a clear list of national priorities for 2016/17 and longer term challenges for local systems, together with financial assumptions and business rules. In response the NHS is required to produce two separate, but connected, plans:

  - A five year Sustainability and Transformation Plan (STP), place based and driving the Five Year Forward View; and
  - A one year Operational Plan for 2016/17, organisation based but consistent with the emerging STP.

  On the STP, every health and care system was asked to come together to create its own ambitious local blueprint for accelerating its implementation of the Forward View. Systems were required to submit their preferred footprint by 29 January 2016 with full blown plans required by June 2016. Following the positive discussions at the recent Board to Board meeting with the CCG, at the January System Resilience Group agreement was reached with all partners that the submission should confirm 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. The submission recognised that for very specialist services a larger population footprint was appropriate and confirmed that the CCG and providers within Torbay and South Devon would collaborate to ensure effective configuration of very specialist services for the wider population.

  At the beginning of February the CCG received feedback that the footprint submission required further thought and that planning footprints were expected to cover much larger populations of between one and three million and therefore the CCG was required to resubmit as part of a larger population place-based planning footprint in partnership with the NEW Devon health and care economy. The two CCGs have therefore written jointly to NHS England confirming they will work to a joint place-based planning footprint that is coterminous with the entire boundaries of NEW Devon CCG and South Devon and Torbay CCG, incorporating the whole of the County of Devon, Plymouth City and Torbay local authorities and will work with key partners to engage on the detail. Whilst acknowledging the wider STP will add value in some specialised services, both CCGs have stressed the need to maintain a local delivery focus at locality level. The Trust will continue to be engaged in both the local and wider strategic planning discussions and processes to fulfil our aspirations of a better future for local people.

  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. The Trust has submitted an expression of interest which has the full support of the CCG.

  With regard to the one year Operational Plan, teams are progressing the detail which builds on our long term plan agreed as part of the Integrated Care Organisation. Central guidance continues to be issued, together with financial allocations and conditions which mean finalising the plan will take us right up to the wire in terms of hitting central submission deadlines.

- The Chief Operating Officer, Chief Nurse and Medical Director had attended a meeting with the CCG, NHSE and Monitor last week for them to better understand the Trust's current performance difficulties in relation to Emergency Department performance. They were assured that the Trust was managing patient safety and quality and had asked that the action plan was updated and submitted to them.

- The Chief Executive had met with a representative from the Department of Further Education as part of the due diligence work in respect of provision of Children's Social Services potentially moving to the ICO.

ICO Developments

11/02/16 Report of the Chief Operating Officer – Care Model Update/Clinical Services Review

The Board noted the work that had taken place on the Care Model since the ICO formed in October 2015.

In terms of the Clinical Services Review, the Trust was working with the CCG to look at how sustainable services in the Trust's local footprint and specialist services in the wider footprint could be delivered.

Councillor Parrott queried the risk of the Trust not having sufficient capacity to deliver change at pace. The Chief Operating Officer explained that her personal capacity had been addressed with an interim Deputy Chief Operating Officer now appointed to free her up to support implementation of the Care Model. She added that there was also capacity in the Transformation Team which was being targeted to deliver the necessary changes.

Workforce and Organisational Development

12/02/16 Report of the Interim Director of Human Resources

The Board noted the following:

- The Trust's long term Strategic Objectives had been agreed and Directors would now agree their own objectives with the Chief Executive.

- There was an overall improved trajectory for sickness and training.

- The Trust had completed an Education Commissioning Demand Forecast which helped informed the numbers of trainees in the future.

- The results of the most recent Friends and Family Survey were above the national average.

- The Trust had one of the lowest spend on its temporary workforce in the area but work was still taking place to reduce reliance on agency staff and increase numbers on the Trust's bank.

- In line with new requirements, the Trust would be seeking to increase its apprentice workforce, which would bring with it benefits for the Trust.

- Mr Furse asked how the agency cap was being managed and the Interim Director of Human Resources said that the Trust was working to reduce its reliance on agency staff but that the sector was experiencing the largest shortfall of doctors and nurses he had experienced in his career. The Chief Executive added that the introduction of the Physician's Associate post in the Trust was a step towards finding alternative solutions to recruitment to challenged specialties.

- Mr Brockwell queried Clinical Supervision and reported performance that in some wards only 21% of staff received supervision. The Chief Nurse said that she was aware of this issue and was taking action to improve performance. The Chief Nurse was asked to provide an update report on progress to a future meeting. CN

- Mrs Lyttle asked if the Trust had a succession plan as a large proportion of the workforce was over 50. The Interim Director of Human Resources acknowledged that the Trust did not have a robust system in place for succession planning but that nurse managers were now encouraged to over-recruit to nursing posts. The Chief Operating Officer added the Clinical Services Review included workforce sustainability.

13/02/16 **Governors' Questions**

Mrs Marshfield queried inpatient medical cover at Brixham Hospital as beds had been closed there last summer due to lack of medical cover. The Chief Operating Officer said that GP cover was currently in place to cover the reduced level of beds. In the longer term, the Trust was working with the CCG to consult on the future configuration of community hospital beds.

Mrs Marshfield also queried stroke performance and the use of beds at Newton Abbot Hospital for stroke patients. The Chief Operating Officer explained that the Trust had agreed the stroke target with the CCG, now using the SSNAP standard which was to ensure 80% of patients who have had a stroke, or suspected stroke, spend at least 90% of their time on a dedicated stroke ward. The Trust had made significant improvement against the target. Improvements, however, could still be made, in particular reducing the time from the Emergency Department to a specialist stroke ward and this was being addressed.

Mr Allison raised an issue where a patient had not received copies of their letters following two appointments and when they asked for copies were told they needed to write in to request one. It was agreed he would speak to the Chief Executive outside of the meeting so that further details could be provided and action taken. RA/CS

Mrs French queried the data in respect of safe staffing for Maternity as it was not included in the Chief Nurse's report. The Chief Nurse explained that it was a timing issue and the data was not available when the report was produced.

14/02/16 **Council of Governor Issues**

It was noted that the Director of Commissioning and Transformation from the CCG would be attending the next Council of Governor meeting to discuss the community hospitals redesign and consultation process.

Interviews for the two soon to be vacant Non-Executive Director posts would be taking place on the 16th February.

Performance

15/02/16 Monthly Finance and Performance Report

Performance

The following was highlighted:

- Safety Thermometer performance in the community was 86% and was in respect of pressure ulcers. This was being addressed by the community Service Delivery Unit.

- Work was taking place to improve Fracture Neck of Femur performance – time to theatre.

- Dementia Find performance was still challenging and would continue to be until the electronic system was in place.

- It was hoped that Safeguarding score in terms of strategy meetings taking place within seven days would improve as performance against the need to have a triage meting within 48 hours had improved.

- Emergency Department 4 hour performance was still below target. This was impacting on ambulance handover time and work was taking place to improve this, in particular to move away from ambulance handovers taking place at the one point of entry to the Emergency Department.

- There continued to be pressure in terms of RTT performance in some specialities. Work continued to take place to find capacity both internally and externally to manage the shortfall and manage patients, taking into account clinical risk and highest priority.

- Diagnostic performance was 1.1% against a target of 1% and work was taking place to improve this including skill mix of the existing workforce.

- All cancer targets had been met in Quarter 3, but there were risks in terms of Quarter 4 linked to RTT performance, in particular in Dermatology.

- Mrs Lyttle queried the data in the Chief Nurse's report in terms of the medication risks, which was green, and the corresponding data in the performance report which was red. The Chief Nurse explained that the data points had been raised artificially because Pharmacy staff were using the system as a reporting tool and this has now been rectified.

- Mrs Lyttle asked whether patients who had not received follow ups on time were the same patients who formed the RTT backlog. The Chief Operating Officer said that in some cases it was the same patients, but that the risk was managed. It was noted that the CCG felt the Trust had a high review rate and have asked the Trust to reduce it, and the Trust was working with Primary Care to do this.

- Mr Brockwell said that the Trust had been struggling with RTT performance for a long time, and that action plans that had been put in place had not secured sustainable performance for a variety of reasons. He asked if the ones in place now would start to make a difference. The Chief Operating Officer acknowledged this and said that once plans had been put in place there had been unexpected changes in circumstances, for example inability to recruit and changes in workforce which then impacted on the plans.

- Mr Allen asked if there were any areas of improvement the ICO had already made, and the following areas were highlighted:

  - MSK Hip and Knee Pathway – 7% reduction in referral to surgery
  - Neurology Pathway – access to consultant advice
  - Intermediate Care pathway changes in Torbay resulting in 30% reduction in attendances at the hospitals
  - Teignmouth and Dawlish service changes

Finance

- The revised plan submitted to Monitor had been accepted. This had previously been retrospectively approved at the January Board, following submission in December.
- Performance at the end of December was in line with plan – a £6.97m deficit.
- A planned reduction in agency staffing spend had not been achieved with current pressures.
- CIP plans were being reassessed and confirmed through the business planning process, and work was taking place to understand what had stopped plans delivering in the past.
- Cash was below plan, but this was a timing issue.

16/02/16 Report of the Director of Estates and Commercial Development

The Board noted the following:

- The works to the bunker for the new Linac accelerator had been completed within budget.
- Arrangements had been agreed and finalised with contracts in respect of the unexpected ground works in respect of the CCU.
- Improvements to the Trust's Car Parks has commenced, creating difficulty for staff as they impacted on the number of spaces available.
- There had been a level of concern at the number of COSHH incidents, however due to the efforts of the COSHH Sub-Group these had reduced.
- Timely responses to estates maintenance remained a challenge and work was taking place to improve performance.

Assurance

17/02/16 Feedback from Chairs of Board Committees

a) **Finance**

Concerns had been raised about business cases requesting investment approval and not linking to compensatory savings and also papers being presented at late notice.

b) **Quality Assurance Committee**

Board assurance was sought for the proposed direction of travel for the Committee and this was provided.

c) **Charitable Funds Committee**

Noted.

d) **Audit Committee**

The Committee noted the importance ensuring that, with the new Quality Assurance Committee, all areas were covered and duplication was eliminated between these Committees. The Committee had also requested a report on Cyber Security.

18/02/16 **Date of Next Meeting**

11.00 am, Wednesday 6th April 2016.

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

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. **Closed.**	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 **Closed.**	2/12/15
3.	**Performance** – data in respect of medical errors to be presented showing the split between the different levels of errors.	CN	Information to be fed back through the Quality Assurance Group. **Closed.**	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
6.	Chief Executive presentation to the CQC to be circulated.	PA to CE	**Completed**.	3/2/16
7.	Update to be provided on progress to improve clinical supervision performance.	CN		3/2/16
8.	**Governors' Questions** – Roy Allison to provide Chief Executive with detail around patient not receiving copy letters.	RA/CS		3/2/16

Report to:	Trust Board
Date:	6th April 2016
Report From:	Mairead McAlinden, Chief Executive
Report Title:	Chief Executive's Business Report

1 ICO Updates

Care Quality Commission: Inspection Report

The draft report from the CQC following their annual inspection which took place in February is expected any day. Directors will have a short period to review the draft report for factual accuracy before the report is finalised and published in advance of the formal Quality Summit which we expect will take place during the first half of May.

As previously reported, on 1 March we received a letter from the CQC formally notifying us of their concerns about staffing levels and delays to triage and assessment within the emergency department. We responded to the CQC to assure them we are actively working on these concerns and, where we can, have taken urgent action to put more staff in place. We recognise the solution needs to go much further. We need to radically transform our services in line with our new care model aspirations to provide an alternative for people – particularly older people with complex care needs and young children – so that they may not need to come in to our Emergency Department or be admitted to the hospital. In response the CQC wrote on 10 March confirming they were satisfied with our response and issued a "requirement notice", which requires a further updated action plan within 28 days (April 6). Directors will update the Board when we meet on 6th on the latest position following Urgent Care Assurance and Improvement Group scrutiny on 5 April.

In the public board pack, Directors will see an update on progress against our current CQC action plan which addresses the areas for improvement identified by the CQC during their visit. Whilst a number of improvements have been made to systems and processes, staffing levels and physical environment, further work is required to provide assurance of sustainable improvement. Board members will have the opportunity for detailed debate and challenge through the enhanced governance arrangements now in place for scrutiny of ED performance and safety.

Cabinet Office: Children's Community and Mental Health Services (CAMHS) Deep Dive

Earlier this month the Trust hosted a visit from the Cabinet Office and Department of Health as part of a deep dive of CAMHS services. The Cabinet Office and the Department of Health Implementation Unit are jointly leading a review exercise on children and young people's mental health and wellbeing on behalf of Ministers. The purpose of their deep dive visits is to support those responsible for delivering this Government's top priorities, to rapidly gain valuable insights on progress while offering robust advice to Ministers on action that reflects experience on the ground in order to support delivery.

The Board will recall the Government committed additional investment of £1.4 billion during this parliament to help improve access and outcomes. Building on the assurance process for Local Transformation Plans, the aim of the deep dive visits is to achieve a better understanding of:

- how local plans are being delivered;
- how progress is being tracked so that outcomes can be measured; and
- what barriers may remain to delivery and what more might be done at a national level to support local areas.

Ann Wagner, who has taken over responsibility for the CAMHS Transformation Programme Board, supported the visit which involved the team manager, senior manager and clinical lead. The team took the opportunity to share key successes, describe challenges and lobby for recurring funding to support transformation. The Cabinet Office team will be reporting back to ministers in the next few weeks.

Monitor Quarter 3 (Q3) Formal Feedback

At the beginning of March we received formal feedback following their analysis of the Trust's Q3 performance confirming that, despite some concerns regarding performance against the A&E 4 hour and Referral to Treatment Time standards, there will be no investigation/regulatory action at this time. A Financial Sustainability Risk Rating of 2 and a Governance Rating of GREEN has been confirmed. As this assessment was received before the CQC raised concerns about patient safety in ED, it is likely that additional assurance will be needed to maintain this rating. A copy of the letter which sets expectations around improvement in Quarter 4 (Q4) is attached (Appendix 1).

Finalising year end and agreeing 2016/2017 Annual Plan

As the Board is well aware the NHS is under huge financial pressure with the majority of Providers straining to deliver stretching quality and access targets in a tightening financial envelope and CCGs required to impose penalties for non-delivery of core standards. Despite having a risk share agreement as part of the ICO business plan supported by the CCG, we find ourselves facing a difficult year end settlement and a remaining gap to close for 2016/2017. As part of the annual planning round providers and commissioners who are not in a position to sign 2016/17 contracts are required to indicate whether they intend going to arbitration or require mediation. The Trust and CCG took the opportunity at a tripartite meeting with regulators held on 11 March to describe the scale and degree of challenge facing key partners in the local health and care community and proposed a solution spanning 18 months which would involve revising the control totals set for the Trust and the CCG so the delivery of the longer–term system transformation programme is not compromised. Whilst the regulators are supportive of our longer term plans, the current business rules for 2016/17 require control totals to be achieved to release sustainability and transformation funding which means the CCG's financial assumptions will therefore need to be recast to achieve this. Further discussions to try to reach a reasonable settlement are being held with CCG colleagues over the next few days. Paul Cooper will update the Board on the latest position when we meet on 6 April. The Annual Plan national submission requirement is 11 April.

Annual Strategic Agreement (ASA) with Torbay Council

The Annual Strategic Agreement with Torbay Council is currently being finalised and will come to the May Board for approval prior to submission to Torbay Council

Annual Blue Shield Awards

This year's Blue Shield awards ceremony took place earlier this month to recognise individuals and groups of staff whose energy, commitment and dedication ensures that high quality and effective services are delivered to patients, services user and staff. This time there were seven 'Gold', seven 'Silver' and 12 'Bronze' award winners as well as two special

awards across nine categories, including individual, team, partnership, innovation, volunteer and lifetime achievement.

All our staff and volunteers work incredibly hard and this was a great opportunity to recognise those who are making a real difference to the people who use our services, and to their colleagues in the Trust. Hearing their stories and what they achieve every day was inspirational and truly heart-warming.

Best Practice Awards: Finalist for Rheumatology/Musculoskeletal project

I am delighted to report that an application led by one of our consultant rheumatologists - Dr Kirsten Mackay - has been selected by the panel as a finalist in the British Society for Rheumatology 2016 Best Practice Awards in Rheumatology and Musculoskeletal health.
I understand the judging panel was particularly impressed by the multidisciplinary approach taken to delivering services to people with rheumatic conditions, and the innovation shown in relation to the rheumatology database and the deployment of biologics co-ordinators.

2 Local Health Economy Update

Local health and Care Economy Sustainability and Transformation Plan (STP)

As the Board is aware the Trust and CCG are now part of a wider Devon STP footprint and Angela Peddar, CEO of Royal Devon and Exeter FT has been confirmed as the STP (and NEW Devon Success Regime) CEO lead. The next outline submission for the STP is due on 15 April. The final full submission is due at the end of June. System wide governance arrangements are currently being finalised. Ann Wagner is coordinating the Trust's contribution which builds on the ICO's 5 year business plan. Ann will bring an update to the May Board for Board consideration.

Stakeholder Engagement Event

Over 50 partner representatives attended the first of a series of stakeholder engagement events post ICO authorisation. The purpose of this first event was to:

- walk the talk on engagement;
- develop lasting partnerships;
- secure stakeholder support and help;
- build stakeholder trust and confidence in us to deliver; and
- help stakeholders deliver their objectives.

The first part of the programme included a 5 months in "where are we now?" update plus supportive views from commissioners – local authority and CCGs – regarding our shared purpose and shared ambition for ICO's role in supporting the local population.

The second half of the event focussed on stakeholder feedback with 2 key questions:

- What do stakeholders want/need from the ICO?
- What can stakeholders bring to the party?

Ann Wagner, who facilitated the event is reviewing all of the wants and offers so we can prioritise next steps. In the main partners told us they want us to:

- be ambitious and deliver our plans – go faster, further;
- let them help us - truly embrace partnership including with the local population
- strengthen relationships with and close gap with primary care and voluntary sector;

- maximise the benefits of technology to transform health and improve care pathways; and
- learn, share and evaluate

A full report of the event and next steps will be published next week. Directors are now planning a follow up event – this time targeted at and in partnership with the voluntary sector.

End of formal intervention measures for Children's services in Devon

On the 1 March 2016 Devon County Council received a letter from Minister Edward Timpson informing them that the Department for Education is ending formal intervention arrangements for Children's Services in Devon. The ending of formal intervention measures is excellent news and a real tribute to their workforce, management and partnership arrangements.

In his letter Children's Minister Edward Timpson says the services provided to children, young people and their families in Devon have improved significantly and Devon County Council can now be an example to other struggling authorities of how to bring about improvement.

The ending of formal intervention measures is a clear signal that the County Council is succeeding in moving forward and improving service to children, young people and families in Devon. Given our aspirations for children's services to be part of the ICO as a key element of our new care model, the Board will welcome this development and will want continued assurance that improvements are embedded and sustained across the service and to ensure consistency across the county.

3 Chief Executive Leadership Visibility

Internal	External
• Child Health Directorate Meeting • Meet Child Diabetes and Child Community Service • Staff Side • Breakfast Seminar to Celebrate National Apprentice Week • Infection Prevention and Control Team Meeting • Blue Shields Awards • Dartmouth Caring • Regional Director South, NHSE • Part of Panel for Director of People Services Interviews, Torbay Council • Health and Wellbeing Board	• CE, RD&E • Children's Improvement Board • Regional Director of Operations, Virgin Healthcare • LoF Monthly Meeting • SRG • LGA Action Planning Workshop • CSTG • Stakeholder Event • Chair, NHS Providers • CE, Taunton and Somerset NHS FT • Strategic Director of People, Business Strategy and Support, DCC • CE, Rowcroft • Kevin Foster, MP

4 National Developments and Publications

There has been another plethora of publications and guidance over the past month as the system works to close down 2015/16, finalise plans and agreements for 2016/17 and work together on the longer term sustainability and transformation plans.

Details of the main national developments and publications since the March Board meeting have been circulated to the Board each week through the new weekly Board developments update briefing which was introduced at the beginning of March.

The Executive Team continues to review the implications of those national developments which particularly affect the ICO and the local health and care system, and will brief the Board and relevant Committees as appropriate. Specific updates to draw to the attention of the Board this month include:

End of Life Care: National Audit

The *End of Life Care Audit: Dying in Hospital* was published on 31 March 2016. This is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians. It is designed to ensure that the priorities for care of the dying person outlined in the document *One Chance to Get it Right* are monitored at a national level. Service commissioners and providers are expected to use the data to improve services.

The Board will be interested to note that we performed above the national benchmark for the following indicators:

Indicator	National	TSDFT
Documented evidence within the last episode of care that the patient would probably die in the coming hours/days	83%	95%
Documented evidence that the above was discussed with a nominated person important to the patient	79%	93%
Documented evidence that the patient was given an opportunity to have concerns listened to	84%	98%
Documented evidence that the needs of the person important to the patient were asked about	56%	80%
Documented evidence in the last 24 hours of life of a holistic assessment of patient's needs for an individual plan of care	66%	96%
Lay member of Trust board with responsibility for end of life care?	49%	Yes
Seeking bereaved relatives/friends views in the last 2 years?	80%	Yes

The Board will also note the Trust did not meet the indicators for:

- Providing specific training in end of life communications skills for medics, nursing staff and Allied Health Professionals. Since the audit was carried out, we have undertaken research with Rowcroft Hospice to determine what education is required and more importantly how it should be delivered;
- Access to specialist face to face palliative care advice 9-5 seven days a week. We have access to palliative care face to face Monday to Friday and via telephone on Saturday and Sunday; and
- Having end of life care facilitators. We have a Palliative care lead nurse and link nurses, but not a role defined as a 'facilitator'. We are currently reviewing staff team and functions as part of our end of life strategy.

At our recent CQC visit, informal feedback indicated a concern about the lack of an EoL strategy. This will form part of the EoL Action Plan being led by the Chief Nurse which will be scrutinised by the Quality Assurance Committee before being brought to the Board.

Lord Carter Productivity and Efficiency Programme: NHS Estates and Facilities Management Efficiency Project

Following the publication of Lord Carter's report in February, the Department of Health is now progressing implementation of the recommendations. The estates and facilities functions at NHS trusts are expected to achieve £1 billion efficiency savings as part of the overall programme. This will, in the first instance, require some significant estates and facilities operational management savings by April 2017. In addition, strategic plans to help support savings in other areas such as space utilisation and energy will need to be put in place and to be successfully delivered by 2020. NHS trusts in the acute sector now need to set out how they will implement the recommendation for estates and facilities management along with the level of savings which are expected to be achieved.

The next step will be to initially agree the savings opportunity figures with all acute trusts for the short term operational management of the NHS. This is expected to be completed by the end of April 2016. Work will then commence to support the long term milestones with regard to delivery of the space utilisation targets and other service reconfiguration plans and strategies. Paul Cooper is co-ordinating the overall 'Carter' Plan for the Trust and will work with Lesley Darke to incorporate this important estates and facilities element which will form a key strand of our CIP programme for 2016/17.

NHS Improvement – letter to Provider CEOs regarding A&E pressure

On 10 March Jim Mackay, CEO from NHS Improvement wrote to all provider CEOs following the publication of the January A&E figures. These confirmed that the pressure on the system continues, with very high levels of attendance and admissions. Headlines included:

- A&E performance in January 2016 was 88.7% compared to 91.0% in December 2015 and 91.2% in January 2015;
- 175,000 more A&E attendances were seen in the month compared to January 2015, an increase of over 10%;
- There were 484,568 emergency admissions in January 2016 an increase of 4.6% from January 2015;
- In January 2016 1,690,633 patients were seen within the 4-hour target, 112,000 more than in January 2015;
- There were 158 over 12-hour trolley waits compared to 650 in January 2015 (or 475 YTD compared to 1010 in same period last year; and
- flu cases have risen since the new year - this has had a significant impact on the NHS.

Jim Mackay wanted to acknowledge that teams have been under immense strain and have done a great job to keep the service running in such difficult circumstances and make sure patients get the care that they need at this time of intense pressure. Whilst recognising there is always room for improvement. I am sure the Board will want to join me in thanking our front line teams and all support staff for their efforts for the local population.

1 March 2016

Mrs Mairead McAlinden
Chief Executive
Torbay and South Devon NHS Foundation Trust
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Making the health sector work for patients

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Dear Mairead

Q3 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q3 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Green

These ratings will be published on Monitor's website later in March.

The trust has been allocated a financial sustainability risk rating of 2 and has failed to meet the A&E Clinical Quality – Total Time in A&E under 4 hours target for the last 8 quarters which has triggered consideration for further regulatory action. The trust also failed to meet the Referral to treatment time, 18 weeks in aggregate, incomplete pathways target at Q3.

Monitor uses the measures of financial robustness and efficiency underlying the financial sustainability risk rating as indicators to assess the level of financial risk and the above targets (amongst others) as indicators to assess the quality of governance at foundation trusts. A failure by a foundation trust to achieve a financial sustainability risk rating of 3 or above and the targets applicable to it could indicate that the trust is providing health care services in breach of its licence. Accordingly, in such circumstances, Monitor could consider whether to take any regulatory action under the Health and Social Care Act 2012, taking into account, as appropriate, its published guidance on the licence and enforcement action including its Enforcement Guidance[1] and the Risk Assessment Framework[2].

We expect the trust to address the issues leading to the financial sustainability risk rating and the target failures and achieve financial sustainability and sustainable compliance with the targets promptly.

[1] www.monitor-nhsft.gov.uk/node/2622
[2] www.monitor.gov.uk/raf

Monitor has decided not to open an investigation to assess whether the trust could be in breach of its licence at this stage. The trust's governance rating has been reflected as 'Green'. Should any other relevant circumstances arise, Monitor will consider what, if any, further regulatory action may be appropriate.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q3 2015/16 will be available in due course on our website (in the News, events and publications section), which I hope you will find of interest.

For your information, we will be issuing a press release in due course setting out a summary of the report's key findings.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0192 or by email (Justin.Collings@Monitor.gov.uk).

Yours sincerely

Justin Collings
Senior Regional Manager

cc: Sir Richard Ibbotson, Chair
Mr Paul Cooper, Finance Director

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6 April 2016
Title:	Annual Plan 2016/17
Lead Director:	Director of Finance Director of Strategy and Improvement
Corporate Objective:	All
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

The Trust is required to submit an Annual Plan, in final form by 11 April 2016. The context within which this plan will be submitted is changing significantly and at great pace during this planning cycle. Most significantly it has been developed in the context of:

- A wider, Devon wide planning footprint; the Service Transformation Plan being imposed by NHS England;
- The requirement, through application of the Service Transformation Fund, to deliver improved performance against financial and key standard metrics
- For the Trust, the need to respond to any issues raised by the Care Quality Commission following their inspection earlier this month;
- The, at this stage apparently informal, engagement of the Torbay and South Devon community in the Devon Success Regime;
- A commissioning relationship with an increasingly challenged CCG

This paper will describe any changes proposed from the first draft, key risks and their intended management and the self-certifications required as part of the submission.

Key Issues/Risks

Key changes / risks identified in this paper are associated:

- Changed contract arrangements, moving to a transaction PbR based contract and away from the Risk Share Agreement previously adopted,
- Delivery of savings targets, that will secure the target surplus position and, as a consequence receipt of the Service Transformation Fund,
- Availability of capital loan financing to support infrastructure development, particularly in support of the urgent and emergency care pathway.

Recommendations

The Board is asked to note and endorse the basis upon which the Annual Plan for 2016/17 has been develop,acknowledge the risks inherent within it and the approach to their management.

Assuming the Board is content it is asked to approve the self-certifications as attached.
Summary of ED Challenge/Discussion: Captured throughout the paper.
Internal/External Engagement including Public, Patient and Governor Involvement: Commissioner All Service Delivery Units Governors NHS England NHS Improvement
Equality and Diversity Implications: No adverse affects identified in this paper.

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Report Title	Annual Plan 2016/17
Meeting	Trust Board – 6 April 2016
Author	Director of Finance
Date	30th March 2016

1. Introduction

1.1 The Trust submitted a first draft of its Annual Plan for 2016/17 to Monitor in February 2016. Previously circulated to Board Members, this is attached as Appendix1 and will, subject to the following matters, remain broadly unchanged for the final submission due on 11 April 2016.

1.2 This paper will describe any changes proposed from the first draft, key risks and their intended management and the self-certifications required as part of the submission. The final document will be circulated once finalised.

2. Summary Financial Plan

2.1 A summary of the proposed financial plan is set out below:

Torbay and South Devon NHS Foundation Trust	
Financial Year 2016/17	
as at 30 March 2016	
Annual Plan Submission	**ICO**
Income and Expenditure	**£m**
Income	**405.0**
Pay	(233.0)
Non Pay	(150.1)
Total Operating expenses	**(383.2)**
EBITDA	**21.8**
Non-operating revenue	-
Financing Cost	(21.8)
Net Surplus (deficit)	**-**
Adjust:	
Deduct: Donated Income & Gain on asset disposal	(0.9)
Add back: Asset Impairment	2.5
Add back: Depreciation and Amortisation - donated/granted assets	0.7
Sub total	**2.3**
Surplus (Deficit) for Monitor's assessment	**2.3**
Monitor's adjusted control total	**2.0**
Other Information	**£m**
Continuous Improvement Plan (CIP)	12.7
Cash Balance	18.3
Capital Expenditure	36.0
Financial Sustainability Risk rating (FSRR)	
Capital Servicing Capacity Rating	2
Liquidity Ratio Rating	3
I&E margin	3
I&E margin - variance from plan	3
Financial Sustainability Risk rating	**3**

3. Income & Expenditure Plan

3.1 NHS Improvement has set a target surplus of £0, which is a normalised surplus of £ 2.0m (previously £1.6m) after excluding donated income, depreciation and impairments.

3.2 This position assumes the receipt of the Strategic Transformation Fund of £6.7m. Receipt of this fund is dependent on achieving the target surplus, the trajectory for 4hour emergency system target and the Referral to Treatment Time trajectory.

3.3 Income Assumptions

The basis of income included within this plan has changed significantly since previous iterations that have been presented to Board.

Material to this is South Devon and Torbay Clinical Commissioning Group's (CCG) inability to commit to the envelope of funding previously agreed as part of the Transaction and supporting Risk Share Agreement (RSA). It has not proven possible negotiate an effective alternative. As a consequence, the default position set out in the RSA has been adopted.

The income position included in this plan therefore assumes a fully variable contract under National Tariff for acute elements, a block contract for the community and a pass through contract for placed people and independent sector, ie no risk share agreements in place 100% of risk on adult social care passes to Torbay Council and 100% of the risk in placed People passes to South Devon and Torbay CCG.

3.4 Cost Assumptions

Budgets have been rolled over based on 2015/16 with inflation as set out in tariff uplift:

Inflation	%
Pay Award/Pensions NI/Increments	2.9
Non Pay general inflation	1.4
Pass through growth/inflation	18.7
Other drugs inflation	8.6
CNST	17.3

Employee inflation has been based on a 1% pay award (with underlying assumptions as nationally agreed last year) supplemented by an assessment of incremental drift, clinical excellence awards and the National Insurance and pensions changes:

Pay Inflation	**%**
Pensions NI	1.7
Increments	0.5
1% pay award	0.6
Clinical Excellence Awards	0.1

The Trust is challenged by the nationally introduced agency caps particularly around access to the approved contracts at capped rates in the South West for both medics and nurses. The

Trust has planned a budget of 1.2% of its staff cost to cover the supplementary cost of agency staff.

Non-Pay inflation has been based on historic trends for drugs, separately looking at pass through and hospital prescribed drug spend, and informed by a bottom up review of expected cost pressure and new drugs conducted within clinical services.

Capital charges have been based on the capital programme and assume appropriate Foundation Trust Financing Facility Loans will be available and used to fund the long term assets at current interest rates.

3.5 Investments

Investments have been planned under the care model changes to align the delivery model to local populations, wrapping services around the person to create a single system of care delivery and the Service Business Units, overseen by the Care Model Executive Group, have developed proposals that will be funded from a, currently centrally held reserve below:

Centrally held	Care Model	1.9
	Other reserve	2.0
Total		3.9

Since the last iteration presented to the Board, planned investments have been reduced from £9.9m to address the overall income and expenditure pressures.

3.6 Cost Improvement Requirement

To deliver this overall position, Service Business Units will be required to:

- Hold normally arising non-recurring savings of £10.3m, the budget having been set for Service Delivery Units net of this amount,
- Identify and deliver an incremental Cost Improvement Plan of £12.7m for the year.

4. Capital Plan

4.1 The Trust's summary capital plan is summarised below:

Planned Expenditure:	£'m
Schemes carried forward from 2015/16	20.01
IM&T strategy	1.93
IM&T infrastructure	1.96
Estates development	3.43
Estates maintenance	4.13
Medical equipment	2.74
Other (inc Torbay Pharmaceuticals)	0.80
Contingency	1.00
Total	36.00

Financed By:

Existing loan finance	10.14
New loan financing requirements	7.71
Internally generated funds	7.31
Planned reduction in cash balances	8.24
Charitable donations	2.60
Total	36.00

4.2 The draft capital requirements presented to Board in March 2016 have been updated as follows:

- The priorities have been re-assessed and re-phased to reduce spend in 2016/17 and 2017/18 with a view to maintaining the Trust's cash balance as per the ICO LTFM at £18.33m.
- All changes have been agreed with the relevant Directors and Service Managers.
- In line with service requirements, new loan financing of £7.71m, included in the ICO LTFM against the St Kilda development, has been re-allocated against to fund a range of Emergency Department / Urgent Care System developments, both community and acute and IM&T developments that will facilitate community wide working.

5. Risks and Issues for Board Consideration

5.1 The inclusion of revised contract arrangements increases the Trusts income levels beyond that included in the first draft plan. The benefit, assuming no risk sharing arrangements with any Commissioner extends to £12.2m. Any change in that position, without a corresponding alteration to the control total, would have a significant impact on the planned surplus position.

5.2 Delivering the scale of efficiency required to generate the target surplus necessary to retain the Service Transformation Fund represents a significant risk.

Service Delivery Units (SDU) have, through a bottom up exercise, assessed requirement for 2016/17 based on existing run rate, new investments required, extrapolation of vacant posts being filled, and inflation assumptions. The budgets have also assumed a vacancy factor will be delivered of £6.3m. Comparing this requirement to the available budget envelope generates £18m gap as per the below table.

The gaps to date are as follows:

	£m
Women's and Children's	2.8
Surgery	5.4
Medicine	6.9
Community Division	10.3
EFM	0.6
Support/ Back office	3.8
PMU	0.4
Less PBR benefit (All commissioners)	-12.2
Total	**18.0**

Whilst £12.7m of this gap represents the CIP assumption not yet reflected in this position, £3.3m (table below) reflects new development expenditure identified by SDUs not included in the plan and the balance of £2.0m most likely reflects gaps in plans for non-recurrent savings remaining unidentified by managers at this stage.

	£m
Surgery	1.6
Medicine	1.0
Community	0.3
Back office	0.4
TOTAL	**3.3**

The level of confidence in the CIP plans shared at the last Board meeting has not improved significantly. Schemes to a value of £11.5m are registered, with a total of £5.8m classified as 'green'.

5.3 In response, the Trust could submit an income and expenditure plan that does not achieve the targeted surplus. To do so would lose £6.7m of income from the Service Transformation Fund already included in this position. This would very quickly result in a significant deficit position that would, within a (maximum) two year period put significant pressure on the Trust's cash reserves. On that basis, the plan is produced on the basis that the target surplus will be achieved.

5.4 Management of these risks to ensure delivery of the target income and expenditure position is therefore critical. Further actions to deliver CIP potential are required and will be addressed through existing committee and performance management arrangements.

5.5 In the short term, and to allow for these actions to deliver results, immediate action is required that will involve:

- The holding of Service Delivery Unit investments (£3.3m above) until savings are identified that will offset the cost,
- The holding of all vacancies in non-clinical posts, other than in exceptional circumstances and by agreement across the Executive Team,
- Continued control of bank and agency expenditure such that, at the discretion of the Chief Nurse and Medical Director, only clinically essential shifts are filled,
- Recruitment to established clinical posts only where it will not increase the run rate of expenditure,
- A hold on all discretionary non-pay expenditure.

These measures will be difficult to manage within the organisation and may have some short term consequences that will need careful handling. The Board will be briefed on any significant issues as they emerge.

5.6 The capital plan has been created to maintain a cash balance sufficient to manage the income and expenditure risk identified in this paper.

5.7 There is £7.7m of loan financing included in the capital plan that is yet to be secured. Given the national messaging, there is a risk that these loans will not be available. To manage this risk the following actions are being taken:

- The urgent development of business cases for urgent submission to the Independent Trust Financing Facility,
- The identification, by relevant Directors, of schemes to remove from the 2016/17 programme if, in the worst case scenario no loan financing proves to be available. This will be completed within one month, and
- An agreement that those schemes will not start until the Trust receives confirmation that loan financing is available.

6. Service Standards

6.1 The Trust has yet to finally agree recovery trajectories with the CCG, that are necessary to secure the Service Transformation Fund. An update will be provided at the Board meeting.

7. Conclusion

7.1 The Board is asked to note and endorse the basis upon which the Annual Plan for 2016/17 has been develop, acknowledge the risks inherent within it and the approach to their management.

7.2 Assuming the Board is content it is asked to approve the self-certifications attached as Appendix 2.

Torbay and South Devon NHS
NHS Foundation Trust

Draft Operational Plan Narrative

Financial Year 2016/17

Contents:

Context and Overview

Torbay and South Devon NHS Foundation Trust was 'formed' on 1st October 2015, through the acquisition by South Devon Healthcare NHS Foundation Trust of Torbay and South Devon Health and Care NHS Trust, creating what we refer to as our 'Integrated Care Organisation' (ICO). In one organisation we now provide acute care, from Torbay Hospital, community services through a network of community hospitals, bases and, increasingly people's homes and Adult Social Care. Our ambition in doing so is to deliver a fundamentally different care model across our health and care system that is well co-ordinated and joined together, designed to support people in managing their own health and wellbeing, easily accessible and responsive to service users and health professionals and provided as close to home as possible.

Examples of the key initiatives, all are aligned with the principle that services should wrap around the person to create a single system of health and care delivery, include:

- Single point of contact – a multi-media gateway to signpost and to mobilise the appropriate assessment and resources;
- Community care – the realignment of community resources and infrastructure to support self-care and prevention,
- Frailty service –a whole system pathway of care, stratifying risk to identify the most vulnerable, largely providing services in a community setting but linking with specialist healthcare of older people and medical admissions avoidance teams,
- Multiple Long Term Conditions service – Providing coordinated multidisciplinary management of coexisting medical conditions in one place at one time; outside of the acute setting where possible and avoiding multiple appointments per condition.
- Referral Management – A framework to facilitate dialogue between professionals to manage patients in the most appropriate and efficient way will ensure that face to face appointments are no longer the automatic default position and that care plans, advice and guidance or specialist support are a viable alternative;
- Muscular-Skeletal Triage – a triage service through the community physiotherapy team, providing a consistent assessment, active early treatment and, if necessary onward referral to secondary that is targeted to the right specialist area.
- Heart Failure – Developing a service where patients are treated in an outpatient setting rather than the more traditional treatment as an inpatient.

As a result, our delivery system will look and feel very different in future. There will be:

- Fewer hospital beds and better developed re-ablement facilities;
- A shift in use of specialist teams, as far as possible, from face to face clinical care, to support of primary care and community colleagues and the continued management of people in the community and avoiding unnecessary referral;

- Local Multi-Agency Teams, working from Locality Hubs, co-ordinating the care and managing personalised care plans for the frail and those most at risk;
- Significant investment in mobile Information Technology; ensuring that all systems are accessible to all health and care;
- A revised contract and risk share agreement that supports this new way of working.

The approval of that transaction required the development of a Full Business Case and a comprehensive implementation plan, describing these changes in more detail and the ways in which we expect them to be delivered.

The plan will take two to three years to implement in full. This first draft of the Trust's Annual Plan describes what we expect to deliver in 2016/17. It is entirely consistent with the Full Business Case and Long Term Financial Model presented in support of the transaction, updated only for significant changes in the environment during the intervening period; the most significant example, of course being the introduction of the Service Transformation Fund.

1. Approach to Activity Planning

Over a number of years the local commissioner and this Trust have worked together to achieve an agreed view of the demand that needs to be planned for in the coming year. This has always included the impact of changes in referral patterns, outsourcing / transfer or repatriation of activity and the estimated level of waiting list reduction needed to achieve the elective waiting times trajectories.

There is an established process for activity planning with the following agreed principles and annual timeline.

1.1 Demand plan

- Demand planning is an inclusive process with commissioners having access to all supporting information. They are also invited to attend the specialty demand planning meetings.
- Delivery of core access standards are agreed with commissioners with initial review and agreement of service performance standards and access times. These include:
    - Stage of treatment waiting times and list sizes that are agreed as necessary to deliver the RTT standard
    - The level of and management of emergency admissions to maintain patient flow and A+E access standards
    - Achievement of all cancer standards and compliance with agreed NICE guidelines
    - Diagnostic waiting times
- All specialties are provided with the most recent annual baseline of information covering referrals and activity across outpatients and admitted patient care.
- The baseline information also covers the previous 3 years of activity split by month and financial year for annual comparison of movements.
- The actual activity baseline for the activity demand plan uses the most recent 12 month period. This year the period October 2014 to October 2015 has been used. Waiting list size at both the start and end of this period are used to create an actual "Demand" baseline plan.
- Referral numbers are reviewed with teams and commissioners to agree any growth that should be applied to the plan. This assessment takes into account factors in the planning period and baseline that may be "one off. Additionally clinical and commissioning intelligence regarding potential future pathway changes and clinical delivery changes is built in.
- In 2016/17 referral and admission rates will be heavily influenced, particularly towards the end of the year, by the care model changes set out the Business Case supporting the creation if the Integrated Care Organisation. The impact of planned developments, in such services as frailty and advice / guidance clinics, are modelled to reduce OP referral and emergency presentations, particularly toward the end of 2016/17.
- Agreed baseline growth rates are applied to the baseline demand model with agreed growth rates for new referrals and subsequent conversion into follow up and admitted activity calculated across the pathway of care.
- Delivery of contracted waiting times: Each of the treatment functions have calculated an agreed target waiting list size to deliver a compliant RTT position. Any reduction in waiting list that is required is identified separately in the plan and is added onto the final demand plan for costing.

1.2 Capacity plan

- In parallel to establishing the demand plan the Trusts operational teams complete a capacity planning exercise. This includes a weekly clinic and theatre list plan to describe available capacity after adjustment for annual leave and on call etc.
- Capacity plans reflect both additional resources, principally in community settings, and efficiencies, mainly in length of stay, generated through the Trust's ICO Care Model implementation.

1.3 Reconciliation

- The demand and capacity for each specialty is published and aggregated to a Trust level.
- The demand and capacity analysis is used, after the implementation of the ICO care model changes, to identify any gaps between demand and capacity.
- Options to balance residual demand and capacity gaps are then described in the Trusts business planning documentation. The operational leadership team will assess options to manage variances that put access standards at risk. These options include
    - Agreement of clinical efficiency measures that can be built into the activity plan
    - Investments to increase capacity that may be offered, where these are funded from savings elsewhere
    - Use of outsourcing to increase capacity and flexibility to manage variation in demand.
    - Engagement with GP's and commissioners to review demand levels and consider alternatives to secondary referral.
    - In 2015/16 a number of action learning sets were created to support this engagement process. Each one chaired by a GP with representation from both primary and secondary care clinicians.
- Specialties with greatest challenge are supported through a more in-depth capacity and demand planning process and the IMAS flow model used.

1.4 Finalisation of Trust Business Plan

- Where solutions to increase capacity through efficiencies have not been identified, the Trust executive may recommend additional investment in additional capacity or choose to accept the consequences on performance standards.
- This submission does not include any the impact of any such recommendations, with detailed proposals expected to emerge from the business planning cycle by the end of February. Activity has therefore been included in this this draft of the plan, and its associated templates, at the last 12 months baseline level.
- The Trust recognises that, within 2016/17 the hospital based emergency system requires significant recalibration in order to reliably deliver the 4 hour standard. Recovery action plans are referenced later in this document and have previously been shared with Monitor. Whilst not increasing activity, this is likely to require significant investment in 2016/17.
- The financial plan currently includes a reserve of £4.4m, being the balance of the Service Transformation Fund not required to achieve the required control total surplus from that set out in the Transaction LTFM. Action plans developed in response to capacity shortfalls and performance issues, principally Emergency Department performance, are assumed, at this stage to be held within this amount.
- The final draft of this plan will include full detail of the proposed actions and their costings.

1.5 Timeline

- September – Business planning process launched
- October - Supporting information produced and released to operational teams
- November and December – Specialty team meetings to review baseline demand plan, agree growth rates and service changes.
- November and December – Team complete clinic and theatre level capacity planning.
- Early January – Demand plan signed off together with waiting list positions for waiting time delivery
- Mid January – Activity plan agreed with commissioners
- Late January – Activity plan priced to inform 1st Draft contract activity plan
- Late February – Proposed capacity investments presented.

2. Approach to Quality Planning

2.1 National and Local Commissioning Priorities

The strategic priorities of Torbay Council and Devon County Council, the Health and Wellbeing Boards and the Clinical Commissioning Groups have a number of common themes:

- A continued focus on health inequalities and the most vulnerable
- Prevention and early intervention
- Integration of health and social care services
- Personal responsibility choice
- Building social capital and strengthening the local economy

These reflect the priorities set out in the NHS England 'Everyone Counts' document and the Department of Health outcomes frameworks for the NHS, Public Health and Adult Social Services, and have informed the South Devon and Torbay CCG Strategic Plan 2014/19 which sets out the CCG vision, responsibilities, intentions and identifies a number of priorities that encompass quality (safety, effectiveness, experience):

- Promoting self-care, prevention and personal responsibility
- Developing joined up community hubs closer to home for all
- Leading a sustainable health and care system encompassing, estates, workforce and I.T.

These quality priorities have been translated into areas of focus for: Prevention, Primary Care, Community Services, Urgent Care, Mental Health, Long-term conditions, Learning Disabilities, Planned Services, Medicines Optimisation and Children's Services each with a set of outcomes. These commissioner areas of focus are reflected in the Trust Strategic Plan which describes the provider response to the delivery of the outcomes.

2.2 Provider Quality Goals as Defined by Trust Strategy and Quality Account

The Trust Strategic Plan Document for 2015/16 set out 5 quality priorities which were reflected in the Trust Quality Account for 2015/16:

- Redesigning the reliability, accuracy and timeliness of information at the point of handover to enable an effective and safe transfer at each and every juncture.
- Establish a single point of contact for people to access community based health and social care services in Torbay.
- Improve the involvement of carers in the management of medications on admission and at discharge at Torbay Hospital and at our community hospitals.
- improve multi-agency working across Torbay and South Devon through developing and extending the existing multi-disciplinary teams working across the community
- Create a reliable and consistent ambulatory emergency care service available 7 days a week for patients coming to Torbay Hospital.

The Trust Strategic Plan quality priorities for 2016/17 are yet to be agreed but the following long list reflects current priorities. The stakeholder event to confirm the short list will be held 24 February 2016.

Likely safety domain priorities include:

- To improve the consistency and reliability of investigations across the system in response to the PHSO publication 'A Review into the Quality of Complaint Investigations'.
- To improve the number of patients lost to follow up in response to the current Trust position.

- To integrate the two early warning trigger tools so they reflect the appropriate triggers for any care setting linked with the Trust.

Likely priorities in the 'effectiveness' domain include:

- To improve the timeliness of discharge for patients who are medically fit and those 'green to go' to leave the acute and community hospitals
- To improve the timeliness of assessment in the Emergency Department
- To improve both the time to stroke ward and time spent on stroke ward
- To reduce the time from arrival to theatre for people with hip fractures
- Reduction in upper GI backlog to achieve RTT standard.

Likely priorities in the 'experience' domain include:

- Implement the recommendations of the 'Breaking down barriers' report improving ways people can raise concerns or make complaints and provide them with the support if they feel unable to do so.
- Test the impact of using the 'talk back' method in a variety of bed based and non-bed based care settings such as SPOC, intermediate care and outpatients.
  To improve for children and young people the feeling they have enough privacy during their care and treatment
- To test the Advanced Care Planning 'Breaking Bad News' tool developed in collaboration with Rowcroft Hospice.

2.3 Existing Quality Concerns

The long list of quality priorities above reflects the current quality concerns identified by the Trust, Monitor, NHSE, CCG and CQC. The CQC inspection is currently in progress, it is anticipated that the report will be published in April 2016. From initial feedback, we can anticipate that the CQC report will reflect some concern already identified by Monitor and NHS England, including:

- Emergency Department performance and the Emergency Pathway: Despite support from The Emergency Care Intensive Support Team (ECIST) and the implementation of a comprehensive recovery plan the Trust has not achieved the 4 hour target for some months. This represents a significant quality challenge as people accessing emergency services experience unacceptable waits. This is reflected on the Corporate Risk Register.
- Lost to Follow Up: The Trust has identified a number of patients who are lost to follow up in the Urology service. An initial piece of work suggests that this issue may be replicated across other services. This issue was initially flagged by the CCG and is reflected on the Corporate Risk Register.
- Stroke pathway: The Trust has been unable to achieve the national stroke target (SSNAP) target for time spent on a designated stroke ward. This is reflected on the Corporate Risk Register.

2.4 Approach to Quality Improvement

The Trust is going through a period of change with the exciting opportunities of the recent integration combined with the organisational pressures brought about through increasing demand and financial constraints. The Trust needs to develop new service models that are sustainable and resilient. This will require specific skills and a significant and consistent leadership effort to move forward. There are specific well recognised characteristics of high performing health care organisations and health care systems. These include:

- Establish a positive culture of dissatisfaction – we can always improve and do better
- Continually redefine what "good" for any particular service looks like

- Having an information system that supports improvement and helps to see risk coming
- Engender a culture where employees own the responsibility to keep patients safe.
- A culture where measurement drives performance and learning
- Safety is a core organisational value
- Visible leadership paying attention with integrity
- A workforce with the skills to "work in the system" as well as "work on the system"

Some of these characteristics may be described as cultural and a guiding principle of our approach is founded on the conclusion to the Berwick Report 'A promise to learn, a commitment to act' that concludes:

"*Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning …..focus on the culture that you want to nurture: buoyant, curious, sharing, open-minded, and ambitious to do even better for patients, carers, communities, and staff pride and joy* " Berwick (2013).

Whilst establishing the right culture is critical to safe, high-quality care there is also a tangible set of core Quality Improvement skills and approaches to doing work and specifically improving services. In order to provide our staff with this core quality improvement skill set we have established Improvement Network. The primary objective of the Improvement Network is to build capability and capacity in Quality Improvement (QI) to support delivery of the organisations key strategic objectives. The following are examples of what the Improvement Network offers to support Quality Improvement across the organisation:

- Map out QI skills across the Service Delivery Units (SDUs) as a stock take of capacity and capability
- Coordinate uptake of QI development opportunities as offered by the Academic Health Science Network (Patient Safety Officer training and Institute for Healthcare Improvement (open school)
- Build a common language and approach to QI across the organisation
- Provide the QI training programme for clinical teams
- Provide coaching support to clinical teams doing specific projects
- Provide coaching support to individuals working though the PSOT course
- Provide a support network and development network for individuals supporting QI
- Provide a skills resource of specific skill sets to be accessed and used as required by teams running QI projects
- Building links through Education to incorporate QI into the ILM programme
- Provide teaching on QI for FI programme
- Provide teaching and small group facilitation of the Junior doctors management course
- Develop a web based resource about QI

We believe that having an approach to QI that builds skills in a consistent standardised way will help to deliver the organisational culture and skills that empowers and supports teams to develop safe resilient clinical services that deliver the organisations key objectives.

2.5 <u>Quality Improvement and Governance Systems</u>

The Trust Board is accountable for the delivery of safe, high quality care. In order to ensure that the Board has a clear line of sight of performance variance, those outside target trajectory are reported on the Board performance dashboard with accompanying narrative on risk mitigation. Lead Executives report on progress or barriers to progress and are held to account for recovery plans. The Board is supported by the Non-Executive and Executive led Quality Assurance Committee (QAC) with responsibility for ensuring that data and information provided to the Board on all quality performance measures is accurate and timely. The Non-Executive and Executive led Quality Improvement Group reports to the QAC and receive reports from a number of services and groups who have operational responsibility for delivery of the quality priorities. Leads are held to account for delivery of the quality priorities by the Quality Improvement Group

(QIG). Sub-groups and have designated leads with a clear line of reporting to the QIG.

The three quality priorities included in the Trust Strategic Plan and Quality Account for 2016/17 are identified as Corporate Risks on the Risk Register and are monitored by the Trust Risk and Assurance Committee.

Quality priorities are embedded in the objectives and appraisals of the Executive team to ensure the Chief Executive and Trust Chair have oversight of progress or variance to delivery milestones.

Executive co-leads for safety and quality are: Dr Rob Dyer, Medical Director and Jane Viner, Chief Nurse**.**

These processes have identified the top three risks to quality in 2016/17 and overseen the development of plans for their mitigation:

1. To improve the timeliness of assessment in the Emergency Department. A Task and Finish Group has been established reporting to the Patient Flow Board with the aims of improving timeliness of assessment in the Emergency Department through (a) improvement in flow through the hospital (b) redesign of urgent care pathways and (c) review of ambulatory care requirements. The resultant plan has been shared widely with Monitor colleagues, including timescales for delivery. The plan describes an 'acute response' including significant changes to medical and nursing job plans and priorities and a reconfiguration of facilities, principally bed stock, and is supported by the Trust's long standing plans to develop enhanced 'out of hospital' care that will reduce demands
2. To reduce the number of patients lost to follow-Up. A loss of outpatient follow up was identified where severe harm occurred to 3 patients with Carcinoma of the Prostate. This was due to booking processes of follow-up appointments that are unduly subject to human error. A task and finish group has been convened under the leadership of the Chief Operating Officer (COO) and with cross-organisational clinical and operational representation to reduce the risk of this occurring again. The risk has been assessed as high and is included on the corporate risk register. Mitigations are in place including clear communication (verbal and written) to patients explaining the process and what they should expect, and encouraging them to make contact if the process is not followed. The main objective is to develop an improved IT-based system for booking of appointments across the whole Trust including community. A suitable system will be identified in 2016/17.
3. To improve both the time to stroke ward and time spent on a stroke ward. The acquisition of Torbay and Southern Devon Health and Care NHS Trust brought, for the first time acute and rehabilitation facilities for stroke patients into a single organisation.

2.6 <u>Sign Up to Safety Priorities</u>

Using Association of Medical Royal College guidance published in June 2014; Guidance for taking responsibility*: accountable clinicians and informed patients,* the Trust has established a number of improvement targets for 2016/17:

- A person admitted to the District General Hospital (DGH) he/she is admitted under the care of the consultant on-call on that day.
- A system of specialty ward-basing means that on transfer from the Emergency Department or the first admission ward, there may be a transfer of care to a new responsible clinician. This decision is based on the clinical needs of the patient and therefore the best ward/unit to continue his/her care. Responsibility for the patient passes to the new responsible clinician automatically unless agreed otherwise.
- The introduction of new ways of working and a new IT system in the Emergency Department has prompted a review of this agreement.
- Results from the National Inpatient Survey 2015 suggest that communication with patients is generally good. Though there is no question referring specifically to the named responsible clinician in the NIP Survey, the answers relating to communication suggest a high level of

satisfaction in most areas.

- A more formal policy is required to ensure that the responsible clinician is correct and clear for all admissions. There is also a need to communicate this more effectively to patients and carers. This will be achieved through an established working group (Patient Flow Board) and will be in place by August 2016.

2.7 Seven Day Services

Torbay and South Devon NHS Foundation Trust has a good record on the development of 7-day services. We were an early adopter of 7-day diagnostic services. We have had 7-day consultant-led Radiological services for 10 years and now have a full range of diagnostic services 7-days a week.

Emergency services function effectively across 7 days in all specialties in the DGH. However there is variability in access to multidisciplinary non-emergency services for inpatients at the weekends and holidays. This affects quality of patient experience and length of stay. It may also be associated with some additional clinical risk. A working group has been established under the leadership of the COO and MD to scope the present availability of services, including medical, nursing and therapy services and social care, and to identify priorities for extension of services across 7-days. This will include availability of services in the community across all professional groups and functions and including community hospitals. This is expected to report in summer of 2016.

Where a need to extend clinical services is already clear, the development of 7-day services is progressing through redesign of working patterns and through the business planning process for April 2016. Some modest investment is required.

The development of 7-day services in the community is already in train through the implementation of locality multi-agency teams (2 localities are implementing in 2016/17 with implementation of the remaining 3 localities completed in 2017/18), being effected through the ICO Care Model implementation.

Improvement in access to community-based services out of hours services is a key feature of the action plan of our Urgent and Emergency Care Vanguard proposals. The 5 work-streams of the U&EC Vanguard are:

- Self-care,
- 111/Integrated Urgent Care,
- Urgent Care Centres,
- Mental Health Services and
- Shared Care Records.

We have a detailed action plan in all these areas including the establishment, within 2016/17 of 2 Urgent Care Centres, the development of a comprehensive community-based approach to prevention and self-care and recruitment to provide 24 hour 7-day cover for all-age Psychiatric Liaison services. This programme is dependent on funding from the U&EC Vanguard programme (not yet confirmed for 2016/17).

2.8 Quality Impact Assessment

Quality priorities are identified as above through triangulation of national, professional, user and stakeholder involvement activity. Each priority has a quality impact assessment covering the three domains of quality and including risk to delivery, mitigating actions, phases and milestones. The business planning process includes a process and timeframe for Medical Director and Chief Nurse review and sign off, for all service changes and the CIP programme. This is managed and monitored through the Trust Quality Improvement Group and through the Trust Senior Business Management Team.

2.9 Triangulation

The revised Board performance report includes sections on quality, performance workforce and financial indicators. These are under review to ensure the 2016/17 quality priorities are reflected. The Board reviews this information monthly and holds the Executive lead to account for delivery. Where performance varies from anticipated trajectory, Executives are required to produce a recovery plan and are held to account for delivery. In addition the Board receives a RAG rated performance dashboard that clearly shows variance to performance across the domains. The Quality Assurance Committee and the Quality Improvement Group have dashboards in development that brings the quality performance data together.

3. Approach to Workforce Planning

The Trust has developed an Integrated Workforce Strategy that sets out how it intends to deliver a fit for purpose workforce to deliver the Trust's model of care for the future. The Strategy was developed from the Trust's business case for an Integrated Care Organisation, working with the Strategic Business Management Team. The Strategy:

- Outlines the key drivers that are influencing the future shape of the health and care workforce in South Devon.
- Summarises at a high level the impact this will have on the workforce and some of the key challenges associated with these changes.
- Identifies the additional challenges that this will present in terms of workforce planning and development and consequent need for an Integrated Workforce Strategy.
- Identifies a route to achieve the required outputs of the strategy, the required resources and governance structure.

This Strategy has been communicated to the organisation and managers have been asked to prepare annual workforce plans in accordance with that strategy.

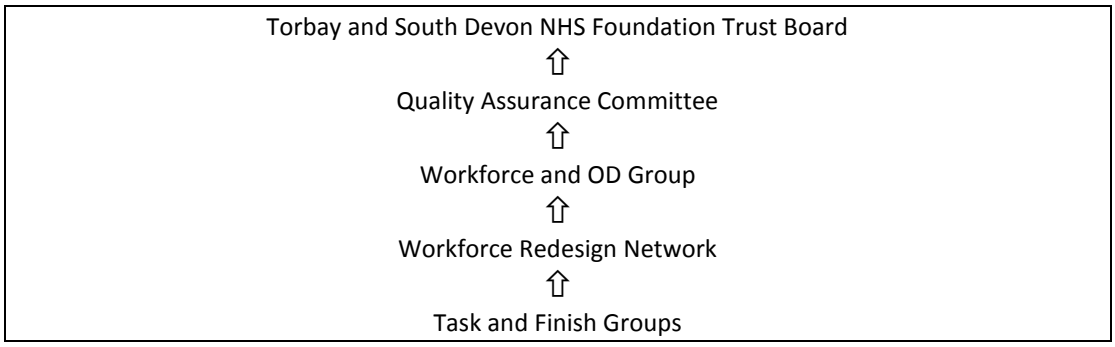
Each year the Trust undertakes an annual workforce planning exercise as part of the business planning process. This process engages clinicians both at the top level using the triumvirate management structure for each Business Unit and by engaging managers for individual specialties in the workforce planning exercise. Taking account of the Integrated Workforce Strategy the workforce planning exercise enables managers and their staff to:

- Identify their current and future service description and workforce profile.
- Identify known and anticipated Workforce changes and challenges (growth, contraction, realignment etc.) now, in the next 2/3 years, and the next 5 years.
- Identify their workforce continuous improvement programme (CIP) savings required and plans for achieving them.
- How they will meet their challenges using transformation i.e. 'Redesigning the Workforce'.
- How they plan to align their workforce to work with partner agencies to cover the whole care and treatment pathway.
- Share any issues in respect of staff morale and job satisfaction and actions to improve and/or where more support is required.
- Highlight their most significant risks and Issues.

The information produced by the Business Units is used to inform:

- The annual plan
- Workforce plans for the organisation
- Education and Development plans
- Reports to the Workforce Redesign Network, Workforce and OD Committee and Trust Board.
- Reports and demand forecasting via the Local Education Training Board and Health Education England.

The Integrated Workforce Strategy and Workforce Plans are subject to the governance process shown in the table below. In addition as part of the annual business planning process workforce plans included in that process will be subject to Board approval. Where CIP plans include workforce changes quality impact assessments are completed as part of that programme.



As detailed above the Trust is focusing its workforce planning on transformation. The Strategy concentrates on workforce redesign and 'growing our own' and the development and use of the following:

- Apprentices – All posts band 2/3 both clinical and non-clinical should be considered as an apprentice in the first instance.
- Assistant Practitioner – When posts at bands 2, 3, 4 and 5 become vacant in clinical areas the skill mix should be reviewed to identify if an Assistant Practitioner post would be a more suitable replacement. This would support the "growing our own" philosophy and support recruitment difficulties.
- More Holistic Roles – There will be a growing requirement for posts that have a broader role to enable them to provide more holistic care. The potential for doing this should be considered within the regulatory framework. Examples already exist such as Health and Social Care Coordinators (HSCC's)
- Physicians Associates – Where difficult to recruit medical posts are identified the redesign of the workforce to include Physicians Associates should be considered. Training numbers have already been commissioned with higher education via the Deanery.
- Advanced Practitioners – Further use of Advanced Practitioners to potentially fill parts of roles for which Medical staff cannot be recruited should be considered.
- Consultant Nurses – As for Advanced Practitioners, Consultant Nurses should be considered as alternatives for Medical and high level skilled roles
- Hybrid Medical Posts – Developing medical posts can cover across acute, community and primary care.
- Surgical Care Practitioners – To support surgical clinicians should be considered where appropriate.
- Personal Care – Exploratory work with Devon County Council and Torbay Council and independent Personal Care Providers has identified a willingness to look at career pathway models that could support the development of Personal Care Workers to enable them to further their career in Health and Social Care. The intention would be to support the recruitment into the ICO and also into the Personal Care market.
- New Roles – In addition as care pathways develop new roles with skills and competencies that would provide a more responsive service will need to be developed.

Current developments include:

- The development of Local Multi Agency Teams working in community hubs and including well-being coordinators providing holistic support and advice in one place.
- The training and employment of Physicians Associates to provide appropriate alternatives to hard to fill medical posts and reductions in junior doctors training placements.
- Improving access to and widening the range of apprenticeship programmes. Including in front line roles as part of 'growing our own'. The Trust will be required to achieve 6% of staff undertaking apprenticeships including 3% apprentices by 2017. We currently have 8% of our staff undertaking apprenticeships of which 2% are apprentices.
- Further work to improve our nurse career pathway to make it genuinely possible to join the Trust in an apprentice role and follow the career pathway to become a Registered Nurse.
- Further use of Surgical Care Practitioners.

The above plans as described focus on the Trusts desire to provide a different model of care and to meet the presenting workforce challenges including reducing reliance on bank and particularly agency. Currently approximately 92.5% of the Trusts workforce is permanent staff and we cover the majority of the balance using bank but with a smaller but more expensive agency component. We are currently implementing a number of initiatives to reduce any agency to a minimum including:

- Recruitment initiatives including overseas, return to nursing, targeting newly qualified, corporate recruitment and as reported above alternative roles and growing our own.
- The implementation of a weekly payroll for bank staff to incentivise existing bank staff and those currently working for agencies to do more bank shifts or move across from agencies.
- A number of financial incentive schemes to incentivise bank working compared to working for an agency.

The Trust currently uses an e-rostering system and regularly reviews its nursing levels as part of the safer staffing process. Our planned Cost Improvement Programme (CIP) includes a further review of rostering practices to ensure effectiveness is being maximised.

Workforce metrics are regularly reported to the Workforce and OD Group and Board and are also triangulated with quality and safety metrics as part of the integrated performance report to the Board. In addition the same set of performance metrics are discussed with each Business Unit at regular performance management meetings.

The Trust is part of an Urgent and Emergency Care Vanguard in South Devon and it is anticipated that this will support the redesign of our workforce and improved productivity.

There is a risk register for workforce and OD risks which has been updated following the creating of the ICO. The risk register is regularly reviewed, updated and discussed at the Workforce and OD Group and where the risk has a score that means it is on the Corporate Risk register it is discussed at the Risk Group and reported to the Board.

4. Approach to Financial Planning

4.1 Overview

The Financial Plan for 2016/17 described in this document and its associated templates is built around the Transaction LTFM submitted to Monitor in support of the Foundation Trusts acquisition of Torbay and Southern Devon Health and Care NHS Trust, which took effect on 1st October 2015. The model has been updated to reflect changes identified since the transaction date' most significantly, at this stage to include acceptance of the Service Transformation Fund and its associated targets. Recovery trajectories for key performance targets remain subject to agreement with Commissioners and, as indicated earlier in this document, fully costed plans are yet to be developed. Further iterations of this plan will reflect the conclusion of this process.

The financial plan for the year, described in detail in the supporting template submission, is summarised below:

	£'m
Operating Income	391.75
Operating Expenses	(369.99)
EBITDA	21.76
Other Operating Income / (Expenses)	(14.34)
Non-Operating Income / (Expenses)	(7.42)
Surplus / (Deficit)	(0.00)

The Trust's target surplus, described in the STF is £1.6m, and reconciles to the planned surplus / (deficit) as follows:

	£'m
Planned Surplus / Deficit	0.00
Impairment	2.50
Donated Income	(0.90)
STF Target Surplus	1.60

4.2 Contract Income

The Transaction Agreement signed in support of the acquisition of Torbay and Southern Devon Health and Care NHS Trust, supported by the associated Risk Share Agreement (RSA) defines the majority of the Trust's clinical income. For parties to the RSA, income has been included on that basis:

- South Devon & Torbay CCG (CCG)
    - Baseline income of £220.8m , being acute services of £160.4m and community services of £60.4m
    - Annual growth of around 1.4% per annum
- Torbay Council
    - Baseline income of £38.7m.
    - Annual volume reduction of 3% per annum
    - Inflation uplift of 2%.

At this stage, these Commissioners are describing an £8m affordability gap in honouring their commitments under the RSA. The Trust continues to negotiate in this regard. Whilst remaining committed to continuation of the proposed contract arrangements for the ICO, the Trust has costed its capacity plan

using national tariff, confirming that the RSA values continue to offer Commissioners a discount of around £5m on a PbR based contract. This is central to negotiations and represents a clear 'fall back' position for the Trust that would underpin the income position included in this submission.

Other healthcare income, principally from Specialist Commissioners, NEW Devon and NCA's has all been priced at national tariff. Provision has also been made for negotiated 'tapering relief' in respect of the stepped costs incurred through Trust's capital investment in replacing Radiotherapy buildings and equipment. At this stage there has been no substantial engagement by Specialist Commissioners, despite contract proposals having been shared.

All other income has been rolled forward, uplifting for inflation and known and specific changes.

4.3 Revenue Expenditure

Service Delivery Units and Corporate Department managers have been budgets that reflect their run rate of expenditure in 2015/16 adjusted for known inflationary pressures, planned investments in and savings from the ICO Care Model and a requirement to deliver a further £12.7m of cost improvement in 2016/17.

In addition, the financial plan currently includes a reserve of £4.4m, being the balance of the Service Transformation Fund not required to achieve the required control total surplus from that set out in the Transaction LTFM, that will be targeted toward the improvement of core performance standards, principally the around urgent and emergency care.

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

Inflation	**£'m**	%
Pay Award/Pensions NI/Increments	£6.2	2.9
Non Pay general inflation	£1.8	1.4
Pass through growth/inflation	£3.6	18.7
Other drugs inflation	£1.0	8.6
CNST	£0.8	17.3

Employee inflation has been based on a 1% pay award (with underlying assumptions as nationally agreed last year) supplemented by an assessment of incremental drift, clinical excellence awards and the National Insurance and pensions changes:

Pay Inflation	**£m**	**%**
Pensions NI	3.7	1.7
Increments	1.1	0.5
1% pay award	1.2	0.6
Clinical Excellence Awards	0.2	0.1

The Trust is challenged by the nationally introduced agency caps particularly around access to the approved contracts at capped rates in the South West for both medics and nurses. The Trust has planned a budget of 1.2% of its staff cost to cover the supplementary cost of agency staff. To achieve this, the Trust has embarked on a further overseas recruitment drive, is reviewing rostering practices and planned investments in the service redesign under the care model. From a medical perspective, we are investing in additional Trust Fellows (doctors not in formal training) in addition to the Physician's Assistants we already have in training. The Trust is also hoping to receive some support from the National agency cap team to address the increased problems of access the national cap has caused in the South West.

Non-Pay inflation has been based on historic trends for drugs, separately looking at pass through and

hospital prescribed drug spend, and informed by a bottom up review of expected cost pressure and new drugs conducted within clinical services.

Capital charges have been based on the capital programme and assume appropriate Foundation Trust Financing Facility Loans will be available and used to fund the long term assets at current interest rates.

Corporation tax on Pharmacy Manufacturing Unit has been assumed to be nil in line with current taxation of Foundation Trusts.

Investments have been planned under the care model changes to align the delivery model to local populations, wrapping services around the person to create a single system of care delivery. The Trust has allocated £4.8m investment in this service delivery change in the annual plan in addition to the sustainability funding above to enable this change.

4.4 Efficiency and Savings

The 16/17 CIP programme builds on the strategies of the past and seeks to addresses the delivery challenges faced through a constructive, inclusive approach to deliver authenticated schemes. The proposed portfolio is based upon the Trust's 5 year plan that was previously submitted to Monitor in 2015 and was the product of Healthcare benchmarking provided by EY, trust-wide engagement and regional networking.

The recent Carter report findings have been cross referenced against that plan, updated for additional potential where identified, and will, alongside the strategy set out in Lord Carter's recently published final report, be used as a platform to drive efficiency through planned activities that will address the root causes of specific inefficient practices reported and tackle the homogenous opportunities observed.

The Trust recognises that successful delivery requires projects that are feasible, clear leadership, sufficient delivery resource and a robust governance framework to ensure visibility and accountability. These principles, together with a supporting action plan that revalidated each scheme have been endorsed by our Executive team. The key steps to date are set out below:

- Each potential scheme within the draft programme was allocated an executive lead to determine desirability and to appoint a project owner for detailed appraisal;
- Designated project owners provided specialist expertise to assess feasibility, scope and scale
- Projects consolidated into an outline programme that is submitted as part of the 1st draft submission.

A summary of the current programme, reflecting this review, is attached as Appendix 1 to this report.

The next phase, for completion by mid-March, sees outline planning for each project to establish key metrics such as timeline, resources, workforce implications and risks. These will be set out on a standard Project Inception Document for all schemes over £50k. A quality impact assessment will also be produced and signed off by the Medical Director and Chief Nurse to ensure any risks to patient care are resolved. All 'approved schemes' will be managed through a revised governance process that includes a community project management office and more robust reporting, assurance and escalation. Delivery will be maintained through collaboration between our operational teams, a newly established Transformation directorate and Finance business partners.

The Trust's 16/17 CIP programme comprises projects that span all areas of our recently integrated community and acute services. The anticipated benefits will be delivered in parallel with the synergies achieved through integration and a new care model that seeks to provide the right care in the right place at the right time for our patients.

Workforce savings will be achieved through a range of initiatives focussing on reducing the need for expensive temporary staff, improved rostering, revised skill-mix, management-restructuring and reduced absenteeism.

Income will be created through partnerships with our neighbours for example utilisation of capacity within our cardiac cath. lab and through exploiting volume based commissioning arrangements where possible. The trust will also continue to run profitable franchised services and further expand salary sacrifice schemes.

A number of procurement schemes, will continue to reduce the costs of our consumables and our cost-base will be further lowed through a range of Pharmacy initiatives to reduce drug spend.
Within Community services, we will continue to reduce costs through further utilisation of the independent sector and improved management/review of care packages through earlier intervention with our primary care provider. We will seek to support greater independence through supported living for our clients with learning disabilities, re-structure our packages of care and remove double handling. The service will also benefit from reduced costs in areas such as insurance as a result of integration.

4.5 Cash and Balance Sheet

A number of planning assumptions used in the Transaction LTFM have been further refined during the course of the preparation of this year's Annual Plan. These changes have impacted upon the forecast cash balance as at 31st March 2017. The Transaction LTFM indicated that the value of cash that would be held by the FT at 31st March 17 would total £26.4m. This draft of the Annual Plan is now forecasting a cash balance of £20.1m, a movement of £6.3m. The most significant components of this movement relate to the timing of loan drawdowns and therefore are not directly associated with the underlying performance of the Trust, and are summarised as follows:

	£'m
Timing / Phasing Issues:	
Earlier repayment of £21.0m working capaital loan	(2.10)
Movement in capital loan phasing	(2.80)
	(4.90)
Other Issues :	
Torbay & Southern Devon Health and Care NHS Trust performance pre-transaction date	(1.60)
Underlying ICO cost pressures reflected in revised Annual Plan submission for 2015/16	(2.50)
Net benefit from STF	1.10
Other working capital movement	1.60
Total	(6.30)

4.6 Capital Plans

The Trust has developed a five year capital plan to enable the Trust to continue to deliver safe patient care and meet the operational needs of the organisation. The program will be further refined over the forthcoming weeks and updates will be incorporated into the Trust's final Annual Plan.

The five year program relies upon some external sources of funding, namely Independent Trust Financing Facility (ITFF) loan funding. Some of this loan funding has already been secured and the Trust plans to draw down this residual approved funding in 2016/17 to support the completion of the new Critical Care Unit development and to complete the replacement of its Linear Accelerator needs. The sum of this approved residual funding totals £10.1m. In addition, the Trust will be applying for further loans totalling £17.6m

across the next three years to support the following developments: -

- Implementation of an Electronic Document Management System to support paperless Clinical processes
- Reconfiguration of the Emergency Department and Emergency inpatient assessment areas.
- Improvements required to inpatient wards including increased provision of single rooms.
- Refurbishment of existing operating theatres and investment in new Theatres to increase capacity.

The Trust uses a robust risk management process to identify and prioritise essential capital investment requirements. This risk management process has contributed to the financial success of the Trust in ensuring that assets are only replaced when the need arises and in ensuring that the Trust explores asset utilisation rates before new investment takes place.

The Trust with support from Commissioners is also continuing to develop Community Care Models. These care models are innovative and will enable a greater number of patients to be treated both at home in other community settings. To support this model a thorough review has been undertaken on the use of the recently acquired community facilities. The exercise has identified a number of facilities that are not being used to capacity. Where this is the case some rationalisation is likely and alternative investment taking place.

To support the Care Model significant IM&T strategy investment is taking place within the Trust. This investment will enable both acute and community healthcare workers to access reliable and up to date care data.

4.7 Sensitivities

A range of sensitivities have been modelled in the planning templates supporting this document, most significantly the withdrawal of the STF should performance recovery trajectories not be achieved and a failure to deliver the CIP programme.

The Trust's Risk Share Agreement with Commissioners represents the principal source of mitigation, whereby any downside from the financial result set out in the Transaction LTFM is shared 50 / 50 with principal Commissioners; South Devon and Torbay Clinical Commissioning Group and Torbay Council.

4.8 Continuity of Service Risk Rating

The planning assumptions set out in this section will deliver a Financial Sustainability Risk rating of 3 for 2016/17 this is consistent with the Acquisition LTFM. The quarterly delivery profiles are draft at present given the stage of the business planning cycle and the acquisition completing later than planned with the consequential slippage in delivery that would be expected in this plan.

5. Link to the Emerging 'Sustainability and Transformation Plan' (STP)

5.1 System Place-Based Context

Partners from across the South Devon and Torbay health and care economy have been collaborating and engaging with the local community on how best to meet the triple aim as set out in the Five Year Forward View and achieve lasting change in the health and wellbeing of all the people who live in South Devon and Torbay.

As a result we have developed a clear shared vision and sense of purpose; agreed priorities for improvement including a focus on health and well-being and implementing new care models; and developed an ambitious local transformation plan for accelerating implementation of the Forward View, based on a place-based approach.

Leaders from all the local NHS and council organisations involved in health and care (the CCG, Torbay and South Devon NHS Foundation Trust, Devon Partnership NHS Trust, Torbay Council, Devon County Council, Rowcroft Hospice and Torbay Community Development Trust) – have been working together – originally through the JoinedUp Board and now through the new SRG - to a common set of priorities and taking joint decisions in line with our shared vision. They are working with the voluntary sector and local community groups in an entirely new way, to improve the quality of life of local people. The overall aim is to join up the health and care system so that patients and people using services don't have to struggle to get what they need. They will be able to tell their story once, and get coordinated care that really meets their individual needs, and which they will be in control of.

In developing our STP we will build on the JoinedUp approach and our integration track record (well established integrated social and community care provision and first wave integration Pioneer) and maximise the potential to accelerate improvement from our latest new models of care developments (Urgent Care Vanguard and first Integrated Care Organisation).

Our shared vision is *'...a community where we are all supported and empowered to be as well and as independent as possible, able to manage our own health and wellbeing, in our own homes. When we need care, we have choice about how our needs are met, only having to tell our story once...'.* Our agreed strategy has at its core a set of shared principles derived from extensive community engagement that all partners have committed to.

Together, we want to ensure full development of our locality based model of care which sees GPs, community health and social care teams and the voluntary sector working together to provide for the vast majority of people's health and wellbeing needs. It is founded on joined-up care across the whole community. We want to be able to provide care as close to home as possible, supporting people to remain independent and in their own homes, reducing reliance on bed-based services, with local communities actively helping to support the wellbeing needs of the local population. This is what patients have told us they want.

As part of this work we are developing an holistic approach to long term condition management with both specialist outreach services and via local multi agency teams with milestones on track to be delivered from April 2016. This work will be underpinned by safe, effective and efficient acute services, a sustainable workforce, IT interoperability and a truly Single Point of Access. The single point of contact model is agreed and the implementation plan in place. Engagement with the community sector will be led by Trust via new engagement mechanism of 2 umbrella organisations and funded posts - HWB Coordinators- to drive community capacity to care.

The plans also include transformation of the acute medical model application to better meet current and future need, linking to Community Hospital reconfiguration, consultation pending, and bed remodelling as part of our ED recovery plan and in response to metrics indication of an under-provision of c30 acute beds,

and in line with the local Vanguard plan for 2 urgent care centres this year.

To support our shared transformation plans and remove barriers to change, partners have signed up to a risk share agreement.

5.2 STP planning Footprint

Agreement was reached with all partners that the preferred STP planning footprint for the majority of services should cover the population of Torbay and South Devon, reflecting population flow and our shared focus on integration of local health and social care provision. Partners recognised that for very specialist services, a larger wider Devon population footprint was appropriate and confirmed that the CCG and providers within Torbay and South Devon would collaborate to ensure effective configuration of very specialist services for the wider population.

The CCG was asked to resubmit its footprint submission in favour of a Wider Devon Transformation Partnership (working title) planning footprint coterminous with the entire boundaries of NEW Devon CCG and South Devon and Torbay CCG, incorporating the whole of the County of Devon, Plymouth City and Torbay local authorities with overall responsibility for a population of circa 1.17 million people. The Partnership's focus will be addressing the national challenges set out in the planning guidance including how to address the gaps around health and wellbeing, care and quality, finance and efficiency and delivering the Government's mandate.

Whilst acknowledging the wider STP planning footprint will add value in some specialised services, both CCGs have stressed the need to maintain a local delivery focus at locality level. The umbrella governance arrangements across this wider STP planning footprint will build on existing extensive joint planning arrangements, and complement existing governance structures.

There are a number of wider planning considerations that need to be taken into account outside of this footprint such as other cross boundary flows eg with Cornwall; specialised service links into the rest of the south west; trauma networks and other legitimate networking arrangements between providers outside of this footprint.

5.3 The ICO's Role in Delivering the STP

Being amongst the first organisations nationally to achieve structural integration via the ICO model gives us an excellent basis from which to deliver the aspirations of the Five Year Forward View in a local context.

Becoming an ICO is an exciting milestone as, for the first time, one single organisation is now responsible for acute and community healthcare along with adult social care services. Our purpose is completely aligned to the system wide aspirations and our operational plans reflect our commitment to the local health and care system's shared vision. Our contribution is to provide high-quality, safe health and social care at the right time and in the right place to support the people of Torbay and South Devon to live their lives to the full.

We want to work in partnership with people and communities – putting them in the driving seat of their own health and care needs. We want services to be easily accessible and work in a way that means people only need to tell their story once. Most importantly, our vision for the future is that care is provided in or as close to a person's home as possible.

We acknowledge we have to transform the way we provide services and we will take the opportunity afforded by the ICO to build on our track record of focussing on the needs of individuals. We use the stories of 'Mrs Smith' and her family to remind ourselves that we have to ask what matters to people, not just what is the matter with them. However complex people's needs are, we see them as individuals with a life that sits outside their experience as a patient or service user.

Our aim is to support everyone in living well and ageing well. We will place greater emphasis on promoting healthy lifestyles, preventing ill-health and enabling self-care. When people do need care, our staff will provide it with compassion because of their dedication, commitment, shared culture and values. Different roles and career pathways will evolve to meet the changing needs of our population, offering our staff new opportunities to grow and develop.

We will invest in technology and shared information to make sure that people need only contact one organisation and tell their story once, whatever their health and care needs. We will assess their situation and arrange the right level of support as close to home as possible, whether it's co-ordinating volunteer hospital drivers, arranging community nurse visits, signposting health information advice, or booking a hip replacement followed by rehabilitation; We will act as a one-stop shop.

We believe that the creation of our integrated care organisation will not only improve local health and social care services through the at scale delivery of our new care model - it will also ensure sustainable services for the future. As an integrated care organisation, we will make best use of our limited resources, confident that we are efficient as well as effective.

The ICO will continue to be engaged in both the local and wider strategic planning discussions and processes to fulfil our aspirations of a better future for local people. We will be opportunistic, taking full advantage of developments that enable us to accelerate our plans. For this reason, as part of the 2016/17 planning response we have submitted an expression of interest in trialling the reinvention of the acute medical model in small district general hospitals, which has the full support of the CCG.

6. Membership and Elections

Governor elections predominantly take place in the autumn each year as the results are welcomed by Governors at their Council of Governors meeting in December. Following the integration with Torbay and Southern Devon Health and Care NHS Trust on 1 October 2015, the Company Secretary delayed the start of the routine elections in order to concentrate on filling two new community staff seats. Four candidates put themselves forward and the results were announced on 5 January 2016. A turnout of 13 per cent was recorded. When public elections are contested, the turnout rates are in excess of 30 per cent suggesting that the public membership is well engaged in appointing new public governors.

Having been a Foundation Trust since 1 March 2007, a number of public Governors are coming to the end of their nine years in office. Combined with Governors stepping down after three years, the Trust has 11 seats to fill from 1 March 2016. As at 31 January 2016, all four Teignbridge seats have been filled uncontested, one of the two South Hams and Plymouth Constituency seats has been taken up and the Torbay Constituency seats are being contested with the results due on 8 February 2016. Unfortunately, no members of staff have put themselves forward for the two non-clinical staff seats. A new election process will commence in February to try and fill these vacant seats.

New Governors are offered the opportunity of attending the external GovernWell induction course as well as the Trust's corporate induction. Due to the number of seats being filled in 2016, the Trust has invited the London-based GovernWell course to Devon and will be offering this course to all Governors. During 2015, the majority of development sessions offered to Governors were in relation to the forthcoming integration and ensuring governors had the necessary information to make an informed decision on the significant transaction that this represented. Alongside this, Governors have been offered training in performance management, patient safety, finance and public relations.

Informally, Governors continue to engage with the Trust's membership several times throughout the year, using a variety of means such as Medicine for Members events, its newsletter, accompanying local Councils at events and setting up local stalls. The formal process involves an annual survey being distributed along with our annual review document to all public members in September, which in previous years has generated a response rate in excess of 30 per cent. The survey is developed by the Mutual Development Group which is a sub-group to the Council of Governors and is chaired by one of our Governors. Surveys results are analysed according to area which enables public Governors to review responses from their respective constituencies. One Governor from each of the three public constituencies is nominated to provide a combined response to the Board-to-Council meeting in March each year. The feedback from Governors to the Board of Directors is received informally and then presented more formally as an agreed improvement plan at the next Council of Governors meeting in April. The 2015/16 improvement plan was reviewed at the Council of Governors meeting in December 2015.

Working in partnership with the Clinical Commissioning Group (CCG), the Trust has developed the Joint Equalities Cooperative to continually engage with the diverse groups of our local community. The Governor-led Mutual Development Group is keen to engage again with Black and Minority Ethnic (BME) groups as well as other under-represented demographic groups within our constituency areas. The challenge to find new members remains and although the Trust has considered targeted campaigns in the past it is likely to revisit patients, service users and clients rather than trying to recruit from the general population at significant cost.

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Self Certification

		2016-17
1	**Continuity of services condition 7 - Availability of Resources**	
	EITHER:	
	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed
	OR	
	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	N/A
	OR	
	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	N/A
2	**Declaration of interim and/or planned term support requirements**	
	The trust forecasts a requirement for Department of Health (DH) interim support or planned term support for the year ending 31 March 2017 Note: If interim support is forecast in the plan period, but was not required in the preceding year, the trust should contact its relationship team by 31 January 2016, and before including any amounts in their plan (unless the DH has already approved the interim support funding). Further information regarding the requirements for trusts forecasting a need for DH funding support can be found in the template guidance.	DH Support Not Required
3	**Statement of main factors taken into account in making the above declaration**	
	In making the above declaration, the main factors which have been taken into account, as stated in section 1b above, by the Board of Directors are as follows:	In making the above declaration, the Directors considered the 2015/16 year end Cash balance derived from ITFF £21m ICO support loan and the Working Capital Facility of £11m .
4	**Declaration of review of submitted data**	
	The board is satisfied that adequate governance measures are in place to ensure the accurat of data entered in this planning template. We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.	Confirmed
5	**Control Total and Sustainability & Transformation Fund Allocation**	
	The Board has submitted a final operational plan for 2016/17 that meets or exceeds the required financial control total for 2016/17 and the Board agrees to the conditions associated with the Sustainability and Transformation fund	Confirmed - control total accepted: S&T fund allocation incorporated in the plan

In signing to the right, the board is confirming that:

To the best of its knowledge, using its own processes and having assessed against Monitor's Risk Assessment Framework, the financial projections and other supporting material included in the completed Annual Plan Review Financial Template represent a true and fair view, are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible.

Approved by:

Signature	
Name	Mairead McAlinden
Capacity	Chief Executive
Date	
Signature	
Name	Richard Ibbotson
Capacity	Chairman
Date	

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Self Certification

2015-16

1 Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards — Confirmed

2 Continuity of services condition 7 - Availability of Resources

EITHER:

2i After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Confirmed

OR

2ii After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 4, below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — N/A

OR

2iii In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — N/A

3 Declaration of interim and/or planned term support requirements

The trust forecasts a requirement for Department of Health (DH) interim support or planned term support for the year ending 31 March 2016 — DH Support Not Required

Note: If interim support is forecast in the plan period, but was not required in the preceding year, the trust should contact its relationship team by 31 January 2015, and before including any amounts in their plan (unless the DH has already approved the interim support funding). Further information regarding the requirements for trusts forecasting a need for DH funding support can be found in the planning guidance and template guidance.

4 Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account, as stated in section 2b above, by the Board of Directors are as follows:

Re: declaration of sustainability: The Trust acquired Torbay and Southern Devon Health and Care NHS Trust under Monitor's transactions process on 1 October 2015. Monitor has been kept informed that in 2015/16 the financial sustainability risk rating (FSRR) is expected to fall to a two, for one year before the financial efficiencies borne from system redesign are realised. As part of Transaction Agreement, the Trust secured sufficient liquidity to underpin change and performance on this period. From 2016/17 forward, a FSRR of three is expected to be maintained.

In the shorter term, and reflecting this medium term plan, the Board has considered its requirement to maintain safety and quality whilst trying to mitigate the financial pressures. The

In signing below, the board is confirming that:

To the best of its knowledge, using its own processes and having assessed against Monitor's Risk Assessment Framework, the financial projections and other supporting material included in

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	please see separate sign off sheet		**Signature**	please see separate sign off sheet
Name	Mairead McAlinden		**Name**	Richard Ibbotson
Capacity	Chief Executive		**Capacity**	Chairman
Date	16/12/2015		**Date**	16/12/2015

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6th April 2016
Title:	Decision paper: Delivery model for community health and social care services for the Brixham community incorporating the re-provision of services currently provided at St Kilda's care home.
Lead Director:	Liz Davenport, Chief Operating Officer
Corporate Objective:	Safe, Quality Care and Best Experience
Purpose:	For the Board to: • **consider** proposals for a new model of care for the Brixham community including the re-provision of services that local people currently access from St Kilda's Care Home • **approve** the proposal to recommend to the Director of Adult Social Care at Torbay Council that the Trust does not proceed with a stand-alone new-build replacement for St Kilda's, but instead re-provides these services within the existing footprint of Brixham Community Hospital and the local care sector as part of a broader reconfiguration within the Brixham and Paignton communities

Summary of Key Issues for Trust Board

Strategic Context:

The Trust is commissioned by Torbay Council as part of the formal Partnership Agreement to deliver care services from St Kilda's Care Home which it sub-contracts to Sandwell Community Caring Trust.

St Kilda's 24-bedded care home is currently delivering residential, care and day services for the population of Brixham and surrounding area. The beds are a mix of intermediate care, 'step-down', respite and residential care. Services are highly valued, but the building is unfit for purpose in the longer-term and a project to replace it has been ongoing for a number of years, involving numerous stakeholders.

The Board has been previously briefed on the rationale for 'pausing' the legacy Care Trust proposal to re-provide services provided at St Kilda's Care Home, through a substantial investment in the redevelopment on the Brixham Community Hospital site. The decision to pause was based on the requirement to assess future needs and consider how a new model of care might be delivered to more appropriately meet these needs, driven by changes to the original assumptions.

This paper recommends that the Trust does not proceed with a stand-alone new-build replacement for St Kilda's, but instead re-provides these services within the existing footprint of Brixham Community Hospital and the local care sector as part of a broader reconfiguration within the Brixham and Paignton communities.

This new model of care is part of our overall strategy to provide more services in people's local communities, in partnership with GPs, other public sector organisations, voluntary agencies and the private sector. By better supporting people to live well at home and in their communities, we will need fewer hospital beds.

If the Board accepts that the new care model requires a different solution to that previously proposed and no longer requires a new build St Kilda, a decision is also needed in relation to the current contract for services from St Kilda's.

The nature of this proposal makes it a "Key Decision" for Torbay Council under the existing formal Partnership Agreement. Following Trust Board consideration and decision the Trust is required to present a formal recommendation to the Director of Adult Social Care Services of Torbay Council for a final decision on the proposed model of care, configuration of services and therefore future of the contract with SCCT for the provision of services from St Kilda's. The final decision rests with the Director of Adult Social Care. A final report will be produced following the consultation to inform the decision making process. It is anticipated that the report will go before the Council and a decision made in May 2016.

Key Issues/Risks

The current building is no longer fit for purpose and the contract for services is not sustainable going forward. The closure will be phased and carefully planned and is likely to take between two and nine months.

We will work with users, residents and their families on finding suitable alternative services and homes that meet their individual needs.

The staff at St Kilda's will not be at risk of redundancy, we will be meeting with them on 1 April to assure them on this and extending the same undertaking given to Trust staff facing change. We will support them to secure alternative employment in the Trust so their valuable skills and experience will not be lost to the local health and social care sector.

Recommendations:

The Trust Board is asked to **approve** the following recommendations:

- that the previously proposed new build St Kilda on the Brixham Community Hospital site does not proceed and instead the Board accepts the revised proposal as presented as the preferred solution;
- that the team undertakes more formal engagement with current service users and with stakeholders in Brixham (League of Friends, Brixham Does Care and the Town Council) with respect to these proposals;
- that the ICO work's in partnership with SCCT to find alternative services for its clients and employment for SCCT staff within the local NHS - the ICO and SCCT will develop a detailed operational plan and agree the sequence of changes required; and
- the output of the engagement will be detailed into a report and a recommendation made to the Director of Adult Social Care at Torbay Council at the earliest opportunity for a final decision (likely early May 2016).

Summary of ED Challenge/Discussion:

Directors have sought assurance that due process has been followed

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

While the re-provision of the services provided from St Kilda's does not require formal public consultation, given the long period of development for the abortive new build scheme and the long standing community involvement in developing the project, it is important we appropriately engage with all the stakeholders with respect to the new proposals.

Although different from the original plan, it is anticipated that this alternative model can be supported by these stakeholders and the Trust will engage with them to explain the model and to provide assurance.

The attached report (page 8, section 7) sets out the proposed engagement activities. The current service users, particularly the four permanent residents of St Kilda's, will be engaged in the development of these plans as they directly affect them, with the alternatives for their future care, fully and sensitively discussed with them and their families.

Staff affected are being briefed on 1 April and will also be supported through the transition process.

Equality and Diversity Implications:

This proposed service change will impact upon people currently using the services at St Kilda's. The relevant impact assessments have been completed and taken into account in preparing the recommendations.

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	6th April 2016
Report From:	Chief Operating Officer
Report Title:	Decision paper: Delivery model for community health and social care services for the Brixham community incorporating the re-provision of services currently provided at St Kilda's care home.

1. Summary

The Board has been previously briefed on the rationale for 'pausing' the legacy Care Trust proposal to re-provide services provided at St Kilda's care home, through a substantial investment in the redevelopment on the Brixham Community Hospital site. The decision to pause this proposal was based on the requirement to assess future needs and consider how a new model of care might be delivered to more appropriately meet these needs, driven by changes to the original assumptions as summarised on page 4 of this paper.

This paper sets out recommendations on how a proposed new model of care for the Brixham community will re-provide the services that local people currently access from St Kilda's care home. The paper will therefore begin by setting out why a new model of care is needed to serve the future needs of local people and describe what this may look like.

In consideration of the new model of care this paper will also explore the set of factors that underpin a recommendation that the services currently provided by St Kilda's care home can be equally well accommodated via an alternative option, rather than through the previously planned new build St Kilda proposal. If the Board decides that the new care model requires a different solution to that previously proposed and no longer requires a new build St Kilda, a decision is also needed in relation to the current contract for services from St Kilda's.

From previous and current assessment it is confirmed and evidenced that the current building is no longer fit for purpose and that the contract for services is not sustainable going forward. As a consequence the Trust would like to work in partnership with Sandwell Community Caring Trust (SCCT) who provides the services at St Kilda's on behalf of the trust, to find suitable alternative services for our current clients and secure alternative employment for SCCT staff within the local NHS. SCCT and the Trust will work together to develop a detailed operational plan to transition services to the new care model and agree the sequence of changes required. We are requesting Board approval to engage with affected clients and local stakeholders to hear their voice in the re-provision proposal for the services currently provided at St Kilda's care home.

The Trust is commissioned by Torbay Council to deliver the services which it sub-contracts to SCCT/St Kilda's. The nature of this proposal makes it a "Key Decision" for Torbay Council under the existing formal partnership agreement. Following Trust Board consideration and decision the Trust is required to present a formal recommendation on the model of care, configuration of services and therefore future of the contract with SCCT for the provision of services from St Kilda's to the Director of Adult Social Care Services (DASS) of Torbay Council for a final decision.

2. Background

2.1 Context - A New Model of Care

The inception of the Integrated Care Organisation in October 2015 provided the platform to deliver a new innovative model of care to deliver high quality services to local people that are designed to more appropriately meet the current and future needs of the local population and are financially sustainable.

The new model of care is based on supporting people to improve their health and wellbeing and 'live their life to the full' through the resources they have or can access in their local community. The model is centered on health promotion, 'recovery' and re-ablement to maximum independence after a period of dependence on health and social care services. People with more complex needs will be supported to become 'experts by experience' through increased investment into local community-based services, reducing the need for hospital-based care and avoiding where possible the deterioration and crisis which often results in long periods of inpatient or professional care.

This new model will be delivered by health and social care staff working as a joined up team in each locality (in this case the locality of Brixham and Paignton), working in partnership with the local voluntary sector, housing, mental health services and others to meet the needs of local populations in a more integrated and effective way, and with an ethos of empowerment, responsibility, choice and independence. The new care model is very different from the way services have been provided in the past and importantly means that additional investment will be made into community based services – statutory, 3rd sector and independent - to help support people where they choose to live. People tell us that the 'best bed is their own bed' and so the plan is to invest in a range of people and services to provide enhanced community support and care delivered as locally as possible. The aim will be to only admit someone to a hospital bed if needed and as a last resort.

2.2 St Kilda's Care Home

St Kilda's Care Home is currently delivering residential, care and day services for the population of Brixham and surrounding area from 24 beds:

- 10 intermediate care beds;
- 10 step down , consisting of 7 step down beds and 3 respite beds; and
- 4 residential care beds.

A recent analysis of people occupying the intermediate care beds at St Kilda shows a spilt of 39% from Paignton, 34% Torquay and 27% Brixham.

The facility is owned and maintained by Torbay Council. Service delivery has been subcontracted by the Trust to Sandwell Community Caring Trust (SCCT) since 2008 and based on the availability of 29 beds, paid for on a block contract with an annual value of £896,000 for bed-based care, £117,000 for Day Care, and £47,000 for community meals. The service contract is in place until 2018, but has within it a break clause that can be activated to give nine month's notice.

The current building is in very poor condition and has significant maintenance issues, such that it is unfit for purpose beyond 2016.

St Kilda's has four permanent residents. There is considerable interest from other stakeholders including residents, Brixham Town Council and the Brixham Hospital League of Friends to ensure that the needs of the local elderly population are met through local social

and health care services located in Brixham. The community and staff at St Kilda would also appreciate a clear message about the future of St Kilda given colleagues have been managing the services for some years against a background of some uncertainty.

2.3 Brixham Community Hospital

Brixham Community Hospital, owned and run by the Trust, provides 20 inpatient beds (only 10 are currently in operation due to limitations of local GPs to provide medical cover beyond that number) and a range of outpatient and community health services. It also has a minor injuries unit.

St Luke's GP practice is located in the centre of Brixham, accommodation is poor, and the GPs have been looking for some time for a viable solution to relocate their premises to the Brixham Community Hospital site. St Luke's has recently merged with Greenswood Road GP practice, which is situated close to Brixham Community Hospital and has similar, if not more pressing, accommodation concerns that are driving the search for more suitable and better quality premises. Both practices together serve a population of 11,000. The total population of Brixham Town is c18,000. The two practices will be key partners in the development of any health-care arrangements at the Brixham Community Hospital site.

The Brixham Health and Social Care team are housed on the Brixham Community Hospital site - their co-location is fundamental to the delivery of 'joined up' care. The team are accommodated in a Portakabin on site, which the Trust purchased two years ago. Following an assessment it has been established that while this temporary accommodation would be suitable in the medium term, this is not an appropriate long-term solution.

3 Evolution of the St Kilda's development and previous plans

2012:
Previously Torbay and Southern Devon Health and Care Trust (TSDHCT) had been seeking to replace the aged St Kilda's care home and were working on the development of a solution for a number of years. The proposal in 2012 was to provide a new build, 36 social care bedded St Kilda's as a like for like, stand-alone development on land on the Brixham Community Hospital site. The new development was envisaged to be afforded in entirety from the existing adult social care revenue budget with the business case predicated on the funding model being a block contract.

2013:
In late 2013 it became apparent that two key changes impacted on the development and the proposed model. The demand for the care in St Kilda's had reduced; particularly the need for residential care. Taken together with the 20% reduction in social care funding, and a direction that all contracts will change from a block to spot purchase over time, this had a significant impact on income assumptions. At this stage, it was also identified that a like for like replacement of St Kilda's did not fit with the future integrated model of care aspired to by the community and commissioners i.e. reduced bed based care and increased investment in community services to care for people at home. These changes adversely impacted on both the service and business model rendering a stand-alone new build unviable.

2014:
In early 2014 a new option was developed and endorsed by the TSDHCT Board. The solution described a c£7m stand-alone, new build, integrated care facility to include inpatient beds from St Kilda's and from Brixham Community Hospital, on land on the Brixham

Community Hospital site. This envisaged the development being part of an integrated "hub" that included Brixham Community Hospital. The new development planned to re-locate 18 community acute beds from the Brixham Community Hospital inpatient unit into the new build, alongside 18 social care beds (36 single rooms) together with a day unit. A new staffing model was developed that saw the social care beds cared for by social care staff and enhanced numbers of professions allied to medicine, with nursing oversight from the staff caring for the 18 acute community beds. The unit was envisaged with dual registration as a social and health facility. The integrated development released some internal space within the existing Hospital that was earmarked for possible occupancy by the local St Luke's GP surgery and an onsite pharmacy. Plans were submitted and permission granted in February 2014 for this development and the outline business case approved by the TSDHCT Board in July 2014.

2015:
Detailed planning was undertaken up to Full Business Case (FBC) stage, which was ready for submission in June 2015. A number of external factors became apparent at this point which affected the viability and affordability of the scheme and the ability to approve the FBC and the final development. These elements were:

- a further reduction in the demand for bed based social and community acute care;
- a change signalled in the commissioning intentions of the CCG around community hospital care;
- further adult social care savings requirements;
- more detail and enhancement of the community integrated care model being developed to be delivered by the new Integrated Care Organisation (ICO);
- insufficient available capital or space to re-locate the newly merged GP services into the existing inpatient area as planned;
- financial challenge and reduced healthcare financial envelope; and
- the capital cost of the development had increased to c£8m.

At a multi stakeholder meeting held in August 2015 it was agreed to take and communicate a six month "pause" to the progression of the St Kilda's scheme to enable the impact of these changes to be considered alongside the affordability and fit of the proposed care model. This decision was disseminated via a joint communication to key community stakeholders including the staff and residents of St Kilda's, Brixham League of Friends, Brixham Town Council and MPs. We appreciate community stakeholder's patience during this period; we believe it was the right decision to pause and make a considered decision because of the significant long-term implications.

Following further work on the needs analysis, progression of the detail of the ICO integrated care model, clarification of commissioner intentions, review of affordability and full analysis of the business model, the multi stakeholder group i.e. senior representatives of the CCG, TSDFT and Torbay Council determined in November 2015 that an alternative option should be developed in the short-term specifically for the services provided within St Kilda's and with reference to future hospital inpatient bed requirements. This decision was made on the grounds that:

- the original proposal was no longer consistent with the whole system integrated model for the delivery of "hub" and "spoke" care across the ICO footprint and within the Paignton and Brixham locality as envisaged by the CCG;
- the original proposal did not fit with the community integrated model, care closer to home and commissioned number of community beds (i.e. it had too many hospital beds);
- the day services model although vital, did not fit with future aspirations of vibrant day services including socialisation fully integrated with the voluntary sector; and

- income streams were significantly reduced from the previous assumptions which rendered the revenue and significant capital cost unaffordable.

Since November 2015 work has been undertaken on developing a model of health and social care to provide an effective re-provision of services delivered at St Kilda's, that is consistent with the need and integrated locality model of care being developed by the CCG and ICO, is affordable and most importantly can be supported by our stakeholders in Brixham.

From our needs analysis work, it is clear that the current model of intermediate care is increasingly challenged in meeting the complex needs of the increasingly aged population and that there is a requirement for a different form of care to that currently delivered in some areas where the challenges are particularly great, including in Brixham. We believe elderly people with this increasing complexity requiring intermediate care would have their needs more safely met by having rapid access to nursing assessment when needed. This would require intermediate care capacity to have the presence of some nursing oversight to be able to meet the progressively complex needs of this cohort of patients.

The revised locality needs assessment determines that the current level of medically supervised hospital beds in Brixham is sufficient to meet current and future demand, as is borne out by the fact that 10 beds have been closed at Brixham Community Hospital over the last six months with minimal impact.

4 Change in the model of care

4.1 Social care

The new model identifies the need to provide services in the client's home or as close to home as possible and at the heart of the community. It is proposed that the step-down and respite care beds and residential beds currently in St Kilda's are re-provided within the local community in other private care homes with capacity. This model supports the care market and utilises private sector assets in delivering these services locally via purchasing contracts as part of the way forward. This is a move away from a centralised model to a person centred model with people cared for within their community.

4.2 Care requiring nursing oversight

Small bed numbers and the need for nursing oversight necessitates consideration of the co-location of acute community and intermediate care beds where possible and where needed, and is the model approved and stakeholder endorsed in the St Kilda's business case. As the demand for acute community beds has reduced, capacity has become available to accommodate the ten intermediate care beds from St Kilda's requiring nursing oversight adjacent to the community hospital beds within the existing inpatient area at Brixham Community Hospital, eliminating the need for a new build to house beds. Investment will be required to provide a suitable single room setting for intermediate care and active assessment and rehabilitation.

4.3 Day Services Model

The day centre at St Kilda's currently provides a regular service to 11 members of the population of Brixham five days per week with the capacity to increase to 20 places. It is an extremely well regarded service for the local population that is seen as vital for the community and an essential service provision. The aspiration is that the day centre will form a critical component of a health and well-being hub centred on the Brixham Community

Hospital site that also provides a base for socialisation opportunities for older people experiencing isolation thus reducing their need for other care services, and which can also support people with more complex needs including essential personal care. Client and carer day support for people with dementia will be provided through tailored activities such as a dementia café. This will help prevent the increasing demand for services driven by isolation and loneliness of older people. While the local voluntary sector, primarily Brixham Does Care, provides a stirling service in this regard, they too have identified an unmet need which such a base could provide a solution to, and have indicated an interest in being involved as a partner to deliver this service. This facility will also provide a location to undertake needs assessments in a more 'normal' environment to evaluate activities of daily living, etc. In summary, the future service model described for day caring is intended to be delivered through partnership with the local voluntary sector, supported by skilled not qualified staff as needed for the complexity of need and with clinical oversight from the nursing leadership within the bed based services in Brixham Community Hospital.

Space can be created within the existing buildings on the Brixham site which, with the investment of c£200,000, could be re-configured as a vibrant day caring and assessment centre at the heart of the Brixham hub. This extended service would be challenging to deliver in St Kilda due to the constraints of the facility. The existing partnership with the voluntary sector is vital to the successful delivery of this service model and both Torbay Council and the ICO would support these services being delivered primarily by the third sector on the healthcare owned site. We would wish to build upon these arrangements and anticipate voluntary sector involvement as Brixham has a strong voluntary sector. This sector has already expressed an interest in being involved in the development of the service model, supporting a co-design with the wider community and in being a potential delivery partner. Upon formal agreement of the model, the plan will be developed and the re-configuration costs and delivery model determined.

This proposal was discussed recently at an engagement event run by Brixham Hospital League of Friends; provisionally this proposal may have good community support, but of course requires further development and discussions with the community.

4.4 Community Meals

About 30 to 40 meals per day are made in the kitchen at St Kilda's and distributed by volunteers. This number, and potentially more if the need presents, could continue to be provided in partnership from the kitchen at Brixham Community Hospital and delivered by volunteers perhaps co-ordinated by Brixham Does Care. This would mean the service would benefit from the oversight of Trust trained catering staff and the security of Trust policies procedures and standards to supplement the excellent work from existing volunteers. The meals are funded through an existing chargeable rate to the clients receiving them, so there is no financial impact on the Trust.

5 Model for Brixham and Future of St Kilda's

In summary the proposal is that 10 enhanced intermediate care beds be provided within Brixham Community Hospital and co-located beside the 10 acute community beds on the Brixham Community Hospital site, with long-stay residential and step-down/respite capacity purchased in the independent sector. This will meet the aspirations, objectives and elements of the previously agreed St Kilda's business case, and bring the service model in line with current need and to provide a practical solution that can be more quickly delivered given the current risks of the St Kilda's building. This proposal includes the creation of a health and well-being centre on the Brixham Community Hospital site, providing a flexible and

integrated response to the needs of older people for community hospital, enhanced intermediate care and day support. This can be achieved by re-configuring existing vacant and other new space within the existing building, which is available as a result of reduced demand, in an affordable and quickly delivered model. The move of the local health and social care team to a fully integrated office accommodation between Brixham and Paignton in turn frees up space for an amenities hub, voluntary sector base and central café.

The land earmarked for the previous development could be prioritised for a GP centre if funding was avaiable through NHS England thereby delivering the full integration aspirations. If this could not be delivered by the partners (CCG, GPs and Trust) the land could be identified for the development of supported or social housing for people who would benefit from proximity to the health and wellbeing hub in line with the Council's Health and Wellbeing plan and Housing Strategy. Likewise, the vacated St Kilda's site could be considered by the Council as a potential site to meet local housing need.

This new model delivers the investment objectives detailed in the original St Kilda's business case, arguably better than the previous model in terms of integrated care. Looking back at the new build business case for St Kilda, the proposed way forward is a solution that meets those original investment objectives in that it:

- replaces the social care provision and health intermediate care delivered in the current St Kilda complex;
- is compatible with the new model of care and its approach to integrated care.
- both delivers savings from the Adult Social Care and NHS revenue budgets (from integration) as well as increases investment in the community to support care at home (from shift in bed based care);
- improves the patient experience and environment and delivers joined up care; and
- creates a vibrant health and social care hub for Brixham at the heart of the local community.

6 Affordability and availability of funding

The Trust had planned to secure a loan of £6m capital to fund the St Kilda new build proposal. The new proposal and model of care will still require capital for the reconfiguration of space in the existing hospital for intermediate and day services. Following Board and stakeholder agreement this will be confirmed in a final business case for approval but costs are likley to be in the region of c£600,000 to £800,000 for the day, social and health services elements which is clearly considerably less than the previous new build scheme.

It is anticipated that, if agreed, termination of the St Kilda revenue contract and the recommissioning of services in the independent sector would deliver an annual net saving in the region of £218,000. However it should be noted that recently Torbay Council agreed a fee increase for the independent sector price per case placements. Potentially this could reduce the net saving however SCCT are holders of a block contract with the ICO in which there is a pricing mechanism independent of the main care homes market and upon which TSDFT decides. The wider care home market fees are met from the agreed Adult Social Care budget, whilst the Council have undertaken to meet any backdated payments that may result from the current Judicial Review. In meeting the pricing and capacity pressures in the market - for example in relation to the new accommodation for the residents in recently opened, up-to-date facilities - this may return the position to a similiar net saving. However it is clear this figure will require a defintive adjustment in due course.

The Brixham League of Friends offered significant funds to support the previous scheme and will be an important stakeholder in taking forward the proposed new projects and developments at the Brixham hospital site if these proposals are agreed by the Board as the preferred way forward.

Developments and funding related to public amenities i.e. café and shop, will be considered for provision by local groups or businesses if possible, enhancing the community hub. Similarly the retail pharmacy will be through a private sector arrangement but will only be a viable proposition if GP services are also on site. Aspirations on co-located and extended GP services will be subject to similar funding and potential business model discussions between the GPs, CCG and the Trust similar to those currently taking place in other areas.

7 Engagement

As outlined, the proposed like-for-like replacement of St Kilda's is no longer a sustainable or desirable option in the context of our aspirations for our new model of care. Given the long period of development for the abortive new build scheme and the long standing community involvement in developing the project, it is important we appropriately engage with all the stakeholders with respect to the new proposals.

The current service users, particularly the four permanent residents of St Kilda's, will be engaged in the development of these plans as they directly affect them, with the alternatives for their future care, fully and sensitively discussed with them and their families.

While the re-provision of the services provided from St Kilda's does not require formal public consultation, it is paramount we engage with and secure support from our key partners representing the views of the local population of Brixham. Although different from the original plan, it is anticipated that this alternative model can be supported by these stakeholders and the Trust will engage with them to explain the model and to provide assurance.

7.1 Engagement process

If the Board approves the recommendations put forward in this paper, an engagement process will begin. As part of this process Torbay Council Overview and Scrunity function will take a role in the programme to ensure our approach is valid and appropriate in terms of engaging with key stakeholders. It is envisaged that this will take four weeks and consist of the following meetings with stakeholders to explain our proposals, the rationale for change and hear views and general feedback that can be recorded and considered. The following sessions are suggested:

Engagement with	**Led by**
Brixham Torbay Councilliors	Torbay Council with ICO support
Brixham Town Council	Torbay Council with ICO support
CCG	Torbay Council with ICO support
Brixham Does Care	Torbay Council and ICO
League of Friends	ICO
Sandwell Community Caring Trust	ICO
SCCT divides into the following sub group, SCCT will be present at all sessions	
Long Stay residents	Brixham Zone & St Kilda matron/staff
Day Services	ICO and SCCT rep
Meals services	ICO and SCCT rep

As this change is classed as a "Key Decision" under the terms of the Trust's Partnership Agreement with Torbay Council, the DASS will take the final decision with respect to the St Kilda/SCCT contract and the proposals in this paper, with the support of the Torbay Council Mayor, having been reviewed by the Council's Senior Leadership group. A final report will be produced following the consultation to inform the decision making process. It is anticipated that the report will go before the Council and a decision made in May 2016.

8 Sandwell Community Caring Trust

Clearly SCCT are key partners in implementing a change to the current arrangements. It is recognised that SCCT and their staff at St Kilda's have delivered a flexible and high quality service despite the limitations of the facilities, and the Trust values and appreciates the quality of care provided to our clients who are placed in this service. The services at St Kilda are also highly regarded in Torbay and Brixham specifically. We should also acknowledge that SCCT worked with us in a partnership throughout the extended planning to deliver the St Kilda rebuild and we are appreciative of all that they have contributed to our community.

On 22nd March a meeting took place with the Trust's Chief Operating Officer and the CEO of SCCT to discuss the new model of care and our conclusion that the original new build proposal no longer fits with future intentions and that it is in everyone's interests to pursue the new care model. A way forward and a partnership approach to the management of change was agreed with a view to bringing the current SCCT contract for St Kilda to a mutually acceptable early conclusion, if the proposal to re-provide in line with the new model of care is approved.

The key elements of this partnership approach are as follows:

- to take a consensual and partnership approach through which St Kilda will close;
- residents/service users will be found replacement services and SCCT staff skills and experience will be retained in new roles in the local health and social care system;
- priority will be given to engaging with existing long-stay residents and their families to discuss and agree alternative suitable and appropriate care placements;
- we agreed to meet with SCCT staff at St Kilda before this matter is in the public arena. This has been a considerable period of uncertainty for staff and we need to provide clarity about the future and assurances about what this decision means for these staff. This staff meeting is scheduled for 1st April 2016 in the afternoon;
- the NHS will facilitate a process to ensure SCCT staff at St Kilda secure employment in the Trust and local health and social care system, and that a clear mechanism to achieve this will be identified to deliver this requirement promptly. Our objective is to secure staff skills and employment in the local health system - detailed arrangements to be confirmed, but this would include consideration to conditions, pay protection, length of service etc; and
- we will work together to expedite this work and deliver the desired outcomes for both organisations including agreeing a phased programme, with a mutually agreed and yet to be confirmed closure date between 2- 9 months (The contractual notice period being 9 months).

9 Next Steps

It is now over six month's since the pause in the St Kilda new build scheme was announced. If the recommendations in this report are approved it is important that the decision and its consequences are communicated and set in context. At the time of writing, the CCG-led public consultation on the wider locality new model of care for South Devon and Torbay is

pending - it is anticipated this will commence in May 2016. This delivery model for the Brixham community is in line with the wider community plans.

As the provider commissioned to deliver the service at St Kilda's, the Trust is required to formally agree and subsequently convey a proposal for consideration by the DASS as this is considered a Key Decision under the terms of our Partnership Agreement with Torbay Council. SCCT are making a financial loss on the current contract and are clear that they were not intended to be a part of the future service provision in the previous St Kilda's business case. Throughout, SCCT's main concern has been two-fold: that staff working at St Kilda find valued and secure employment elsewhere in the health and social care system locally and that the people receiving services at St Kilda are provided with appropriate alternatives. SCCT have now formally given notice on their contract for St Kilda's.

10 Conclusion

The model presented for health and social care in Brixham represents the most pragmatic and cost effective option that meets the objectives of the original scheme, reflects the current assessment of need, fits with the CCG locality model and is affordable within the financial envelope available.

It achieves the objective of mitigating the risk around the condition of St Kilda's care home whilst maintaining day services, some intermediate care provision in Brixham and creating an integrated health and well-being hub centred on the Brixham Community Hospital site.

It offers additional opportunities for other schemes to enhance the integrated offering including a possible new build GP centre and co-located services as well as possible opportunities for local housing with nominated rights for the Brixham population. This is also an opportunity for the voluntary sector to be involved in planning the future and using the facilities on the hospital site.

Finally it includes an agreed way forward for people in receipt of services at St Kilda and for the valued SCCT staff.

11 Recommendations

The Trust Board is asked to approve the following recommendations:

- that the previously proposed new build St Kilda on the Brixham Community Hospital site does not proceed and instead the Board accepts the revised proposal as presented as the preferred solution;
- that the team undertakes more formal engagement with current service users and with stakeholders in Brixham (League of Friends, Brixham Does Care and the Town Council) with respect to these proposals;
- that the ICO work's in partnership with SCCT to find alternative services for its clients and employment for SCCT staff within the local NHS - the ICO and SCCT will develop a detailed operational plan and agree the sequence of changes required; and
- the output of the engagement will be detailed into a report and a recommendation made to the Director of Adult Social Care at Torbay Council at the earliest opportunity for a final decision (likely early May 2016).

Torbay and South Devon NHS
NHS Foundation Trust

Meeting Date:	6 April 2016
Title:	Terms of Reference – Children's Services Integration Board
Lead Director:	Chief Executive
Corporate Objective:	Well Led
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

At its meeting in January 2016, the Board approved a paper setting out an outline strategy that could lead to the Integration of Children's Social Care services into the Integrated Care Organisation. Approval was granted for the Executive to investigate the viability of such a strategy and to further develop a proposal.

Key Issues/Risks

Being, at the least a material transaction in Monitor's Risk Assessment Framework definition, it is important that appropriate governance arrangements are created from the outset that are capable of determining and managing risks associated with this project.

The first step in developing these governance arrangements has been to establish a Joint Board with Torbay Council to oversee the project. The Terms of Reference of the Project Board are attached to this paper.

Recommendations:

To note the Terms of Reference of the Children's Services Integration Board.

Summary of ED Challenge/Discussion:

Executive Directors have agreed representation on the Board and likely timetable for implementation that includes sufficient

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

Torbay Council
Trust's Children's Services
Monitor

Equality and Diversity Implications:

None associated with the establishment of this Terms of Reference.

PUBLIC

Terms of Reference

Integration Board

Purpose

The Integration Board will act as the key management body for the proposal to integrate Torbay Children's Social Care delivery into the Torbay and South Devon NHS Foundation Trust (TSDNHSFT). Using the MONITOR Risk Assessment Framework document, the Board will undertake due diligence on the proposal, ensuring that the performance outcomes, and financial viability for Children's Services and for the ICO are strengthened and not put at risk through the process of integration, providing an overall benefit to children and families in Torbay.

Governance and authority to act

The Integration Board is a temporary non-Executive group with no powers other than those specifically delegated in these terms of reference. The Integration Board will be accountable directly to both the Torbay and South Devon NHS Foundation Trust and to the Torbay Executive Head of Finance and Operations and the Section 151 Officer.

Members of the project team will be tasked to bring together project teams and resources to progress the integration process outlined in this TOR, reporting back to formally on a monthly basis.

Membership

Richard Williams	Interim Director of Children's Services Torbay Council
Paul Cooper	Director of Finance and Deputy CEO, Torbay and South Devon NHS Foundation Trust
Caroline Taylor	Director of Adult Services, Torbay Council
Gail Rogers	Innovation Lead (SWIFT)
Jane Viner	Professional Safeguarding Lead Torbay and S Devon NHS Foundation Trust
Martin Phillips	Torbay Council Chief Accountant
Jacqui Jensen	Assistant Director Children's Safeguarding

Key Responsibilities

- To manage the risk assessment process required through MONITOR, holding a risk register
- To report on risks and mitigation to risks, enabling full awareness of these within the governance structure of the project
- To identify and unblock potential barriers to integration
- To agree resourcing required to effect the integration process and integration itself
- Engage the necessary Human Resources, Commissioning and Legal processes to enable timely and effective integration
- To agree strategies, such as consultation and communication
- To provide effective monitoring of resources, transactions and timescales
- To manage the transactional process of transformation
- To oversee development of appropriate documentation in support of the proposal – Strategic Outline Case, Outline and Full Business Case.

Milestones

Action	**Date**
Project Team established	03/12/15
Terms of Reference formally agreed by Board	24/02/16
Job Description completed and agreed for Interim Director of Children's Safeguarding	24/02/16
Decision by MONITOR as to whether this constitutes a material or significant transaction	31/03/16
6 month report and improvement progress - TC	31/09/16
Outline business case - ICO	31/09/16
RAF, full business case and due diligence triggered	01/10/16
RAF, full business case and due diligence completed	01/01/17
Recommendation to the Boards for decision (assuming) to proceed	01/02/17
Shadow period of integration	01/04/17
Go-live transfer of provider responsibilities to TSDNHSFT	01/09/17

Review

The project team will review progress and TOR within 3 months of TOR sign off.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6th April 2016
Title:	EDMS Business Case
Lead Director:	HIS Director
Corporate Objective:	To digitise the entire paper case note estate currently being stored in the medical records library, including records held in specialty/service areas and in the Community.
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:
The proposed investment fits with the IT Strategy for the Organisation of capturing and making available as much information electronically as possible to the widest audience possible. The Trust currently holds in excess of 315,000 patient records across the South Devon Health Community and one off-site storage facility, with around 20,000 new patient registrations being created each year. The storage, management and maintenance needed for these records is continually growing.

As the number of patient records continues to increase, so will the need for extra resource as this is a labour intensive operation. The Trust currently use WinDIP as a central storage repository for digitised patient records which currently number approximately 44 million images for 394,000 patients. We are looking to expand our capacity to scan more of these paper records by increasing the number and type of records to be scanned by our existing provider, Gateway. This would enable the Trust to further continue to provide for a modern medical records service, ensuring that the right record is available at the right time in the right location for the right patient.

The implementation of this solution will further ensure that this information is delivered in a safe, secure and speedy fashion at the point of patient contact. It would also ensure that patient care is not compromised due to missing patient records. Staffing and off-site storage costs would also be reduced due to the decrease in the need for the retrieval, filing storage and delivery required for the medical records estate.

Current State: SDHC FT have merged with T&SDHCT, which means that the continued provision of a paper based medical records service will be inefficient operationally and unsustainable financially . With the increase in new registrations and the possibility of having to scan all specialty held records within each specialty, more storage space will be required. Without the extra physical storage capacity, be it on or off site, will mean that these records may no longer be able to fit into the existing filing racks. Apart from the obvious costs associated with providing this extra storage capacity, the Health and Safety risks to staff are high.

A large proportion of Health Records staff are used to retrieve, prepare and file patient records on a daily basis, and whilst over 98.94% of records are retrieved in time for every patient visit, the staff are unable to locate a number of them, which imposes a significant clinical risk to patients. Health Records also have to operate a 24hr, 5 days a week and 12hrs per weekend day, 365 days a year service to be able to provide patient records on demand for emergency admissions, which incurs a considerable 'out of hours' staffing cost to the Trust.

The Vision: The Trust wishes to improve the patient experience at every opportunity. An upgraded CDMS and increased scanning capacity, will ensure that every patient record is available for every patient at point of contact. The Trust also aims for the effective utilisation of staff, our biggest resource.

Key Issues/Risks

1. Non compliance with DoH/NHS England directives on the provision of a single electronic paper record (EPR) and being paperless by 2018.
2. Increased staffing costs to manage and maintain the increase in paper medical records.
3. An increase in the unavailability of records as the estate grows, resulting in cancelled patients and loss of revenue.
4. Further storage costs (Internal & External) would be guaranteed as the paper record estate grows.
5. A large Health & Safety risk from the loss of records due fire, flood, misplacement and natural degradation over time, as well as injury to staff who have to manually handle records on a daily basis.

Recommendations:

That the Board approve this Business Case to fund the project in order to realise the full range of identified savings.

Summary Challenge/Discussion:

Summary of IM&T Group (28/1/2016) Challenge/Discussion:

- The benefits profile shows increasing delivery year on year, continuing beyond year 5; could the benefits profile be front-loaded and delivered sooner? Assurance: The profile is based on the planned delivery of the wider ICT Strategy which will increasingly reduce the amount of paper-based information going into the casenotes.

Summary of ED (16/2/2016) Challenge/Discussion:

- Is there no opportunity to go paperless rather than paper-light immediately? Assurance: No, some clinical noting too complex for paperless currently and will need new IT systems to go paperless.
- If a patient quickly comes back into the community after an acute episode will their clinical information be available? Assurance: Yes.
- What would the turnaround time for scanning be? Assurance: We have several pick up a day under a service level agreement (SLA), so a few hours.
- Why offsite scanning at Yeovil? Assurance: The requirement to adhere to BS10008 makes this more cost-effective.
- Availability of notes going to Yeovil should they be needed urgently? Assurance: Will turn around if within an hour of site, otherwise will be priority scanned within an hour upon arrival at Yeovil and then be available electronically.
- For how long will we continue to send paper to the scanning site? Assurance: For as long as we continue to have paper generated as part of clinical noting. Probably forever.
- Operational impact and capacity to support making it happen can be underestimated, is this factored in? Assurance: Yes, but always a challenge to meet the requirement without ‘over-engineering’.
- Has the potential impact on operational clinical performance been factored in? Assurance: This will be accounted for and will liaise with Clive (Interim Deputy COO) and be detailed before going live.
- There are some operational savings identified such as ward clerks time; have these savings been ‘stress tested’ with operational departments? Assurance: These are non-cash releasing anticipated time savings and have not been used to support the business case.
- Has this been done elsewhere and have we taken the learning from that? Assurance: Yes, the project manager has managed three implementations of this approach previously. The CCIO and HISD have visited two sites in addition, and fed the learning into our plans.
- Have we planned for the clinical engagement required for the project timescale? Assurance: We will detail this and profile more fully, with Jane Viner and Rob Dyer inputting after taking clinical soundings. We will also use a clinical advisory group to provide assurance around proposed implementation timescale.
- Have we shared with staff side? Assurance: Not yet.
- Are the revenue costs of £300k in the next financial year accounted for in the Trust’s financial plan? Assurance: Yes.

Summary of Workstream 3 (Finance Committee) (23/2/2016) Challenge/Discussion:

- The business case shows a current workforce of 42WTE but only ≙30WTE contracted. Is the department currently understaffed? Assurance: The CMDS project has been in planning for a number of years and the department has as a result been managing its workforce in line with this. The department is materially at full complement and the 'missing' WTE is accounted for by temporary Bank staff, as this facilitates the required staffing transition needed by this project.
- Does the HIS IT Programme have the staff necessary to undertake the project? Assurance: The business case includes funding for additional project and change support staff necessary to implement the project. Some of the required staff have already been identified and pre-employment activities undertaken to move this forward as soon as approval is given.
- Is the capital planning process which will go to Trust Board for approval in April cause a delay to the project if approved by Trust Board in March? Assurance: Whilst no financial commitments will be able to be undertaken by the CDMS project until the overall capital position is approved, there are enabling activities which would be able to commence in lieu of this such as starting recruitment processes which should enable the project to proceed without undue delay should the Trust Board approve the project in March.

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

Records Management, IT, CAG, Divisional Directors/managers, Specialty Leads.

Equality and Diversity Implications:

None

PUBLIC

EDMS (Electronic Document Management Solution) Project – Summary Overview

The EDMS Project and the proposed investment fits with the IT Strategy for the Organisation of capturing and making available as much information electronically as possible to the widest audience possible. The Trust currently holds in excess of 315,000 patient records across the South Devon Health Community and one off-site storage facility, with around 20,000 new patient registrations being created each year.

The storage, management and maintenance needed for these records is continually growing. As the number of patient records continues to increase, so will the need for extra resource as this is a labour intensive operation. The Trust currently use WinDIP as a central storage repository for digitised patient records which currently number approximately 44 million images for 394,000 patients. We are looking to expand our capacity to scan more of these paper records by increasing the number and type of records to be scanned by our existing provider, Gateway. This would enable the Trust to further continue to provide for a modern medical records service, ensuring that the right record is available at the right time in the right location for the right patient.

The implementation of this solution will further ensure that this information is delivered in a safe, secure and speedy fashion at the point of patient contact. It would also ensure that patient care is not compromised due to missing patient records. Staffing and off-site storage costs would also be reduced due to the decrease in the need for the retrieval, filing storage and delivery required for the medical records estate.

Current State:
SDHC FT have merged with T&SDHCT, which means that the continued provision of a paper based medical records service will be inefficient operationally and unsustainable financially . With the increase in new registrations and the possibility of having to scan all specialty held records within each specialty, more storage space will be required. Without the extra physical storage capacity, whether it be on or off site, will mean that these records may no longer be able to fit into the existing filing racks. Apart from the obvious costs associated with providing this extra storage capacity, the Health and Safety risks to staff are high.

A large proportion of Health Records staff are used to retrieve, prepare and file patient records on a daily basis, and whilst over 98.94% of records are retrieved in time for every patient visit, the staff are unable to locate a number of them, which imposes a significant clinical risk to patients. Health Records also have to operate a 24hr, 5 days a week and 12hrs per weekend day, 365 days a year service to be able to provide patient records on demand for emergency admissions, which incurs a considerable 'out of hours' staffing cost to the Trust.

The Vision:
The Trust wishes to improve the patient experience at every opportunity. An upgraded EDMS, coupled with increased scanning capacity, will ensure that every patient record is available for every patient at point of contact. The Trust also aims for the effective utilisation of staff, our biggest resource.

Financial Summary:
Based on a 10 year plan the following costs and savings have been identified.

Financial Overview	
Combined Capital & Revenue Costs:	£5,761,412
Cash & Non Cash Releasing Savings:	£9,126,442
Overall Return of:	**£3,365,030**

Once this Business Case has been approved, Project implementation will begin with Organisation wide communication and clinical engagement. The aim is commence scanning late summer.

Dan McLachlan
EDMS Project Manager.

The table(s) below are based on the original cost savings sheet used in the briefing paper submitted in 2014 and approved.

	2015-16	2016-17	2017-18	2018-19	2019-2020	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Total
Non Cash Releasing Savings (Ward Clerks)	£0	£57,357	£57,357	£57,357	£57,357	£57,357	£57,357	£57,357	£57,357	£57,357	£57,357	£573,573
Total Non Cash Releasing Savings:	**£0**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£57,357**	**£573,573**

Cash Releasing Savings	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Total
Pay Savings	£0	£129,933	£701,568	£740,192	£806,104	£825,416	£825,416	£864,040	£864,040	£864,040	£864,040	£7,484,792
Pre-printed / Printed forms / templates	£0	£0	£16,914	£33,827	£33,827	£33,827	£33,827	£33,827	£33,827	£33,827	£33,827	£287,533
Estates Purchased Contracts (Racking Maintenance Contract)	£0	£0	£0	£5,963	£5,963	£5,963	£5,963	£5,963	£5,963	£5,963	£5,963	£47,704
Office Equip-General	£0	£0	£1,268	£1,901	£1,901	£1,901	£1,901	£1,901	£1,901	£1,901	£1,901	£16,479
Office Equip-Computer Hardware	£0	£0	£1,999	£2,999	£2,999	£2,999	£2,999	£2,999	£2,999	£2,999	£2,999	£25,991
Office Equip-Print/Stationery	£0	£0	£29,143	£43,714	£43,714	£43,714	£58,286	£58,286	£58,286	£58,286	£58,286	£451,713
Transport - General/Petrol/Diesel/Insurance/Taxis	£0	£0	£1,988	£1,988	£1,988	£1,988	£1,988	£1,988	£1,988	£1,988	£1,988	£17,893
ESA - Non-Healthcare Service Contract Iron Mountain	£0	£0	£0	£0	£29,000	£29,000	£29,000	£29,000	£29,000	£29,000	£29,000	£202,997
Operating Lease Payments - Plant & Hire.	£0	£0	£1,974	£1,974	£1,974	£1,974	£1,974	£1,974	£1,974	£1,974	£1,974	£17,767
Total Savings Non pay:	**£0**	**£129,933**	**£754,854**	**£832,559**	**£927,471**	**£946,783**	**£961,354**	**£999,978**	**£999,978**	**£999,978**	**£999,978**	**£8,552,869**
Total Combined Savings:	**£0.00**	**£187,290**	**£812,211**	**£889,917**	**£984,828**	**£1,004,140**	**£1,018,712**	**£1,057,336**	**£1,057,336**	**£1,057,336**	**£1,057,336**	**£9,126,442**

VAT Incl		2015-16	2016-17	2017-18	2018-19	2019-2020	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Total
Y/N	**Capital Costs**												
EV	Additional CDMS Software (PARIS Integration)	£0	£32,995										£32,995
EV	Civica Professional Services	£8,594	£37,776	£37,776									£84,146
EV	RFID Unit Costs In Total		£240,240										
EV	Scanning Services (SoD & Archive)	£0	£882,506	£882,506	£220,626								£1,985,635
EV	Scanning Servcies (Day Forward/Off-site)	£0	£84,305	£59,014	£41,310	£28,917	£20,242	£14,169	£9,918	£6,806	£4,860	£3,402	£272,942
IV	Laminated "Thin Folders"	£0	£20,240										£20,240
EV	Infrastructure (Additional disc space)	£0	£9,899	£804									£10,703
EV	Civica eForms Training	£0	£7,562										£7,562
EV	Hardware (iPAD mobile/static devices)	£0	£125,000	£75,000	£50,000		£35,000	£55,000	£25,000				£365,000
EV	Civica Project Management	£0	£89,700	£60,450									£150,150
EV	Civica CDMS Training Support	£0	£58,650										£58,650
EV	Temporary staff (pulling for SoD/Prep)	£0.00	£77,248	£77,248									£154,496
	Total Capital Setup Costs	**£8,594**	**£1,666,120**	**£1,192,797**	**£311,936**	**£28,917**	**£55,242**	**£69,169**	**£34,918**	**£6,806**	**£4,860**	**£3,402**	**£3,142,518**

	Revenue Costs	2015-16	2016-17	2017-18	2018-19	2019-2020	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	Total
EV	WinDIP Support licenses	£53,122	£54,715	£56,357	£58,048	£59,789	£61,583	£63,430	£65,333.21	£67,293	£69,312	£71,391	£608,982
EV	RFID Support & Maintenance		£10,199	£10,199	£10,199	£10,199	£10,199	£10,199	£10,199	£10,199	£10,199	£10,199	£101,990
EV	Remote SQL server monitoring	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£1,000	£11,000
EV	Hardware(iPADs/BYOD)	£0	£55,000	£45,000									£100,000
EV	Other (Iron Mountain release payment)				£45,000								£45,000
EV	Staff (eForms & Windip Support)	£0	£104,378	£104,378	£104,378	£104,378	£104,378	£104,378	£104,378	£104,378	£104,378	£104,378	£939,402
EV	Change Management Team	£0	£145,525	£145,525	£36,381								£327,431
IV	Trust Project & Support Management Resource	£146,520	£112,856	£112,856	£112,856								£485,088
	Total Non Recurring Revenue Costs	**£200,642**	**£483,673**	**£475,315**	**£367,862**	**£175,366**	**£177,160**	**£179,007**	**£180,910**	**£182,870**	**£184,889**	**£186,968**	**£2,618,894**

	Total Costs Capital & Revenue	**£209,236**	**£2,149,793**	**£1,668,112**	**£679,798**	**£204,283**	**£232,401**	**£248,176**	**£215,829**	**£189,676**	**£189,749**	**£190,370**	**£5,761,412**

Calendar	**2015**	**06-Mar-16**	
DMc	**£97,350**	**£24,750**	
VAT	**£19,470**	**£4,950**	
Total	**£116,820**	**£29,700**	
8a		**£4,888**	**Feb-16**
8a		**£4,888**	**Mar-16**
Dmc Tot:	**£146,520**	**£69,177**	**£215,697**

Yr 1	**Band 5**	**£2,425**	**£29,105**
Yr 1	**Band 4**	**£2,091**	**£25,091**
	Other Total	**£4,516**	
	Yr1 Tot:	**£220,213**	
	8a	**£58,660**	
	Band 5	**£29,105**	
	Band 4	**£25,091**	
	Yr 2 Tot:	**£112,856**	

Line 57	**250.151**
	250.1515
	£13,007.88

After Costs, Project will return savings of: **£3,365,030**

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form - based on the 5 case Business Model

Executive Summary

Scheme Name EDMS

Bus.Case Number
(SFMT to Issue after Exec Sponsor email rec'd)

It is essential all Business Cases have an Executive Sponsor who supports the proposal so please ensure you have discussed with an Exec prior to completion of this Business Case Approval form. A Business Case Reference Number cannot be obtained from Finance without this sponsor, and any Business Case without a reference number will not be signed off by the Chief Executive, Director of Finance or CEG per the Investment policy. Please also ensure if this investment relates to a new clinical procedure that protocol number 0530 via the Clinical Effectiveness Department has been adhered to and signed off before investment is sought.

If the Investment value is <£50k, completion of the executive summary, Part 1 , and sign off Part 7 should be completed. Any Investment >£50k will require completion of the full Business Case Approval Template for CEG (Clinical Executive Group) as outlined in this document.
Any investment >£250k that CEG support following sight of this Business Case Approval Template will require a Full Business Case which will require expansion of each part in greater detail, for example detailed evidence, sensitivity analysis, Discounted Cash Flow Statement, Pay Back analysis, and PPE proposals.
These should be appended to each part of the 5 stages in this document.

Purpose of Funding

The purpose of the funding is to provide an integrated South Devon Health Community with an operationally effective Clinical Electronic Document Management System, complete with Scanning Solution for the entire Medical Records Estate

Option Proposed and why?

Options 2 & 3 proposed
The proposed options is to scan all records held within the Trust. These are "Active" records (Scan on Demand) where a patient is currently undergoing a pathway of care, Inpatient, Outpatient and Community, "Inactive" records, which are those patients who have been discharged from all forms of care, and "Specialty Held" records. It will also include a "Day Forward" scanning solution for "Thin Folder" operations for annotation notes and continuation sheets as currently provided by the Medical Records Department until such times as these sheets are made available electronically. South Devon Healthcare NHS Foundation Trust hereafter referred to as SDHFT and Torbay and Southern Devon Health and Care Trust, hereafter referred to as T&SDHCT, have recently merged to become one Integrated Health Care Organisation, hereafter referred to as the South Devon Health Community. As one Healthcare provider, they will provide high quality, patient centred care for upwards of 300,000 people across the South Devon region as well as approximately 100,000 visitors per year.Hospital Medical Records are fundamental to the provision of safe and effective patient care as well as for clinical audit, research and medico-legal purposes. South Devon Healthcare NHS Foundation Trust currently manages over 315,000 medical records. The Trust currently provide up to 2,000 Patient records per day. Statistics show that there is an average growth in the number of new records of approximately 20,000 per year. Requests for notes for emergency admissions are also pulled on demand. This numbers approximately 3,000 per month of which almost 1,300 are Out of Hours. There is a pressing need to improve the medical record service provision to clinicians so that they can be sure that they have access to essential patient information in the right location, at the right time, for the right patient, in a secure, efficient and speedy manner. There is also an on-going requirement to improve services to patients, ensuring that those associated with their care have up-to-date, accurate and timely information made available to them across the health economy. At present, South Devon Healthcare NHS Foundation Trust is faced with a growing requirement to manage health records. There are specific problems relating to space needed to store records, timeliness and accuracy of delivery and the availability of records across multiple sites. The current paper health record is already being transported and used for OP (Outpatient) and IP (Inpatient) activity in the local community hospitals as well as here at the Torbay site. Apart from the obvious security implications, this has obvious limitations on the availability of information and the flexibility of their use. The planned transfer of services from the Community Trust only serve to increase the pressure for storage space around the Trust estate. As part of the Department of Health's (Jeremy Hunt) drive for Healthcare, South Devon Health Community aim to be paperlight/less by 2018. To help facilitate this, the Trust are looking to digitise the paper medical record estate to enable these records to be made available at the point of patient contact, in a safe and secure manner. The Trust currently use WinDip, an EDMS (Electronic Document Management System) solution provided by Civica. The Trust is looking to expand their relationship with Civica in order to utilise the current EDMS to store scanned, digital images of medical records. For future reference, the term "solution" means both the facility to scan the paper medical records, as well as to view them in a clinical or administrative setting.

How does the proposed Investment improve the patient experience?

This will ensure that the scanned paper record will be made available at the point of patient contact, in a safe, secure and speedy fashion. It will also guarantee that the right record is made available for the right patient, at the right time in the right location, thus negating the need to cancel patient visits for Outpatient or Surgical appointments.

Does the Proposed option enable service improvement/innovation, and if so how? Eg ELVIS outcomes

This option will enable service improvement and innovation by virtue of the fact that outpatient appointments, day or elective surgery appointments will no longer be cancelled, or potential revenue will not be lost due to lost or missing case notes.

How will the Proposed development improve integration with Primary care, community services and social services?

This proposed development will improve integration with Primary Care, Community and Social Services, by making digitised paper case notes available to all Healthcare Service Providers, at the point of patient contact in a safe and secure manner. It will also ensure that records will not be lost or missed during storage, delivery and transportation. It will allow for simultaneous, multiple access to the patient record across the Health Economy.

How have Commissioners and Patients been involved in the development of the proposed scheme if there are any changes to patient pathways?

Drivers -
Patient access to records (Single EPR)
Government lead
Patient story available to all clinicians (not having to tell it twice) PKB

What Groups of staff have been involved in the Option Appraisal exercise to ensure the proposed scheme delivers maximum benefits?

Records management, IT, CAG, Divisional Directors/Managers, Specialty Leads. The Project Manager assigned to organise, coordinate, manage and plan the project has similar experience at 3 other NHS Trusts.

Scheme Sponsor	Mike Green	**CEG Member**	Gary Hotine
		E:mail Address	gary.hotine@nhs.net
		Telephone Number	01803 653458
Operational Lead	Gill Otway	**Directorate**	Health Informatics Service
		E:mail Address	gill.otway@nhs.net
		Telephone Number	01803 653550
Date Submitted			
Forum Submitted to	MDOG, HIB, MDPG, CMG, CEG, WORKSTREAM		

Following the Investment Policy approval process:

Date taken to DOF	
Date taken to CEG	
Date proposed for Finance Committee	23rd February 2016
Date Proposed for Trust Board	2nd March 2016

Summary of Funding Requested:

	Year 1 PYE £'000	Year 2 £'000	Year 3 £'000
CAPITAL			
REVENUE			
	WTE	**WTE**	**WTE**
WORKFORCE CHANGES			

Please liaise with your HR lead to support you with workforce impacts such as TUPE, pay protection or redundancies

Reference to Risk Register

PRE INVESTMENT	POST INVESTMENT

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part One - Strategic Case for the Preferred option

1. Preferred Option

The preferred options is to scan all records held within the Trust. These are "Active" records (Scan on Demand) where a patient is currently undergoing a pathway of care, Inpatient, Outpatient and Community. "Inactive" records, which are those patients who have been discharged from all forms of care, and "Specialty Held" records. It will also include a "Day Forward" scanning solution for "Thin Folder" operations for annotation notes and continuation sheets as currently provided by the Medical Records Department until such time as all sheets are made available electronically.

2. How the proposed investment aligns with both the overall strategy of the organisation and the Specialties strategy.

The proposed investment fits with the IT Strategy for the Organisation of capturing and making available as much information electronically as possible to the widest audience possible. The Trust currently holds in excess of 315,000 patient records across the South Devon Health Community and one off-site storage facility, with around 20,000 new patient registrations being created each year. The storage, management and maintenance needed for these records is continually growing. As the number of patient records continues to increase, so will the need for extra resource as this is a labour intensive operation. The Trust currently use WinDIP as a central storage repository for digitised patient records which currently number approximately 44 million images for 394,000 patients. We are looking to expand our capacity to scan more of these paper records by increasing the number and type of records to be scanned by our existing provider, Gateway. This would enable the Trust to further continue to provide for a modern medical records service, ensuring that the right record is available at the right time in the right location for the right patient. The implementation of this solution will further ensure that this information is delivered in a safe, secure and speedy fashion at the point of patient contact. It would also ensure that patient care is not compromised due to missing patient records. Staffing and off-site storage costs would also be reduced due to the decrease in the need for the retrieval, filing storage and delivery required for the medical records estate. Current State: SDHC FT have merged with T&SDHCT, which means that the continued provision of a paper based medical records service will be inefficient operationally and unsustainable financially . With the increase in new registrations and the possibility of having to scan all specialty held records within each specialty, more storage space will be required. Without the extra physical storage capacity, be it on or off site, will mean that these records may no longer be able to fit into the existing filing racks. Apart from the obvious costs associated with providing this extra storage capacity, the Health and Safety risks to staff are high. A large proportion of Health Records staff are used to retrieve, prepare and file patient records on a daily basis, and whilst over 98.94% of records are retrieved in time for every patient visit, the staff are unable to locate a number of them, which imposes a significant clinical risk to patients. Health Records also have to operate a 24hr, 5 days a week and 12hrs per weekend day, 365 days a year service to be able to provide patient records on demand for emergency admissions, which incurs a considerable ‘out of hours’ staffing cost to the Trust. The Vision: The Trust wishes to improve the patient experience at every opportunity. An upgraded CDMS and increased scanning capacity, will ensure that every patient record is available for every patient at point of contact. The Trust also aims for the effective utilisation of staff, our biggest resource.

3. Consequences of NOT Funding the Project

The need for paper patient records would continually increase putting more pressure on the storage areas that cannot accommodate any more records. More funding would be required to store records off-site to try to create storage space on-site. A large Health and Safety risk would still remain, firstly to the safety and integrity of the patient records against fire and flooding, and secondly to staff, who have to manually handle the records on a daily basis. Large staffing costs would still be required to manage and maintain the increase in paper medical records and their service provision. The risk of patient records being unavailable when required would also remain, and even increase, which could result in patients being cancelled at short notice. There would also be potential loss of revenue due to these cancelled patients. The Organisation will not be able to move to paperless case notes which will have an impact on the ability of the Trust to make savings of circa £1 million per annum by reducing the requirement for medical records staff.

4. Directorates Plans for ensuring the Trust's DOS (Directory of Service) is updated with any patient pathway or service changes

N/A

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Two - Economic Case - for All Options Considered

How will success of the investment be measured?

Through the delivery of the identified benefits through benefits realisation modelling.

SDHC-Benefits Realisation Map v1.4.pdf | SDHC-Benefits Realistation Plan v1.4.pdf | SDHC-Measurable Benefits Analysis v1.4.pdf

Over what time frame will this measurement be taken?

Benefits should start to be realised within the first 2 years of the Project being implemented. This will be mainly due to the downturn in staffing requirements to locate, prepare, transport, deliver, collect and return medical record case notes from the medical records library to the point of patient contact wherever that may be.

Dan to elaborate

Agreed KPI/Criteria to be measured.

KPI/Criteria	Pre Investment		Post Investment	Anticipated Realisation Date	Monitored by	Presented back to which work stream	
Health Records KPI-Availability of Records	98.90%		100%	Within 2 years of Project Implementation	Review of case note availability	Workstream 3	
Saving of Health Records Staff	£1,300,000		300,000	3 years after Project Implementation	Staffing Costs	Workstream 3	
Daily thin file scanning	0		100%	Immediately	Updated patient record	Workstream 3	

Please feel free to append to Part 2 Economic Case Word Documents with the Options listed:

SDHCT-CDMS Options Appraisal Paper v0.9.pdf

What Options have been considered, what will there impact be, how many patients will benefit from the investment, and what risks do each option have?

What is the Preferred Option as detailed on the Executive Summary?

A combination of Options 2 & 3 including Specialty Held records.

Financial and workforce consequences of all Options Considered: Activity and Income changes, non-pay and workforce changes - all Recurrent, Capital Requirements - Non Recurrent

Detail	Full Year affect								
insert lines for	Capital	Recurring Revenue							
costs as appropriate	Year 1 outlay	Capital I&E Charges	Activity/Income changes			Workforce/Pay		Non-Pay	TOTAL
per option	£'000	£'000	Patient No's	Contract Type	£'000	WTE	£'000	£'000	£'000
Option 1:									
TOTAL	0	0	0	0	0	0	0	0	0
Option 2:			215,224						
TOTAL	0	0	215,224	0	0	0	0	0	0
Option 3:			35,683						
TOTAL	0	0	35,683	0	0	0	0	0	0
Option 4:									
TOTAL	0	0	0	0	0	0	0	0	0

Timescales and Slippage on schemes considered:

	Anticipated start date Yr. 1	Yr. 1 slippage/revenue benefit £'000
Option 1:		
Option 2:		
Option 3:		
Option 4:		

Any additional non-Recurrent set up costs:

	£'000
Option 1:	
Option 2:	
Option 3:	
Option 4:	

Please liaise with your HR lead to support you in completing these sections:

What will be the impact on the workforce of the options considered? E.g. potential redeployment, pay protection, redundancies, skill mixes, banding changes etc.

There are a number of staff who presently work in Medical Records who would not be required if this Project went ahead. There are numerous members of staff who are either Bank/Agency staff or who are on fixed term contracts, and therefore the exposure to redundancy payments would be minimal.

Will the options involve the transfer of services from other providers either NHs or private? If so could there be a TUPE transfer of staff?

Not Applicable.

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Three - Commercial Case - for All Options Considered

How will the Procurement Process be managed and what Procurement routes are proposed?

Not Applicable - EDMS and scanning operation is already in place.

Date Formal Specification would be written by:

Date	Who

Date Formal Specification would be released to Market:

Date	Who

Date Quotation/Tender responses will be evaluated:

Date	Who

Who will authorise the placement of a contract with the winning bidder and describe the process?

Not Applicable - As Above

Who will complete a Business case amendment form should the quotes be materially different from the original Outline Business Case?

Date	Who

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Four - Financial Case - for All Options Considered

How will the Project be financially resourced? E.g. new income stream, increase to Trust Expenditure due to risk, Capital Plan

This Project will be resourced through the Capital Plan.

What is the impact on the Specialties Service line Reporting Results for each Option:

	Before	After
Option 1:		
Option 2:		
Option 3:		
Option 4:		

What is the impact on the Services National Reference Costs Index?

	Before	After
Option 1:		
Option 2:		
Option 3:		
Option 4:		

BUSINESS ADVISOR SIGN OFF:	**Yes/No**	**FYE £'000**
Are the Capital Funds part of the Trusts Annual Capital Plan?		
Are the capital funds still required?		
Have the Revenue consequences been accurately quantified?		

If Equipment: has a CA1 Form been applied for ?	**Yes/No**
Application must be approved by the Trust Medical Equipment Group prior to Purchase	**N/A**

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Five - Management Case - for Preferred Option

How will the Project be managed? Are any additional Resources Required, recurrently or non-recurrently?

The Project will be managed through the IT Projects Team. It is envisaged that there will be a requirement for a Project Manager and Project Support Officer to help plan, manage and coordinate the Project until the Project's objectives have been achieved.

Who will be responsible for finalising the service design and scheme design, and ensuring that any project variations are appropriately communicated and agreed?

The Project Manager. IT Change Team and the Health Records Manager.

What support is required from other areas within the organisation and outside the organisation to ensure that the project is delivered on time and within budget?

The Organisation needs to recognise that paper notes will be replaced by digitised/electronic notes. This can be achieved by forming a close working relationship with the Health Records Committee and the CAG to help manage this transformational change, as well as by establishing a collaborative partnership with the Specialties to ensure that their needs and requirements are fully identified, managed and actioned.

Outline the implementation plan and key milestones:

Once approval has been given, implementation will commence by reviewing the existing IT infrastructure including e-form development and training, to ensure that all areas meet with the technical specification requirements. Key milestones are Infrastructure set up, clinical engagement and commencement of large scale scan on demand scanning operations.

Please provide evidence that this Investment Proposal has been shared and contributed to by support services that may be impacted by this investment: e.g. embed emails

Therapies
Radiology
Pathology
Theatres
Anaesthetics
HSDU
Infection Control
Estates
General Outpatients
Medical Electronics
Other

All departments and specialties within all Directorates of the newly integrated Torbay & South Devon Healthcare NHS Foundation Trust.

SDHC EDMS Risk & Issue Register.pdf

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Six - Risk rating

Line Ref and Date Added	Lead Executive Director	Operational Lead	Date reviewed	Reference (WS, Div or Dept)	Trust Objective 2012/13	Workstream \ Division Objective	Principal Risk	Link to Care Quality Commission / National Targets	Lead Director	Inherent Risk			Existing Risk Control Measures	Status - risk control measures	Current Residual			Sources of		Status - sources of assurance	Gaps in Assurance on Existing Controls		Gaps in Control and Planned Action	Status - gaps in assurance/control	Target date	Lead Person for the Act	Further Review Date	Planned Sources of Assurance	Computer Generated Risk Score (inherent risk)	Computer Generated Risk Score (current residual risk)
										Consequence	Likelihood	Risk Score			Consequence	Likelihood	Risk Score	Internal Assurance	External Assurance		Consequence (present)	Likelihood (present)								
Reference number (if applicable) and date the risk was added to the register	*Executive accountable for delivering the corporate objective*	*Role title (not persons name)*	*Date the objective / risk was reviewed*	*e.g WS1*	*The Trust has set 7 objectives with 7 enablers for 2012/13 as outlined in the Annual Plan. Please*	*What we are aiming to deliver?*	*What could prevent this objective being achieved? 'Cause' and 'effect' to be included.*	*Main link to "CQC", HTMs etc. e.g. Outcome 7*	*Lead Director for the principal risk*	*Enter a value (1, 2, 3, 4 or 5)*	*Enter a value (1, 2, 3, 4 or 5)*	Automated calculation	*What controls/systems we have in place to assist in securing delivery of our objective.*	*Current RAG Rating*	*Enter a value (1, 2, 3, 4 or 5)*	*Enter a value (1, 2, 3, 4 or 5)*	Automated calculation	*Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective.*		*Current RAG Rating*			*Where we are failing to put effective controls/ systems in place/ where we are failing to make them effective.*	*Add the favoured action or favoured range of actions to adequately reduce the risk to a reasonable level and/or to*	*Current RAG Rating*	*Insert the date when you expect the actions to be completed to ensure the risk is reduced/ mitigated.*	*Role title (not persons name)*	Date the risk/actions will be reviewed	*Hyperlink to an action plan preferred or provide commentary on the current action taken to*	*Please do not delete this column - automated calculation for column 'N'*	*Please do not delete this column - automated calculation for column 'S'*
												NH					NH												16	16
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Risk scoring = consequence x likelihood (C x L)

	Likelihood				
	1	2	3	4	5
Consequence	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 None	1	2	3	4	5

Summary of Risk Grading Process

No harm / damage	Low harm / damage	Moderate harm / damage	Severe harm / damage	Catastrophic harm /

Definitions for likelihood of

What is the likelihood of the consequence described					
	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	< 1%	1 – 5%	6 – 20%	21 – 50%	> 50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Seven - Scheme Signatories and Sign Off

Scheme Name: EDMS

Bus.Case Number (SFMT to Issue)

Section One - Scheme Signatories

Signature of Executive Scheme Sponsor

I confirm that the project details contained in this application and estimates are complete and accurate, and that should approval be gained that I will undertake post evaluation of the investment, and update the Trust's Directory of Service (DOS) for changes to any clinical service.

Where there is a service redesign that impacts on patients/service users there is a requirement to complete an Equality Impact Assessment that will form part of this Business Case Approval.

I confirm that an EIA (Equality Impact Assessment) has been completed - see EIA tab for guidance and form (Full guidance can be found on the intranet) YES/N/A

Signature: _____ Name:

Telephone No.:

Designation: _____ E:Mail Address:

Signature of Operational Lead

Signature: _____ Name:

Telephone No.:

Designation: _____ E:Mail Address:

Signature of Clinical Lead

Signature: _____ Name:

Telephone No.:

Designation: _____ E:Mail Address:

Signature of Business Advisor/Trust Wide Finance Manager

Signature: _____ Name:

Telephone No.:

Comments E:Mail Address:

Section Two - Approval/ Rejection

Approval **Rejection**

Signature: _____ Date: _____

Signature of Director of Finance Performance and information on behalf of the Trust Board

South Devon Healthcare NHS Foundation Trust

Business Case Approval Form

Part Eight - Post Evaluation Sign Off

Scheme Name: EDMS

Bus.Case Number (Finance to Issue)

Section One - Scheme Signatories

Work stream/Forum Post Evaluation KPI's to be presented to:

Date:

KPI Results as detailed in Part 2:

What has been learnt and can be applied to future investment proposals?

Signature of Executive Scheme Sponsor

Signature: _____ Name:

Telephone No.:

Designation: _____ E:Mail Address:

Signature of Operational Lead

Signature: _____ Name:

Telephone No.:

Designation: _____ E:Mail Address:

Signature of Clinical Lead

Signature: _____ Name:

Telephone No.:

Designation: _____ E:Mail Address:

Full guidance on the Equality Impact Assessments is available on the intranet

Guidance Prompts to Assist with Equality Impact Assessments. (Some questions may not be applicable to all services)

Age	**Yes**	**No**	**N/A**	**To action**
Is it easy for a person of any age to find out about and to use your service?				
Does your service make assumptions about people simply because of their age?				
Does your service give out positive messages about all ages in the leaflets and posters that it uses?				
When you are recruiting staff, have you thought about age and how you can recruit people of all ages?				
Could younger and older people in your staff team feel equally valued?				
Do you monitor age to make sure that you are serving a representative sample of the population?				
Do any eligibility criteria for your service discriminate against older or younger people without just cause?				
Do your staff treat people of all ages with dignity and respect?				
Have you considered including age equality into staff objectives and appraisal?				
Disability	**Yes**	**No**	**N/A**	**To action**
Is it easy for people with disabilities to find out about your service?				
Does your printed information take account of the communication needs of people with various disabilities and is it easy to understand?				
Have you decided what core information you need available in large print, audiotape or Braille?				
Is your service physically accessible to people with mobility problems or who use a wheelchair?				
Do your staff members know how to access a sign language interpreter or an interpreting service for deaf and hearing impaired people, how to use an induction loop and where to get advice on material in different formats?				
Do you routinely record the communication needs of patients with a disability when sending out appointments etc?				
Have you put in place a procedure to record the uptake for sign language interpreters, appointment letters/leaflets in Braille etc?				
Do you currently monitor whether or not patients have a disability so that you know how well your service is being used by people with a disability?				
Do your staff members treat people with disabilities with respect and dignity?				
Is your service religiously and culturally sensitive to meet the needs of disabled people from minority ethnic groups?				
Have you thought about your assessment materials and methods and made sure that they are relevant to people with disabilities?				
Have you considered incorporating disability equality objectives into staff appraisals?				
Faith and Belief/Non Belief	**Yes**	**No**	**N/A**	**To action**
Is it easy for people from different religious backgrounds to find out about your service? Is your printed information religiously appropriate/sensitive?				
Do you currently record patients' religion in order to assist you in identifying users and non-users of your service from various religious backgrounds?				
Are your staff members treating people from different religions/beliefs/non belief with respect and dignity?				
Do your staff know how to access the Trust's Religious and Cultural Handbook?				
Have your staff members received training on religion and belief?				
Is your service religiously and culturally sensitive to meet the needs of people from various religious backgrounds?				
Have you identified any specific dietary or other needs related to a person's religion which you need to be sensitive to?				
Some religious and cultural traditions require particular dress e.g. wearing head coverings such as hijabs or turbans or modes of clothing which covers the body. Have you demonstrated flexibility and sensitivity to accommodate the wearing of religious dress safely?				
If you are running inpatient or residential services have you thought about prayer needs or the need for a quiet space for your patients/residents?				
Have you considered obtaining a list of various festivals to use to avoid arranging appointment/visits etc on any particular religious festivals, days or times?				
Have you considered incorporating religion and belief equality objectives in staff appraisal?				
Gender	**Yes**	**No**	**N/A**	**To action**
If your service is for men and women, do you routinely monitor the uptake of your service with gender breakdowns and take appropriate action?				
Does your service/policy affect men and women differently - is this equal?				
Do more women/men use your service? Do you need to consider positive action to get the gender balance even?				
Do you need to review your service and accommodation with regard to dignity and respect i.e. with regard to bed, toilet and bathroom space?				
Have your staff members received Gender Equality Training?				
Have you considered incorporating gender equality objectives in your staff appraisals?				
Race	**Yes**	**No**	**N/A**	**To action**
Have you decided what core information you need available in other languages?				
Do your staff members know how to access an interpreter for booking appointments or how to access telephone interpreting (in situations where it may not be possible to arrange an appropriate interpreter)? Do your staff members know where to get advice on material in other languages and formats?				
Do you currently record the ethnicity of patients so that you know how well your service is being used by people from minority ethnic backgrounds?				
Are your staff members treating patients from a minority ethnic background with respect and dignity?				
Have you identified any specific dietary or any religious needs of patients or any other specific requirements which you need to be sensitive to?				
Have your staff members received Equality Impact Assessment training as well Diversity Training?				
Have you considered incorporating race equality objectives in staff appraisal?				
Sexual Orientation	**Yes**	**No**	**N/A**	**To action**
Do you and your team give positive messages and a positive reception to gay men, lesbians, or bisexual people?				
Does information about your service use visual images that depict mainly heterosexual couples?				
When carrying out assessments, do you make it easy for someone to talk about their sexuality if it is relevant or do you assume that they are heterosexual?				
Would staff in your workplace feel comfortable about being 'out' or would the office culture make them feel that this might not be a good idea?				
Have your staff had training on sexual orientation and equality?				
Do you make sure that staff treat lesbian, gay and bisexual people with dignity and respect?				
Have you considered incorporating sexual orientation equality objectives in staff appraisal?				
Transgender	**Yes**	**No**	**N/A**	**To action**
Is your service sensitive to transgender individuals or those undergoing gender reassignment?				
Do your staff understand transgender terminology?				
Have your staff had transgender training?				
Do your staff treat transgender individuals with dignity and respect?				
Have you considered incorporating transgender equality objectives in staff appraisal?				

EQUALITY IMPACT ASSESSMENT FORM
Please refer to the guidance prompts in previous table before completing this form

Name of Service or Policy	
Department	
Managers Title	
Date	
Contact Telephone Number	

Part 1	**GENERAL**
1	Provide a brief description of the main service or policy for assessment including its aims and objectives
2	List the main stakeholders/beneficiaries in terms of the recipients of the service or the target group at whom the service/policy is aimed
3	What data, evidence, studies, reports, audits, surveys or feedback have you researched, with particular regard to equality groups? Roughly how many/what proportion of staff or patients will be affected? (Census data available in appendix 1. Census Profiles for Devon and Cornwall)
4	Who have you consulted with: e.g. staff, patients, service users? What consultation methods did you use e.g. satisfaction surveys, focus groups or patient observations, meetings, exit interviews or networking, and any alternative arrangements you have made or are planning for consulting with particular groups of people. When did you carry out this consultation and how were the results publicised?

Part 2				
Equality Group	**Positive Impact**	**Negative Impact**	**Neutral Impact**	**Reasons for Impact**
Age				
Disability				
Faith and belief/Non Belief				
Gender				

Race				
Sexual Orientation				
Transgender				

Outcomes

What changes will you make to remove to reduce any negative impact? Any action points should be included in Departmental action plans, with monitoring and review processes.

Signature Date

Please send this form electronically to Kelly.ebdon@nhs.net

Appendix 1

CENSUS PROFILES FOR DEVON AND CORNWALL
(Census 2001)

DISTRIBUTION OF BME, GENDER, AND HOUSEHOLDS WITH LIMITING LONG-TERM ILLNESS, WITHIN DEVON LOCAL AUTHORITIES.

Local Authority	Total Number	Number BWE	% BWE	% Gender	% Households with limiting long-term illness
Exeter	111076	2,667	2.4	49 m 51 f	32
Plymouth	240720	3,849	1.6	49 m 51 f	37
Torbay	129706	1,555	1.2	48 m 52 f	39
Teignbridge	120958	1,209	1.0	48 m 52 f	35
South Hams	81849	736	0.9	48 m 52 f	34

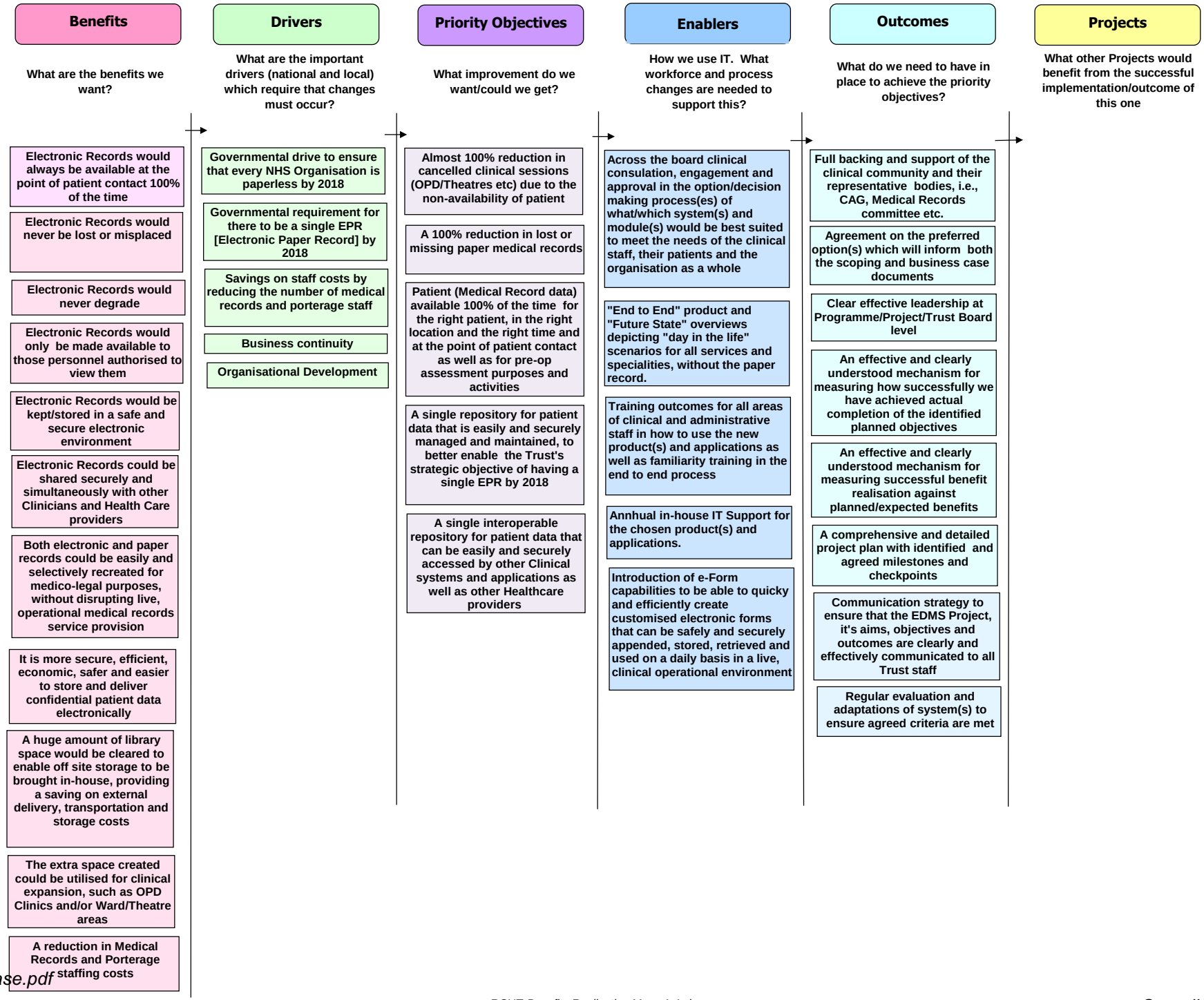
DISTRIBUTION OF RELIGION WITHIN DEVON LOCAL AUTHORITIES

Local Authority	% Christian	% Hindu	% Jewish	% Buddhist	% Muslim	% No Religion	% Religion Not Stated
Exeter	69	0	0	0.3	1	20	9
Plymouth	74	0	0	0.2	0	18	7
Torbay	76	0	0		0	15	8
Teignbridge	76	0	0	0.2	0	16	8
South Hams	75	0	0	0.4	0	17	8

DISTRIBUTION OF AGE WITHIN DEVON LOCAL AUTHORITIES

Local Authority	% 0-15	% 16-24	% 25-64	% 65+
Exeter	17	16	50	16
Plymouth	20	13	52	16
Torbay	18	9	51	23
Teignbridge	19	8	51	22
South Hams	19	8	52	21

Benefits Realisation Map EDMS.



Benefits Realisation Plan

Ref	Description of Benefit	How Benefit is Realised	Benefit Enabler	Benefit Owner	Benefit Type	Financial Quantifier	Baseline Measure	Improvement Measure	Realisation Timeframe
B1	Electronic Records would always be available at the point of patient contact 100% of the time	By monitoring cancelled OPD/Theatre etc sessions due to non-availability of medical records data	SDHC HIS & Product Supplier	TBC	Operational & Governance	Reduction in paper, delivery, transportation, storage and staff costs	Established non delivery data	Decrease in the number of non delivered records	March 2016 +
B2	Electronic Records would never be lost or misplaced	By virtue of the fact that digitised records would have replaced the paper copy and by monitoring all reported incidents of non-availability of medical records data	SDHC HIS & Product Supplier	TBC	Operational & Governance	Possible litigation costs due to negligence because of lost or misplaced notes/diagnoses	Established lost or misplaced records data	A reduction in the number of case notes that have been reported as lost or misplaced	March 2016 +
B3	Electronic Records would never degrade	By virtue of the fact that digitised records would have replaced the paper record	SDHC HIS & Product Supplier	TBC	Operational & Governance	As Above	Established degraded medical records data	A reduction in the number of case notes that have been reported as totally unusable due to degradation	March 2016 +
B4	Electronic Records would only be made available to those personnel authorised to view them	By ensuring that role based access privileges are in place for each clinical user as well as a detailed and robust audit log of user system access	SDHC HIS, Product Supplier & Clinical Engagement Team	TBC	Operational & Governance	Possible litigation costs due to unauthorised access to patient data	Currently anyone can potentially have access to a paper medical record	Increase in number of EDMS & EPR Users and requests for EDMS access	March 2016 +
B5	Electronic Records would be kept/stored in a safe and secure electronic environment	By ensuring that the EDMS repository is securely hosted (in the UK), by either the Trust's IT Services department or the chosen product provider	SDHC HIS & Product Supplier	TBC	Operational & Governance	Reduction in paper, delivery, transportation, storage and staff costs as well as on-site storage issues	Established numbers of current digitised patient records	Increase in the number of digitised (scanned) medical records and a decrease in the number of paper medical records being stored and delivered at the point of patient contact	March 2016 +
B6	Electronic Records could be shared securely and simultaneously with other clinicians and healthcare providers	By monitoring a system audit log of who, when and where the data was shared with and for how long	SDHC HIS, Product Supplier & Clinical Engagement Team	TBC	Operational & Governance	Reduction in paper, delivery, transportation, storage and staff costs	Established number of digitised records that are currently available	Inrease in the number of digitised records available	March 2016 +
B7	Both electronic and paper records could be easily and selectively recreated for medico-legal purposes without disrupting live, operational medical record service provision	By ensuring that the EDMS Solution can provide both a paper or electronic (CD, FTP) copy of the digitised case note as and when required	SDHC HIS, Product Supplier & Clinical Engagement Team	TBC	Operational & Governance	Reduction in paper, delivery, transportation, storage and staff costs	Established costs and processes for producing copies of medical records for medico-legal purposes	Reduction in the costs for reproducing paper medical records	March 2016 +
B8	It is more secure, efficient, economic, safer and easier to store and deliver confidential patient data electronically	Monitoring the reduction in paper costs and the reduction in medical records and porterage staff as well as delivery and transportation costs	SDHC HIS, Product Supplier, Clinical Engagement Team & Finance	TBC	Operational, Governance & Finacial	Reduction in paper, delivery, transportation, storage and staff costs	Established number of reported security breaches, time and cost to store and deliver paper case notes on demand	Decrease in the number of reported security breaches, time and costs to store and deliver paper case notes on demand	March 2016 +
B9	A huge amount of library space would be clearerd to enable off-site storage to be	By monitoring the amount of cleared Medical Records Library space is made	Medical Records, Finance, Clinical Engagement Team and	TBC		Reduction in paper, delivery	Reduction in existing off-site	Either (or both) a	

	brought in-house, providing a saving on external delivery, transportation and storage costs	available throughout the life of the project	Estates		Operational & Financial	delivery, transportation, storage and staff costs as well as on-site storage issues	storage costs and increase in revenue income due to increased clinical capacity	reduction in off-site storage costs or an increase in revenue income	March 2016 +
B10	The extra space created could be utilised for clinical expansion, such as OPD Clinics and/or Ward/Theatre areas	As above	Medical Records, Finance, Clinical Engagement Team and Estates	TBC	Operational & Financial	Possible increase in revenue income due to increased clinical capacity	Current established revenue income for clinical activity	Increase in revenue income due to increased clinical capacity	March 2016 +
B11	A reduction in Medical Records and Porterage staffing costs	See B8	Medical Records, Estates & Finance	TBC	Operational & Financial	Reduction in paper, delivery, transportation, storage and staff costs	Established Medical Records and Porterage staffing costs	A reduction in paper, delivery, transportation, storage and staff costs	March 2016 +

EDMS Project Benefits Analysis – Measurable Benefits.

	Benefits	Supporting Evidence	Source of Evidence
1	Electronic Records would always be available at the point of patient contact 100% of the time	1. Zero reports of non-availability of medical record at the point of patient contact	1. Reports to Medical Records/HIS reporting non availability of patient record 2.
2	Electronic Records would never be lost or misplaced	1. Zero reports of lost or misplaced records to Medical Records	1. Reports to Medical Records/HIS of lost or misplaced digitised patient record 2.
3	Electronic Records would never degrade	1. Zero reports of degraded medical records	1. Reports to Medical Records/HIS of degraded digitised patient records 2.
4	Electronic Records would only be made available to those personnel authorised to view them	1. Role and User based access information provided for each service and speciality	1. Requests to/from Service and Speciality Clinical Leads to HIS/EDMS Support for authorised access to patient data via the EDMS 2.
5	Electronic Records would be kept/stored in a safe and secure electronic environment	1. Decrease in the number of paper records. 2. Increase in the number of digitised records	1. Medical Records and HIS (EDMS Support). 2.
6	Electronic Records could be shared securely and simultaneously with other clinicians and healthcare providers	1. Increase in numbers of EDMS Users 2. Increase in requests from external healthcare providers for access	1. Requests to HIS/EDMS Support 2.
7	Both electronic and paper records could be easily and selectively recreated for medico-legal purposes without disrupting live, operational medical record service provision	1. Report on number of requests for copies of patients medical records details	1. Requests to Medical Records and/or Governance 2.
8	It is more secure, efficient, economic, safer and easier to store and deliver confidential patient data electronically	1. Numbers of lost, misplaced or degraded records. 2. Costs to store, deliver, transport, manage and maintain the existing paper medical records estate.	1. Medical Records HIS/EDMS Support and Finance 2.
9	A huge amount of library space would be cleared to enable off-site storage to be brought in-house, providing a saving on external delivery, transportation and storage costs	1. Off-site storage and delivery costs. 2. On-site storage capacity issues 3. On-site Health & Safety issues	1. Medical Records and Finance 2.
10	The extra space created could be utilised for clinical expansion, such as OPD Clinics and/or Ward/Theatre areas	1. Existing clinical revenue data	1. Clinical Engagement and Finance 2.
11	A reduction in Medical Records and Porterage staffing costs	1. Existing Medical Records and Porterage costs	1. Medical Records and Finance

CDMS & Medical Records Scanning

Project ref: ???-??

Options Appraisal v0.9

Revision History

Date of this revision:

Revision Date	Reason for Change	Author	Vers
Feb 2015	1ST Draft	Dan McLachlan	0.1
Feb 2015	2nd Draft	Dan McLachlan	0.2
Feb 2015	3rd Draft for Review	Dan McLachlan	0.3
Feb 2015	4th Draft for Review	Dan McLachlan	0.4
Mar 2015	Additions after Civica Review	Dan McLachlan	0.5
Mar 2015	Further Financial Model Updates	Dan McLachlan	0.6
April 1st-8th	Updates to Sections 3.1, 3.2, 3.5, 3.6, & Number of Options	Dan McLachlan	0.7
April 9th	Updates to Section 3.4, 3.5 & & Weighted Evaluation.	Dan McLachlan	0.8
April 24th	Updates to Section 3.6 to include Benefits & Risks for each Option	Dan McLachlan	0.9

Distribution & Approval

This document has been distributed to:

Name	Title	Role	Date of Issue	Vers
Mike Green	CCIO	Project Sponsor	4th May	0.9
Gary Hotine	Director of ICT Services		4th May	0.9
Gill Otway	IT Programme Lead		4th May	0.9
Liz Williams	Head of Medical Records			

Service Approval Signatures

Approved by: (Signature) _____

Name: MIKE GREEN **Title: CCIO & Project Sponsor**

Approved by: (Signature) _____

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Name: LIZ WILLIAMS **Title: Head of Medical Records**

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CONTENTS PAGE

1 Purpose of this document

The purpose of this document is to provide a summary of options to assist the Project Board and Clinical Engagement Group in deciding which option would provide the most economically and operationally effective solution in their deliberations to implement a South Devon Health Community Clinical (Electronic) Document Management System and scanning solution for the Medical Records estate.

Once this document has been approved, any changes to the identified and approved scope of the project, its deliverables, objectives and/or goals and timelines, will be handled by the recognised change control process, which in turn will also be approved by the signatories identified previously.

2 Introduction

South Devon Healthcare NHS Foundation Trust hereafter referred to as SDHFT and Torbay and Southern Devon Health and Care Trust, hereafter referred to as T&SDHCT, plan to join together to become one Integrated Health Care Organisation, hereafter referred to as the South Devon Health Community. As one Healthcare provider, they will provide high quality, patient centred care for upwards of 300,000 people across the South Devon region as well as approximately 100,000 visitors per year.

Hospital Medical Records are fundamental to the provision of safe and effective patient care as well as for clinical audit, research and medico-legal purposes. South Devon Healthcare NHS Foundation Trust currently manages over 315,000 medical records. The Trust currently provide up to 2,000 Patient records per day.

Statistics show that there is an average growth in the number of new records of approximately 20,000 per year. Requests for notes for emergency admissions are also pulled on demand. This numbers approximately 3,000 per month of which almost 1,300 are Out of Hours.

There is a pressing need to improve the medical record service provision to clinicians so that they can be sure that they have access to essential patient information in the right location, at the right time, for the right patient, in a secure, efficient and speedy manner.

There is also an on-going requirement to improve services to patients, ensuring that those associated with their care have up-to-date, accurate and timely information made available to them across the health economy.

At present, South Devon Healthcare NHS Foundation Trust is faced with a growing requirement to manage health records. There are specific problems relating to space needed to store records, timeliness and accuracy of delivery and the availability of records across multiple sites.

The current paper health record is already being transported and used for OP (Outpatient) and IP (Inpatient) activity in the local community hospitals as well as here at the Torbay site. Apart from the obvious security implications, this has obvious limitations on the availability of information and the flexibility of their use.

The planned transfer of services from the Community Trust only serve to increase the pressure for storage space around the Trust estate.

As part of the Department of Health's (Jeremy Hunt) drive for Healthcare, South Devon Health Community aim to be paperlight/less by 2018. To help facilitate this, the Trust are looking to digitise the paper medical record estate to enable these records to be made available at the point of patient contact, in a safe and secure manner. The Trust currently use WinDip, an EDMS (Electronic Document Management System) solution provided by Civica. The Trust is looking to expand their relationship with Civica in order to utilise the current EDMS to store scanned, digital images of medical records. The Trust is also looking to rent or procure a number of scanning machines, capable of coping with the anticipated demand for digitised records within the project timeline.

For future reference, the term “solution” means both the facility to scan the paper medical records, as well as to view them in a clinical or administrative setting.

3 Executive Summary

3.1 Strategic Case

The Trust currently holds in excess of 315,000 patient records across the South Devon Health Community and one off-site storage facility, with around 20,000 new patient registrations being created each year. The storage, management and maintenance needed for these records is continually growing. As the number of patient records continues to increase, so will the need for extra resource as this is a labour intensive operation.

The Trust currently use WinDIP as a central storage repository for digitised patient records which currently number approximately 44 million images for 394,000 patients. They are looking to expand their capacity to scan more of these paper records by increasing the number and type of records to be scanned by the existing provider, Gateway, as well as implementing an in-house scanning solution.

Increasing the current scanning capacity by Gateway, whilst setting up our own in-house scanning bureau, would enable the Trust to further continue to provide for a modern medical records service, ensuring that the right record is available at the right time in the right location for the right patient. The implementation of this system will further ensure that this information is delivered in a safe, secure and speedy fashion at point of contact.

This would also ensure patient care is not compromised due to missing patient records. Staffing and off-site storage costs would also be reduced due to the decrease in the need for the retrieval, filing, storage and delivery required for the medical records estate.

3.2 Current state

SDHC FT will shortly be merging with T&SDHCT, which means that the continued provision of a paper based medical records service will be inefficient operationally and unsustainable financially . With the increase in new registrations and the possibility of having to scan all speciality held records within each speciality, more storage space will be required. Without the extra physical storage capacity, be it on or off site, will mean that these records may no longer be able to fit into the existing filing racks. Apart from the obvious costs associated with providing this extra storage capacity, the Health and Safety risks to staff are high.

A large proportion of Health Records staff are used to retrieve, prepare and file patient records on a daily basis, and whilst over 98.94% of records are retrieved in time for every patient visit, the staff are unable to locate a number of them, which imposes a significant clinical risk to patients. Health Records also have to operate a 24hr, 5 days a week and 12hrs per weekend day, 365 days a year service to be able to provide patient records on demand for emergency admissions, which incurs a considerable ‘out of hours’ staffing cost to the Trust.

3.3 The vision

The Trust wishes to improve the patient experience at every opportunity. An upgraded CDMS and increased scanning capacity, will ensure that every patient record is available for every patient at point of contact. The Trust also aims for the effective utilisation of staff, our biggest resource.

3.4 Economic Case

When considering how to meet the business requirements, an options appraisal with estimated costs needs to be undertaken. It should be remembered that on average each paper record contains approximately 300 pages which equates to 600 images. Please see the model below:

This model is based on the following calculations which have been arrived at after consultation with both Medical Records, Civica and Gateway Scanning Bureau Services.

1. Approximately 300 pages per paper Medical Case Note (Main Library, Speciality & Iron Mountain).
2. 1 page equals 2 images (front and back).
3. Approximately 40,000 speciality held Medical Records (All Specialities).
4. Approximately 3,240 Oncology Records with about 75 pages per Record.
5. Black & White (bi-tonal) imagery will be scanned at 200 DPI and costs £19.51p per 1,000 images. This equates to £0.0195p per image (£0.02p).
6. Colour imagery will be scanned at 300 DPI and costs £59.80p per 1,000 images. This equates to £0.059p per image (0.06p).
7. It is estimated that about 5% of the content of the Medical Case Note will need to be scanned in colour.
8. Pricing is inclusive of transportation, scanning, indexing, transfer of imagery to WinDIP, and destruction of the paper record and is exclusive of VAT.
9. The admin cost for the Trust to pull, box and catalogue records for dispatch to Gateway is 0.25p per file. If this work was undertaken out of hours (which due to current work pressures it is likely to be initially) we'd need to add on an additional 30% on costs. This equates to £0.325p per file for admin costs. This is the figure that has been used for the cost calculations in the tables below.
10. Once scanned, paper medical records will not be reconstituted and will be destroyed after 30 days.
11. All pricing is based on the scanning operation being conducted off site, i.e., at Gateway Scanning Bureau.
12. Based on the numbers and costs above, to scan 1 paper Medical Record from the Main Library & Iron Mountain equates to approximately £13.20p. £1.18p would need to be included as a "Perm Out" cost for permanently removing the medical record from Iron Mountain.
13. Timescales are based on approximately 2,000 records per week which can be scanned by Gateway, although they have said that they can ramp up scanning schedules to suit at no extra cost. I have used 46 weeks in a calendar year for the timeline calculations.

3.5 MAIN MODEL

Medical Records Library & Speciality Held Records ONLY

EDMS
Option Appraisal **A typical patient record contains, on average, 300 pages which equates to 600 images**

Legend

Active Record	A patient with a current open episode of care
Inactive Record	A patient that has been discharged and has not re-presented for 2 years since date of discharge
Deceased Record	A deceased patient (RIP)

			TORBAY & SPECIALITIES					
			Torbay	Speciality Held	Total Torbay & Speciality Records	Pre Scan Admin & Prep Costs	Scan Cost	Total Scanning Cost
1	ACTIVE	Records	174,751	40,473	215,224	£69,948	£2,840,956.80	£2,910,904.60
		Pages	52,425,300	3,035,475	55,460,775			
		Images	104,850,600	6,070,950	110,921,550			
2	INACTIVE	Records	34,044	1,639	35,683	£11,597	£471,015.60	£482,612.58
		Pages	10,213,200	491,700	10,704,900			
		Images	20,426,400	983,400	21,409,800			
4	DECEASED	Records	13,326	0	13,326	£4,331	£175,903.20	£180,234.15
		Pages	3,997,800	0	3,997,800			
		Images	7,995,600	0	7,995,600			
							TOTAL COST	£3,573,751.33

	Total Records	Total Pages	Total Images	Total Cost Per Record
ACTIVE	215,224	55,460,775	110,921,550	£2,910,905
INACTIVE	35,683	10,704,900	21,409,800	£482,613
DECEASED	13,326	3,997,800	7,995,600	£180,234
	264,233	70,163,475	140,326,950	£3,573,751

LW- CSP to quote for different types of Slim Folder (Temp Folder).

Medical Records Held Records at Iron Mountain ONLY					
EDMS					
Option Appraisal	**A typical patient record contains, on average, 300 pages which equates to 600 images**				
Legend					

	Deceased Record	A deceased patient (RIP)				Total Scanning Costs
			Iron Mountain	Perm Out Cost	Scan Cost	
1	DECEASED	Records	51,511	£60,783	£802,335.34	£863,118
		Pages	15,453,300	£0	£0.00	
		Images	30,906,600	£0	£0.00	

	Total Records	Total Cost
ACTIVE	N/A	N/A
INACTIVE	N/A	N/A
DECEASED	51,511	£863,118
	51,511	£863,118

3.6 FURTHER CONSIDERATIONS

Based on these figures, a number of options have been identified.

Option 1 - Do nothing. Stay as we are.
Option 2 - Scan on demand – all ACTIVE records only.
Option 3 - Only scan INACTIVE records.
Option 4 - Only scan DECEASED records.
Option 5 - Scan all ACTIVE and INACTIVE records simultaneously.
Option 6 - Scan all INACTIVE and DECEASED records simultaneously.
Option 7 - Scan ALL records simultaneously.
Option 8 - Scan IRON MOUNTAIN Records only. (Deceased Records).
Option 9 - Split scanning of selected/all records simultaneously.

3.6.1 Option 1

Do nothing, Stay as we are.

The need for paper patient records would continually increase putting more pressure on the storage areas that cannot accommodate any more records. More funding would be required to store records offsite to try to create storage space onsite. A large Health and Safety risk would still remain, firstly to the safety of the patient records against fire and flooding and secondly to staff who have to manually handle the records on a daily basis. Large staffing costs would still be required to manage and maintain the records. The risk of patient records being unavailable when required would also remain, and even increase, which could result in patients being cancelled at short notice.

Opt 1	Benefits	Benefit & Risk Levels
B1	Clinicians would still receive paper case notes on demand - no change to operational service (Benefit to Clinicians)	HIGH
	Risks [Dis-Benefits]	
R1	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R2	A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who have to manually handle records on a daily basis	HIGH
R3	An Increase in the unavailability of records as the estate grows resulting in cancelled patients and loss of revenue	HIGH
R4	Increased staffing costs to manage and maintain the increase in paper medical records	HIGH
R5	Certain non compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH

3.6.2 Option 2

Scan on demand – all ACTIVE records only.

Scan all records for those patients due to attend the Trust and make their record electronic in time for their visit, therefore scanning all active records. For each attendance, a slim folder would need to be provided for the clinical teams to write on any continuation sheets required as the Trust is not currently paperless. A scanning mechanism would need to be implemented so that any correspondence is scanned immediately after contact with the patient and added to the electronic record.

ITEM	Costs (Exclusive VAT)	Timescale
Scan All Active - External	£2,910,905	2 Years 3 Months
Day Forward Scanning Internal	£0	Until Paperless
Day Forward Scanning External	£0	Until Paperless
Total Cost / Timeline	**£2,910,905**	**2 Years 3 Months**

Opt 2	Benefits	Benefit & Risk Levels
B1	Electronic Records would always be available at the point of patient contact 100% of the time	HIGH
B2	Electronic Records would never be lost or misplaced	HIGH
B3	Electronic Records would never become degraded	HIGH
B4	Electronic Records would be kept in a safe and secure electronic environment	HIGH
B5	Electronic Records could be securely shared instantaneously and simultaneously with other Health Care providers.	HIGH
B6	Both electronic and paper copies could be quickly and easily created for medico-legal purposes without disrupting live, operational medical record service provision	HIGH
B7	It is cheaper, safer, quicker and easier to store and deliver confidential patient data electronically	HIGH
B8	A huge amount of library space would be cleared to enable off site storage to be brought in house, thus saving on external delivery and storage costs	HIGH
B9	The extra space created could be utilised for clinical expansion, such as OPD Clinics and/or Ward areas.	MEDIUM
	Risks [Dis-Benefits]	
R1	Clinical opposition to the digitisation and removal of the paper medical record from clinical circulation	HIGH
R2	Certain non compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH
R3	The Business Case may not be approved to support this option	MEDIUM
R4	IT Infrastructure may not be in place to support digitised medical record service provision	MEDIUM
R5	Change management and Clinical operational processes may not be clearly defined, communicated and understood by all Stakeholders resulting in a disjointed and confused operational environment, coupled with increased and acrimonious opposition to the project and its objectives	LOW

3.6.3 Option 3

Only scan INACTIVE records.

Scan all records for those patients classed as inactive and continue to deliver paper records for patient appointments. If the patient re-presented at the Trust, their records would be available in electronic format. This would also create some space within the storage areas which would reduce the Health and Safety risk and relieve pressure on the storage areas for a short time.

ITEM	Costs (Exclusive VAT)	Timescale
Scan Inactive - External	£482,613	4 Months
Total Cost	**£482,613**	**4 Months**

Opt 3	Benefits	Benefit & Risk Levels
B1	Clinicians would still receive paper case notes on demand - no change to operational service (Benefit to Clinicians)	HIGH
B2	If a patient represented, their records would be available electronically	HIGH
B3	Just under 10% of library space would be cleared to enable off site storage to be brought in house, thus saving on external delivery and storage costs	MEDIUM
	Risks [Dis-Benefits]	
R1	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R2	A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who have to manually handle records on a daily basis	HIGH
R3	Increase in the unavailability of records as the estate grows resulting in cancelled patients and loss of revenue	HIGH
R4	Increased staffing costs to manage and maintain the increase in paper medical records	HIGH
R5	Non Compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH

3.6.4 Option 4

Only scan DECEASED records. (At Torbay).

Scan all records for those patients that are deceased and continue to deliver paper records for patient appointments. Should the records need to be viewed they would be available in electronic format and they will be held on the system for their full retention period. This would create space within the storage areas which would reduce the Health and Safety risk and relieve pressure on the storage areas for a short time.

ITEM	Costs (Exclusive VAT)	Timescale
Scan Deceased - External	£180,234	2 Months
Total Cost	**£180,234**	**2 Months**

Opt 4	Benefits	Benefit & Risk Levels
B1	Clinicians would still receive paper case notes on demand - no change to operational service (Benefit to Clinicians)	HIGH
B2	Deceased records would be available electronically for research, test, trial and audit purposes	MEDIUM
B3	Just under 5% of library space would be cleared to enable off site storage to be brought in house, thus saving on external delivery and storage costs	LOW
	Risks [Dis-Benefits]	
R1	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R2	A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who may have to manually handle records on a daily basis	MEDIUM

3.6.5 Option 5

Scan all ACTIVE and INACTIVE records simultaneously.

Scan all records for those patients that are classed as both active and inactive. This would include scanning on demand for all active patients in conjunction with scanning inactive records. This would create considerable space within existing storage areas. **N.B**. I have calculated 2 years and 7 months to take into account a fall off in scanning production once the active records have been digitised.

ITEM	Costs (Exclusive VAT)	Timescale
Scan Active - External	£2,910,905	2 Years 7 Months
Scan Inactive - External	£482,613	
Day Forward Scanning Internal	£0	
Day Forward Scanning External	£0	
Total Cost /Timeline	**£3,393,518**	**2 Years 7 Months**

Opt 5	Benefits	Benefit & Risk Levels
B1	Electronic Records would always be available at the point of patient contact 100% of the time	HIGH
B2	Electronic Records would never be lost or misplaced	HIGH
B3	Electronic Records would never become degraded	HIGH
B4	Electronic Records would be kept in a safe and secure electronic environment	HIGH
B5	Electronic Records could be securely shared instantaneously and simultaneously with other Health Care providers.	HIGH
B6	If a patient represented, their records would be available electronically	HIGH
B7	Both electronic and paper copies could be quickly and easily created for medico-legal purposes without disrupting live, operational medical record service provision	HIGH
		HIGH
B8	It is cheaper, safer, quicker and easier to store and deliver confidential patient data electronically	HIGH
B9	A huge amount of library space would be cleared to enable off site storage to be brought in house, thus saving on external delivery and storage costs	HIGH
B10	97% of library space would be cleared which could be utilised for clinical expansion, such as OPD Clinics and/or Ward areas	HIGH
	Risks [Dis-Benefits]	
R1	Clinical opposition to the digitisation and removal of the paper medical record from clinical circulation	HIGH
R2	Certain non compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH
R3	Increase in the unavailability of records as the estate grows resulting in cancelled patients and loss of revenue	HIGH
R4	Increased staffing costs to manage and maintain the increase in paper medical records	HIGH
R5	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R6	A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who may have to manually handle records on a daily basis	MEDIUM
R7	The Business Case may not be approved to support this option	MEDIUM
R8	IT Infrastructure may not be in place to support digitised medical record service provision	MEDIUM
R9	Change management and Clinical operational processes may not be clearly defined, communicated and understood by all Stakeholders resulting in a disjointed and confused operational environment, coupled with increased and acrimonious opposition to the project and its objectives	LOW

3.6.6 Option 6

Scan all INACTIVE and DECEASED records simultaneously.

Scan all records for those patients that are classed as inactive and for deceased patients and continue to deliver paper records for patient appointments. The need for these records to be recalled is low and would create a considerable amount of space within existing storage areas.

ITEM	Costs (Exclusive VAT)	Timescale
Scan Inactive - External	£482,613	7 Months
Scan Deceased - External	£180,234	
Total Cost	**£662,847**	**7 Months**

Opt 6	Benefits	Benefit & Risk Levels
B1	Clinicians would still receive paper case notes on demand - no change to operational service (Benefit to Clinicians)	HIGH
B2	If a patient represented, their records would be available electronically	HIGH
B3	Deceased records would be available electronically for research, test, trial and audit purposes	MEDIUM
B4	Just under 15% of library space would be cleared to enable off site storage to be brought in house, thus saving on external delivery and storage costs	MEDIUM
	Risks [Dis-Benefits]	
R1	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R2	A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who have to manually handle records on a daily basis	HIGH
R3	Increased staffing costs to manage and maintain the increase in paper medical records	HIGH
R4	Non Compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH
R5	Increase in the unavailability of records as the estate grows resulting in cancelled patients and loss of revenue	MEDIUM

3.6.7 Option 7

Scan ALL records simultaneously.

Scan all records currently held at the Trust. This would require a large amount of resource from the chosen scanning solution, but would enable all records to be scanned and made available electronically. This responsibility could also be shared with the existing scanning provider and the in-house scanning bureau. This would free up existing storage areas once the roll out programme had been completed and would be a large step forward into the Trust becoming a paper light/less South Devon Health Community. This would also have the added benefit of having all records available electronically for clinical research, tests or trials.

ITEM	Costs (Exclusive VAT)	Timescale
Scan Active - External	£2,910,905	2 Years 9 Months
Scan Inactive - External	£482,613	
Scan Deceased – External	£180,234	
Day Forward Scanning Internal	£0 (TBC)	Until Paperless
Day Forward Scanning External	£0 (TBC)	Until Paperless
Total Cost	**£3,573,752**	**2.5 - 3 Years**

Opt 7	Benefits	Benefit & Risk Levels
B1	Electronic Records would always be available at the point of patient contact 100% of the time	HIGH
B2	Electronic Records would never be lost or misplaced	HIGH
B3	Electronic Records would never become degraded	HIGH
B4	Electronic Records would be kept in a safe and secure electronic environment	HIGH
B5	Electronic Records could be securely shared instantaneously and simultaneously with other Health Care providers.	HIGH
B6	If a patient represented, their records would be available electronically	HIGH
B7	Both electronic and paper copies could be quickly and easily created for medico-legal purposes without disrupting live, operational medical record service provision	HIGH HIGH
B8	It is cheaper, safer, quicker and easier to store and deliver confidential patient data electronically	HIGH
B9	A huge amount of library space would be cleared to enable off site storage to be brought in house, thus saving on external delivery and storage costs	HIGH
B10	97% of library space would be cleared which could be utilised for clinical expansion, such as OPD Clinics and/or Ward areas	HIGH
B11	Deceased records would be available electronically for research, test, trial and audit purposes	MEDIUM
	Risks [Dis-Benefits]	
R1	Clinical opposition to the digitisation and removal of the paper medical record from clinical circulation	HIGH
R2	Certain non compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH
R3	Increase in the unavailability of records as the estate grows resulting in cancelled patients and loss of revenue	HIGH
R4	Increased staffing costs to manage and maintain the increase in paper medical records	HIGH
R5	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R6	A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who may have to manually handle records on a daily basis	MEDIUM
R7	The Business Case may not be approved to support this option	MEDIUM
R8	IT Infrastructure may not be in place to support digitised medical record service provision	MEDIUM
R9	Change management and Clinical operational processes may not be clearly defined, communicated and understood by all Stakeholders resulting in a disjointed and confused operational environment, coupled with increased and acrimonious opposition to the project and its objectives	LOW

3.6.8 Option 8

Scan all records held by Iron Mountain Only.

Only scan all records currently held by Iron Mountain, our off-site storage facility provider. These records are predominantly deceased records and apart from having these records made available electronically for research, test and trial purposes, there would be no immediate demand or need to scan them. As well as providing the Trust with a large step forward into becoming a paper light/less Organisation, the only other tangible benefit of selecting this option would be from harvesting the savings made from transportation and off-site storage costs.

ITEM	Costs (Exclusive VAT)	Timescale
Scan Iron Mountain Records	£863,118	7 Months
Total Cost	**£863,118**	**7 Months**

Opt 8	Benefits	Benefit & Risk Levels
B1	Clinicians would still receive paper case notes on demand - no change to operational service (Benefit to Clinicians)	HIGH
	Risks [Dis-Benefits]	
R1	Further Storage costs (Internal & External) would be generated as the paper record estate grows	HIGH
R2	The Business Case may not be approved to support this option	HIGH
R3	Non Compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	LOW

3.6.9 Option 9

Split Scanning of selected/all records simultaneously.

Scan selected/all records currently held by both internal and external storage facilities simultaneously between Gateway and ourselves. This would enable all records to be scanned and made available electronically regardless of age or status. As in option 7, this would free up existing storage areas within the Trust, and would negate the need and cost associated with outsourced storage and transportation. It would also provide a large step forward into the Trust becoming a paper light/less South Devon Health Community.

ITEM	Costs (Exclusive VAT)	Timescale
Scan both Internal & Externally Held Records	£4,436,870	3 Yrs 4 Months
Total Cost	**£4,436,870**	**3 Yrs 4 Months**

Opt 9	Benefits	Benefit & Risk Levels
B1	Electronic Records would always be available at the point of patient contact 100% of the time	HIGH
B2	Electronic Records would never be lost or misplaced	HIGH
B3	Electronic Records would never become degraded	HIGH
B4	Electronic Records would be kept in a safe and secure electronic environment	HIGH
B5	Electronic Records could be securely shared instantaneously and simultaneously with other Health Care providers.	HIGH
B6	Both electronic and paper copies could be quickly and easily created for medico-legal purposes without disrupting live, operational medical record service provision	HIGH
B7	It is cheaper, safer, quicker and easier to store and deliver confidential patient data electronically	HIGH
B8	100% of library space would be cleared which could be utilised for clinical expansion, such as OPD Clinics and/or Ward areas	HIGH
B9	Full Compliance with DOH/NHS England directives on provision of a single electronic paper record [EPR] and being paperless by 2018	HIGH
B10	Deceased records would be available electronically for research, test, trial and audit purposes	MEDIUM
	Risks [Dis-Benefits]	
R1	Clinical opposition to the digitisation and removal of the paper medical record from clinical circulation	HIGH
R2	IT Infrastructure may not be in place to support digitised medical record service provision	HIGH
R3	The Business Case may not be approved to support this option	HIGH
R4	Change management and Clinical operational processes may not be clearly defined, communicated and understood by all Stakeholders resulting in a disjointed and confused operational environment, coupled with increased and acrimonious opposition to the project and its objectives	LOW

Option Assessment & Selection Overview

Weightings to be agreed at the meeting on the 16th April.

The options have been assessed on a balance of time to implementation of the option, the amount and/or number of tangible (Clinical and Operational) and financial benefits that could be harvested, tempered by the perceived level of risk associated with the option.

A weighting has been applied to each of these influencing factors to determine the preferred option.

4 = Best possible outcome (or least amount of risk associated with the option) through to
1 = Worst possible outcome.

The table below summarises this assessment.

	Time (1)	Cost (2)	Benefit (3)	Risk (4)	Overall Score	Overall Position
Option 1	4	8	3	4	19	4th
Option 2	3	4	9	4	20	3rd
Option 3	2	4	9	12	27	2nd
Option 8	1	2	12	16	31	1st

For example, if it was felt that option 8 scored 1 on the Time element because out of all 9 options, it would take the longest to implement, hence the worst possible association for the time element.
Ergo: The calculation is 1 for the worst possible outcome x 1 for the weighting associated with the Time element = **a score of 1.**

Another example would be under the benefits element for the same option.
Here the calculation would be 4 for the best possible outcome (maximisation of multiple benefits) x 3, the weighting associated with the Benefits element = **a score of 12**

Weighted Evaluation:

The table below depicts how the scoring mechanism above has been applied to the 9 options.
The weighting applied is indicative and can be changed and re-evaluated after consultation with our clinical colleagues.

SOD =	Scan On Demand
Pts 1-4 =	1 Point = Bad to 4 Points = Best
POSN =	Options Appraisal Position after weighted scoring

ITEM	OPTION	TIME X1	Pts 1-4	Total	COST X2	Pts 1-4	Total	BENEFIT X3	Pts 1-4	Total	RISK X4	Pts 1-4	Total	TOTAL PTS	POSN
Do Nothing	1	0	1	1	0	1	2	0	1	3		1	4	10	9th
SOD - Active Records	**2**	**2Yr 3Mth**	**2**	**2**	**2.9M**	**2**	**4**		**4**	**12**		**4**	**16**	**34**	**1st**
Inactive Records	3	4Mth	4	4	483,00	4	8		3	9		2	8	29	3rd
Deceased Records	4	2Mth	4	4	180,000	4	8		2	6		1	4	22	7th
Active & Inactive Recs	5	2Yr 7Mth	2	2	3.4M	2	4		3	9		2	8	23	4th
Inactive & Deceased Recs	6	7Mth	3	3	663,000	3	6		2	6		2	8	23	4th
All Records	7	2Yr 9Mth	1	1	3.6M	1	2		4	12		4	16	31	2nd
Iron Mountain Records Only	8	7Mth	3	3	863,000	3	6		1	3		1	4	16	8th
All Records split with Supp	9	2.5-3Yrs	1	1	4.5M	1	2		4	12		2	8	23	4th

	Time (1)	Cost (2)	Benefit (3)	Risk (4)	Overall Score	Overall Position
Option 1	1	2	3	4	10	9th
Option 2	**2**	**4**	**12**	**16**	**34**	**1st**
Option 3	4	8	9	8	29	3rd
Option 4	4	8	6	4	22	7th
Option 5	2	4	9	8	23	4th
Option 6	3	6	6	8	23	4th
Option 7	1	2	12	16	31	2nd
Option 8	3	6	3	4	16	8th
Option 9	1	2	12	8	23	4th

Based on the weighted scoring criteria, this makes Option 2 the preferred Option based on Time to implement, against the Cost and Risk elements, balanced with the perceived Benefits.

N.B. GILL, We may wish to consider a supplier based Option only??? as the preferred option as it will provide a single, unified, modular based solution, with high benefit delivery potential, for low risk, and where the support and maintenance of the solution is owned and managed by the supplier.

3.5 Financial Case

The project requires capital investment of ??? and additional annual revenue funding of ???. This investment is expected to generate gross savings over a ??? year period of ??? from the implementation of the new solution.

The project is an enabler with regards to the potential savings opportunities that will materialise from this solution's implementation.

- Reductions in staffing costs.
- Reductions in lost outpatient and inpatient capacity where slots are cancelled at short notice due to case note unavailability.
- Reduction in storage costs.
- Reduction in delivery and transportation costs.

Based over a ??? year period, indicative total project savings after implementation have been calculated at approximately ??? gross. The indicative net position saving minus total revenue costs equates to ??? over the same period.

N.B. GILL, I CAN WORK THESE FIGURES OUT WITH THE FINANCE LEAD AND CIVICA/GATEWAY

Programme Title:	TBC
Project Title:	TSDHC EDMS Project
Register Version:	v0.1
Date:	May 2015
Author:	Dan McLachlan - Project Manager

	Insignificant	Minor	Moderate	Major	Catastrophic
Almost Certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	5	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	4	4	5

Likelihood Key		Value
Almost certain	> 75% chance	5
Likely	50 - 75% chance	4
Possible	20 - 50% chance	3
Unlikely	5 - 20% chance	2
Rare	< 5% chance	1

IMPORTANT NOTE: IF EITHER:

1. The Risk impacts on Patient or Staff Safety.
2. The Risk concerns Patient privacy or System security.
3. The Risk rating is RED.

You **MUST** also enter the risk on the Strategic Risk Register and re-assess using the Trust Risk Ratings.

Consequence Key		Value
Catastrophic	Would result in early Project closure	5
Major	Would delay whole Project or increase Project costs	4
Moderate	Would delay current stage but overall Project timescales & cost not exceeded	3
Minor	Would not delay current stage or cost but could lead to a project change	2
Negligible	Would not delay current stage, cost or project, but should be monitored	1

Risk ID	Log Date	Risk Status	Likelihood	Consequence	Risk Rating	Residual Risk	Review Date	Closed Date	Description of Risk	Controls in Place	Control Effectiveness	Input By	Risk Owner	Additional Narrative relevant to the Risk
R1	4/5/15	Open	5	5	25	High	1/2/16		Certain non complaince with DOH/NHS England directives on provision of a single electronic paper record (EPR) and being paperless by 2018	Approve the most suitable option for the scanning of the medical record estate	Effective	Dan Mc	TBC	
R2	4/5/15	Open	5	4	20	High	1/2/16		Increased staffing costs to manage and maintain the increase in paper medical records	Approve the most suitable option for the scanning of the medical record estate	Effective	Dan Mc	TBC	
R3	4/5/15	Open	5	4	20	High	1/2/16		An increase in the unavailability of records as the estate grows resulting in cancelled patients and loss of revenue	Approve the most suitable option for the scanning of the medical record estate	Effective	Dan Mc	TBC	
R4	4/5/15	Open	5	4	20	High	1/2/16		Further storage costs (Internal & External) would be generated as the paper record estate grows	Approve the most suitable option for the scanning of the medical record estate	Effective	Dan Mc	TBC	
R5	4/5/15	Open	4	4	16	High	1/2/16		A large Health & Safety risk from loss of records due to fire, flood, misplacement and natural degradation over time as well as injury to staff who have to manually handle records on a daily basis	Approve the most suitable option for the scanning of the medical record estate	Effective	Dan Mc	TBC	
R6	4/5/15	Open	4	4	16	High	1/2/16		Clinical opposition to the digitisation and removal of the paper medical record from clinical circulation	Undertake a Trust wide clinical engagement inclusive of "day in the life" scenarios to showcase transformational change	Effective	Dan Mc	TBC	
R7	4/5/15	Open	3	4	12	Significant	1/2/16		The Business Case may not be approved to support the Project			Dan Mc	TBC	
R8	4/5/15	Open	2	4	8	Moderate	1/2/16		IT infrastructure may not be in place to support digitised medical record service provision	Ensure that IT Leads confirm the capacity to support, manage and maintain the transformational change	Effective	Dan Mc	TBC	
R9	4/5/15	Open	2	3	6	Low	1/2/16		Change management and clinical operational processes may not be clearly defined, communicated and understood by all stakeholders resulting in a disjointed and confused operational environment, coupled with increased and acrimounious opposition to the project and its objectives	Undertake a Trust wide clinical engagement inclusive of "day in the life" scenarios to showcase transformational change and consult and engage with clinical colleagues at every level to ensure buy in	Effective	Dan Mc	TBC	
R10					0									
R11					0									
R/CI/002	dd/mm/yy	Closed	0	0	0	Significant	TBC				Satisfactory	Dan Mc	TBC	
R/CL/003	dd/mm/yy	Moved	0	0	0	High	TBC				Satisfactory	Dan Mc	TBC	

		High	
Open		Significant	Effective
Closed		Moderate	Satisfactory
Moved		Low	Weak

5
4
3
2
1

Torbay and South Devon NHS
NHS Foundation Trust

Meeting Date:	6th April 2016
Title:	CQC Update
Lead Director:	Chief Nurse & Medical Director
Corporate Objective:	Best Experience / Safest Care
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The Care Quality Commission (CQC) completed their inspection of services over a three week period beginning February 2nd. During the time of the visit the Emergency Department (ED) experienced significant demand that resulted in delays and overcrowding that led to the Trust declaring an internal significant incident in order to mobilise further resources to meet the demands. Whilst acknowledging the increased demand and stress on the service, the CQC raised significant concerns about the care and safety of patients in the department and signalled to Executives that a further communication should be expected. The CQC formally notified the Trust of their concerns on March 1st.

The challenges of meeting the four hour Emergency target have been reported to the Board over the last year with the associated risk to quality and safe care highlighted on Trust risk registers. Failure to meet the four hour standard is a consequence of the pattern of attendances and acuity of patients, of the efficiency of assessing and treating patients within the ED and of how patients move or 'flow' through the whole Trust including wards, community hospitals, care home and onward to home. Whilst failure to achieve the four hour target reflects the efficiency and effectiveness of the whole system, the Emergency Department is the area where the pressure is most acutely evident. As new patients arrive, if not efficiently assessed, treated and flowed out, the department becomes over crowded, waits to be seen increase, patient experience is poor and quality is compromised. This challenging situation is compounded by an ED environment that was not built to meet the current level of demand.

Over the last year a number of actions have been taken to improve care in the department and reduce and mitigate risks to safety and performance. The Trust has opened a Clinical Decision Unit, a Medical Admissions Unit and a Paediatric Admissions Unit to improve flow. Medical and Nursing staffing has been reviewed and, despite challenges of recruitment, staffing numbers have been increased. The Trust has invested in electronic systems to improve 'real time' information about patient status and care and flow. A comprehensive improvement plan was in place prior to the CQC inspection but it is clear from the CQC concerns that additional actions to reduce the risk to the safety of patients in ED and additional actions have been added to the improvement plan to address their specific concerns, and where possible timelines for existing actions have been brought forward.

The delivery of the action plan will be monitored through a governance and reporting process agreed with the CQC, the Clinical Commissioning Group (CCG) and National Health Service England (NHSE), and through enhanced internal monitoring including a more detailed report to the Board. The paper below provides an account of actions that have been taken to improve the care and safety of patients in the Emergency Department.

Key Issues/Risks:

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The CQC raised a number of concerns under three headings:

- Time to initial triage and initial assessment
- Monitoring and action regarding early warning scores and sepsis
- Staffing within the resuscitation area and the paediatric area.

A response was provided to the CQC immediately to address these areas of concern. This included a

review of the emergency admission process, enhanced monitoring and reporting of the early warning score and sepsis and additional staffing. Recommendations: To consider the Executive actions to address CQC concerns and whether the Board requires further information/assurance or additional action to be taken.
Summary of ED Challenge/Discussion: The draft CQC report expected in early April will provide a comprehensive review of the services of the newly formed Integrated Care Organisation (ICO). The report will describe examples of good practice but it will also highlight the concerns already noted with regard to the Emergency Department and other services and activities that require improvement. At the time of the inspection, the ICO was four months old and still in the initial stages of bringing together services, teams and cultures. We anticipate a detailed report setting out clearly where we are doing well and where there are opportunities to improve. We will be receiving the report at just the right time to inform our priorities over the coming year. The report will provide an opportunity for the Trust to develop actions to address any concerns raised and to be fully ready for the Quality Summit planned in May.
Internal/External Engagement including Public, Patient and Governor Involvement: Governor observer on the Quality Improvement Group CQC and NHSE oversight of the ED improvement plan
Equality and Diversity Implications: None

Public

CQC Update

1.0	Time to initial Triage, initial assessment and timely access to be seen by an ED Doctor
1.1	At the time of the inspection the Emergency Department (ED) and the wider health and social care system was experiencing significant demand that resulted in delays and an overcrowded department. The CQC noted delays in the initial assessment of patient vital signs and long waits to be seen by a Doctor. The Emergency Department team endeavour to ensure that patients are seen and assessed (triaged) by a clinician, usually an experienced nurse, within 15 minutes of arrival to the department and that patients are seen by a Doctor within 60 minutes of arrival. This standard was not being met at the time of the inspection with delays in initial assessment communicated in the CQC feedback. Since the inspection, the ED team have redesigned the triage pathway for self-presenting patients and for patients arriving by ambulance which has resulted in an improvement in compliance with the standard of '15 minutes to initial assessment'. Reports from the last week of March showed that between 60% and 80% of initial assessments were completed within the 15 minutes standard, the majority of the remaining assessments were completed within 30 minutes and a small number over 60 minutes. However, work is underway to improve the electronic data collection as it may not accurately reflect the time of assessment. The ED team have reviewed how information is put into the Symphony System and it has emerged that the system was recording the time the information was put into the computer, not the time the actual initial assessment was completed. This IT and performance team are working to ensure future reports reflect the time the initial assessment was completed. The medical team have also made some changes in their rota to attempt a better alignment of numbers of medical staff to respond to patterns of patient arrival - particularly the increased numbers and acuity of patients arriving into the late evening – to improve compliance against the standard of '60 minutes to medical review'. The Medical Director has met with the ED clinical team and Clinical Director on a number of occasions to discuss the challenges of implementing a new rota with the current Consultant establishment of 8 substantive and 1 locum consultant. Evidence would suggest that 10 consultants is the minimum required to achieve this in full, however rota changes are being discussed to improve the current alignment and utilisation of consultant staff across the evening and weekend. The issues with 'real time' information recording is also relevant to measuring current

	compliance with the 1 hour standard and the Trust IT team are working with the ED team to improve data accuracy.
2.0	**Delays in assessing and responding to patient risk, the monitoring of and acting upon early warning scores**
2.1	The CQC noted instances where vital signs were not completed in a timely way or in some instances were omitted. The initial patient assessment should include completion of the first set of vital signs within 15 minutes followed by regular monitoring of those at risk of deterioration. The ED, in line with practice across the Trust, uses a national system called the Early Warning Score (EWS) to identify those at risk of deterioration, if the EWS is assessed as greater than 5 the patient is considered to be at risk and the frequency of observations is increased. The CQC were concerned about how the EWS was recorded and acted on during their observations. In addition the CQC were concerned that in some cases, delays in initial assessment led to delays in the completion of vital signs and administration of antibiotics within the 'golden hour' to those at risk of severe sepsis. The ED team introduced the electronic Symphony System for documenting all vital signs and other information about patients. This system has brought a number of benefits including the ability to display the EWS of every patient in ED and the clinical team believe this has improved safety. The CQC inspection has highlighted how the overcrowding in ED led to inefficiency and increased risk of patients not being seen quickly and vital signs being omitted. The benefit of the new system to capture 'real time' information on the monitoring of patients was not being fully realised. Since the inspection, a number of changes have been made to improve compliance with vital signs recording. • Daily audit of vital signs compliance has been undertaken. • The Symphony IT system has been updated to provide staff with triggers and flags to ensure vital signs are completed. • Staff have received update training on use of the system. • The system now allows real time audit of vital signs to monitor compliance with the 15 minute and 60 minute vital signs standard. • The system is being redesigned to allow real time monitoring of vital signs and antibiotic administration to monitor compliance with the sepsis 'golden hour' standard. These measures are providing the evidence to show improved compliance but there is further work to do to ensure the data is accurately reflecting the time the observations were completed rather than the time the data was put on the computer.
3.0	**Suitable and sufficient staffing of the ED resuscitation area and the paediatric area**
3.1	The CQC had specific concerns about staffing in the resuscitation and paediatric areas. It was indicated that the number of staff available during the shift did not allow sufficient flexibility to respond to surges of activity in the resuscitation area or increased numbers of children in the paediatric area. Operational decisions about nursing staff deployment are made by the Matron or Senior Sister in charge. It requires a degree of flexibility as activity in the resuscitation area fluctuates. Ensuring the right staffing levels in this area is essential as this is where the sickest patients are cared for. With immediate effect the numbers of staff in the area was increased and this has been maintained. Whilst the department has a paediatric trained nurse on duty all day and into the evening, the CQC concluded that the volume of attendances merited a second nurse in the paediatric area. This recommendation was acted on immediately. A full ED nursing establishment review was planned for early 2016 following the anticipated publication of the National Institute for Health and Care Excellence (NICE) ED staffing guidance. This has not been published however and in response to the CQC concerns a review using the Baseline Emergency Staffing Tool (BEST) has been completed. Whilst full analysis of the data is yet to be completed, early analysis suggests that total numbers of nursing staff may be adequate but that shift patterns may need to be reviewed to better align capacity with predictable activity surges in the evening and night. In addition to the nurse establishment review led by the Chief Nurse, as referenced under 1.1, the

	Medical Director is leading a review of medical staff and similarly considering the current rota for better deployment of capacity with predictable surges in demand.
4.0	**Governance**
4.1	Currently the Emergency Department risks to quality and safe care are reflected in the Trust risk registers: The Medical Service Delivery Unit (SDU) risk register has three ED risk areas: 1. Demand exceeding capacity and the associated poor patient experience and potential for adverse clinical outcomes. 2. The risk to 60 minute medical review and associated risk to care. 3. The risk of overcrowding with associated poor patient flow and potential for compromised care. These are discussed at the monthly SDU meeting where improvement plans are developed, managed and monitored. Risk are also flagged at the monthly COO led Senior Business Management Team Meetings and the quarterly SDU quality and performance meetings. Risks are escalated to the Quality Improvement Group, the newly formed Quality Assurance Committee, and consideration is given to whether such risks require to be escalated to the Corporate Risk Register. The Quality Improvement Group risk register has two ED risks: 1. Overcrowding and the associated quality and safety risks. 2. Compliance with the adult and paediatric sepsis bundle is also listed. These are discussed at the monthly QIG meeting and associated actions monitored. The ED team attended in December 2015 to discuss challenges and actions being taken to mitigate quality risks. The initial CQC findings and the Trust response were discussed at the March 2016 Quality Assurance Committee. The committee reviewed the quality of the information provided by the new Symphony System and recent amendments to provide weekly reports on compliance with initial assessment, monitoring of vitals signs and sepsis golden hour. The use of the BEST tool to review nurse staffing and the medical staffing review was also discussed. The current Board performance dashboard provides monthly information on performance and includes: • Ambulance handover delays • A&E patients seen in 4 hours • Trolley waits in A&E of more than 12 hours The CQC findings highlight the need to review this performance dashboard to include specific quality and safety indicators such as: • % triage within 15 minutes • % medical review within 60 minutes • Vital signs and sepsis compliance • Monthly complaints and incidents Work is in progress to amend the Trust Board performance dashboard to include the standards above and other markers of quality. The Corporate Risk Register (CRR) identifies the general risk of demand exceeding capacity and associated quality and safety risks. These are reviewed and discussed bi-monthly and SDU managers are held to account for delivery of improvements. Given the CQC concerns and the level of scrutiny on ED safety and performance, the Executives have agreed that this now merits a separate risk on the Corporate Risk Register, and this risk assessment and escalation to CRR will be actioned by the Chief Nurse and COO. In addition to these internal governance arrangements, there is a system wide governance framework led by the CCG that has the System Resilience Group, the Urgent Care Board and monthly performance meetings where the Trust and CCG discuss performance.

	The CQC concerns have highlighted a need to strengthen internal and external oversight of the quality risks associated with the Emergency Department performance. The Trust and CCG have agreed a revised governance framework with weekly Executive led performance meetings where progress on the urgent actions taken in response to the CQC concerns are monitored. Delivery of the ED plan is being driven through the Urgent Care improvement and Assurance Group with onward reporting to the Executive Team, the Quality Improvement Group and the Quality Assurance Committee. Weekly performance meetings are also held with the CCG. This weekly review meeting will assess progress and compliance levels, including agreeing Executive action if needed to remove blocks to progress, and this assessment will form the basis of reports to the Trust Quality Improvement Group, to the Quality Assurance Committee and to the Board.

Torbay and South Devon NHS
NHS Foundation Trust

Meeting Date:	6th April 2016
Title:	Quality Account
Lead Director:	Chief Nurse
Corporate Objective:	Best Experience / Safest Care
Purpose:	Approval

Summary of Key Issues for Trust Board

Strategic Context:
The Trust is required to identify priorities for inclusion within the Quality Account 2015/16 which will be delivered in 2016/17. As in previous years the as sought involvement and feedback of key stakeholders including patients, carers, staff, Governors and the CCG in order to ensure the final priorities reflect the needs of the health and social care community. As part of this year's Quality Account we have reviewed information from incidents, patient feedback, staff feedback, operational challenges and external reports to inform the priorities. The need to continue existing work such the rapid identification of severe sepsis and the development of the Acute Medical Assessment Unit is recognised.

Key Issues/Risks:
Risks to delivery relate to capacity and resource over the course of the year. This is mitigated by the involvement of the Improvement and Innovation team who contribute to the delivery of action plans and associated service improvements. We have a good track record for delivering the QA priorities which will be monitored through the Quality Improvement Group.

Recommendations:
The Trust Board are asked to agree the final priorities set out below for inclusion in the Quality Account.

Summary of ED Challenge / Discussion:
The production of the Quality Account must meet the requirements set out in the Monitor Guidance Document. For the first time this requires the collation of information and data across the whole integrated Trust which may prove challenging.

Early guidance on development of the CQUINS suggests a different approach this year with a greater focus on the delivery of national CQUINs over locally set ones. Further guidance from the CCG is awaited.

Internal/External Engagement including Public, Patient and Governor Involvement:
Governor observer on the Quality Improvement Group

Equality and Diversity Implications:
None

Public

1.0	**Purpose and Content of the Report**
1.1	To update the Board on the activity relating to the production of the annual quality accounts and to update on progress against the priorities identified last year.

2.0	**Quality Account**
2.1	Suggested QA priorities for 2015/16 to be delivered in 2016/17 **<u>Patient safety</u>** **Priority 1:** to improve the consistency and reliability of complaint investigations and associated systems for organisational learning across the care system now within the integrated care organisation. **Priority 2:** to integrate and develop the two safety toolkits used separately in the community (QuESTT) and at Torbay Hospital (EWTT) so they can be used across any health and care setting supported by the integrated care organisation. **<u>Clinical effectiveness</u>** **Priority 3:** to improve the timeliness of assessment of within the Emergency department as demonstrated through reliable achievement of: o time to triage (seen within 15 minutes) o time to be seen by a doctor (seen within 60 minutes) **Priority 4:** to improve the stroke pathway across our organisation through improving stroke coordination and remapping the whole pathway, focusing first on the acute elements of the pathway. The outcome will be improved performance against the national standards. **<u>Patient experience</u>** **Priority 5:** Test the impact of using the 'Institute of Health Improvement's teach back' method to improve communication between patients, families and health and care professionals.
2.2	Progress on quality improvement priorities from previous year

Patient safety: transfers of care Second exercise undertaken looking at the transfer from a patient's perspective. Responses collated and incorporated into a transfer bundle. The bundle has been put into the Nerve Centre work, an electronic handover tool, and this is being tested in April.	
Clinical effectiveness: ambulatory care With the increase in pressure on beds, the ambulatory care unit has been unable to function successfully over the winter as at nights / weekends the designated area gets switched to beds. As a result, a new AMU has been set up on level 2 after a bed reconfiguration options appraisal. This opened on time with the team now undertaking small rapid tests of change.	
Clinical effectiveness: multidisciplinary working (LMAT) Work has been progressing on the LMAT model. This has now been agreed by the Community Services Transformation Group. There have been several tests of change including: • Enhanced intermediate care tested in Torquay which now includes medical and pharmacy cover. The outcomes have been positive and there is now a planned test of change in Moor to Sea. • The wellbeing coordinator role has been tested in Newton Abbot. An investment proposal has gone forward to the Care Model Executive Group to employ up to 12 coordinators across Torbay & South Devon.	
Patient experience: medicines management Surveys completed on two acute wards and community hospital survey on-going. Planned development and trial of medicines passport.	

Patient experience: SPOC A new model for the Single Point of Contact has been developed taking the learning from Care Direct & Care Direct Plus. An options appraisal has been undertaken and a recommended model of delivery shared with the Community Services Transformation Group.	

The CQUINs form part of the annual Quality Account and as of Q3 the Trust is reporting:

Indicator Number	Indicator Name	Q3 outcome - CCG
1.1	Acute kidney injury - improvement in recording diagnosis, treatment & plan of care after discharge	
2.1	Sepsis - sepsis screening	
2.2	Sepsis - antibiotic administration	
3.1	Dementia -Find, Assess, Investigate and Refer - target 90% Find & Assess	
3.2	Dementia - staff training	
3.3	Dementia & carers	
4.1	Unplanned emergency care- reducing the proportion of avoidable emergency admissions to hospital	
4.2	Unplanned emergency care - Improving Diagnoses and Re-attendance Rates of Patients with Mental Health Needs at A&E	
5.1	Improving nutrition & hydration	
6.1	Improving incident investigation	
7.1	Improving patient experience	

Work has been on-going to improve sepsis performance with data collection using the symphony system. Dementia remains problematic until the Trust moves over to a single method of data collection. The community services continue to perform well against this target.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6th April 2016
Title:	Report of the Medical Director
Lead Director:	Medical Director
Corporate Objective:	Safest Care
Purpose:	Information/Assurance/Decision

Summary of Key Issues for Trust Board

Strategic Context:

- The Junior Doctors' industrial action continues. Two further strikes are planned - emergency only 6th-7th April and an all-out strike 26th-27th April 2016
- The Trust has been instructed to impose the disputed new Junior Doctors' contract from August 2016

Key Issues/Risks

- Trust staff have managed the emergency care strikes to date without significant incident and with minimal disruption to patients
- The strikes continue to be the cause of inconvenience and distress to some patients
- The planned 'all-out' strike 26 and 27 April will be associated with greater disruption and significantly increased risk to patients. Plans in are place to mitigate this risk.
- Initial assessment of the impact of implementing the new Junior Doctor contract indicates potential risk for staffing duty rotas and for increased costs.
- The Chief Executive has received correspondence from Junior Doctors asking the Trust to consider whether the Trust would refuse to implement the new contract.

Summary of ED Challenge/Discussion:

1. The Medical Director will lead the planning for the up-coming strikes.
2. The Medical Education Department and Medical HR are establishing an assurance group to oversee the implementation of the new Junior Doctors' contract.
3. The request of our Junior Doctors that the Trust should refuse to implement the new contract requires Board level consideration of the consequences and a Board decision.

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

Equality and Diversity Implications:
Nil

Report of the Medical Director
6 April 2016

1. **Junior Doctors' Industrial Action**

The dispute over the new Junior Doctors' contract is unresolved. The Government have instructed all employers to implement the new contract from August 2016.

So far we have had 4 days of 'emergency only strike'. Trust staff have responded very positively to the need for flexibility to cover the absence of junior staff and there have been no incidents attributable to the strike. There has been significant disruption and distress caused to patients. We have maintained good relationships with junior medical staff throughout the period of Industrial action.

Two further strikes are planned:

08.00 hrs 6th April to 08.00 hours 9th April – emergency cover only

08.00 – 17.00 26th April – 'All-out strike' and 08.00 – 17.00 27th April – 'All-out strike'

Planning for the strike on 6-9 April is underway. The risk of this strike is assessed as moderate. It is taking place during a time of a high level of senior doctor leave and also at the time of changeover for some junior medical staff. Some adjustments have been made to mitigate risk. There will be disruption to routine clinical activity to support emergency and inpatient management. Expected cancellations in the region of 40 inpatient operations, 75 day-case procedures and up to 400 outpatient appointments over the period of the strike are anticipated. Communications for staff and patients will be updated from previous strikes.

A meeting is planned on 12 April to agree mitigations of the risk of the 'all-out' strike on 26 and 27 April. Disruption to routine activity will be greater and there will also be greater risk to patients as senior staff take on emergency roles.

2. Implementation of the new Junior doctor contract

The implications of implementation of the new contract are not clear. There are additional restrictions of working hours which will have impact on our ability to cover duty rotas. Achieving safe cover may have financial implications.

Medical HR are leading on the planning and implementation and conducting modelling exercises in conjunction with clinical teams and the Medical Education department. An assurance group will be established to oversee the planning and implementation of the contract.

As advised under (1) above, the Trust has been instructed to implement the new contract, and Health Education South West have been instructed not to fund Junior Doctor posts in Trusts that have not implemented the new contract. The following letter has been received by the Chief Executive. **The Board is asked to consider the contents of the letter and to decide on the Trust's position in relation to implementing the new contract, and the Chief Executive will respond accordingly.**

Letter from Junior Doctors at Torbay and South Devon Foundation Trust to consider refusal to implement the new contract

26th February 2016
(Item 7/3)

Dear Mairead McAlinden,

The enclosed letter is signed by over 2000 health care professionals from over 240 trusts and Universities. It calls for you, as CEO of a Foundation Trust and your counterparts across England, to collectively reject the imposition of a contract for junior doctors.

Many of you have publicly stated that you do not agree with contract imposition and we call upon you to act on these words and show your staff that they were not just said to placate. As Professor Don Berwick, the government's own former patient safety adviser recently said, "You cannot achieve excellence in combat with your future workforce; it makes no sense at all". Imposition itself has led to low morale and anger amongst junior doctors.

Further, the Francis report specifically states that to create the right culture, frontline staff should be empowered with the responsibility to deliver safe care and that any reorganisation should have a publicly debated risk assessment. Neither of these have occurred and 54,000 junior doctors are now blowing the whistle to highlight this unsafe contract. We call upon you to listen.

Finally, we are aware that Health Education England has suggested they may remove trainee doctors from those Trusts that do not impose the contract. We are sad that a supposedly apolitical body has made this intervention. We would draw your attention to the fact that if you act collectively, this veiled threat is meaningless.

Many thanks for your time

Junior doctors

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6th April 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. There has been an improvement in HSMR as a consequence of the inclusion of community hospitals in the Trust data.

Pressure ulcers Grade 4 have risen and this trend is being investigated for escalated action.

Two red flags on the Dr Foster Patient Safety Dashboard are being reviewed.

- 'Deaths in Low-risk diagnosis groups', and
- 'Postoperative sepsis'.

The former will form the basis of a mortality review through the newly formed Mortality Surveillance Group. A previous red flag for postoperative sepsis was due to incorrect coding and will be investigated again.

Summary of ED Challenge/Discussion:

The Chief Nurse alerted Executives to the increase in Grade 4 ulcers, and set out the actions underway. She advised that the recording of pressure ulcers at Emergency Department may be a contributory factor, and that the CCG have confirmed the 'safeguarding' status and process which is now being progressed.

Internal/External Engagement including Public, Patient and Governor Involvement:
There is CCG and Governor oversight at the Quality Improvement Group.
Systems for reviewing and reporting mortality will be considered at the Quality Assurance Committee in May 2016.

Equality and Diversity Implications:
Nil

Safety Score Card No. 38

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, with a summary report of key issues brought to the Board by the Medical Director.

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 N38.

Safety Indicator		Data Source	Target	RAG
Hospital Standardise Mortality Rate Summary Hospital-level Mortality (Appendix 1)	Mortality	Dr Foster 2014/15 benchmark year DH SHMI data	≤90	
Unadjusted Mortality rate (Appendix 2)		Trust Data	Yearly Average ≤3%	
Dr Foster Patient Safety Dashboard (Appendix 3)		Dr Foster	All 15 safety indicators positive	2 flags
Trust wide hand washing compliance (Appendix 4)	Infection Control	Trust Data	95% compliance	
MRSA bacteraemia Days Between (Appendix 5)		Trust data	Zero in year	2 MRSA
C Diff Number (Appendix 6)		Trust data	DH target ≤18 lapses in care	
Patient Incidents (Appendix 7)	Patient Incident	Trust Safeguard system	Positive reporting	
Major & Catastrophic Incidents (Appendix 8)		SPI/NHS SW Safety Programme from trust data	10% reduction from prior year	
Falls Rate, Harm from falls (Appendix 9)		Trust Safeguard system	Rate of ≤4	
Pressure Ulcers Data (Appendix 10)		Trust Safeguard system	10% Reduction in pressure ulcers	
Medicines (Appendix 11)		Trust wide monthly audit	95% compliance with the three measures	
Cardiac Arrest Calls (12)		Trust wide monthly audit	Year on Year reduction	
Safety Thermometer (Appendix 13)	Assurance	DH point prevalence monthly audit tool measuring harm free care	95% or high T&SDT Harm Free Care	
Never Events (Appendix 14)		Trust Safeguard system	Zero in any financial year	2

Overview:

The Safety Score Card (SSC) will now be generated on a monthly basis and feed directly into the Quality Assurance Committee.

The score card has now been defined into four areas, outlined as below, along with a RAG rating and an overview section.

Mortality
The data is now being expressed for the new Integrated Care Organisation, including all the community hospitals.

The HSMR position remains below the 100 line and within the expected range. The latest data point is in the *better than expected* bracket.

Triangulating with Dr Foster's Safety Dashboard, the two areas flagging will be investigated and a report sent back to the Quality Improvement Group

Infection Control
The data is showing a decreasing trend in CDT numbers, which are within target for 15/16, and is recorded via the monthly Performance and Quality Data book and monitored by the Infection Control Group which reports to the QIG/QAC. A Peer Review of Infection Control systems and processes has been completed and the report and associated action plan will be owned by the Infection Control Committee and will be reported to the Board through the Chief Nurse's report.

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

Patient falls are showing a reduction in recent months and a winter falls campaign has been launched in December 2015 to reduce harm from these falls, particularly in the frail elderly. The data so far is showing a reduction with a report to follow in May to the Falls committee.

Grade 3 & 4 pressure ulcers have increased in January, this is being investigated. Investigations into previous years data shows a normal variation increase in Q4 each year. Heel pressure ulcers are increasing despite the use of pressure relieving mattresses and we are exploring the option of using repose boots to reduce these. The Emergency Department have reported an increase in pressure ulcers, actions to address this increase are being led by the Deputy Director of Nursing and Tissue Viability Specialist. A specific Q4 pressure ulcer report will be brought to the Quality Improvement Group when the RCA's have been undertaken.

Missed medication doses are showing a continued reduction. However compliance levels for Medicines Reconciliation within 24 hours of admission has reduced as Pharmacy, to ensure an accurate overview of performance, have included all weekend admissions to the data analysis. Further work is being done to improve overall performance and improvement work is underway to return the process to a 95+ reliability level including additional pharmacist being recruited to increase capacity for medicines reconciliation. Performance on medicines reconciliation is reported through the Quality Improvement Group by the Chief Pharmacist.

Cardiac arrests are reducing over time. This is the result of sustained service improvement activity focussing on Trust-wide 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. However CQC have concerns about increased risk to patient safety in the Emergency Department, and a separate detailed report will be brought to the April Board meeting.

Appendix 1

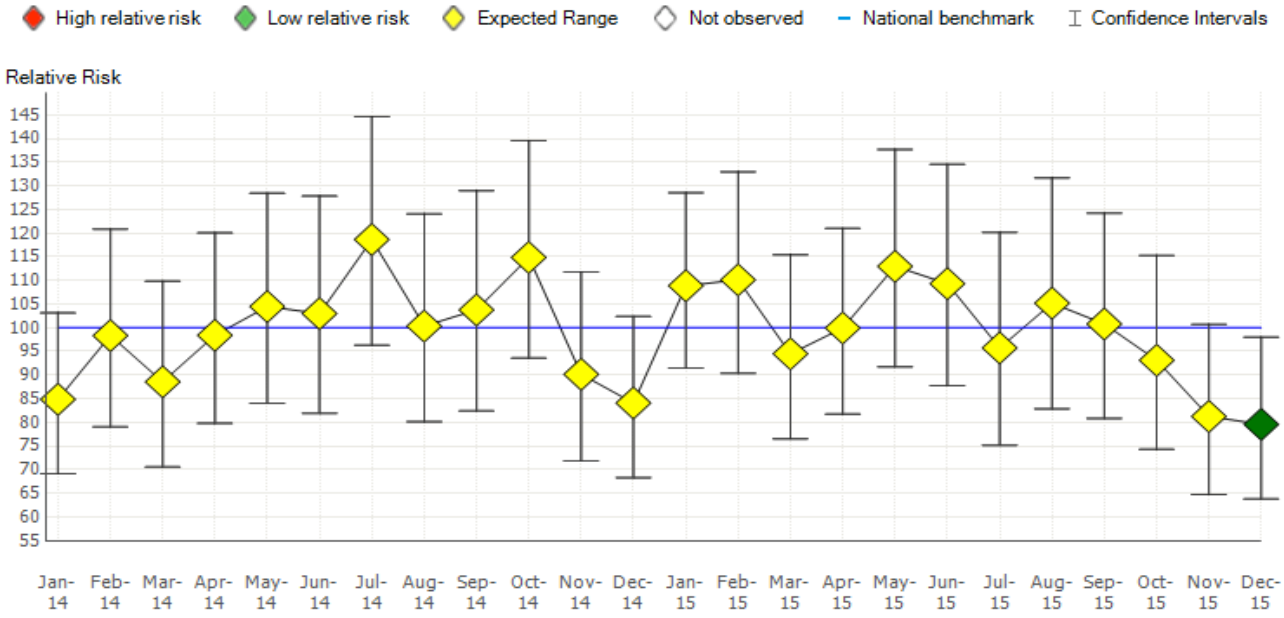
This metric looks at the two main standardised mortality tools:
(A) Hospital Standardised Mortality Rate (HSMR) and
(B) Summary Hospital Mortality Index (SHMI)
(Data obtained from Dr Foster)

Measure: to sustain HSMR below a rate of ≤90
The Dr Foster mortality data, as shown below, are taken from the benchmark data year **2014/15,** unless stated. Traditionally, Dr Foster rebases the data every year, to make it harder to achieve the 100 average line, as individual Trusts improve performance.

A rate above 100 with a *high relative risk* may signify a concern and needs to be investigated.

(A)- Hospital Standardised Mortality Rate (HSMR) basket of 56

T&SDT - HSMR from Jan 14 – Dec 15



Narrative
This data is based on the newly formed Torbay and South Devon Trust

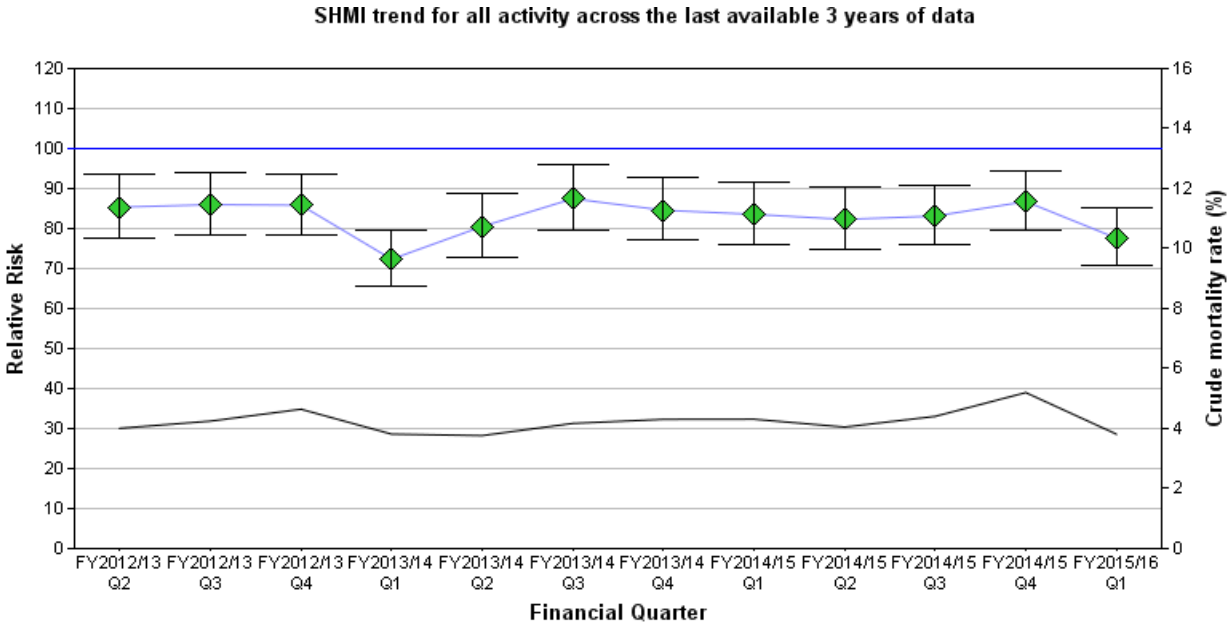
Our latest data point, Dec 15, is showing a very low relative risk of 79.57, and the last 5 data points are showing a positive downward trend in the data, this being achieved over the winter periods when mortality tends to peak. This will need to be observed to look for any delayed winter effect into the months of March & April and is to be welcomed.

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 changes in care pathways have been undertaken with that learning.

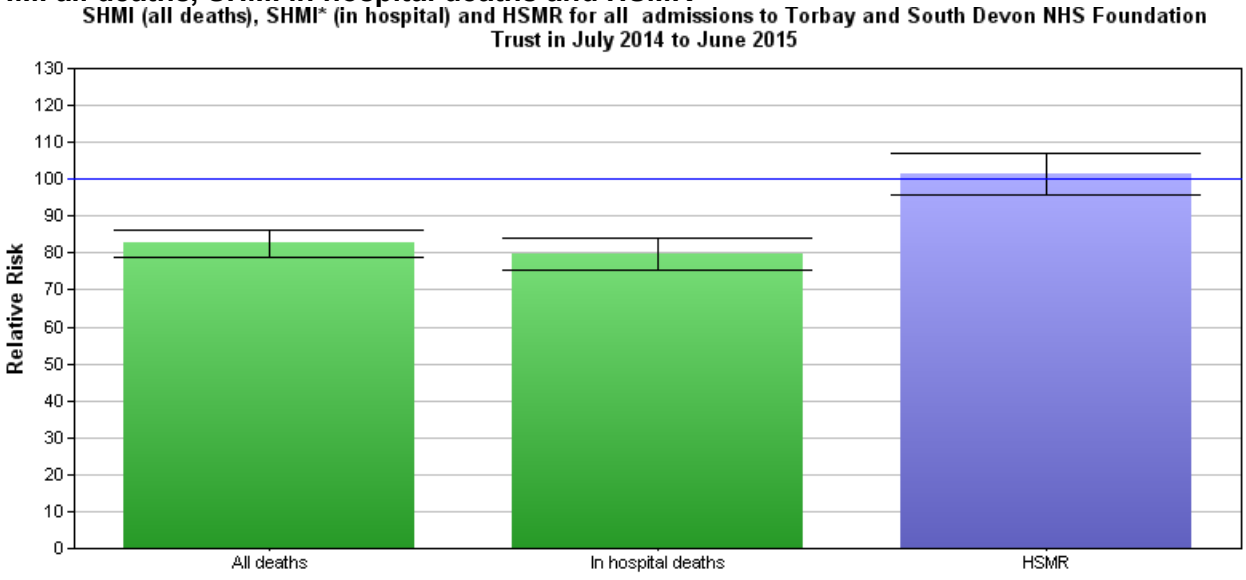
The Medical Director & Director of Patient Safety are leading on the establishment of a Mortality Surveillance Group to provide assurance that robust investigation of avoidable deaths is undertaken and to ensure that learning is shared across the organisation when suboptimal care has been identified relating to any death. This review will include assurance around 'duty of candour'.

(B) Summary Hospital Mortality Index (SHMI)
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 *very* retrospective; therefore, please note *the following data is from July 2014 - June 2015* and will be very 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 and trending below our 90 target

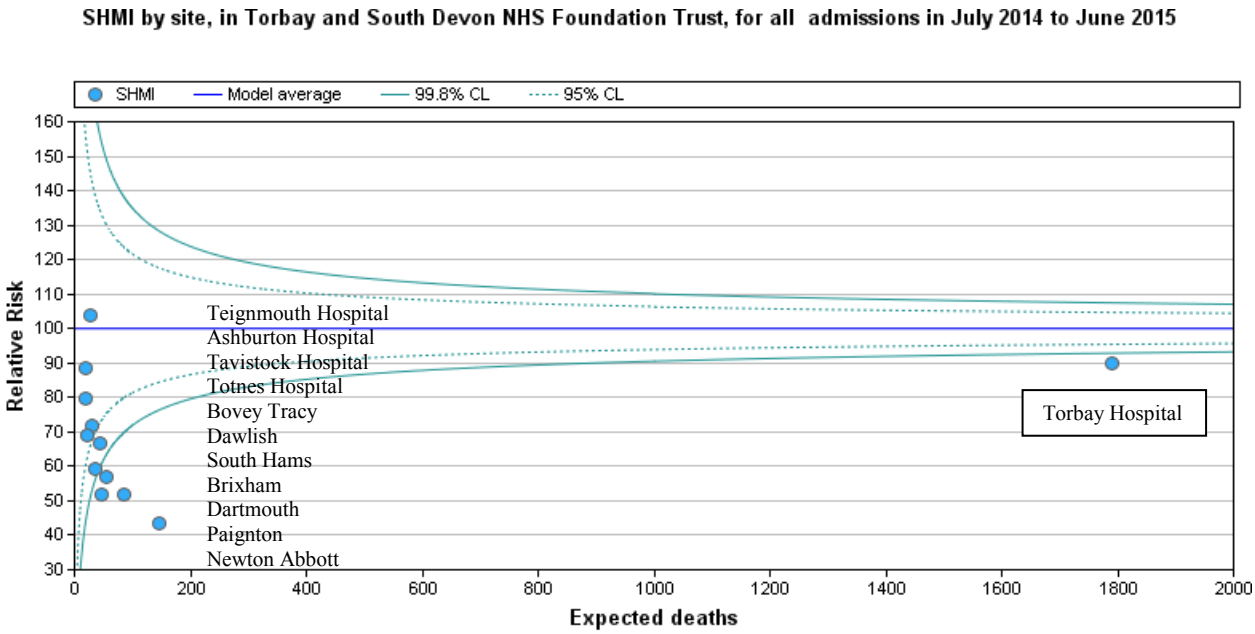


SHMI all deaths, SHMI in hospital deaths and HSMR

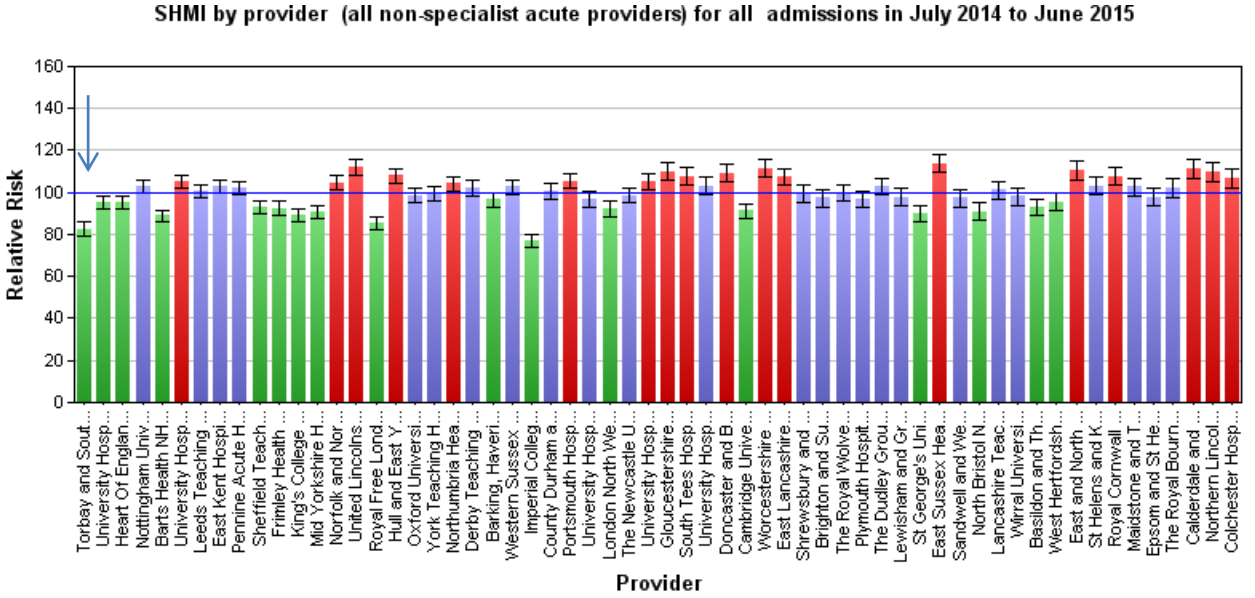


The above chart records all SHMI deaths, deaths in hospital as well as a comparison with HSMR for the time period July 2014 – Jun 2015. All are within expected range and with the in-hospital deaths at a very low relative risk.

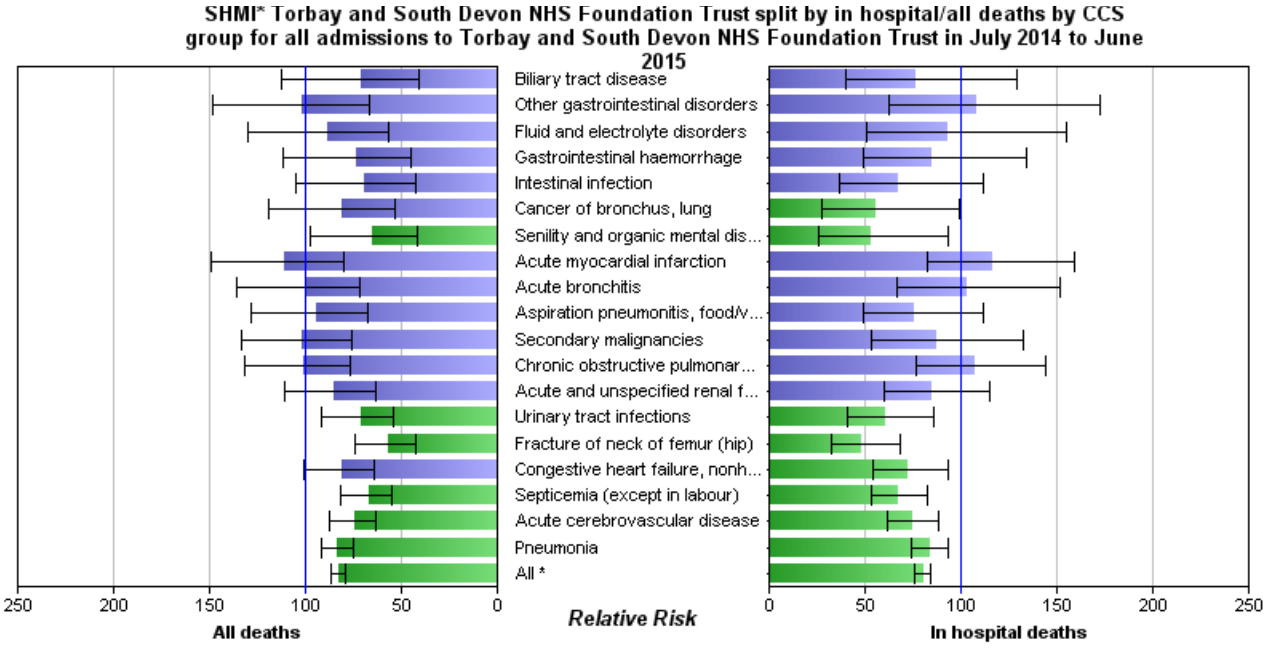
The third chart (as below) plots the SHMI mortality via a funnel plot for the time period July 2014 - Jun 2015, again showing SDHCFT performing within the expected range. This chart also shows the individual community hospitals data



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



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)

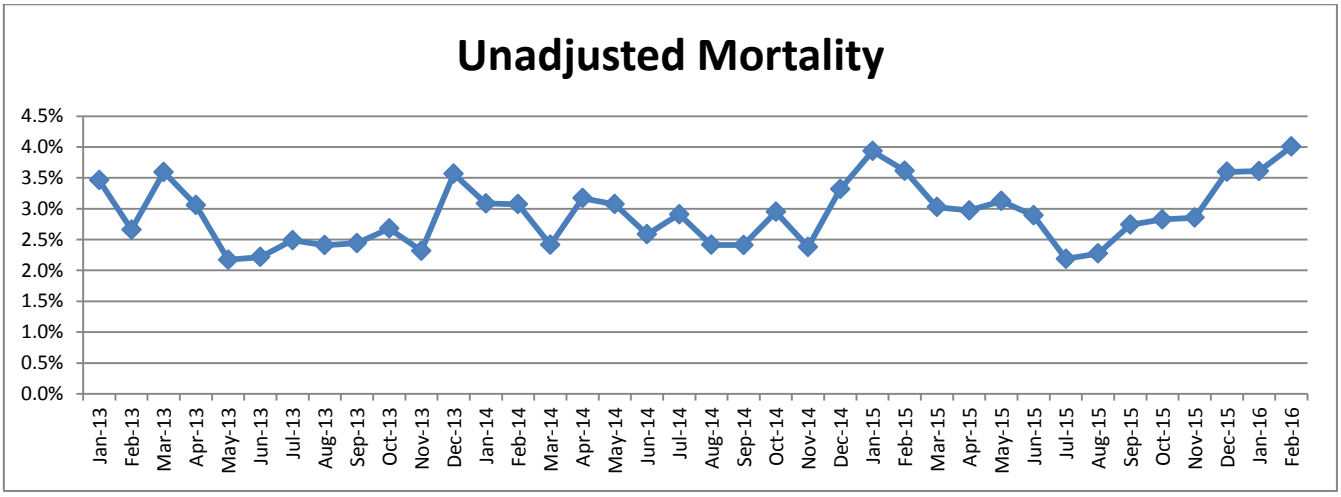
This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

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 15/16 saw February recording peak mortality, this being in line with the temperature dropping. Triangulation with the HSMR is only available to Dec and will need to be tracked back to the unadjusted data once it's produced by Dr Foster.

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*	27,434	28	16.5	1.0	0.6	170
Decubitus Ulcer	7,746	337	374.8	43.5	48.4	90
Deaths after Surgery	483	41	43.2	84.9	89.4	95
Infections associated with central line*	14,223	1	0.8	0.1	0.1	128
Postoperative hip fracture*	21,088	3	1.3	0.1	0.1	237
Postoperative Haemorrhage or Haematoma	18,710	10	8.4	0.5	0.4	119
Postoperative Physiologic and Metabolic Derangement*	15,992	3	1.5	0.2	0.1	206
Postoperative respiratory failure	14,613	13	12.3	0.9	0.8	106
Postoperative pulmonary embolism or deep vein thrombosis	18,881	35	38.5	1.9	2.0	91
Postoperative sepsis	518	12	4.4	23.2	8.5	272
Postoperative wound dehiscence*	739	0	0.6	0.0	0.9	0
Accidental puncture or laceration	64,989	87	77.1	1.3	1.2	113
Obstetric trauma - vaginal delivery with instrument*	253	21	21.2	83.0	83.6	99
Obstetric trauma - vaginal delivery without instrument*	1,303	35	52.8	26.9	40.6	66
Obstetric trauma - caesarean delivery*	588	0	2.5	0.0	4.2	0

Of the 15 indicators above, the relative risks of 2 post-operative sepsis and Deaths in low-risk diagnosis groups are currently flagging outside of the expected norm.

Deaths in low-risk diagnosis groups

This is being investigated firstly by coding to identify the cases and will be presented back to the Quality Improvement Group. If further analysis is need a small team will interrogate the data from the Mortality Surveillance Group

Post-Operative Sepsis

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. This will be looked at again via Patient Safety and Clinical Coding

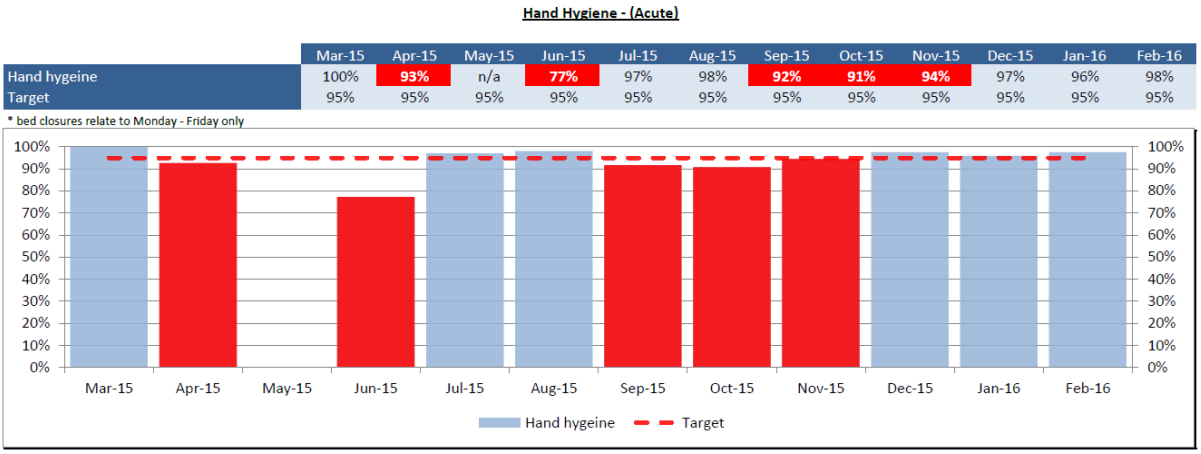
Appendix 4

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.

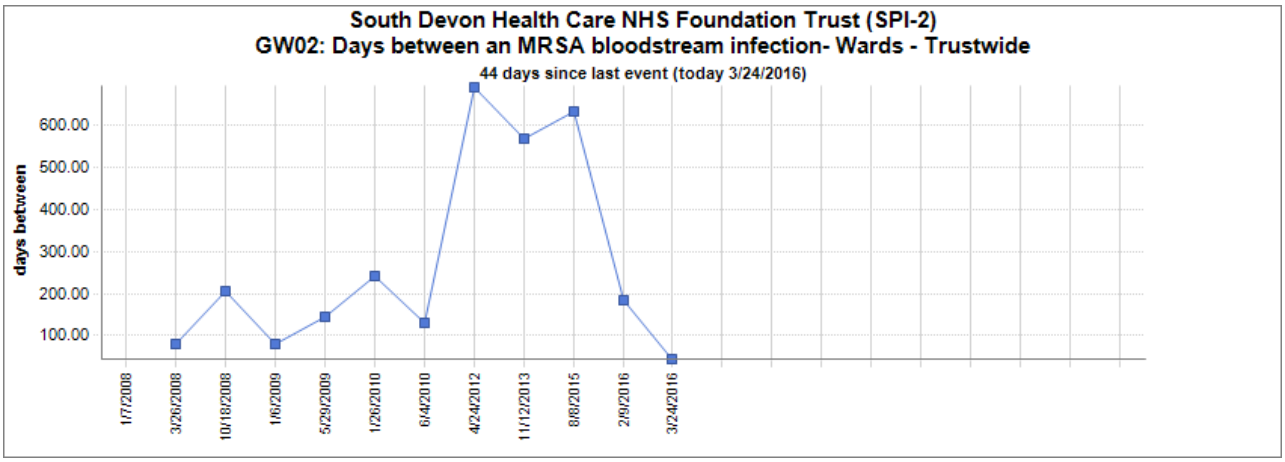


Commentary

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 44 days. The longest count has stood at 633 days and the data chart shows performance back to 2008

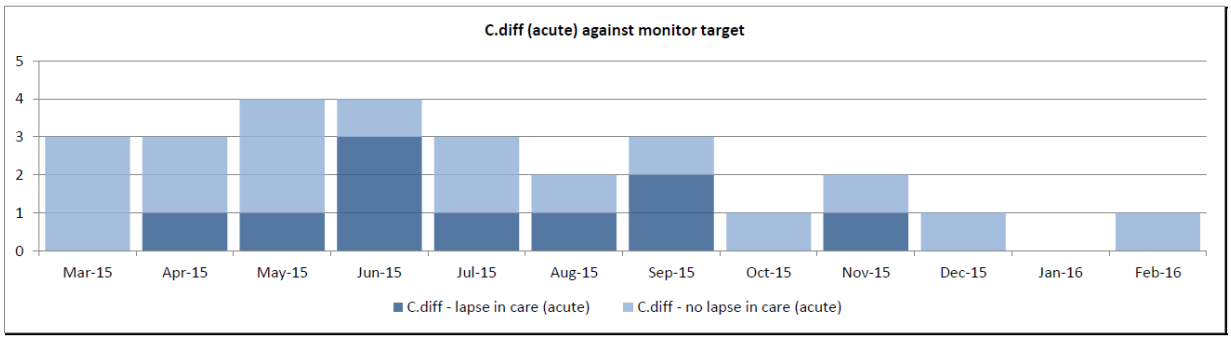
Appendix 6

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

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
C.diff - lapse in care (acute)	0	1	1	3	1	1	2	0	1	0	0	0
C.diff - no lapse in care (acute)	3	2	3	1	2	1	1	1	1	1	0	1
C.diff - Total (acute)	3	3	4	4	3	2	3	1	2	1	0	1
C.diff - lapse in care (community)	n/a	0	0	0	1	0	0	0	0	0	0	0
C.diff - no lapse in care (community)	n/a	0	0	1	0	1	0	0	0	1	1	0
C.diff - Total (community)	n/a	0	0	1	1	1	0	0	0	1	1	0



Commentary

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

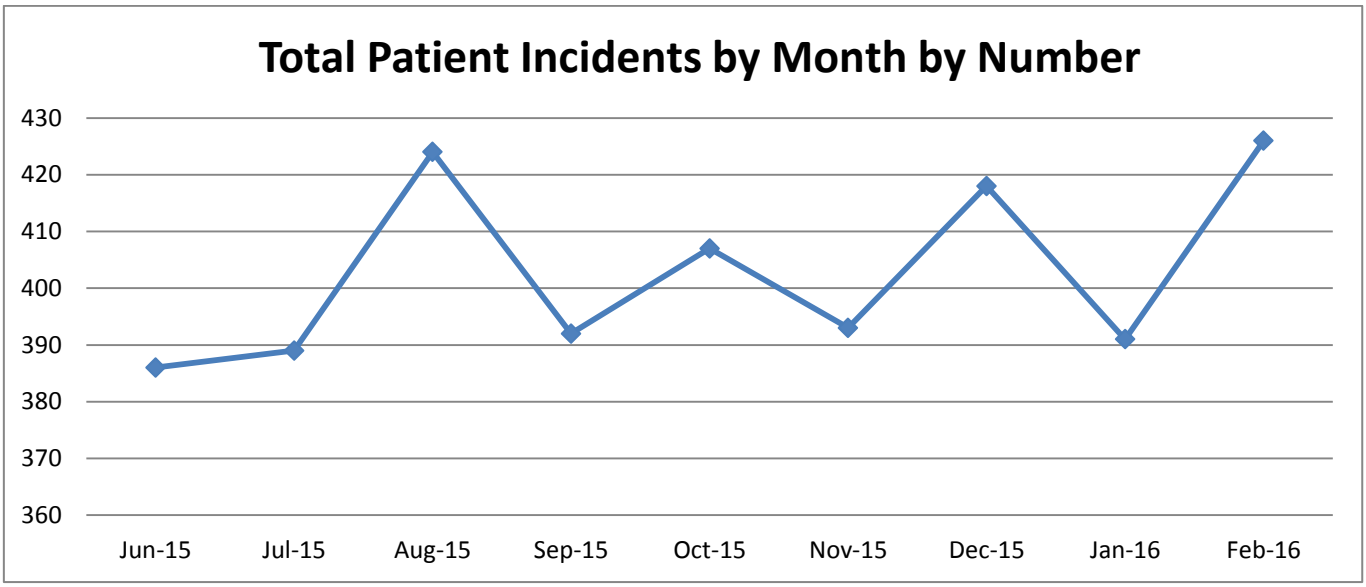
The infection control team when analysing the investigations also now code each case into *lapse of care* or *no lapse of care* and this is identifiable on the chart. The target set the Trust is ≤18 lapses in care for the financial year and the Trust's count stands at 10

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.

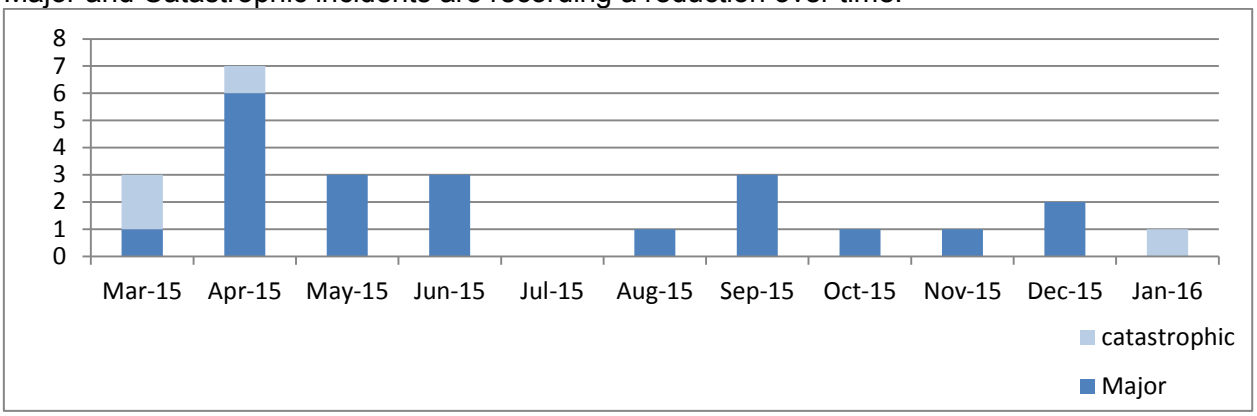
SDHCFT's reporting is remaining in a healthy position.



Appendix 8

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

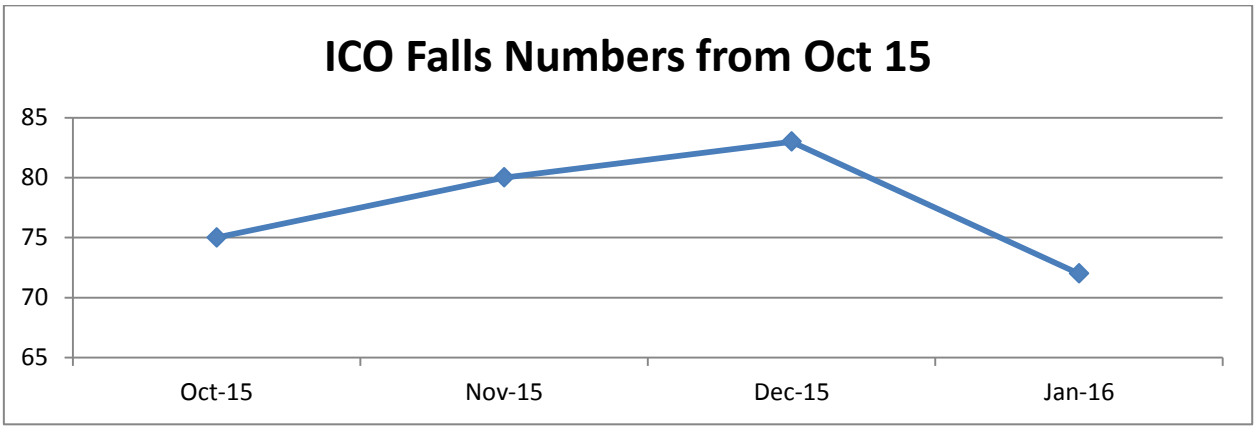
Major and Catastrophic incidents are recording a reduction over time.



All major and catastrophic incidents are recorded on the STEIS system, presented to the Serious Adverse Events Group, complete with an investigation, root cause analysis and action plan, which is logged and monitored.

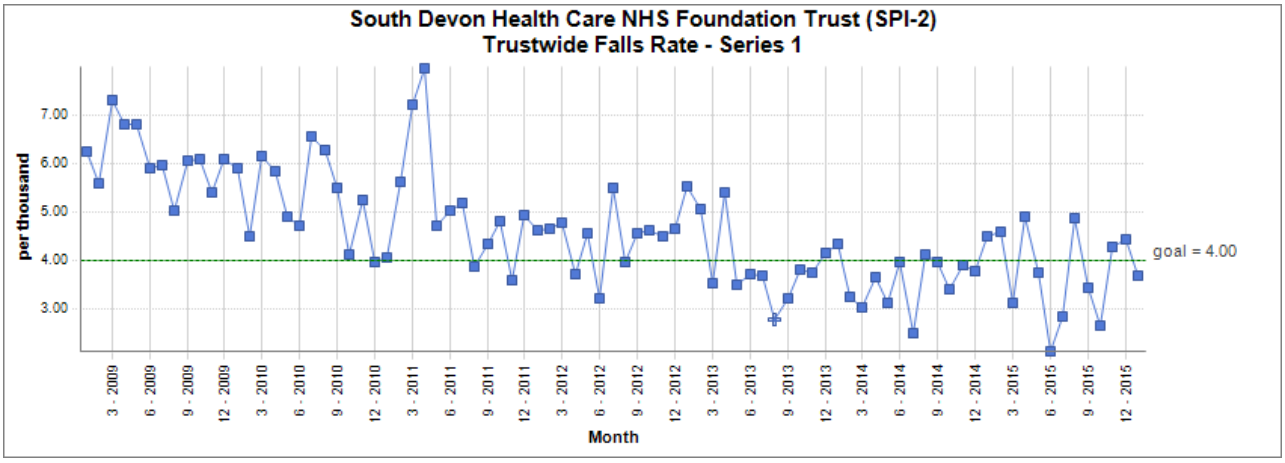
In Hospital Falls

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

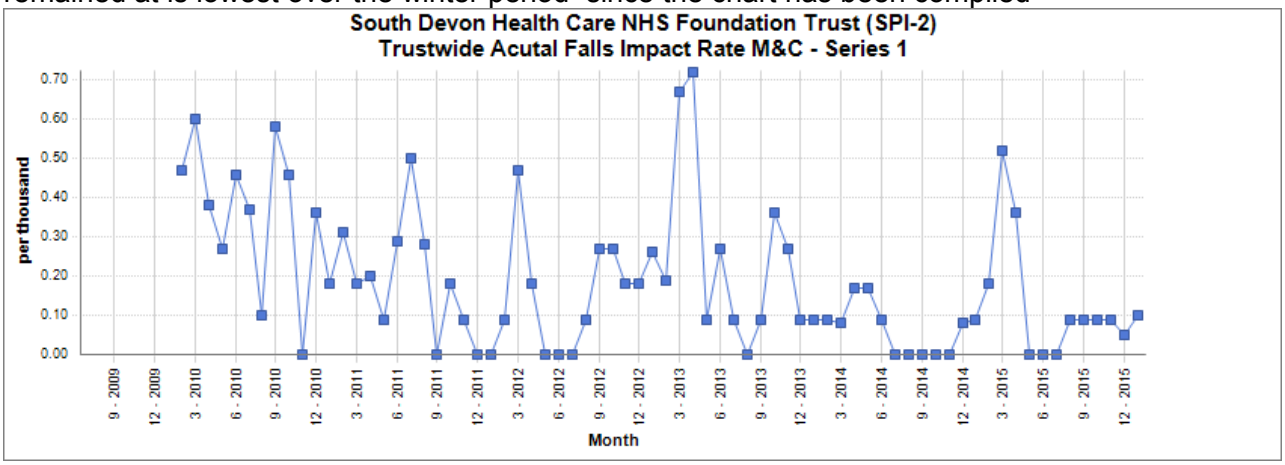


The above chart records the total number of falls within the newly formed ICO, with the latest data point downward. The falls data is shared with the Falls Nurse and at the Falls committee

The falls rate per 1000 occupied bed days, a measure that reflects hospital activity is reducing downward to the rate of 4 this nationally being a low rate



The final chart records the harm rate as expressed per thousand occupied bed days which has remained at is lowest over the winter period since the chart has been compiled



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

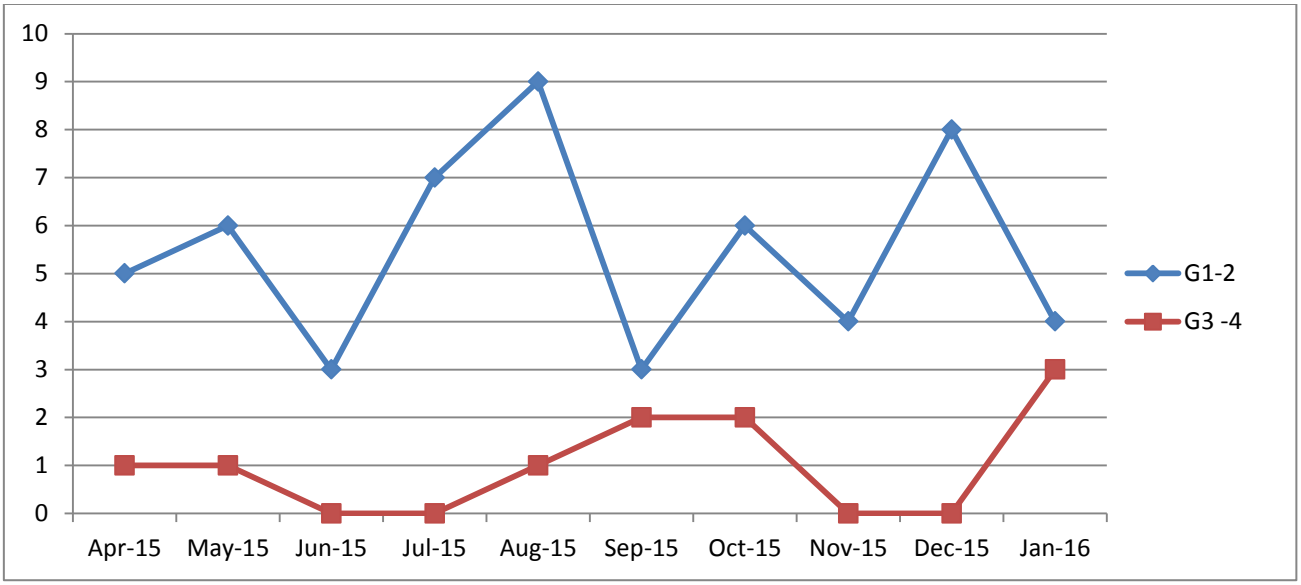
Appendix 10

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 need to be observed for patterns and trends. 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.

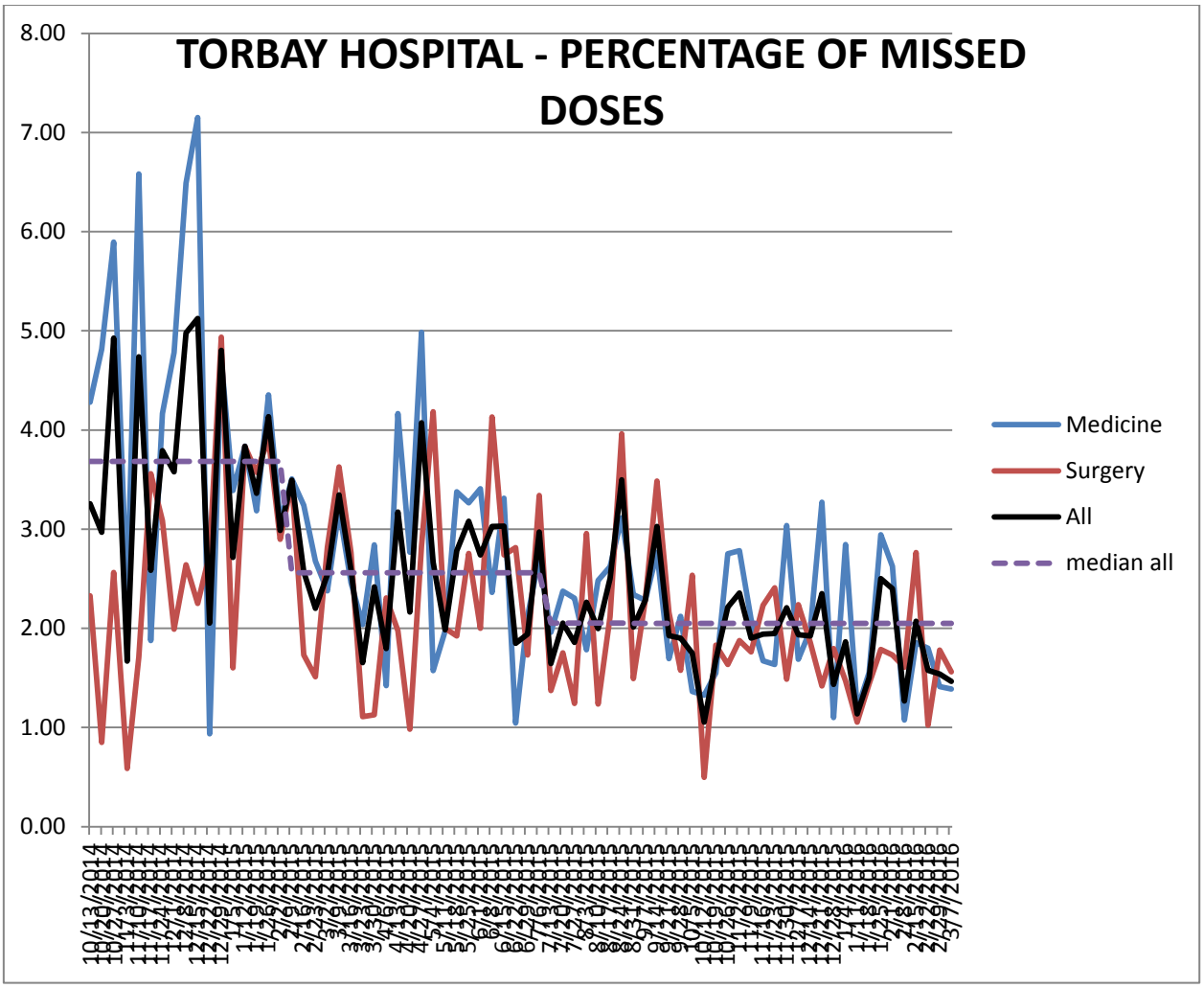


The rise in January has been noted and is being reviewed, the findings of which will be reported back to the Quality Improvement Group

Appendix 11

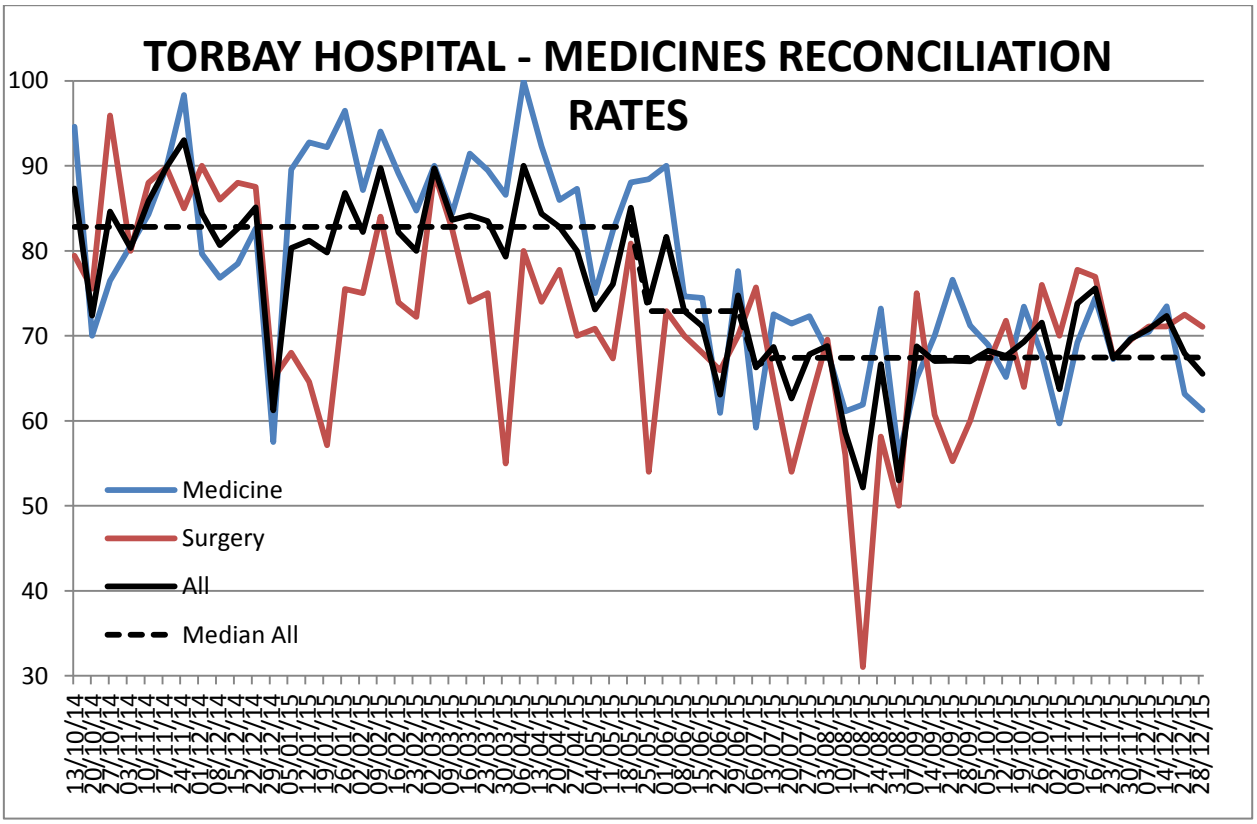
Medication Missed Doses

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 just over 97% compliance 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.

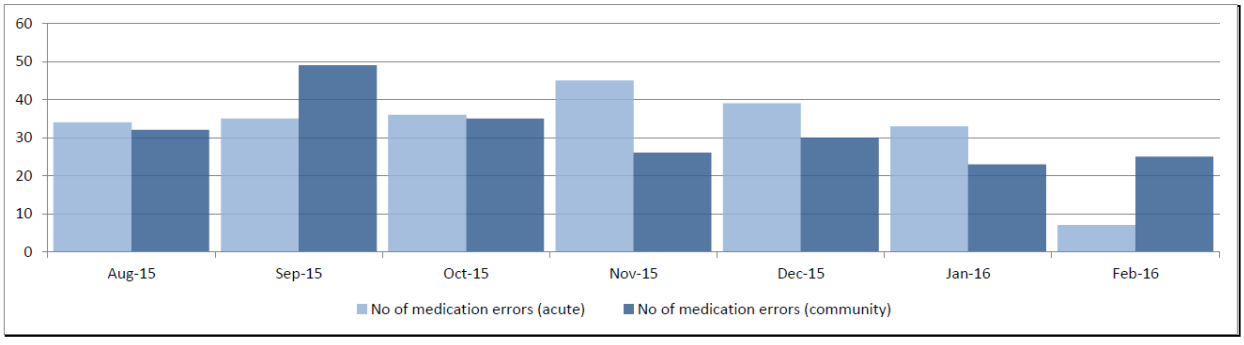


The meds reconciliation figure has decreased from a relatively high position due to a change in the data gathering methodology. Pharmacy, to ensure enhanced compliance, are now applying the Meds Rec within 24 hours of hospital admission to all weekend admissions. This has resulted in the change and improvement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

The final chart records medication incidents from the incident reporting system by number by month. The chart includes Acute and Community incidents.

Medication errors - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
No of medication errors (acute)	34	41	207	28	30	34	35	36	45	39	33	7
No of medication errors (community)				40	33	32	49	35	26	30	23	25

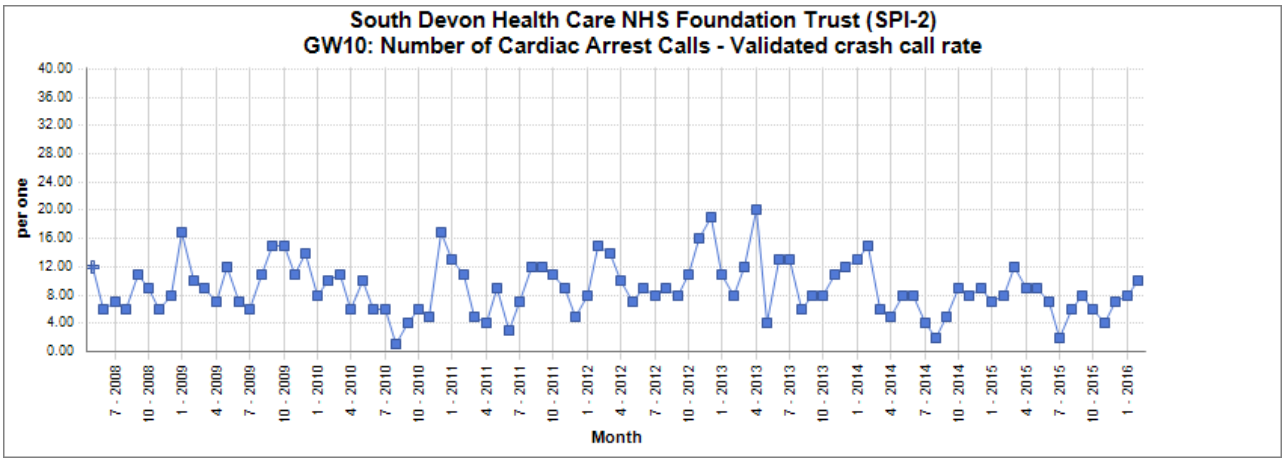


Appendix 12

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



Compared with 2014, there was a drop of 18% in cardiac arrests in the Year 2015, 85 compare to 104, which is roughly 1.66 fewer cardiac arrests each month and this was the lowest number of cardiac arrests in the Trust for several years.

Appendix 13

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).

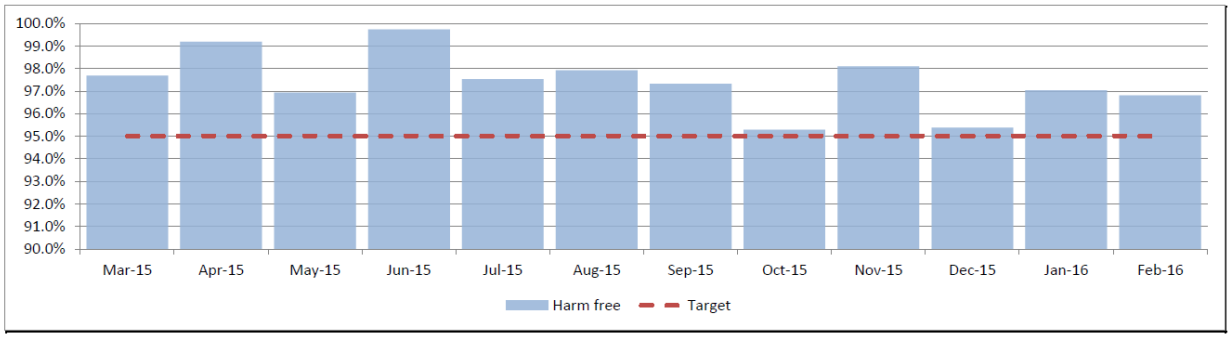
The ST provides a quick and simple method for surveying patient harms under the four headings of falls, catheter infections, pressure ulcers and venous thromboembolic events (VTE).

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. November onwards presents the new organisation hence the increase in patients sampled. Total harm free is running at 96.8%

Harm Free - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients	387	367	358	377	365	336	372	360	366	888	1012	972
New harms	9	3	11	1	9	7	10	17	7	41	30	31
Harm free	97.7%	99.2%	96.9%	99.7%	97.5%	97.9%	97.3%	95.3%	98.1%	95.4%	97.0%	96.8%
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 14

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 2015/16 the Trust has recorded two such events, one in Obstetrics (Sept) and one in Theatre (July); in all cases the patients did not suffer any immediate physical harm and investigations and changes have been implemented.

Data 1st April 2015 – 23rd March 2016 source Safeguard

	Description	
1.	Wrong site surgery	0
2.	Wrong implant / prosthesis	0
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 organs	0
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

REPORT SUMMARY SHEET

Meeting Date:	6 April 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:

Appraisal compliance has recovered and is now at 85% (February 2016) which although below the 90% target benchmark is higher than the compliance rate in other local Trusts, as reported at January 2016 (86%). Section 4.2 refers.

Mandatory training is compliant against target in 6 of the 9 key modules, amber in Information Governance, Fire and Infection Control training. Section 4.3 refers.

Sickness absence continues a downward trend, reducing to 3.99% in January 2016 against a target of 4.10% or less. The end of year (March 2016 target is 4.00%). Section 4.4 refers.

The comparative performance of each area of the Trust for appraisals, mandatory training and sickness absence is included as appendix C.

Vacancy factor relative to other Trusts remains low, at 7.01% in February excluding temporary workforce and is 1.22% including temporary workforce. The vacancy factor for nursing is now included and for registered nursing was 8.26% in January. The workforce planning section also includes activity to manage the demand and supply of the workforce including, roles redesign and “growing our own”. Sections 4.5 & 4.6 refer.

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.

The Staff Survey 2015 has recently been published in response to the key findings and an action plan has been developed. Section 7.6 refers

Risks

Agency capped rates will reduce further on 1 April 2016. The Trust is committed to achieving the requirement and is participating in a regional group which is working to address the lack of agencies in the South West which are on a nationally agreed framework and that comply with the capped rates. Section 7.9.1 refers.

A range of initiatives are being actioned and/or considered in support of trust wide recruitment issues, Section 7.8 refers. Medical recruitment remains a challenge in key areas as reported in Section 7.10.2

There is a risk to the Occupational Health Service as a consequence of being unable to recruit to the Consultant post, although a locum is currently in post. It should be noted that good progress is being made with the work to secure external service provision Section 8.1 refers.

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

Recommendations:

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

Summary of ED Challenge/Discussion

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

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
6th April 2016

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 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. This is the last report that will include the 2015/2016 objectives and development of the 2016/2017 objectives are included in 2.2 below.

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

In common with each Directorate the Workforce and Organisational Development are developing objectives for 2016/2017 based on the previously agreed corporate long term strategic objectives. These objectives will be included in future Workforce and OD Directorate reports to the Board.

3.0 CQC Inspection

3.1 In the last report to the Board action in respect of preparation for the CQC inspection was reported. The inspection has now of course taken place and the Trust is awaiting the draft report which is expected at the beginning of April.

3.2 There were no pre-report action plans instigated by CQC in respect of specific Workforce and OD activity. However some of the action plans included issues that relate to the Directorates activity and will require the Directorates support.

3.3 Significant amounts of workforce information was requested both pre, during and post inspection by the CQC with a particular emphasis on training compliance. Much of this information was used by the CQC in their inspections of the different services. The CQC report should be available for consideration at the next Workforce and OD Committee in May.

4. Progress on Key Performance Indicators

4.1 Workforce and OD Metrics Reports

The following reports to monitor key workforce ad OD metrics for February 2016 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 February 2016. 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 February 2016 are highlighted in this section of the report.

4.2 Staff Appraisals

Following actions reported in the last Workforce and Organisational Development report to the Board the staff appraisal completions rate has improved from 78% in December 2015 to 85% in February 2016. This is a significant improvement but still below the target of 90%. Section 7.2 includes further analysis and actions in respect of appraisal rates.

4.3 Mandatory Training

Of the nine key modules six were rated green and three were rated amber in February 2016. Overall the combined average compliance was 89% which is above the current target of 85% but marginally below the revised target of 90% for 2016/2017. Section 10.5 includes further analysis and actions in respect of mandatory training compliance rates.

4.4 Sickness Absence

The sickness absence rate reduced to 3.99% in January 2016 which is within the 4.10% target for January 2016 and the target of 4.00% for March 2016. This is a further reduction to a very satisfactory trend and of course represents a significant saving. Section 7.1 includes further analysis and actions in respect of sickness absence management.

4.5 Vacancy Factor

The vacancy factor was 7.01% in February 2016. 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, less reduced hours are taken into account the residual vacancy factor is 1.22%. The table below shows this position by WTE and percentage.

Funded Establishment WTE	In-Post (WTE Contracted)	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 % Incl temp workforce and add hours
5125.18	386.60	7.01%	239.78	115.45	-31.07	62.44	1.22%

The above shows that from a Trust wide position vacancies are covered by our temporary workforce and staff working additional hours. However it is recognised that this results in increased expenditure and concerns about continuity of service and quality. Actions to improve the recruitment and retention position are included in this report in sections 7.8 and 7.9.

4.6 Vacancy Factor – Nursing

Due to the particular concerns in respect of nursing vacancies and consequent use of bank and agency as requested by the Board separate information in respect of that staff group is included below. This was discussed by the Workforce and Organisational Development Group and on-going actions to improve are included in this report.

Nursing Vacancies at 31.01.2016

	Month 8			Month 9			Month 9		
	Registered	Nursing Support	Total	Registered	Nursing Support	Total	Registered	Nursing Support	Total
Establishment WTE	1280	661	1941	1284	699	1983	1307	742	2049
In-Post WTE	1190	617	1807	1194	662	1856	1199	664	1863
Vacancies WTE	90	44	134	90	37	127	108	78	186
Vacancy Factor	7.03%	6.66%	6.90%	7.01%	5.29%	6.40%	8.26%	10.51%	9.08%

4.7 Key Performance Indicators Benchmarking

To enable the Trust to benchmark itself with a number of local Trusts the following information was obtained for comparison. These comparisons are for January 2016 and show that the Trust performs well in respect of these indicators.

	Torbay & South Devon NHS Foundation Trust	Plymouth Hospitals NHS Trust	Royal Cornwall Hospitals NHS Trust	Royal Devon & Exeter NHS Foundation Trust	Taunton & Somerset NHS Foundation Trust	Northern Devon Healthcare NHS Trust
Sickness Absence	3.98%	3.81%	4.72%	4.03%	3.67%	**3.52%**
Appraisal Rate	**86%**	76%	63%	84%	83%	74%
Mandatory Training	**90%**	88%	80%	88%	86%	88%

5. Workforce Planning

5.1 Integrated Workforce Plan

The Workforce Redesign Network is the sub-group of the Workforce and Organisational Development Group responsible for steering and coordinating delivery of the Integrated Workforce Strategy. The Network has held two meetings since the last Workforce and Organisational Development report to the Board. The key actions and further activity in respect of the Integrated Workforce Plan is summarised below.

- The Workforce Redesign Network has agreed Terms of Reference which have been agreed by the Workforce and Organisational Development Group.
- The development of the care model has been discussed at the Network including the planned introduction of Wellbeing Co-ordinators, as part of the multi-disciplinary teams and further new roles. Plans are now moving from scoping to implementation.
- Workforce planning by operational teams as part of the business planning process is progressing. The submissions will be used in tandem with organisational planning to develop key actions in accordance with the Integrated Workforce Strategy.
- Workforce intelligence from the business planning process will also be used to inform the Trusts annual plan and the Education Commissioning Demand Forecasting exercise
- The on-going development of a nursing career pathway as part of "growing our own" is progressing. A plan has been developed and is being delivered to support the pathway from apprentices to RGN's. The Workforce Redesign Network has supported this work including for other professions particularly in respect of considering sponsoring training and this is being scoped.
- The medical workforce review was discussed and further information in respect of this activity is included in the Medical Education section of this report.
- The placement capacity meeting with the Universities took place on Friday 22nd January 2016 and agreement to increase placements across the professions was made as far as is possible to increase the likelihood of newly qualified staff joining the Trust when they complete their training.

The Workforce Redesign Network had a more detailed discussion about managing and monitoring the demand/supply gap for each staff group. The challenge of reducing the existing Registered Nursing Vacancies of C90WTE and turnover of C150WTE per year was discussed and the following current and planned actions were endorsed and agreed to maximise the supply routes:

- Redesign and growing our own in accordance with our plans
- Overseas recruitment in the short term
- Return to Nursing
- Sponsorship of nurse and other registered staff training
- Targeting newly qualified
- General recruitment initiatives

More detailed work was requested to identify targets for each supply route and this will be progressed and reported.

5.2 Education Commissioning Demand Forecast

As indicated above a major supply route for the Trust workforce is of course newly qualified staff. The Education Commissioning Demand Forecast exercise is undertaken annually by HEE via their regional offices. Each NHS organisation is asked to complete a demand forecast and narrative in early summer to help determine the number of education commissions regionally and nationally. The HEE Commissioning and Investment Plan 2016/2017 was published at the start of the New Year and the South West Education, Commissioning and Training Plan 2016/2017 has recently been published.

It should be noted that training in 2016/2017 will have no impact on supply until four years' time and for medical commissions longer. It should also be noted that there is an intention that current bursary and fee arrangements for undergraduate nursing, midwifery, AHP's and other clinical groups will be replaced by student loans for new students from 2017. The intention is that this will create the opportunity for the future training volumes not to be constrained by the overall amount of funding available. The future arrangements for demand forecasting as a consequence of these planned changes are yet to be confirmed.

Despite the proposed changes to funding HEE have continued with the current demand forecasting for this year and their report reflects this. In broad terms the Trust requested training commissions of 10% of its planned workforce for most professional groups for the 5 years of the exercise. This is based on the anticipated levels of turnover and the age profile of the workforce but also taking account of other supply lines. In its narrative the Trust reported particular challenges in respect of the medical workforce, particularly physicians to provide acute and health care to older people and in A & E, nursing with a particular emphasis on community, MIU and ICU, physiotherapists, occupational therapists, radiology, radiography and social workers. In addition emphasis on the skills concurrent with our planned model of care was requested to be built into training programmes.

The HEE report emphasises that it has to operate within its resources and to prioritise accordingly. It also points out that in accordance with five year forward view plans there is a need to concentrate on a workforce vision designed around transformed services and the multi-professional teams that will deliver them. This is of course consistent with the Trusts own plans but it should be emphasised that this was taken into account when undertaking the demand forecasting in the Trust. This

position has translated into an outcome where the demand of Trusts in respect of education commissions is not wholly reflected in planned commissions. However there are some small increases in education commissions for some groups in 2016/2017 including:

- Adult Nurses
- Mental Health Nurses
- Diagnostic Radiography
- Paramedics
- Pre-reg Pharmacists
- HCS Scientist Training Programme
- Physicians Associates
- Dental Hygienists
- Medical and Dental – Core Medical Training, Acute Internal Medicine, Geriatric Medicine, Dermatology, Paediatric and Perinatal Pathology, Vascular Surgery, Child and Adolescent Psychiatry, Old Age Psychiatry, Clinical Radiology and Dental Public Health

The HEE commissioning and investment plan – 2016/17 is available by clicking this link
https://hee.nhs.uk/sites/default/files/documents/HEE%20commissioning%20and%20investment%20plan.pdf

The South West Education, Commissioning and Training Plan 2016/2017 reflects the HEE Plan.

As described above meeting the workforce demand for the Trust will require the achievement of plans to redesign the workforce and grow our own in accordance with our plans. In addition to continue to maximise other supply routes in the meantime for professional groups both in the short term (overseas recruitment of nurses) and the longer term sponsorship for nurses (current) and AHP's (planned), Return to Nursing etc.

6.0 Pay, Pensions and Expenses

6.1 Staff Expenses System

As previously reported the Trust currently uses the electronic Software Europe system for acute staff to claim expenses. It had always been intended to roll out the same system for those staff in the community once the ESR systems were merged. However an expenses system via ESR is to being made available free of charge.

The Workforce and Organisational Development Group considered a number options for the way forward and agreed that each of the systems that are being offered for free as part of the ESR suite i.e. Allocate Software and Giltbyte should be reviewed with a view to using for all staff as soon as possible. There would be no annual cost but the Trust would need to continue to pay Software Europe C£8K per annum until September 2018. However staff would be on the same system that has the advantage of being a part of ESR. In addition any costs would not continue beyond September 2018.

6.2 Pay Award and National Insurance Changes

All Trust staff excluding Medical and Dental Staff have been awarded a 1% pay increase in accordance with the Agenda for Change national agreement. Medical and Dental Staff are subject to different agreements as reported in section 7.10.

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 affect all Trust staff who are currently members of the NHS Pension Scheme.

A message has been included in the staff bulletin to inform staff and also on payslips.

6.3 Pensions Tax Allowances

As previously reported 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 £100K advising them of this change and inviting them to an event that was held on the 2nd March 2016 where those that attended were provided with further information in respect of the changes.

6.4 External Services

The Trusts Payroll and Pensions Department currently provides pension services to Northern Devon Healthcare NHS Trust and Yeovil District Hospital NHS Foundation Trust. There have been two recent developments in respect of these and linked services.

As a consequence of Northern Devon Healthcare NHS Trust transferring some services to Royal Devon and Exeter NHS Foundation Trust the number of staff this Trust provides a service to will reduce. This could have implications for staffing levels in the department. We are currently communicating with Northern Devon Healthcare NHS Trust to identify the full effect to the contract and liaising with the Trusts Commercial Department for advice.

Another local Trust has approached the Trust asking if we would wish to provide them with a payroll service. We have had preliminarily meetings with that Trust and the Workforce and Organisational Development Group and Executive Directors have agreed that we should work with that Trust to develop a service specification and contract. The rationale for proceeding is that it maintains a quality local service whilst achieving economies of scale and integration of back office services with another Trust. The Trusts Commercial Department are also engaged in this activity.

6.5 Weekly Payroll

As included elsewhere in this report the introduction of a weekly payroll for bank workers only is one of a number of initiatives to incentivise workers to be a part of the bank rather than work agency shifts. All bank only workers have been offered the opportunity to move to weekly pay and of C800 workers to date C300 have opted to move. All new bank workers will also be put on the weekly payroll. The week will run from Monday to Sunday with the worker being paid in the following week. The start date will be for shifts commencing in the week beginning Monday 11th April 2016 to Sunday 17th April 2016 with pay day on Friday the 29th April 2016.

6.6 Payroll and Pensions Audit

The recent annual audit of the Payroll and Pensions Department resulted in an overall green assurance rating which is also consistent with the previous year.

7.0 Human Resources

7.1 Managing Sickness Absence

As reported in 4.4 above the data for sickness absence at the end of January 2016 indicates a rolling 12 month figure of 3.99%. This is below the end of year target of 4%.

Long term sickness continues to make up the higher proportion of the overall figure and this currently stands at 65%.'Stress, anxiety and depression' and MSK are the top declared categories of sickness absence both standing at around 18%. This relates to days lost through sickness rather than episodes of sickness and is mainly represented by long term sickness. However, if reasons for absence are looked at in relation to the numbers of episodes then 'Colds and Flu' are the top reasons for absence.

As previously reported the Sickness Absence Management Policy was reviewed by Internal Audit in October 2015 and given an overall green assurance rating. This indicated that the policy followed good practice and is fit for purpose. However, that notwithstanding and within the context of absence levels having been successfully reduced to below Trust target levels, there is the intention to review some aspects of the policy. This review will be with the aim of removing any areas of ambiguity and ensuring there is a balanced approach between supporting staff whilst at the same time effectively managing attendance levels. Such a balanced approach needs to be consistent with actions plans in respect of the staff survey outcome for staff feeling pressure in the last 3 months to attend work when feeling unwell as detailed in 7.6 below.

7.2 Staff Appraisal

The compliance rate for completed PDRs/Appraisals had been the focus of improvement efforts for both organisations prior to integration and subsequently as a single organisation. As reported in 4.2 above the current recorded rate for completed appraisals was 85% in February 2016. The 2015 Staff Survey outcome for the Trust for the percentage of staff appraised in the last 12 months was 88% with the national average for similar type organisations being 86% (for comparison purposes, the previous Staff Survey had SDHCFT at 78% and TSDHCT at 85%. The staff survey results and our own records confirm the improvement in completed appraisals.

The improvement in compliance levels is a welcome outcome and particularly so given the context of the integration exercise and increasingly challenging work pressures. However, work needs to be carried out to ensure that not just the level of compliance but the quality of the PDRs/Appraisals carried out is improved. This will be a continuing focus for the coming year.

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

The Staff FFT went live in Quarter 3 within the month of December in Women's, Children's, Diagnostics and Therapies. Whilst the detailed findings are awaited, the raw data indicates that 90% of staff were likely or extremely likely to recommend the Trust for care/treatment with 87% of staff likely or extremely likely to recommend the Trust for work.

The survey went live within the month of February within; Corporate Services (Acute), Estates and Facilities Management, Continuing Healthcare, Community

Services and Medical – community. The survey closed on 29th February 2015 and the findings are awaited.

7.4 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).

The quarter 3 objectives are as identified below;

- Attendance & input to MASEN meetings evidenced by discussions/notes from meetings and report of progress.
- Each organisation to be able to demonstrate improvement within themes as analysed from the National Staff Survey 2014_15. These improvements will be shared within the MASEN and shared within each organisation using internal media, (for example under a "you said…we did" format). CQUIN Panel to be provided evidence of this.
- Evidence of 3 cross organisational "Always Events" occurring supported by feedback via peer review (eg, mystery shopper, evaluative questionnaire etc.)

The continued implementation of the Staff Survey action plan and 'Always' events means that the end of quarter 3 CQUIN report was submitted with a green RAG status. This was supported by the commissioners.

7.5 Freedom to Speak Up Guardians

As part of phase two of the 'See something, say something' initiative the Trust has successfully appointed 9 *'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.

Guardians have started working together to develop the systems, processes and support needed for their role, and are planning for a 'Go Live' launch in April 2016.

7.6 NHS Staff Survey 2015

7.6.1 Background

The National NHS Staff Survey 2015 was issued to all staff in October 2015 to seek their views about their jobs and working for the Trust. This was slightly later than in previous years, as a conscious decision was taken to delay the fieldwork to allow the survey to be completed, for the first time, as an integrated Care Organisation.

The findings from the survey have been summarised and presented in the form of 32 key findings with an overall indicator of staff engagement.

7.6.2 Response rate

By the time the fieldwork for the survey closed at the end of November 2015, 2698 staff had taken part in the survey. This represents a response rate of 46% which is above average for combined acute and community trusts in England.

7.6.3 Summary of key findings

In comparison to combined acute and community trusts in England, staff responses have rated the Trust as average or above average in 28 out of the 32 key findings.

This compares to both Trusts in 2014 being rated as average or above in 21 out of 29 key findings.

	2015 Staff Survey
Above the national average	8
Average	20
Below average	4

The Trusts overall indicator of staff engagement is measured on a scale summary score from 1 to 5, where 1 represents poorly engaged and 5 represents highly engaged. The Trusts score of 3.87 is above (better than) average when compared with trusts of a similar type and exceeds that of both Trusts in 2014.

7.6.4 Details of key findings

Areas in which the Trust performed above the national average included;

KF 1 - Staff recommendation of the organisation as a place to work or receive treatment
KF 5 - Recognition and value of staff by managers and the organisation
KF14 - Staff satisfaction with resourcing and support
KF15 - Percentage of staff satisfied with opportunities for flexible working patterns.
KF16 - Lower levels of staff working extra hours
KF18 - Lower levels of staff suffering from work related stress
KF19 - Organisation and management interest in and action on health/wellbeing
KF27 - Percentage of staff reporting incidents of harassment, bullying or abuse, when experienced.

The Trust also performed well in regards to staff motivation, effective team working and support from immediate manager.

Prior to integration, both South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust shared 4 common areas in which they required further work. It is pleasing to see that the 2015 findings indicate 3 of these areas have improved, namely; the percentage of staff appraised, the percentage of staff agreeing that their role makes a difference to patients and addressing discrimination at work.

Whilst it is important that we strive to maintain areas of high performance, it is those areas in which we have performed less well that will be the priority. The survey highlighted 4 principle areas that require further work;

- Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell. The Trust finding is 65%, compared to a national average of 58%.

- Percentage of staff witnessing harmful errors, near misses or incidents in last month. The Trusts finding of 30% is 1% above the national average and not withstanding that work needs to be done in this area. It is heartening to see that 91% of staff report incidents once witnessed – this is 1% above the national average.

- Fairness and effectiveness of procedures for reporting errors, near misses and incidents. The Trust scale summary of 3.65 is just below the average of 3.71.

- Staff confidence and security in reporting unsafe clinical practice. The Trusts scale summary of 3.59 is marginally below the national average of 3.64. Work is already underway to improve upon this key issue and has included the appointment of 9 Freedom to Speak Up Guardians and the launch of the 'See something, say something' initiative

  Details of all the key findings are included in Appendix D.

7.6.5 Next steps

- Trust Actions

Following staff engagement with key stakeholders, an action plan is included at Appendix E. This action plan has been developed to address those areas highlighted for development. The implementation of the action plan will be monitored through the Workforce and Organisational Development group.

- Local Actions

  Where available, Directorates will be provided with local findings from the survey. Directorates will then be asked to engage with their teams and develop local action plans to address those areas identified for development.

7.7 Integration of South Devon Healthcare NHS Foundation Trust & Torbay & Southern Devon Health and Care NHS Trust Employment Policies

Following the creation of the one Trust work to integrate employment polices of what were previously two Trusts is continuing, where they are applicable to the new Trust. This includes integrating some policies that transferred with staff from NHS Devon.

From these three organisations 59 polices have been integrated with a further 40 policies having been reviewed, updated or removed. Work continues with staffside to ensure all employment policies are fully integrated

7.8 Recruitment

7.8.1 Strategic Recruitment and Retention Group

The steering group held its second meeting recently and each of the four task groups work continues to progress around agency and temporary staffing, recruitment and retention and succession planning and role redesign.

Recent task group feedback is as follows:-

- **Recruitment and Recruitment Processes Working Group** - identified a number of potential work streams, which includes for example, the use of social media, marketing, recruitment fairs, overseas recruitment.

  Action plans are being developed which are being shared with the Strategic Recruitment & Retention Group.

- **Retention Sub Group** - will focus on a detailed analysis of registered nursing staff leaving after 1-2 years' service with the Trust with the aim of identifying and offering some solutions to this area of turnover. In addition the Group is reviewing exit questionnaires/interviews.

- **Succession Planning and Role Redesign** – have prepared a paper for the next Strategic Recruitment and Retention Group meeting to agree. The paper includes a definition of the work and an outline plan for the activity and outcomes of the work. The activity includes identifying business critical positions, talent spotting, identification and development of individuals to fill business critical posts.

7.8.2 Overseas Nurse Recruitment

From January 2016, the NMC requires applicants from countries in the European Economic Area to produce evidence showing their English language competency. If applicants cannot demonstrate competence, the candidates have to pass the IELTS test, with a minimum of 7.0 in each of the four areas of reading, writing, listening and speaking. Since the introduction of this requirement the Trust has seen a reduction in the number of applicants expressing an interest in coming to the UK.

However the Government have added nurses to the shortage occupation list which means that the Trust can explore the potential to recruit from outside of the EU, eg Philippines. To this end the Trust is in the process of tendering for a Recruitment Agency in the Philippines with a view to appointing 70-80 nurses, with a range of skills and experience. Should this be successful, because of the visa and NMC requirements it could take up to 10 months before the applicants are able to practice as a registered nurse. An update on this proposal, with timescales will be produced for the next meeting.

7.9 Temporary Staffing

7.9.1 Monitor Agency Requirements

It is now six months since Monitor and the TDA introduced rules to help Trusts reduce their agency expenditure. Nationally it is considered that the rules are having a positive effect as agency expenditure is now falling. This has not been the case in the South West due to the limited number of framework agencies that operate in the area. However the Trust is part of a South West regional group to improve the situation both in respect of the increasing the number of framework agencies and also compliance with the capped rate.

NHS Improvement has recently confirmed a range of measures for Trusts to reduce spending further and ensure that staff move back to substantive and bank roles. The measures are:

- a further agency price cap reduction from 1 April 2016–the hourly charge for all agency and locum staff would fall to 55% above substantive rates.
- the requirement to use approved frameworks for all agency procurement from the 1st April 2016 – all Trusts must use approved framework agreements to procure all agency and locum staff from the 1st April 2016.
- the publication of consolidated guidance which covers the full agency rules

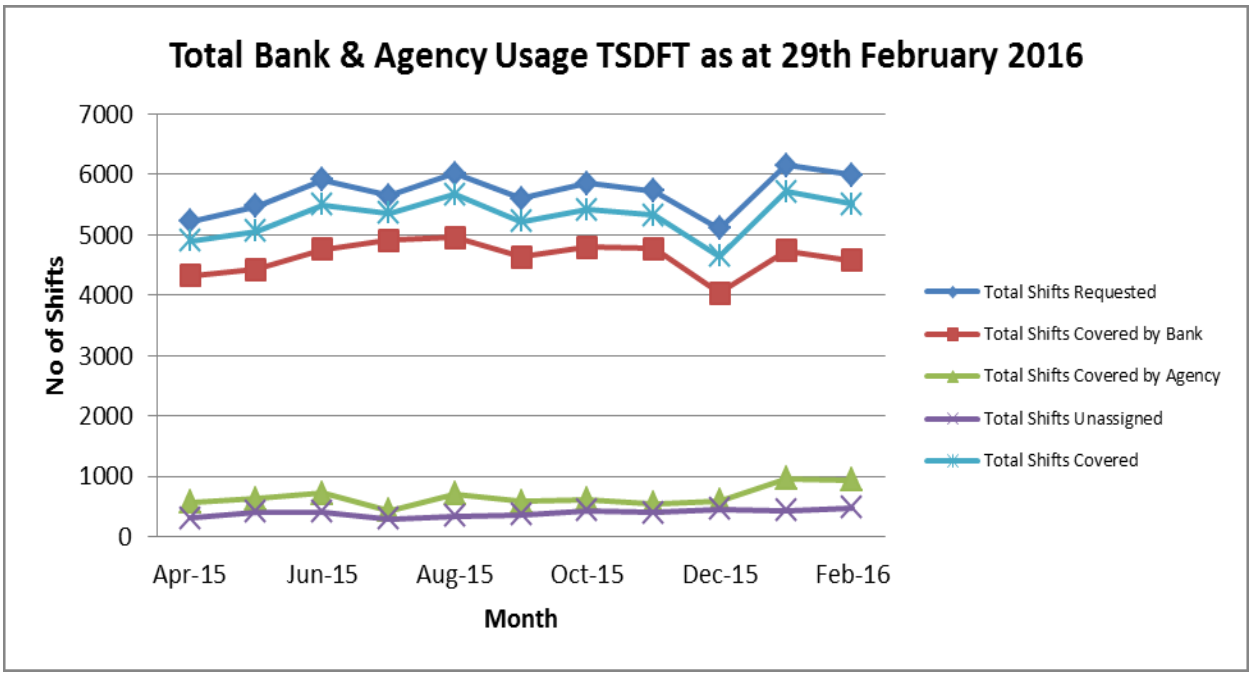
7.9.2 Initiatives in the use of Bank and Agency Staff

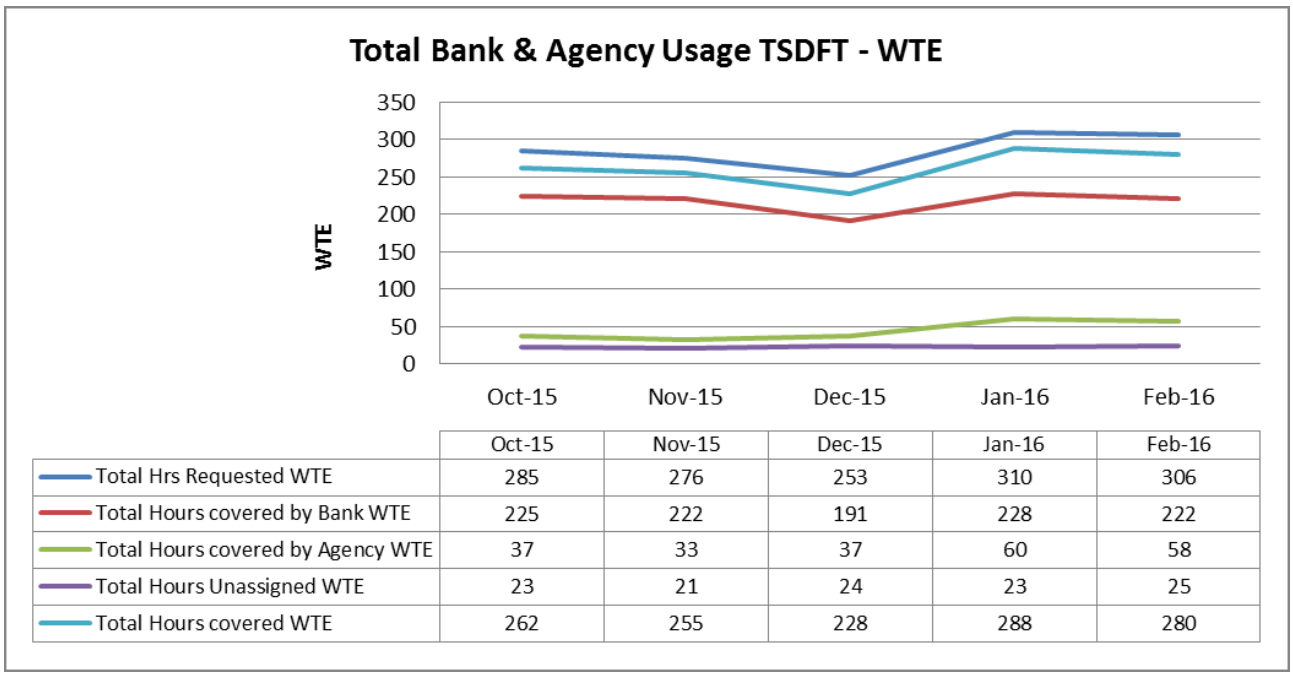
The level of bank and agency usage remains under constant under review, with the aim of decreasing the level of overall usage of temporary labour and secondly to increase the proportion of Bank as opposed to Agency.

Therefore are a number of initiatives have been identified for consideration at the next Finance Committee Meeting to ensure the overall package for bank workers is financially viable. This includes:

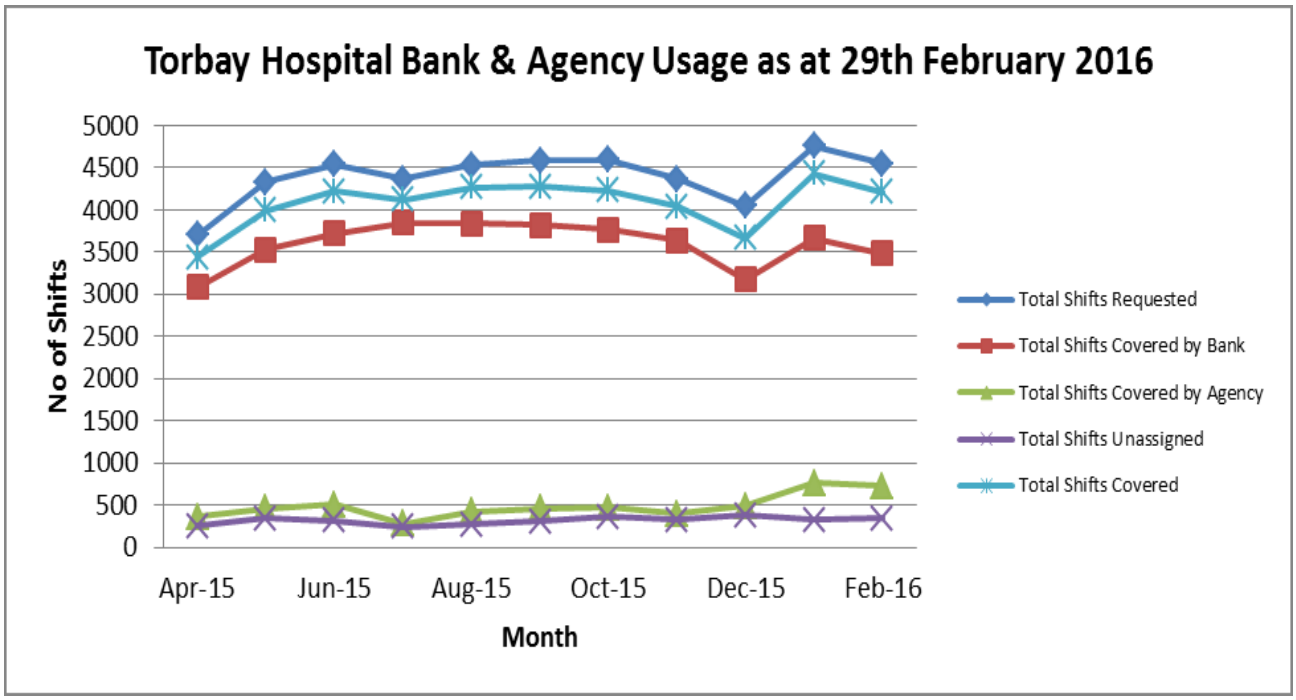
- The provision of weekly pay to staff who are bank workers only. Staff who have substantive contracts with the Trust but also work on the bank will still be paid monthly. It is proposed that these arrangements will come into effect from 4th April 2016.
- Full time staff to be offered on a consistent basis overtime rates to work additional hours.
- Part time staff to be offered additional hours at plain time rates up to 37.5 hours a week and thereafter overtime rates.
- 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, at public transport rate.
- The introduction of a reliability payment.
- The introduction of a recommend a friend scheme.
- Formal permission with centralised backup to Managers to over recruit in certain staff group.

7.9.3 Bank & Agency Utilisation

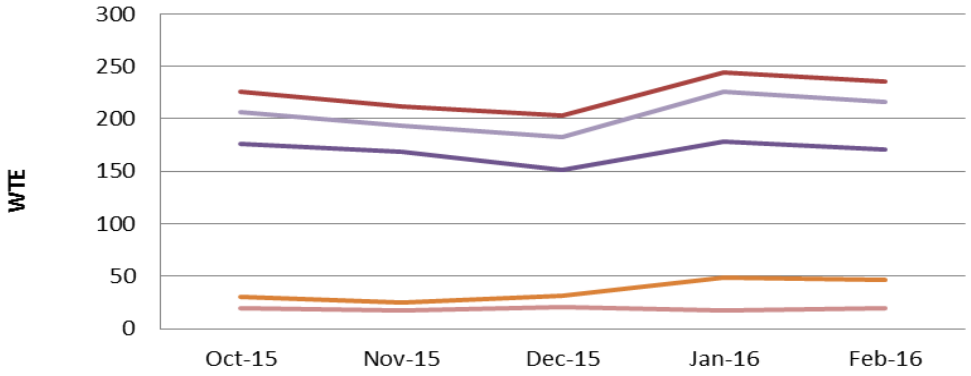




	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Total Hrs Requested WTE	285	276	253	310	306
Total Hours covered by Bank WTE	225	222	191	228	222
Total Hours covered by Agency WTE	37	33	37	60	58
Total Hours Unassigned WTE	23	21	24	23	25
Total Hours covered WTE	262	255	228	288	280

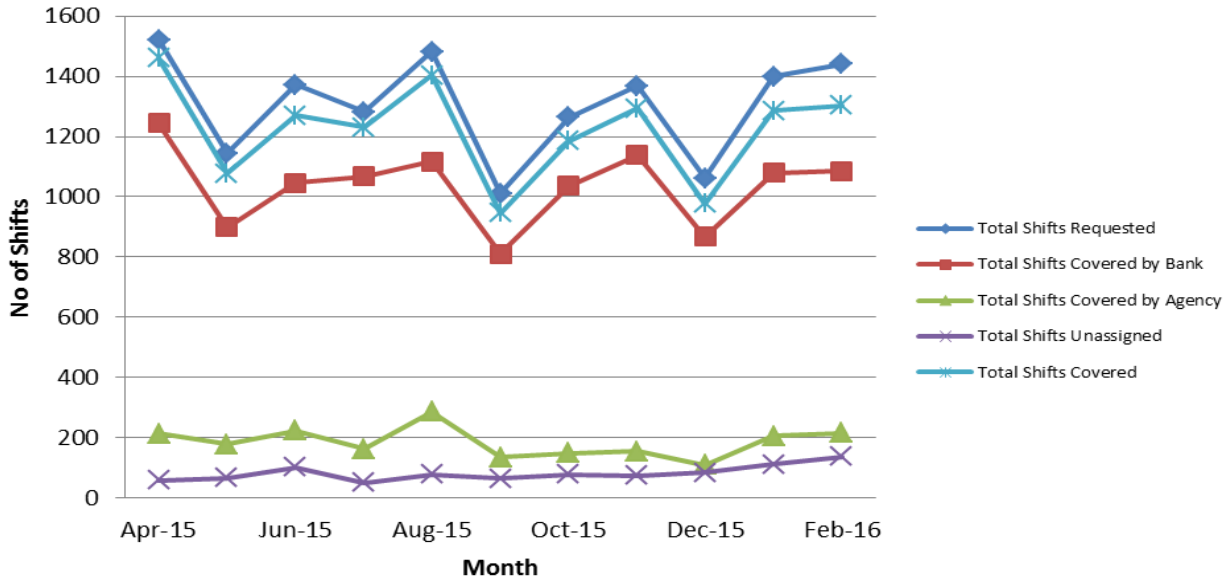


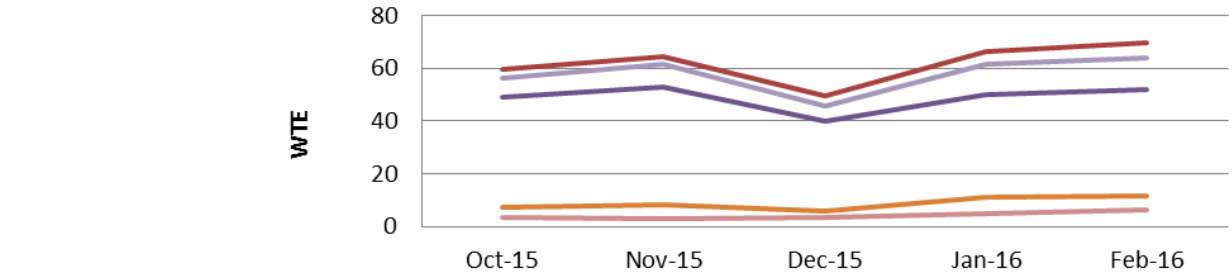
Torbay Hospital Bank & Agency Usage - WTE



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Total Hrs Requested WTE	225	211	203	244	236
Total Hours covered by Bank WTE	176	169	151	178	170
Total Hours covered by Agency WTE	30	25	31	48	46
Total Hours Unassigned WTE	19	18	21	18	19
Total Hours covered WTE	206	194	182	226	217

Community Areas Bank & Agency Usage as at 29th February 2016





	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Total Hrs Requested WTE	60	64	49	66	70
Total Hours covered by Bank WTE	49	53	40	50	52
Total Hours covered by Agency WTE	7	8	6	11	12
Total Hours Unassigned WTE	3	3	4	5	6
Total Hours covered WTE	56	61	46	61	64

7.10 Medical HR

7.10.1 Junior Doctor 2016 Contract

New contractual arrangements will be introduced from 3rd August 2016 for trainees in hospital posts approved for postgraduate medical/dental education. These will replace the existing New Deal arrangements, 2000 and the Hospital Medical and Dental Staff Terms and Conditions (Ts & Cs)s 2002.

The introduction of this contract will significantly change working patterns for doctors in training. A phased implementation plan has been developed by NHS Employers and is currently being reviewed locally.
The plan will be to transfer the trainees onto the new contract on different dates over a 12 month period, commencing August 2016 dependent upon the natural end of their current contract.

Trainees will retain their existing New Deal contract pay, Ts & Cs until the date on which they transfer to the new contract and it's associated Ts & Cs.

The following trainees will be moved onto the new Ts & Cs ad new pay system effective from 3 August 2016, where they move between posts and/or contracts of employment, and will be offered cash pay protection:

- All trainees remaining on F1 or remaining on F2
- All trainees entering Foundation 2.
- All new entrants to core or run through specialty training (CT1 / ST1 points)
- All trainees moving into CT2 / ST2 existing points (and CT3 point where it exists) would be paid according to the new contract in August 2016.
- All trainees remaining in the CT1, ST1, CT2, ST2 or CT3 (where it exists) grades in August 2016
- All new entrants to higher (non-run through) training (at ST3 point and in some specialties at ST4 point)

Their pay protection will be calculated as follows on 3 August 2016 and this amount will apply as a baseline or "consistent cash floor" for each year until either the trainee exits training or until 31 March 2020, whichever is the sooner:

- Take the incremental pay point for eligible trainees as of 31 October 2015 and add any uplift that may be awarded in April 2016.

- Add the value of the banding supplement for the rota on which they are working on 31 October 2015, up to a maximum banding supplement of 50% (band 1A) or, for those trainees who have opted out of the Working Time Regulations, to a maximum of Band 2A (80%), which is also the highest level to which protection can be applied under the current contract. Trainees protected at 80% supplement would however have to accept a contract for up to 56 hours per week for this protection to apply; accepting a contract of only 48 hours would reduce the protected supplement to 50%.

Trainees pay will be worked out on the new system, and if it is below the cash floor, pay protection will be paid. This means trainees could earn more under the new system but they can never be paid less than the cash floor.

Trainees already in run-through specialty training or higher specialty training at ST3 level or above before 3 August 2016, and moving to ST4 or above in August 2016 will be moved onto the terms of the new contract on 3 August 2016 but remain on the existing pay system. The new Ts & Cs would be used for the purposes of organising their work and all other matters but under transitional pay protection, they would continue to be paid using the old system of banding (subject to the maximum of band 2A - 80% - for those who have opted out of the Working Time Regulations, which is also the highest level to which protection can be applied under the current contract) and annual increments until they exit the programme or until 31 March 2020, whichever is the sooner.

The NHS Employers factsheet with details of the key features of the new contract is attached.

7.10.2 Medical Recruitment

The Trust has been successful in finding replacements for three consultant posts; in Ophthalmology, Urology and Trauma and Orthopaedics. The Trust has also been successful in appointing to a new post in Oncology; appointing 2 part-time consultants to cover the full-time role.

The Trust has had difficulty in permanently recruiting a replacement Consultant for Occupational Health but has been successful in securing a fixed term locum and continues to explore other options for a long term resolution.

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:

Grade	Specialty	Status
Consultant (new post)	Histopathology	Out to advert (been trying to recruit since April 2015)
Consultant (Three posts)	Radiology	Recently held interviews and one candidate was
Consultant (replacement)	Gastroenterology	Last candidate withdrew and we will shortly re-advertise.
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)
Consultant (New Post)	GUM	Interviews on 14th April
Consultant (New Post)	Anaesthetics- Pain Management	Out to advert and closes on 20th March
Consultant (New Post)	Dermatology	Interviews on 8th April
Consultant (Replacement)	Diabetes and Endocrinology	Interviews on 28th April
Consultants (replacement x2)	Neurology	Interviews on 23rd March
Consultants (replacement)	Healthcare of Older People	Out to advert closes on 30th April

8.0 Occupational Health

8.1 Occupational Health

Our work towards securing a service from our preferred provider Optima is progressing. We have confirmed that we are able to proceed to agree contractual provisions under the terms of the national procurement framework using a single tender waiver. This has been approved by our Executive officers for Finance and HR and we are now moving to finalise the agreement with Optima and create an implementation plan with a view to a start date for the new service around the beginning of June. Meanwhile we continue with our interim agency Occupational Health Consultant Physician who has agreed an extension to his short term contract to cover the remaining period.

9.0 Workforce and OD Systems

9.1 ICO Project Plan – ESR Merge

As previously reported the National process for merging our two separate ESR systems was completed over the weekend of the 27/28th February 2016. Over 6000 substantive staff and over 1000 Bank and other staff were consolidated into one system which will simplify many back office functions for Payroll, Recruitment, Workforce and Finance teams.

Reporting hierarchies have been amended to reflect the new organisation and reporting as one Trust will be improved as a consequence. Further housekeeping

activities to remove duplicate information (particularly for Bank staff) are currently being performed.

9.2 ESR Input

The new electronic starters, change of circumstance and termination forms for the whole Trust were implemented at the start of February 2016. No major concerns have been raised and following further communication only the new electronic forms will be accepted after the end of March 2016.

9.3 ESR Post Merge

A number of factors have combined to suggest the Trust should adapt its strategy for workforce information inputting and management. These factors include the following:

- The changing profile of the Trust which has meant that different options for workforce information inputting and management now operate in different parts of the Trust.
- The merge of the ESR systems provides an opportunity to improve the reporting hierarchy between Manager and Staff member within ESR to increase the accuracy for reporting and communications.
- The ESR Enhance Project will significantly improve the system including access via mobile devices, customer facing design in line with modern media and improvements to self-service for managers and staff. This will enable managers and staff to manage their workforce and access and amend information respectively using one portal. The changes are being designed with a number of NHS organisations with roll out planned for the autumn.
- Continued concerns about the burden of using the Rosterpro e-rostering system in areas where there is only a requirement for time and attendance recording.
- Mangers desire to have live information available to them to support the management of their workforce. Workforce information is currently available in ESR for managers to view but predominantly managers wait for the reports provided by the Workforce Information Team.

The following outlines proposed adaptation to our strategy for workforce information inputting and management which the Workforce and Organisational Development Group were asked to endorse:

- Improving the reporting hierarchy between Manager and Staff member within ESR to increase the accuracy for reporting and communications
- Start to transition certain cost centres away from manual timesheets and the current e-rostering system to input time and attendance via ESR self-service to improve live attendance information whilst reducing licensing costs for an e-rostering system (key clinical areas such as wards can then be more supported around use of e-rostering)
- Continue to roll-out ESR self-service to Managers so they have direct access to key HR information such as Sickness, Training and Appraisal information
- Continue to maximise the use of ESR self-service for staff including moving to electronic pay slips, and information using one portal.
- Part of this strategy will be to over time move to staff and managers managing annual leave, expenses etc. using managers and staff ESR self-service.

In addition an options appraisal for a change to the e-rostering system has been drafted that proposed that option 3 of the following three options is adopted.

Option One – Maintain Current State

This option is for the Trust to remain with its disparate current systems across the staff and service areas and not to undertake any further development the IT systems, other than business as usual upgrades.

Option Two – Implement a new comprehensive e-rostering system in the next financial year

This option proposes the large scale implementation of a new system in the next financial year, which consists of a number of fully linked suite of modules.

Option Three – Implement a coordinated and actively managed programme of works with the ultimate aim of procuring the Allocate solution and commencing a staged implementation

This option proposes an immediate review of the current IT systems and processes across the new organisation with the purpose of standardising and simplifying within staff groups over the next year, whilst working on a comprehensive business case and project implementation plan to move to the Allocate Software.

One of the major factors for recommending option three was the cost of option two. However the Workforce and Organisational Development Group whilst supporting the overall thrust of the adaptions to the strategy asked for further consideration of option 2 to identify if it might be achievable and offer better alignment with Trust Corporate Objectives than the recommended option three. A group has been set up to consider this and will report back to the Workforce and Organisational Development Group in the first instance.

9.4 Learning Management System (LMS)/Nurse Revalidation

The business case for the procurement of the Totara LMS that will also provide a nurse revalidation system has been approved on the following basis: That Totara will provide the LMS and user experience element, but ESR will provide the information (e.g. Hierarchies, competencies, historical data, etc.) and the reports for compliance (Mandatory training). The exact detail of how this will be achieved is a part of the Project Group activity to implement the new system which is now meeting on a regular basis. This approach will ensure managers and staff have consistent information in ESR when using managers and staff ESR self-service as described above.

9.5 Annual Employment Declaration Form

The Trust implemented the Annual Employment Declaration Form for all staff in January 2016. The form was introduced to ensure compliance with NHS employment checks and standards and Trust policies during employment by the Trust. The check should be undertaken at the same time as the employees annual PDR and the PDR policy have been updated to reflect this. For Executive Directors an additional requirement has been added to ensure they comply with the fit and proper persons test. Each Executive Director has been required to complete this immediately and then at their annual PDR. This will be further extended to Non-Executive Directors.

The form has now been updated to further cover bank workers and volunteers and will be completed on an annual basis for these groups too.

10.0 Education and Development

10.1 Digital Learning

10.1.1 Learning Management System

As mentioned elsewhere in the report the business case for a new Learning Management System (Totara) has been agreed. A procurement process is on-going with the provider due to be selected on the 14th March. A project team comprising of Education, Workforce, IT and nurse revalidation team (with input from the comms) will support the implementation. The intention is to enhance learner experience and engagement through hosting a range of digital content presented in through a user friendly interface. Compliance reporting will be delivered through ESR as currently. Once the preferred provider has been identified a project timeline will be developed.

10.1.2 Patient VR

Learning Technologies Research and Development Lead has been successful in our bid to Torbay Medical Research Projects to support PhD research into the role of virtual reality (3D video) in teaching non-technical skills (such as empathy and compassion) to health care staff. The videos enable staff to experience receiving care from the patients' perspective and is an approach unique in healthcare education. This research programme will run over three years and be delivered in conjunction with the University of Plymouth.

10.2 Medical Education

10.2.1 GMC Regional review

As part of the GMC regional review of the South West during 2016 they will be visiting the Trust on Thursday 28th April. They will be assessing undergraduate and postgraduate medical education during the review and visit to the Trust. During the Trust visit they will be meeting with the exec team, education team, trainee doctors and medical students and clinicians involved in supervising and training. The specialties being focused on are ED, Acute medicine, Cardiology, Gastroenterology and Respiratory.

10.2.2 Contract Meeting and Quality assurance

HEE SW visited the Trust in December as part of the quality assurance process for postgraduate medical education. Feedback overall was positive and GMC survey results have been consistently good. The latest quality register results and Dean's report are now available and we have had 11 actions closed. 4 actions remain open within the specialties of ED, O&G, T&O and COTE. The Director of Medical Education will be working with the medical education team and the relevant specialties in relation to these specific actions. The individual specialty quality panel reports have been coming in for the last few weeks and are currently being analysed by the team.

10.2.3 Cost Collection

We are in the process of collecting data to help us formulate the funding models for our 2016 submission to DOH. A survey has been sent to all trainee doctors asking them how much time is spent undertaking education and training and trainers have been sent a questionnaire about how much education they deliver. Similarly we have met with some matrons and nurses to find out how much time they spend delivering education and we will be meeting with some more ward staff over the coming weeks. A meeting has been arranged with finance and Education in May to

discuss how we will integrate education in to the reference cost process which is ultimately the aim.

10.2.4 Medical Workforce developments

The Medical Workforce Review Group met in January the focus of discussion was the current review of the Hospital @ Night cover, potential role of Physicians Associates and progressing the career development of SAS doctors. The Specialty Doctor Emergency Department/SAS Tutor has mapped expected clinical competencies against clinical responsibility for SAS doctors in ED. This provides a route of career progression for doctors who are outside a formal training programme. This approach has potential transferability to other area of the medical workforce.

A business plan has been improved by Executive Board for the appointment of 12 Trust Fellow posts in order to support service continuity. Interviews will be on the 16th March and allocations are to be confirmed, but likely to include to T&O, Acute medicine, ED and General Surgery.

It was highlighted at the MWRG that the future development of the medical workforce, including the integration of new roles will need cross departmental, Directorate and Divisional working (including business planning). The group felt that this significant piece of work will require senior clinical leadership with dedicated time and it was agreed to explore potential options with the Medical Director. This need will also be identified to the Workforce Redesign Network.

10.3 Professional Practice

10.3.1 Cost Collection

Work is continuing on the HEE SW dictat for cost collection evidence relating to cost of providing education and training to students.

Two wards have been piloted to ensure the questions are sensible to garner evidence for ward staff mentoring, assessing and signing – off student nurses in the clinical setting. Evidence so far demonstrates parity across a medical and surgical ward. This pilot will then roll out across the acute and community setting to give a wide arena of clinical placement mentor activity.

10.3.2 Mask Fitting for pandemic outbreaks

Over the past two years the Education Directorate has undertaken a vast amount of training for staff to be mask fitted with named ward staff having the ability to ensure 24/7 coverage.

Real issues still remain in relation to the acute wards releasing staff to attain this training and to have the right number of staff having the ability to mask fit at all times. The tendency is still to rely 24/7 on the education team and this is not achievable or acceptable.

An options' appraisal paper will be presented to the Senior Business Group on Monday 14th Match to address this real issue so that the clinical areas will take responsibility for a day to day approach; time tabled training will still be offered each month for any members of staff nominated to take on this role.

10.3.3 The Foundation Degree in Healthcare programme (FdSc) for our Assistant Practitioners (Band 4s)

This innovative and nationally known programme was written up in the Guardian on 24th February 2016. The programme delivered to our staff over two years allows this staff group to apply to Registered Nurse training and due to the extent of the clinical and academic components undertake only 18 months of the three year nursing programme (known as APEL).

This is in direct line with DH and the Chancellors Autumn Spending Review agenda. Over the past few years, more in house staff are being put forward by managers to undertake the FdSc in Podiatry, Physiotherapy and Occupational Therapy and this is growing year on year as clinical areas cannot recruit trained staff in these disciplines.

In the past month active discussions have taken place with the Head of School for Allied Health Professionals at Plymouth University and the Dean of the School for Health & Human Sciences Plymouth University to start the process with South Devon College and the Education Directorate to APEL the first year of the training for Podiatry, Physiotherapy and Occupational Therapy.

Named Trainee Assistant Practitioners will undertake modules and competencies relating to advanced Anatomy and Physiology as well as in their second year undertake new competencies that relate directly to those fields of Registration for first years students in these disciplines.

This is unique and is being observed by the HEE SW.

10.3.4 Numeracy and English for nursing students

Traditionally anyone applying for adult student nursing had to achieve GCSE grade C or above to be contemplated for a place on the training. This was blocking our Assistant Practitioners from attaining student nursing application.

In recent discussions with Plymouth University, HEE SW and the Education Directorate we will run a pilot Numeracy day on 4th April 2016 for Band 4 Assistant Practitioners whom managers wish to support into nursing and on completion of the shortened 18 month programme offer them Band 5 nursing posts.

The day will be run in conjunction with a senior nursing lecturer from Plymouth University and will culminate in an exam set by Plymouth in functional Maths. If individuals pass this (100% pass rate required) then the University will waive the need for GCSE Maths.

The English GCSE can also be waived due to the amount of writing, discussion and PowerPoint assessments that make up the FdSc programme.
All applicants must have successfully achieved the FdSc programme and Functional Skills Level 2 in Maths and English.

This format, if the pilot is a success, will be transferable across the Country.

10.4 Vocational Training

10.4.1 Apprenticeships

In support of National Apprenticeship Week 2016, the Horizon Centre hosted an open day on the 17th March that featured information stands and speakers from

areas including the NHS Apprenticeship Service, Job Centre Plus, South Devon College, healthcare representatives and the Trust's Vocational Education Team. Current and past apprentices attended the event, allowing the students to gain a valuable insight into the opportunities available for apprenticeships at the Trust. An 'application station' where attendees were able to apply for real 'live' jobs was available on the day; at least ten of those vacancies were Health Care Assistant apprentice posts across the Emergency Departments. The Trust currently has122 apprentices working towards qualifications in a wide range of roles from Healthcare to Creative and Digital Media and from Laboratory Technicians to Customer Service. The Trust is looking to recruit a further 50 new apprentices across the organisation including Healthcare apprentices straight from Devon Studio School.

10.4.2 New Degree BSc Apprenticeships'

The government has announced the roll-out of 9 new industry designed Degree Apprenticeships - an innovative new model bringing together the best of higher and vocational education. A new partnership has been created with our local provider South Devon College where I will be looking at developing practical, vocational degree courses which will allow people to combine both the academic study from a traditional university degree and the practical experience and wider employment skills. We are aiming to launch this in the autumn.

10.4.3 New Chartered Management Higher Diploma's including Project Management

CMI are the only chartered professional body in the field of management and leadership, and recognised throughout the UK and Europe. For the very first time, the Trust is running two cohorts, in partnership with South Devon College, at level 4 and 5 for middle and senior managers. In order to be chartered, the individual requires a degree level qualification or level 5 diploma in management or higher level qualification and 3 years management experience plus the successful completion of a Charter assessment covering the application of skills and CPD.

10.4.4 Vocational Education

The Trust continues to deliver Health and Health and Social Care qualifications up to level 5 on the Qualifications and Credit Framework Apprenticeships (QCF). QCF is a credit transfer system which has replaced National Vocational Qualifications. It recognises qualifications and unit credits such as in most clinical areas such as, administer medication, end of life, dementia etc.

10.4.5 Care Certificate

The Trust has Secured funding for 18 months to implement a QA framework across the SW to support the PVI sector. As of the 01.02.2016 65 Trust staff have been required to undertake the Care Certificate. Of those required to undertake the certificate **46%** have completed and **54%** are continuing. The Trust delivered Care Certificate Assessor Training to **195** eligible members of staff internally and externally**. Of these 195, 56%** completed across the Trust and **44 %** completed in the private voluntary sector. Phase 2 will require all support staff to undertake some or all of the Care Certificate. Preparation for the higher Care Certificate commences from April 2016.

10.5 Mandatory Training

10.5.1 Trust Compliance

The overall compliance rate for the Trust is reported in 4.3 above as 89%. The table below shows the rate for each of the 9 key modules in February 2016.

Conflict Resolution	Equality & Diversity	Fire	Health & Safety	Infection Control	Information Governance	Manual Handling	Safeguarding Adults - Level 1	Safeguarding Children - Level 1
90.88%	92.96%	83.40%	88.21%	82.73%	89.03%	86.09%	93.65%	92.60%

The mandatory compliance rate is now set at 85% and will be raised to 90% from April 2016 for all modules with the exception of Information Governance which is and will remain at 95%. A new Clinical Infection control film is being trailed by Rainbow Day Nursery to help increase compliance and enable staff to access more digital learning. Information Governance is the next topic to be filmed.

Hotel services within the acute setting remains the biggest area for concentrated support. Bespoke sessions continue to be provided.

To assist with the push towards digital learning we are exploring utilising the space in the Bowyer building entrance to be used as an eLearning hub. This will increase the number of computers for staff to use and provide a quiet area for learning.

11.0 Organisational Development (OD)

11.1 Leadership Development

11.1.1 Core Leader Development Programme (ILM Level 5 Award)

This programme has been redesigned and is aimed specifically at established core leaders i.e. someone in a leadership or management position who is responsible for both the operation of a particular unit, team or ward in addition to the strategic development of that area. They are likely to be managerially or professionally responsible for others in either supervisory or senior professional roles and have been in management/ leadership/ roles for some time but who have had minimal if any formal training or are Leading to the ILM Level 5 Award in Leadership and Management this programme uses a variety of methods (classroom, Action Learning Sets, experiential, 360° feedback, self- study and group work) to support leaders development in their role. The programme aims to:

- Challenge leaders to consider their accountabilities and working practices as managers and how they may be perceived by others.
- Provide and develop a safe environment where leaders can reflect upon their strengths and weaknesses as leaders, identify areas for further development and explore any blocks or barriers to their future growth.
- Develop a number of skills and applications of existing skills which broaden the repertoire available to individual leaders in their day to day work.
- Increase the sense of confidence and self-efficacy of core leaders in using a range of management styles including directing, coaching and facilitating and as a result increase their resilience and well-being
- Establish on-going networks of support available to leaders both during and subsequent to the programme.

The first cohort of 15 members of staff commenced on 22 February.

11.1.2 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.

11.2 Developing the Strengths-based Approach

A Strengths-based is approach is the style in which we will be working within the LMATs and across the whole ICO in all aspects of our work be it within health, social care or leadership style. It will be the golden thread which runs through all our interactions with people, both in terms of how we invest care and support in our teams and how our teams in turn invest care and support in the people they serve. Furthermore it supports the more holistic approach of 'what matters to you' moving away from 'what's the matter with you'.

This approach will also have an impact on some of the systems, processes and documentation that is already in place.

There are a number of methods and models used already in existence within the organisation that use a similar approach i.e. Guided Conversations, shared decision making and Talk Back. In order to bring these methodologies together in the spirit of a strengths-based approach OD will be working with key people and other agencies. An initial conversation has already been had with the Royal College of Physicians in how the delivery of training for shared decision making for clinicians can be aligned and underpinned with the strengths-based approach. Other training will need to be adapted to incorporate the strengths-based approach including the delivery of educational and personal effectiveness programmes.

11.3 Culture Barometer

The cultural barometer has been implemented in-conjunction with the Matron from the Emergency Department as a result of the CQC action plan for ED. The purpose of which is to help identify any areas where staff need to be supported.

11.4 New Model of Care

OD are supporting managers and teams within the creating of the new model of care and LMATs in facilitation, team and individual development.

11.5 Staff Appreciation and Recognition

This will include the annual Blue Shield Awards and existing WOW Awards. The latter are currently presented by the Chairman. It is anticipated that these presentations will be shared amongst the other Non-Executive Directors and will be announced in the ICON weekly bulletin and at monthly All Managers meetings.

Retirement and Long-Service Awards will also be developed and be presented to staff by the Chairman or representative on a six-monthly basis at an 'afternoon tea' event for those identified recipients. Both will be announced in ICON within and identified section in the weekly bulletin.

'Thank-you' cards are being produced for Executives and Senior Managers to be used as a means to thank, recognise and in turn incentivise staff who have gone above and beyond roles and responsibilities. This has been tested and instigated by Devon Partnership Trust (DPT) and has been shared with the Multi-Agency Staff

Experience Network which is a CQUIN for TSDFT, DPT, Mount Stuart & the Community Care Trust.

The cards can be sent in a hard form through the post and also uploaded to the Staff Intranet which, it is anticipated, will have a designated page. The cards have proven particularly effective in strengthening relationships for staff across DPT. It is viewed as a good way to recognise staff contribution for smaller efforts than an award or award nomination would justify.

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

Feb-16

Indicator and (Target)	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bank/Agency Spend Total	£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	£10,494,361	£11,816,473
Bank Monthly	£392,172	£319,911	£321,918	£394,001	£366,133	£375,545	£451,147	£373,237	£522,045	£644,746	£544,710	£577,004	£554,756
Agency Monthly	£418,259	£368,600	£415,706	£458,466	£542,262	£514,071	£544,332	£673,990	£765,391	£555,446	£596,361	£857,850	£767,356
Staff Headcount Number	4268	4255	4255	4255	4262	4256	4262	4276	6089	6078	6057	6071	6069
Staff Establishment WTE			3866.41	3872.03	3819.94	3844.10	3855.00	3887.31	5506.99	5527.21	5524.46	5503.96	5511.78
Staff in Post WTE			3615.57	3599.98	3597.75	3594.88	3682.92	3638.56	5144.64	5153.82	5108.62	5128.76	5125.18
Cumulative Vacancies WTE			250.84	272.05	222.19	249.22	172.08	248.75	362.35	373.39	415.84	375.20	386.60
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%	6.82%	7.01%
Bank Usage (WTE)	173.34	154.08	144.73	172.97	155.70	165.76	204.57	166.33	185.09	223.51	243.61	240.63	239.78
Agency Usage (WTE)	24.53	57.37	58.51	81.36	65.74	47.38	44.60	92.58	53.87	98.78	124.20	107.26	115.45
Additional Hours/Reduced Hours (-) (WTE)			-6.84	-16.23	3.75	6.07	-78.25	-28.72	3.82	42.85	2.37	-33.43	-31.07
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%	1.10%	1.13%
Starters (Exc Junior Doctors)	26.7	21.5	20.1	19.9	16.5	24.3	32.4	48.3	70.0	59.9	23.9	53.4	62.5
Leavers (Exc Junior Doctors)	32.0	42.2	26.2	32.5	21.3	36.3	36.3	41.8	54.5	68.1	45.9	62.3	46.5
Staff Turnover Rate % (Between 10% - 14%)	10.96%	10.80%	10.78%	12.80%	11.00%	11.17%	11.05%	11.09%	12.79%	12.97%	13.15%	12.94%	13.09%
Sickness Absence Rate % (4.05% or less)	4.26%	4.23%	4.19%	4.18%	4.16%	4.13%	4.12%	4.12%	4.07%	4.04%	3.98%	3.99%	
Bradford Score % over 250 Points	12.41%	12.54%	12.53%	12.76%	12.38%	12.53%	12.23%	12.20%	11.62%	11.69%	10.76%	9.18%	
Sickness Cost	£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	£6,042,868	£6,043,671	
Skill Mix (Registered/Non-registered)	54/46	53/47	54/46	54/46	54/46	54/46	54/46	54/46	55/45	55/45	55/45	55/45	55/45
Staff appraised in last year (90% or above)	83%	82%	83%	83%	84%	85%	85%	83%	80%	77%	78%	86%	85%
Age Profile - % of staff over 55 years of age	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	21.0%	22.0%	22.0%	22.0%	22.0%	23.0%

Training and Development - Percentage of staff compliant

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

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%	6.82%	7.01%	
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%	1.10%	1.13%	
Sickness Absence - All ICO Staff	4.26%	4.28%	4.19%	4.16%	4.15%	4.12%	4.07%	4.04%	3.98%	3.99%		
Community BU Total	4.77%	5.01%	4.67%	4.54%	4.50%	4.53%	4.38%	4.43%	4.27%	4.44%		
Medicine BU Total	3.85%	3.87%	3.79%	3.75%	3.80%	3.85%	3.84%	3.83%	3.87%	3.94%		
Surgery BU Total	4.40%	4.41%	4.45%	4.47%	4.40%	4.36%	4.26%	4.19%	4.08%	4.10%		
WCD BU Total	3.64%	3.59%	3.57%	3.53%	3.46%	3.41%	3.27%	3.26%	3.19%	3.19%		
Staff Appraisals - All ICO Staff	84%	84%	86%	86%	86%	84%	80%	77%	78%	86%	85%	
Community BU Total	84%	86%	89%	89%	86%	86%	83%	80%	85%	90%	90%	
Medicine BU Total	84%	83%	86%	87%	86%	86%	81%	80%	76%	83%	81%	
Surgery BU Total	83%	82%	84%	86%	90%	89%	88%	85%	86%	90%	89%	
WCD BU Total	81%	84%	86%	85%	85%	79%	81%	80%	87%	92%	89%	
Mandatory Training - % Completion of 9 competencies - All ICO Staff	87%	87%	87%	88%	88%	87%	89%	89%	90%	90%	89%	
Community BU Total	93%	93%	91%	92%	92%	91%	92%	92%	93%	92%	91%	
Medicine BU Total	83%	84%	84%	83%	86%	85%	85%	85%	85%	85%	86%	
Surgery BU Total	85%	86%	86%	86%	87%	86%	87%	87%	88%	88%	89%	
WCD BU Total	90%	90%	90%	90%	90%	89%	89%	89%	89%	89%	89%	

Appendix C

TSDFT	Sickness	Appraisal	Training (Average)	Staff	FTE
Division/Directorate	Jan-16	Feb-16	Feb-16	Feb-16	Feb-16
CHARITABLE FUNDS DIVISION	2.90%	92%	70.59%	34	18.63
Dir - Public Health	4.43%	96%	90.75%	203	160.76
Dir - SD Community Services	3.65%	85%	90.03%	206	167.26
Dir - Torbay Community Services	5.37%	87%	88.88%	459	391.85
COMMUNITY SERVICES DIVISION	4.75%	89%	89.59%	868	719.88
Dir - Chief Executive	4.81%	78%	96.61%	26	23.89
Dir - Education & Development	2.26%	83%	95.92%	90	84.59
Dir - Finance, Performance & Information	2.70%	75%	93.24%	319	292.96
Dir - Medical Director	4.42%	81%	91.04%	31	26.15
Dir - Nursing & Quality	2.80%	95%	92.95%	197	161.99
Dir - Operations	4.73%	93%	90.08%	167	150.00
Dir - Pharmacy Services	4.09%	73%	93.23%	87	74.54
Dir - Workforce	3.20%	95%	94.38%	82	70.93
CORPORATE SERVICES DIVISION	3.29%	84%	92.93%	999	885.06
Dir - Estates & Facilities	3.88%	65%	98.32%	53	51.57
Dir - Hotel Services	7.10%	82%	83.47%	378	284.95
ESTATES & FACILITIES MANAGEMENT DIVISION	6.58%	79%	85.28%	431	336.52
Dir - Hospital Services - Brixham	3.44%	100%	97.13%	31	23.24
Dir - Hospital Services - Coastal	3.21%	87%	92.21%	66	52.74
Dir - Hospital Services - Dartmouth	1.71%	100%	94.44%	32	25.28
Dir - Hospital Services - MIU Services	4.65%	88%	88.54%	32	25.98
Dir - Hospital Services - Moorland	3.80%	86%	80.22%	41	32.43
Dir - Hospital Services - Newton Abbot	4.11%	96%	89.09%	114	94.30
Dir - Hospital Services - Paignton	5.15%	89%	90.56%	60	46.58
Dir - Hospital Services - Totnes	3.49%	94%	95.93%	41	32.24
HOSPITAL SERVICES DIVISION	3.81%	93%	90.57%	417	332.77
545 Dir - Independent Sector Adult Social Care - Torba	4.05%	85%	84.88%	58	44.68
546 Dir - Independent Sector Health	3.83%	61%	90.12%	26	23.41
INDEPENDENT SECTOR DIVISION	3.97%	78%	86.55%	84	68.10
INTERNAL AUDIT	5.02%	82%	95.06%	18	16.57
Dir - Cancer Services - Medicine	4.29%	83%	84.02%	188	163.10
Dir - Care of the Elderly - Medicine	5.21%	83%	79.14%	141	127.69
Dir - Derm, Rheum, Neurology, Thoracic- Medicine	1.85%	74%	87.91%	34	27.95
Dir - Emergency Services	3.81%	94%	88.66%	239	202.49
Dir - Gastoenterology/Endocrinology- Medicine	3.33%	35%	83.28%	100	85.78
Dir - General Medicine	3.33%	84%	87.35%	73	61.94
Dir - Heart & Lung- Medicine	3.67%	83%	86.47%	196	170.89
MEDICAL SERVICES DIVISION	2.18%	81%	85.28%	971	839.84
PHARMACY DIVISION (Manufacturing)	2.61%	40%	92.39%	128	118.19
RESEARCH & DEVELOPMENT DIVISION	5.07%	100%	92.04%	42	34.07
Dir - Breast Care	2.66%	97%	93.83%	44	35.15
Dir - General Surgery	5.04%	91%	85.37%	261	222.94
Dir - Head & Neck	2.33%	95%	87.69%	102	76.31
Dir - Ophthalmology	3.36%	93%	88.43%	121	103.55
Dir - Surgical Division	3.65%	98%	93.19%	76	68.52
Dir - Theatres, Anaesthetics and ICU	4.42%	82%	89.11%	404	362.35
Dir - Trauma and Orthopaedics	3.83%	90%	89.50%	163	139.55
SURGICAL SERVICES DIVISION	4.10%	89%	88.57%	1171	1008.37
Dir - Child Health	3.05%	89%	89.32%	153	126.99
Dir - Lab Medicine	2.99%	84%	85.89%	126	109.29
Dir - Obs & Gynae	3.72%	91%	89.68%	210	167.50
Dir - Radiology & Imaging	3.49%	88%	90.41%	136	114.42
Dir - Sexual Health	3.55%	71%	87.46%	38	29.67
Dir - Therapies	2.79%	93%	87.82%	213	171.82
Dir - Women's, Children's and Diagnostics	2.23%	88%	94.07%	30	28.39
WOMEN'S, CHILDREN'S & DIAG' DIVISION	3.19%	89%	88.82%	906	748.07
Grand Total	**3.99%**	**85%**	88.84%	**6069**	**5126.05**

Appendix D

Staff Survey Key Findings

Key Finding	Title	National 2015 average for combined Acute and community Trusts	TSDHCFT 2015
1	Staff recommendation of the organisation as a place to work or receive treatment	3.71	3.92
2	Staff satisfaction with the quality of work and patient care they are able to deliver	3.94	3.94
3	Percentage of staff agreeing that their role makes a difference to patients	91%	90%
4	Staff motivation at work	3.92	3.94
5	Recognition and value of staff by managers and the organisation	3.42	3.48
6	Percentage of staff reporting good communication between senior management and staff	30%	30%
7	Percentage of staff able to contribute towards improvements at work	71%	72%
8	Staff satisfaction with level of responsibility and involvement	3.93	3.93
9	Effective team working	3.77	3.78
10	Support from immediate managers	3.72	3.76
11	Percentage of staff appraised in last 12 months	86%	88%
12	Quality of appraisals	3.03	3.01
13	Quality of non-mandatory training, learning or development	4.04	4.01
14	Staff satisfaction with resourcing and support	3.30	3.34
15	Percentage of staff satisfied with the opportunities for flexible working patterns	50%	54%
16	Percentage of staff working extra hours	72%	69%
17	Percentage of staff suffering work related stress in last 12 months	36%	34%
18	Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell	58%	65%

19	Organisation and management interest in and action on health and wellbeing	3.59	3.66
20	Percentage of staff experiencing discrimination at work in the last 12 months	10%	10%
21	Percentage believing that trust provides equal opportunities for career progression or promotion	87%	89%
22	Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	14%	14%
23	Percentage of staff experiencing physical violence from staff in last 12 months	2%	2%
24	Percentage of staff/colleagues reporting most recent experience of violence	52%	50%
25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27%	27%
26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	25%
27	Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	38%	41%
28	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	29%	30%
29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	90%	91%
30	Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.71	3.65
31	Staff confidence and security in raising concerns about unsafe clinical practice	3.64	3.59
32	Effective use of patient/service user feedback	3.65	3.64

Appendix E

STAFF SURVEY ACTION PLAN: 2015-16

Scope of Action plan

Previous reports have detailed the outcomes of the NHS Staff Survey 2015. The action plan detailed below seeks to improve those areas in which the Trust has performed below the national average when compared with our comparator organisations.

Act No	Action	Action Assigned To	Deadline	Progress
For the key findings detailed below the data will be interrogated to identify whether there are any key areas where the issues are particularly prevalent. In such circumstance, a small task and finish group will be established within the area to consider additional actions.				
KF 18 Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell.				
	To review the Sickness Absence Management policy and toolkit in partnership with the Trade Unions.	Mike Mogford	30/06/16	
	Ensure weekly drop in sessions are available for managers to discuss sickness absence cases and the tools and techniques available to staff in returning to work.	Human Resource Advisors	01/03/16	
	To work in partnership with the Trade Unions to expand and promote the wellbeing initiatives available to staff in maintaining health and wellbeing.	Penny Gates	On-going	
	To further develop and launch guidance on proactively managing long term sickness.	Mike Mogford/ Jenny	30/06/16	

		Shepherd		
	Introduction to Line management course to develop communication skills orientated around this issue.	Chris Edworthy	30/05/16	
	Explore the development of a trigger tool to be used to assess the need for additional resource.			
	To explore a regular and standardised approach to supervision			
KF 28 Percentage of staff witnessing harmful errors, near misses or incidents in last month.				
Improved education has improved the level of understanding of what constitutes an incident/near miss and as such staff can better identify when they have witnessed a harmful incident. It is heartening to see that 91% of staff report incidents once witnessed (above the national average). Through better reporting the Trust is able to take appropriate actions as identified through the example below;				
	There had been an increase in the number of COSHH incidents as such a COSHH working party was established. The group is improving the management of COSHH within the Trust by; - reducing the number of COSHH items available to order, - developing a single location for the material safety data sheets (MSDS) for all COSHH substances to be held and accessed	COSHH Working Party	01/07/16	
	Ensure all incidents continue to be closely monitored by the Health and Safety team, including the identification of annual key performance indicators.	Health and Safety Team	monthly	
KF 30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents				
	Commission and implement single incident reporting system (Datex), supported by appropriate staff training.	Implementation team	01/06/16	
	Health and Safety Audit to be completed within each department in Estates and Facilities Management	Lesley Darke	01/05/16	
	Review and amend Induction and mandatory training for Health and Safety to incorporate the importance of feedback.	Maurice Lidster	01/04/16	

	Amend 'Workplace Health and Safety Audit' checklist to include evidence that feedback has been provided to the individual reporting the incident/near miss.	Maurice Lidster	01/04/16	
	To explore the potential of Incident Reporting being incorporated into the Line Managers Induction programme	Maurice Lidster	01/06/16	
	On a monthly basis, utilise the staff bulletin, to publicise incident data, themes and actions.	Steve Carr	30/04/16	
	On a quarterly basis utilise 'You said, we did' to communicate the actions taken as a result of incident reporting, via a corporate newsletter.	Steve Carr/ Maurice Lidster	30/06/16	
	Create a divisional newsletter that will message the divisional incidents and themes.	Steve Carr	30/04/16	
	To explore the potential for incident data to be displayed in back of house areas and communicated via local forums	Steve Carr	30/06/16	
	To review how drug errors are investigated	Cathy Bessent	30/06/16	
KF 31 Staff confidence and security in reporting unsafe clinical practice				
4.1	Launch of Freedom to Speak Up Guardians	Guardians	Spring 2016	Network of Guardians appointed 28th Jan 2016.
4.2	Maintaining momentum on 'See something, say something' initiative	Jenny Shepherd/ Guardians	On-going	
4.3	Develop and implement training for staff on raising concerns	Chris Edworthy/ Jenny Shepherd/ Guardians	30/06/16	
4.4	Develop and implement management training in managing concerns	Chris Edworthy/ Jenny Shepherd	30/06/16	

A number of additional actions will be taken to improve and sustain performance in those areas where the Trust performs well. Of key importance is the need to sustain the level of staff engagement. This will be achieves through a combination of actions including the adoption of a strength based methodology.

NHS Employers

Junior Doctors – the new 2016 contract – at a glance factsheet

The new 2016 contract

- The current contract is 15 years old. It is no longer fit for purpose in the modern NHS.
- The BMA agreed back in 2008 that it needed to be changed and updated and agreed heads of terms for negotiations.
- The formal negotiation period with the BMA began in October 2013.
- During talks with the BMA, agreement was reached on about 90 per cent of the items discussed. NHS Employers, along with lead negotiator Sir David Dalton, made a best and final offer in Feb 2016, which included a further concession on Saturday pay in the hope of reaching agreement with the BMA. The BMA again rejected the offer.
- The government has now introduced the contract from 3 August 2016.
- The new 2016 contract will be more effective across the week, fairer for doctors, safer for doctors and their patients, and better for training.

Pay – the facts:

- Junior doctors moving to the new pay system can expect an average increase to their basic pay of 13.5 per cent.
- Average earnings will remain the same. The contract is cost neutral and there was never an intention to reduce pay.
- Pay protection during the three years of transition will ensure that no junior doctor, working up to the legal or contractual limit on working hours, will see their pay cut compared to their current contract.
- Junior doctors will be paid for every hour they are scheduled to work
- There will be a clear link between level of responsibility and pay
- Flexible pay allowance will be available for GP trainees, hard to fill training programmes and approved academic work.

  The flexible pay premia values are:

  - Academia £4,000
  - Emergency medicine training programmes at ST4 and above £1,500
  - General practice £8,200
  - Oral and Maxillofacial £1,500
  - Psychiatry training programmes at ST1 and above £1,500

NHS Employers

Unsocial hours – the facts:

- Banding supplements will be removed. Instead, doctors will be paid for every hour they work between 9pm-7am every day at a 50 per cent premium
- Work between 5pm-9pm on a Saturday and 7am–9pm on a Sunday will be paid at a 30 per cent premium
- If a junior doctor works a shift starting on a Saturday on one in four weeks, or more frequently, any hours worked by that doctor on a Saturday between 7am-5pm will also be paid at a 30 per cent premium
- A 10 per cent premium is payable to junior doctors who are rostered as being on call for one in four weekends or more frequently, and 5 per cent of basic salary if rostered less frequently

Patient safety – working patterns - the facts:

- The BMA agreed improved safeguards that will protect doctors through limits on safe working hours and therefore improve patient safety
- Contractual hours for the average working week will remain the same at 40-48 hours
- The maximum number of hours that can be worked in one week will be reduced from 91 hours under the current contract, to a new absolute limit of 72 hour under the new contract
- No doctor will ever be rostered on consecutive weekends
- Shifts will be rostered for no more than 13 hours
- The maximum number of consecutive nights will be reduced from seven under the current contract to four under the new contract
- The maximum number of consecutive long days (a long day constitutes 10 hours or longer) will be reduced from seven under the current contract to five under the new contract
- There will be guaranteed minimum rest periods after a run of night shifts or long days (Paid rest breaks: 30 minutes if shift exceeds five hours; two x 30 minutes if shift exceeds nine hours, taken flexibly across the shift).

Patient safety – safeguarding - the facts:

- Every trust will have an independent guardian who will assure the board that doctors are rostered to work safe working hours and that they are actually doing so
- The guardian will require work schedule reviews where there are regular breaches of safe working hours
- The guardian will escalate issues over safe working hours that are not addressed locally and intervene directly when the safety of doctors or patients is being compromised
- Work schedules will be discussed regularly with educational supervisors
- Junior doctors can request a work schedule review at any time
- An annual report on the outcome of all reviews will be mandatory to the Deanery and national regulators – Care Quality Commission (CQC), and will need to be made available to the General Medical Council (GMC) and Health Education England (HEE).

For more information go to: www.nhsemployers.org/juniordoctors

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6 April 2016
Title:	Overseas Nursing Recruitment (Philippines) Update including revised Financials
Lead Director:	Paul Cooper - Director of Finance, Performance and Information
Corporate Objective:	The Trust is planning to recruit 80 Nurses from the Philippines to fill the vacancies to maintain the minimum safe staffing levels and reduce the usage of Agency staff which is causing cost pressure in the organisation.
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

The Executive Team and Finance Committee approved the recommended option of pursuing direct recruitment of Nurses from the Philippines in January 2016 and the Trust's Overseas Nursing Team interviewed the potential partners in February 2016.

The cost of the recruitment is now £553K (previous costing £238K, an increase of £315K) due to the increase in number of planned recruits and the support offered to Nurses to make our package more attractive; further information is in section 2.3 of the attached Overseas Nursing Report number 2.

The potential saving is still at £1.7m per annum, similar to previous financial analysis.

The option of pursuing direct recruitment already saved the Trust circa £300K in Agency cost in comparison with sourcing through CPL, the Trust's European recruitment partner.

Key Issues/Risks

The Agencies already started advertising for these posts and interviews are planned in April/May. The length of recruitment time is 9-12 months so earlier sourcing will bring early benefit to the Trust.

The Trust is planning to lead this recruitment drive for the Peninsula (through PPSA); early indications are positive and some Trusts already expressed interest on partnering with us which will bring income generation.

Recommendations:

1. The Trust Board is asked to approve the appointment of the two Philippine recruitment agencies – IPAMS and EDI Staffbuilders.

2. The Trust Board is asked to note and approve the proposed support package for Nurses.

3. The Trust Board is asked to note and approve the updated recruitment cost of Nurses from the Philippines totalling £553K.

Summary of ED Challenge/Discussion: The Executive Team (on its 8th March meeting) and the Finance Committee (on its 29 March meeting) already approved the recommendations.
Internal/External Engagement including Public, Patient and Governor Involvement: Senior Nursing staff, Finance, Executive Team, Procurement, Human Resource (HR) & Operational Leads.
Equality and Diversity Implications:

PUBLIC

Report Reference: **OVN 2**
Date: 30 **March 2016**

Overseas Nursing Recruitment (Philippines) Update

1. Background

The Trust's Overseas Nursing Team visited the Philippines in February and met and interviewed four Agencies who are potential recruitment partner. The recruitment agencies submitted the Invitation to Tender (ITT) document to the Procurement portal end of February.

The Executive Team (on its 8th March meeting) and the Finance Committee (on its 29 March meeting) already approved the recommendations and items below are being put forward to the Trust Board to approve as well.

2. Recommendation

2.1 The Trust's Overseas Nursing Team has now evaluated the ITT documents and would like to recommend to the Executive Team to appoint the following recruitment agencies:

- Industrial Personnel and Management Services Incorporated (IPAMS) who will manage the recruitment for Visayas and Mindanao areas – areas in the South of the Country

- EDI Staff Builders will manage the Luzon area (Manila, North of the Country and nearby areas)

On interviewing the Philippine Agencies both gave assurance to the Team with regard to delivery of the specified requirement together with demonstrating a personable approach in developing working relationships - in particular for EDI Staffbuilders as this will be their first UK healthcare/NHS contract. Both achieved top score in the ITT evaluation.

Further information on the Agencies:

- They are both high performing recruitment organisation in the Philippines having received the 'Presidential Awardee of Excellence' award in 2014, the highest award in the recruitment industry. EDI has been recognised internationally by the International Labour Organisation (ILO) for best recruitment practice.

- The Agencies are both well established and in the recruitment industry for 43 years (IPAMS) and 36 years (EDI Staffbuilders).

- They practice ethical recruitment policy and processes – no fee charges to the candidates and demonstrated continued support to deployed workers.

- Their facilities and resources offer sufficient capacity to deliver the Trust's requirement for Nursing candidates.

- Both have experience in recruiting for Healthcare clients – IPAMS (UK, Canada and US) and EDI Staffbuilders (US, Canada, Middle East, Finland and Germany).

- For EDI Staffbuilders this will be their first venture in the UK Healthcare market and NHS therefore this presents a huge opportunity for them to market the Trust nationally.

- IPAMS already work with a number of UK clients namely: Gloucester Royal Hospital, HCL Permanent t and Continental Travelnurse.

2.3 The Team would like to propose the following support package for the Nursing candidates which will be specified in the advert; this is in line with support package offered by other NHS organisations and the Trust hope to offer these to make our Trust more attractive to candidates given the competition in the Philippines and the EU market drying up. Our EU recruitment partner CPL informed us no candidate for the Portugal trip in February so this has been cancelled and the Greece trip planned this month was also cancelled as there are only two candidates.

IELTS Review and Exam fee -	£310 per Nurse (IELTS exam fee to be reimbursed only once in the UK)
NMC Costs	£1,415 (two/three year contract needs to be completed)
Flight to/from Manila	£1,100 (return flight after 3 year contract)
Immigration Health surcharge	£600 (for a 3 year contract)
Visa Cost	£750 (for a 3 year contract)
Accommodation	£400 (first month only)
Other	will be specified in the advert

The Trusts offer is better than other NHS organisations as we paying for the IELTS review and exam fee (these are usually paid for by the candidates) which will give us an advantage.

Timing is critical to ensure that we recruit at the earliest opportunity as a number of other NHS organisations have been out to the Philippines and offered job roles already as well as the number of advertisements in the country.

2.3 The Team also want the Executive Team to approve the increased cost of the Philippine Nursing recruitment, this is now at £553K (previous costing £238K, an increase of £315K) due to the increase in number of planned recruits and the support offered to Nurses to make our package more attractive as outlined above.

The main reasons for the cost increase relate to the following:

IELTS Review and Exam fee -	£25K (IELTS exam fee to be reimbursed only once in the UK)
NMC Costs	£100K (two/three year contract needs to be completed)
Flight to Manila	£50K (return flight after 3 year contract)
Immigration Health surcharge	£50K (for a 3 year contract)
Contingency	£30K
Cost increase	£60K (due to volume from 70-80 Nurses and other)

The net saving expected is still £1.7m similar to the previous costing (Overall cost of £2.3m less £0.6m recruitment cost) due to additional cost increase offset by additional Qualified Nurses.

3. Action

3.1 The Trust Board is asked to approve the appointment of the two Philippine recruitment agencies – IPAMS and EDI Staffbuilders.

3.2 The Trust Board is asked to note and approve the proposed support package for Nurses.

3.3 The Trust Board is asked to note and approve the updated recruitment cost of Nurses from the Philippines.

Prepared by:
Tracey Collins – Associate Director of Nursing & Workforce
Rica Broom, Senior Finance Manager – Corporate Services

Torbay and South Devon NHS
NHS Foundation Trust

Board Performance Report

February 2016

1. Summary & Key Issues

1.1 Service and Quality Standards

- Quality indicators
  - The latest Intelligent monitoring report (May 2015) maintains an overall score of 3 with 9 risks identified.
  - Time to theatre for fracture neck of femur admissions remains a challenge. An exception reported is provided in this report.
  - Capturing VTE assessment on admission and Dementia screening information remains a challenge. Improvements are linked to the introduction of clinical support IT systems.
  - The number of follow up appointments passed their 'to see by date' reduced in February, however this remains a challenge a priority for teams to improve.

- Monitor Compliance Framework
  - The 4 hour standard was not met in February. There are continuing discussion with the CCG regarding the remedial action plan. A revised Plan has been submitted showing a recovery trajectory to achieve the standard from October 2016.
  - The RTT incomplete pathways standard was not met in February. More patients are waiting longer than 18 weeks compared to the standard of 8% of all those waiting. A second trajectory and Remedial Action Plan (RAP) has been submitted showing achievement of the 92 % minimum standard by November 2016.
  - Cancer standards. One cancer standards is not achieved in February, with two indicators forecast at high risk of failing against the Q4 monitor performance declaration.

- Contractual Framework
  - The number of patients waiting longer than 6 weeks for a diagnostic test achieved the maximum 1% standard in February.
  - The timeliness of care planning summaries remains a challenge with 59% meeting the 24 hour standard during weekdays and 22% at weekends during February.

- Community and Social Care framework
  - The percentage of safeguarding strategy meetings within 7 days is identified in the report as performance has deteriorated.

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 with forecasted spend to the end of the financial year.

- 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 ten months ending 29th February 2016 is £4.23m which is £1.77m behind a plan of £6.0m.

- The year to date I&E deficit of £9.5m is behind the revised plan by £1.2m. The capital to revenue transfer of £2.5m is to be released in month 12.

- The Trust has a £1.8m 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 £1.7m due to working capital movement offset by lower than planned Capital expenditure.

- The year end forecast for capital expenditure now totals £18.6m which is lower than the revised plan of £19.4m

- Agency Registered Nursing spend to date is running at 8.6% in month, 7.3% year to date, against a cap of 4%.

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	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	YTD 15/16
QUALITY FRAMEWORK																							
Safety Thermometer - % Harm Free - (Acute)	✓		✓			> 95%	<95%		>=95%	98%	99%	97%	100%	98%	98%	97%	95%	98%	95%	97%	97%	97%
Safety Thermometer - % Harm Free - (Community)	✓		✓			> 95%	<95%		>=95%		89%	88%	88%	88%	87%	88%	90%	87%	86%	90%	88%	88%
Avoidable Pressure Ulcers - Category 3 + 4 - (Acute)	✓		✓			Nil	>=1		<1	0	1	1	0	0	1	2	2	0	0	0	0	7
Avoidable Pressure Ulcers - Category 3 + 4 - (Community) 1 month arrears	✓		✓			Nil	>=1		<1		1	0	0	0	0	0	0	0	0	0	tbc	1
Reported Incidents - Major + Catastrophic - (Acute)	✓		✓			Nil	>=20	Between	<5	2	4	2	0	0	0	2	1	0	1	0	0	10
Reported Incidents - Major + Catastrophic - (Community)	✓		✓			Nil	>=20	Between	<5		0	1	1	0	1	1	1	0	0	0	0	5
Never Events - (Acute)	✓		✓			Nil	>=1		<1	1	0	0	0	1	0	1	0	0	0	0	0	2
Never Events - (Community)	✓		✓			Nil	>=1		<1		0	0	0	0	0	0	0	0	0	0	0	0
Written Complaints - Number Received - (Acute)	✓	✓	✓			<30	>=30		<30	33	26	23	22	18	18	22	22	24	18	23	24	240
Complaints - Number Received - (Community) - includes written and telephone	✓	✓	✓			<30	>=30		<30		14	11	17	18	8	11	14	18	14	17	18	93
(P) - VTE - Risk assessment on admission - (Acute)	✓		✓		✓	>95%	<93%	Between	>95%	89.9%	93.4%	94.0%	94.0%	95.2%	95.3%	94.6%	96.2%	96.1%	95.8%	95.6%	95.0%	95.0%
(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%	98.7%	88.8%	95.8%
Medication errors - (Acute)	✓		✓			<15	>=30	Between	<20	34	41	207	28	30	34	35	36	45	39	33	7	535
Medication errors - (Community)	✓		✓			<15	>=30	Between	<20		40	33	32	49	35	26	30	23	25	18	32	245
HSMR - hospital standardised mortality rate	✓		✓			<100%	>=105%	Between	<100%	91%	108%	110%	95%	100%	113%	108%	93%	99%	96%	90%	82%	
Infection Control - Bed Closures - (Acute)	✓		✓			<100	>=170	Between	<100	104	358	955	288	40	68	18	54	92	36	12	57	1978
Fracture Neck Of Femur Best Practice	✓		✓		✓	>90%	<90%		>=90%	60%	70%	74%	50%	59%	62%	61%	64%	71%	76%	79%	80%	68%
(P) - Stroke patients spending 90% of time on a stroke ward - 72hr cohort from Nov-	✓	✓	✓		✓	>80%	<80%		>=80%	75%	78%	78%	78%	87%	87%	87%	74%	83%	85%	75%	71%	68%
CQC Compliance intelligent monitoring score / banding										4	4	3	3	3	3	3	3	3	3	3	3	3
(P) - Dementia - Find - monthly report						>90%	<90%		>=90%	41%	49%	41%	52%	55%	75%	71%	74%	74%	66%	64%	53%	62%
(P) - Dementia - Assess & Investigate - Monthly report						>90%	<90%		>=90%	68%	48%	81%	61%	66%	73%	80%	62%	57%	64%	66%	56%	65%
(P) - Dementia Refer - Monthly report						>90%	<90%		>=90%	96%	100%	100%	100%	100%	100%	100%	96%	100%	93%	100%	96%	99%
Clinic letters timeliness - % specialties within 4 working days							<80%		>80%	91%	82%	86%	73%	86%	77%	73%	59%	59%	73%	77%	73%	74%
Follow ups past to be seen date						Nil				3115	3294	3577	3745	4020	4570	4873	4731	4542	5090	5291	4938	
MONITOR COMPLIANCE FRAMEWORK																							
Referral to treatment waiting times – admitted - (Acute)		✓	✓			90%	<90%		>=90%	76%	82%	76%	72%	74%	77%	81%	80%	75%	73%	74%	74%	76%
Referral to treatment waiting times – non-admitted - (Acute)		✓	✓			95%	<95%		>=95%	96%	95%	95%	95%	95%	95%	95%	94%	93%	93%	93%	94%	94.4%
Referral to treatment - % Incomplete pathways - (Acute)		✓	✓			92%	<92%		>=92%	92%	91%	92%	91%	92%	92%	92%	91%	91%	91%	91%	91%	91.6%
Number of Clostridium Difficile cases - Lapse of care - (Acute)	✓		✓			Nil	>=2		<2	0	1	1	3	1	1	2	0	1	0	0	0	10
(P) - Cancer - Two week wait from referral to date 1st seen		✓	✓			93%	<93%	Between	>93.5%	96.4%	94.8%	94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.7%	98.7%	96.8%	96.2%
(P) - Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients		✓	✓			93%	<93%	Between	>93.5%	96.8%	98.8%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%	97.1%
(P) - Cancer - 31-day wait from decision to treat to first treatment		✓	✓			96%	<96%	Between	>96.5%	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	94.5%	98.7%	98.2%
(P) - Cancer - 31-day wait for second or subsequent treatment - Drug		✓	✓			98%	<98%	Between	>98.5%	98.3%	100.0%	100.0%	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%	98.4%	94.1%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%	87.9%	96.6%	95.9%
(P) - Cancer - 31-day wait for second or subsequent treatment - Surgery		✓	✓			94%	<94%	Between	>94.5%	97.1%	96.4%	93.8%	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	96.0%	95.1%	90.0%	94.4%
(P) - Cancer - 62-day wait for first treatment - from 2ww referral		✓	✓			85%	<85%	Between	>85.5%	85.2%	96.0%	92.5%	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.1%	90.4%	89.7%
(P) - Cancer - 62-day wait for first treatment - screening		✓	✓			90%	<90%	Between	>90.5%	91.7%	100.0%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%	96.6%
A&E - patients seen within 4 hours (ICO combined A&E figs from Oct 2015)	✓	✓	✓			95%	<95%		>=95%	88%	94%	90%	91%	82%	80%	90%	91%	88%	85%	82%	82%	87%
CONTRACTUAL FRAMEWORK																							
Diagnostic tests longer than the 6 week standard - (Acute)		✓	✓			<1%	>=1%		<1%	1.0%	4.5%	2.5%	1.2%	1.1%	2.6%	2.7%	0.4%	0.8%	1.1%	2.8%	1.0%	1.9%
Mixed sex accomodation breaches of standard - (Acute)		✓	✓			<1	>=1		<1	0	0	0	0	0	0	3	1	0	0	0	0	4
Care Planning Summaries % completed within 24 hours of discharge - Weekday	✓	✓	✓			>77%	<77%		>=77%	56%	57%	56%	60%	61%	62%	62%	62%	62%	55%	58%	59%	59.4%
Care Planning Summaries % completed within 24 hours of discharge - Weekend	✓	✓	✓			>60%	<60%		>=60%	41%	34%	27%	33%	37%	28%	24%	27%	30%	24%	35%	22%	29.3%

Torbay & South Devon NHS FT Performance Report - February 2016

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	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	YTD 15/16
On the day cancellations for elective operations		✓	✓			<0.8%	>=0.8%		<0.8%	1.65%	0.72%	1.31%	1.02%	0.71%	0.84%	0.84%	0.98%	0.96%	1.37%	1.29%	1.40%	1.0%
Cancelled patients not treated within 28 days of cancellation		✓	✓			<4	>=4		<4	2	4	2	4	3	2	0	0	2	3	2	9	31
Ambulance handover delays > 30 minutes	✓	✓	✓			<50	>=75	Between	<50	34	23	27	18	68	87	86	42	103	75	113	239	881
Ambulance handover delays > 60 minutes	✓	✓	✓			<5	>=10	Between	<5	4	0	0	0	1	3	2	2	2	5	2	35	52
A&E - patients seen within 4 hours DGH only	✓	✓	✓				<95%		>=95%	88%	94%	90%	91%	82%	80%	90%	88%	83%	80%	75%	74%	85%
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	3	1	13	10	27
Number of Clostridium Difficile cases - (Acute)							>=3		<3		3	4	4	3	2	3	1	2	1	0	1	24
Number of Clostridium Difficile cases - (Community)							>=1		<1		0	0	1	1	1	0	0	0	1	1	0	5
Number of Clostridium Difficile cases - Lapse of care - (Community)							>=1		<1		0	0	0	1	0	0	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	325	415	4094
Timeliness of Adult Social Care Assessment			✓			75%	>75%		<75%		70%	71%	71%	71%	70%	70%	70%	71%	67%	69%	69%	0%
Clients receiving Self Directed Care				✓		70%	<70%		>70%		89%	92%	92%	93%	93%	93%	93%	93%	93%	92%	93%	0%
Carers Assessments Completed year to date				✓		>40%					7%	11%	19%	18%	24%	27%	32%	36%	38%	41%	43%	0%
Number of Permanent Care Home Placements			✓			<630					649	652	652	646	645	639	645	630	636	637	640	0
Children with a Child Protection Plan				✓		TBC					160	157	156	161	190	199	216	216	212	tbc	tbc	
4 Week Smoking Quitters				✓		>50							126			231			303			
% OCU in Effective Drug Treatment				✓		>9.3							7%			6%			6%			
% Safeguarding Strategy Meetings within 7 Days				✓		>80%					73%	57%	45%	38%	38%	46%	44%	44%	41%	42%	39%	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				2597	2729	2546	2631	2732	2580	2694	2776	2760	2708	2609	2739	29504
Average Length of Stay - Emergency Admissions - (Acute)		✓	✓		✓	TBC				3.72	3.32	3.43	3.52	3.24	3.25	3.20	3.22	3.41	3.53	3.53	3.35	
Hospital Stays > 30 Days - (Acute)		✓	✓		✓	TBC				27	24	23	33	27	21	28	17	18	21	21	28	261
LMAT Population Coverage			✓	✓		TBC																
CORPORATE MANAGEMENT FRAMEWORK																						
Staff Vacancy Rate - (Trustwide)						<4%	>6%	Between	<4%		6.49%	7.03%	5.82%	6.48%	4.46%	6.40%	6.58%	6.76%	7.53%	6.82%	7.01%	
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%	3.98%	3.99%	tbc	
Appraisal Completeness - (Trustwide)						>90%	<80%	Between	>90%		84.00%	84.00%	86.00%	86.00%	86.00%	84.00%	80.00%	77.00%	78.00%	86.00%	85.00%	
Mandatory Training Compliance - (Trustwide)						>85%	<80%	Between	>85%		87.00%	87.00%	87.00%	88.00%	88.00%	87.00%	89.00%	89.00%	90.00%	90.00%	89.00%	

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.

The main CQC inspection was carried out between Tuesday 2nd and Friday 5th February. A full team consisting of 70 inspectors visited most parts of the trust covering acute and community services. The Draft report is expected between the 1st - 14th April with full publication of the final report approximately 13th May.

3.2 Fractured neck of femur time to theatre

There has been steady improvement in the % of patients achieving a time to theatre of less than 36 hours having presented with a fractured neck of femur. Performance has improved in February to 80% of patients to theatre within 36 hours (target 90%).

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

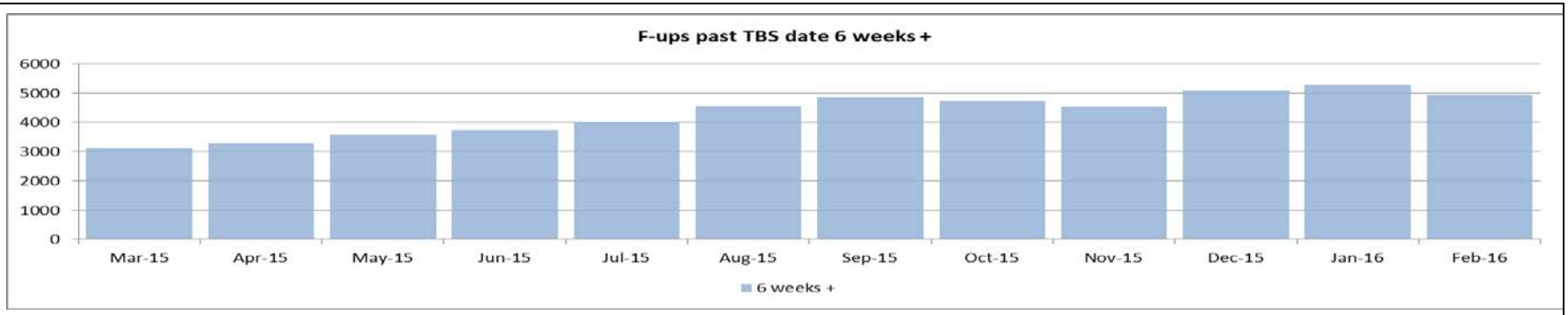
In the latest Stroke audit data for period September to December 2015 the Trust has moved up in the performance banding for Domain 2 SSNAP assessment, and is now placed in band D. 70% of trusts score higher than this and 13% of trusts score below this level of assessed performance. Against the two key indicators performance has improved. The percentage of patients admitted to the stroke unit within 4 hours of arrival remains the greatest challenge with 43% achieving this standard in the Q3. This represents an increase from 36.7% reported in Q2, the National Median is 60%.
For the time spent on a stroke unit performance is being maintained with 82% of patients spending 90% of their overall stay on the stroke unit. The standard is 80%.

3.4 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. In February 53% of eligible patients were assessed, the standard is 90%. A nurse led approach is being trialled in surgical wards, this will be evaluated with potential to roll out to other areas.

3.5 Follow up appointments passed their to be seen by date

The number of follow up outpatients waiting 6 or more weeks beyond their 'see by date' continues to be high. The overall number reduced in February by 353 to 4938.



The numbers of patients in each specialty are routinely monitored at the RTT meetings. Service Delivery Units are asked to provide assurance that clinical priority patients are being reviewed and seen if not discharged. The teams are seeking to increase capacity to see these patients and work with primary care and the CCG to agree alternative clinical pathways. Clinical teams also ensuring appropriate timelines for review 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
2. RTT admitted performance – from October 2015 the only RTT standard to be used in the risk assessment is the incomplete RTT standard. This standard is the percentage of patients waiting less than 18 weeks to be treated – the target is 92%

4.2 February 2016 update against declared risks

4.2.1 4 hour standard for time spent in A&E

The standard of 95% was not achieved in February and therefore remains at variance to the declared Monitor plan. The ICO performance which combines the Torbay Hospital (type 1 dept.) and the community MIU activity is 82%. Torbay Hospital performance on its own is 74% against the target of 95%. The community minor injury units achieved 100% against the 4 hour standard.

Summary of A+E performance for February

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-Feb-2016	8,083	1,459	81.95%	5,692	1,459	74.368%	2,391	0	100.00%

The 4 hour action plan has been agreed and is being led by the Chief Operating Officer. Following initial feedback from the CQC a range of other actions have been incorporated into this plan to provide comprehensive assurance on actions to improve performance and give assurance on patient safety.

The action plan is attached as an appendix to this report

4.2.2 RTT incomplete pathways

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

FEBRUARY 2016 Incomplete 92% Table - National Specialty

	<126		>126			
Submitted Spec	Incomplete IPDC	Incomplete Outpatients	Incomplete IPDC	Incomplete Outpatients	Grand Total	% < 18wk
Cardiology	107	747	24	63	941	90.75
Pain Management	171	258	37	19	485	88.45
Trauma & Orthopaedics	655	887	142	89	1773	86.97
Anaesthetics		24		4	28	85.71
Colorectal Surgery	67	271	26	42	406	83.25
Ophthalmology	538	1351	409	19	2317	81.53
Upper Gastrointestinal Surgery	97	229	131	15	472	69.07
Clinical Neuro-Physiology		26		12	38	68.42
Grand Total	3090	11476	894	484	15944	91.36

The Trust has submitted a revised remedial action plan in relation to the under performance against the delivery of the incomplete RTT standard. The plan shows a trajectory of non-compliance beyond the 31st March 2016, with compliance being achieved in July 2016. This revised trajectory has been submitted to the CCG and will be submitted as part of the Monitor Annual plan for 16/17. The CCG is seeking to deliver the trajectory one month earlier by the end of June. They are considering alternative providers to deliver the capacity required.

The Submitted trajectory in the latest remedial Action Plan is based on a number of specialities gaining approval for significant financial investment to enable backlogs to be reduced to a compliant and sustainable level.

Progress against the RTT agreed trajectories is being monitored closely. This performance report includes exception reports against the 3 areas with greatest variance to plan for incomplete pathways backlog numbers. The overall the trajectory remains on track to be delivered.

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)

The 2015/16 Monitor target for c-diff was not to exceed 18 lapses in care.
In February, one new cases of c-diff is reported, not identified as a lapse in care. The cumulative total to end of February, for the acute site is 24 cases with 10 lapse in care and for community bed based care no new cases of C-diff reported in February, with the cumulative total remaining at 5 cases and one identified as lapse in care. For a combined ICO position this would represent 29 cases in total with 11 identified as a lapse in care.

The c-diff objectives for 16/17 have just been released. This gives a combined target for the ICO of 18 cases. This will determine the thresholds for contract monitoring and Monitor compliance in 16/17 risk assessment and represents the number of c-diff cases assessed as a 'lapse in care'.

4.2.4 Cancer standards

One Cancer standard is not met in February, 31 days to subsequent surgery.

The forecast for Q4 shows non delivery of both the 'subsequent Radiotherapy' and 'subsequent surgery' standards. In addition the 31 day 1st treatment standard is high risk for the quarter as a result of the number of breaches in January and those predicted in March.

Capacity in Dermatology, Colo-rectal and Urology remain high risk. Lack of theatre capacity in March due to loss of elective activity is preventing escalation and timely treatment for colo-rectal, urology and breast patients.

Radiotherapy subsequent treatment times are improving however the number of breaches in January (8) already puts the quarter position at risk with an average maximum tolerance of 10 patients per quarter to achieve the Q4 position.

Across a number of pathways the impact of annual leave being taken over the Easter holiday period is a risk. These risks have been escalated by the operational teams to ensure continuity of service and waiting times maintained. The loss of outpatient clinics due to junior doctor strikes and cancellation of elective clinics/theatre lists to support the current pressures within the organisation to recover the 4 hour target is also causing delays. Every effort is being made to avoid this impacting on cancer pathways.

There is continued validation of the CWT projections and performance, capacity of the coordinators to track patient pathways remains a high concern. This is due to the high volume of work within the current establishment and increase number of patients with suspected and confirmed cancers being tracked on a cancer pathway and the significant increase in the number of patients discussed at the weekly MDT meetings.

Table of performance in Q4 - the Q4 position remains un-validated and includes activity recorded up to 18th March

	January 2016				February 2016			4th Quarter Total			
	Target	No. Seen	Breached	%	No. Seen	Breached	%	Target	No. Seen	Breached	%
14day 2ww ref	93.0%	706	14	98.0%	854	27	96.8%	93.0%	1560	41	97.4%
14day Br Symp	93.0%	97	4	95.9%	97	2	97.9%	93.0%	194	6	96.9%
31day 1st trt	96.0%	167	10	94.0%	150	2	98.7%	96.0%	448	16	96.4%
31day sub drug	98.0%	59	0	100.0%	47	0	100.0%	98.0%	138	0	100.0%
31day sub Rads	94.0%	66	8	87.9%	57	2	96.5%	94.0%	176	11	93.8%
31day sub Surg	94.0%	40	2	95.0%	42	4	90.5%	94.0%	108	8	92.6%
31day sub Other	-	18	0	100.0%	20	0	100.0%	-	47	0	100.0%
62day 2ww ref	85.0%	82	8.5	89.6%	80	8	90.0%	85.0%	250	27.5	89.0%
62day Screening	90.0%	15	1	93.3%	7	0	100.0%	90.0%	31.5	1	96.8%

5.0 Contract Framework

The contract for 2016/17 is in the process of being agreed, NHS Improvement set a deadline of the 23rd March for parties to agree heads of terms setting out the volumes and finance. In the absence of confirming agreed Heads of Terms NHS Improvement and NHS England will operate on the basis that mediation is required, this is likely to affect many providers and commissioner's including ourselves.

The volume of activity required to deliver expected demand has been assessed along with clinical teams capacity to deliver this level of activity within funded resources. This has resulted in a number of areas having work to do to close the gap between demand and their available capacity.

This year NHS England is providing significant funding through the sustainability and transformation fund. This is dependent on the successful agreement of a health community sustainability and transformation plan. The plan must include agreed recovery trajectories to support areas of underperformance and delivery of an agreed financial control total. The Trust has submitted improvement trajectories for the 4 hour standard and for the referral to treatment standard. STP funding is dependent on delivery of the agreed trajectories. To avoid the potential double jeopardy of penalties for non delivery of standards and loss of STP funding, the NHS contract has been changed to exclude the application of penalties in 2016/17.

The South Regional Tripartite has issued a statement and follow-up addendum setting out what the improvement trajectories must deliver. This sets the minimum requirements that are required to avoid the STF being lost. Locally this has provided an opportunity to review the trajectory we agreed with commissioners. The minimum acceptable trajectory is set out below compared to the recovery plan that was submitted as part of an earlier draft. NHS Improvement requires the baseline period to be Q2 in 2015/16, at this point we were not an ICO. The performance during this period has therefore been assessed using the A&E performance only and is below the trigger point of 89% which allows for a more gradual improvement than was set out in our draft improvement trajectory. Post integration the performance includes the impact of the MIU's which adds around 2% to the underlying performance as we deliver 100% of patients seen within 4 hours in MIU's.

The proposal is that locally we monitor to the improvement trajectory agreed through the System Resilience Group, whilst submitting the minimum requirement required by NHS Improvement as part of our final plan submission, against which the achievement of the STF will be assessed.

With respect to the finance agreement, the local arrangement for continuation of the risk share agreement is being developed but this remains a challenge with the pressure on overall financial positions of both commissioner and the Trust. The Trust and CCG are also concluding the final agreeemnt on the RTT, Diagnostic and 4 Hour trajectories.

5.1 Contract performance notices received - The Table below confirms the formal contract performance notices received

TSDFT Contract Notices	Issued
Contract Performance Notice TSDFT CPN01 (A&E)	09-Oct-15
Exception Report TSDFT ER01	01-Dec-15
Exception Report TSDFT ER02	11-Jan-16
Contract Performance Notice TSDFT CPN02 (RTT)	09-Dec-15
Failure to Agree RAP - notice to Boards (FTA01)	19-Jan-16
RAP not agreed	05-Feb-16
Contract Performance Notice TSDFT CPN03 (Diagnostics)	25-Jan-16
Contract Performance Notice TSDFT CPN04 (Amb Handovers)	25-Jan-16
Contract Performance Notice TSDFT CPN05 (Trolley Waits)	25-Jan-16

5.2 Commissioning for Quality and Innovation (CQUIN)

The CQUIN assessment for Q3 has been submitted to commissioners. The Specialist CQUIN schemes have all been signed off. There are no further risks being identified to the Board.

5.3 Diagnostic tests waiting over 6 weeks

The performance standard against the 6 week standard was achieved in February. There remain capacity pressures particularly in CT, MRI and ultrasound . Recruitment to vacant radiologist posts and maternity cover remains the current challenge in radiology. Immediate plans include outsourcing for scan reporting to release radiologist time, along with mobile CT capacity and sonographer sessions.

5.4 12 hour Trolley wait in A+E

In February, ten patients waited over 12 hours in the emergency department from decision to admit to actual admission to a ward bed. The long waiting times for admission to a ward bed were all managed as part of the wider system escalation and in the best interests of overall patient safety. The remedial action plan for the 4 hour standard covers the actions needed to prevent these long waits for admission and is being monitored as part of the overall plan. All 12 hour trolley waits have been validated prior to reporting and shared with commissioners for exception reporting.

5.5 Cancelled operations

In February, the number of elective operations cancelled on the day of admission exceeded the national standard of 0.8% with 1.4% (40 patients) of patients cancelled on the day of surgery. Emergency pressure on beds has been severe throughout this period and has also impacted on the number of patients cancelled on the day who are readmitted for surgery within 28 days of the original cancellation. Nine patients previously cancelled on the day of surgery were not readmitted within 28 days in February.

6.0 **Community and Social Care Framework**

The Community Quality and performance dashboards have been reviewed. The Adult safeguarding standard has been escalated as a priority risk, with an exception template included in this report.

7.0 **Attached to this report**

Appendix 1 - Performance M11 databook

3.1 Board Performance Dashboard - Exception Reports

Performance Standard	Summary	Exception Report
RTT incomplete standard 92%	Exception reports for the 3 areas showing greatest variance to plan at the end of February. The areas are Trauma and Orthopaedics; colorectal surgery and Respiratory medicine.	
4 hour A+E target	Performance remains below 95%. The exception report sets out the key actions and governance arrangements. The agreed action plan is included as an appendix to this report.	
Cancer	Exception report against the delivery of cancer standards in Q4	
Fractured Neck of Femur	the 36 hour to surgery standard has not been achieved this year. The exception report sets out the planned actions to improve performance.	
Safeguarding Adults	The exception report identifies the key metrics, issues and actions to the current reported performance identified in the performance dashboard for % of patients receiving safeguarding strategy meeting within 7 days.	

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
MRSA bacteraemia	An MRSA bacteraemia was reported to the Board in July 2015. We have had a further 2 MRSA bacteraemia in February 2016. Investigations are underway but initial review suggests the two recent incidents are not related.	

Torbay and South Devon NHS
NHS Foundation Trust

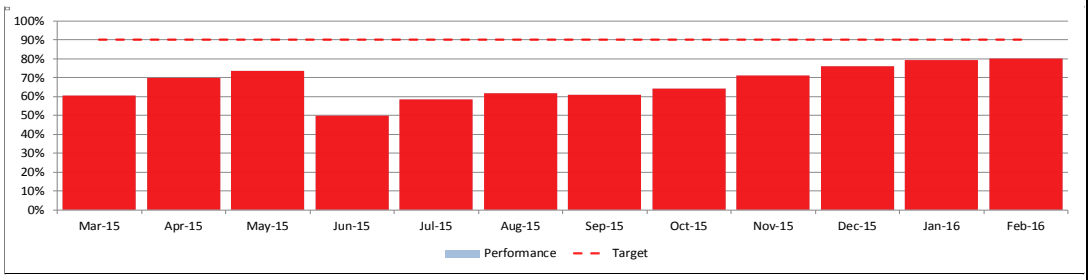
Key Performance Indicator Exception Report	Fractured Neck of Femur time to theatre	M11 - exception template

Data Analysis

Monthly performance summary

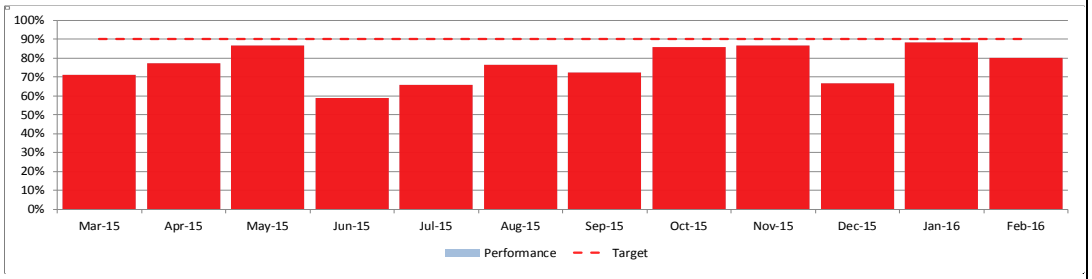
Fracture neck of femur

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients with a fractured neck of femur	43	40	38	40	41	34	36	28	38	42	34	30
Patients achieving best practice tariff	26	28	28	20	24	21	22	18	27	32	27	24
Performance	60%	70%	74%	50%	59%	62%	61%	64%	71%	76%	79%	80%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



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

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
To surgery within 36 hours	27	31	33	23	27	26	26	24	33	28	30	24
To surgery outside 36 hours	11	9	5	16	14	8	10	4	5	14	4	6
Performance	71%	78%	87%	59%	66%	76%	72%	86%	87%	67%	88%	80%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Commentary

The standard is to achieve 90% of patients admitted with a fractured neck of femur going to theatre for surgery within 36 hours.

This standard has consistently not been met however there has been some improvement over recent months.

The challenge remains in having sufficient theatre capacity routinely available to be able to manage the fluctuations in the number of patients presenting for urgent trauma operations.

A scheme has been worked up to extend the available scheduled trauma sessions available by extending lists by 2 hours per day. This will require additional funding to support the cover needed however this has been agreed as part of the surgical units business plan for 16_17.

The timeline for implementation is to be confirmed and this will then determine the trajectory for improved performance against this standard. The work is being led by the Surgical Units Business manager

Improvement Plan

No.	Action	Lead	Date
1	Confirm the final details of the business case to deliver extended lists 5 days a week		
2	Complete the necessary changes to job plans for associated staff		
3	Recruitment to ensure sufficient cover across theatre and anaesthetic teams		

Governance Arrangements

The delivery of the extended theatre lists will be led by the Surgical Unit Business manager and report to the Theatre improvement board and the Executive Quality and performance review meeting

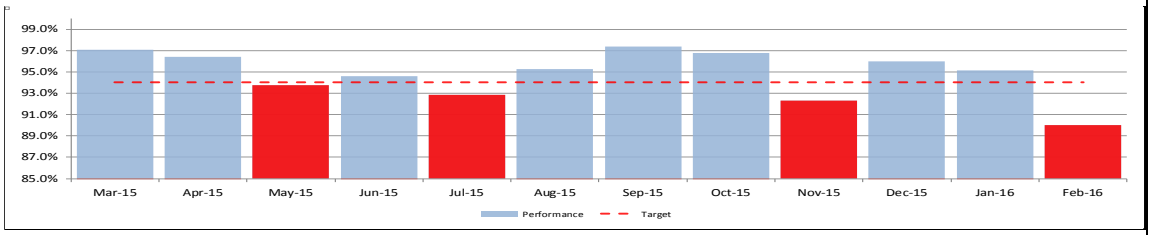
Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	Cancer Waiting Time Targets	M11 - exception template

Data Analysis

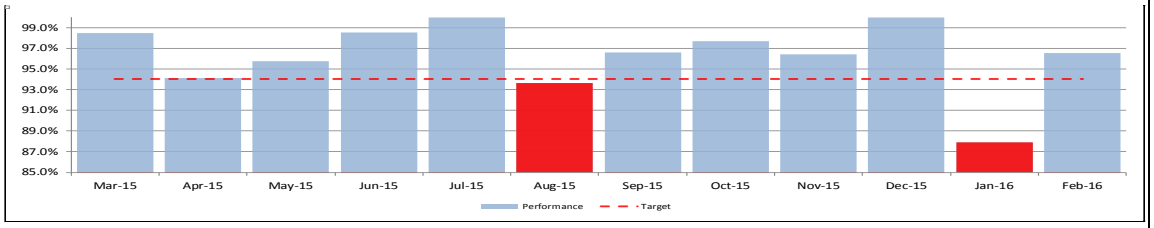
Subsequent treatment - 31 day from decision to treat to treatment - Surgery

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Subsequent surgery treatments	34	28	32	37	28	21	38	31	39	25	41	40
Subsequent surgery breaches	1	1	2	2	2	1	1	1	3	1	2	4
Performance	97.1%	96.4%	93.8%	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	96.0%	95.1%	90.0%
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%



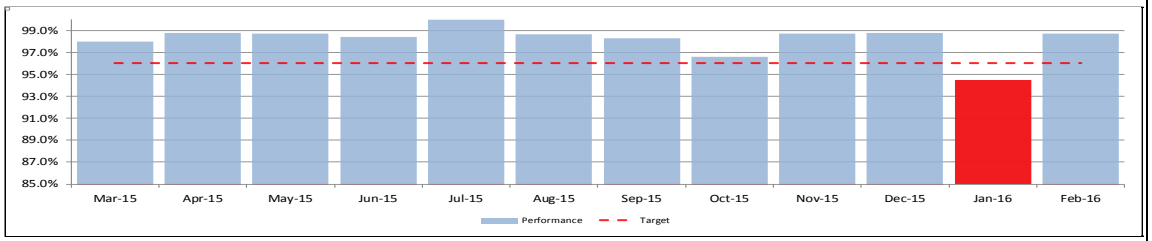
Subsequent treatment - 31 day from decision to treat to treatment - Radiotherapy

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Subsequent radiotherapy treatments	64	51	47	67	46	47	59	43	56	42	66	58
Subsequent radiotherapy breaches	1	3	2	1	0	3	2	1	2	0	8	2
Performance	98.4%	94.1%	95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%	87.9%	96.6%
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%



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

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
1st treatments	200	159	155	185	169	149	172	176	156	163	163	157
31 day 1st treatment breaches	4	2	2	3	0	2	3	6	2	2	9	2
Performance	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	94.5%	98.7%
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%



Commentary

The Q4 predicted performance risks are

1. 31 day subsequent surgery - 92.7 (target 94%) - Fail
2. 31 day subsequent Radiotherapy - 93.8 (target 94%) - Fail
3. 31 day first treatment - 96.6% (target96%) - High Risk

The Trust reported high number of breaches in January following patient choice to defer outpatient treatments until after Christmas. This put the quarter 4 performance at high risk.

Subsequent surgery targets for February and March have not been achieved (actual performance will be confirmed May 2016 following full validation).

The challenges are largely due to the lack of MDT resources to track the patients in a timely way. This results in the data used to project performance and manage breaches is not up to date and patients booked outside of cancer target dates are not escalated to prevent avoidable breaches.

No.	Action	Lead	Date
1	Continue to support team working overtime to reduce back log in tracking	Chris Bell	March/April 2016
2	Fully validate all CWT performance	Chris Bell	Continuous
3	ECF to increase current establishment within CWT team by 2 x wte to ensure all cancer sites	Emma Wheatfill	01/03/2016
4	Work with Cancer site specific teams to reduce delays in reviewing all pathways	Emma Wheatfill	From November 2015

Governance Arrangements

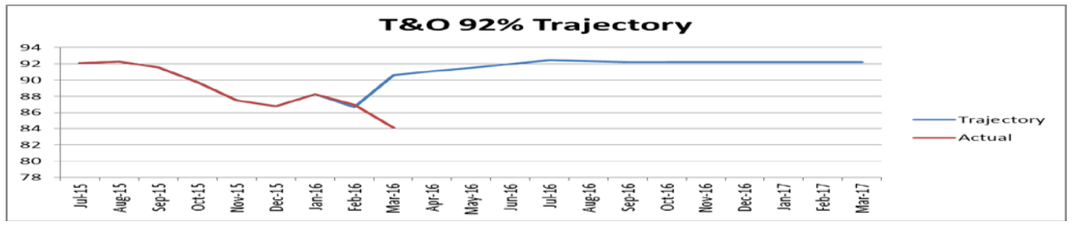
Daily validation of CWT performance. New report available every day to manage site specific performance. Feedback through Risk & Assurance meeting potential risks to the Trust's achievements against the CWT.

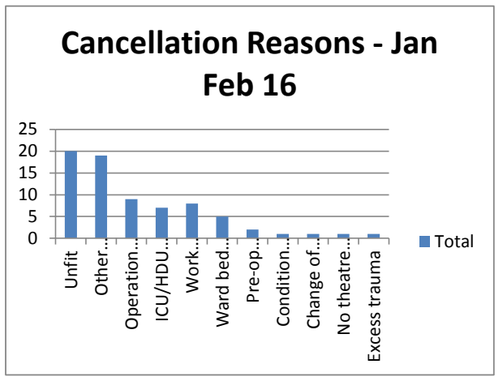
Torbay and South Devon NHS
NHS Foundation Trust

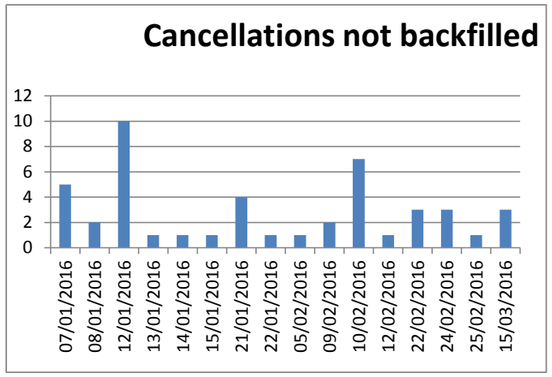
Key Performance Indicator Exception Report	RTT incomplete standard	M11 - exception template

Data Analysis

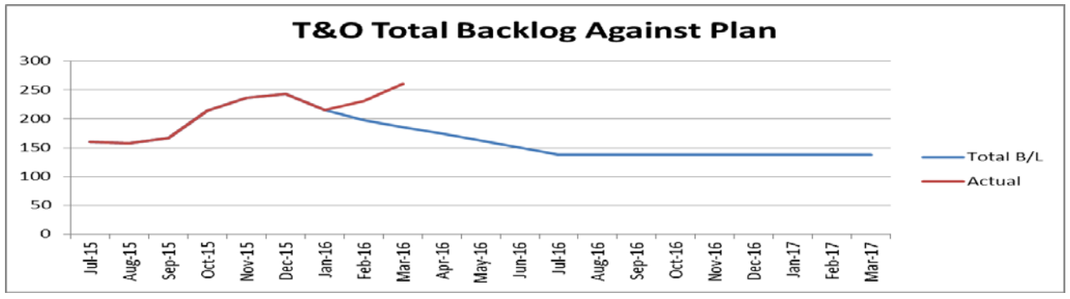
Monthly performance summary







Trajectory of backog reduction to 31st March



Commentary

1) Backlog increased 6 consecutive months

2) High level of cancellations is creating 'churn' in the waiting lists increasing number of > 18 week patients listed for surgery. 46 cancellation in January and February.

Cancellation Reasons

Other' is mainly due to stike and will be seperated next data run

'Unfit' biggest element is UTi's picked up by out reach team, we are updating the policy through High Efficiency list project (HELP) project.

Lists lost – some overlap in data but also shows effect of having one consultant post uncovered until Feb 22 and half term leave.

Cancellations not Backfilled

Cancellations not backfilled for Jan/Feb total 74 well in excess of what we would normally expect

Row Labels	Count of Reason list not used
Surgeon Unavailable	6
No patients	4
Trauma pressure	3
Strikes	2
No beds	2
Audit	1
(blank)	
Grand Total	**18**

Improvement Plan

No.	Action	Lead	Date
1	Continue to outsource to MSH - looking at approx 20 cases per month - TBC as part of budget setting / alternative in house delivery linked to Trauma business case.	Neal Foster	
2	Pick up additional in-house sessions where ever possible	Neal Foster	
3	Single Point of Access roll out to ll GP practices (From April16) - potential to reduce referrals	Neal Foster	

Governance Arrangements

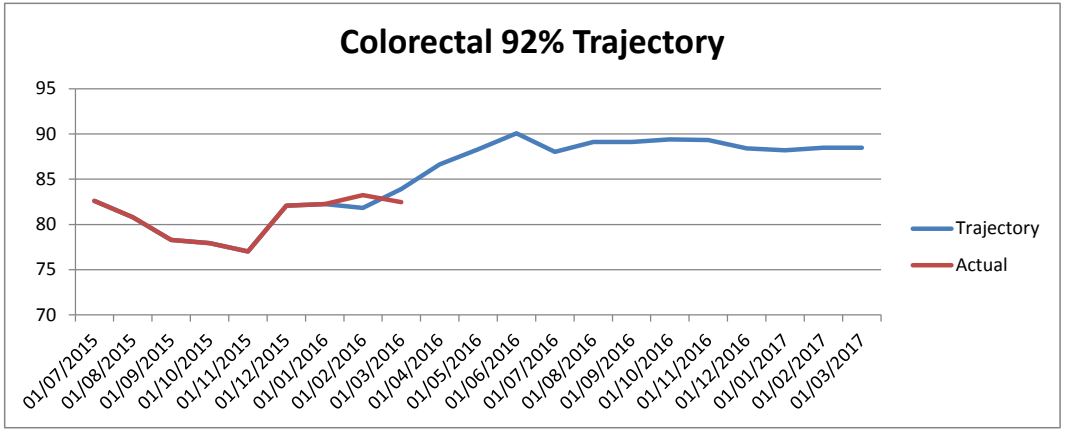
Review at fortnightly RTT & Diagnostic Risk and Assurance meeting

Torbay and South Devon NHS
NHS Foundation Trust

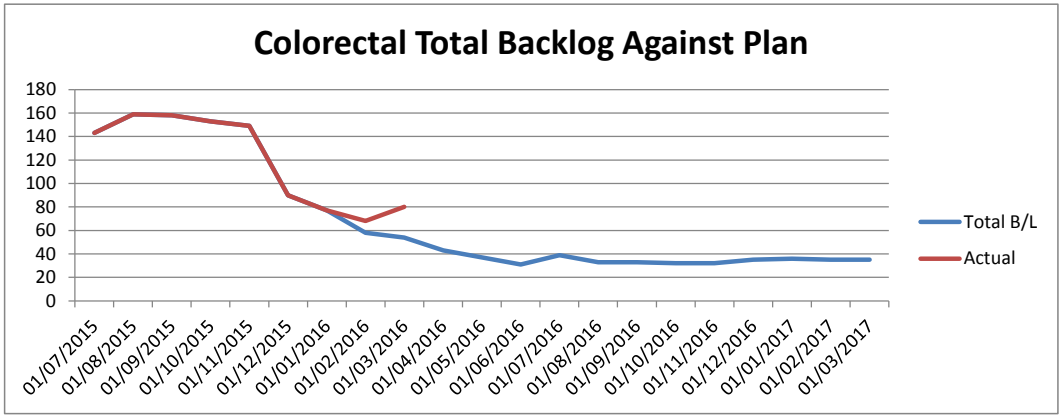
Key Performance Indicator Exception Report	RTT incomplete standard	M11 - exception template

Data Analysis

Monthly performance summary



Trajectory of backlog reduction to 31st March



Commentary

Colorectal have suffered from a loss of theatre time for routine patients due to a lack of beds in the Trust both on the ward and in ITU. This has been compounded by a loss of activity due to the junior Dr strikes.

The priority has been to maintain treatment of patients on urgent and cancer pathways.

The team are planning to pick up extra lists on Saturdays however, due to the bed pressures in the Trust, these are only Day cases.

It is forecast that this position against the RTT standard may not recover in the short term due to continued bed pressures, and the impact of scheduled leave and Dr strike action.

Improvement Plan

No.	Action	Lead	Date
1	Continue to book longest waiting patients where possible.	DW	On-going
2	Continue to run Saturday lists	DW	On-going
3	Maintain the timeliness of treatment of urgent and cancer patients	DW	On-going

Governance Arrangements

Review at fortnightly RTT & Diagnostic Risk and Assurance meeting

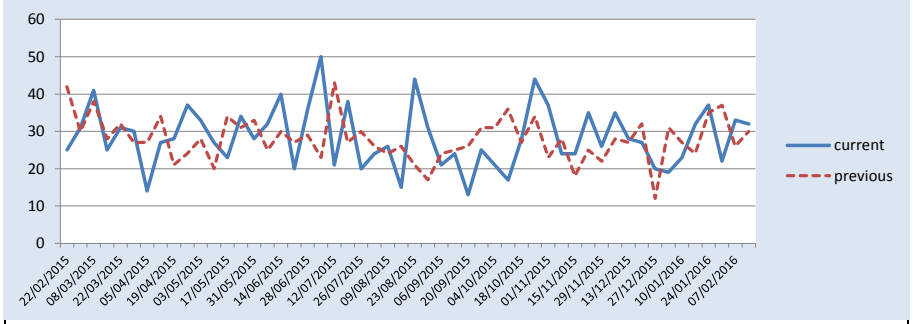
Torbay and South Devon NHS
NHS Foundation Trust

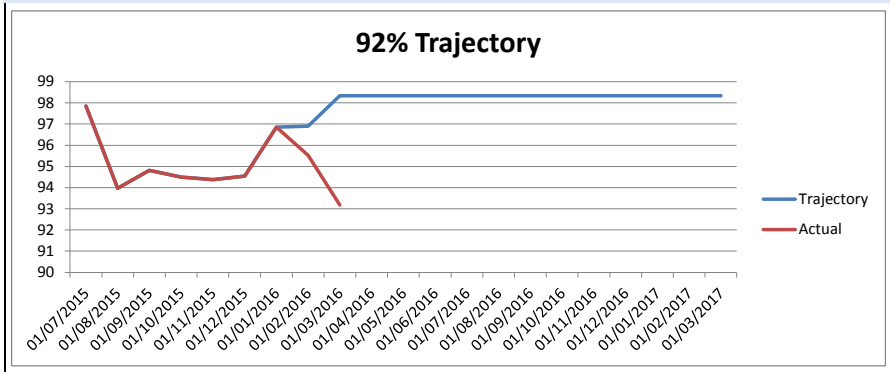
Key Performance Indicator Exception Report	RTT incomplete standard - Respiratory Medicine	M11 - exception template

Data Analysis

Monthly performance summary

GP referrals - Cumulative referrals 1478 - Cumulative previous year 1456 - Increase 22 pts. - Increase 2%

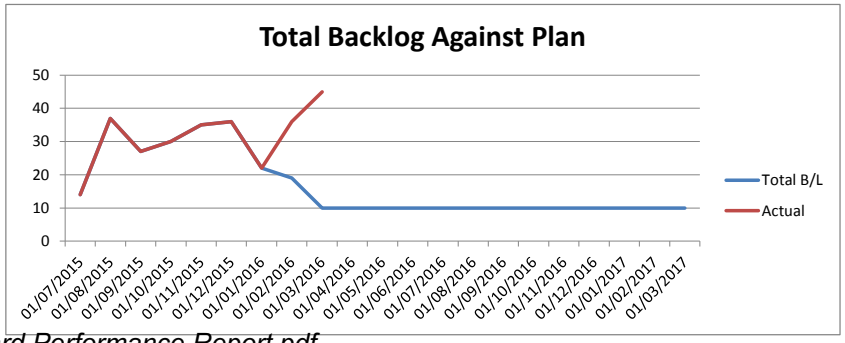




Current GP to 1st OPA wait at 16 weeks

Trajectory of backlog reduction to 31st March

No further clinics have been planned for March due to internal inpatient pressures and Consultant and SpR Annual Leave. Looking to try and provide extra evening capacity, but still having initial discussions.



Commentary

The specialty has been dealing with a number of challenges in the last 6 moths.
1. Retirement of Consultant October 2015. Appointment of new Consultant commenced mid-November 2015.
2. Sudden ill health of Consultant from October 2015.
3. Junior Dr Strikes - specialty has had to cancel 11 clinics.
4. Internal Significant Incident - 2 clinics cancelled
5. Undertaking extra Consultant Medical On-call weekend work due to ED and bed flow pressures, which has resulted in extra lieu days - revised clinic templates due to new Consultants joining resulting in insufficient TWW capacity being incorporated.
6. SpRs have provided extra TWW capacity clinics where possible, but due to pressures on inpatient work have not been able to support OP activity. 7. 53 Sleep pts awaiting OP appointment with very limited sleep capacity at present due to pressures of cancelled clinics due to strikes and TWW patients.
Delay in the advertising consultant replacement, due to confirmation of extra PAs linked to ICO workstream to an existing Consultant's Job Plan.

All the above have had a detrimental impact on the service over the last 3-5 months.
Ongoing discussions with the Clinical Team and Operational Support Manager to discuss provision of additional clinics.

Improvement Plan

No.	Action	Lead	Date
1	Agreement from the ICO Executive Board to fund 4 PAs for Consultant		
2	ECF form completed for Dr Sinclair's replacement. Awaiting approval	Sara Dorrans	
3	Additional Clinics to be agreed. Provided by Consultants and SpR to increase capacity	Sara Dorrans	Agreement yet to be made with Consultants
4	TWW Capacity - clinic templates amended in line with demand. Any leave TWW will be incorporated in other clinics.		

Governance Arrangements

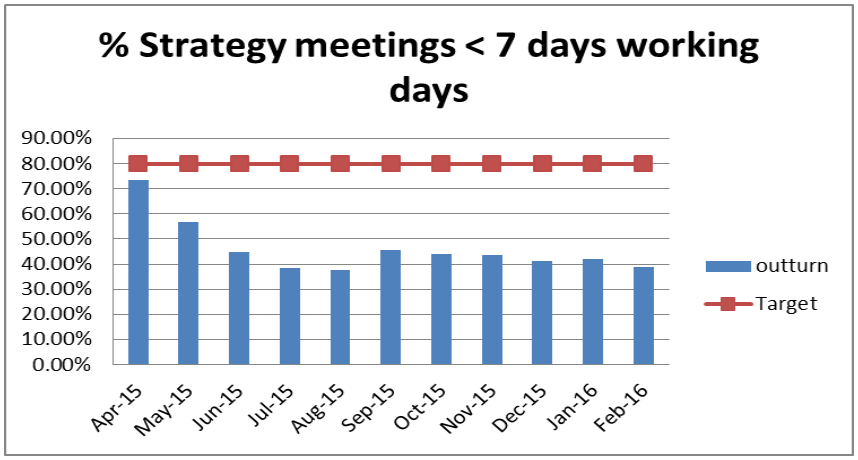
The impact of capacity is discussed and raised with the Clinical Team and Operational Support Manager

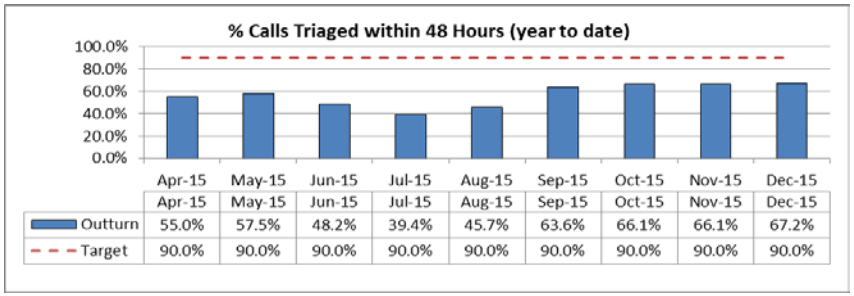
Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	Adult Safeguarding % strategy meeting within 7 days	M11 - exception template

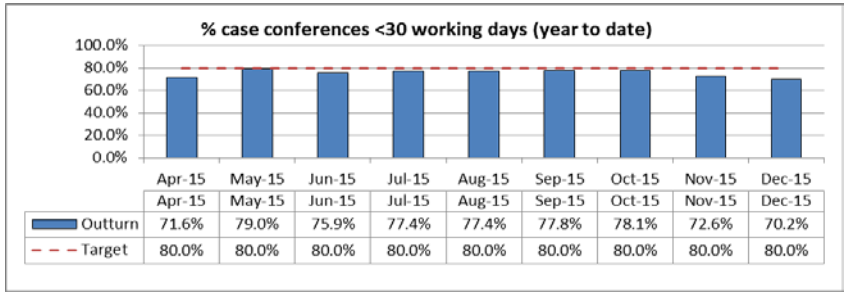
Data Analysis

Monthly performance summary





	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Outturn	55.0%	57.5%	48.2%	39.4%	45.7%	63.6%	66.1%	66.1%	67.2%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Outturn	71.6%	79.0%	75.9%	77.4%	77.4%	77.8%	78.1%	72.6%	70.2%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Commentary

The Trust has delegated responsibility for the Safeguarding Adults Single Point of Contact (SPOC), and co-ordination of strategy and case conference meetings in the operational teams.

There are three locally agreed performance targets in place:

- Percentage of Safeguarding Calls Triaged within 48 Hours - Performance to January 2016 was 70% against a target of 90% - rated red

- Percentage of Safeguarding Strategy Meetings held within 7 working days of alert - Performance to January 2016 was 42% against a target of 80% - rated red

- Percentage of Safeguarding Case Conferences held within 30 working days of alert - Performance to December 2015 was 66% against a target of 80% - rated red

We are currently not meeting the above targets. **Issues**:

1) Capacity in SPOC to Triage calls within 48hrs;
2) Resilience of the SPOC Function;
3) Appropriateness of the targets;
4) Delays in the initial 48hr triage.

No.	Action	Lead	Date
1	In June 2015 measures were put in place to increase the capacity in the Safeguarding Single Point of Contact, which sits in the Professional Practice Directorate		
2	The Band 7 replacement is due to start work on 4th April 2016 and will require training into this specialist role.		
3	Additional capacity has been identified, but ongoing difficulties remain in ensuring adequate cover. Cover is requested from Torbay zones as a part of contingency agreements – but this is not always available.		
4	Proposals are being discussed which would see this operational service (and staffing) transfer to the Torbay Zones; which would enable these functions to be more safely delivered from a wider staffing and skill mix pool		

Governance Arrangements

Safeguarding Adults activity is monitored internally through the Integrated Safeguarding Committee with external oversight from the Torbay and Devon Safeguarding Adult Boards

Torbay and South Devon NHS
NHS Foundation Trust

Key Performance Indicator Exception Report	4 hour standard - recovery plan	M11 - exception template

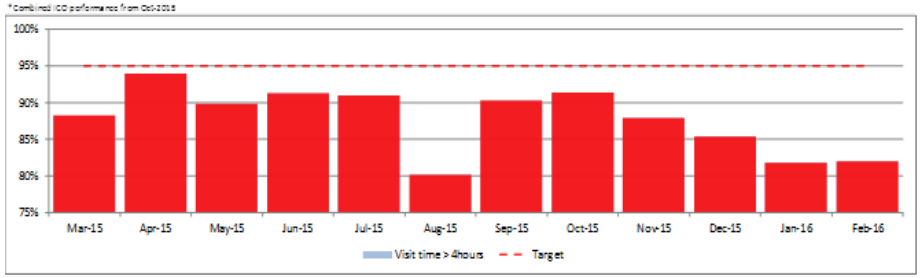
Data Analysis

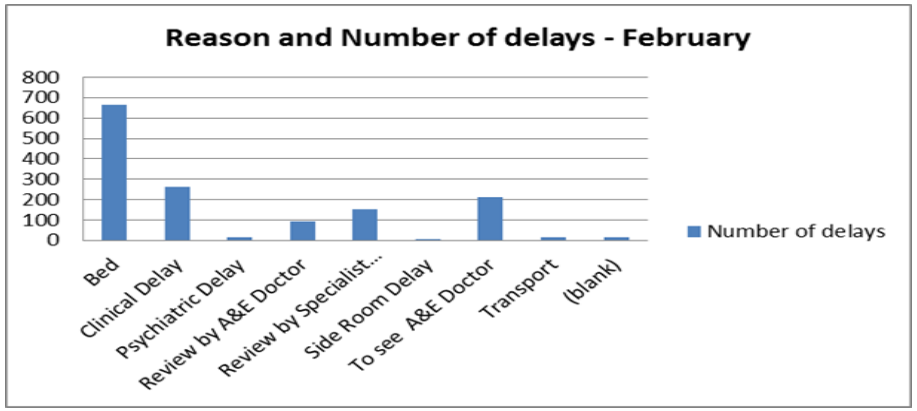
Monthly performance summary

Time spent in A&E

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
A&E attendances	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135	8223	8084
Percentage of patients treated within 4 hours	758	394	674	571	608	1232	594	753	1020	1192	1500	1459
Visit time > 4hours	88%	94%	90%	91%	91%	80%	90%	91%	88%	85%	82%	82%
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 February with 82% achieved against the 95% target

Since the last exception report to the board there have been a number of further actions taken and incorporated into the action plan. These are outlined below and a copy of the action plan attached to this report

The Acute Medical Admission unit has been moved to a non ward clinical area to increase available assessment bed capacity and promote non bed based assessment for GP referred medical patients following initial triage. The new unit officially opened on 21st March.

A range of additional operational metrics have been made available to support real time operational management of delays to patient flow. This encompasses a bespoke operational dashboard for IP flow and bed state measures and a second dashboard covering ED metrics.

In support of the ED action plan a range of indicators have agreed to monitor the impact on patient flow and quality of care.

The Chief operating Officer chairs a weekly meeting to review progress against the recovery plan.

Improvement Plan

No.	Action	Lead	Date
1	Opening of new AMU	COO	
2	Develop indicators to support the monitoring of action plan	Head of performance and contracting	
3	Develop operational performance measures to support operational control an escalation	Head of performance and contracting	

Governance Arrangements

Action plan reviewed weekly by COO and monthly patient flow board. Performance review at Urgent Care Board and System Resilience Group.

4. Financial Performance

4.1 Summary of Financial Performance

	Year to Date - Month 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Income & Expenditure					
Income	286.32	284.94	(1.37)	(0.38)	↑
Operating expenses	(280.31)	(280.71)	(0.40)	0.06	↑
EBITDA	**6.01**	**4.23**	**(1.77)**	**(0.31)**	↑
Non-operating revenue	0.27	0.64	0.37	0.27	↓
Non-operating expenses	(14.54)	(14.35)	0.19	0.15	↓
Net surplus / (deficit)	**(8.26)**	**(9.48)**	**(1.22)**	**0.11**	↑
Gain/(loss) on transfers by absorption	37.40	42.37	4.96		
Surplus / (deficit)	**29.14**	**32.89**	**3.74**		
Cash & Balance Sheet					
Cash Balance	32.72	31.03	(1.69)	(2.81)	↑
Capital Expenditure	17.10	13.98	(3.12)	(1.95)	↓
Loans & leases Drawn down	30.38	30.51	0.13	0.21	↓
Key Metrics					
EBITDA Margin	2.1%	1.5%	(0.6%)	(0.1%)	↓
I&E Surplus Margin	(2.9%)	(3.3%)	(0.4%)	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	3	(1)	(1)	↔
Overall Financial Sustainability Risk Rating	**2**	**2**	**0**	**0**	↔

This report monitors against the revised Annual Plan agreed and submitted to Monitor 18th December 2015 based on actual spend to month 8, with forecasted spend between month 9 to the end of the financial year.

At EBITDA level, performance for ten months ending 29th February 2016 is £4.23m which is behind plan of £6.01m by £1.77m.

Within this position, income is behind plan by £1.37m which is mainly miscellaneous income. Healthcare income both in the acute and community are broadly in line with plan. Expenditure overall is behind plan by 0.40m, pay is showing an over spend against plan by £0.81m, offset by under spends in non pay of £0.41m.

Under the terms of risk share agreement income to date includes an additional £1.8m 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 ahead of plan by £0.56m being £0.37m on non operating revenue, and £0.19m on non operating expenses.

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.

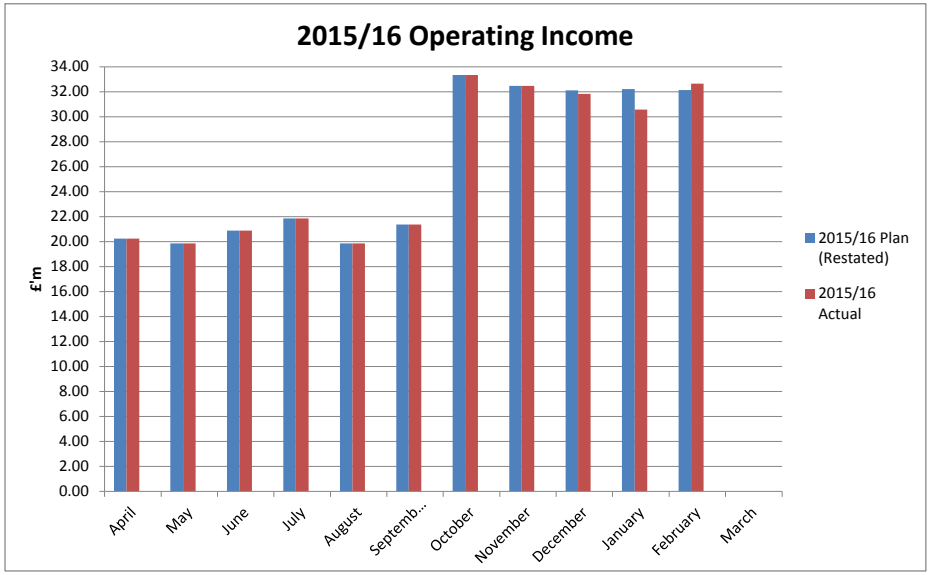
Cash balances are lower than plan by £1.69m mainly due to the SoCI position being adverse to Plan, working capital movements and the PDC repayment of £2.5m, partly offset by lower than planned capital expenditure.

The I&E Margin variance risk rating is lower than plan at '3', due to the SoCI position being adverse to Plan. The overall Financial Sustainability Risk Rating is in line with plan at a score of '2'. The overall rating will remain 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

	Year to Date - Month 11			Previous Month	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Income by Category					
Healthcare (Acute and Community)	222.61	222.60	(0.02)	0.55	↓
Social Care	22.35	22.36	0.01	(0.03)	↓
Other Income	41.35	39.99	(1.37)	(0.91)	↓
Total	**286.32**	**284.94**	**(1.37)**	**(0.38)**	↓



- Income is £1.37m behind plan for the period to 29th February 2016.
- There are no material issues driving the healthcare income variance (£0.55 adverse) following the rebasing of the Monitor Income plan.
- Social care income is broadly in line with plan with a marginal over recovery of £0.01m
- Other income is £1.37m behind plan. There has been higher than expected income in Non Mandatory / Non Protected Clinical Revenue 0.48m. This is offset by lower than planned income in Non-Patient services to Other Bodies £0.82m, and Miscellaneous other income £0.82m, these income levels however are consistent with the previous several months .

Healthcare Income - Commissioner Analysis					
South Devon & Torbay Clinical Commissioning Group	146.57	148.05	1.48	1.23	↑
North, East & West Devon Clinical Commissioning Group	4.70	4.58	(0.12)	(0.08)	↓
NHS England - Area Team	6.24	6.28	0.04	0.05	↓
NHS England - Specialist Commissioning	24.21	23.75	(0.46)	(0.30)	↓
Other Commissioners	8.36	7.41	(0.95)	(0.36)	↓
Sub-Total Acute	**190.08**	**190.07**	**(0.01)**	**0.55**	↓
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	32.03	32.03	0.00	0.00	↔
Other Commissioners	0.50	0.50	0.00	0.00	↔
Total Acute and Community	**222.61**	**222.60**	**(0.01)**	**0.55**	↓

Healthcare Income - By Business Unit					
Medical Services	83.75	80.33	(3.42)	(3.14)	↓
Surgical Services	66.05	63.11	(2.94)	(2.74)	↓
Women's, Childrens & Diagnostic Services	38.40	38.57	0.17	0.17	↑
Community Services	32.53	32.53	0.00	0.00	↔
Non-Clinical Services / Central Contract Income	1.88	8.07	6.19	6.26	↑
Total	**222.61**	**222.60**	**(0.01)**	**0.55**	↓

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

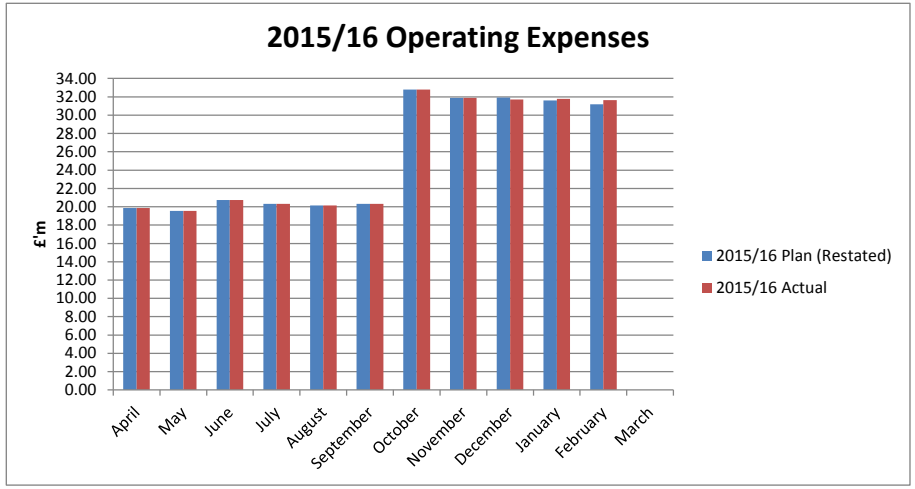
4.2.1 Operating Income (Continued)

	Year to Date - Month 11			Previous Month	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Healthcare Activity - By Setting					
	Activity	Activity	Activity	Activity	
Elective In-Patient Admissions	4,773	4,192	(581)	(557)	↓
Elective Day Case Admission	31,330	30,488	(842)	(691)	↓
Urgent & Emergency Admissions	102,313	103,210	897	187	↑
Out-Patients	434,834	404,867	(29,967)	(29,749)	↓
Total	**573,250**	**542,757**	**(30,493)**	**(30,810)**	↑
Social Care Income					
Torbay Council - ASC Contract income	16.31	16.31	0.00	0.00	↔
Torbay Council - Public Health Income	2.07	2.07	0.00	0.00	↔
Torbay Council - Client Income	3.97	3.98	0.01	(0.03)	↑
Total	**22.35**	**22.36**	**0.01**	**(0.03)**	↑
Other Income					
Non Mandatory/Non protected clinical revenue	2.25	2.73	0.48	0.23	↑
R&D / Education & training revenue	8.57	8.36	(0.21)	(0.05)	↓
Site Services	1.91	1.91	(0.01)	0.00	↑
Revenue from non-patient services to other bodies	8.74	7.93	(0.82)	(0.50)	↓
Misc. other operating revenue	19.88	19.07	(0.82)	(0.59)	↓
Total	**41.35**	**39.99**	**(1.38)**	**(0.91)**	↓

4.2 Statement of Comprehensive Income

4.2.2 Operating Expenditure

	Year to Date - Month 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Total Operating Expenses Included in EBITDA					
Employee Expenses	171.11	171.92	(0.81)	(0.56)	↑
Non-Pay Expenses	108.83	108.49	0.33	0.55	↓
PFI / LIFT Expenses	0.37	0.30	0.08	0.07	↓
Total	**280.31**	**280.71**	**(0.40)**	**0.06**	↑

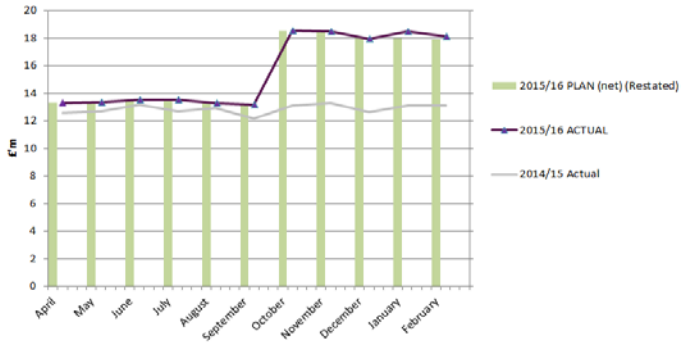


- Total Operating Expenditure included in EBITDA is £0.40m above plan and therefore showing an adverse overspent position to date.
- Pay has moved adversely from the previous month, and is showing an overspend against plan of £0.81m. This is mainly due to agency costs in Medicine, Community Hospitals and Surgery due to escalation and a requirement to cover absence, vacant posts and to address back log issues. Substantive posts are marginally underspent against plan.Pay costs continue to be reviewed and monitored for costs driven by these staffing requirements.
- Care model changes continue to be made on an incremental basis, however at this time due to the current patient flow in the hospital no savings can be delivered this financial year.
- 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 8.6% giving a year to date position of 7.3%. Monthly and cumulative data can be seen on the attached Agency Cap Appendix.

Employee Expenses - By Category					
Medical and Dental staff	46.11	45.60	0.52	0.26	↓
Registered nurses, midwives and health visiting staff	41.31	41.99	(0.67)	(0.44)	↑
Qualified scientific, therapeutic and technical staff	30.27	30.57	(0.30)	(0.19)	↑
Support to clinical staff	13.59	13.73	(0.14)	(0.08)	↑
Managers and infrastructure Support	39.82	40.04	(0.23)	(0.10)	↑
Total	**171.11**	**171.92**	**(0.81)**	**(0.56)**	↑
Employee Expenses - By Type					
Substantive	160.21	159.29	0.91	0.62	↓
Bank	4.27	5.13	(0.86)	(0.65)	↑
Locum	1.24	1.30	(0.06)	(0.06)	↔
Agency	5.39	6.20	(0.81)	(0.46)	↑
Total	**171.11**	**171.92**	**(0.81)**	**(0.56)**	↑

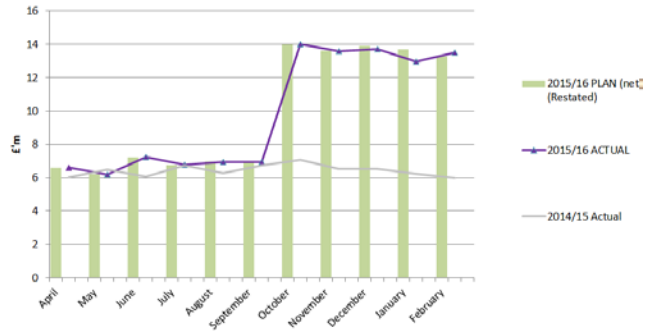
	Year to Date - Month 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Employee Expenses - By Service					
Medical Services	38.03	38.43	(0.40)	(0.26)	↑
Surgical Services	40.29	41.58	(1.29)	(1.18)	↑
Women's, Childrens & Diagnostic Services	32.79	31.38	1.41	1.26	↓
Community Services	18.05	17.71	0.34	0.15	↓
Non-Clinical Services + Harmonisation	41.96	42.83	(0.87)	(0.52)	↑
Total	**171.11**	**171.92**	**(0.81)**	**(0.56)**	↑

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



Non Pay Expenses - By Category					
Clinical Supplies	20.02	20.33	(0.31)	(0.21)	↑
Drugs (Excluding Pass through)	10.43	9.57	0.85	0.62	↓
Pass through Drugs, Blood and Devices	16.92	17.23	(0.31)	(0.31)	↔
Non Clinical Supplies	2.48	2.51	(0.03)	(0.03)	↔
Miscellaneous / Other	58.98	58.85	0.13	0.47	↓
Total	**108.83**	**108.49**	**0.33**	**0.55**	↓

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



Overall the non-pay expenses variance is £0.62m favourable against plan. This comprises of:-

- Clinical supplies are overspent against plan by £0.21m year to date. However spend has reduced in Month 11 and is in line with the plan
- Drugs are under spent against plan by £0.62m. Spend in Month 11 is consistent with the previous month's spend.
- Pass through Drugs, Bloods and devices are £0.31m over spent against plan, income is received to offset against these costs. This includes high cost drugs, and the pass through drugs are reflected in additional specialist commissioning income.
- Non clinical supplies spend has moved marginally and is broadly in line with plan.
- Miscellaneous expenditure, Adult social care and continuing healthcare placements are underspent against plan by £0.30m, and premises costs £0.10m.

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	Issued
12	Review of asset lives in line with Monitor's suggested recovery actions	Rod Muskett	31/03/2016

Governance Arrangements

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

Agency Nursing Information
Financial Year 2015/16

Combined (ICO) - data submitted		Actual April	Actual May	Actual June	Actual July	Plan 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	Actual ICO January	Actual 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)	(0.461)	(0.412)		(3.062)	(0.830)	(0.425)	(1.807)
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)	(4.808)	(4.779)		(41.987)	(12.268)	(6.111)	(23.608)
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%	9.6%	8.6%	#DIV/0!	7.3%	6.8%	7.0%	7.7%

4.2 Statement of Comprehensive Income

4.2.4 Non Operating Revenue & Expenses

	Year to Date - Month 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Non-Operating Expenses					
Donations & Grants	0.17	0.24	0.07	(0.03)	↓
Depreciation & Amortisation	(8.90)	(8.71)	0.20	0.19	↓
Impairments	0.00	0.00	0.00	0.00	↔
Restructuring Costs	(1.43)	(1.43)	0.00	0.00	↔
Finance Income	0.10	0.10	0.00	0.00	↔
Gains / (Losses) on Asset Disposals	0.00	0.30	0.30	0.30	↔
Gains / (Losses) on Transfers by Absorption	37.40	42.37	4.96	4.96	↔
Interest	(1.87)	(1.69)	0.18	0.15	↑
Public Dividend Capitals	(2.18)	(2.18)	(0.00)	0.00	↔
PFI Costs	(0.14)	(0.32)	(0.18)	(0.18)	↔
Income Tax refund	(0.02)	(0.02)	0.00	0.00	↔
Total	**23.13**	**28.65**	**5.52**	**5.39**	↑

- 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 £5.52m primarily relates to a delay in the transfer of assets within the South Hams area to NHS Property Company £4.96m which is due to transact in 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 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Schemes Delivered to Date M1 to M12					
Delivered Schemes : Recurrent	15.20	3.00	12.20	12.20	↔
Delivered Schemes : Non-Recurrent	0.00	8.70	-8.70	-7.40	↓
Delivered Schemes : Total	**15.20**	**11.70**	**3.50**	**4.80**	↓
Full Year Forecast Delivery					
Forecast Schemes : Recurrent	15.20	3.00	12.20	12.00	↓
Forecast Schemes : Non-Recurrent	0.00	9.30	-9.30	-8.60	↓
Forecast Schemes : Total	**15.20**	**12.30**	**2.90**	**3.40**	↓

	CIP Target £'000	Risk Rating	Lead
Community Business Unit Schemes	6,271	Green	COO
Medical Business Unit Schemes	2,693	Amber	COO
Surgical Business Unit Schemes	2,772	Amber	COO
WCDT Business Unit Schemes	1,368	Amber	COO
Support Services Business Unit	2,096	Amber	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 £2.9m year-end deficit. However, as just £3.0m of the £15.2m target is delivered recurrently, a £12.2m shortfall will carry forward into the next financial yr.

Improvement Plan

No.	Action	Lead	Date
1	Full review the undelivered schemes as part of the 2016/17 Business Planning Process	Paul Cooper	Ongoing
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	Complete
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 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Non-Current Assets					
Intangible Assets	5.84	6.61	0.77	(0.36)	↑
Property, Plant & Equipment	161.45	162.85	1.40	3.53	↓
On-Balance Sheet PFI	20.36	20.32	(0.04)	(0.02)	↓
Other	2.43	2.55	0.12	0.14	↓
Total	**190.07**	**192.33**	**2.26**	**3.29**	↓
Current Assets					
Cash & Cash Equivalents	32.72	31.03	(1.69)	(2.81)	↑
Other Current Assets	21.71	27.81	6.10	6.92	↓
Total	**54.42**	**58.84**	**4.41**	**4.12**	↑
Total Assets	**244.49**	**251.16**	**6.67**	**7.40**	↓
Current Liabilities					
Loan - DH ITFF	(5.82)	(5.71)	0.11	0.12	↓
PFI / LIFT Leases	(0.61)	(0.72)	(0.11)	(0.11)	↔
Trade and Other Payables	(32.22)	(37.29)	(5.08)	(1.92)	↓
Other Current Liabilities	(0.51)	(0.63)	(0.12)	(0.11)	↓
Total	**(39.15)**	**(44.35)**	**(5.19)**	**(2.03)**	↓
Net Current assets/(liabilities)	**15.27**	**14.49**	**(0.78)**	**2.09**	↓
Non-Current Liabilities					
Loan - DH ITFF	(63.27)	(63.50)	(0.23)	(0.33)	↑
PFI / LIFT Leases	(20.58)	(20.54)	0.03	0.03	↔
Other Non-Current Liabilities	(3.94)	(3.97)	(0.03)	0.00	↓
Total	**(87.79)**	**(88.02)**	(0.23)	(0.30)	↑
Total Assets Employed	**117.56**	**118.80**	**1.24**	**5.08**	↓
Reserves					
Total	**117.56**	**118.80**	**1.24**	**5.07**	↓

Intangibles and property, plant and equipment are higher than Plan by £2.2m, principally due to the delay in the transfer of Kingsbridge Hospital (£5.1m) to Plymouth Community Healthcare, partly offset by capital expenditure lower than plan.

Cash is lower than Plan by £1.7m (please see section 4.4 Cash Flow).

Current debtors are higher than Plan by £6.0m, largely due to the £1.8m debtor in respect of Risk Share Agreement income and legacy debtors relating to the Care Trust which are in the process of being resolved.

Trade and Other Payables are higher than Plan by £5.1m, largely due to the deferral of the £2.5m Capital to Revenue income and capital creditors higher than Plan by £1.1m.

4.4 Cash Flow Statement

	Year to Date - Month 11			Previous Month YTD	
	Plan £m	Actual £m	Variance £m	Variance £m	Change
Opening Cash Balance	**31.09**	**28.28**	**(2.81)**	(4.36)	↑
Cash Generated From Operations	0.98	(0.52)	(1.51)	(0.33)	↓
Debtor Movements	0.34	1.17	0.83	(3.56)	↑
Creditor Movements	0.00	3.19	3.19	3.80	↓
Capital Expenditure	(2.24)	(1.10)	1.15	1.21	↓
Net Interest	(0.17)	(0.15)	0.02	(0.05)	↑
Loan drawndown	2.79	2.71	(0.08)	0.22	↓
Loan repayment	0.00	0.00	0.00	0.00	↔
Other (PDC Dividend)	0.00	0.00	0.00	0.00	↔
Other	(0.08)	(2.56)	(2.48)	0.27	↓
Current Cash Balance	**32.72**	**31.03**	**(1.69)**	**(2.81)**	↑

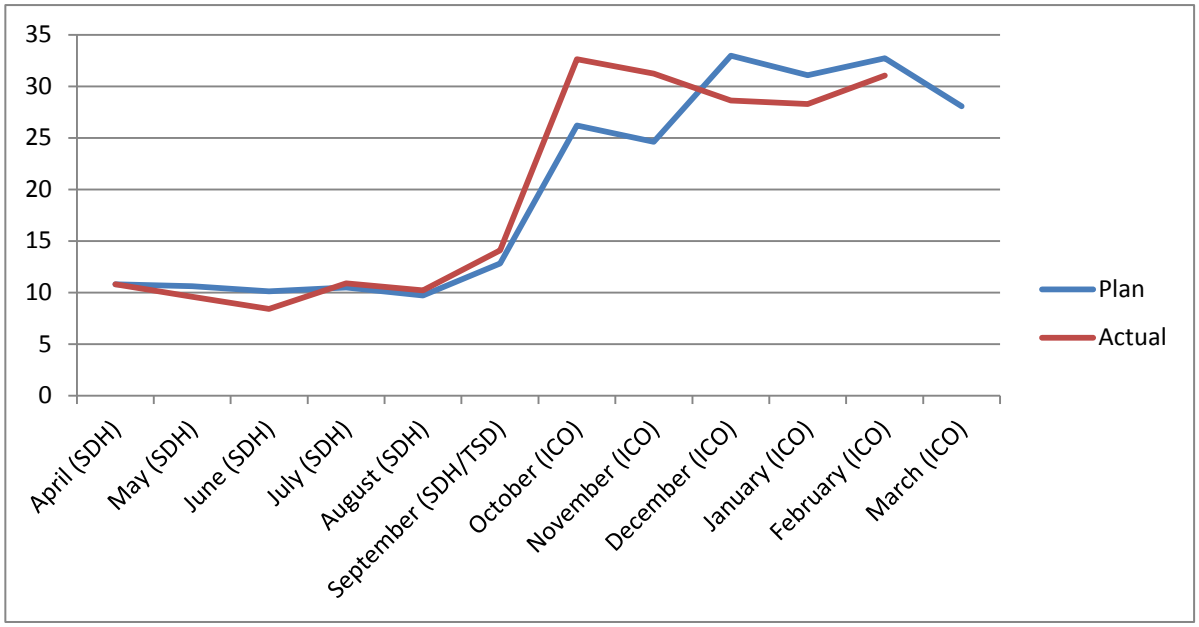
The closing cash balance is lower than plan by £1.7m, principally due to:

- YTD SoCI (excluding Absorption) adverse by £1.2m
- Stock and current debtors/creditors higher than Plan by £0.9m
- Repayment of PDC £2.5m

partly offset by:

- YTD capex lower than Plan by £3.1m

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	16.97	14.00	(2.97)	19.43	18.64	(0.79)

Significant Variances in Planned Expenditure by Scheme:

HIS schemes	1.84	0.89	(0.95)	2.72	2.32	(0.40)
Estates schemes	9.97	8.65	(1.32)	11.08	11.02	(0.06)
Medical Equipment	3.40	3.09	(0.31)	3.66	3.34	(0.32)
Other	0.30	0.32	0.02	0.30	0.31	0.01
PMU	1.36	1.10	(0.26)	1.48	1.48	0.00
Contingency	0.15	0.00	(0.15)	0.24	0.22	(0.02)
Prior Year schemes	(0.05)	(0.05)	0.00	(0.05)	(0.05)	0.00
Total	**16.97**	**14.00**	**(2.97)**	**19.43**	**18.64**	**(0.79)**

As reported in previous Trust Board Reports, Capital Expenditure was significantly behind the phased budget incorporated into the initial Annual Planning assumptions. A revised Annual Plan for 2015/16 was therefore submitted to Monitor in December 2015.

This has reduced the planned 2015/16 capital expenditure value from £27.19m to £19.43m

Scheme leads have been asked to provide year end forecasts throughout the financial year. The latest information received has been incorporated into the adjacent analysis. The forecast indicates that the capital programme will be underspent by £0.79m which represents 4% of the Revised Plan.

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	319.8	1.00	1.50	↓
Operating expenses	(313.2)	(314.2)	(1.00)	0.00	↓
EBITDA	**5.6**	**5.6**	0.00	1.50	↓
Non-operating revenue	37.4	37.4	0.00	0.00	↔
Non-operating expenses	(15.0)	(14.8)	0.20	0.00	↑
Net surplus / (deficit)	**28.0**	**28.2**	**0.20**	**1.50**	↓
Net surplus/(deficit) net of Gain on Absorption	(16.7)	(16.5)	0.20	1.50	↓
Operating surplus (deficit)	**(8.9)**	**(8.7)**	**0.20**	**1.50**	↓
Cash Flow					
Opening Cash Balance 2014/15 -SDH	**12.1**	**12.1**	0.0		
Cash Generated From Operations	4.2	4.0	-0.2	1.5	↓
Debtor Movements	3.5	3.5	0.0	0.0	↔
Creditor Movements	2.1	2.1	0.0	0.0	↔
Capital Expenditure	-19.6	-18.6	1.0	0.0	↑
Net Interest	-2.3	-2.3	0.0	0.0	↔
Loan drawndown	31.8	31.8	0.0	0.0	↔
Loan repayment	-4.4	-4.4	0.0	0.0	↔
Other (PDC Dividend)	-2.2	-2.2	0.0	0.0	↔
Other	0.0	-2.5	-2.5	0.0	↓
Cash Transferred from TSD	2.8	2.8	0.0	0.0	↔
Current Cash Balance 2015/16 -ICO	**28.0**	**26.3**	-1.7	1.5	↓

Income & Expenditure is forecast to be £0.2m favourable to the revised Plan.

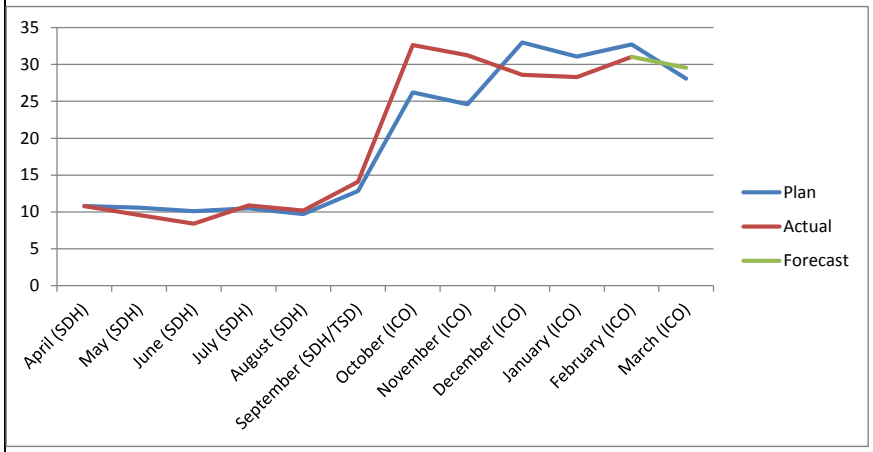
Income is forecast to be £1.0m favourable to the revised plan, principally due to additional 'capital to revenue' income of £2.5m plus e-Prescribing income of £0.6m, offset by a reduction in non-clinical income of £2.2m.

Operating expenses are forecast to be £1.0m adverse to the revised plan, principally due to a forecast adverse variance of £1.0m on agency staffing costs.

Non-operating expenses are forecast to be £0.2m favourable to plan, principally due to reduced depreciation expense. Other I&E items are forecast to be in line with the revised plan.

Cash is forecast to be £1.7m adverse the the revised Plan. This is principally due to the repayment of £2.5m of PDC, partly offset by reduced capital expenditure.

Cash Flow Forecast £m:

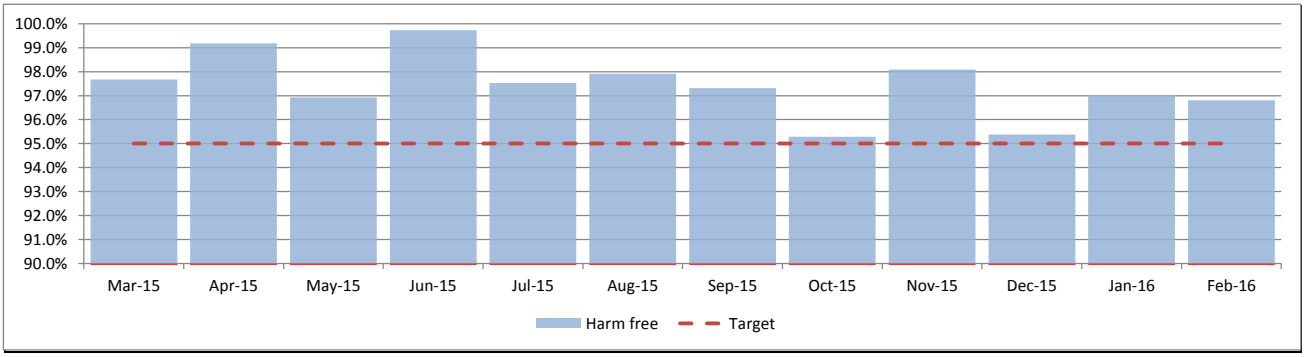


Performance & Quality Databook

Month 11 February 2016

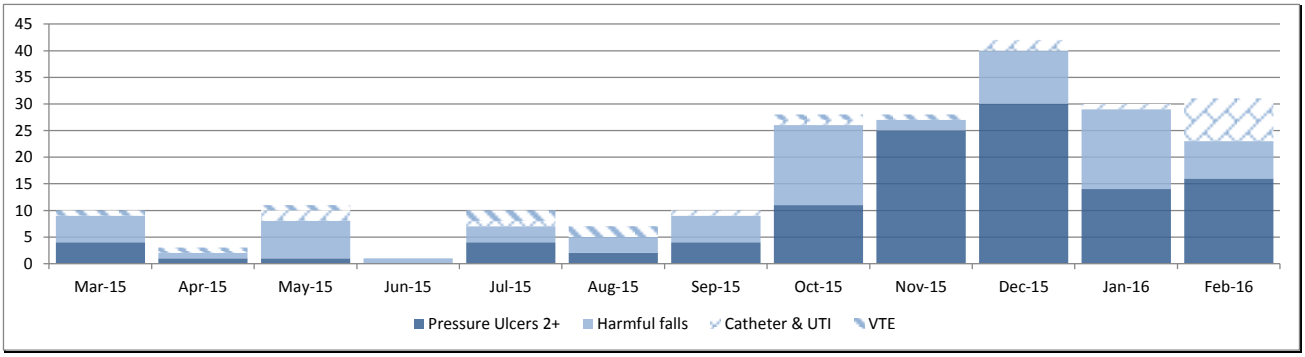
Harm Free - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients	387	367	358	377	365	336	372	360	366	888	1012	972
New harms	9	3	11	1	9	7	10	17	7	41	30	31
Harm free	97.7%	99.2%	96.9%	99.7%	97.5%	97.9%	97.3%	95.3%	98.1%	95.4%	97.0%	96.8%
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

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
New Harms	9	3	11	1	9	7	10	17	7	41	30	31
Pressure Ulcers 2+	4	1	1	0	4	2	4	11	25	30	14	16
Harmful falls	5	1	7	1	3	3	5	15	2	10	15	7
Catheter & UTI	0	0	2	0	1	0	1	1	0	2	1	8
VTE	1	1	1	0	2	2	0	1	1	0	0	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.

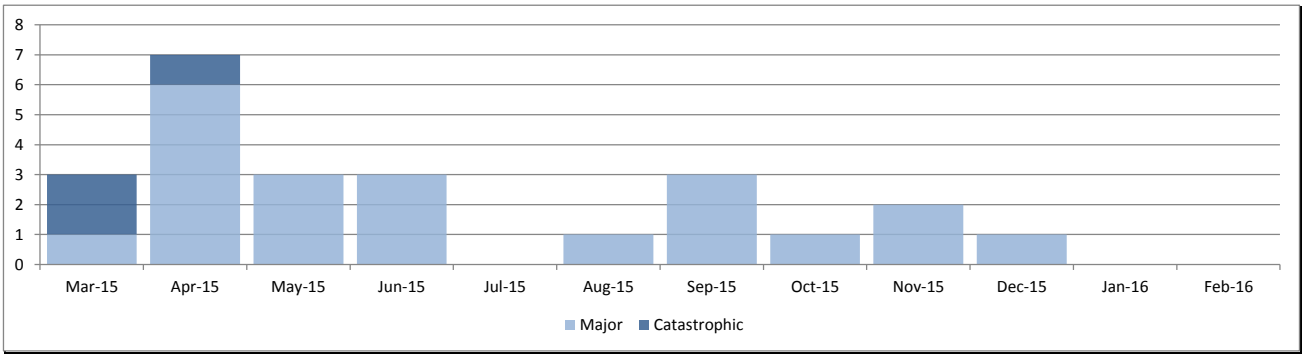
- SWARM continues to be used should a serious pressure ulcer develop. This involves a meeting of the ward manager, matron, TVN as soon after the event as possible to gather information as to why the event occurred.

- 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

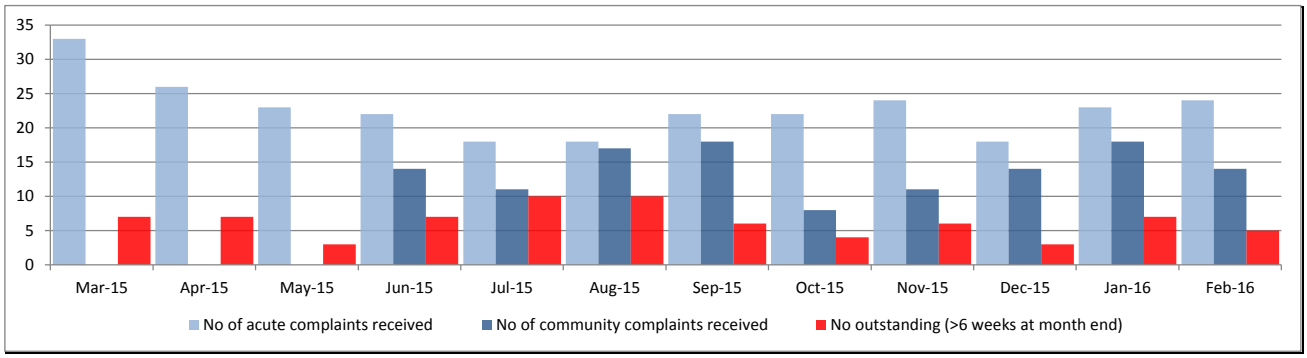
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Near miss	74	77	104	63	85	57	67	56	44	48	56	49
Near miss - major	7	13	15	7	3	5	4	3	6	11	4	7
No harm	234	227	349	202	202	222	207	226	225	130	219	194
Insignificant	44	45	42	42	30	44	44	38	22	28	35	29
Minor	127	145	163	139	130	148	118	133	110	100	120	114
Moderate	33	44	22	19	25	27	24	22	15	6	20	14
Major	1	6	3	3	0	1	3	1	2	1	0	0
Catastrophic	2	1	0	0	0	0	0	0	0	0	0	0
(blank)	0	6	2	1	1	1	1	0	0	0	0	0
Total	522	564	700	476	476	505	468	479	424	324	454	407



Incident reporting remains consistent in November and December. An ICO view of incident data combining safeguard and Datex reporting systems is being developed.

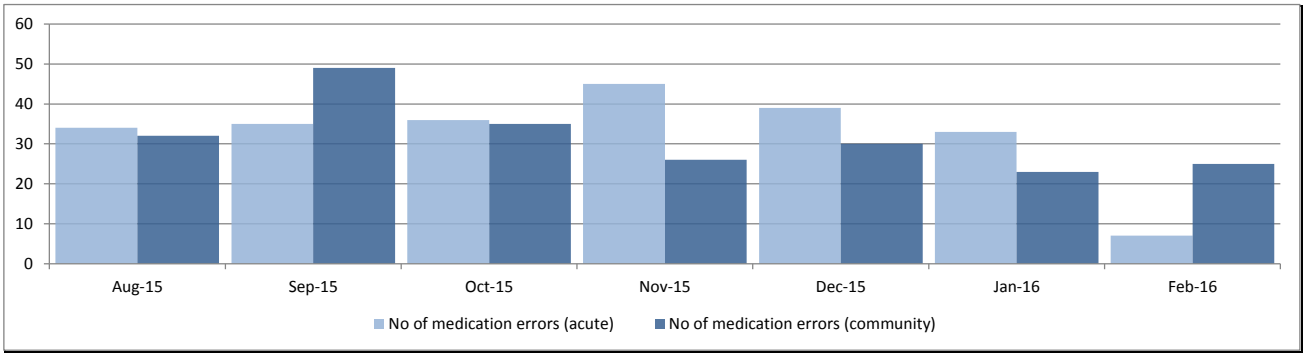
Written complaints - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
No of acute complaints received	33	26	23	22	18	18	22	22	24	18	23	24
No of community complaints received				14	11	17	18	8	11	14	18	14
No outstanding (>6 weeks at month end)	7	7	3	7	10	10	6	4	6	3	7	5



Medication errors - Trust Total

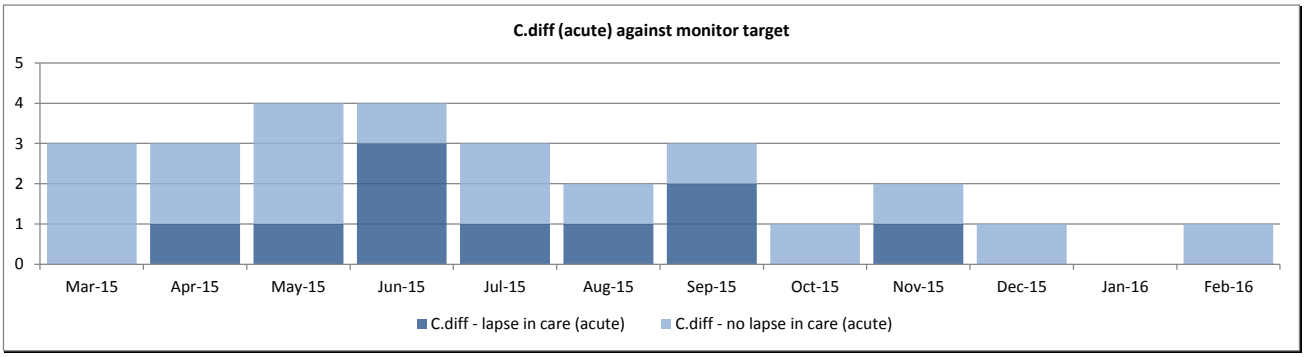
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
No of medication errors (acute)	34	41	207	28	30	34	35	36	45	39	33	7
No of medication errors (community)				40	33	32	49	35	26	30	23	25



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.

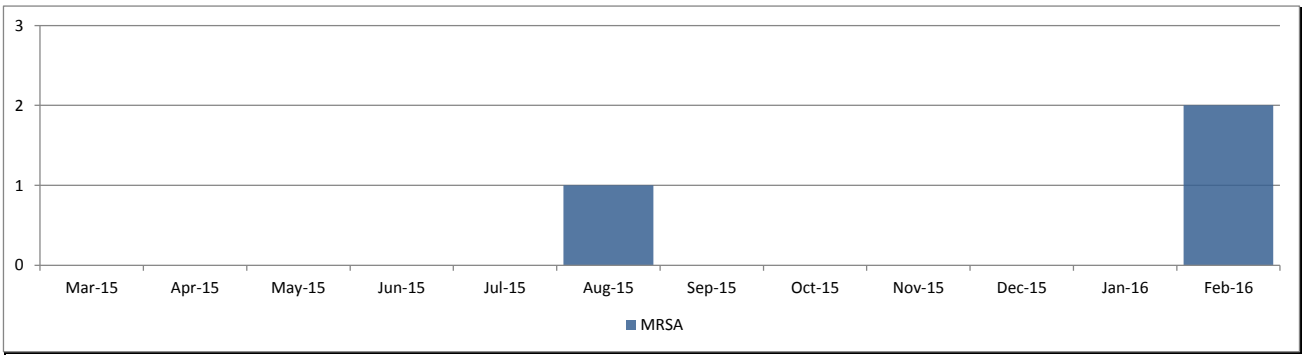
Clostridium difficile

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
C.diff - lapse in care (acute)	0	1	1	3	1	1	2	0	1	0	0	0
C.diff - no lapse in care (acute)	3	2	3	1	2	1	1	1	1	1	0	1
C.diff - Total (acute)	3	3	4	4	3	2	3	1	2	1	0	1
C.diff - lapse in care (community)	n/a	0	0	0	1	0	0	0	0	0	0	0
C.diff - no lapse in care (community)	n/a	0	0	1	0	1	0	0	0	1	1	0
C.diff - Total (community)	n/a	0	0	1	1	1	0	0	0	1	1	0



Methicillin-resistant Staphylococcus aureus (MRSA) - (acute)

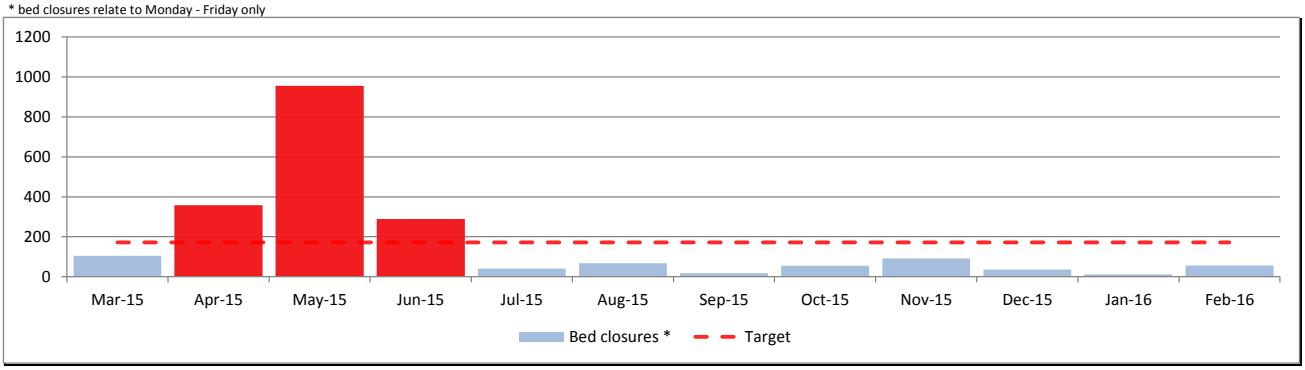
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
MRSA	0	0	0	0	0	1	0	0	0	0	0	2



Bed closures due to infection control measures - (Acute)

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Bed closures *	104	358	955	288	40	68	18	54	92	36	12	57
Target	171	171	171	171	171	171	171	171	171	171	171	171

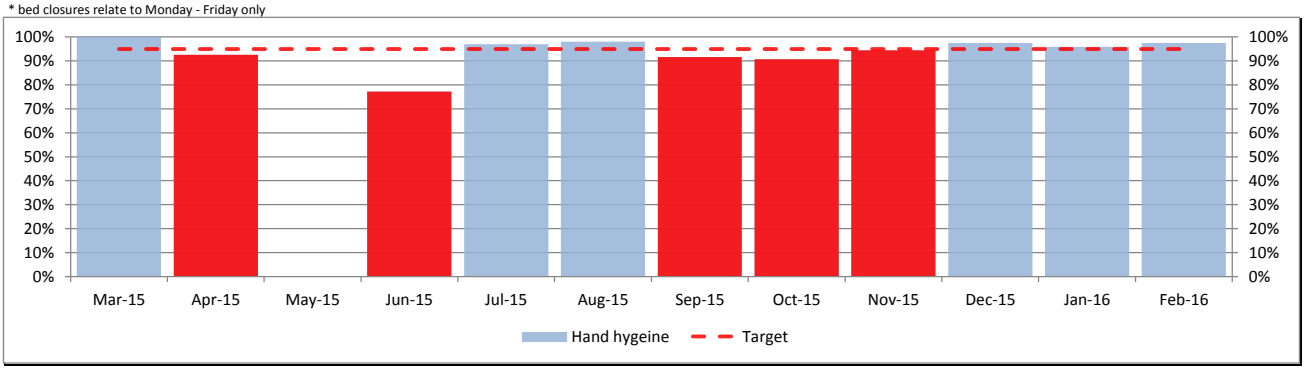
* bed closures relate to Monday - Friday only



Hand Hygiene - (Acute)

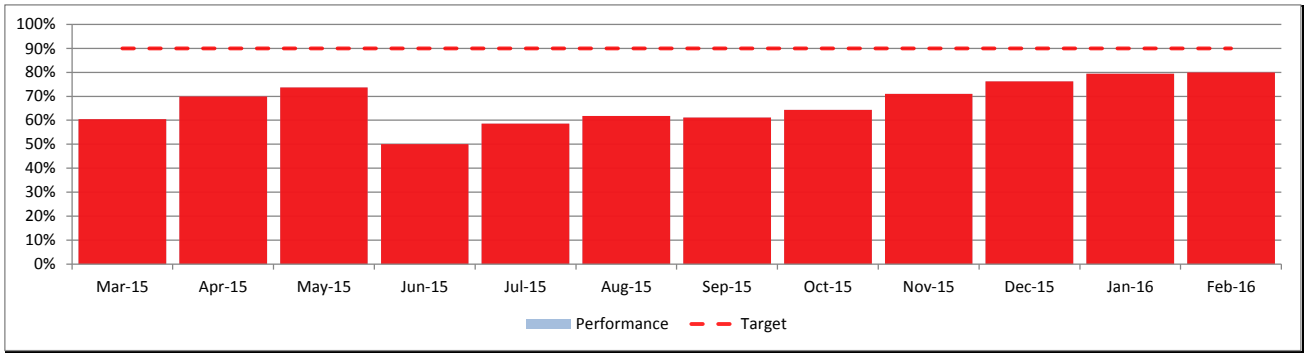
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Hand hygeine	100%	**93%**	n/a	**77%**	97%	98%	**92%**	**91%**	**94%**	97%	96%	98%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

* bed closures relate to Monday - Friday only



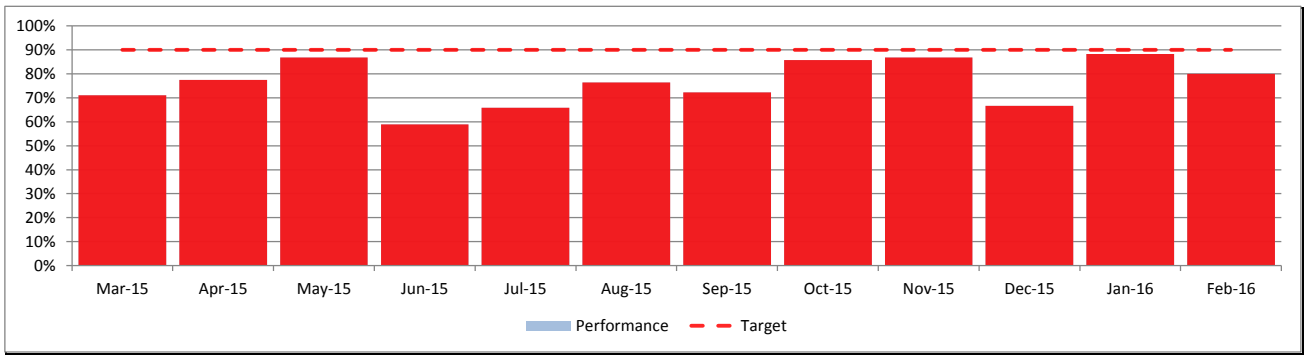
Fracture neck of femur

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients with a fractured neck of femur	43	40	38	40	41	34	36	28	38	42	34	30
Patients achieving best practice tariff	26	28	28	20	24	21	22	18	27	32	27	24
Performance	60%	70%	74%	50%	59%	62%	61%	64%	71%	76%	79%	80%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



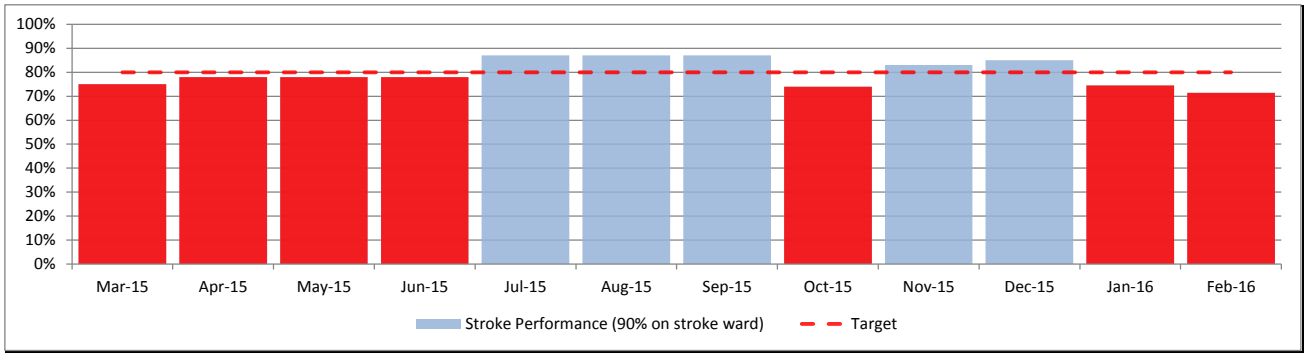
Fracture neck of femur - Admission to surgery less than 36 hours

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
To surgery within 36 hours	27	31	33	23	27	26	26	24	33	28	30	24
To surgery outside 36 hours	11	9	5	16	14	8	10	4	5	14	4	6
Performance	71%	78%	87%	59%	66%	76%	72%	86%	87%	67%	88%	80%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



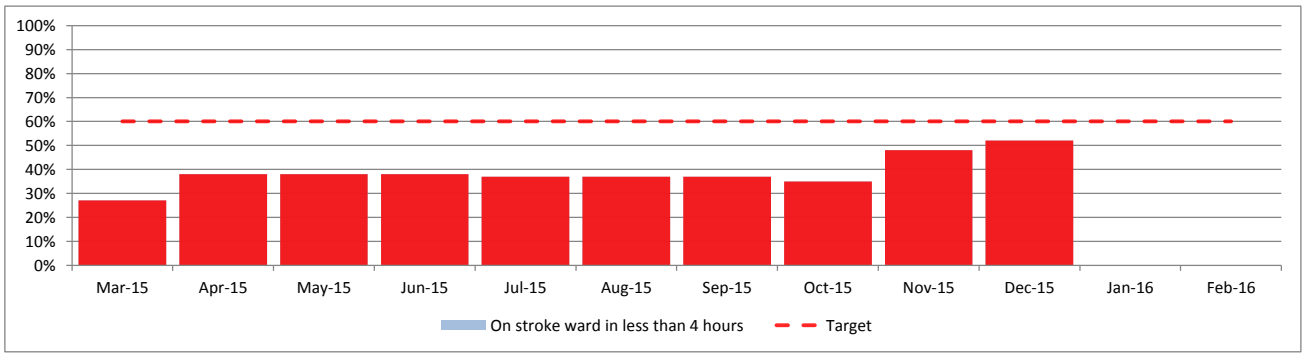
Stroke patients spending 90%+ of their time on a dedicated stroke ward - data based on SNAP audit

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Stroke Performance (90% on stroke ward)	75%	78%	78%	78%	87%	87%	87%	74%	83%	85%	75%	71%
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



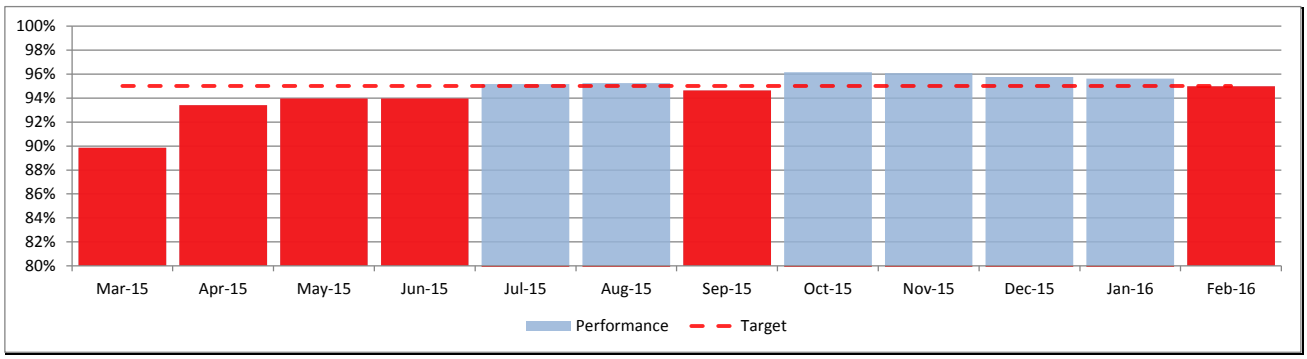
Time to stroke ward within 4 hours - data based on SNAP audit

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
On stroke ward in less than 4 hours	27%	38%	38%	38%	37%	37%	37%	35%	48%	52%	n/a	tbc
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%



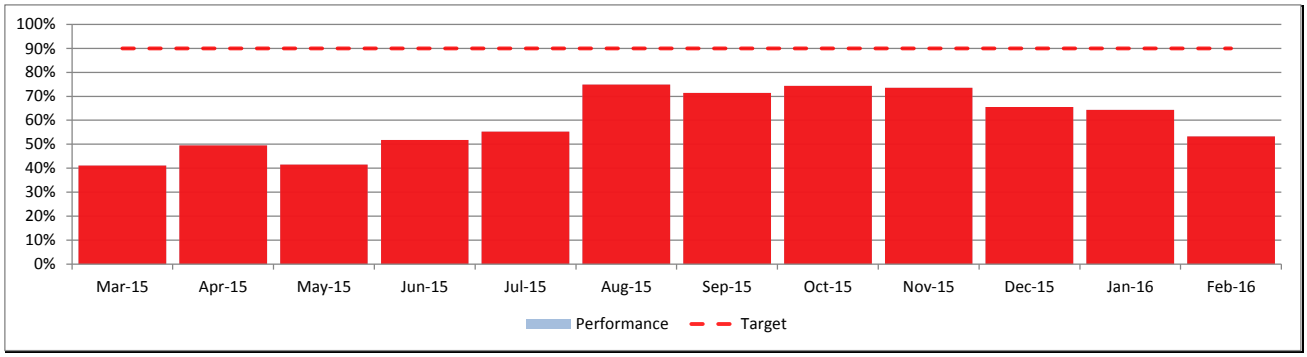
VTE risk assessment on admission - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Adult patients admitted	5984	5940	5334	6076	6257	5803	6266	5967	5821	5589	5911	5710
No risk assessed for VTE using national tool	5377	5549	5013	5709	5955	5528	5930	5738	5593	5352	5653	5424
Performance	90%	93%	94%	94%	95%	95%	95%	96%	96%	96%	96%	95%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



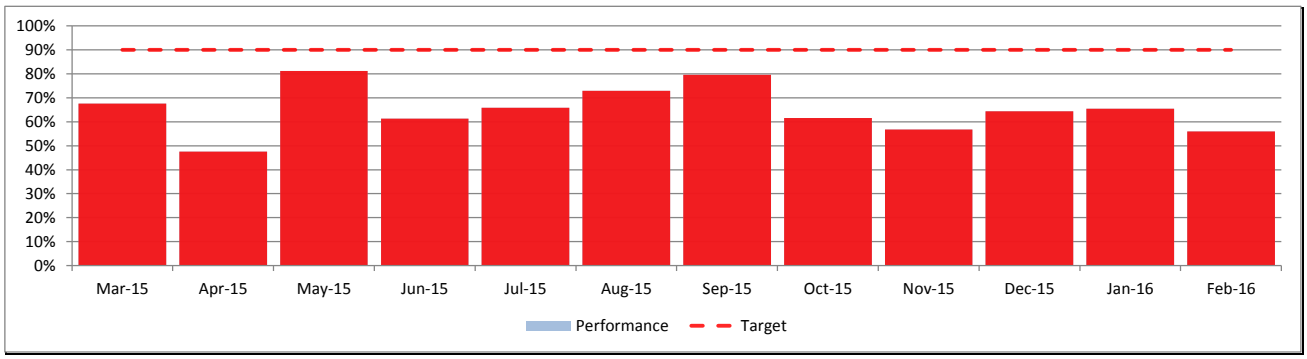
Dementia - Find

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Emergency admissions with LoS >3days (75+)	304	273	251	224	239	278	283	316	306	348	322	306
Finding question completed within 72 hours	125	135	104	116	132	208	202	235	225	228	207	163
Performance	41%	49%	41%	52%	55%	75%	71%	74%	74%	66%	64%	53%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



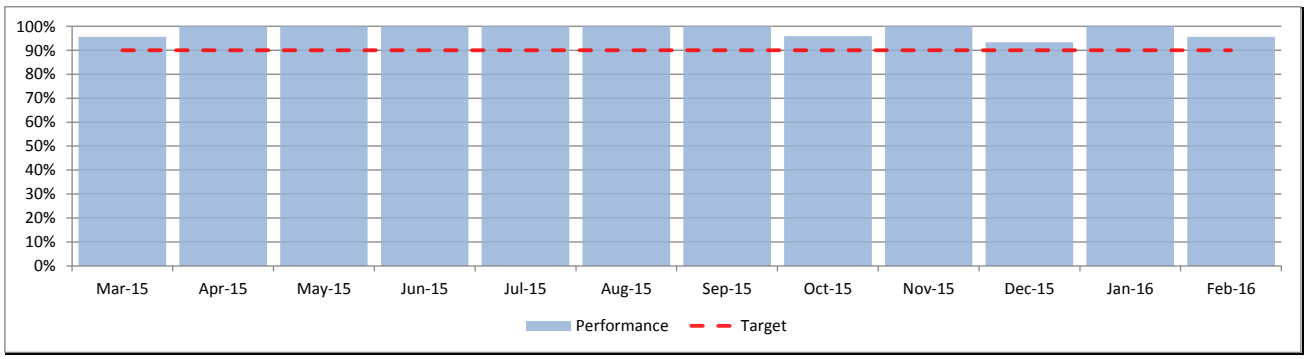
Dementia - Access and Investigate

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
+ve finding question or diagnosed delirium	37	40	32	31	38	48	49	65	44	59	58	50
Diagnostic assessment	25	19	26	19	25	35	39	40	25	38	38	28
Performance	68%	48%	81%	61%	66%	73%	80%	62%	57%	64%	66%	56%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



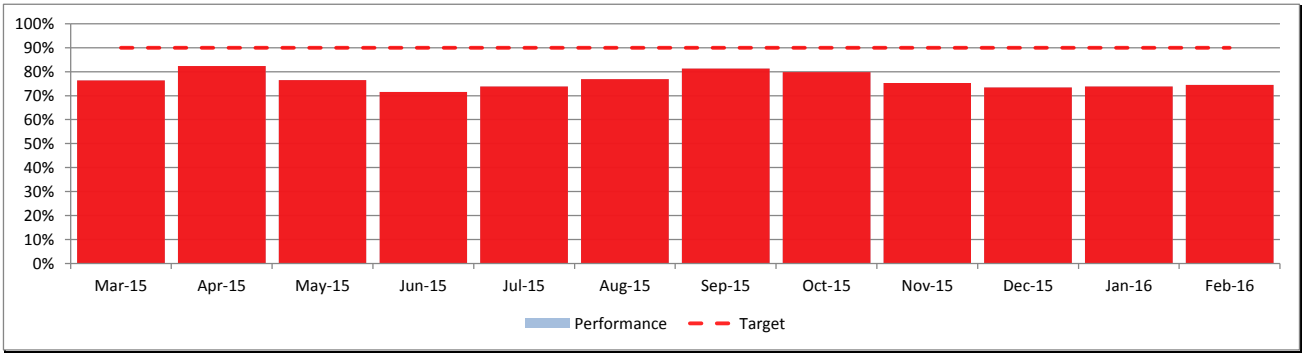
Dementia - Refer

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
+ve / inconclusive result from assessments	23	22	23	17	23	24	35	24	23	30	31	23
With a sufficient plan of care on discharge	22	22	23	17	23	24	35	23	23	28	31	22
Performance	96%	100%	100%	100%	100%	100%	100%	96%	100%	93%	100%	96%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



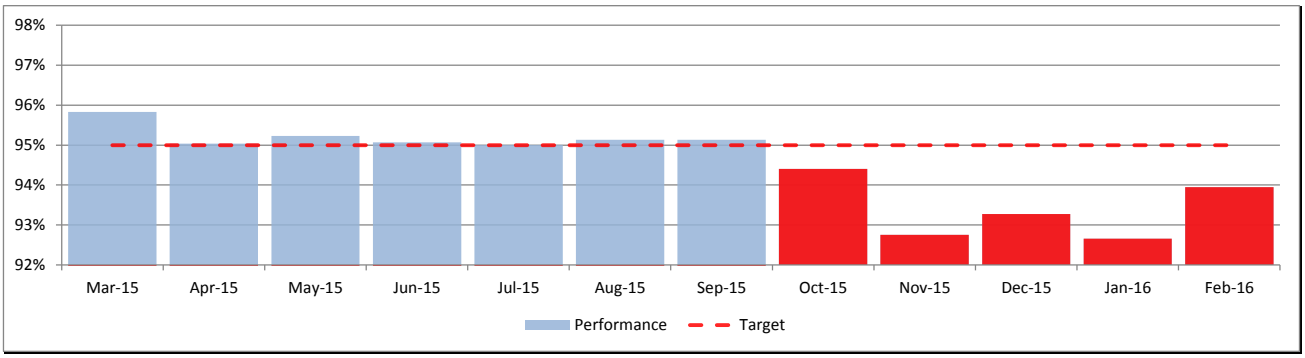
Admitted 18 week referral to treatment - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
RTT admitted clock stops	1570	1438	1246	1587	1594	1459	1616	1367	1365	1261	1352	1347
RTT admitted breaches	372	253	293	451	418	338	302	275	337	336	355	344
Performance	76%	82%	76%	72%	74%	77%	81%	80%	75%	73%	74%	74%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



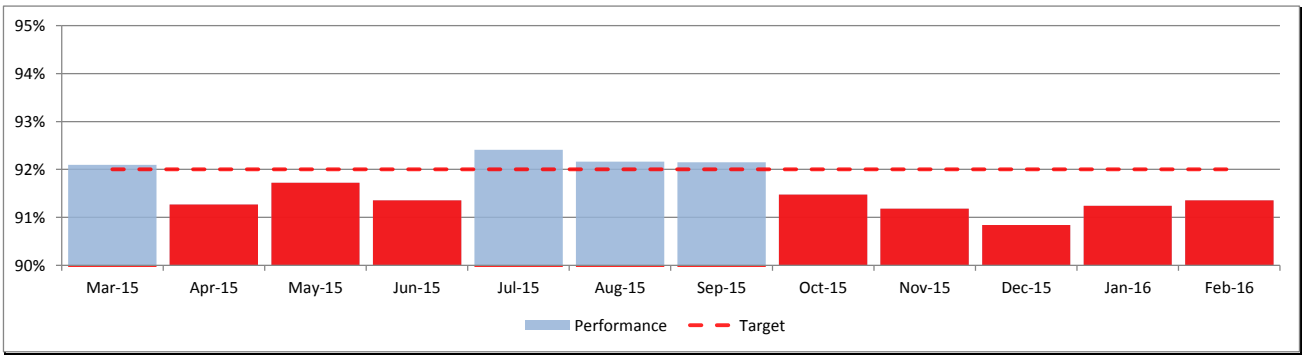
Non-admitted 18 week referral to treatment - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
RTT non-admitted clock stops	5665	5262	4992	5716	6229	4887	5935	6108	5326	4699	5187	4960
RTT non-admitted breaches	236	261	238	282	311	238	289	342	386	316	381	300
Performance	96%	95%	95%	95%	95%	95%	95%	94%	93%	93%	93%	94%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



Incomplete 18 week referral to treatment - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
RTT incomplete pathways	15284	15230	15648	15572	17424	17104	16114	15458	15464	15965	15664	15944
RTT incomplete pathway breaches	1208	1330	1295	1346	1323	1341	1265	1318	1364	1462	1372	1378
Performance	92%	91%	92%	91%	92%	92%	92%	91%	91%	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

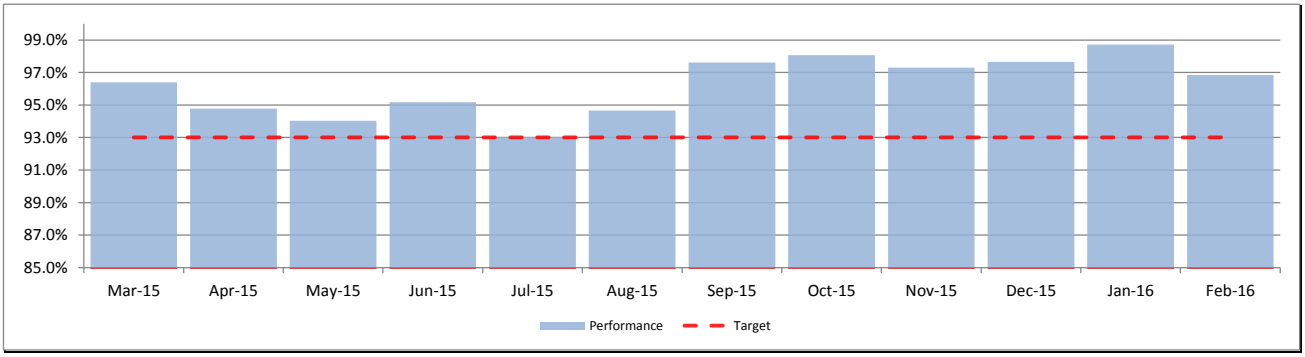
	<126 days	>126 days	Total	Performance
Cardiology	137	33	170	81%
Dermatology	427	4	431	99%
Ear, Nose & Throat (ENT)	324	18	342	95%
Gastroenterology	277	30	307	90%
General Medicine	114	0	114	100%
General Surgery	554	64	618	90%
Geriatric Medicine	21	0	21	100%
Gynaecology	457	2	459	100%
Neurology	106	5	111	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%

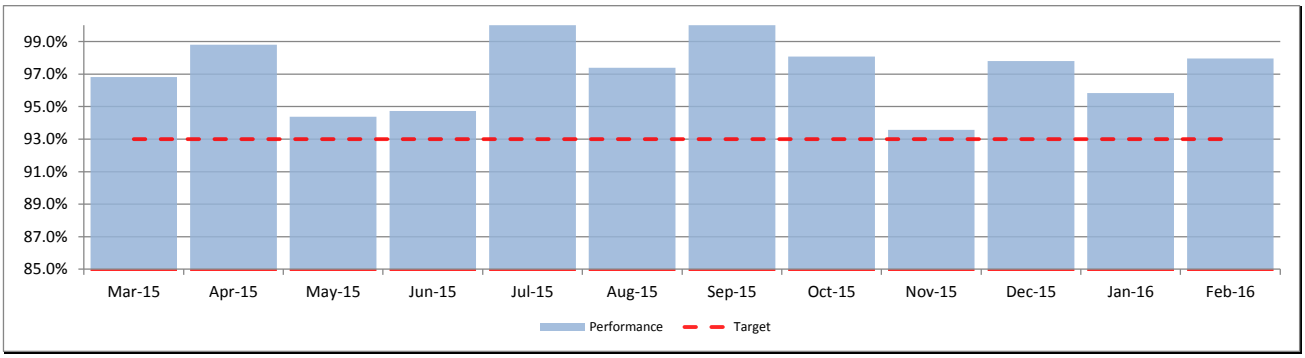
Two Week Wait Referrals - seen within 14 days

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
2ww referrals seen	915	746	753	913	903	826	884	879	889	897	705	856
2ww referral breaches	33	39	45	44	63	44	21	17	24	21	9	27
Performance	96.4%	94.8%	94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.7%	98.7%	96.8%
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%



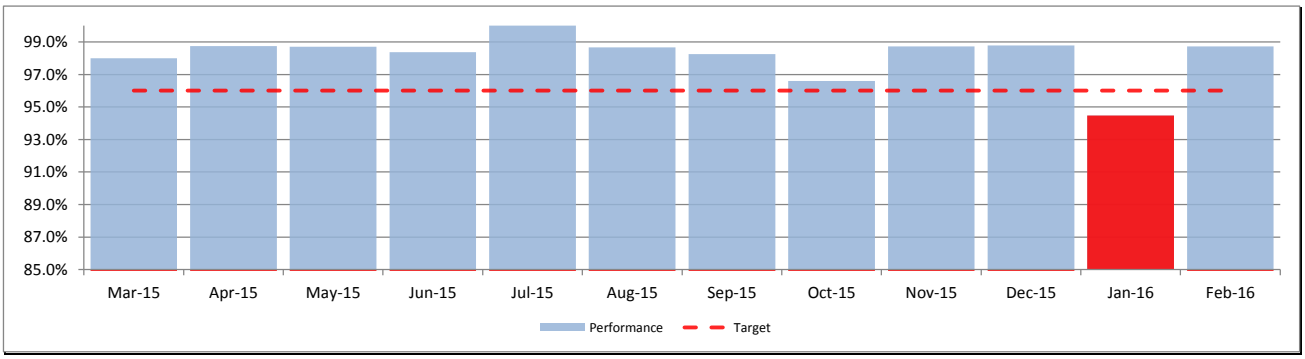
Breast Symptomatic referrals - seen within 14 days

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Breast symptomatic referrals seen	94	84	89	114	112	115	90	104	109	137	96	98
Breast symptomatic referrals breached	3	1	5	6	0	3	0	2	7	3	4	2
Performance	96.8%	98.8%	94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%
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%



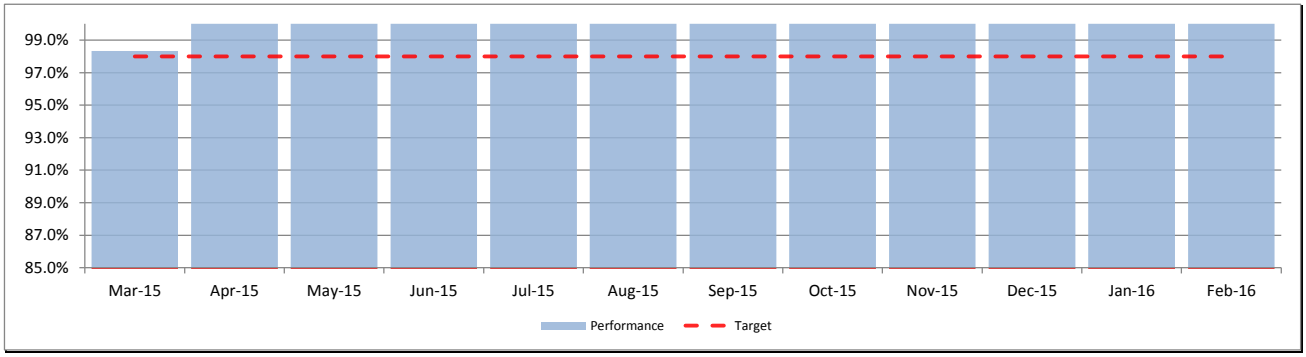
1st treatment - 31 day from decision to treat to treatment

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
1st treatments	200	159	155	185	169	149	172	176	156	163	163	157
31 day 1st treatment breaches	4	2	2	3	0	2	3	6	2	2	9	2
Performance	98.0%	98.7%	98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	**94.5%**	98.7%
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%



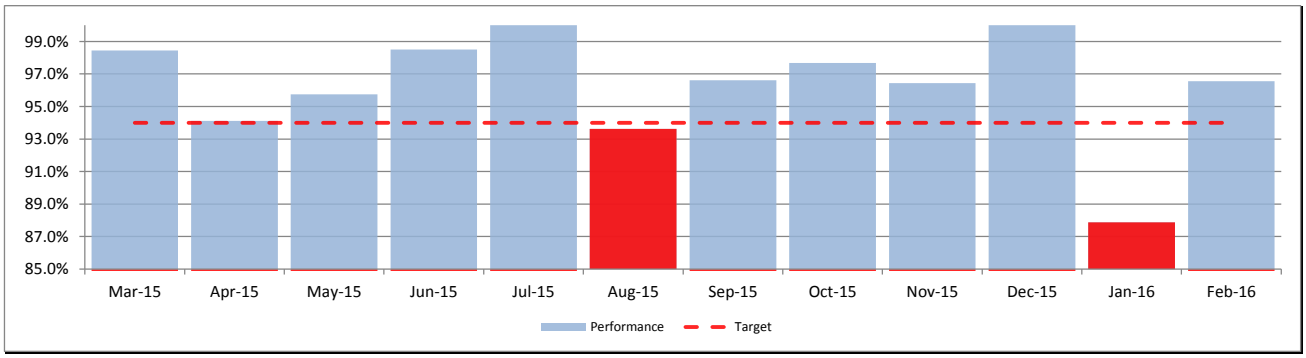
Subsequent treatment - 31 day from decision to treat to treatment - Drug

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Subsequent drug treatments	60	45	49	57	48	38	55	52	49	47	59	46
Subsequent drug breaches	1	0	0	0	0	0	0	0	0	0	0	0
Performance	98.3%	100.0%	100.0%	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%



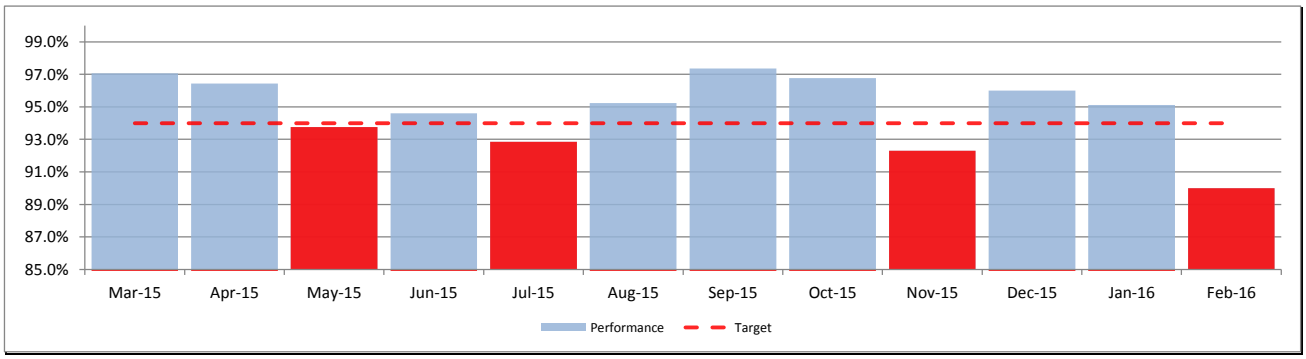
Subsequent treatment - 31 day from decision to treat to treatment - Radiotherapy

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Subsequent radiotherapy treatments	64	51	47	67	46	47	59	43	56	42	66	58
Subsequent radiotherapy breaches	1	3	2	1	0	3	2	1	2	0	8	2
Performance	98.4%	94.1%	95.7%	98.5%	100.0%	**93.6%**	96.6%	97.7%	96.4%	100.0%	**87.9%**	96.6%
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%



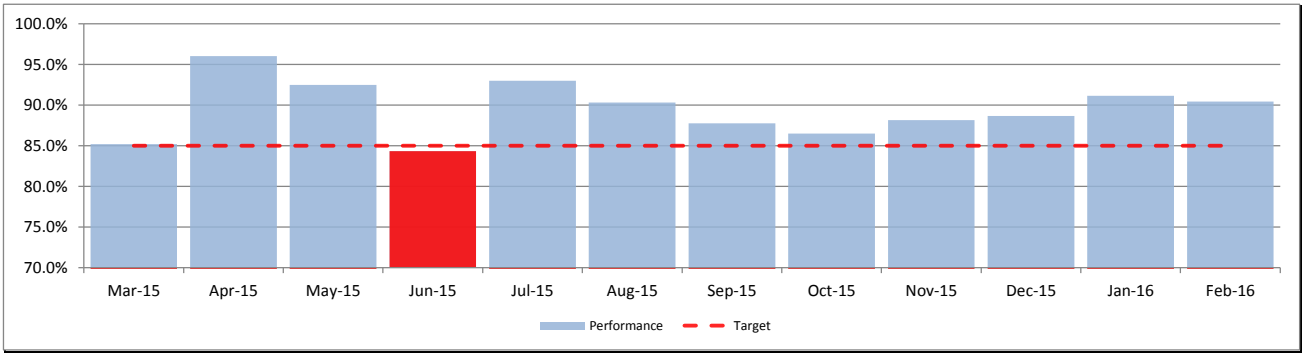
Subsequent treatment - 31 day from decision to treat to treatment - Surgery

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Subsequent surgery treatments	34	28	32	37	28	21	38	31	39	25	41	40
Subsequent surgery breaches	1	1	2	2	2	1	1	1	3	1	2	4
Performance	97.1%	96.4%	**93.8%**	94.6%	**92.9%**	95.2%	97.4%	96.8%	**92.3%**	96.0%	95.1%	**90.0%**
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%



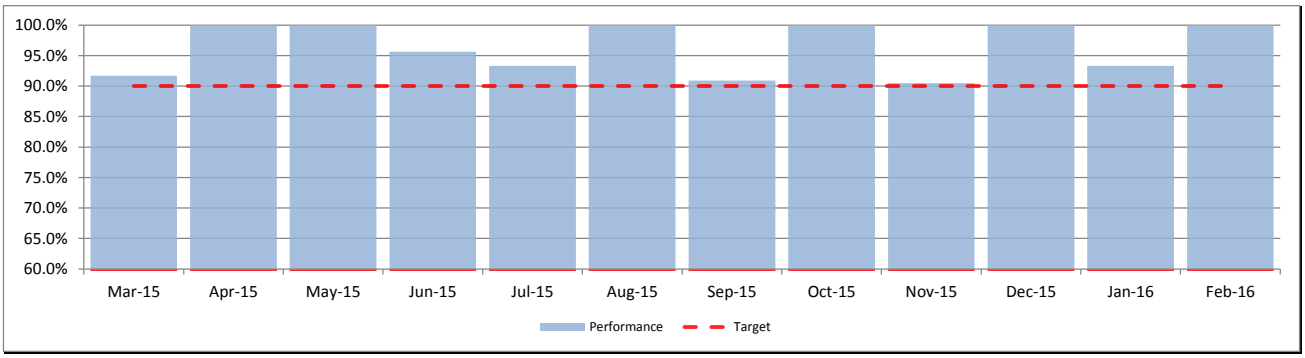
62 day 1st treatment from two week wait referral - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	108	75.5	73	92.5	85.5	77.5	98	100	76	75	79	83.5
62 day 1st treatment breaches	16	3	5.5	14.5	6	7.5	12	13.5	9	8.5	7	8
Performance	85.2%	96.0%	92.5%	**84.3%**	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.1%	90.4%
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%



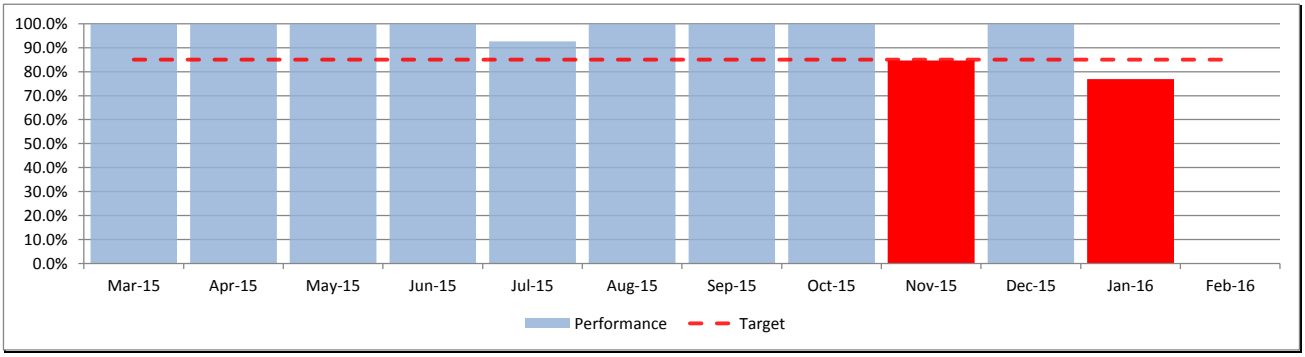
62 day 1st treatment from screening

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	12	9.5	11	11.5	7.5	8	11	11	10.5	15.5	15	7
62 day 1st treatment breaches	1	0	0	0.5	0.5	0	1	0	1	0	1	0
Performance	91.7%	100.0%	100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



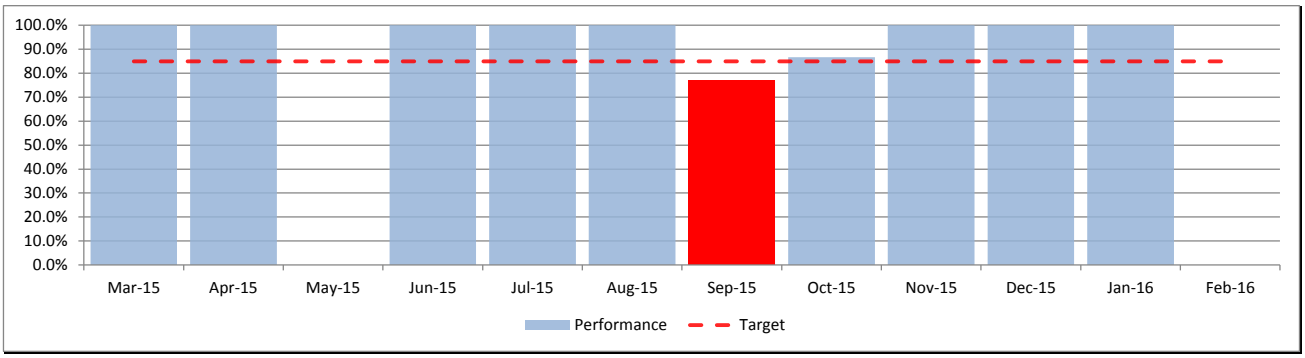
62 day 1st treatment from two week wait referral - BREAST

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	10	10	10	9	13.5	10	14	8	13	9	13	0
62 day 1st treatment breaches	0	0	0	0	1	0	0	0	2	0	3	0
Performance	100.0%	100.0%	100.0%	100.0%	92.6%	100.0%	100.0%	100.0%	84.6%	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%



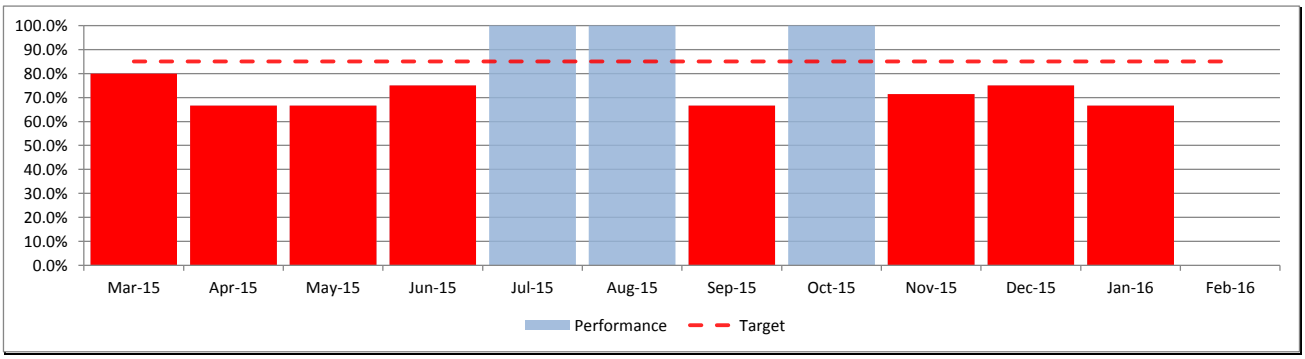
62 day 1st treatment from two week wait referral - GYNAECOLOGY

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	4	3.5	0	1.5	2	1	6.5	7.5	5	2.5	3.5	0
62 day 1st treatment breaches	0	0	0	0	0	0	1.5	1	0	0	0	0
Performance	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	76.9%	86.7%	100.0%	100.0%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



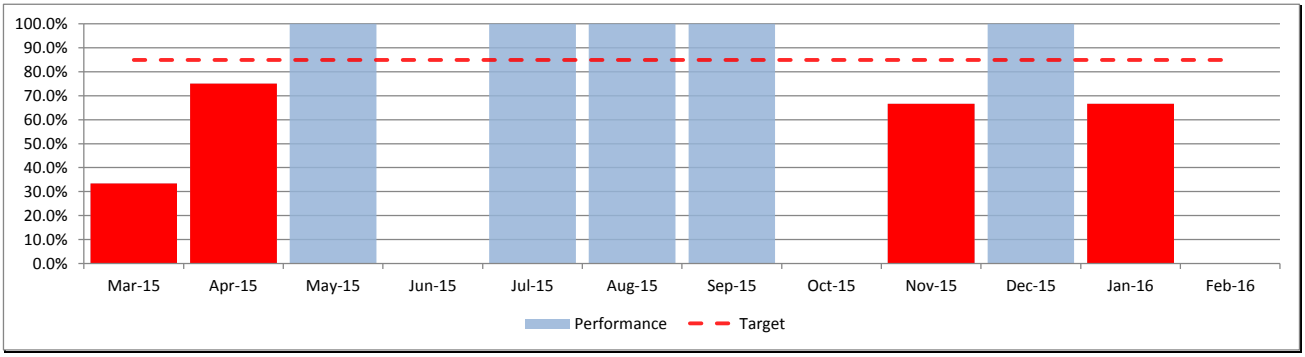
62 day 1st treatment from two week wait referral - HAEMATOLOGY

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	5	3	3	4	4	3	3	2	7	4	3	0
62 day 1st treatment breaches	1	1	1	1	0	0	1	0	2	1	1	0
Performance	80.0%	66.7%	66.7%	75.0%	100.0%	100.0%	66.7%	100.0%	71.4%	75.0%	66.7%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



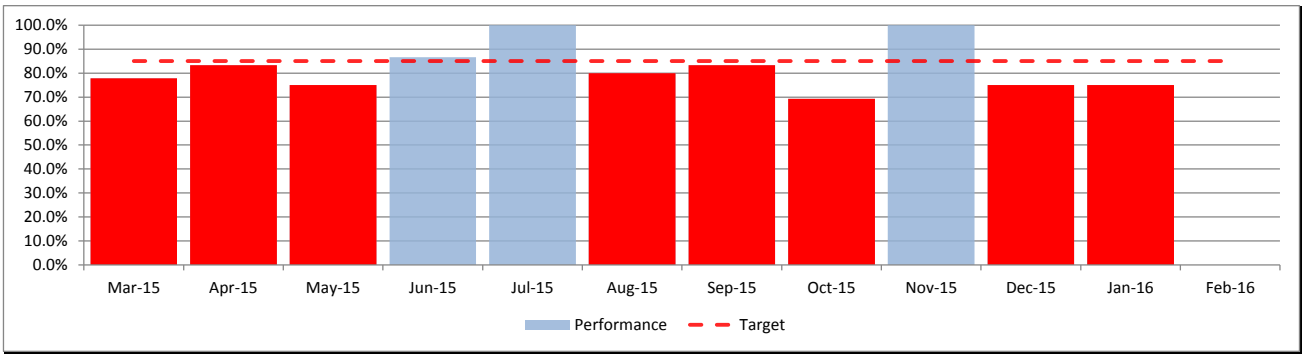
62 day 1st treatment from two week wait referral - HEAD AND NECK

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	4.5	4	1	4	5.5	2	2	0.5	3	1.5	3	0
62 day 1st treatment breaches	3	1	0	4	0	0	0	0.5	1	0	1	0
Performance	33.3%	75.0%	100.0%	0.0%	100.0%	100.0%	100.0%	0.0%	66.7%	100.0%	66.7%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



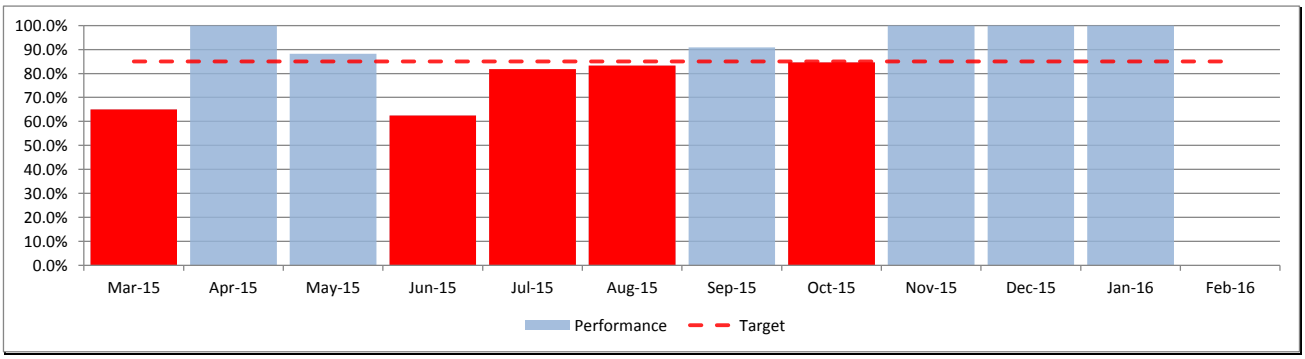
62 day 1st treatment from two week wait referral - LOWER GI

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	9	6	4	7.5	7	10	12	13	1	8	8	0
62 day 1st treatment breaches	2	1	1	1	0	2	2	4	0	2	2	0
Performance	77.8%	83.3%	75.0%	86.7%	100.0%	80.0%	83.3%	69.2%	100.0%	75.0%	75.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



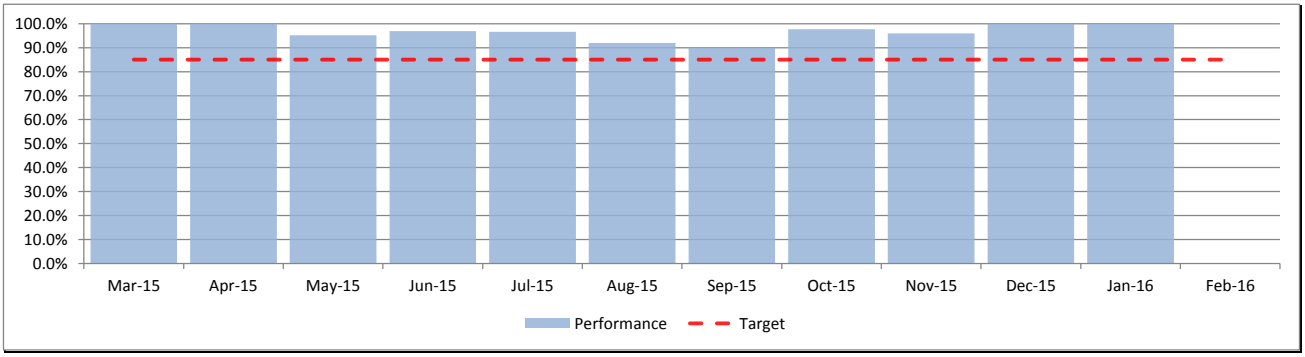
62 day 1st treatment from two week wait referral - LUNG

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	10	5	8.5	8	5.5	6	5.5	13	6	2	2	0
62 day 1st treatment breaches	3.5	0	1	3	1	1	0.5	2	0	0	0	0
Performance	65.0%	100.0%	88.2%	62.5%	81.8%	83.3%	90.9%	84.6%	100.0%	100.0%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



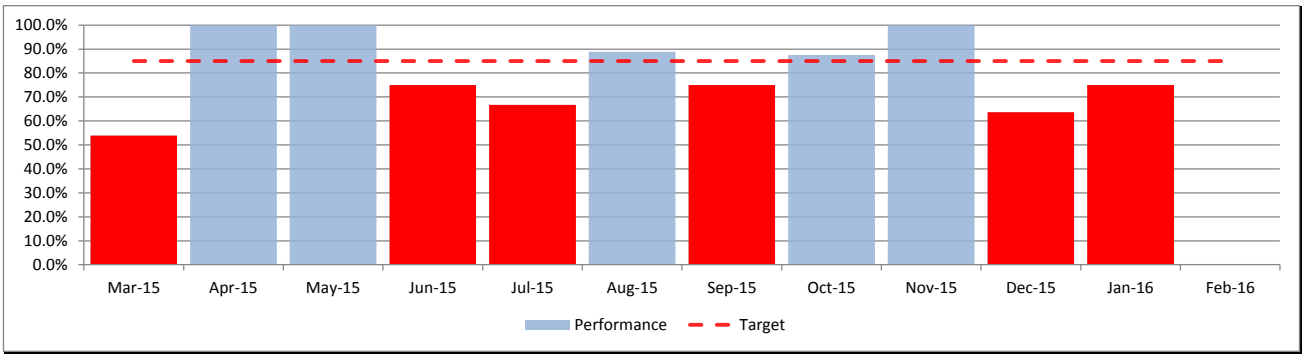
62 day 1st treatment from two week wait referral - SKIN

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	26	24	21	33	30	25	30	22.5	25	20	22.5	0
62 day 1st treatment breaches	0	0	1	1	1	2	3	0.5	1	0	0	0
Performance	100.0%	100.0%	95.2%	97.0%	96.7%	92.0%	90.0%	97.8%	96.0%	100.0%	100.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



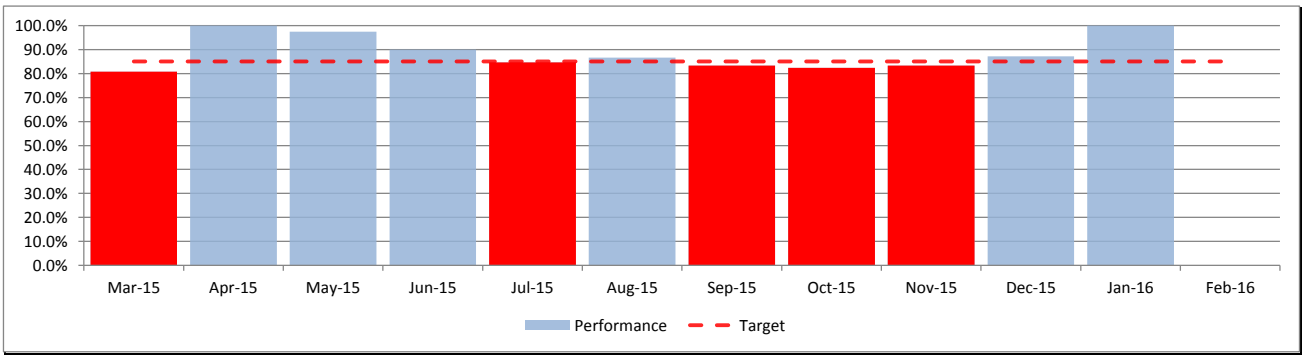
62 day 1st treatment from two week wait referral - UPPER GI

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	6.5	5	1	4	3	4.5	4	8	2	5.5	4	0
62 day 1st treatment breaches	3	0	0	1	1	0.5	1	1	0	2	1	0
Performance	53.8%	100.0%	100.0%	75.0%	66.7%	88.9%	75.0%	87.5%	100.0%	63.6%	75.0%	#DIV/0!
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



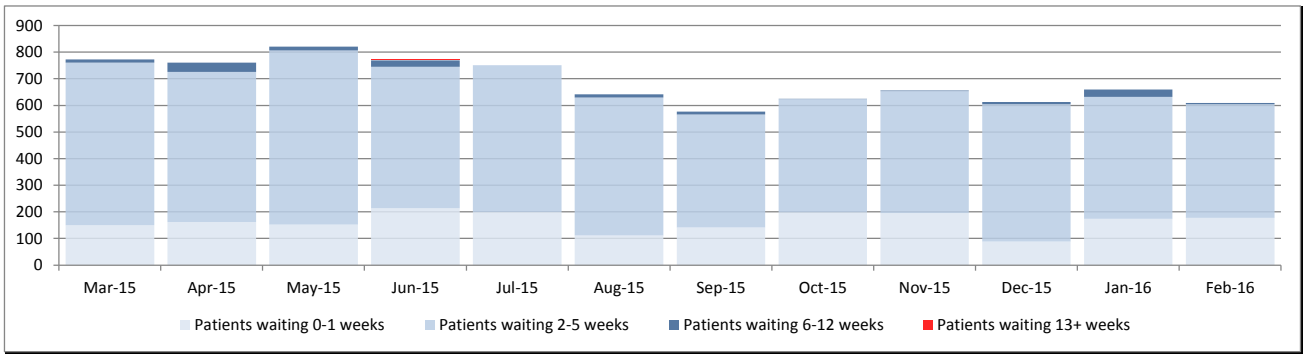
62 day 1st treatment from two week wait referral - UROLOGY

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
62 day 1st treatments	23.5	12	19.5	20	13	15	18	25.5	12	19.5	16	0
62 day 1st treatment breaches	4.5	0	0.5	2	2	2	3	4.5	2	2.5	0	0
Performance	80.9%	100.0%	97.4%	90.0%	84.6%	86.7%	83.3%	82.4%	83.3%	87.2%	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%



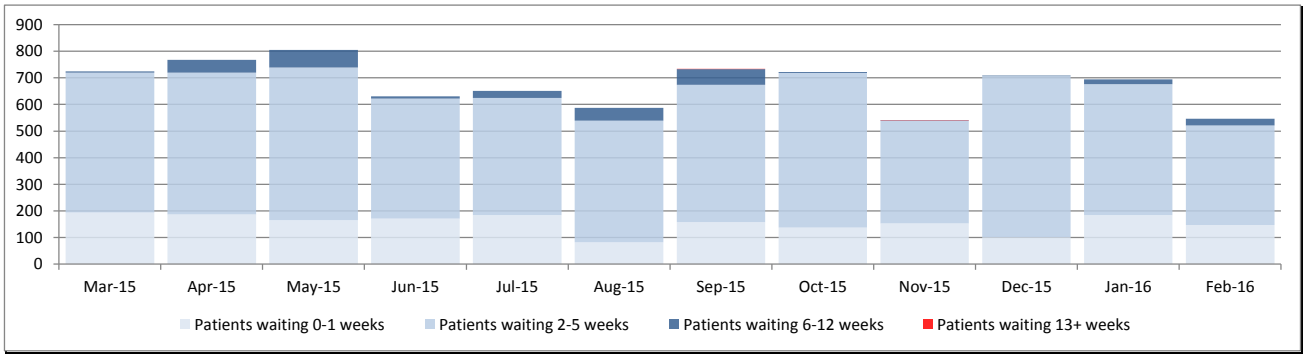
MRI Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	150	162	152	213	199	111	142	198	195	89	174	177
Patients waiting 2-5 weeks	610	564	654	532	552	519	424	425	459	515	458	427
Patients waiting 6-12 weeks	13	35	14	24	0	12	10	2	2	9	28	5
Patients waiting 13+ weeks	0	0	0	4	0	0	0	0	0	0	0	0



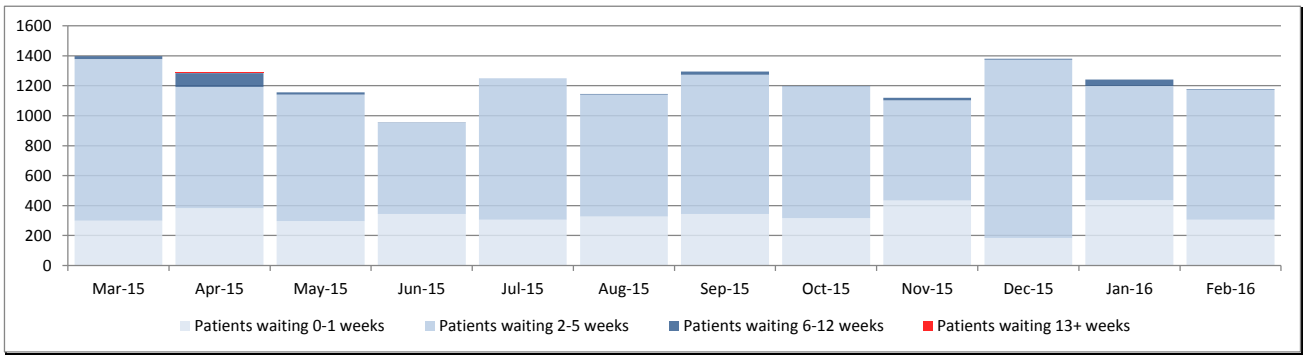
CT Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	194	187	165	171	184	82	158	138	153	102	184	147
Patients waiting 2-5 weeks	525	533	574	451	441	457	516	580	387	604	492	374
Patients waiting 6-12 weeks	5	48	66	9	26	48	59	4	1	2	18	25
Patients waiting 13+ weeks	0	0	0	0	0	0	1	0	1	0	0	0



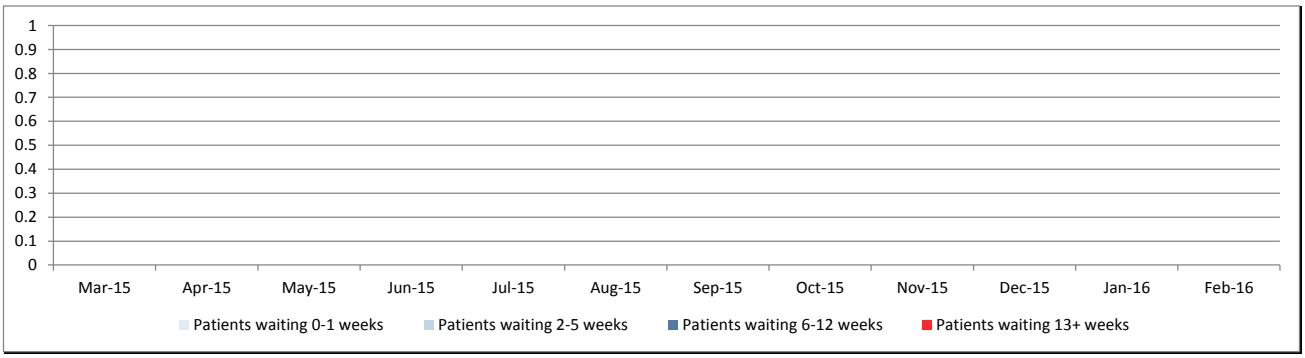
Non-Obstetric Ultrasound Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	299	382	296	344	306	327	345	316	434	184	436	306
Patients waiting 2-5 weeks	1079	811	846	610	943	814	928	881	668	1191	762	868
Patients waiting 6-12 weeks	19	92	15	1	0	5	21	2	17	5	44	3
Patients waiting 13+ weeks	0	1	0	0	0	0	0	0	0	0	0	0



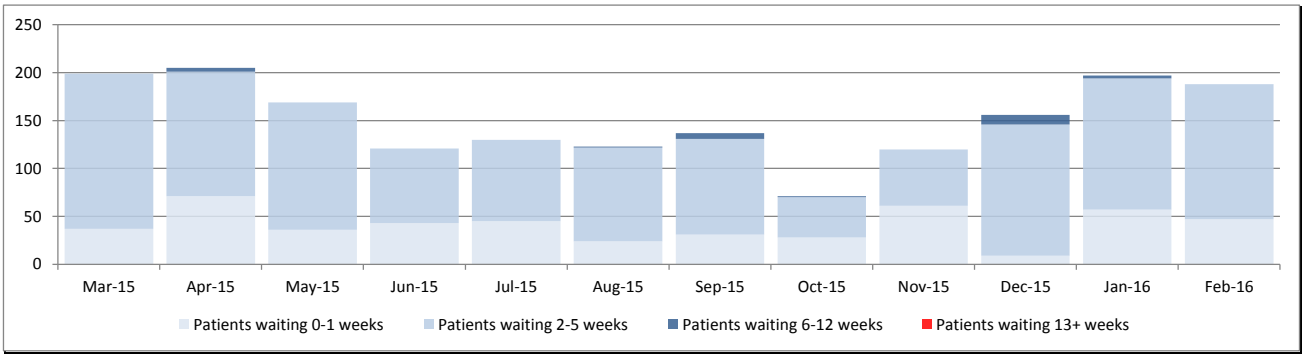
Barium Enema Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 2-5 weeks	0	0	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



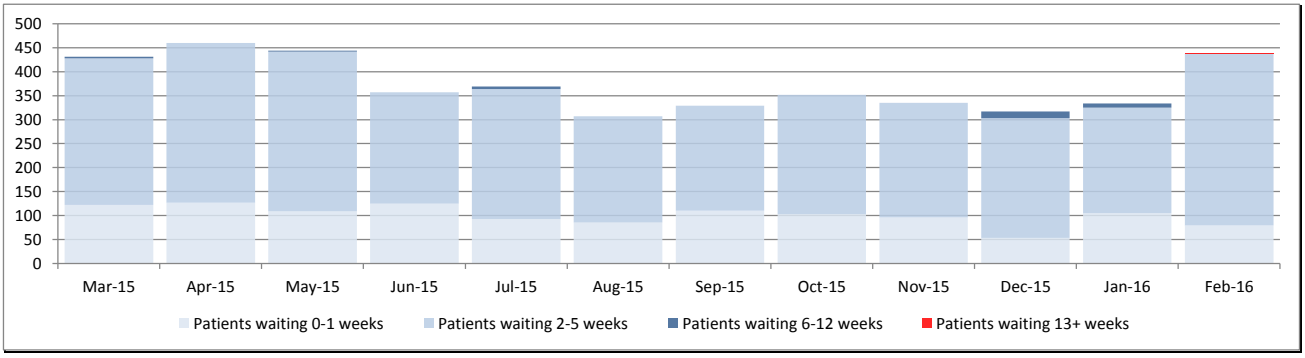
Dexa Scan Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	37	71	36	43	45	24	31	28	61	9	57	47
Patients waiting 2-5 weeks	162	130	133	78	85	98	100	42	59	137	137	141
Patients waiting 6-12 weeks	0	4	0	0	0	1	6	1	0	10	3	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



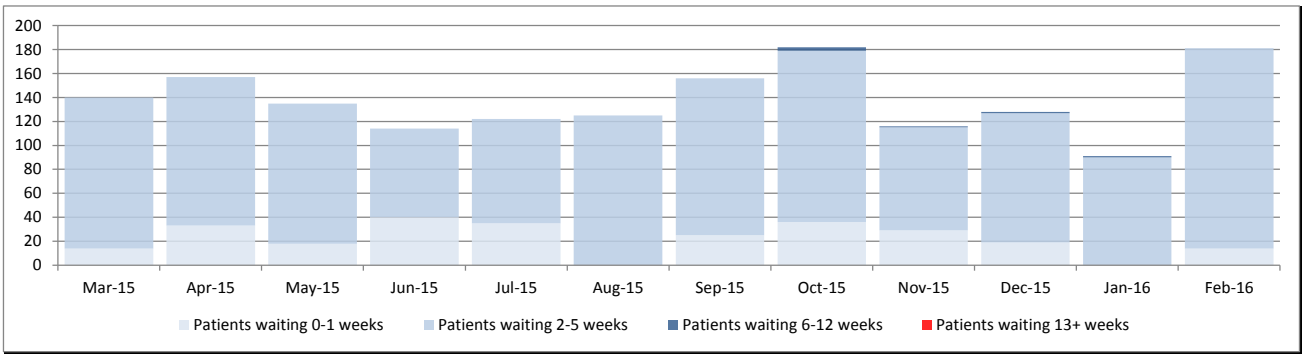
Audiology Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	122	127	109	125	93	85	110	103	96	53	105	79
Patients waiting 2-5 weeks	306	333	333	232	271	222	219	249	239	250	220	359
Patients waiting 6-12 weeks	3	0	2	0	5	0	0	0	0	14	9	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	2



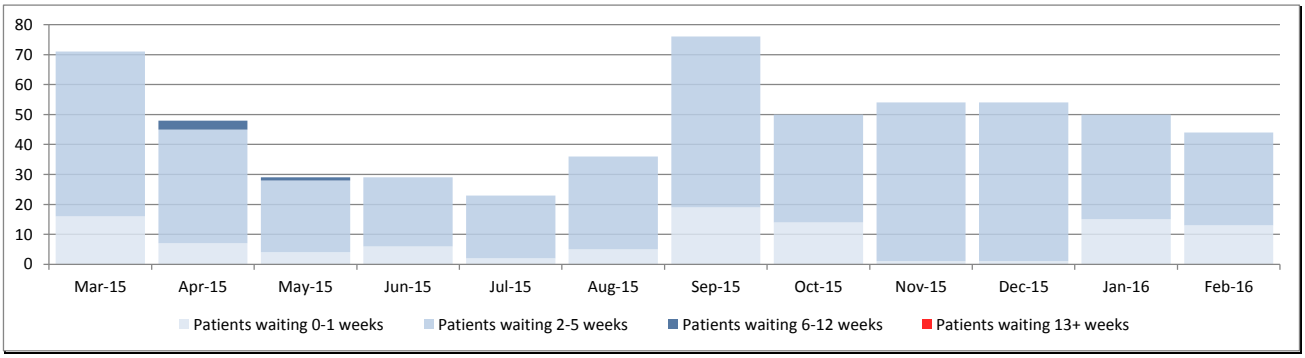
Cardiology (Echocardiology) Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	14	33	18	40	35	0	25	36	29	19	0	14
Patients waiting 2-5 weeks	126	124	117	74	87	125	131	143	86	108	90	167
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	3	1	1	1	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



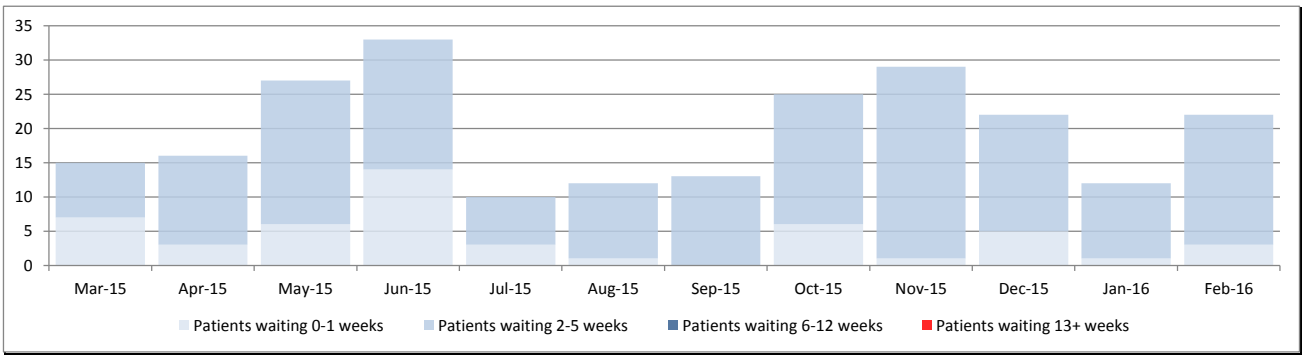
Neurophysiology Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	16	7	4	6	2	5	19	14	1	1	15	13
Patients waiting 2-5 weeks	55	38	24	23	21	31	57	36	53	53	35	31
Patients waiting 6-12 weeks	0	3	1	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



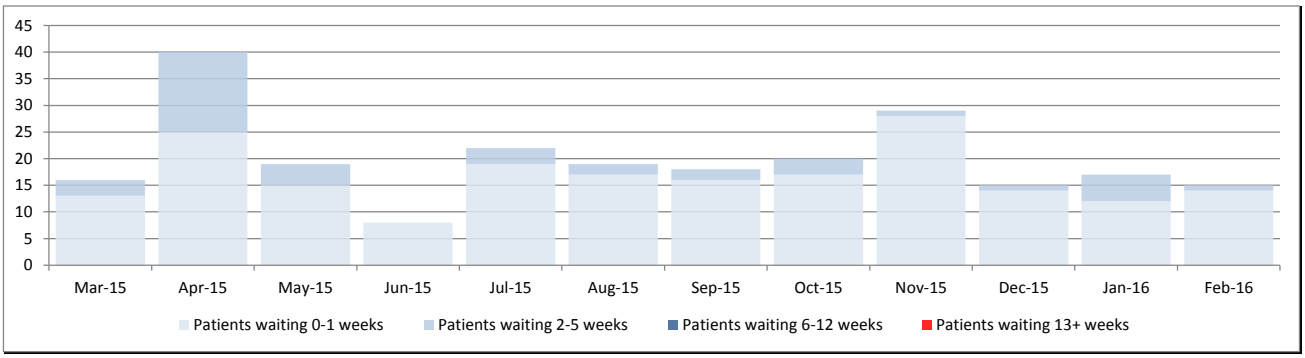
Respiratory Physiology - Sleep Studies

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	7	3	6	14	3	1	0	6	1	5	1	3
Patients waiting 2-5 weeks	8	13	21	19	7	11	13	19	28	17	11	19
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	0	0	0	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



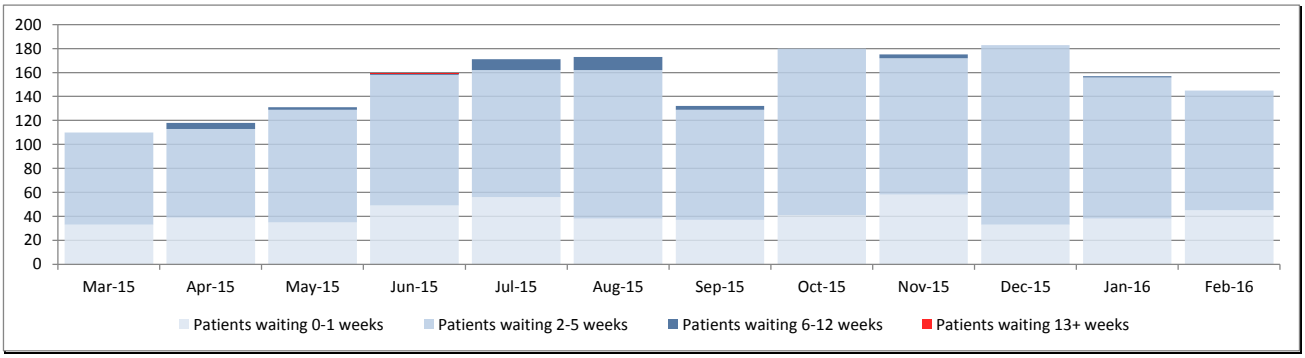
Urodynamics - Pressures & Flows

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	13	25	15	8	19	17	16	17	28	14	12	14
Patients waiting 2-5 weeks	3	15	4	0	3	2	2	3	1	1	5	1
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



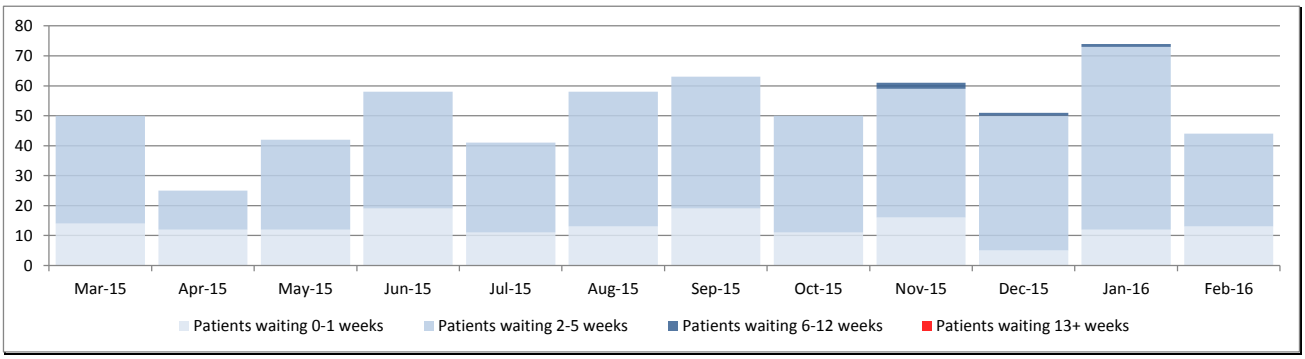
Colonoscopy Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	33	39	35	49	56	38	37	41	58	33	38	45
Patients waiting 2-5 weeks	77	74	94	109	106	124	92	139	114	150	118	100
Patients waiting 6-12 weeks	0	5	2	1	9	11	3	0	3	0	1	0
Patients waiting 13+ weeks	0	0	0	1	0	0	0	0	0	0	0	0



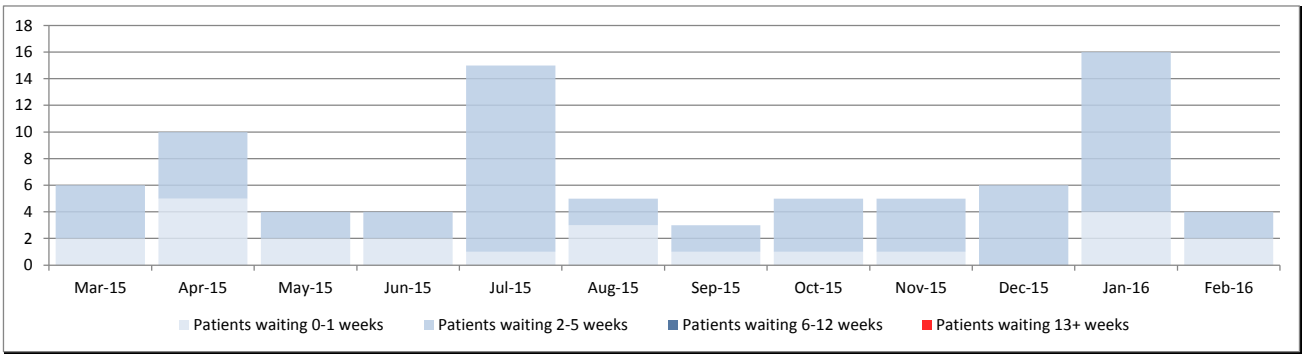
Flexi Sigmoidoscopy Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	14	12	12	19	11	13	19	11	16	5	12	13
Patients waiting 2-5 weeks	36	13	30	39	30	45	44	39	43	45	61	31
Patients waiting 6-12 weeks	0	0	0	0	0	0	0	0	2	1	1	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



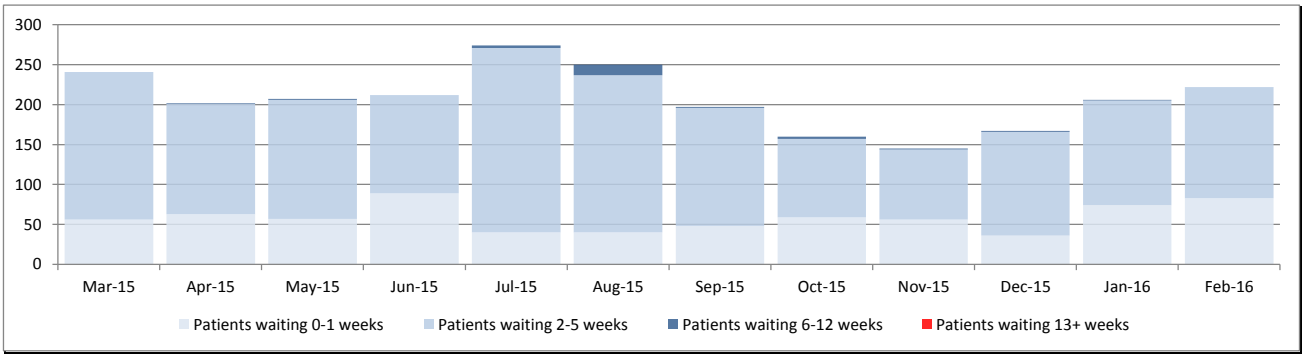
Cystoscopy Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	2	5	2	2	1	3	1	1	1	0	4	2
Patients waiting 2-5 weeks	4	5	2	2	14	2	2	4	4	6	12	2
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



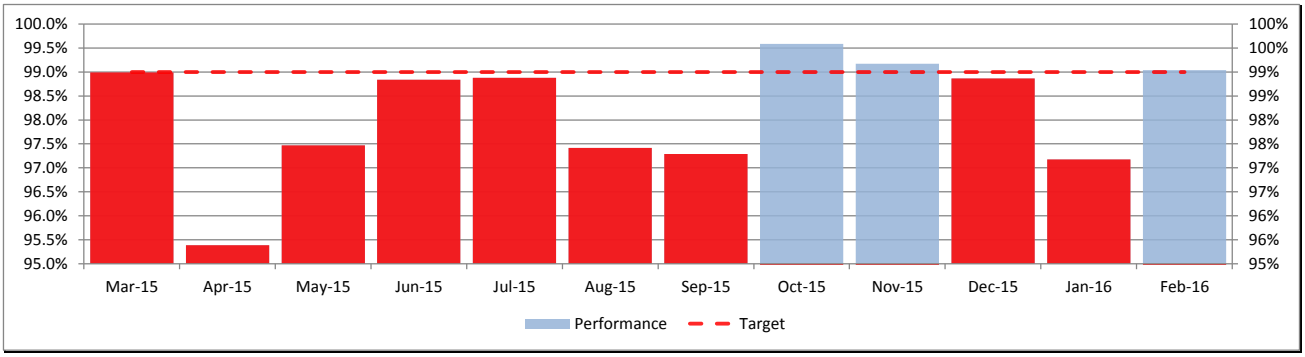
Gastroscopy Waiting Times

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients waiting 0-1 weeks	56	63	57	89	40	40	48	59	56	36	74	83
Patients waiting 2-5 weeks	185	138	149	123	231	197	148	98	88	130	131	139
Patients waiting 6-12 weeks	0	1	1	0	3	13	1	3	1	1	1	0
Patients waiting 13+ weeks	0	0	0	0	0	0	0	0	0	0	0	0



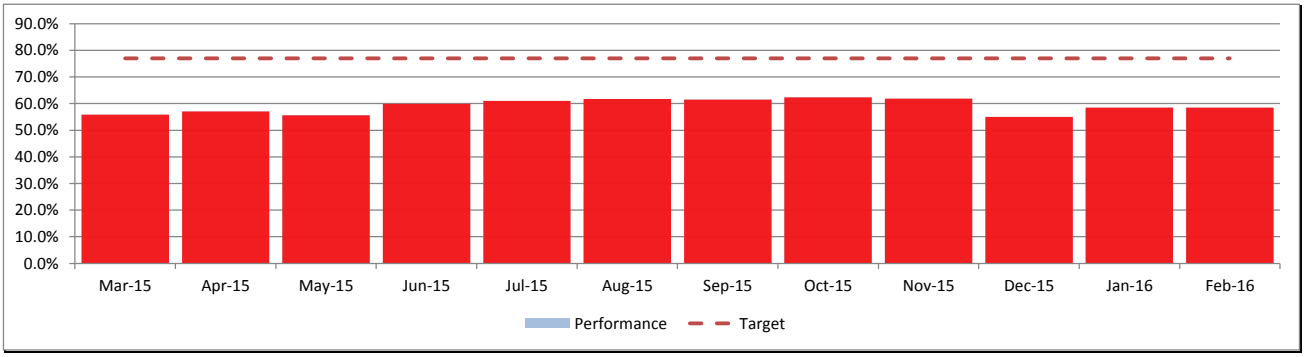
Overall diagnostic position

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Total waits	4158	4096	3989	3455	3828	3483	3728	3641	3386	3800	3750	3637
Total breaches (6+ weeks)	42	189	101	40	43	90	101	15	28	43	106	35
Performance	99.0%	95.4%	97.5%	98.8%	98.9%	97.4%	97.3%	99.6%	99.2%	98.9%	97.2%	99.0%
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%



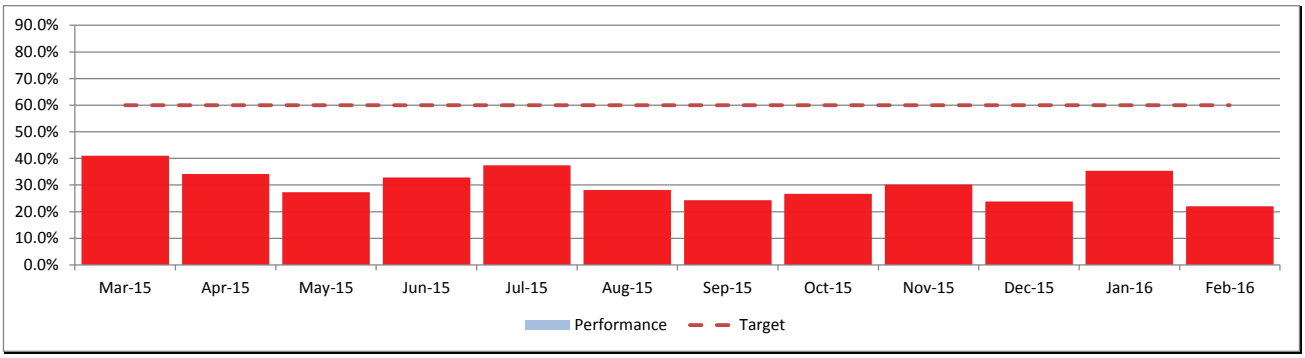
CPS completed within 24 hours - Weekday - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients	2140	2066	1701	1833	1913	1673	1893	1840	1831	1863	1705	1860
CPS completed within 24 hours	1194	1179	946	1099	1167	1032	1165	1148	1132	1025	997	1089
Performance	55.8%	57.1%	55.6%	60.0%	61.0%	61.7%	61.5%	62.4%	61.8%	55.0%	58.5%	58.5%
Target	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%



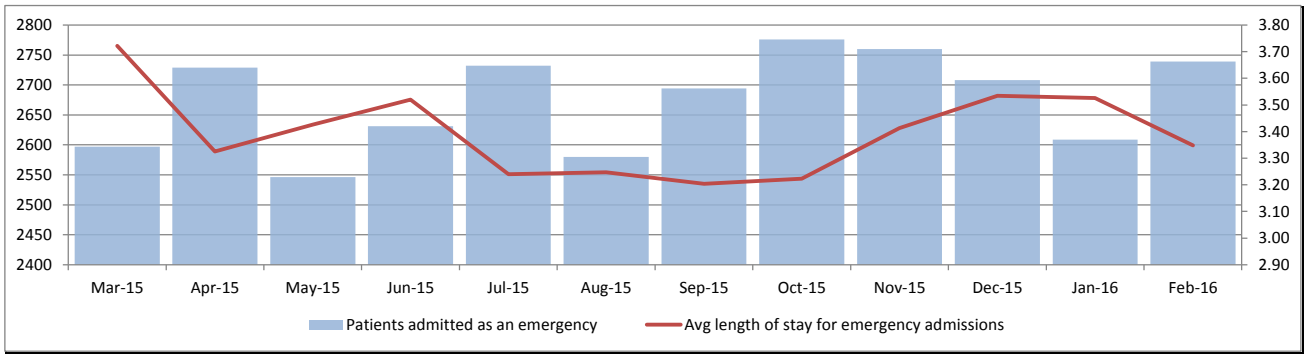
CPS completed within 24 hours - Weekend - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients	529	506	524	418	423	565	444	495	444	390	470	414
CPS completed within 24 hours	217	173	143	137	158	159	108	132	134	93	166	91
Performance	41.0%	34.2%	27.3%	32.8%	37.4%	28.1%	24.3%	26.7%	30.2%	23.8%	35.3%	22.0%
Target	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%



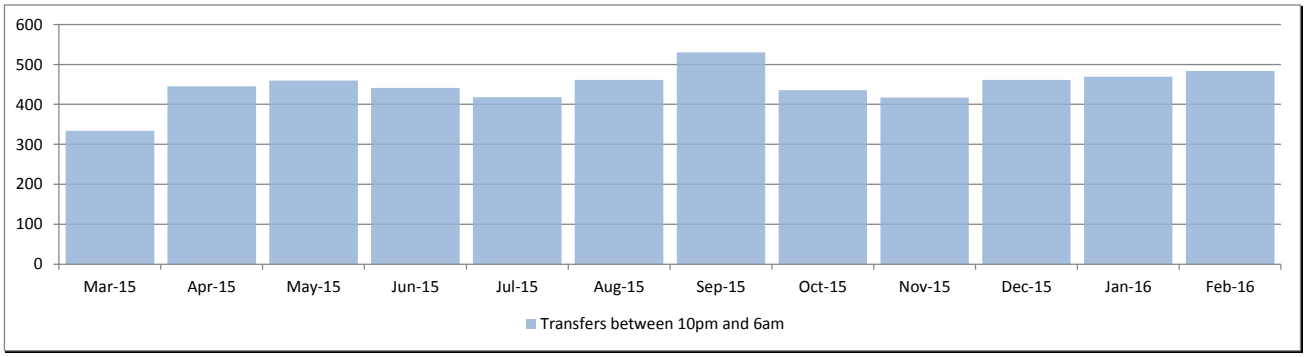
Emergency admissions - Trust Total

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Patients admitted as an emergency	2597	2729	2546	2631	2732	2580	2694	2776	2760	2708	2609	2739
Avg length of stay for emergency admissions	3.72	3.32	3.43	3.52	3.24	3.25	3.20	3.22	3.41	3.53	3.53	3.35



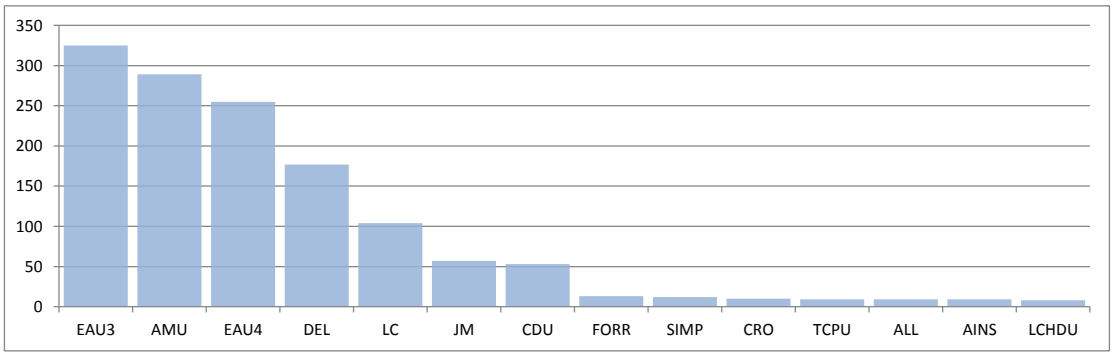
Transfers

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Transfers between 10pm and 6am	334	445	460	441	418	461	530	436	417	461	469	484
Transfers between 10pm and midnight	139	158	173	181	167	173	186	176	171	173	202	188
Transfers between midnight and 2am	107	140	148	139	132	137	179	111	112	153	131	177
Transfers between 2am and 4am	50	83	88	72	69	87	106	100	76	70	84	57
Transfers between 4am and 6am	38	64	51	49	50	64	59	49	58	65	52	62



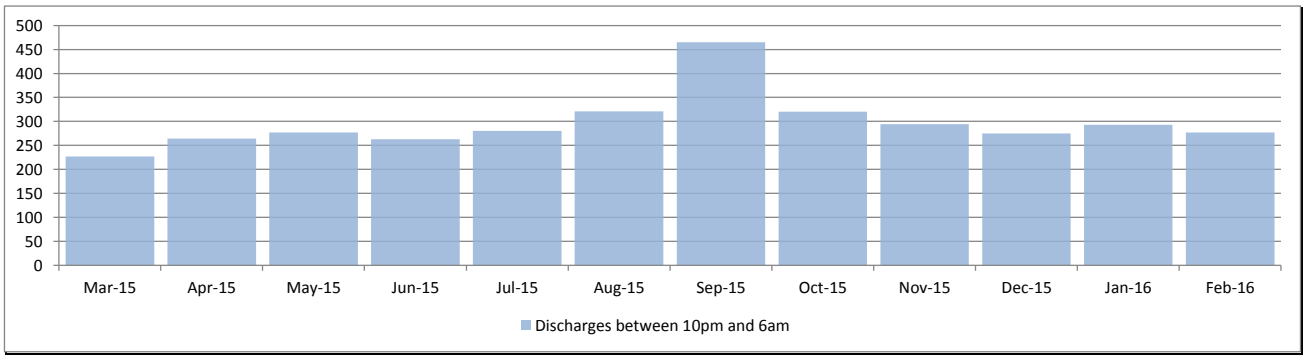
Night time transfers by ward (last 3 months)

Ward	Transfers
EAU3	325
AMU	289
EAU4	255
DEL	177
LC	104
JM	57
CDU	53
FORR	13
SIMP	12
CRO	10
TCPU	9
ALL	9
AINS	9
LCHDU	8



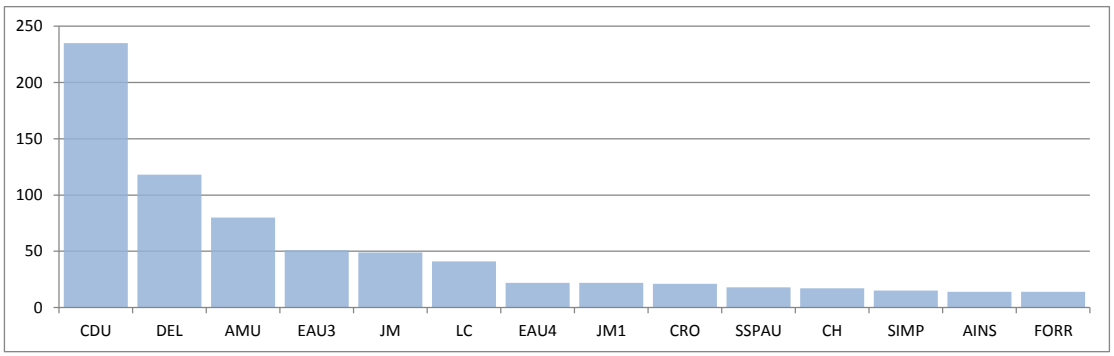
Discharges

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Discharges between 10pm and 6am	227	264	277	263	280	321	465	320	294	275	293	277
Discharges between 10pm and midnight	109	134	138	131	144	138	289	154	129	130	140	145
Discharges between midnight and 2am	62	67	76	63	73	92	88	78	91	76	84	71
Discharges between 2am and 4am	32	46	42	49	37	55	47	54	40	42	47	34
Discharges between 4am and 6am	24	17	21	20	26	36	41	34	34	27	22	27



Night time discharges by ward (last 3 months)

Ward	Discharges
CDU	235
DEL	118
AMU	80
EAU3	51
JM	49
LC	41
EAU4	22
JM1	22
CRO	21
SSPAU	18
CH	17
SIMP	15
AINS	14
FORR	14



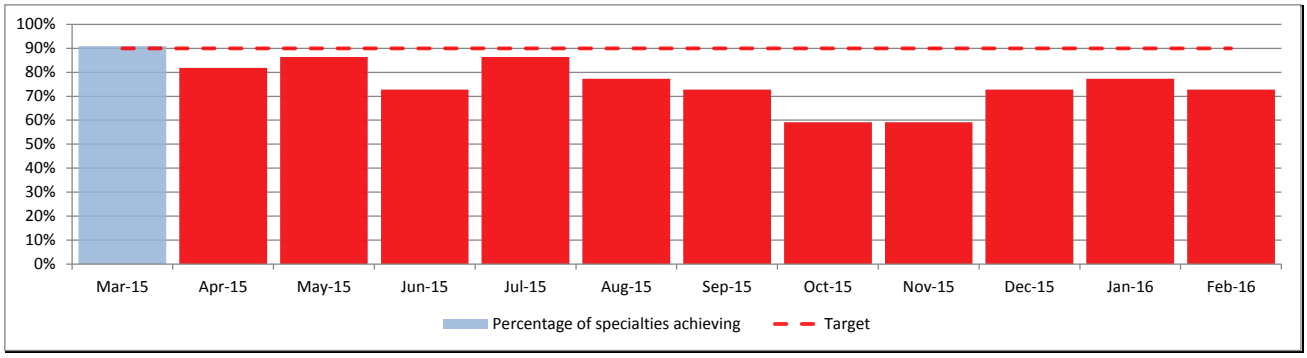
Night time discharges commentary

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

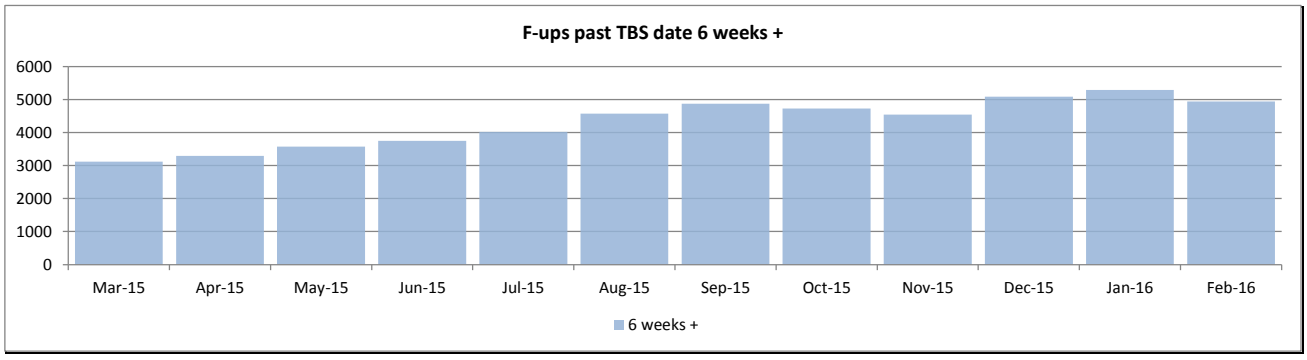
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Specialties breaching	2	4	3	6	3	5	6	9	9	6	5	6
Percentage of specialties achieving	91%	82%	86%	73%	86%	77%	73%	59%	59%	73%	77%	73%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%



Follow up appointments past to be seen date

	0-6 Weeks	6-12 Weeks	12-18 Weeks	18 Weeks +	Grand Total
Audiology	45	4	1	4	54
Breast Surgery	194	3	1	0	198
Cardiology	114	45	72	101	332
Colorectal Surgery	7	3	8	4	22
Dermatology	248	159	107	112	626
Diabetic Medicine	52	43	20	32	147
ENT	270	100	36	144	550
Endocrinology	76	11	1	1	89
Gastroenterology	27	13	28	54	122
General Medicine	7	0	0	0	7
Geriatric Medicine	9	7	3	0	19
Gynaecology	44	32	13	4	93
Medical Oncology	0	0	0	1	1
Nephrology	30	4	0	0	34
Neurology	136	23	20	14	193
Ophthalmology	1231	605	758	641	3235
Oral Surgery	75	9	21	15	120
Orthodontics	92	21	0	0	113
Orthoptics	320	70	40	28	458
Paediatrics	250	92	91	125	558
Pain Management	26	3	8	29	66
Plastic Surgery	50	27	24	21	122
Podiatry	0	0	0	0	0
Respiratory Medicine	115	68	82	28	293
Restorative Dentistry	5	2	0	0	7
Rheumatology	396	186	311	254	1147
Thoracic Surgery	0	0	0	0	0
Trauma & Orthopaedics	50	16	4	2	72
Upper Gastrointestinal Surgery	18	16	13	13	60
Urology	41	22	27	38	128
Vascular Surgery	1	0	0	0	1
Total	3929	1584	1689	1665	8867

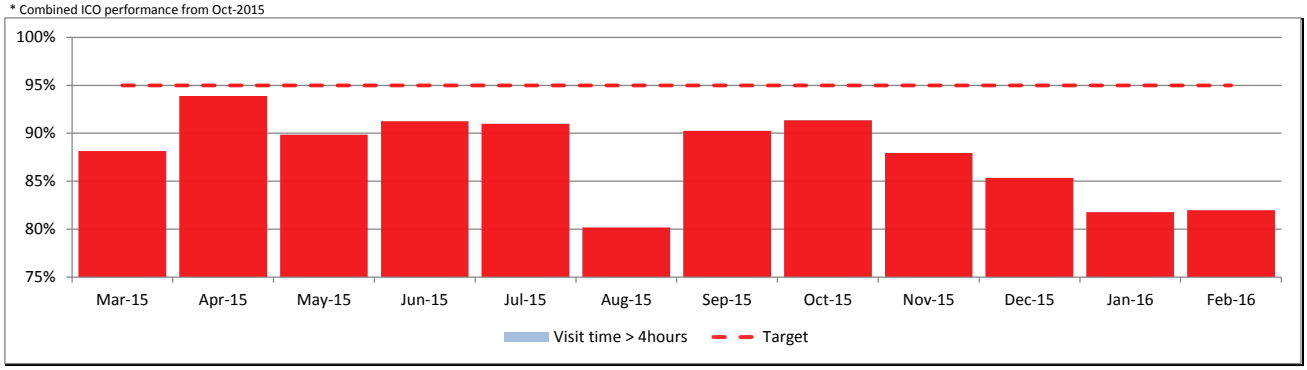
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
0-6 weeks	3309	3307	3781	4105	4211	4068	3886	3794	3556	4195	4500	3929
6-12 weeks	1072	1253	1274	1337	1511	1593	1771	1589	1546	1697	1685	1584
12-18 weeks	1046	1044	1196	1344	1420	1761	1778	1754	1608	1836	1924	1689
18 weeks +	997	997	1107	1064	1089	1216	1324	1388	1388	1557	1682	1665
6 weeks +	3115	3294	3577	3745	4020	4570	4873	4731	4542	5090	5291	4938



Time spent in A&E

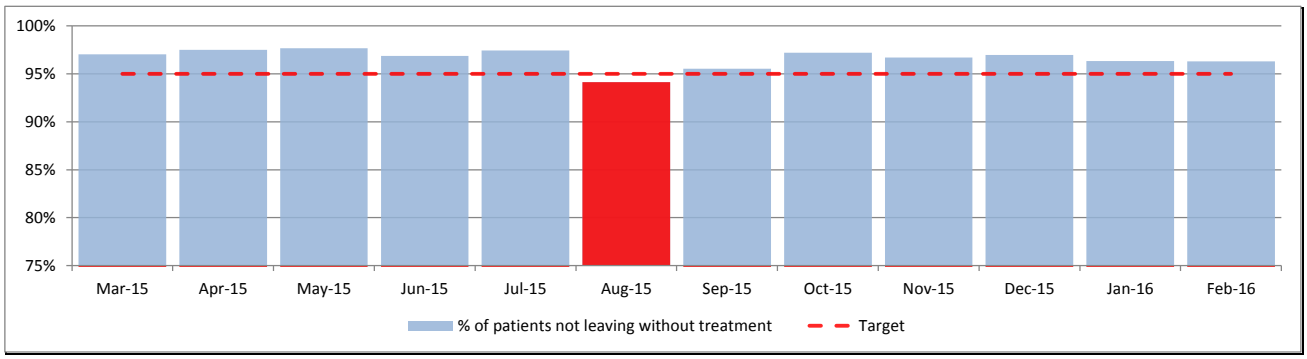
	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
A&E attendances	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135	8223	8084
Percentage of patients treated within 4 hours	758	394	674	571	608	1232	594	753	1020	1192	1500	1459
Visit time > 4hours	88%	94%	90%	91%	91%	80%	90%	91%	88%	85%	82%	82%
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

	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
A&E attendances	6397	6446	6646	6518	6752	6209	6087	8712	8451	8135	8223	8084
Percentage of patients treated within 4 hours	189	160	154	204	172	365	271	243	277	245	302	300
% of patients not leaving without treatment	97%	98%	98%	97%	97%	94%	96%	97%	97%	97%	96%	96%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%



1. Quality: Rapid Action Plan in response to CQC

Date Last Updated: 18.03.16

Management Lead: Shely Machin
Executive Lead: Jane Viner

			Governance/ Accountability								
Objective	**Action no**	**Action**	**Executive Lead**	**Clinical Lead**	**Management Lead**	**Action Lead**	**Timescale/ Deadline**	**Status**	**Metrics/Measurement**	**Progress Update**	**Evidence/ Assurance**	**CQC KLOE**
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	1	**Update the Emergency Department (ED) Flow dashboard data to include** - Time to initial clinical assessment (first set of observations EWS) - Time to ED doctor assessment banded - Overcrowding score from Alamac system - Ttme to triage triage data available on ED revised dashboard, split by time band.	Ann Wagner	N/A	John Harrison	Stephen Macey (Information Team)	07/03/2016	Complete	% seen in 15 mins banded Time to ED Doctor Assessment banded Crowding score % of times RAG last 7 days	ED dashboard is in process of being updated to include specified criteria listed - in development due close of play 7/3/16. However, this information is available on Symphony for every patient and can be interrogated individually in the interim. 08/03/16 achieved 91% compliance JV Triage data, split by time band has been developed and is available on the revised ED Dashboard	Clarification - initial clinical assessment and time to triage same or different?	
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	2	a) **Rollout of updated dashboard to ED department** for the shift co-ordinator and control room in order to proactively manage patient flow (this will facilitate immediate escalation of variance to the ED lead clinician and control room team as deatiled in SoP, should performance vary. b) **Information to be visible via current PC screen in ED and additional screen installed**, to improve visibility of information to whole ED team.	Ann Wagner	N/A	John Harrison	Dave Hayes (HIS Team)	07/03/2016	Complete	Record number of times dashboard is refreshed per day.	a) Large screen being fitted in ED staff base w/e 11/3/16 to ensure that data is readily available to staff. Synchronised display implemented in the control room. b) Live dashboard is also available on ED PC screen and additional display has been installed to facilitate access to data - completed JV 09/03/16.	Visual check week beginning 143/16 whether board displayed and discussed during control meetings Rollout to ANU ext step after control room & ED	
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	3	**Escalation process put in place triggered by Alamac crowding tool (every 2 hours) in line with ED escalation SoP**	Liz Davenport	Chris Manlow	Cathy Gardner	Shelly Machin (DGM)	07.03.16	Complete	N/A	Escalation process triggered by ED crowding tool is now in place and being utilised - SoP triggered internal incident 07/03/16		
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	4	**Observation escalation process: variance reported by ED co-ordinator to control room and actioned by the ED Clinical Director management team.**	Liz Davenport	Chris Manlow	Cathy Gardner	Lisa Houlihan (matron), Nick Mathieu (consultant)	07/03/2016	Complete	Daily Summary of initial assessment performance (time banded).	Variance reporting is now taking place as described. SoP complete and informed a move to Internal Significant Incident on 07/03/16		
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	5	Audit of performance / compliance to be **undertaken via Symphony data on a daily basis and a daily report submitted to the control room team**.	Liz Davenport	Chris Manlow	Cathy Gardner	Performance Lead PP	07/03/2016	Complete	% seen in 15 mins banded.	Symphony audit of compliance data is now being undertaken on a daily basis - over the weekend, the compliance rate was as follows: Sat 5/3 = 54.5% Sun 6/3 = 56.0% Following the changes described (fast registration pod implementation), which started on 7/3, the report shows		
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	6	**Doctor review within 60 minutes to be discussed at control meetings 3 times a day, escalated to on call manager.**	Liz Davenport	Chris Manlow	Cathy Gardner	Shelly Machin (DGM)	07.03.16	Complete	Observations	Live performance re: Doctor review within 60 minutes is being discussed at control meetings 3 times a day. Escalation process to on-call manager. Monitoring in placer, links to ED escalation SoP		
Real time monitoring of ED, CDU & AMU activity and patient flow across all bed based care acccessible & visible from ward to board level, enabling pro-active management 7 days a week	7	**Daily audit of new initial clinical assessment system** (obs undertaken at SWAST handover) and, **Added to the SoP for escalation to demonstrate reliability and added to ED dashboard monthly** and, **Added to the Quality Improvement Group performance dashboard and the Board performance dashboard.**	Liz Davenport	Chris Manlow	Cathy Gardner	Shelly Machin (DGM)	02/03/2016			Daily audit of new initial clinical assessment process for patients arriving by ambulance is now taking place. Data to be added to the Quality Improvement Group performance dashboard and the Board performance dashboard with immediate effect (7/3/16). We will add time to triage compliance data to QIG performance dashboard, this will be reported to Board	How is the audit being undertaken and data recorded and who will be undertaking the audit?	

Improve the timeliness to be seen (time for arrival to triage & doctor)	2	**Implementation of new triage system in ED Waiting Room** 1. Fast registration (recording time of arrival) will be implemented with registered nurse sited in the waiting room carrying out initial observations and assessing risk. 2. Patient to then fully register at reception desk. 3. Additional 24/7 HCA to be allocated (initially via bank)	Jane Viner	Chris Manlow	Shelly Machin (TBC)	Lisa Houlihan (matron)	07/03/2016		Performance compliance with initial assessment within 15 mins P1O64 performance report.	A fast registration pod is now in place in the waiting room for patients as soon as they arrive, before they register fully at reception. This is overseen by a Registered Nurse. An additional HCA has been allocated to support the fast registration process 24/7. Small rapid tests of change with pathway being mapped.		Avoidance of new harm KLOE C1
Improve the timeliness to be seen (time for arrival to triage & doctor)	9	**Purchase of ticket machine: Ticket in turn system** to be piloted for walk-in patients and ambulance patients fit for the waiting room (piloted in other ED departments)	Jane Viner	Chris Manlow	Shelly Machin (TBC)	Lisa Houlihan (matron)	21/03/2016		N/A	Ticket machine procured, install w/c 14/03/16		
Improve the timeliness to be seen (time for arrival to triage & doctor)	10	**Pathway redesign of ED pathway** (Majors & Minors) as a result of implementing and testing new triage	Jane Viner	Chris Manlow	Shelly Machin (TBC)	Chris Manlow (Clinical Director)						
Improve the timeliness to be seen (time for arrival to triage & doctor)	11	A series of measures have been planned to free up more senior ED doctor time to enable the introduction of a 'Pit stop' system. This system works in conjunction with the nurse-co-ordinator (who will have taken immediate set of obs) to ensure that once a patient has been handed over from SWAST, that a doctor based within RAA can commence immediate assessment. The actions to release this time are listed below:- (a) **Rapid review of performance and governance framework and enhanced process to support Board governance process as previously referenced.** We have put in place enhanced daily reporting against key standard. b**) Enhance current Rapid Assessment Area (RAA) process to deliver 15 mins to first nurse assessment and 60 mins to first Medical assessment.** 'Golden Hour' triage actions in place and monitored (pain relief, diagnostics ordered, etc). Senior Dr allocated to RAA Alamac tracking of compliance through use of crowding tool.	Jane Viner	Chris Manlow	Shelly Machin (TBC)	Dr Ben Benjamin	07/03/2016 30/06/15		% of patients seen within 15 min (triage) and 60 minute standard (doctor) Handover timeliness EAU/AMU measures	Governance regarding ED risk to safety has been strengthened, Exec meeting held 8/3/16 to revise the operational delivery group terms of reference, including KPIs. Meeting to be weekly, reports to QIG. Additional medical capacity recruited to commence in February, review of team job plans will support extended senior medical presence in ED and provide capacity for senior doctor RAA		
Improve the timeliness to be seen (time for arrival to triage & doctor)	12	**Observations for patients arriving by ambulance to the majors area to be completed immediately at SWAST/co-ordinator handover 24/7 by nurse co-ordinator facilitated by increased nursing capacity**.	Jane Viner	Chris Manlow	Shelly Machin (TBC)	Lisa Houlihan (matron)	Commenced 02/03/16			Obs are now being undertaken at co-ordinator/SWAST handover for all patients arriving by ambulance - Compliance now at 91% 09/03/16 JV	Need clinical sign off of fields being used to calculate triage and doctor seen metrics.	CQC KLOE – C1
Improve the timeliness to be seen (time for arrival to triage & doctor)	13	Improve timeliness of handover with **all patients admitted under ED and going to Emergency Admissions Units and the Acute Medical Unit to be put on the 'O flow drive' and handed over to medicine, under medic of the day system.** This provides greater oversight of flow and activity.	Jane Viner	Chris Manlow	Shelly Machin (TBC)	Lis Houlihan (Matron) Acute Physicians - KL & BB	07/03/2016		N/A	All patients admitted under ED and going to Emergency Admissions Units are now put on the 'O flow drive' and handed over to medicine, under medic of the day system (as of 07/03)		
Improve ED Governance	14	**Internal audit review of performance and governance framework**	Ann Wagner	Chris Manlow	Shelly Machin (TBC)	John Harrison	01/04/2016		N/A	Action in progress - ED Board governance meeting to be revised to include specific KPIs		
Improve Board visibility of ED performance	15	**Doctor review within 60 minutes to be included in the Board performance Dashboard** include -Time to triage -Time to doctor -Did not wait. -Re-attendance rate.	Ann Wagner	N/A	John Harrison	Paul Procter	April Board		N/A	To be determined by Execs		

Increase access to and optimise use of the Short Stay Paediatric Unit 7 days a week	16	**Short Stay Paediatric Assessment Unit to restart the 'pull' system and increase to 7/7**. Requires additional B2 ward clerk 0.8WTE, B2 HCA 0.8WTE, B6 nurse 0.8WTE	Rob Dyer	CD Paeds	Keith Goldsworthy	Keith Goldsworthy	05/03/2016		N/A	The system is now in place and operational. Additional B2 ward clerk 0.8WTE, B2 HCA 0.8WTE, B6 nurse 0.8WTE have been put in place. On a short-term basis, staff are working additional hours, however recruitment for substantive posts is in progress		CQC KLOE E1
Improve the reliability of sepsis screening & antibiotic administration in ED	17	**Staff in ED will receive refresher training for sepsis recording, reporting and application of bundle**	Rob Dyer	Chris Manlow	Shelly Machin (TBC)	Steve Carr	Ongoing		Sepsis screening measure Time from ED triage to appropriate antibiotics given is less than 1 hour			
Improve the reliability of sepsis screening & antibiotic administration in ED	18	**Monthly audit of 10 sets of case notes will be undertaken**. Sepsis bundle audit will be undertaken to validate the discrepancy between paper-based (10 note audit) and electronic systems	Rob Dyer	Chris Manlow	Shelly Machin (TBC)	Steve Carr	UFN		N/A			
Improve the reliability of sepsis screening & antibiotic administration in ED	19	**Inclusion of case note audit data set in the ED governance dashboard and onward reporting through governance structures with management of exceptions to performance by the QIG.**	Rob Dyer	Chris Manlow	Shelly Machin (TBC)	TBC	UFN		N/A	Initial audit undertaken, daily 10 case note audit to be undertaken on a daily basis until further notice. As shown in previous audits, the Trust are average of 60% time to 2nd obs and 60% time to Antibiotics within 1 hour. Improvement team to implement rapid improvement plan JV 09/03/16	Is this the ED flow dashboard or something different or do we need both?	
Improve the reliability of sepsis screening & antibiotic administration in ED	20	**Review of Sepsis reports and subsequent management to validate process and robustness**	Jane Viner	Chris Manlow	Shelly Machin (TBC)	SS and SJ			1: Add live feed for ED dashboard for ESW greater than 5 where sepsis indicated. 2: For ED weekly dashboards number/ % of patients EWS greater than 5 with Sepsis seen within 15 mins.	Sepsis CQUON has been reported to QIG CCG as required - Actions to improve compliance have not delivered the required improvement to date. Improvement Team to develop a rapid improvement plan. JV 09/03/16		
Ensure EWS & PEWS scores reliability undertaken , recorded and actioned	21	**Improve PEWS Audit** The department has a named lead for proactive development whose role includes responsibility for leading audit activity for department. Clinical audit of PEWS in progress. We have initiated an annual programme of audit activity to be agreed within the ED governance meeting. **Evidence patients at risk of deterioration are identified, monitored and managed promptly. Vital signs completed on admission & EWS noted** **Vital signs repeated in an appropriate timescale**	Jane Viner	Chris Manlow	TBC	Steve Carr	07/03/2016		Monthly PEWS & EWS audit Pts with EWS>5 report no of delays>60 mins for subsequent obs, daily	Actions to improve PEWS audit underway JV 09/03/16 Symphony system in place		Demonstrate safe care CQC KLOE -S1
Ensure consistent safe staffing 7 days a week	22	**Additional HCA post to be allocated to move between the resus area and paeds area.**	Jane Viner/ Rob Dyer	Rob Dyer	Shelly Machin (TBC)	Lisa Houlihan (matron)	03/03/2016		N/A	An additional HCA has now been put in place to move between the resus and paeds areas (as of 04/03)		
Ensure consistent safe staffing 7 days a week	23	**2 additional nurse posts to be added to current establishment for resus**, pending review of workforce plan (initially via bank with agreement from board to go to agency if required). This will be reviewed quarterly through the refresh of the departmental workforce plan.	Jane Viner/ Rob Dyer	Rob Dyer	Shelly Machin (TBC)	Lisa Houlihan (matron)	03/03/2016		N/A	An additional HCA has now been put in place to move between the resus and paeds areas (as of 04/03)		
Ensure consistent safe staffing 7 days a week	24	**Monthly safe staffing report and six monthly deep dive safer staffing report will both include this area in future**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	CN? TBC	03/03/2016		N/A	2 additional Registered Nurse posts have now been added to the current establishment for resus (as of 04/03)		
Ensure consistent safe staffing 7 days a week	25	A review of the ED nursing establishment is included in the nursing workforce programme activity for 2016. **In the absence of the NICE guidance, we will undertake an establishment using the BEST tool commencing immediately.**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Tracey Collins			N/A	Assistant Director of Nursing called meeting, held 07/03 to review BEST tool, actions agreed. Developing a process to undertake the BEST staffing review JV 09/03/16		
Ensure consistent safe staffing 7 days a week	26	**Ensure staffing levels for Children's and Young People's Services adhered to including cover within ED.** Action GS	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Keith Goldsworthy			N/A	Safe staffing report due May 16. If paediatric nurse needs to leave ED to go to ward, there is a discussion between the paediatric nurse and the shift co-ordinator to ensure the paediatric area is covered. To be reported to Board through Safer Staffing Report.		

Ensure consistent safe staffing 7 days a week	27	**Protect band 7 nurse co-ordinator as supernumerary role 09:30 - 22:00**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Lisa Houlihan	07/03/2016		N/A	Governance regarding ED risk to safety has been strengthened, Exec meeting held 8/3/16 to revise the operational delivery group terms of reference, including KPIs. Meeting to be weekly, reports to QIG. A band 7 nurse co-ordinator as supernumerary role 09:30 - 22:00 is now in place (as of 04/03/16) to ensure ability to commence initial set of obs at SWAST handover. Subject to bank staff availability and short term sickness.		
Ensure consistent safe staffing 7 days a week	28	**Support from orthopaedics and radiology to take over the daily reviews of X-rays**. This will release 2.5 sessions per week	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Keith Goldsworthy	07/03/2016		N/A	In place		
Ensure consistent safe staffing 7 days a week	29	7 clinical sessions released through **Acute Physicians and General medical take consultants taking over patients on EAU ward round** and releasing ED doctor's need to attend daily board round	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Ben Benjamin	07/03/2016		N/A	Acute physicians took over responsibility for EAU admitted patients from 07/03/16. Released 7 clinical sessions for ED doctor per week.		
Ensure consistent safe staffing 7 days a week	30	**Named lead to cover Rapid Assessment Area (RAA) at weekends and Mon to Fri 22:00 - 08:00 when consultant for RAA off duty**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Nick Mathieu	07/03/2016		% of triage within 15v mins banded by day and time.	We have now put in place a named lead to cover Rapid Assessment Area (RAA) at weekends and Mon to Fri 22:00 - 08:00 when consultant for RAA off duty. 21/03/16 this will extend to weekend cover.		
Ensure consistent safe staffing 7 days a week	31	**Appoint locum consultant** whilst we recruit substantive vacant post to bring ED consultants numbers from 9 (8 + 1 locum) to 10 (8 + 2 locums)	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Alex Finch	In progress			Recruitment in progress		
Ensure consistent safe staffing 7 days a week	32	**a) Review staffing across the emergency pathway** **b) Review shift patterns to ensure shift patterns reflect the attendance patterns of patients later into the evening.**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Tracey Collins	a) Immediate action Complete end Q4 b) Q1 confirm current position. Review and confirm required June		Weekly automated report which highlights variance from expected norms. - attendances by age - attendance outcome - attendance by day - attendance by hour - performance by day	Review recent NICE guidance and benchmark current position Included in current establishment review work. Prioritise. Date regarding patient attendance patterns collated		CQC KLOE-S4
Ensure consistent safe staffing 7 days a week	33	**ED Doctors to work until midnight Mon to Fri.**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Nick Mathieu	07/03/2016			ED doctor shift pattern changed to include cover until 00:00 Mon to Fri (commenced 07/03)		
Ensure consistent safe staffing 7 days a week	34	**Change ED doctor weekend rota 08:00 - 00:00**	Jane Viner	Rob Dyer	Shelly Machin (TBC)	Alex Finch	21/03/2016			Medical lead cover extended, will cover weekend from 21/03/16		

2. Effective Clinical Pathway Development

Date Last Updated: 18.03.16

Management Lead: Lesley Wade
Executive Lead: Rob Dyer

			Governance/ Accountability									
Objective	**Action no**	**Action**	**Executive Lead**	**Clinical Lead**	**Management Lead**	**Action Lead**	**Timescale/ Deadline**	**Status**	**Metrics/Measurement**	**Progress Update**	**Evidence/ Assurance**	**KLOE**
Redesign urgent and care pathways in order to increase the % of appropriate U&EC patients admitted directly to a ward or an appropriate service 7 days a week	1	1) Terms of reference 31.01.16 2). Agree scope at PFB 10.02.16. 3) Clinical recommendations for improvement 4) Workforce & Logistics. May 2016 5) Executive approval May 2016 6) Implementation phase May/ June 2016	Rob Dyer	TBC	Shelly Machin (TBC)	TBC	30/06/2016		% of patients admitted directly to wards from urgent and emergency care pathways A&E quality standards - time to triage, time to treatment, did not wait, re-attendance rate)	TOR for clinical discussion; agreement of leads and time-frame for work plan. Additional clinical, operational and project management capacity identified. ASU pathway developed AMU service specification in place		Earlier senior medical review and decision making on next step in care will increase performance against 4 hour standard
Reduction in the number of avoidable admissions at Torbay Hospital through optimising ambulatory emergency care (49 conditions) and reducing the % of GP medically expected patients admitted by x%.	2	**Re-align acute bed stock** to enable the development of a short term acute medical unit which includes ambulatory emergency care	Liz Davenport	Rob Dyer	Shelly Machin (TBC)	Shelly Machin	21/03/2016		Total no of ambulatory classed non elective admissions to medical services with los =0<1 day No of ambulatory conditions admitted	Pre-assessment relocated 11/3/16 on time. Level 2 available for enabling works.		Infection control risk assessments documented. Service users located appropriately.
Reduction in the number of avoidable admissions at Torbay Hospital through optimising ambulatory emergency care (49 conditions) and reducing the % of GP medically expected patients admitted by x%.	3	**Redesign AMU pathways** 1. GP medically expected 2. Walk-ins to ED with ambulatory condition or acute medical problem where a patient has a high likelihood of being discharged on the same day .	Rob Dyer	Alice Miller	Shelly Machin (TBC)	Ben Benjamin Helen Waters Alice Miller	21/03/2016		Total no of ambulatory classed non elective admissions to medical services with los =0<1 day No of ambulatory conditions admitted	Pathway developments started for GP medically expected patients . Agreed to start small with raid small tests of change Next meeting 15/3/16		Reduce assessment delays
Improve the pathway for Paeds, in particular the flow of Paeds through ED	4	**a)Review Paediatric flow, using evidence based tool to track patient's journey** **b) Identify blocks**	Jane Viner	CD Paeds	Keith Goldsworthy		Review current state end Feb 16			Children currently segregated in ED - need to extend the pathway from ED as well as for GP referrals		CQC KLOE E1

3. Implement SAFER bundle

Date Last Updated: 18.03.16

Management Lead: Cathy Gardner
Executive Lead: Liz Davenport

			Governance/ Accountability									
Objective	**Action no**	**Action**	**Executive Lead**	**Clinical Lead**	**Management Lead**	**Action Lead**	**Timescale/ Deadline**	**Status**	**Metrics/Measurement**	**Progress Update**	**Evidence/ Assurance**	**KLOE**
Improve the timeliness of patients being discharged with complex care needs	1	**Review Processes for MFFD patients in acute and community beds. To include:** 1) Panel Processes- March 2016 2) Social-care input- March 2016 3) Discharge coordinators support to community hospitals- March 2016 4) Res/Nursing Home and intermediate care capacity- from March 2016 5) Patient/Family Choice policy and implementation plan- March 2016 6) Enhanced 7 day working for discharge planning and delivery 7) New 'Discharge to Assess' model agreed by end April, implementation- from March 2016	Liz Davenport	Rob Dyer	TBC	TBC	31/03/2016		Total inpatients medically fit for discharge Daily no of pts MFFD for the ED dashboard Weekly ave days lost per pt MFFD to discharge Number of available community beds at census point, daily (morning bed state)	Patient and family policy in place requiring final ratification. Enhanced social care capacity on site week- days to facilitate discharge		Evidence CQC KLOE - C1 – C4
Reduce the number of patients medically fit for discharge with a LoS of more than 7 days	2	Daily pro-active reliable management of patients with a LOS>7 days	Jane Viner	ADNs	Shelly Machin, Jane Sangoor, Keith Goldsworthy	Matrons (TBC)	31/05/2016		LoS & % of discharge >10 days		Check whether 7 or 10 days?	
Increase the number of patients discharged before 12:00 noon, 7 days a week	3	**Implementation of safer flow bundle** - 9am early discharge 'huddle' supported by senior management at ward safety briefing – in place - Senior Review: all patients will have a consultant review by 11am – 75% by March 2016 and 100% by May 2016. - All patients will have a planned discharge date embedded in practice. - Flow of patients will commence by 10am from assessment units to inpatient wards.	Rob Dyer	ADNs and AMDs	Shelly Machin, Jane Sangoor, Keith Goldsworthy	Matrons (TBC)	31/05/2016		% of discharges pre 12pm , by day of week (improvement trajectory 35%) Total number of discharges per day, and variance per day (SPC chart based on current average)	Pilot of the safer care bundle standards in June 2015. Limited implementation due to clinical concerns about capacity Senior support to 9 am safety briefings now in place. Earlier Board rounds in place in some wards, discussions on wider roll out underway Ward-specific targets for discharge by midday from February '16 with senior oversight on performance EDD captured		Enhance capacity to monitor and provide comfort.
Reduce the number of patients at risk of developing a pressure ulcer whilst in ED	4	**Beds to be provided for those at risk of pressure ulcers in the department over 4 hours**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			% of patients with pressure ulcers as a result of ED attendance			Meeting complex needs CQC KLOE - R2
Reduce the number of patients at risk of developing a pressure ulcer whilst in ED	5	**5 note weekly audit of pressure ulcer risk assessments undertaken and beds/mattresses used**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			% of patients with pressure ulcers as a result of ED attendance			Evidence based tool to ensure effective care. CQC KLOE – E5

Reduce the number of patients at risk of developing a pressure ulcer whilst in ED	6	**Map current processes & implement rapid small tests of change**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			% of patients with pressure ulcers as a result of ED attendance			Evidence based tool to track child's journey. Identify blocks CQC KLOE – E1
Reduce the number of patients at risk of developing a pressure ulcer whilst in ED	7	**Action learning from pressure ulcer safety incidents reported March 16 to CCG**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			% of patients with pressure ulcers as a result of ED attendance			Evidence based tool to ensure safe staffing CQC KLOE – S4
Reduce the number of patients at risk of developing a pressure ulcer whilst in ED	8	**Review of pressure ulcer management in ED** **a) undertake training needs analysis for ED staff re: pressure ulcer** **b) Review actions to address PUP performance in ED**	Jane Viner	Lisa Houlihan	Shelly Machin	TBC				Actions identified as part of whole service safeguarding for ED initial meeting		
Reduce the number of patients at risk of Falls while in ED	9	**Review of falls management in ED** **a) undertake training needs analysis for ED staff re: Falls** **b) Review current management process and idenify relevant changes**	Jane Viner	Lisa Houlihan	Shelly Machin	TBC				Actions identified as part of whole service safeguarding for ED initial meeting		
Increase capacity in order to ensure reliable intentional rounding 7 days a week in ED	10	**Extend volunteer presence**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			Rota	Six volunteers in place, rota being reviewed in order to prioritise gaps		
Increase capacity in order to ensure reliable intentional rounding 7 days a week in ED	11	**Weekly audit process set up with timely reporting & actions**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			Weekly audit of 5 sets of case notes for compliance with intentional rounding standard	outstanding		
Increase capacity in order to ensure reliable intentional rounding 7 days a week in ED	12	**Locate 10 care apprentices to rotate across the ED / EAU3 / EAU4 departments**	Jane Viner	Lisa Houlihan	Shelly Machin (TBC)	TBC			Rota	Placement starts April 16		
Increase the timeliness of infection control information available to support operational management team decision making	13	**Review infection control risk assessment tool to ensure accurate and timely information available to operational management team.**	Jane Viner	TBC	TBC	Infection Control Lead - LK		29/02/2016	TBA	Risk assessment tool developed, being refined		Avoidance of new harm CQC KLOE – C1
Ensure effective and timely Board round	14	**Review current hourly Board rounds process for reliability and productivity** **Review recent NICE guidance and benchmark current position**						Immediate action plan complete end Q4		Included in current establishment review work		Evidence based tool to ensure safe staffing CQC KLOE S4

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	Trust Board 6th April 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.

Key Issues/Risks

Pressure remains on the acute sector estate with continued challenged performance in responding to urgent requests for estates maintenance and a continued number of critical failures. Work is taking place to understand the profile of the urgent requests to understand if it is related to a specific area, maintenance item or specialty. It is likely that critical failures will continue to be an issue until the estates backlog is reduced the team will work hard to reduce and mitigate any operational impact of this. Performance on the estates response indicator is expected to improve in the next two months.

Reported stress in February has risen to the highest level this year. There is no defined pattern and this is spread across the Trust. This is thought to be related to the significant activity pressure the organisation has been under over the last month. There is good staff support and counselling available that is being made use of by staff as and when needed. The health and safety team and occupational health will keep this under constant review.

Recommendations:

The Trust Board is asked to note the performance exceptions and assurance provided within this report.

Summary of ED Challenge/Discussion:
Are the patterns of stress in any particular area across the Trust and is it related to the continued pressure on emergency services. Possibly but not certainly. The is no one department or area that has a high level of referrals, it is a general issue across the Trust.

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.

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	April 2016
Report From:	Director of Estates & Commercial Development
Report Title:	Estates and Facilities Management Key Performance Indicators: Exception report

1. EFM Performance report for February 2016

Table 1 below identifies performance for January & February and changes between months for EFM. Any area of concern for the attention of the Board, with appropriate explanation and action to a resolution, is shown in Table 2.

Table 1 Changes between January 2016 and February 2016 Scorecard Indicator

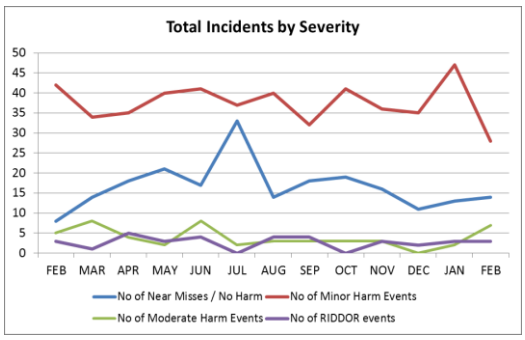
Green ✓	Amber !	Red ✘

Setting	Improving Indicators	January 2016 Position	February 2016 Position
Community	1.1g: % of Estates Reactive work resolved within target - <1-4 Days (Routine)	✘	✓
Acute	5.3: Non-patient incidents resulting in minor harm	!	✓
Acute	6.4: No of Fire Audits undertaken	✘	✓
Community	6.5: % of Compliant Fire Audits	✘	✓
	Deteriorating Indicators		
Acute	3.1: Total Tonnage per month all waste streams	!	✘
Community	3.1: Total Tonnage per month all waste streams	!	✘
Community	3.4:% of Total tonnage of Clinical Non Burn Waste	✓	!
Community	Number of Waste Audits undertaken per month	✓	✘
Acute	5.4: Non-patient incidents resulting in moderate harm	!	✘
Community	5.4: Non-patient incidents resulting in moderate harm	✓	!
	Red Rated Indicators with no change		
Acute	1.1g: % of Estates Reactive work resolved within target - <1-4 Days (Routine)	✘	✘
Acute	1.2: Number of Estates Internal Critical Failures	✘	✘

	Table 2: Areas with Specific Cause for Concern		**Anticipated timeline for improvement**
Acute	1.1g	% of Estates Reactive work resolved within target - <1-4 Days (Urgent) **[88% decrease to 80%]**	
	Performance of this indicator remains red, decreasing from 88% to 80%. This is probably attributable to resources being diverted to support CQC related activity and it is expected that this indicator will improve by the end of Quarter 4.		Quarter 4 2015- 16
Acute	1.2	Number of Estates Internal Critical Failures	
	1 in February 2016 – the Special Theatre AHU frost coil ruptured. It has been isolated, and as a result it is difficult to maintain sufficient warmth in the air supply to Special Theatres. The replacement frost coil is in course of supply and expected to be delivered and fitted w/c 14 March 16.		March 2016
Acute	3.1	Total Tonnage per month all waste streams	
Community	The monthly target tonnage for the current financial year is 157 tons of waste or less, this month the Trust produced 176 tonnes, which is the largest quantity of waste produced in one month since the start of the financial year, and exceeds the monthly average for the financial year by 34 tonnes. The increase in the amount of waste produced can be directly attributed to "Dump the Junk" Days which are held on an annual basis and are days when departments are given the opportunity to get rid of items which are stored in their areas but are no longer required.		March 2016
Community	3.7	Number of Waste Audits undertaken per month	
	This is a monthly variation in performance as the overall number of audits undertaken yearly remains "Green".		March 2016
Acute	5.4	Non-patient incidents resulting in moderate harm	
	The number of moderate harm incidents reported in February shows an increase to last month but remains a single figure. The Health and Safety team will closely monitor this situation and remind staff at every opportunity of the importance of reporting near misses in order to avoid harm incidents. All of those reported cannot be attributed to any single location or cause.		

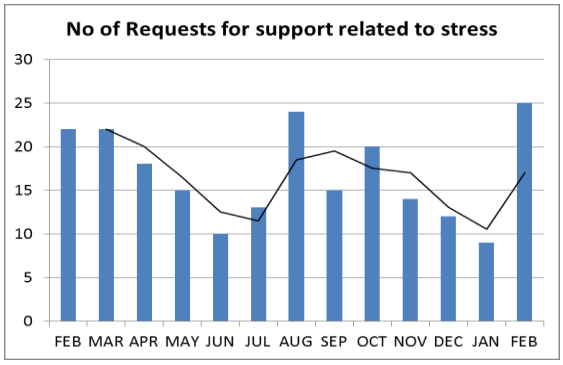
2. Health & Safety Exception report

There was a downward trend of numbers of incidents across both settings, however February saw an increase in the number of moderate harm events and three RIDDOR (serious) reports to the HSE. There incidents were unrelated and there was no pattern or trend.



February had the highest number of reports of stress over the year, with a mixture of management referrals and counselling in the 25 cases reported. These are not centered in any

specific area or department of the Trust. There is a comprehensive staff counselling and support structure in place. The H&S team and occupation health team will keep this under constant review.



In the Acute setting training compliance remains above 80% with a steady rise since December 2015, in the Community setting this remains above 85% but demonstrates a steady decline since December 2015 (excluding conflict resolution) thought to be related to winter pressures. A renewed focus will be placed on this for the forthcoming months.

Manual handling incidents are on the decrease.

3. Recommendations

The Trust Board is asked to note the performance exceptions and assurance provided within this report

Appendix 1: Estates and Facilities – KPI's Torbay and South Devon Foundation Trust – Acute Setting – February 2016

	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	1188	1263			1106				
1.1b	PPM (Estates) % success against plan			100%	89%	90%	88%	88%	88%	90%	84%	87%	85%	85%	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		0	0.4		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	137	118	137	134			112				
1.1e		Emergency – P1	<2 Hour	100%	96%	97%	98%	95%	98%	98%	95%	96%	98%	96%	100%		100%	97%		R<90%	A90-94%	G≥95%
1.1f		Urgent – P2	Total Requests	Variable	314	272	332	311	313	331	405	327	303	352	318			330				
1.1g		Urgent – P2	<1- 4 Days	100%	85%	88%	90%	95%	92%	91%	80%	88%	84%	88%	80%		100%	88%		R<90%	A90-94%	G≥95%
1.1h		Routine – P3 + P4	Total Requests	Variable	483	386	484	524	420	486	386	349	282	349	327			414				
1.1i		Routine – P3 + P4	<7- 30 Days	100%	86%	74%	75%	69%	73%	78%	90%	89%	95%	89%	89%		100%	80%		R<85%	A85-89%	G≥90%
1.2	Number of Estates Internal Critical Failures			0	0	0	3	0	3	2	2	1	2	2	1		0	2		R1	-	G0
	Facilities																					
2.1	Compliance **Very High Risk** Cleaning Audit			98%	100%	100%	99%	99%	100%	99%	100%	99%	100%	100%	99%		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%	99%	99%		95%	99%		R<90%	A90-94%	G≥95%
2.3	Compliance **Significant Risk** Cleaning Audit			85%	99%	99%	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%	92%	97%	99%	99%	99%	99%	99%	99%	99%	99%		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		0	0		R1	-	G0
	Waste																					
3.1	Total Tonnage per month all waste streams			157	127	138	148	126	116	119	151	154	154	162	**176**		≤157	142		R≥173	A158-172	G≤157
3.2	% of Total tonnage Recycled Waste			31%	30%	43%	43%	33%	25%	33%	42%	44%	37%	38%	**45%**		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%	33%	**29%**		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%	17%	**16%**		18%	17%		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%	8%	**5%**		11%	10%		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%	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**		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%**		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%**		100%	100%		R<90%	A90-94%	G>95%

	Health & Safety																		
5.1	Number of RIDDOR Incidents	0	3	2	3	0	2	3	0	2	1	2	2		0	2		R≥3	A1-2	G0
5.2	Number of days lost (due to incidents in month)	65	23	21	42	5	30	269	6	45	47	4	6		65	55		R≥81	A66-80	G≤65
5.3	Non-patient incidents resulting in minor harm	30	24	31	30	28	31	25	32	28	28	35	19		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	2	4		1	2		R≥4	A2-3	G≤1
5.5	Number of near misses	16	18	16	14	27	12	16	17	12	6	7	13		16	14		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%	88%	88%		85%	89%		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		0	0.11		R1	-	G0
6.2	Number of fire alarm activations	12	7	4	8	5	7	6	13	12	14	12	3		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	0	1		6	1.88		R>11	A6-11	G<6
6.4	No of Fire Audits undertaken	6	4	4	6	5	5	6	5	6	3	1	5		6	4.88		R<3	A5 - 3	G>6
6.5	% of Compliant Fire Audits	100%	25%	75%	100%	100%	80%	0%	80%	67%	66%	100%	100%		100%	58.55		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%	90%	90%		100%	92.22		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%	83%	85%			82.88		R<80%	A 80-85%	G≥85%

Torbay and South Devon NHS
NHS Foundation Trust

Appendix 2 : Estates and Facilities – KPI's Torbay & South Devon Foundation Trust – Community Setting – February 2016

	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	156	273	235			245				
1.1b	PPM (Estates) % success against plan			100%	93%	89%	97%	98%	95%	88%	97%	95%	92%	92%	94%		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		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	18	7			15				
1.1e		Emergency – P1	<2 Hour	100%	93%	75%	100%	100%	100%	92%	100%	100%	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	58	57			60				
1.1g		Urgent – P2	<1- 4 Days	100%	98%	88%	90%	96%	87%	94%	89%	81%	95%	83%	95%		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	62	154			117				
1.1i		Routine – P3 + P4	<7- 30 Days	100%	96%	78%	96%	89%	88%	86%	95%	92%	92%	90%	92%		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		0	0.2		R1	-	G0
	Facilities																					
2.1	Compliance Very High Risk Cleaning Audit			98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	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%	96		95%	**98%**		R<90%	A90-94%	G≥95%
2.3	Compliance Significant Risk Cleaning Audit			85%	99%	99%	98%	98%	99%	99%	100%	93%	98%	91%	92		85%	**96%**		R<80%	A80-84%	G≥85%
2.4	Compliance Low Risk Cleaning Audit			75%	99%	96%	100%	96%	96%	96%	100%	95%	91%	80%	94		75%	**92%**		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		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	38.32%	41.05%		35.1	37.45		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%	41.23%	41.61%		31.34%	33.49%		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%	35.65%	35.62%		39.89%	41.90%		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%	9.08%	8.04%		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%	1.51%	1.14%		1.71%	1.60%		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%	12.52%	13.59%		17.09%	14.58%		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	4		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%		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%		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	1	1	2		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	18	8	34		60	21		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	12	9		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	0	2		1	1		R≥4	A2-3	G≤1
5.5	Number of near misses	5	0	5	3	6	2	2	2	4	5	6	1		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%	90%	90%		85%	92%		R<80%	A 80-85%	G≥85%
	Fire																			
6.1	No. of Fires	0	0	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	1	1		12	0.67		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	1	0		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	5	7		8	6.44		R<4	A8-4	G>8
6.5	% of Compliant Fire Audits	100%	100%	100%	100%	100%	100%	100%	80%	63%	100%	80%	100%		100%	93.67%		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%	95%	95%		100%	97.78%		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%	87%	85%		90%	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.

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6 April 2016
Title:	Chief Operating Officers Report
Lead Director:	Liz Davenport
Corporate Objective:	Safe care/best care
Purpose:	Information

Summary of Key Issues for Trust Board

Strategic Context:

To report sets out progress against key delivery objectives of the Trust including implementation of the planned care model changes and compliance with delivery against the Urgent Care Improvement plan.

Key Issues/Risks

- Clinical capacity to support delivery of plans
- Environmental challenges
- Vanguard funding reduction

Recommendations:

To **note** the content of the report

Summary of ED Challenge/Discussion:

The Care model changes have been discussed at the Executive Team and agreement reached on priorities for 2016/17.These discussions have been in the context of the Trust financial plan and contract discussions

Weekly review of delivery against the Urgent Care Improvement plan are held and issues escalated for Executive attention this has included workforce and estates issues.

The Clinical services review proposals have ben discussed and used to inform discussions with partners on potential options for future service configuration.

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

The Care model changes will be subject to public consultation

Equality and Diversity Implications:
None

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	6th April 2016
Report From:	Chief Operating Officer
Report Title:	Report of Chief Operating Officer

1 Purpose

To provide the Board of Directors with an update against key operational issues

2 Provenance

The report is informed by the following:

- Minutes and action log from the Care Model Operational Group
- Terms of reference and minutes and action log from the Urgent Care Improvement and Assurance Group
- Minutes and action log from the Clinical Services Review Group
- Minutes of the Executive Team

3 Care Model Delivery

The Care model operational group meets on a monthly basis and is chaired by the Chief Operating Officer. An agreement on the funding envelope to support development of the care model has been agreed by the Executive Team enabling progress to be made in 2016/17 in a number of care model areas. A programme of work has commenced to review the planning assumptions in the original business case including the anticipated benefits to be realised from the care model investments and service changes.

Community services delivery model including Local Multi Agency Teams
A revised service delivery model was approved by the Community Services Transformation Group chaired by the CCG at its meeting in March 2016. Subject to CCG Governing Body approval the intention is to commence a period of public consultation on the proposed changes from May 2016. The changes already approved for the Coastal locality are progressing but with some delay in implementation of the rehabilitation service while further discussions are completed on the service specification for this service with the CCG.

Wellbeing coordinators
These posts have been developed in partnership with our voluntary sector partners and will have an important role in supporting the wellbeing agenda and care of people with multi- long-term conditions. The posts will be advertised in April with people taking up posts from May 2016.

Extension of the MSK pathways
The changes the to the MSK pathways for hips and knees were implemented from October 2015 with a resulting change to the numbers of people being referred to outpatients clinics for review by the orthopaedic team. Although it is early in the development of the project these findings are consistent with the experience of other services that have implemented this service model. It is has therefore been agreed with the orthopaedic team that the programme will be extended to include pathways foot and ankle and spinal.

Discharge to assess and intermediate care development
The implementation of discharge to assess model and an increase in intermediate care capacity will support our ambition to support care closer to home. The discharge to assess model has been developed to support the needs of frail elderly patients supported by the frailty team that work in the Emergency department and the, now extended, Acute Medical Unit. It is our intention to extend this programme of work to other care groups and have engaged expertise to support delivery of the plan. Detailed plans have also been approved to extend development of intermediate care to the Moor to sea locality.

Respiratory pathways
A proactive model of supporting people with respiratory conditions to remain well reducing outpatient attendances and hospital admissions has been developed with recruitment to the clinical posts underway.

Multi long term conditions clinics
The plans to introduce in clinics in 2 localities in May are on track for delivery.

Other areas
Other areas of work in support of the care model delivery plan include:

- 'Discharge to assess' - work is underway with external support to design a wider model
- Estates plan
- IM&T
- Workforce development including introduction of the strengths based approach.
- Personal planning through use of direct payments and personal health budgets
- Review of community pharmacy services
- Review of operational delivery structures

4 Urgent care Improvement plan (4 hours)

A plan to address on-going challenge in meeting the 4-hour standard was approved by the Systems Resilience Group in February. The plan focused on a number of areas where it was believed that we could make a significant impact on the experience of people using our services and with it the required improvement in delivery of the performance standard. The plan was aimed at securing compliance with the standard by end of October 2016.

The plan has subsequently been developed to take account of initial feedback from the CQC.

The areas of work include:

- Implementation of revised clinical process for triage and first medical review in line with ALAMAC recommendations
- Review of bed base including increased AMU capacity
- Review of care pathways into and out of bed based care
- Introduction of the SAFER a care standards to improve flow in the hospital
- Review of discharge processes including discharge to assess
- Implementation of Urgent Care centres through the National Vanguard programme
- Monitoring of patient safety and quality standards including sepsis monitoring and staffing levels

In addition to the above discussions on the future environmental changes required to support an improved emergency department have commenced.

Delivery of the plan is being driven through the Urgent Care improvement and Assurance Group with onward reporting to the Executive Team and the Quality Improvement Group and the Quality Assurance Committee. Weekly performance meetings are also held with the CCG.

Each element of the work programme has a named Executive, clinical and operational lead who are accountable for delivery of the plan against agreed timescales. The transformation team and performance team have identified capacity to support the work programme. Each area of work has an identified set of key performance indicators that will be used to evidence that the action taken has had the required impact. A number of these indicators will be incorporated into future reporting to the Board of Directors.

The Board will want to cross reference this update with current performance against national standards set out in the Performance Report and the report of the Director of Nursing on the CQC action plan progress to address patient safety issues. .

Risks to delivery

- Clinical capacity to meet changing expectations and to respond to new ways of working
- Vanguard funding yet to be confirmed
- Environmental constraints

5 Clinical services review group

A group has been established, jointly chaired by the CCG and the Trust, to take a consistent approach to making changes to way clinical services are provided for our community. The drivers for change being external advice and information about the pattern of service use and relative efficiency of these services for example the map of healthcare variation and Right care. Information is also received from Regional Clinical Networks.

The group has now established a methodology and has identified clinical leads. The work is focusing on areas where we have existing challenges to delivery and where we believe there is an opportunity to work differently to improve consistency of services and reduce costs. There will be an opportunity to make links with the

Success Regime in the NEW Devon area where this has been identified as creating opportunities for our local community as part of the approach to the Wider Devon Sustainability and Transformation Plan (STP).

Recommendation

To **note** the contents of the report

Liz Davenport

Chief Operating Officer

31 March 2016

Torbay and South Devon NHS
NHS Foundation Trust

Report of Quality Assurance Committee Chair to TSDFT Board of Directors

Meeting date:	18 February 2016
Report by + date:	David Allen, 25 February 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 Committee has finalised its terms of reference. Its key aims are as follows:

1. Constitution

1.1 The Quality Assurance Committee (The Committee) is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Aim

2.1 The Committee will monitor, review and report on the quality (safest care, effectiveness of care, best experience) of clinical and social care services provided by the Trust. This will include review of:

- the systems in place to ensure the delivery of safe, high quality, person-centred care.
- quality indicators flagged as of concern through escalation reporting or as requested by the Trust Board.
- progress in implementing action plans to address shortcomings in the quality of services, should they be identified.
- Progress on care model strategy

2.2 The Committee will review at each meeting the Trust's recent operational and quality and safety performance (excluding financial performance) and identify the key issues and risks requiring discussion or decision by the Trust Board.

2.3 The Committee will be responsible for reviewing, on behalf of the Trust Board, the proposed quality improvement targets set in the annual plan. It will provide assurance to the Trust Board that improvement targets are based on achievable

action plans to deliver them and that quality performance issues are followed up and acted on appropriately."

3. Secretariat Support

While grateful for the efforts of those concerned, the Committee has yet to establish a Secretariat to support it in the way that other senior committees are supported i.e. timely production of agenda, minutes, papers and establishment of a schedule of meetings. The Chief Nurse has kindly taken this matter up with the Corporate Secretary, since there may be wider issues in terms of how the Trust provides professional administrative support to its committees. Until the matter is satisfactorily resolved the extent to which QAC can provide assurance will necessarily be compromised.

4. Membership

The Committee includes provision for a patient/client/carer representative and a Governor observer so expressions of interest would be welcome, via the Lead governor in respect of the Governor observer.

5. ED Quality and Safety Metrics.

The Committee considered the revised Emergency Department quality and safety indicators. This led to a useful discussion as to how we know that ED is safe. How do we use data and who proactively monitors it? How do we know it is accurate? How is it quality assured? How are gaps in assurance escalated? Comparison was drawn with the work of Audit and Assurance Committee which has the support of internal and external auditors.

In relation to material service changes, QAC has an assurance role, not operationally but in relation to testing that appropriate systems and processes, including key performance indicators are in place to ensure that service changes and improvements are safe and improve on current provision. In this context it will be important to have good communications with Audit and Risk Committee, cross reference to the Corporate Risk Register and the capacity to revisit and test whether what actually happened was foreseen on the Register.

6. Bed assumptions

The Committee noted that real world experience was testing previous estimates of bed requirements and their distribution across acute and community settings. The Community Services Transformation Group was considering the issue.

7. Mortality Data

The Medical Director reported on national concerns over mortality data and how providers reviewed and determined whether deaths were expected or unexpected. NHS England has mandated that Mortality Surveillance Groups be established. The Trust already has such a process in the community and it will be established for the acute hospital. A screening tool will be developed and reports made to the Quality Improvement Group.

8.	**Junior Doctors Industrial Action** The Medical Director briefed the Committee on the operational changes that had been made to accommodate the continuing action and the warning from it eg in increased senior clinical presence on wards for longer alongside senior therapy staff. The Care plan Summary system had been identified as in need of review and this was being actioned. The Committee agreed that the challenge would be to implement the learning on a sustainable basis.
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

Meeting Date:	6 April 2016
Title:	Amendment to Scheme of Delegation
Lead Director:	Director of Finance
Corporate Objective:	Well Led
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

The Trust's Scheme of Delegation ensures appropriate delegation of managerial function within the organisation, ensuring sufficient capacity to operate the control environment set out in the Standing Financial Instructions.

Key Issues/Risks

Due to availability of key staff there have been a number of occasions where approval of the weekly payment run of approved invoices has been difficult to organise and, on rare occasion been delayed.

This paper proposes an amendment to Section 10.1.4of the Scheme of Delegation to ensure better coverage.

Recommendations:

To amend Section 10.1.4 of the Scheme of Delegation from:

Determining, and setting out, the level of delegation of non-pay revenue and capital expenditure/ Requisitioning/ Ordering/ Payments of goods and Services for budget managers.
a) Requisitioning of non pay revenue governed by Agresso procurement and the authorisation of invoices within the approved budget.

For Invoices and Agresso procurement , authority is delegated at the following levels:

Chief Executive – Unlimited
Director of Finance (and Deputy DoF in DoF's absence) – Unlimited
Other Directors and Divisional Managers - £100k

To now read:

Determining, and setting out, the level of delegation of non-pay revenue and capital expenditure/ Requisitioning/ Ordering/ Payments of goods and Services for budget managers.
a) Requisitioning of non pay revenue governed by Agresso procurement and the authorisation of invoices within the approved budget.

For Invoices and Agresso procurement , authority is delegated at the following levels: *Chief Executive – Unlimited* ***Director of Finance, Deputy DoF and Assistant Directors of Finance – Unlimited*** *Other Directors and Divisional Managers - £100k* [Amendment highlighted In bold text]
Summary of ED Challenge/Discussion: All invoices will already have been approved by the appropriate Budget Holder and / or the relevant supervising manager depending upon value. Segregation of duties will be maintained as all BACS payments in excess of £100,000 remain subject to a review by two Senior Finance staff before payments are processed.
Internal/External Engagement including Public, Patient and Governor Involvement: None applicable to this decision
Equality and Diversity Implications: None applicable to this decision

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Meeting Date:	6 April 2016
Title:	Approval of Banking Arrangements - Health and Care Videos LLP
Lead Director:	Director of Finance
Corporate Objective:	Well Led
Purpose:	Decision

Summary of Key Issues for Trust Board

Strategic Context:

Finance Committee approved the business case to enter into a Limited liability Partnership (LLP) with Rockland's Ltd. This is a commercial partnership to develop patient and staff information and training videos. The Trust has been piloting this project for the last two years.

Standing Orders requires the Board to approve banking arrangements.

Key Issues/Risks

The Finance Committee approved the business case for investment in the joint venture on a 50% ownership basis, with two Directors. The Trust's nominated director is the Director of Medical Education, with Rocklands Ltd nominating their Managing Director.

The key risk in relation to the establishment of a bank account for the LLP, is that it used for purposes other than those agreed by the Partnership. This risk is mitigated by:

- The LLP Agreement requires the directors of the Partnership both approve all expenditure.
- The accounts of the LLP will be maintained by the Trust finance department and will be subject to annual audit.
- Monthly management meetings will be held to ensure appropriate control of the business.
- The Deputy Director of Finance will act as a deputy in the absence of the Trust's nominated director.
- Initial financing requirements, at £65,000 in cash, have been agreed through the Finance Committee. Trading losses are predicted to be minimal and the financial modelling suggests even at 50% of the predicted sales the LLP will have sufficient cash to generate profits in the second year of trading. On this basis, the Board can expect the account to be operated within normal terms and conditions of a commercial bank.

Recommendation:

The board is asked to approve the banking arrangements for the LLP and the opening of a current account with Nat West Bank PLC in the name of the LLP.

Summary of ED Challenge/Discussion:

Overall business case agreed and approved by Finance Committee, with a maximum cash risk of £65k being seen as reasonable in comparison to projected return.

External Auditors were consulted on the proposed accounting treatment prior to Finance Committee Approval.

Finance Committee approved banking arrangements, with the key controls accepted, most significantly joint authorisation of expenditure and use of the Trust's own finance systems and staff to manage the accounts of the Partnership.

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

None in relation to this decision.

Equality and Diversity Implications:

None in relation to this decision.

PUBLIC

Late papers tabled at the meeting

Report on actions you plan to take

Please see the covering letter for the date by which you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RA9
Our reference	SPL1-220799933
Location ID	RA9
Trust name	Torbay and South Devon NHS Foundation Trust

Regulated activity(ies)	Regulation
Treatment of disease, disorder or injury Diagnostics and screening	Regulation 12 (2) (a)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment
	How the regulation was not being met:
	• Patients will or may be exposed to the risk of harm because you were failing to ensure that all patients receive adequate care and treatment. This was due to inadequate ongoing assessment and response to patient's presenting conditions. The completion of Early Warning Scores to identify any deterioration in patient's condition must be undertaken at the timed intervals indicated. We looked at 10 sets of patients' notes where early warning scores had been completed. For five of those patients the scores would indicate an increased level of observation was required which was not consistently completed. • We saw delays to initial assessment / clinical observation in excess of 15 minutes which placed patients at risk of delays in receiving the care and treatment they needed. Data provided by the trust showed that for December 2015, January 2016 and February 2016, the assessment within 15 minutes was not met in majors on initial arrival and less than 50% of patients had a clinical assessment within 15 minutes. The remaining patients waited much longer periods. • Delays were seen in the time for patients to see a doctor from arrival at the emergency department. The national target is a median wait of below 60 minutes. From July 2015 onwards the trust reported nearly double this waiting time. We saw numerous long delays to see a doctor, with some exceeding three hours.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve	
Actions to ensure that patients receive safe care and treatment	**Outcomes** that demonstrate patients receive safe care and treatment
Ensure risks to the health and safety of patients when identified are actioned <u>Completion of Early Warning Scores</u> (EWS): to identify any deterioration in patient's condition undertaken at the following timed intervals, initial assessment /clinical observations: ➢ Triage category 1-3 - all patients to have vital signs completed within 15 minutes of arrival to ED ➢ Triage category 4-5 – vital signs to be completed within 15 minutes of initial arrival for those assessed at triage as requiring vital signs <u>Repeat EWS consistently undertaken</u>: ➢ Daily audit of electronic patient record to monitor the consistent achievement of the standard for repeat vital signs for those with an EWS of 5 or above. <u>Improve reliability of sepsis screening</u>: ensure plans in place to monitor sepsis pathways are completed, including ➢ Staff in ED will receive refresher training for sepsis recording, reporting and application of bundle ➢ Develop daily automated reporting from the Symphony system to replace the manual audit ➢ Review of sepsis reports and subsequent management to validate process and robustness ➢ Sepsis management identified in the CQUIN / Quality Account in 2015/16. This work to continue in 2016/17. <u>Improve timeliness to be seen by a doctor from time of arrival</u>: Patients to see a doctor/clinical decision maker within 60 minutes of arrival at ED Free up more senior ED doctor time to enable the introduction of the RAA process. ➢ Introduce timely monitoring of ED, CDU & AMU activity and patient flow – including ALAMAC overcrowding score – to make information available across all	• Improved compliance with the EWS monitoring standard and prompt escalation • Patients receive timely care and treatment • Patients are prioritised according to need • Improved reliability of sepsis screening & antibiotic administration in ED • Accessible & visible monitoring from ward to board level enabling pro-active patient flow management, 7 days a week • Facilitate immediate escalation of variance to the ED lead clinician and control room team as detailed in SoP, should performance vary

bed based care ➢ Daily audit of performance/compliance to be undertaken via Symphony data. ➢ Daily report submitted to the control room team	

Note: a copy of our detailed rapid action plan is attached which sets out key actions with timelines and KPIs; governance and accountability arrangements; latest progress update and evidence of assurance.

Who is responsible for the action?	The Chief Nurse is overall Executive lead with an identified NED providing additional assurance to the Board. Individual actions have identified Executive Director, Clinical, Management and Action leads.

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

With regard to operational delivery, the Trust ensures that the improvements have been made and are sustainable as follows:

- Escalation process put in place triggered by Alamac crowding tool (every 2 hours) in line with ED escalation SoP
- Observation escalation process: variance reported by ED co-ordinator to control room and actioned by the ED Clinical Director management team.
- Audit of performance/compliance undertaken via Symphony electronic patient record (SEPR) data on a daily basis and a daily report submitted to the control room team.
- Doctor review within 60 minutes discussed at control meetings 3 times a day - escalated to on call manager.
- Daily audit of new initial clinical assessment system (observations undertaken at SWAST handover) and added to the SoP for escalation to demonstrate reliability. This information to be added to ED dashboard monthly and added to the Quality Improvement Group performance dashboard.
- This process and the data generated will be quality assured by the Quality Assurance Committee and reported on Trust Board performance dashboard.

Assurance on action plan delivery is organised as follows:

Weekly Urgent Care Improvement and Assurance Group (UCI&AG):

- reviews progress on actions and seeks assurance on delivery
- Chaired by Chief Operating Officer (or other Executive Director as substitute)
- CCG representatives in attendance to observe, support and take assurance
- Group currently refining assurance reporting mechanisms – Trust has set up a single point of contact to record and respond to all information requests and record feedback

Executive Assurance:

- An Executive Director review takes place every Wednesday to receive the update from the UCI&AG in order to seek assurance, enable escalation of issues to be discussed and unblocked

and to agree key messages for Board and partner weekly brief

- Chaired by CEO (or other Executive as substitute)

Board Assurance:

- Executive Directors prepare an additional weekly briefing report for the Board to provide assurance of delivery. This is also shared with the CCG and Governors.
- A NED (Jacqui Lyttle) has been identified to provide additional board scrutiny, oversight and support

CCG Assurance:

- The CCG takes an active role in observing delivery to obtain assurance.
- The CCG's Governing Body met with the Trust CEO and key directors in March and has arranged a follow up session in June to review progress.
- CCG Execs meet with Trust reps (usually Chief Operating Officer) on a weekly basis to review latest performance. Most recent verbal feedback confirms they are assured we have a plan in place and governance arrangements to oversee delivery. They remain "not assured" regarding performance delivery pending further sustained improvements.
- The CCG has a weekly teleconference with the NHS E regional team where they feedback updates from the UCI&AG.

Who is responsible?	The Chief Nurse is overall Executive lead with an identified NED providing additional assurance to the Board.

What resources (if any) are needed to implement the change(s) and are these resources available?

The Trust has provided/is providing additional resource to enable these actions to be delivered. This includes:

- Investment in additional clinical staffing
- 7 day on site Exec on call leadership
- IT systems and equipment to enable real time data entry
- Estate reconfiguration to enable AMU development
- Dedicated project and change management

Date actions will be completed:	The actions set out above were taken with immediate effect. It is anticipated that the actions will be reviewed and refined to achieve consistent compliance in April.

How will people who use the service(s) be affected by you not meeting this regulation until this date?

The Trust is committed to ensuring that all patients receive safe care and treatment. Delivery of the action plan has begun and the improvements we have already made are having some impact to reduce the effect of not meeting this regulation on people using the service.

Regulated activity(ies)	Regulation
Treatment of disease, disorder or injury Diagnostics and	Regulation 18(1)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing

screening	
	How the regulation was not being met:
	• At times, there were not enough registered nurses in the resuscitation room and the children's emergency department. We observed on each day of inspection that the four bedded resus room had only one registered nurse allocated for between two and four patients with high dependency needs. When extra staff was needed they were pulled from other areas of the emergency department, so leaving those areas short of registered nurses. • There was a registered nurse on each shift in paediatric area but no resilience in the department for when that nurse had to leave the department to transfer patients. The one registered nurse on duty would leave the paediatric area unstaffed when escorting a patient to the ward.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

Actions to ensure consistent safe staffing levels, 7 days a week	**Outcomes** that demonstrate safe staffing levels achieved
Ensure there are sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of all patients in the ED and specifically in the resuscitation room and children's emergency department: ➢ Additional HCA post to be allocated to move between the resuscitation area and paediatric area area. ➢ 2 additional nurse posts to be added to current establishment for resus, pending review of workforce plan. ➢ Ensure nursing staffing levels for Children's and Young People's Services adhered to including cover within ED. ➢ Protect band 7 nurse co-ordinator as supernumerary role 09:30 - 22:00. ➢ Baseline Emergency Staffing Tool audit completed, awaiting analysis of data. ➢ Support from orthopaedics and radiology to take over the daily reviews of X-rays – this will release 2.5 sessions per week; ➢ Exploring opportunities to release 7 clinical sessions released through Acute Physicians and General medical take consultants taking over patients on EAU ward round and releasing ED doctor's need to attend daily board round. ➢ Appoint locum consultant whilst recruit substantive vacant post to bring ED consultants numbers from 9 (8 + 1 locum) to 10 (8 + 2 locums).	• Patients in the resuscitation room, children's ED and general ED department are safely cared for at all times • Increased staffing levels are maintained across the whole ED without leaving other areas short of registered nurses

➢ Addition of a GP Sat and Sun and Bank Holidays to support flow through the department, particularly for minor ailments. ➢ Review of shift patterns underway to ensure they reflect attendance patterns of patients later into the evening. <u>Provide evidence of the sustainability of these increased levels</u> and how monitoring of sufficient staffing is being maintained. Ensure other areas of the emergency department maintain safe staffing levels. ➢ Daily staffing audit of staffing levels provided to CCG and reported to Quality Improvement Group and Trust Board.	

Note: the detailed rapid action plan is available. This sets out key actions with timelines and KPIs; governance and accountability arrangements; latest progress update and evidence of assurance.

Who is responsible for the action?	The Chief Nurse is overall Executive lead with an identified NED providing additional assurance to the Board. Individual actions have identified Executive Director, Clinical, Management and Action leads.

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

The Trust ensures that the improvements have been made and are sustainable as follows:

- Weekly report to CCG of compliance with increased staffing levels in ED.
- Monthly safe staffing report and six monthly deep dive safer staffing report will both include this area in future
- In the absence of the NICE guidance, we are currently undertaking an establishment review using the BEST tool

Assurance and governance arrangements as described earlier

Who is responsible?	The Chief Nurse is overall Executive lead with an identified NED providing additional assurance to the Board.

What resources (if any) are needed to implement the change(s) and are these resources available?

The additional staff were put in place with immediate effect as demonstrated in the daily ED nurse staffing report to CCG. The substantive establishment will be reviewed once the BEST analysis is complete.

Date actions will be completed:	The actions relating to staffing were implemented with immediate effect using temporary staff known to the department. The move to substantive increased

	establishment will be determined by recruitment. Interviews are being held in April.

How will people who use the service(s) be affected by you not meeting this regulation until this date?
Our action plan includes a number of steps to ensure safe staffing 7 days a week. Many of the actions have been completed and are reducing the effect of not meeting this regulation on people using the service.

Completed by: (please print name(s) in full)	Jane Viner
Position(s):	Chief Nurse
Approved by	Urgent Care Improvement and Assurance Group (UCI&AG) Trust Executive Trust Board
Date:	

Torbay and South Devon NHS
NHS Foundation Trust

Equality Impacts St Kilda Board report April 2016

Identify the potential positive and negative impacts on specific groups

This Equality Impact Assessments uses the Torbay Council format as the decision with respect to this matter will be made by the Director of Adult Social Care at Torbay Council.

The Board paper recommends that the Trust does not proceed with a stand-alone new-build replacement for St Kilda's, but instead re-provides these services within the existing footprint of Brixham Community Hospital and the local care sector as part of a broader reconfiguration within the Brixham and Paignton communities.

This new model of care is part of our overall strategy to provide more services in people's local communities, in partnership with GPs, other public sector organisations, voluntary agencies and the private sector. By better supporting people to live well at home and in their communities, we will need fewer hospital beds. If the Trust Board accepts that the new care model requires a different solution to that previously proposed and no longer requires a new build St Kilda, a decision is also needed in relation to the current contract for services from St Kilda's.

The nature of this proposal makes it a "Key Decision" for Torbay Council under the existing formal Partnership Agreement. Following Trust Board consideration and decision the Trust is required to present a formal recommendation to the Director of Adult Social Care Services of Torbay Council for a final decision on the proposed model of care, configuration of services and therefore future of the contract with SCCT for the provision of services from St Kilda's. .

The proposal is not to proceed with the planned St Kilda new build to re-configure the provision of services from St Kilda's in Brixham with the services being re-provided locally across the statutory, independent and voluntary sectors. The services being provided at St Kilda's cover long-stay placements for four residents, Intermediate Care, Short-Breaks capacity, Day Services and Community Meals.

Group	Positive Impact	Negative Impact & Mitigating Actions	Neutral Impact
Older or younger people			The services at St Kilda are for Older People
People with caring Responsibilities		St Kilda enjoy an excellent reputation with carers and the cared for and thus the loss of these services (Long Stay placements, Intermediate Care and Short Breaks) will be a concern, but will be mitigated by the proposals below: **Social Care** The new model identifies the need to provide services in the client's home or as close to home as possible and at the heart of the community. It is proposed that the step-down and respite care beds and residential beds currently in St Kilda's are re-provided within the local community in other private care homes with capacity. This model supports the care market and utilises private sector assets in delivering these services locally via purchasing contracts as part of the way forward. This is a move away from a centralised model to a person centred model with people cared for within their community. **Care requiring nursing oversight** Small bed numbers and the need for nursing oversight necessitates consideration of the co-location of acute community and intermediate care beds where possible and where needed, and is the model approved and stakeholder endorsed in the St Kilda's business case. As the demand for acute community beds has reduced, capacity has become available to accommodate the ten intermediate	

		care beds from St Kilda's requiring nursing oversight adjacent to the community hospital beds within the existing inpatient area at Brixham Community Hospital, eliminating the need for a new build to house beds. Investment will be required to provide a suitable single room setting for intermediate care and active assessment and rehabilitation. **Day Services Model** The day centre at St Kilda's currently provides a regular service to 11 members of the population of Brixham five days per week with the capacity to increase to 20 places. It is an extremely well regarded service for the local population that is seen as vital for the community and an essential service provision. The aspiration is that the day centre will form a critical component of a health and well-being hub centred on the Brixham Community Hospital site that also provides a base for socialisation opportunities for older people experiencing isolation thus reducing their need for other care services, and which can also support people with more complex needs including essential personal care. Client and carer day support for people with dementia will be provided through tailored activities such as a dementia café. This will help prevent the increasing demand for services driven by isolation and loneliness of older people. While the local voluntary sector, primarily Brixham Does Care, provides a stirling service in this regard, they too have identified an unmet need which such a base could provide a solution to, and have indicated an interest in being involved as a partner to deliver this service. This facility will also provide a location to	

		undertake needs assessments in a more 'normal' environment to evaluate activities of daily living, etc. In summary, the future service model described for day caring is intended to be delivered through partnership with the local voluntary sector, supported by skilled not qualified staff as needed for the complexity of need and with clinical oversight from the nursing leadership within the bed based services in Brixham Community Hospital. Space can be created within the existing buildings on the Brixham site which, with the investment of c£200,000, could be re-configured as a vibrant day caring and assessment centre at the heart of the Brixham hub. This extended service would be challenging to deliver in St Kilda due to the constraints of the facility. The existing partnership with the voluntary sector is vital to the successful delivery of this service model and both Torbay Council and the ICO would support these services being delivered primarily by the third sector on the healthcare owned site. We would wish to build upon these arrangements and anticipate voluntary sector involvement as Brixham has a strong voluntary sector. This sector has already expressed an interest in being involved in the development of the service model, supporting a co-design with the wider community and in being a potential delivery partner. Upon formal agreement of the model, the plan will be developed and the re-configuration costs and delivery model determined. This proposal was discussed recently at an engagement event run by Brixham Hospital League of Friends; provisionally this proposal may have good community	

		support, but of course requires further development and discussions with the community. **Community Meals** About 30 to 40 meals per day are made in the kitchen at St Kilda's and distributed by volunteers. This number, and potentially more if the need presents, could continue to be provided in partnership from the kitchen at Brixham Community Hospital and delivered by volunteers perhaps co-ordinated by Brixham Does Care. This would mean the service would benefit from the oversight of Trust trained catering staff and the security of Trust policies procedures and standards to supplement the excellent work from existing volunteers. The meals are funded through an existing chargeable rate to the clients receiving them, so there is no financial impact on the Trust.	
People with a disability	Services would be delivered in an improved estate.		The St Kilda services, despite having quality staff, operate in a building with limitations. With any replacement facility the environment for disabilities would be at least the same and most probably improved.
Women or men			We would only organise services from a provider that complies with all relevant legislations and standards, and is non-discriminatory.

People who are black or from a minority ethnic background (BME))			We would only organise services from a provider that complies with all relevant legislations and standards, and is non-discriminatory.
Religion or belief (including lack of belief)			We would only organise services from a provider that complies with all relevant legislations and standards, and is non-discriminatory.
People who are lesbian, gay or bisexual			We would only organise services from a provider that complies with all relevant legislations and standards, and is non-discriminatory.
People who are transgendered			We would only organise services from a provider that complies with all relevant legislations and standards, and is non-discriminatory.
People who are in a marriage or civil partnership			We would only organise services from a provider that complies with all relevant legislations and standards, and is non-discriminatory.
Women who are pregnant / on			Not applicable for service users for this cohort of services and its age

maternity leave			range
Socio-economic impacts (Including impact on child poverty issues and deprivation)	If the site was made available for housing and key workers it would further improve the Brixham economy and help with the supply of essential staff/workers to key care and education services Affordable homes would support local families to stay local and work and live in Brixham and the surrounds One potential option is also for land at Brixham Hospital to be used in this manner.		

Public Health impacts (How will your proposal impact on the general health of the population of Torbay)			Not applicable
Cumulative Impacts – Council wide (proposed changes elsewhere which might worsen the impacts identified above)	None identified by this proposal		