AGENDA

#	Description	Owner	Time
1	Chairman's welcome and apologies: D Allen, R Dyer, J Furse, J Viner For information	Chairman	
2	Declaration of interests To receive	Chairman	
3	Minutes of the last meetings held on 20 April 2016 (enc) To approve 03 - 2016.04.20_DRAFT_CoG_minutes.pdf 5	Chairman	5
4	Chairman's report (verbal) To receive	Chairman	5
5	Chief executive's report (enc) inc. integrated care organisation update (verbal) To ask questions 05 - 2016.07.20_CX_Report.pdf 15	CEO/DoF	20
6	Rapid Response in Torbay and South Devon and reablement in Torbay (verbal) To receive	COO/team	15
7	Lead governor's report including constituency reports (enc) To receive 07 - 2016.07.20_Lead_Governors_Report.pdf 103	Lead Governor	5
8	Estate's strategy (verbal) To receive	DoECD	10
9	Secretary's report (enc) To receive 09 - 2016.07.20_Secretarys_Report.pdf 109	CoSec	5

#	Description	Owner	Time
10	Sustainability and Transformation Plan (verbal) To receive	DoS&I	10
11	Quality and Compliance Committee Report (enc) To receive & approve 11 - 2016.07.20_QCC_Report.pdf 111	W Marshfield	5
12	Membership development report (enc) To receive & approve 12 - 2016.07.20_Membership_Development_Report.pdf 121	CoSec	5
13	Urgent motions or questions To receive & action	Chairman	
14	Motions or questions on notice To receive & action 14 - 2016.07.20_Questions_on_Notice.pdf 133	Chairman	5
15	Date of next meeting: 23 September 2016 CLOSED SESSION – please leave the meeting at this point if you are not a governor / board member		
16	Private minutes of the last meeting held on the 20 April 2016 (enc) To approve 16 - 2016.04.20_DRAFT_PRIVATE_CoG_minutes.pdf 135	Chairman	1
17	Board matters (verbal) -opportunity for the board to advise governors on any new issues; sensitive and/or confidential To receive	Chairman/CEO	5
18	Appointment of external auditor (enc) To receive & approve 18 - 2016.07.20_External_Auditor.pdf 139	S Taylor	5
19	Remuneration Committee report (enc) To receive & approve 19 - 2016.07.20_PRIVATE_RemCttee_Report.pdf 141	Lead Governor	10

Torbay and South Devon NHS
NHS Foundation Trust

MINUTES OF THE COUNCIL OF GOVERNORS MEETING

HELD IN THE ANNA DART LECTURE THEATRE, HORIZON CENTRE,

TORBAY HOSPITAL

20 APRIL 2016

Governors

		*	Richard Ibbotson (Chair)		
	Lesley Archer	*	Terry Bannon	*	Nicola Barker
*	Christina Carpenter		Adrian Cunningham		Craig Davidson
*	Carol Day	*	Cathy French	*	Sylvia Gardner-Jones
*	Diane Gater	*	Carol Gray	*	Annie Hall
*	Lynne Hookings	*	Barbara Inger	*	Mary Lewis
*	Wendy Marshfield	*	Gill Montgomery		Julien Parrott
*	David Parsons		Mark Procter	*	Andy Proctor
*	Rosemary Rowe	*	Sylvia Russell		Simon Slade
*	John Smith	*	Peter Welch	*	Simon Wright

Directors

*	Mairead McAlinden	Chief Executive
*	Paul Cooper	Director of Finance
*	Lesley Darke	Director of Estates and Commercial Development
*	Liz Davenport	Chief Operating Officer
	Rob Dyer	Medical Director
	Gary Hotine	HIS Director
	Martin Ringrose	Interim Director of Human Resources
*	Jane Viner	Chief Nurse
*	Ann Wagner	Director of Strategy & Improvement
	David Allen	Non-Executive Director
	James Furse	Non-Executive Director
	Jacqui Lyttle	Non-Executive Director
	Jacqui Marshall	Non-Executive Director
	Sally Taylor	Non-Executive Director
	Jon Welch	Non-Executive Director

In Attendance:	*	Richard Scott	Company/Corporate Secretary
	*	Monica Trist	Corporate Governance Manager and Note taker

(* denotes member present)

Action

1. **Welcome and apologies**

Apologies were received from: Lesley Archer, Adrian Cunningham, Craig Davidson, Julien Parrott, Mark Procter, Simon Slade, Rob Dyer, Martin Ringrose, David Allen, James Furse, Jacqui Lyttle, Jacqui Marshall, Sally Taylor, Jon Welch.

Richard Ibbotson welcomed members and all in attendance to the meeting, including new governors attending their first meeting.

2. **Declaration of Interests**

There were no declarations of interest.

3. **Minutes**

The minutes of the meeting held on 9 December 2015 and the Extra Council of Governors meeting held 9 March 2016 were approved as an accurate record of the meetings.

4. **Chairman's report**

Richard Ibbotson responded to comments from the Lead Governor regarding issues raised at the governor-only meeting held before the Council of Governors. Governors felt that they had not been kept informed regarding the Trust's strategy and plans for the use of Community Hospitals and had only learned of meetings at which this was being discussed from reports in the press. The governors sought assurance from the Chair that no patients would be disadvantaged and no Community Hospitals closed unless suitable alternatives were in place.

The Chair acknowledged that he would take these comments on board. He went on to say that governors were now kept informed of developments through various communications, including stakeholder briefings, emergency department updates, monthly back pocket briefings, press releases and staff bulletins. He felt there was a very difficult balance between providing insufficient information and too much, and any feedback regarding this balance should be provided to the Company Secretary.

The Chair thanked the governors for the concerns raised, enabling a frank and open discussion to take place.

The Chair went on to provide an update to changes in relation to the Trust Board. He emphasised that all members and attendees including governors have a duty to read Board papers in advance, and drew governors' attention to the executive summaries attached to the minutes. This would then allow the time allocated to the Board to be used constructively for debate and discussion leading to better-informed decisions. Regarding timing of Board meetings, the Chair advised that public Board meetings would now be held on a monthly basis, rather than bi-monthly, starting at 9am and finishing once all business had been concluded. He apologised if these new arrangements would cause any difficulties for governors.

With regard to private Board meetings, the Chair advised that these would no longer be held regularly although provision would be made at the end of each public Board if members needed to raise any urgent issues which were not appropriate for the public Board. The Chair may on occasion need to request that governors withdraw in order to protect their independence.

Moving to the topic of Board agendas, the Chair explained that these would be re-arranged to allow for topics requiring in-depth discussion and decision-making to be placed before items which needed only to come to the Board as a statutory requirement or to be noted. In future, there would be one presentation only at each meeting, to allow time for questions whilst the presenter was still available. All other meetings, for example Executive Nominations and Remuneration Committee, would take place after Board business had been concluded.

Terry Bannon (TB) thanked the Chair for the information provided: he particularly welcomed the opportunity to ask questions regarding any presentations made and confirmation was given that questions could also be asked in relation to verbal reports, for example from the Chair or CEO.

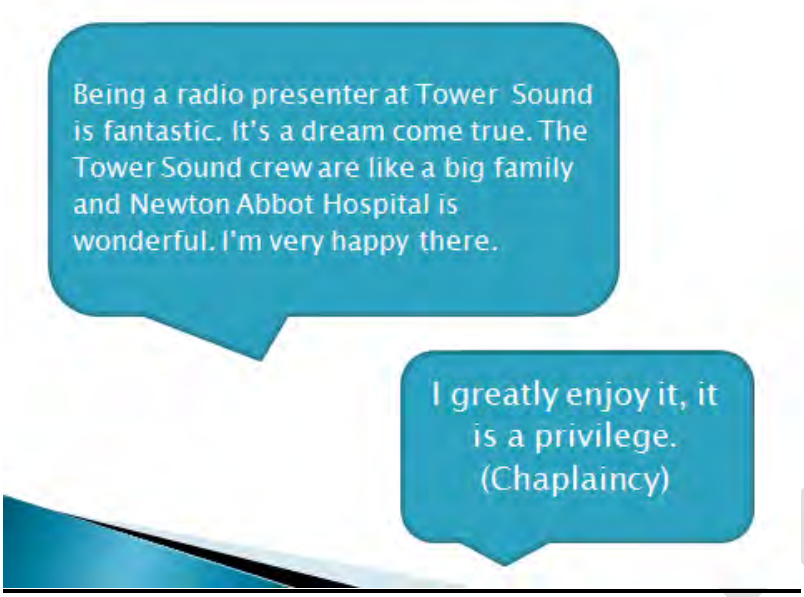
TB confirmed the decision made in 2015 in relation to governors' attendance at private board meetings and that this should be an issue to be resolved by the Chair and CEO. The Chair thanked TB for his comments and confirmed that if there were any private Board items which governors need to be made aware of, he would raise these with the Lead Governor at their regular review meetings.

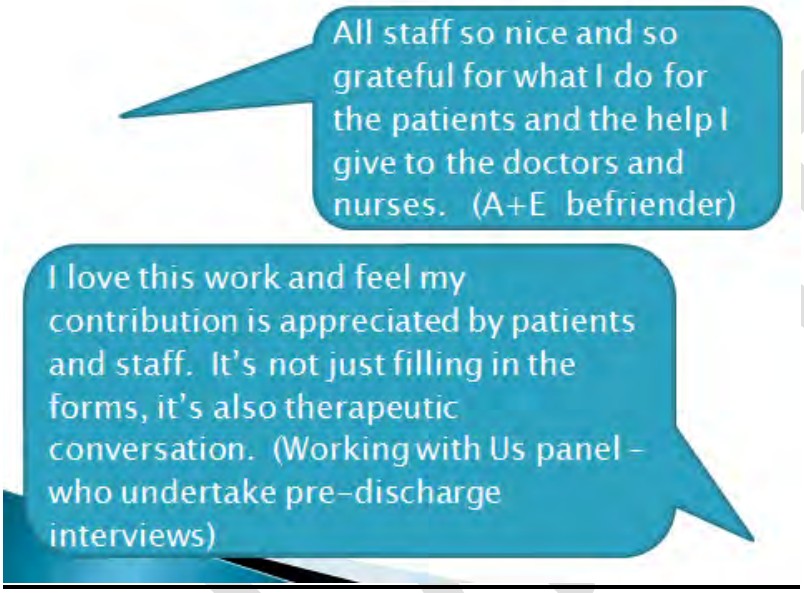
5. **Appointment of the Lead Governor**

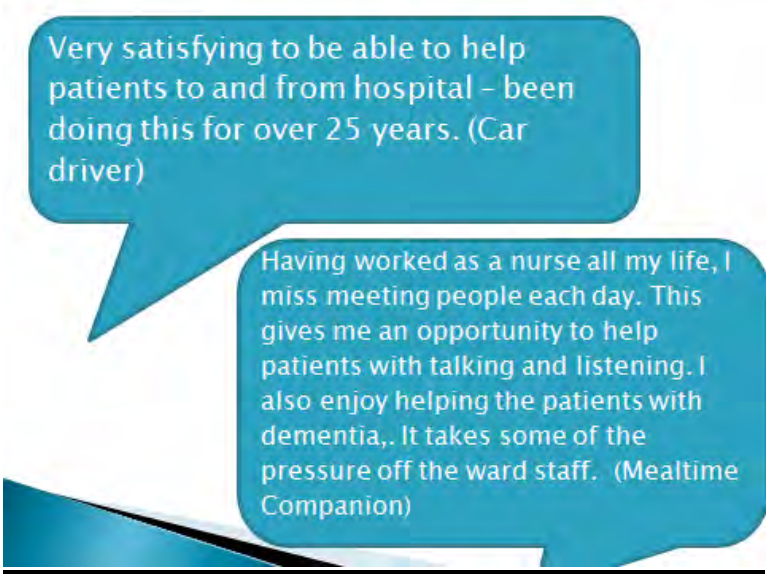
The Company Secretary informed the meeting that the only nominee was the current Lead Governor, Cathy French. Peter Welch proposed, Christina Carpenter seconded the nomination of Cathy French as Lead Governor and members confirmed unanimously her re-election for one further year to April 2017.

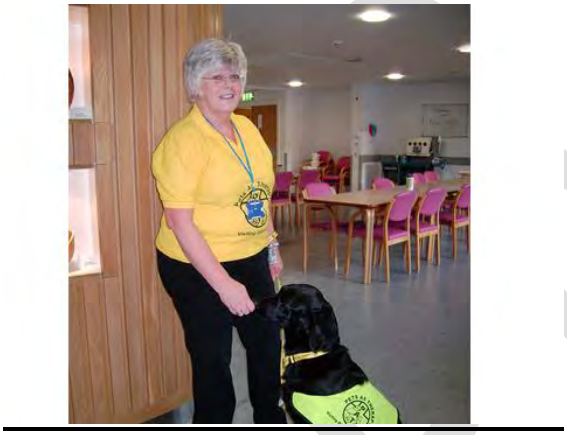
6. **Volunteering in Care Torbay (VICtor)**

Emma Swanton, the Trust's Project Manager for Volunteering in Care Torbay (VICtor) provided the following presentation for governors on volunteering in the Integrated Care Organisation (ICO):-


Being a radio presenter at Tower Sound is fantastic. It's a dream come true. The Tower Sound crew are like a big family and Newton Abbot Hospital is wonderful. I'm very happy there.
I greatly enjoy it, it is a privilege. (Chaplaincy)


All staff so nice and so grateful for what I do for the patients and the help I give to the doctors and nurses. (A+E befriender)
I love this work and feel my contribution is appreciated by patients and staff. It's not just filling in the forms, it's also therapeutic conversation. (Working with Us panel – who undertake pre-discharge interviews)


Very satisfying to be able to help patients to and from hospital – been doing this for over 25 years. (Car driver)
Having worked as a nurse all my life, I miss meeting people each day. This gives me an opportunity to help patients with talking and listening. I also enjoy helping the patients with dementia,. It takes some of the pressure off the ward staff. (Mealtime Companion)



Plus
Cancer Support
Kidney Support
Breast Care / Reconstruction Support
Play Assistant
Cardiac Rehab
Ward Buddies
Talking Newspaper
Befrienders
Meeters and Greeters
IBD Friends
Experts By Experience

Total =
640 volunteers

Emma Swanton confirmed that work is currently on-going to develop a database of all Trust volunteers (643) and their roles across the Trust (currently 70) and its various locations. Each volunteer carries out on average six hours per month of direct patient contact, although some, such as hospital car drivers, often do more, totalling 3,850 hours per month.

Emma spoke about the diversity of volunteer roles, including mealtime companions. In addition to the help provided to the Trust, these voluntary roles contribute to the health and wellbeing of the volunteers.

Emma referred to the forthcoming National Volunteers' Week (1-12 June 2016) and the teaparty being held locally to celebrate the role of volunteers locally, inviting governors to contact her via the Foundation Trust Office if they were interested in finding out more about the role of volunteers, or in meeting existing volunteers.

The Chairman thanked Emma for attending and for providing such an informative presentation – he confirmed the thanks of the Board for the various roles carried out by the volunteers.

7. **Chief Executive report including Integrated Care Organisation update (verbal)**

The CEO provided a verbal update on items which had arisen since preparation of her April Board report.

It was agreed governors would join her in sending condolences to the family of Dr Rose Polge, whose death had recently been confirmed and the governors confirmed.

The CEO advised that the Trust had just been informed that the draft Care Quality Commission (CQC) inspection report was due to be received late April, with the Quality Summit planned for 14 June 2016. Information had been circulated to the governors on initial concerns raised by the CQC inspectors with regard to the Emergency Department and the Trust's response to these.

The CEO advised current position of 2016/17 contract negotiations with Clinical Commissioning Group (CCG): discussions were ongoing at a senior level to secure a fair risk share arrangement.

The CEO informed governors of a series of recent pre-consultation meetings with stakeholders organised by the CCG, which had been attended by representatives from the Trust's Executive Team. This was the next stage in the consultation process described at the March Council of Governors (CoG) by the Chief Operating Officer (COO) and Simon Tapley of the CCG, identifying the need for service change with regard to Community Hospitals. These stakeholder engagement meetings were being held ahead of the formal public consultation process. The Lead Governor raised concerns that the governors had not been advised of these events, but the CEO reiterated these were meetings organised by the CCG as a pre-public consultation phase: the Trust did not own or lead on either the pre-consultation stakeholder events or the public consultation process - both were down to the CCG. Trust staff had expressed surprise at some of the proposals, such as the potential closure of Paignton hospital.

Following further questions from the floor on this issue, the Chair confirmed that the Trust's Executive Team make every effort possible to keep governors informed, however the recent stakeholder events were led by the CCG. He had asked the Executive Team to keep the Board and governors informed once any firm decisions were made by the CCG with regard to Community Hospitals, confirming that the consultation process was only in its early stages. He recommended that governors attend any consultation meetings being held in their localities and constituencies and report back to fellow governors in due course.

The CEO provided further information on the development of the future Model of Care and the provision of services closer to home. The Lead Governor asked about closer working with the Trust's partners and availability of capacity in nursing and residential homes. The CEO described a series of future meetings with staff and then partners to ensure everyone is kept informed of future plans and developments. Barbara Inger asked if the proposals would result in staff redundancies and the CEO reiterated the Trust's policy of no compulsory redundancies and that the Trust now had only 20 less staff than at the formation of the ICO on 1 October 2015.

8. **Questions arising from Annual Plan – 9 March presentation to governors and April Board paper**

The Director of Strategy confirmed that the final version of the Annual Plan had been presented at the Trust Board and circulated to governors as part of the meeting papers.

Questions were invited on the Annual Plan – there were none.

9. **Lead Governor's report including constituency reports**

The Lead Governor congratulated new governors on their recent appointment and looked forward to working with them. She also congratulated governors on their appointment as committee/group observers and she hoped all governors felt engaged with Trust business, inviting governors to contact her if they had any concerns.

Reports of Teignbridge Constituency meeting held on 24 March and the Torbay meeting held on 6 April 2016 were provided for information – there were no questions on these reports.

10. **Company Secretary report**

The Company Secretary reported good attendance at the governors' training provided by GovernWell on 15 April, and that he had received good feedback from the governors who attended. He was looking to produce a skills matrix in order to make best use of governor skills and experience. Although analysis of governor attendance at meetings was not yet finalised, he reminded governors of the requirement to attend at least two CoG meetings per year.

The Company Secretary suggested the governors might like to consider setting up a formal buddy system in view of the large numbers of new governors recently appointed.

11. **Quality and Compliance Committee report**

Minutes of the last meeting (18 November 2015) had been provided to the December CoG.

Wendy Marshfield, Quality and Compliance Committee Chair, advised that the planned meeting on 3 March 2016 had been cancelled, as not quorate owing to changeover in governors. The next meeting is due to be held in June at which feedback would be received on the recent CQC inspection. She would continue to circulate meeting notes to all governors.

12. **Membership development report**

Lynne Hookings, Chair of Mutual Development Group, advised that the meeting due to be held on 16 March 2016 had been cancelled owing to the number of apologies received. Notes of the last meeting held on 26 November 2015 were included with the meeting papers for information.

13. **Rotation of committees/group membership (results of secret ballot)**

Following a request for nominations to sit on committees\groups and a ballot process, the meeting noted the outcome in respect of unopposed seats.

Committee / Group	Governor	Term	Other
Nominations Committee	Lesley Archer (staff seat)	1 year	
	Cathy French (Lead Governor)	1 year	Subject to agenda item 5
	Lynne Hookings	2 years	
	Barbara Inger	2 years	
Remuneration Committee	Cathy French (Lead Governor)	1 year	Subject to agenda item 5
	Mary Lewis (South Hams seat)	1 year	Torbay seat available
	Carol Day	*	*Lots will be drawn to determine number of years
	Barbara Inger	*	
Mutual Development Group	Christina Carpenter	*	1 staff seat available
	Cathy French	*	1 other seat available
	Sylvia Gardner-Jones	*	
	Lynne Hookings	*	*Lots will be drawn to determine number of years
	Mary Lewis	*	
Audit and Assurance Committee	Cathy French	1 year	
Capital Infrastructure and Environment Group	Wendy Marshfield*	1 year	*elected unopposed if Wendy does not obtain another seat
Quality and Compliance Committee	Diane Gater	1 year	Staff seat unopposed
Disability Awareness Action Group	David Parsons*	1 year	*elected unopposed if David does not obtain another seat

The Company Secretary then informed the meeting of the outcome of the various ballots and which governor had been elected until April 2017:

- Wendy Marshfield, Quality Assurance Committee;
- John Smith, Finance, Performance and Investment Committee;
- Andy Proctor, Quality Improvement Group;
- David Parsons, Workforce and Organisational Development Group;
- Terry Bannon, Information Management and Technology Group;
- Lynne Hookings, Quality and Compliance Committee;
- Sylvia Gardner-Jones, Infection Prevention and Control;
- Carol Day, Torbay Pharmaceutical; and
- Christina Carpenter, Charitable Funds Committee.

It was noted that there were still vacancies for the Remuneration Committee, Mutual Development Group, Safeguarding\Inclusion Group, Capital Infrastructure and Environment Group, Joint Equalities Cooperative and Disability Awareness and Action Group.

The Company Secretary thanked governors for their nominations as committee/group observers and also to governors who had voted. He agreed to issue a full list of appointments as quickly as possible including future dates for all meetings. It was noted that he would also circulate the vacancies on offer and seek further interest from governors. CS

14. **Urgent motions or questions**

The Director of Estates and Commercial Development was asked to report on the current position of various building projects taking place. She provided a verbal update and was pleased to report that all projects were progressing satisfactorily: she would provide a detailed report to the next CoG meeting. DoECD

The CEO informed governors that the Trust's capital plans were due to be revisited in light of the current financial position. She confirmed that some projects would still be taken forward and thanked the League of Friends for their on-going support.

The Chairman advised that the non-executive directors were aware that the ICO now encompassed both the acute hospital and community locations and had asked that due consideration is given to this when finalising capital expenditure plans for the new year.

15. **Motions or questions on notice**

There were no motions or questions on notice.

16. **Details of the next meeting**

20 July 2016, 3pm – 5pm, Anna Dart Lecture Theatre, Horizon Centre

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 20 July 2016

Agenda Item:	5
Report Title:	Chief Executive's Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest from the Chief Executive and Executive Team covering issues arising since the last Council of Governors meeting on 20 April 2016.

1.2 Please note that the next Finance Committee is not due to take place until the 26 July 2016 therefore at the time of writing, this paper highlights the latest Trust position.

1.3 The report as at attachment four shows May's performance figures; all figures that were available as at 13 July 2016. If an up-to-date dashboard is available, this will be presented on the day of the meeting.

1.4 The majority of the information as at attachments one, two and three was presented at the public Board of Directors in July hence this is an opportunity for governors to ask questions rather than be advised of the report's content.

1.5 On 1 June 2016 the Trust received as at attachment five, its quarter four feedback from NHS Improvement (previously known as Monitor pre 1 April 2016).

2. Decisions Needed to be Taken

2.1 Comment and receive the attached information.

3. Attached to this Report

Attachment one	-	Chief Executive's report as presented at July's Board.
Attachment two	-	Chief Nurse's report as presented at July's Board.
Attachment three	-	Chief Operating Officer's report as presented at July's Board.
Attachment four	-	Integrated Quality, Performance and Finance report as presented at July's Board.
Attachment five	-	Quarter four 2015/16 letter from NHS Improvement.

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

1 ICO Key Issues and Developments Update

Care Quality Commission: Inspection Report
Following the publication of our CQC report on 7 June, the formal Quality Summit was held with health and care partners on 14 June. Four key themes were identified for system-wide action plan:

- **Can we better manage urgent care demand** especially out of hours/weekends?
- **Can we reduce risk of delay to 'right care'** for very vulnerable people?
- **Can we improve outcomes and choice** for people approaching end of life?
- **Can we improve pace of transfers of care** to meet needs in the right place of care?

The Trust's action plan in response to the six CQC Requirement Notices is due for submission on 30 June and will be reported to the Board by the Chief Nurse..

A follow up inspection by CQC of our urgent and emergency care system is expected before September, and a full inspection within the next 12 months.

Interim Director of Human Resources and Organisational Development
Martin Ringrose, our Interim Director of Human Resources and Organisational Development, will be leaving the Trust at the end of July to take up a regional role with the Devon-wide Sustainability & Transformation Plan team, providing his wealth of experience and expertise to addressing the workforce challenges for the Devon health and social care system.

Martin has made a major contribution in our journey as an Integrated Care Organisation, guiding the complex workforce issues involved in bringing together our two legacy Trusts and ensuring staff were supported and protected in transitioning to the new organisation. I know the Board will wish to express our gratitude for his guidance and leadership, and join me in wishing him every success in his new role.

Judy Saunders, who has been appointed to the substantive role of Director of Workforce and OD, is taking up post on 1 August.

Urgent and Emergency Care Plan
The Board will receive a detailed update from the COO report on progress against plan and the performance report included in the board pack confirms that combined performance (ED and MIU) is 87.4% for the month of May against the SRG approved trajectory of 85%, and the trajectory target will increase to 92% by September 2016 to be maintained for the remainder of the financial year. This agreed trajectory, which is below the national target, is in recognition of the reduction in the funding for the local Urgent Care Vanguard plan, and work will continue with the CCG to identify system-wide development plans to achieve 95% compliance. Cumulative performance for June to 29th June for ED performance is 87.3% with performance exceeding 90% on 13 days and exceeding 95% on 5 days, which demonstrates that achievement of improved performance is becoming more embedded, supported by much improved flow across the system.

Voluntary Sector Engagement
I attended an engagement event held with voluntary organisations n 27th May organised through a partnership between the Trust, the Torbay Community Development Trust (CDT) and Community Voluntary Services (CVS) in South Devon. My presentation emphasised the vital role which voluntary organisations play in supporting local communities and the intention to develop more formal partnerships as we develop and implement our new model of care. Confirmation of the investments which have been agreed in services provided by local voluntary organisations was provided with intent to increase this investment.

The event was attended by representatives from across the voluntary sector and our own services. The key messages from this event and March's partnership event divide into two broad areas:

- Improvements in the way that we work with partners from all sectors in the future
- Priority areas for new partnerships with the voluntary and community sectors. These include consideration of issues such as community transport, low level mental health services, and some issues associated with housing.

The event has begun a new and stronger approach to engagement through which the Trust listens and responds to feedback from our partners and stakeholders and develops new delivery models in partnership with the 3rd Sector.

Post European Union Referendum Communication
Following the vote to leave the EU, the Chairman and I issued a communication to all staff to recognise the contribution of those who have come to the UK from overseas to work for this Trust. Whether that be from EU countries or elsewhere their contribution to the safety and quality of the services we provide is immense and is very much valued by the Trust. These staff are a key part of our workforce, a workforce committed to the delivery of high quality services to our 375,000 local people and who have contributed to the CQC's rating of 'Outstanding' for caring.

Dermatology Team National Recognition
I am delighted to inform you that our Dermatology Team has won a National Award from the British Dermatology Nursing Group. The team from the John Parkes Unit won the Dermatology Team of the Year Award for 2016. Sarah Burns, Advanced Nurse Practitioner, and Natalie Taylor, Dermatology Research Nurse, collected the award in Bournemouth at a ceremony earlier this month

This award was introduced to celebrate team work and to recognise the importance of working together effectively for patients. Our team is made up of nursing and administration staff who are all well supported by Dr Mihaela Costache. On behalf of the Board, I heartily congratulate the team at the John Parkes Unit who fully deserve the recognition this award gives them.

2 Local Health Economy Update

Wider Devon Sustainability and Transformation Plan (STP) Update
The Devon STP was submitted at the end of June, with full input from Torbay and South Devon system co-ordinated by Ann Wagner, with clinical leadership by Rob Dyer. Once approved, this submission will be circulated to all key stakeholders.

Healthwatch Devon and Healthwatch Torbay are supporting the engagement of key local stakeholders and an information and engagement event was held on 21 June at Upton Vale Main Hall in Torquay. It was attended by a wide range of people and groups including the voluntary sector, elected representatives and trades unions. The feedback is now being collated and will be used to inform future communications and engagement.

Community Services Consultation
It was originally planned that the CCG led Community Consultation would begin in May. However, due to the NHS England (NHSE) assurance process, consultation could not start as soon as had been planned.

The NHSE checking process is now nearing completion. Subject to final NHSE sign off it is likely that the consultation will not start until early September, as feedback from CCG engagement has indicated it would be preferable to avoid the core summer holiday period.

Key regional appointments/changes
Andrew Ridley, NHS England South Regional Director, is to take up a new post as the chief executive of Central London Community Health NHS Trust. Following Andrew's departure, the South's regional director role will be split into two posts because of the scale of the challenges in the South and the size of the region as it is.

Giles Charnaud, Rowcroft Hospice Chief Executive is to step down at the end of this summer. For the next few months Giles will be supporting the Board of Trustees and acting CEO to ensure a smooth handover of responsibilities and to introduce the new phase of leadership. In the interim before a new Chief Executive Officer is appointed, Jon Hill will lead Rowcroft as Acting Chief Executive Officer in addition to his role as Finance and Commercial Director.

3 Chief Executive Leadership Visibility

Internal	External
	Programmes/Boards/Groups
Volunteers' Tea Party	
Dartmouth Hospital Walk around	SW Chief Executives' Meeting
Freedom to Speak Up Guardians	Wider Devon STP Programme Delivery Executive Group
CCU Topping Out Ceremony	System Resilience Group
Theatres Walk around	CQC Quality Summit
General Surgery Team Meeting	Children Services' Open Day
Orthopaedic Consultants' Team Meeting	CCG Governing Body Meeting
Innovation Team	Dartmouth GPs
90 Years Celebration	Director of Children's Services Interviews
All Managers Meeting	
Clinical Managements Group	**Individuals**
Radiology Consultants' Team Meeting	
Medical Staff Committee	Chair, Dartmouth Hospital LoF
	Chair, Dartmouth Caring
	Director of People Business Strategy & Support and Cabinet Member for Adult Social Care and Health Services, Devon County Council

4 National Developments and Publications

Details of the main national developments and publications since the July Board meeting have been circulated to the Board each week through the weekly Board developments update briefing.

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 developments of interest from the past month to highlight for the Board include:

- Simon Stevens' speech to NHS Confederation stressing the importance of using the current year as a 'reset moment' to get NHS finances and performance on track
- Latest national emergency department performance figures
- Latest financial performance figures for the provider sector published by NHS I forecasting £500m deficit for 2016/17
- CCGs to be rated on STP progress, GP access and new care models
- NHS Improvement consultation on new 2016/17 provider performance framework
- NHS Confederation and the Local Government Association vision for integrated care.
- Getting serious about prevention paper on the work that Vanguards are doing to drive prevention and reduce health inequalities
- Call to speed up innovation from Sir Bruce Keogh medical director for NHS England
- Language test for overseas nurses eased by the Nursing and Midwifery Council in an attempt to address NHS staff shortages.

- Department of Health restructure to 4 new directorates - community care, global and public health, acute care and workforce and finance – as part of drive to reduce costs by 30%

The following national clinical reports/findings which warrant further “could it happen here?” consideration will be reviewed for learning through our clinical governance system:

- Stroke care improvements needed according to a report into stroke care by the Royal College of Physicians.
- Findings of the latest independent review of children’s cardiac services in Bristol
- Worldwide review of results on invasive surgery in end of life geriatric care

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6 July 2016
Title:	Report of the Chief Nurse
Lead Director:	Chief Nurse
Corporate Objective:	Objective 1: Safe, Quality Care and Best Experience Objective 4: Well led
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

The NHSE Serious Incident Reporting Framework (2015) sets out the process for reporting serious incidents. The Quality Improvement Group received a report in June that highlighted an increase in the number of incomplete investigations and STEIS reportable incidents outside timeframe.

This report sets out the Trust response to the requirement notices included in the CQC report published in June. This includes actions underway to ensure safe staffing.

Key Issues/Risks:

Incident reporting:
The increase in reporting of incidents and near miss events reflects the work undertaken over the last two years to improve the process and make it easier. Ensuring that investigations and reports are completed in the required timeframe is a challenge for the Service Delivery Unit (SDU) Governance Coordinators as incident reports increase. The number of 'no harm' to 'moderate harm' incidents pending completion has risen above the average in quarter 1. Associate Nurse Directors are undertaking work in July to complete and close these investigations. The Trust wide adoption of the Datix system in October will enable ward and department teams to monitor and manage their incidents locally with oversight from the SDU senior management team and the Trust incident team. The Quality Improvement Group will monitor progress on incident management.

Strategic Executive Reporting System (STEIS):
The June Quality Improvement Group received a report that there were eleven STEIS reported investigations outside timeframe, validation of the data shows that there were nine. The reasons for delay in completion are understood and valid under the NHSE guidance. The incident team are working closely with the SDU senior management teams to bring the investigations to conclusion. It is anticipated that six will be closed by 1st July. The CCG have requested further information on the remaining three. The Serious Adverse Events Group and the Quality Assurance Committee will monitor progress.

CQC requirement notices:
In addition to the requirement notice issued in March 2016 regarding the urgent and emergency care department, the CQC final report included five further requirement notices. Action plans to address the issues were submitted to the CQC by the required date of 30 June 2016. These action plans are included as appendices to this report.

The CQC requirement notices link to the regulated activities provided by the Trust. Service Delivery Unit senior management teams have developed action plans to address the issues raised and ensure the CQC standards are met. The teams have used the Simple, Measureable, Achievable, Realistic and Timely (SMART) framework to develop the plans. It is critical that the plans address the specific issues raised, that they are aspirational but also deliverable within the timeframe set. The action plans will form a key element of the SDU work plans for 2016/17. These action plans will be subject to revision and amendment by the CQC prior to formal ratification. Progress will be monitored through the SDU Quality and

Performance meetings, the Quality Improvement Group and the Quality Assurance Committee. Recommendations: To consider and if necessary challenge to assurance provided in this report.
Summary of ED Challenge / Discussion: The report and mitigating actions with regard to incidents were noted. The Executive Team discussed the CQC requirement notice action plans and the need to ensure these address the issues and are deliverable. Executive leads reviewed and agreed the action plans prior to submission.
Internal/External Engagement including Public, Patient and Governor Involvement: CQC / CCG / NHSE
Equality and Diversity Implications: None

PUBLIC

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	6 July 2015
Report From:	Chief Nurse
Report Title:	Report of Chief nurse

1 Purpose

To provide the Board of Directors with an update against key quality issues

2 Provenance:

The report is informed by the following:

- Minutes and action log Quality Improvement Group (QIG) / Quality Assurance Committee
- Senior Nurse Strategy Meeting
- Minutes of the Executive Team
- CQC Assure Meeting

3 Safe Staffing:

Acute hospital: Allerton ward had a staffing deficit in June but recent recruitment will address this. The Associate Director of Nursing for Surgery is monitoring staffing levels daily to ensure safe staffing levels are maintained. More detailed reports are provided monthly to the Quality Improvement Group.

Special Care Baby Unit (SCBU) continues to experience staffing issues despite attempts to recruit specialist nurses. The Associate Director of Nursing for Women's, Children's and Diagnostics utilises staff flexibly across the whole paediatric service to ensure is SCBU staffed safely.

Community hospitals: Teignmouth Hospital inpatient activity has relocated to Newton Abbot. There are staffing issues at Paignton Hospital with senior staff taking up other posts in the Trust. Safe staffing is being monitored and managed over the course of the day by the Community SDU team and is reported to the Trust control room.

Quality Effectiveness and Safety Trigger Tool:

The majority of service teams are now integrated onto the Quality Effectiveness and Safety Trigger Tool (QuESTT). This provides a single page view of quality for the whole Trust. The 23 quality indicators include: leadership, sickness absence, vacancy factor, % unfilled shifts, patient feedback, hand hygiene compliance and safeguarding training. The 23 indicators have an individual score that indicate areas of performance variance. These are totalled to provide an overall score with scores greater than 12 being highlighted and discussed at the monthly QIG meeting.

In June the Forrest Ward score was 18, this relates to the loss of the Senior Sister and staff vacancies. The Senior Sister post has been filled and the other vacancies are advertised.

The Coastal Nursing Team score is 17 due to vacancies. Recruitment is underway and vacancies have been appointed.

The out of Hours nursing team scores 23 due to vacancies and sickness. This is under daily review with staff being deployed flexibly to ensure the caseload is covered.

4. Clinical Supervision Update:

Clinical Supervision (CS) is a formal process where clinical staff reflect on and discuss their clinical work with someone who is experienced and qualified. It enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient protection and safety of care in complex clinical situations.

Although not mandatory, CS is strongly recommended by the Trust and Governing bodies to all clinical staff and should be encouraged by clinical managers. It is recommended that clinical staff access supervision for a minimum of one hour every two months and that this is documented. There is currently no target set as CS is reviewed annually and is not mandatory.

The last Clinical Supervision Review was carried out in November 2015. For this review the data was collected in a different way from previous years. In the past, survey questionnaires had been sent out to individuals and they were asked to return them. Response rates were historically very low and returned questionnaires were usually from those who accessed CS, making the results questionable. For this current review, each clinical area manager or senior clinician was contacted by telephone or face to face and asked five questions about the CS activity in their area, therefore ensuring a more accurate result from each area across the Trust. The results are set out below.

Acute nursing areas (Excluding Maternity Services)	**25%**
Community Nursing/ hospital areas	**91%**
Maternity Services	**100%**
AHP and Social work	**100%**

At 25%, the review highlighted that the acute hospital clinical ward areas were least likely to access CS. Many of these areas understood the benefits of CS and supported one another with informal and undocumented CS, however, time and staffing issues appeared to be the main barriers to formal access. Following the review we have now been able to target the development of CS training and support for the acute areas and guide specific parties to develop supervision, such as the matrons and ward managers. I will be reviewing the Clinical Supervision policy later this year to reflect the evolving needs of the clinical areas in accessing CS., The CS Review action plan and current update is set out below.

	Action	**Complete by**	**Update 19.5.16**
1	Meet with senior managers and directors to identify new ways of encouraging a wider uptake of CS by clinical staff	May 2016	CS lead has been liaising with managers and introducing supervision in two areas within the acute trust. Attended the Senior Strategy Meeting in July to discuss the uptake of Supervision in clinical areas with the managers
2	Offer CS to clinical managers at senior lead meetings so that benefits and CS structure can be realised, experienced and cascaded to other teams.	April 2016	CS lead attending meetings to set up Supervision in July 2016. I have also made contact with some band 7s to run action learning with them.
3	To create a team of CS facilitators to facilitate supervision, provide motivation, information and	February 2016	4 facilitators have been trained, 2 concentrate their time with action learning for the overseas nurses currently within the trust. 2 facilitators are continuing

	support to encourage supervision uptake.		to deliver training sessions and providing supervision.
4	Run local CS information and training sessions.	July 2016	Supervision training sessions have been run in various locations across the trust since January 2016. Attendance has been variable but those sessions that have been run have been well evaluated.
5	Further develop the webpage and encourage teams to visit for updates and tips.	March 2016	The webpage has been updated with Supervision and 'Time to Talk' ideas and templates.
6	Support teams to achieve CS, particularly where there is poor uptake.	July 2016	The facilitators have been visiting areas wherever possible; however, in areas where there is poor uptake it has been difficult to get staff engaged with supervision. Staff shortages, sickness, no time and high workloads are reasons given. The facilitators will continue to attend meetings, offer training and try to engage staff in supervision.

5. Safeguarding (pressure ulcers / falls) Emergency Department:

In February / March the Emergency Department had a cluster of five grade 3 – 4 pressure ulcers. This triggered a referral to the safeguarding team and investigations led by the CCG. Three cases are now closed, two are awaiting final case meeting. The pressure ulcer prevention (PUP) work is ongoing in the Emergency Department and reported monthly to the Urgency Care Improvement and Assurance Group (UCIAG).

A fall resulting in serious harm was reported to the safeguarding team in March and has been the subject of external investigation. The investigation is complete and the report anticipated early July. Falls prevention work is underway in ED which includes a review of the existing ED trolleys and the use of falls alarms. This work is reported to the UCIAG.

6. Strategic Executive Information System (STEIS) overdue incidents:

At present there are 9 STEIS reported incidents outside the 60 day timeframe for completion. STEIS is the national incident reporting system that collates incidents and enables national benchmarking data to be analysed and reported.

The NHSE Serious Incident Reporting Framework (2015) sets out the criterion that determines a STEIS reportable incident. This framework explains the responsibilities and actions for dealing with serious Incidents and the tools available. It outlines the process and procedures to ensure that serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

The Patient Experience and Feedback Team work closely with the Service Delivery Unit Governance Coordinators to ensure the serious incident reporting process is followed. Every effort is made to conclude the process as soon as is practicably possible. However, the process can be extended for up to 6 months if the incident is subject to external investigation / review. An extended timeline can also be agreed with the CCG for the following reasons:

- The incident is subject to enforced compliance with the timetable of an external agency, such as police, Coroner, Health and Safety Executive or Local Children Safeguarding Board or Safeguarding Adult Board.

- Investigation of highly specialised and multi-organisation incidents, such as those involving a national screening programmes.
- Incidents of significant complexity.

Of the nine cases outside timeframe:

- 1 is multi-agency
- 2 are internal delay
- 3 are categorised as complex
- 3 are subject to a further information request from the CCG

The Trust is working closely with the CCG to bring these incidents to closure, it is anticipated that six will be completed and reported by 1st July. The three remaining will be forwarded to the CCG for comment; these will be considered closed pending CCG approval. All STEIS incidents are reported to the CCG and upward to NHSE where progress on quality indicators including timely reporting, transparency, quality of investigation and escalation / collaboration are monitored. STEIS incidents are reported and monitored by the Serious Adverse Events Group and the Quality Assurance Committee.

7. Unmerged incidents:

There has been considerable work in the last two years to increase incident reporting and for this reason there has been an increase in the reporting of 'no harm' to 'moderate harm' and near miss incidents. Over the same period, the number of major and catastrophic incidents has reduced.

We manage approximately 400 incidents a month, circa 5000 incidents in a year. In each month there will be between 600 – 700 incomplete incident investigations in the Safeguard / Datix system. The majority of these actual or near miss incidents are graded as 'no harm to minimal harm' with a small number graded 'moderate'. These incidents have been coded and had initial review and are at various stages of the investigation process. The majority have been investigated and are awaiting quality assurance check or confirmation of the associated actions by the SDU governance coordinator prior to upload to the national system, this is the merging process. These incident investigations waiting upload to the national system are reported monthly to the Quality Improvement Group as 'unmerged incidents'. In quarter 3 and 4 of 2015 there was a steady decline in the total number but there has been a significant increase during quarter 1 of 2016 taking the total figure to 928. June figures show:

Unmerged Incidents by Month:

	Med	Surg	WCD	
June	88	240	90	
May	49	114	70	
Jan April	70	163	50	
Total	200	518	210	928

At present the unmerged incidents are monitored and managed by the single SDU Governance Coordinator and it is an ongoing challenge to complete, report and upload this volume of incidents. The Associate Nurse Directors are reviewing the unmerged incidents for each SDU and will undertake focussed action to review and close them. Progress on this will be monitored weekly by the Chief Nurse. The Datix system will facilitate local ownership of the incidents by Senior Sisters / Matrons and the SDU team. 'No harm' to 'Minor Harm' will be managed and merged by the ward / department team with oversight from the Governance Coordinators and the Trust incident team. It is anticipated that this will significantly reduce the number of no harm / low harm investigations that are unmerged.

8 Pressure Ulcer Collaborative.

It is recognised that Pressure ulcer prevention is fundamental in providing high quality, safe care. In the Acute setting, between April 2015 and March 2016, 15 avoidable Grade 3 and 4 pressure ulcers were acquired in our care. In the same time period three avoidable pressure ulcers, Grade 3 and 4, developed in the community. The community achieved a reduction of 17 avoidable pressure ulcers in 2015/16 due to implementation of the Pressure Ulcer Collaborative Programme over a two year period. This work has been led by the Head of Community Tissue Viability Services who has recently extended her remit to include both the Acute and Community parts of our organisation.

Starting in September 2016, under the leadership of the Head of Tissue Viability Services, the Collaborative programme will be rolled out across the Acute setting. Utilising information from the incident reporting system, the programme will commence with those wards with the highest levels of pressure ulcer harms over the last twelve months.

As the programme is implemented and embedded across all wards is for a 50% reduction in Grade 3 and 4 avoidable pressure ulcers. This will therefore be a yearend target of no more than eight avoidable ulcers in the acute setting.

9. CQC requirement notice action plans.

The CQC requirement notices link to the regulated activities provided by the Trust. These are:

- Regulation 12 safe care and treatment
- Regulation 13 safeguarding service users from abuse and improper treatment
- Regulation 15 premises and equipment
- Regulation 17 good governance
- Regulation 18 staffing

Each requirement notice covers the issues highlighted in the full report with regard to the following services:

- urgent and emergency care
- medicine
- outpatient and diagnostic
- children and young people
- end of life care
- critical care services.

The service delivery unit senior management teams have developed the attached action plans to address the specific issues raised. The plans are subject to CQC amendment and revision, we anticipate approval in July. These action plans will be monitored through the

SDU Quality and Performance meetings, the Quality Improvement Group and the Quality Assurance Committee.

CQC report – nurse staffing:

The CQC report highlighted three areas where nurse staffing should be reviewed:

- The Emergency Department
- Louisa Carey Paediatric Ward
- The general medical wards

The Emergency Department:

The Baseline Emergency Staffing Tool (BEST) has been used to review the ED nursing establishment. Early analysis and supports the CQC finding that an increase is required to support the Resuscitation area and ED Paediatrics area. This increase has already been approved and staff are being recruited. The BEST review has highlighted the need to align nursing shift times to reflect the changing pattern of attendance into the late evening and night. This will be considered as part of the ED recovery plan.

Medicine:

In line with the Nursing Quality Board (NQB) mandate of 2014, safe staffing levels are displayed daily at ward entrances, published on the Trust public website and reported monthly to the Trust Quality Improvement Group.

Staffing across the Trust is monitored three times daily at the control room meeting. At each meeting, a Matron is responsible for ensuring safe staffing is maintained through flexible allocation of substantive staff, bank or agency. The CQC confirmed that general wards had safe staffing levels but there was day to day variability resulting in staffing at less than established levels over the month on some general medical wards.

Over the last two years, two general ward staffing establishment reviews have been undertaken. These have used evidence based tools such as Hurst, Shelford, the Royal College of Nursing, the National Quality Board and professional judgement. The first of these led to an increase of 14 wte nurses across general wards in 2014 through the redistribution of existing funds. The second, more detailed review has just been completed and suggests that the medical wards require an increase in staffing to meet the changing dependency of patients. This review is in the process of validation and the findings will be presented to the Executive team, the Quality Improvement Group and Finance Committee in July.

Louisa Carey Paediatric Ward:

The staffing establishment for Louisa Carey ward was informed by Royal College of Paediatric Nurses Association and indicates the need for a small increase to provide resilience on the night shift.

Recommendation

To **note** the contents of the report

Jane Viner

Chief Nurse

29 June 2016

Children's & Young People

Accountability: **Executives** - Chief Nurse **Service Manage**r - KG

Ref:	Reg:	Regulation 12(1)(2)	Action required	Action taken	Evidence	By who	By when	Completed
CYP1	12(1)(2)	Initial health assessments for 'looked after' children were not meeting the statutory timescales.	To develop a robust process in order to meet statutory timescales for Initial Health assessments (IHA) for Looked After Children (LAC)	• A process mapping event was held on the 11/2/16 together with Children's services to identify why delays occur, simplify the very complex process of notification to health, consent for and booking of IHAs. From this, actions have been identified both within Children & Young Persons Service (CYPS) and health to improve timescales.	Notes of the meetings and associated actions	Trust Child safeguarding lead, HP	February 2016	
CYP2				CYPS are to ensure foster carers are aware of the need for timeliness of these assessments through training and case review. Action from mapping event agreed. Link with permanancy services within LA.	Training schedule and attendees register.	Designated Doctor - MG	30-Sep-16	
CYP3				Health will notify CYPS when a child's appointment is cancelled or not attended so this can be followed up with the carer and rebooked quickly. Spreadsheet completed by LAC secretary.	**Audit:** monitored monthly by the Designated Doctor who report to CYPS / Corporate Parenting Board - (multiagency board).	Designated Doctor - MG	01-Jun-16	
CYP4				The referrals in for IHAs are monitored weekly by the Child Health Practice Manager with support of LAC secretary. Additional capacity available for IHA's, by designated doctor during summer. From September middle grade doctors will be trained to undertake assessments, therefore facilitating greater flexibility to meet flutuating demand.	**Audit**: training schedule and attendees register	Practice Manager - SD	Review October 2016	
CYP5				CYPS to notify health of newly looked after children & young people and request IHA within 5 working days. Designated doctor is liaising with LA permanancy service. Spreadsheet completed by LAC secretary.	**Audit:** monitored monthly by the Designated Doctor who report to CYPS / Corporate Parenting Board - (multiagency board)	Designated Doctor - MG	Review Oct 2016	
CYP6	12(1)(2)	There was a long waiting list for an assessment to diagnose an autistic spectrum disorder inspection for those aged five to 18 years documentationat the CDC. At the time of our inspection showed there was a 17 month wait time.	To decrease the waiting times alongside an increase in completed assessments.	New service commissioned to meet increase in demand. Commenced April 2015. Degree of ongoing risk is monitored via regular review of risk register via SDU Governance monthly meetings. To create additional capacity during summer school holidays to help reduce backlog. Further review of the service September 2016 with up to date trajectory of improvement.	**Audit:** Outcomes for this to be monitored through Service delivery Unit (SDU) Dashboard and presented to Performance and Quality meeting bi-monthly.	Service Manager - AG	Review Sept 2016	
CYP7	17(1)(2)	Records must be accessible to authorised people as necessary. Not all staff were able to access the electronic and paper records when required to access information.	Health Visitor and School Nurses functionality to be available on PARIS	New Health Visitor and School Nurses functionality will be available on PARIS by the end of 2016, which will enable them to share information with other services who have access to PARIS (new users will request access through their managers).	Audit: case sample to review accessibility of PARIS. Method to be determined.	Service Manager-LW (John Broom)	30-Sep-16	
				The Health Visitor staff who had insufficient room and IT equipment are being moved to new premises from the two GP surgeries where there was an issue.	**Audit**: staff located in new premises	Health Visitor Lead - CT	End sept 2016	
				Managers to progress access to childrens social service PARIS (run by Torbay Council), the first meeting to discuss this is to be held in Q2.	**Audit:** meeting notes and associated actions,	Public Health General Mgr - LW	End Decemeber 2016	
CYP8	18(1)(2)	The trust did not have adequate staffing levels on Louisa Cary Ward to ensure it met the recommended guidance (RCN 2013) particularly at night.	Service to review establishment and present to Exec / Performance and Quality review	Extensive establishment review undertaken in December 2015, and presented as part of the business planning process. Further discussions at the service unit performance meetings.	**Audit**: evidence of establishemernt review and progress through Trust governance system..	ADN WCDT (HP)	May-16	
				Buisiness case developed to increase establishmnet Awaiting decision by Exec	as above	ADN WCDT (HP)	May-16	
CYP9	18(1)(2)	A lack of capacity in the looked after children (LAC) nurse role had been identified	To increase dedicated LAC nursing resource	Business case submitted to the CCG by the Designated Nurse for LAC. Joint funding agreed between CCG and PH to increase resource.	**Audit**: increase in capacity	ADN WCDT (HP)	Sep-16	
CYP10				0.8wte Named Nurse for LAC interviewed on 14th June and due to commence employment July 16. Band 6 nurse post is awaiting job matching. In the meantime the activity for Review Health Assessments (RHA) is being covered by bank staff.,	**Audit**: staff rota reflects increase.	ADN WCDT (HP)	Sep-16	
CYP11				RHA activity monitored through Safeguarding Children Operational group (SCOG) and Integrated Safeguarding Committee (ISC).	**Audit**: SCOG and ISC notes and associated actions	ADN WCDT (HP)	Sep-16	
CYP12	18(1)(2)	Shortage of middle grade doctors	Appoint to all vacant posts	We have carried out several interviews, but unsuccessful. To mitigate, we will continue to use locums and agency's when required to cover service. Number of substantive middle grade doctors increases to 5wte from 3.9wte as of september Long term national issue being discussed within the deanery.	**Audit:** Notes of SDU governance meetings regarding progress on recruitment and mitigating actions.	CYP Ops Manager (GS)	To review in Sept 16	

Critical Care

Accountability: **Executive** - Chief Nurse; **Service Manager** - NF

Ref:	Reg:	Regulation 13 (1)(2)(5)	Action required	Action taken	Evidence	By who	By when	Completed
CC1	13 (1)(2)(5)	Staff in critical care had a limited understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS).	Training to ensure all staff have a fundamental understanding of MCA / DoLs.	Trust Safeguarding Lead has provided 3 seminar sessions to staff on CCU. Specific focus on bands 6,7,8.	**Audit**: Training program and attendance register. Report to dept audit meeting.	Matron and CD	Sept 16	
CC2	13 (1)(2)(5)	Training compliance data specifically for critical care was not available	Training log	Training commenced	**Audit**: MCA / DoLs training schedule and attendance register available. Report compliance with training targets to dept audit meeting.	Matron and CD	Sept 16	
CC3	13 (1)(2)(5)	The unit did not have any useful guidance or support tools readily available for staff.	Review of guidance and support tools for staff, location and access	Guidance and support tools current and easily accessible on the unit and on the Trust intranet site.	**Audit**:Spot check that staff can access the Intranet site. MCQ to assess staff understanding of MCA/DoLs. Report to dept audit meeting.	Matron & CD	Oct-16	
CC4	13 (1)(2)(5)	There was a lack of assurance that a patient requiring an authorisation for the deprivation of their liberty would have this appropriately applied for.	Training to ensure staff confident in making a referral.	The training of senior team members to ensure there is always at least 1 person on shift who is familiar with the process.	**Audit**: rota hilights the shift senior lead for MCA/DoLs			
CC5	13 (1)(2)(5)		MDT to include consideration of MCA / DoLs	Use of MCA / DoLs prompt	**Audit**: MDT sample of notes monthly. Report to dept audit meeting.	Matron and CD	Oct-16	
CC6	13 (1)(2)(5)		CCU staff aware of process to contact safeguarding team to seek advice. Safeguarding contact details easily accessible to all staff.	Check staff knowledge of accessing safeguarding team for advice and for MCA / DoLs information on the Trust intranet site.	**Audit**: MCA / DoLs MCQ. Method to be determined.	Matron & CD	Dec-16	

Outpatients - Dermatology

Accountability: **Executive -** Chief Operating Officer**; Service Manager -** KT

Ref:	Reg:	Regulation 12(1), Regulation 15(1), Regulation 17(1)(2)	Action required	Action taken	Evidence	By who	By when	Completed
D1	12(1)(2)	Emergency oxygen in the dermatology outpatient procedure rooms had not been regularly checked and there were no written records of any checks.	Oxygen to be check daily with written records of compliance	Daily checks implemented with sign off sheet. Person responsible for this is allocated each morning at the safety brief.	**Audit:** Unit manager is reviewing weekly. Reports to Medical audit meeting monthly.	Service Manager (SD)	Commenced March 2016	
D2	12(1)(2)	The processes and systems in place to monitor refrigerator temperatures were not being followed	Fridge temperatures to be checked daily	Fridge temperatures are checked daily and recorded in the register. The person responsible for this is allocated each morning at the safety brief. Any discrepencies in temperature and actions taken to be fed back to the nurse in charge. Unit manager to review registers and action weekly to ensure that this is happening.	**Audit**: daily recording. Roports to medical audit meeting monthly.	Service Manager (SD)	Commenced March 2016	
D3	12(1)(2)	In the dermatology and urology outpatient departments There were missing temperature registers and other temperature registers were incomplete.	Fridge temperature registers to be in place for all fridges and daily checks to be carried out as above	All fridges have a temperature register. Plus actions as above.	**Audit:** monthly. Reports to medical audit meeting monthly,	Unit Manager, SD	Commenced March 2016	
D4	12(1)(2)	The processes and systems in place to monitor hand hygiene in the outpatient and diagnostic imaging departments were not being followed	Hand hygiene audits to be monitored	Hand hygiene audits undertaken monthly. Audit results are shared with the Unit Manager and Matron to identify any learning needs for staff.	**Audit:** results are uploaded onto our on line infection control system and checked monthly by the unit Manager who will address actions at that time. This is documented in the safety brief. Reports to medical audit meeting monthly,	Unit Manager, SD	Mar-16	
D5	15(1)	The premises used for the delivery of minor surgical procedures in dermatology general outpatients were visibly not clean, with unclear guidance on responsibility for cleaning, and no records of cleaning could be produced	Premises will be visibly clean with cleaning records.	Both clinic rooms to be decluttered. SOP in place for the standard required for domestic staff to clean to. Cleaning sign off sheet in place. SOP in place for nursing staff to clean the room prior to each proceedure.	**Audit**: weekly audit of compliance with SOP. Reports to medical audit meeting monthly,	Unit Manager, SD	Aug-16.	
D6	15(1)	The premises used for the delivery of minor surgical procedures in dermatology general outpatients did not have adequate ventilation or extraction.	Review the environment and make the necessary adjustments.	Infection Control team advise that fly screens on the windows and natural ventilation is sufficient. Quotes have been received regarding the fitting of the fly screens and will be in place by 1/8/16.	**Audit**: fly sheets in place	Operational Support Manager - KB	Aug-16	
D7	17(1)(2)	The dermatology department had no system in place to assess post infection rates of patients undergoing minor surgical procedures in the general outpatient department. When an infection was identified, it was not recorded or investigated.	Infections to be investigated and learning shared	Incident form to be completed by the medical and nursing team for any infections. Incident forms to be directed to the appropriate clinican for review. Learning to be shared at dermatology clinical meetings.	**Audit:** Post op wound infection is an agenda item at quarterly clinical governance meetings within dermatology and incident forms will be discussed in this forum.	DGM, KT	01/08/2016	

End of Life

Accountability: **Executive**s - Chief Nurse; **Service Managers** - JS / CB

Ref:	Reg:	Regulations 11(1), 12(1)(2), 17(1)(2)	Action required	Action taken to 30.06.16	Evidence	By whom	By when	Completed
EOL1	17(1) (2) C	The provider (**community)** did not ensure that patients were protected against the risks of unsafe or inappropriate treatment arising from the lack of proper information about them by means of maintenance of an accurate record including appropriate information and documents in relation to Do Not Attempt Resuscitation decisions.	Ensure that community treatment escalation plans and do not attempt resuscitation decisions are appropriately completed and recorded in line with trust policy and that audits of these lead to measurable action plans used to improve performance.	Review existing guidance for GP's re the completion of TEP.	**Audit**: Revised guidance will be sent out to all GP with read receipt.	EoL community lead, CG	30/07/2016	
EOL2				CCG primary care leads (KK & EC) to develop a GP education program which will incorporate TEPs. CCG Education facilitators contacted in May	**Audit**: track number of GPs who have recieved the training.	CCG primary care education facilitators	30/09/2016	
EOL3				Discuss the audit of TEP at Community Matrons Community Nurse Leads meetings (meetings booked for 14/7/16 & 19/7/16).	**Audit:** meeting notes and associated actions available	EoL Community lead, CG	19/07/2016	
EOL4	11(1)	The provider (**community**) had failed to ensure that the requirements of the Mental Capacity Act 2005 were adhered to in situations where a person lacks mental capacity to be involved in discussions about do not attempt resuscitation decisions.	Ensure that patients who do not have capacity to be involved in decisions about resuscitation have a clearly recorded capacity assessment along with clearly documented best interest decisions and a detailed record of all discussions with the patient and family members.	Set up a new audit programme following discussions with community nurses community hospital that **reviews on a monthly basis** the adequate completion of TEP's in line with Trust policy. To include the documentation of capacity & best interests decision.	**Audit:** monthly compliance discussed at communiyt matorn meetings. Monthly.	EoL community lead, CG	30/09/2016	
EOL5	Reg 12(1)(2)	The provider (**community**) had failed to comply with the proper and safe management of medicines as not all staff checking the administration of controlled drugs and the use of syringe drivers had been **trained or competency** assessed to do so.	Ensure that healthcare assistants checking controlled drugs and syringe drivers are risk assessed and that training is provided and they are competency assessed.	Training and competency course is set up and in place for HCA acting as second signatory/checker for syringe pumps from 22/3/16. A registered course with Horizon centre. Data accessible from spread sheet. (EOL administrator). Records to attendance kept.	**Audit**:Training schedule and attendance register. HCA staff have attended training.	EoL community lead, CG	31/08/2016	
EOL6	Reg 17(1)(2)	Not all (**acute**) staff were suitably competent to monitor and adjust syringe drivers and some staff were **unable to demonstrate understanding of policy** regarding syringe drivers	Ensure that all (acute) staff are suitably competent to monitor and adjust syringe drivers and some staff were unable to demonstrate understanding of policy regarding syringe driversSyringe pump policy in place.	Training the trainers programme set up to ensure a minimum of 1 trained nurse and preferably 2 on each adult ward where patients may die. Ward based end of life teaching includes necessity to check syringe pumps every 4 hrs according to policy. Syringe pump sheets on wards also state that pump needs checking 4hrly. Policy already in place. Ward based end of life training already in progress. Training the trainers achieved apart from 3 wards who are currently identifying trainers. First spot check undertaken on 10/6/2016.	**Audit:** Spot checks on adult wards each month with immediate feedback to ward manager if non-compliant. Report to SDU audit meetings and QIG.	Palliative Care Lead DR JS	31/07/2016	
EOL7	Reg 17(1)(2)	**Risk registers** (**acute**) did not reflect current risks or contain clear action plans for addressing risks relating to end of life care. End of life risks were not captured on a single risk register to ensure monitoring of these across the trust.	Establish EOL risk register and ensure that current risks regarding end of life care are added to the register. Risks to be managed by the appropriate service delivery unit but will be monitored by the Trust End ofLife group. SDU Managers to ensure that risks are added to the register.	Risk Register for EoLC reviewed and Key risks identified: Mortuary Syringe pump checking Adherence to syring pump policy EoL documentation	**Audit**: Risk register in place.Trust EoL meeting notes. Trust Risk and Assurance Group notes. **Audit:** Bi-monthly EoL Group	Palliative Care Lead DR JS	01/08/2016	

Medical Care

Accountability: **Executive** - Chief Operating Officer; **Service Managers** - KT

Ref:	Reg:	Regulations 12(1)(2), 18(1)(2)	Action required	Action taken	Evidence	By who	By when	Completed
MED1	12(1)(2)	The Trust was not doing all practicable to mitigate risks to patients. This was because patients in the hospital at weekends did not always have appropriate or up to date risk assessments to reflect reduced staffing levels at weekends.	All medical patients to have weekend plans	Weekend plans sheets are now available in all clinical areas. It has been agreed with Consultants that all medical patients should have weekend plans	Audit: Junior doctors will be undertaking weekly audit on how may patients had weekend plans in place. These will be reported to Medical Department Audit meeting monthly, with the first presented in September 16	Clinical Director - Medicine (KL)	Aug-16	
MED2	12(1)(2)	Patients being cared for on outlier wards or escalation wards did not have risk assessments or care and treatment plans to mitigate the risks associated with less frequent medical oversight or specialist management.	All patients on outlier Wards and escalation wards to have weekend Plans.	Weekend plans sheets are now available in all clinical areas. It has been agreed with Consultants that all medical patients should have weekend plans	**Audit**: Junior doctors will be undertaking weekly audit on how may patients had weekend plans in place. These will be reported to Medical Department Audit meeting monthly, with the first presented in September 16	Clinical Director - Medicine (KL)	Aug-16	
MED3	12(1)(2)	The trust needed to review how staff were trained in fire safety on wards and ensuring a named competent fire warden was in place.	Each ward area to have a fire warden	All Medical wards have nominated a fire warden. All wards have up to date fire folders which includes a checklist of the relevant fire safety checks.	**Audit:** compliance checked by Matron monthly and reported to Medical Audit Meeting quarterly.	ADN - Medicine (MB)	Jun-16	
MED4	12(1)(2)		Staff training in place	All fire wardens to undergo training from the Trust fire safety officer to clarify the role and responsibility including the required safety checks.	**Audit**: Training log available & checked at the Medical Audit Meeting quarterly	ADN - Medicine (MB)	Nov-16	
MED5	12(1)(2)		Matron for each area to check compliance with completion of fire safety checklist	Process in place	**Audit:** safety audit and action any concerns underway. reported to Medical Audit Meeting quarterly.	ADN - Medicine (MB)	Jun-16	
MED6	12(1)(2)		All members of ward teams to be released to undertake mandatory fire training as face to face learning or as e-learning or buzz video.	Training commenced. Current compliance with fire safety training is 83% across all wards (Acute). Care of Older person is currently 74%. Compliance at 90% will be achieved by Nov 16.	**Audit**: Medical Audit Meeting Monthly.	ADN - Medicine (MB)	Nov-16	
MED7	12(1)(2)	Staff responsible for ward safety had not sought advice and guidance, or a review of changes imposed on them, by the trust's facilities team in relation to shortfalls in fire safety.	Advice and guidance will be acted upon	All advice and guidance notes to be sent to the ward manager and matron for the relevant clinical area. Fire folders will be reviewed yearly by the fire safety manager or more frequently if urgent action is required.	**Audit**: Actions to be checked for completion medical at monthly safety review of fire folders. **Audit:** Review fire folders monthly	ADN - Medicine (MB)	Aug-16	
MED8	18(1)(2)	The trust had not ensured there were sufficient numbers of suitably trained, competent and skilled staff deployed to meet the needs of patients at weekends.	Review medical staffing availability at the weekend	Medical Clinical Director met consultant staff on 10th June to discuss the requirement for weekend working. Minutes sent to Medical Director. Further discussion of solutions to take place 15th July and options appraisal to be submitted.	Notes of clinical meetings. Options appraisal on new medical staffing modelto be presented to Senior Business Management Team. Notes of Executive Team Meetings Notes of QIG meeting Notes of SBMT	Clinical Director (KL)	Oct-16	
MED9				Impact on flow within ED, and discharges over weekend will be reviewed. Outcomes (readmission rates, mortality) for pateints admitted over the weekend will be reviewed to confirm model of care is effective.	Notes of clinical meetings. Options appraisal on new medical staffing modelto be presented to Senior Business Management Team. Notes of Executive Team Meetings Notes of QIG meeting	Clinical Director (KL)	01/10/2016	

Accountability: **Executive** - Chief Nurse; **Service Manager** - Heather Parker

Ref:	Reg:	Regulation 15 (1)	Action required	Action taken	Evidence	By who	Completed	status
SCBU1	15(1)	Milk Kitchen door on SCBU to kept shut at all times	Key pad to be fitted to door as parents need regular access to maintain sterilisers etc.	Urgent request submitted to estates and laminated sign put up re keeping door closed. Concern also placed on handover sheet. 12/02/2016 - Key pad fitted to milk kitchen door 11/02/2016	**Audit**: Monthly spot check door locked. Report to audit meeting.	Matron - KG	05/02/2016	
SCBU2	15(1)	Breast milk fridge and freezer not lockable	New fridge and freezer to be ordered with locks and temperature gauges.	Scoping of available products. New product request underway 12/02/2016 - Confirmed on system and order placed for both fridge and freezer. Arrived and insitu.	**Audit:** Monthly spot check door locked. Report to audit meeting.	Ward Manaer - VD	05/02/2016	
SCBU3	15(1)	Milk kitchen door on Louisa Cary to be kept closed at all times and locked.	Door to be kept locked at all times	Keypad lock already insitu. Reminder to all staff to ensure door kept shut at all times Also placed on safety briefing.	**Audit:** Monthly spot check door locked. Report to audit meeting.	Ward Manager - SD	05/02/2016	
SCBU4	15(1)	No separate fridge for the storage of breast milk	All other products removed from current fridge temporarily, to be able to provide breast milk only storage. New fridge to be ordered.	Order placed for temperature controlled fridge 12/02/2016 - awaiting delivery. New fridge arrived and installed in milk kitchen.	**Audit:** Monthly spot check fridge temperature. Report to audit meeting.	Ward Manager - SD	08/08/2016	
SCBU5	15(1)	Storage policy	Existing policy to be updated to include signing in and out of breast milk	Staff identified to update policy as a matter of priority. Policy updated and currently in circulation for ratification. To be presented at the next Quality & Safety meeting 10/07/16.	**Audit**: meeting notes. Staff awareness and understanding to be checked at 6 months. Method to be determined.	Matron - KG	01/12/2016	
SCBU6	15(1)	Above to be placed on Risk Register	To be identified on Child Health Risk Register	Risk placed on register	**Audit**: Governance meeting notes demonstrate review. Trust Risk and Assurance group notes.	Matron - KG	12/02/2016	

Substance Misuse

Accountability: **Executive** - Chief Operating Officer; **Service Manager** - LW

Ref:	Reg:	Regulation 12(1)(2)	Action required	Action taken	Evidence	By who	By when	Completed
SM1	12(1)(2)	The clinic room was not locked and the keys to obtain access to the medicine cupboard and fridge were stored on a shelf in the clinic room.	A digital keypad to be fitted to the clinic room door. Keys to the medicine cabinet and fridge to be stored securely when not in use or kept on clinical staff when in use.	A digital keypad has been fitted to the clinic room door. The keys are kept in a locked safe in the drug team office upstairs and on clinical staff when in use.	**Audit** of compliance weekly. Reported to team meeting. Notes available.	Service Manager, GS	Immediately	

Community Inpatients

Accountability: **Executive** - Chief Nurse; **Service Manager -** SM

Reg:	Regulation 17(1) (2)	Action required	Action taken	Evidence	By who	By when	Completed
17(1)(2)	The systems and processes in place did not ensure information in relation to safety, particularly regarding staffing levels and skill mix, was shared and understood between ward and board level.	The systems and processes in place ensure that information in relation to safety, particularly regarding staffing levels and skill mix, is shared and understood between ward and board level.	SAFER Staffing Escalation Governance Process available, distributed, displayed and understood by all staff. Bed Escalation Governance Process available, distributed, displayed and understood by staff.  C:\Users\golds97\Desktop\Bed Escalation.docx  C:\Users\golds97\Desktop\Safer Staffing.docx	**Audit**: Control room meetings notes. Training schedule and staff attendance register. Quarterly. Chief Nurse report to Trust Board on safe levels of nurse staffing across the whole Trust.	AD Community IP - PMcD	Jul-16	
17(1)(2)	The audit and governance system in place was not effective as concerns identified in the management and staffing of escalation wards in early 2015 had not been addressed.	The audit and governance system in place is effective to ensure that management and staffing of escalation wards is identified and addressed	Patient Safety/Staffing levels/Skill Mix concerns Escalation Governance Process available, distributed, displayed and understood by staff  C:\Users\golds97\Desktop\Escalation Governance	**Audit**: Control room meetings notes. Training schedule and staff attendance register. Chief Nurse reports to Quality Improvement Group, Quality Assurance Committee and Board.	AD Community IP - PMcD	Jul-16	

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6th July 2016
Title:	Chief Operating Officer's Report
Lead Director:	Liz Davenport
Corporate Objective:	Safe, Quality Care and Best Experience
Purpose:	Information and **DECISION**

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.

Key Issues/Risks

- Delay to Community Consultation commencing - the NHSE Gateway Process is ongoing and therefore a firm date for the CCG to commence public consultation cannot be confirmed, but it is anticipated that this will be delayed until September 2016 with a final decision by the CCG Governing Body in January 2017 (Section 3).
- Associated risks to maintaining levels of safe nursing care during this extended period of uncertainty over the future of Community Hospitals, and escalated risk in relation to Paignton Hospital (Section 3)
- Pace of change in implementing the new Care Model, with plans to move to full model implementation in 2 localities by September 2016.
- Delivery of the Urgent Care improvement plan and achievement of SRG-approved performance trajectory linked to:
    - Increasing numbers of shifts in Emergency Department being covered by Agency nurses while recruitment to vacant posts continues and people take up post.
    - Consultant Medical staffing capacity to cover 16 hours per day to meet Royal College of Emergency Medicine guidelines, and interim proposals for rota changes.
    - Utilisation of Symphony to deliver robust, real time data on compliance and performance
    - Governance due to incomplete assurance against work plan due to delays in submitting evidence in support of completed actions

Recommendations:

The Board is asked to:

- **Consider and challenge the progress and assurances within this** report, advising whether additional actions are required.
- **Approve** the recommendation to manage a critical risk to quality and safety of inpatient care at Paignton Hospital due to inability to maintain safe nurse staffing levels by reducing beds from 28 to 16 and increasing intermediate care capacity (Section 3)
- **Endorse** the proposed Carers' pledge that the health and wellbeing of carers a key priority in the delivery of our new model of care.

Summary of ED Challenge/Discussion:

The Executive Team has a weekly 'huddle' to provide direction and challenge to the Urgent Care Improvement Plan and has approved actions to address any barriers and delays, including discussions with consultant colleagues on aligning medical capacity to demand, nurse staffing levels, environmental

improvements, and care pathways changes including more recently additional investment in an alternative pathway for Gynaecology patients.

The care model implementation plans have been reviewed with a particular focus on increasing the pace of change including introduction of new ways of working. A further development session is planned with the Executive Team on 8 July 2016.

The management of risk during the extended period of uncertainty for our Community Hospitals has required the Executive Team to urgently consider and challenge options to maintain a safe service.

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

CCG involvement in Urgent Care Improvement Governance system.

Ongoing engagement with local stakeholders on the proposed changes to Community Hospitals.

Ongoing engagement with voluntary and community sector partners on new ways of working in partnership at local level.

GP engagement on medical support for care model and co-design .

Equality and Diversity Implications:

An Equality Impact assessment has been completed on the care model changes.

PUBLIC

Report to:	Board of Directors
Date:	6 July 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
- Minutes and action log from Senior Business Management Team
- Minutes and action log from Community Services Transformation Group
- Minutes of the Executive Team
- A written briefing from the Trust Carers lead

3 Care Model Delivery

Delivery structures

Work is in progress to design the delivery structure for the organisation. The Clinical Management Group have approved the key principles that inform the structure and a subgroup led by Shelly Machin and Morven Leggott have undertaken to bring back proposals on how this would work in practice with the intention of commencing implementation in the autumn. Recruitment to the GP Clinical Directors is progressing with interviews due to take place in August 2016.

Coastal- Teignmouth Hospital

As part of the planned service changes in the Coastal locality the inpatient beds were closed at Teignmouth Hospital on 6 June 2016 with 5 of the 12 beds transferring to Newton Abbott Hospital to support the transition. These changes allow for the consultation with staff to support the enhancement of staffing levels at Dawlish and the development of the rehabilitation function at Teignmouth Hospital in line with plans agreed as part of the public consultation in 2015.

Community services consultation

The NHSE Gateway Process is ongoing and therefore a firm date for the CCG to commence public consultation cannot be confirmed, but it is anticipated that this will be delayed until September 2016 with a final decision by the CCG Governing Body in January 2017. These proposals, which support the development of our new model of care, involve the reduction and relocation of community hospital inpatient beds supported the Board's decision to invest £3.9m this year in additional community services. This proposed reduction in inpatient beds affects four of our nine Community Hospitals – Bovey Tracey, Ashburton, Paignton and Dartmouth. When these proposals were made public by our CCG in May, it was anticipated that public consultation would begin shortly after and we were confident that, although very challenging, we could maintain inpatient services in Paignton, Dartmouth and Ashburton until the

consultation process produced a decision. Inpatient beds at Bovey Tracey Hospital have already been temporarily relocated to Newton Abbot Hospital because of the inability to provide safe levels of nursing care.

The Chief Nurse has kept the Board informed of the risks arising from the national shortage of trained nurses, with around 90 current nursing vacancies within our Trust and an over-reliance on a flexible workforce of bank and agency nursing. The Board has supported local and overseas recruitment to minimise this risk to the stability and safety of our services and, in seeking to retain our current nursing workforce, we have reassured all staff that there will be no compulsory redundancies as a consequence of service change, as long as people are able to be flexible about roles and location. This message has again been reinforced with staff in our Community Hospitals, and Senior Managers, HR and Trade Union colleagues have visited these hospitals as requested to ensure staff are supported and their concerns addressed.

However the extended period of uncertainty over the future of the Community Hospitals proposed for closure as a consequence of delays in the public consultation process referred to above has increased the challenge of providing safe levels of nurse staffing in these Hospitals. It has become increasingly difficult to maintain safe levels of nursing care, with an inability to recruit to cover an increasing level of vacancies as staff retire or secure new posts. This, together with the usual level of sickness absence and leave, has resulted in an increasing reliance on temporary nursing cover which is becoming increasingly difficult to secure.

Paignton Hospital

The risk to providing safe levels of nurse staffing in our Community Hospitals, referred to above, has become particularly critical in Paignton Hospital. On 28 June the Senior Operational Manager responsible for Community Hospitals escalated urgent concerns about stability and safety of nurse staffing levels at Paignton, which would create an unacceptable risk to the quality and safety of the inpatient service, and presented the Executive Team with a range of options aimed at securing continuity of a safe, good quality service. The Executive Team, having considered all possible options to address these urgent concerns, propose the following risk management strategy for Board approval:

- To temporarily reduce the bed numbers at Paignton Hospital from 28 to 16 in July 2016.

- To work with staff across the organisation, with a view to strengthening the core staffing numbers at Paignton including a workforce strategy to engage with staff who have secured posts elsewhere in the Trust to discuss a delay in taking up these posts to help maintain the safety of care in Paignton Hospital.

- To optimise capacity within Intermediate Care so that more people can be supported with this local service where this is a suitable alternative to community hospital inpatient care.

Executives have alerted CCG colleagues to this risk and the proposals to manage it, and received support for the proposed reduction in beds to maintain the safety of services at Paignton Hospital.

A communications plan has been prepared to communicate the Board's decision today, and staff and key local stakeholders have been informed that the Board is considering this proposal at this meeting.

The Board of Directors is asked to consider and endorse this proposal.

Care model developments
Progress is being made against all aspects of the care model delivery programme:

Ways of working
At the heart of the care model ethos is an intention to develop a proactive strengths based approach that supports delivery of the agreed prevention and proactive care strategy. The work programme that supports implementation of the new ways of working to include introduction of a competency based framework, skills development for all staff and design and implementation of a series of tools that workers will be able to use as part of their engagement with people who use our services.

It is our intention to build on this work by enhancing the approach to personalised care planning. To achieve this, the Trust has entered into a partnership with the Community Development Trust (CDT) and 'My Support Broker' to introduce a model of personal brokerage which has a track history of improving outcomes and reducing costs. The programme will commence implementation in July 2016.

Wellbeing coordination
Recruitment is underway through the voluntary sector with the expectation that remaining staff will be in post by July 2016. These staff will have an initial period of training and will be located in localities supporting people to access the right level of support from a range of community and service options including access to services within the Multi- Long term Conditions service.

Intermediate care
The funding allocations have been made to the locality clinical hubs, the workforce plan has been developed and recruitment has commenced. Discussions are underway to agree the medical support arrangements. These developments are critical to the implementation of the 'Discharge to Assess' model which will enable more people to be assessed and care needs determined at home or near to home to expedite hospital discharge or as an alternative to hospital admission. The model will be operational in advance of the winter months.

Multi- long term conditions
The service is now operational in 2 of the 5 localities and after an initial test period it is expected that the service will increase numbers of clinics and capacity. In September the intention is to roll out clinics to all 5 localities incrementally increasing capacity from 800 patients per annum pro rata to 2000 patients in 2017.

GPs are identifying suitable patients to be referred to these clinics and MDT meetings are in place with the first people being seen in Brixham and Teignmouth.

MSK pathways

The hip and knee pathway has resulted in a significant reduction in people listed for surgery. Although the referrals to the Trust have remained broadly consistent we understand that less complex referrals to other providers have reduced. We are working with our commissioning colleagues to understand the scale of the reduction and the cost saving to the system.

Single point of coordination

Initial discussions with the Head of Adult Social Care at Devon County Council have concluded that there is a potential mutual benefit in developing a shared approach to a Single Point of Coordination. It is the intention to develop a formal proposal for consideration in July.

Next steps

Good progress has been made with delivery of the individual components of the care model but in order to deliver the benefits to the level described in the Business Plan it is critical that the components are brought together into a fully functional delivery system at locality level. It is intended to implement in two localities in September 2016 and work is underway to achieve this. It will involve consolidating the delivery of the key building blocks of the care model for example discharge to assess, frailty pathways, outpatient innovations and multi- long term conditions management with the introduction of new ways of working and implementation of multi- disciplinary team structures. Teams are coming forward wishing to participate in this important next step in our work programme.

4. Carers pledge

Whilst we move towards the new model of care where 'the best bed is your own bed' and 'care closer to home', we must be mindful that, although this is undoubtedly preferable for a multitude of reasons, it necessarily entails additional responsibility upon the unpaid Carers within our community, 83% of whom share that home. In order for the new model of care to succeed, we must therefore support Carers in the same way as the people for whom they care.

The first step is to join Carers UK leading organisations across the country to make a pledge for Carers – 'to make the health and wellbeing of Carers a key priority in the delivery of our new model of care'. Responsibility can be given to the Care Model Operational Group for identifying the actions that need to be taken to make this a reality, and to bring recommendations back to a future Board meeting. The Board of Directors are invited to endorse this recommendation.

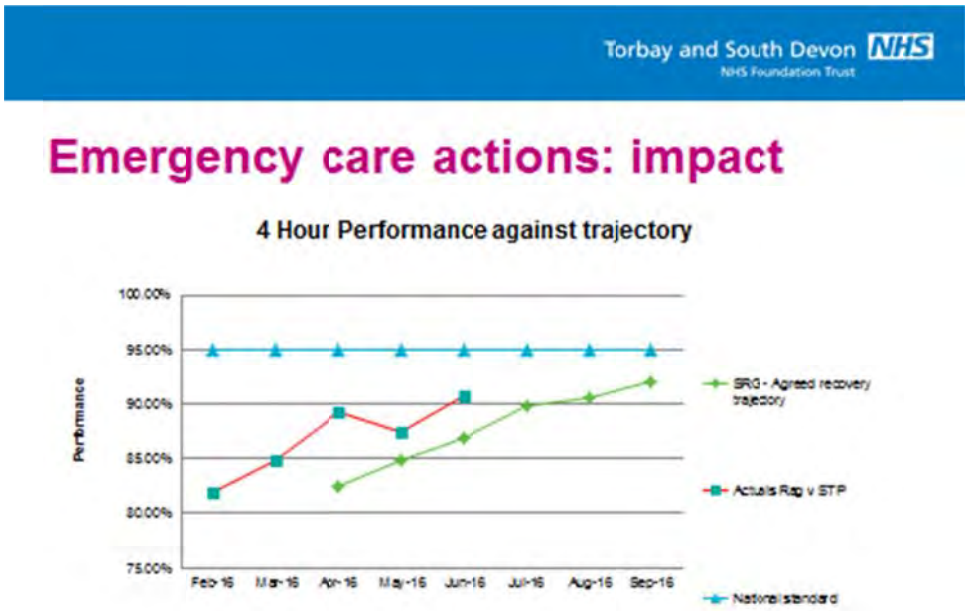
5. Urgent Care Improvement Plan

Progress against trajectory

The Trust agreed a revised trajectory for delivery of the 4 hour target which requires the Trust to meet 92% compliance with the target by September 2016. This is a measure of performance across the Emergency Department and Minor Injury Units. At present performance is above the planned trajectory with the expectation that the

performance target will be met by September 2016 and maintained to end March 2017.

The Trust will be working with the membership of the Urgent Care Board to develop a further plan to deliver the required 95% target.



Work plan progress

The Urgent Care Improvement group meets on a weekly basis to review progress against the action plan. An update is provided to the Board of Directors on a weekly basis. Key points to note:

- The department continues to maintain delivery against the 15 minute time to triage standard
- Time to 60 minute clinical review remains inconsistent with particular challenges out of hours and at weekends when staffing levels are lower
- There has been an improvement in compliance with the sepsis standards evidenced through weekly audit of case notes
- Delays in recording on clinical systems results in information from symphony being inconsistent with observed practice
- Work is progressing to improve the environment to include improvements to the waiting and triage area with dedicated assessment areas and paediatric waiting. A mental health assessment room is being completed.
- Formal discussions have commenced with the Emergency Department Consultants on job plans and working patterns
- Interviews for Consultants in Emergency Medicine are due to take place on 7 July 2016 with 2 applicants short listed for interview
- The Trust has received 2 applicants for middle grade posts with interviews being arranged.
- The ED Team have reviewed their escalation framework and are trialling their new working arrangements from 27 June 2016 with a named Clinician and Senior Nurse managing the floor on every shift.

- A further 4 days monitoring of dependency of patients in the Emergency department has been completed using the BEST tool to inform workforce plans.
- The SAFER standards have been implemented in 4 areas and the process is being rolled out across our inpatient units.
- The care pathway group has approved the introduction of a pathway for Obstetrics and Gynaecology which will enable direct referral to speciality for up to 10 people a day helping to further reduce crowding in the Emergency Department. This is due to start in July 2016.

Internal Audit review of governance arrangements

Internal Audit has completed an audit of the governance arrangements that underpin delivery of the Urgent Care Improvement Plan. The assessment has rated the programme as Amber with the potential impact on organisations objectives as low. An action plan was agreed with the Urgent Care Improvement Group on receipt of the feedback with internal audit agreeing to do a review of progress within the next 2 months.

Risks and issues

The Urgent Care Improvement Group has identified the following risks and issues:

- Increasing numbers of shifts in Emergency Department being covered by Agency nurses while recruitment to vacant posts continues and people take up post.
- Consultant Medical staffing capacity to cover 16 hours per day to meet royal College of Emergency Medicine guidelines
- Utilisation of symphony
- Incomplete assurance against work plan due to delays in submitting evidence in support of completed actions

6. Vulnerable services

As part of the STP planning process a small number of services have been identified as vulnerable from a sustainability perspective. The STP clinical cabinet has confirmed that there is an opportunity to work collaboratively across the wider system to secure improved sustainability of these services. They include:

- Head and neck/ ENT
- Interventional radiology
- Breast services
- Histopathology
- Stroke

The Executive has commissioned a series of deep dives into these services to inform discussions with colleagues in the other provider units in Devon.

6. St Kilda

Torbay Council has confirmed agreement with proposals made by the Trust that services are re-located and St. Kilda is closed.

Following confirmation of the decision the team led by Steve Honeywill continue to work with the service provider Sandwell to manage the closure programme. To date the discussion has been constructive and good progress has been made. The key areas of progress include:

- The 4 long stay residents at St Kilda have alternative independent placements identified and with some having moved and the remaining moving in the near future.
- Arrangements have been put in place to increase intermediate care capacity in the Brixham area allowing the discontinuation of intermediate care placements at St Kilda from 25 July 2016. It is anticipated that the remaining people will be discharged from the unit within a further 6 weeks.
- Day Care will initially transfer to Brixham Hospital on a 'lift and shift' basis following modest changes to the estate. The plans for this are due to be confirmed at a meeting on 13 July 2016. Voluntary sector partners have expressed an interest in becoming the provider of day services in the future and the first meeting to plan the proposed service is being facilitated by the Community Development Trust with the involvement of the Brixham League of Friends and Brixham Does Care.
- An HR meeting has been held to agree next steps in relation to the onward employment of St Kilda staff. A letter will be shortly issued to staff and 1:1 meetings will commence the week beginning 27 June 2016.

There is one remaining issue to be resolved which is the re- provision of the meals service. Options are being explored including the option of in house provision.

6. Bay Tree House

The plans to close Bay Tree House are confirmed for 30 June 2016. The unit is currently operates 4 days a week to take account of the reduced demand and workforce changes. Staff will continue to work in the building for a further 10 days to de- commission the building and then formal arrangements to hand the building back to the council will commence.

The 3 individuals who had not identified alternative provision have been allocated social workers and needs are being re- assessed, the support planning service will be working with individuals to ensure that alternative services are in place. The team remain optimistic that alternative options are available to meet the needs of the remaining people and their families.

The Trust has received consistent positive feedback about the staff at Bay Tree who have provided care that has been highly valued by the people who use the service and their families and carers. I would like to thank all the staff for their commitment and professionalism through this period of change.

Recommendation

- To **consider the progress and assurances within this** report
- To **approve** recommendation to reduce beds at Paignton Hospital as a measure to maintain quality and safety of services

- To **endorse** the pledge that the health and wellbeing of carers a key priority in the delivery of the care model

Liz Davenport

Chief Operating Officer

24 June 2016

Torbay and South Devon NHS
NHS Foundation Trust

Recent Board Visits and Staff Briefings
Council of Governors
20 July 2016

Board Visits

Chairman

30th March - Staff Drop in Session, Newton Abbot Hospital
21st April - Paignton Hospital Visit
12th May - Staff Drop in Session, Dawlish Hospital
7th June - Staff Drop in Session, Dartmouth Hospital
9th June - Dartmouth Hospital Visit

Chief Executive

13th April - Community Consultation Meeting, Dartmouth Academy
14th April - Community Consultation Meeting, Dartmoor Lodge
21st April - Whitelake Delivery Suite Visit, Newton Abbot Hospital
21st April - Paignton Hospital Visit
9th June - Dartmouth Hospital Visit

Medical Director

Meetings with medical staff at Paignton and Brixham hospitals and renegotiated community hospital contracts there.

Meetings with GPs in Teignmouth, Dawlish and the Moor to Sea locality team to discuss new models of care and GP medical cover provision to the hospitals.

Chaired the community hospitals leads meeting (GP leads in each locality and matrons) three months ago. Some discussion about future models.

Staff Briefings

Briefing – CCG Consultation	Date	Undertaken by:
Brixham	12th April	Assistant Director for Community Hospitals & Senior Human Resources (HR) Manager
Paignton	12th April	
Dartmouth	13th April	
Ashburton & Buckfastleigh	14th April	
Totnes	18th April	
Paignton (2nd round)	19th April	
Brixham (2nd round)	20th April	
Newton Abbot	25th April	
Ashburton & Buckfastleigh (2nd round)	27th April	
Bovey Tracey	27th April	
Totnes (2nd round)	28th April	
Dartmouth (2nd round)	3rd May	
Public Health Briefing ~ Brixham	4th May	
Public Health Briefing ~ Newton Abbot	5th May	
Paignton Hospital staff briefing	8th July	Interim, Director of HR, Assistant Director for Community Hospitals & Senior HR Manager

Staff Surgeries (1:1s)	Date	Undertaken by:
Dartmouth	11th May	Assistant Director for Community Hospitals & Senior HR Manager
Paignton	18th May	
Ashburton & Buckfastleigh/Bovey Tracey	20th May	
Newton Abbot	20th May	

Coastal Redesign Updates	Date	Undertaken by
Dawlish Hospital staff	29th April	Assistant Director for Community Hospitals
Teignmouth Hospital staff	16th May	Assistant Director for Community Hospitals
Teignmouth Hospital staff on Teign ward, NAH	28th June	Assistant Director for Community Hospitals & Senior HR Manager
1:1 sessions with Teignmouth Hospital staff on Teign ward (NAH)	5th July	Assistant Director for Community Hospitals & Senior HR Manager

Torbay and South Devon NHS
NHS Foundation Trust

REPORT SUMMARY SHEET

Meeting Date:	6th July 2016 – Trust Board
Title:	**Integrated Quality, Performance & Finance Report**
Lead Director:	Ann Wagner, Director of Strategy & Improvement
Corporate Objective:	Objective 1**: Safe, Quality Care and Best Experience** Objective 4: **Well led**
Purpose:	Assurance

Summary of Key Issues for Trust Board

Strategic Context:

This month's Integrated Quality, Performance and Finance Report, comprising high level summary performance dash board, narrative with exception reports, detailed data book And financial schedules provides an assessment of the Trusts position for May (month 2) 2016/17 and the cumulative position for April and May for the following:

- key quality metrics;
- regulator compliance framework national performance standards and financial risk ratings;
- local contractual framework requirements;
- community and social care framework requirements;
- change framework indicators; and
- corporate management framework KPIs.

Areas of under delivery or at risk of not delivering are identified and associated action plans are reported. The report also identifies areas where performance has improved.

This report has been reviewed by the Finance and Performance Committee (28th June) and Executive Director Group (28th June). Contribution and performance of each Service Delivery Unit (SDU) is reviewed by Executive Directors on a bi-monthly basis through the Quality and Performance review meetings. This enables the corporate team to receive assurance, prioritise areas for improvement, consider support required and oversee action plan delivery. This month the Medical and Community Service Delivery Units were reviewed (20th June).

Following feedback from key stakeholders the Quality and Performance report is undergoing significant development. This month there are some developments included within the dashboard and some within the data book. This includes amalgamating several acute and community measures and removing measures where performance continues to be measured via an alternative metric. The inclusion of run charts is intended to help communicate the performance clearly and accurately. There are a range of other formatting changes, including 13 rather than 12 months data so that the same month in the previous year can be seen. This is the first set of changes which will continue with more significant enhancements over coming months.

Key Issues/Risks:

Quality Framework:

15 indicators in total of which 4 were RAG rated RED for May as follows:

- VTE risk assessment on admission (community) – 92.9% (target 95%)
- Medication errors (Acute) – 45 (threshold < 20)
- Dementia Find – 29.8% (target 90%)

- Follow ups past to be seen date – 6073 marginal improvement

Of the remaining 11 indicators, 5 were rated GREEN, 6 AMBER

Of note is improvement in the fractured neck of femur (time to theatre) – 88.6% from 69% in April

NHS I (Monitor) Compliance Framework:
12 performance indicators in total including the quarterly governance rating of which 2 RAG rated RED for May as follows:

- Cancer 31 day wait for second/subsequent treatment (Surgery) 93.6% (target 94%)
- Urgent care (ED/MIU combined) 4 hour wait– 87.4% against national standard 95% - note overachieving against SRG agreed STF trajectory

All of the remaining 10 indicators were rated GREEN including RTT and the FORECAST Monitor governance rating. The forecast Monitor governance rating includes cancer standards which are assessed quarterly. Following May's addition to the April performance the cumulative quarter to date position has moved to compliant and reduced the score by 1 point.

At month 2 for 2016/17 the Trust is in line with the planned Financial Sustainability Risk Rating of a 2. Areas under pressure include:

- EBITDA adverse position
- CIP delivery
- Capital expenditure behind plan
- Agency spend on nursing above agreed cap

Contractual Framework:
15 indicators in total of which 11 RAG rated RED as follows:

- RTT waits over 52 weeks – 6 (standard 0)
- On the day cancellations for elective operations – 1.4% (target 0.8%)
- Cancelled patients not treated within 28 days of cancellation – 9 (standard 0)
- Ambulance handovers greater than 30 minutes 149 (target 40)
- Ambulance handovers greater than 60 minutes 12 (standard 0)
- A&E patients (Type 1 ED only) – 81.2% (target 95%)
- Number of Clostridium Difficile cases (acute & community) – 5 (threshold <3)
- Care plan summaries % completed within 24 hrs discharge weekdays 56% (target 77%)
- Care plan summaries % completed within 24 hrs discharge weekend 22% (target 60%)
- Clinic letter timeliness % specialties within 4 days – 72.7% (threshold 80%)

All of the remaining 4 indicators were rated GREEN

Community and Social Care Framework:
11 indicators in total of which 1 RAG rated RED as follows:

- CAMH's % of referrals seen within 18 weeks – 80% (target >92%) improvement from April

Of the remaining 10 indicators, 6 were rated GREEN, 1 amber and the remaining 3 awaiting data.

Of note is the significant improvement in beds days lost in community hospitals from delayed discharges. In May 166 days were lost compared to 351 in April.

Change Framework
3 indicators in total – no RAG ratings available pending agreement on tolerances

- Board will note average length of stay reduced by 0.4 of a day and hospital stays in

excess of 30 days remained fairly constant.

Corporate Management Framework
4 indicators in total of which 1 RAG rated RED as follows:

- Staff vacancy rate (trust wide) – 7.99% (threshold 4%)

Of the remaining 3 indicators, 1 rated AMBER, 1 GREEN and 1 data was not available

Recommendation:

1. To **note** the contents of the report and appendices and **seek further assurances** and **action** as required.

Summary of ED Challenge/Discussion:
The Executive Directors have considered the May position. In addition to the usual focus on urgent care and the other targets linked to the STF, Directors also held a deep dive on stroke services at their meeting on 21st June and on Nursing expenditure at their meeting on 28th June. In relation to CIP Programme Delivery this month's Finance and Performance Committee considered plans for PMO arrangements and reviewed latest updates on CIP delivery, CARTER and Care Model developments and further actions to close the efficiency gap which are being driven by the newly established Efficiency Delivery Group Chaired by the Director of Strategy and Improvement.

Internal/External Engagement including Public, Patient and Governor Involvement:
Public scrutiny is available through the publishing of this report and the associated data book. Executive briefings to monthly all managers meetings provide a comprehensive update for the Organisation and helps team leaders in setting priorities. Weekly report on Urgent Care issued to all stakeholders.

Equality and Diversity Implications:
N/A

Torbay and South Devon NHS
NHS Foundation Trust

Report to:	Trust Board
Date:	6th July 2016
Report From:	Director of Strategy & Improvement
Report Title:	Integrated Performance Report (Month 2: May 2016)

1 Introduction

This report provides commentary against performance variances and improvements at the end of May (month 2) highlighted in the performance dashboard, supported by the detailed data book and finance schedules. It has been informed from the outcomes and actions from the Quality and Performance Review meetings, Executive debate and challenge and Finance and Performance Committee scrutiny.

The report is structured by each section of the dashboard and draws out areas of significant variation for review and comment. The report also highlights those indicators where improvements have been secured.

2 Quality Framework Indicators

2.1 CQC regulation compliance assessment

The CQC carried out a comprehensive inspection of Torbay & South Devon NHS Foundation Trust in February 2016. The final inspection report was received in May. The overall rating for the Trust is Requires Improvement. Overall we were given an Outstanding for Caring.

The CQC inspected 20 core services (locations) in total. 4 were rated Outstanding overall, 8 were rated as Good and 6 as Requires Improvement. Walnut Lodge did not receive a rating, as CQC do not have the ability to do this, although a report with no concerns is available.

Overall the Emergency Department was rated as Inadequate. A requirement notice was issued to the Trust in March 2016 and an action plan has been submitted to CQC and monitored by NHSE / CCG / CQC collectively.

A further 6 requirement notices were issued with the final report – responses are currently being prepared. Delivery will be monitored through the CQC Assurance Group reporting to the Quality Improvement Group and to the Quality Assurance Group with Trust Board oversight.

The formal Quality Summit was held on the 14th June and the final report is now published.

The Trust expects a follow up inspection to ED within the next three months, and a follow up inspection sometime before the end of February 2017.

2.2 Fractured neck of femur time to theatre

RAG RATING: AMBER

The percentage of patients who have suffered a fracture and who receive their procedure within 36 hours of arrival in hospital has improved from 69% in April to 88.6% in May, the target is 90%.

ACTION: The plan to extend trauma operating capacity to provide an additional 2 hours operating per day will increase resilience and improve this performance. The business case which has been presented to Executive Directors was challenged on costs which are being reviewed with a refreshed business case due by early July for Executive decision and Committee approval.

2.3 Stroke time spent on a stroke unit - part of SSNAP domain 2

RAG RATING: RED

There has been deterioration against the overall performance rating from C to D in the latest national reports. The table below identifies the movement in performance over the last 4 quarters;

SSNAP Scoring Summary:	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*	*Routinely admitting team*
Team	Torbay Hospital	Torbay Hospital	Torbay Hospital	Torbay Hospital
Quarter	***Apr-June 2015***	***July-Sep 2015***	***Oct-Dec 2015***	***Jan-Mar 2016***
SSNAP level	D	C	C	D
SSNAP score	57	66	68	49.6
Team-centred Domain KI levels:				
1) Scanning	D	D	D	D
2) Stroke unit	E	E	D	E
3) Thrombolysis	D	C	C	D
4) Specialist Assessments	D	D	C	D
5) Occupational therapy	B	A	A	A
6) Physiotherapy	D	B	B	C
7) Speech and Language therapy	D	C	C	D
8) MDT working	C	C	C	C
9) Standards by discharge	B	B	A	C
10) Discharge processes	B	A	B	C
Team-centred KI level	D	C	C	D
Team-centred Total KI score	52	64	68	52
Team-centred SSNAP level	D	C	C	D
Team-centred SSNAP score	52	64	68	46.9

The local data which does not provide for national comparison indicates little overall change in the performance rating for April and May. There has however been an improvement in the percentage of time spent on a stroke ward from 61% in April to 87% in May against the target of 80%.

ACTION: The National Stroke Audit (SSNAP) performance for the period January to March has been reviewed in detail and Executive Team undertook an in depth assessment with the operational team on the 21st June. This highlighted the challenges in achieving the compliance required to meet standards as a 'stand-alone' service and, while areas for immediate improvement are being pursued by the Team, it is likely that further improvement in the short term will be limited by workforce constraints. There is currently only one substantive consultant in place, and recruitment is a major challenge while there is uncertainty about the future configuration of services. Neighbouring Trusts are also challenged and a review of stroke services is identified as a potential priority for a Devon-wide plan under the STP.

2.4 Completion of Dementia 'find' assessment on admission to hospital
RAG RATING: RED

The standard of completing a dementia assessment for all patients admitted to hospital over 75 years old is not being achieved. In May 30% of eligible patients were assessed, the standard is 90%. The introduction of "Nerve Centre" clinical data system will make recording of this data part of the routine electronic data capture and remove the issues of double transcription currently needed which impacts out our reported compliance figures.

ACTION: Three pilot wards are due to commence using Nerve Centre in September 2016 (Allerton, Midgley and Louisa Cary).

2.5 Care Planning Summary timeliness
RAG RATING: RED

There remain challenges with the time it takes to complete CPS conflicting with junior doctor clinical commitments. In May 56% (target 77%) were sent to GPs within 24 hours on weekdays and 22% (target 60%) on the weekends.

ACTION: Content of new CPS agreed. Implementation dependent on software rewrite expected to be complete by early July. New version will be tested on wards in July in time for implementation for new intake of junior doctors 3 August 2016. Implementation will be supported by new communication and incentivisation being considered through the CPS group.

2.6 VTE Risk Assessment on admission
RAG RATING Amber (acute) / Red (community)

The completeness of patient risk assessments on admission for venous thromboembolism is recorded as below target of 95%. In May the performance was 94% for acute admissions and 93% for community admissions. We have good evidence for the acute that this is a recording issue relating to reliance on the CPS for collection of data. This standard is expected to improve with the Nerve Centre implementation.

2.7 Follow up appointments passed their to be seen by date
RAG RATING: RED

The number of follow up outpatients waiting six or more weeks beyond their 'see by date' remains too high, 6072 patients waited beyond six weeks in May. Clinical teams with the greatest number of patients waiting over six weeks have been asked to assess the clinical risk for patients and the steps they can take to reduce any risks identified. Exception reports for Ophthalmology and Orthotics have been produced and provided to Board previously. Other specialties in this position have been requested to provide their risk assessments and exception reports.

ACTION: These reports are being prepared over the next two weeks and will be shared at the next Board Meeting in August. They will detail the key issues and assessment of the clinical risk as well as the actions agreed or decisions required to achieve reduction in this clinical risk.

3 NHS Improvement (NHS I) [1]performance framework indicators

3.1 Annual Plan for 2016/17

The Trust's Annual Plan for 2016/17 was submitted to NHS I in April with declared risks against the following national standard indicators:

- **A+E and MIU 4 hour 95% standard:** The submitted annual plan declaration showed risk of delivery in relation to the national 95% 4 hour standard with an initial trajectory submitted to deliver 95% by October 2016. Following the annual plan submission in April, a revised trajectory was agreed through the local System Resilience Group (SRG) following a case for change review to achieve stepped improvement to 92% (combined performance ED and MIU) by September and to sustain this level for the remainder of the year to March 2017. This revised trajectory has been submitted to NHS I as part of the Service Transformation Fund (STF) submissions. Performance monitoring will be against the revised STF trajectory.
- **Referral to Treatment (RTT) 92% standard** – compliance is planned from July 2016 and supported by a detailed action plan.

3.2 May 2016 update against NHS I risk assessment framework performance indicators

3.2.1 4 hour standard for time spent in A+E

RAG RATING AGAINST SRG TRAJECTORY: GREEN

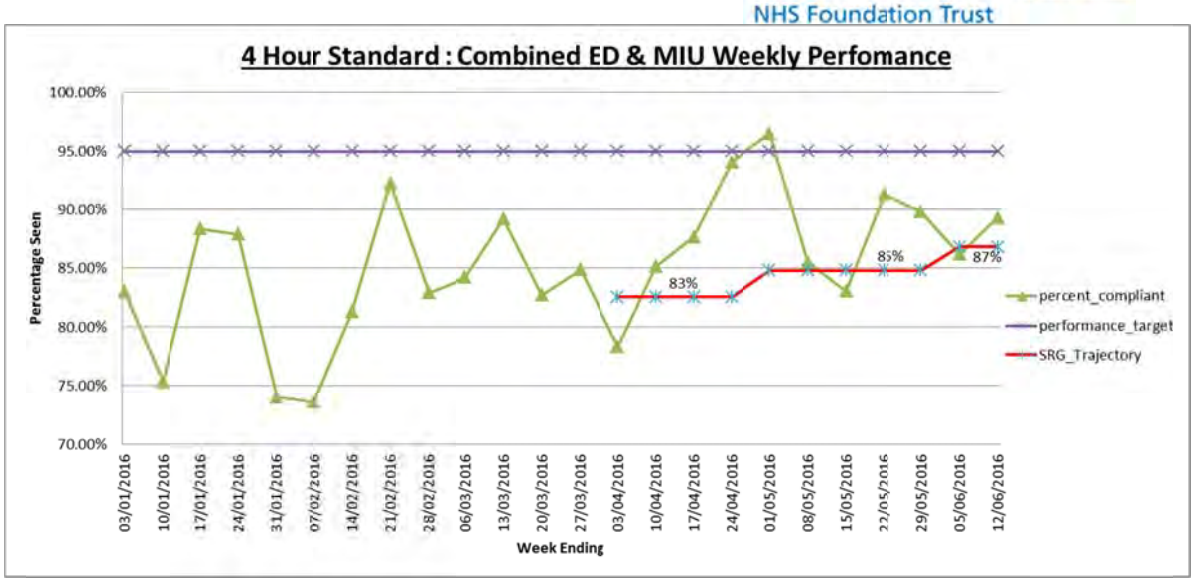
The 4 hour action plan continues to be reviewed weekly by the Urgent Care Improvement and Assurance Group (UCIAG) led by the Chief Operating Officer. To support this oversight and track the impact of service improvement, a detailed weekly performance report has been developed. The weekly report provides a detailed analysis of the work to improve clinical pathways, safety indicators and system performance oversight.

A Summary of most recent progress and issues against action plan monitoring are summarised below:

- The combined performance of ED and MIU's in May was 87.4% against the STF trajectory for May of 85%. Performance in the first two weeks of June has shown a slight improvement from May with 88.3% of patients in MIU's and A&E being seen in 4 hours, and the combined target for the last two weeks has been over 94%. This is compliant with the trajectory which for June has stepped up by 2% to 87%.

  The following graph illustrates the weekly performance against the standard and the SRG agreed STF trajectory;

[1] From the 1st of April Monitor formally became known as NHS improvement (NHSI).



- Time to initial assessment has improved and this has been consistently maintained over the period, with the implementation of the Rapid Assessment Area and additional nursing for triage. Processes have also been implemented which have improved SWAST handover times. The median time to initial assessment is consistently just below 10 minutes however, more work is required to achieve the target of 85% seen within 15 minutes.

Increasing senior doctor presence later in the evening and at weekends is key to embedding and improving performance and safety of care. The operational team is engaging with consultants about a change in the doctors working pattern with an intended implementation date of September 2016. Further details are included in the Chief Operating Officer's report.

3.2.2 Referral to Treatment (RTT) incomplete pathways

RAG RATING: GREEN

The confirmed RTT performance for May is that 92.5% of patients waited 18 weeks or less for their treatment at the Trust. This is the second month in a row the Trust has delivered the 92% standard when taking the total performance of all specialities together. This performance represents earlier delivery than originally planned as the trajectory is to deliver 92% by July.

However a number of specialties and in particular Neurology have been identified as 'at risk' due to workforce and other challenges and the cumulative effect is creating a corporate risk to the delivery of the 92% target in aggregate. More Information on individual specialties is included below. The forecast is for RTT performance in June to fall back from 92.5%, at this stage in the month it is too close to say whether this will be below the standard of 92%.

At individual specialty level further significant improvement in Ophthalmology has continued. The backlog of Ophthalmology patients waiting over 18 weeks has reduced further and is now 80 better (or fewer) than the trajectory. This is the main factor for achievement against overall target in May.

There are a number of specialties where performance is deteriorating and will threaten delivery of the Trust aggregate 92% position these are summarised below:

Neurology – The backlog over patients waiting over 18 weeks has risen to 91 due to loss of consultant capacity. **ACTION:** Discussions with neighbouring trusts to create arrangements for partnership working and increased on site capacity are on-going. It is unlikely that any substantive arrangements will be in place before Sept 2016.

Pain Management – The backlog has risen to 83 due to a locum consultant leaving and not being able to recruit to this vacant post which has impacted on capacity and the backlog of patients waiting treatment is therefore increasing. **ACTION:** A local in-house solution to change work plans is being sought, once implemented this will replace the lost capacity, but it will not be in place until Sept 2016.

Gastroenterology – The current shortfall in capacity will continue until the new consultant starts in Sept 2016. **ACTION:** The clinical team are supporting additional clinics but this remains below the level of capacity that is required to reduce current backlog.

Orthopaedics – Pressure on beds over the winter and spring resulted in high numbers of elective cancellations. Recent reduction in referrals for hip and knee outpatients following introduction of the new MSK service under the 'care model' changes is encouraging, and while this frees up outpatient clinical capacity, as expected the numbers of patients being added to the operating list have remained unchanged. The RTT backlog of patients over 18 weeks has risen to 277 and is likely to increase further as a consultant has resigned. **ACTION:** The Trust is working with our local private provider to help reduce the number of patients waiting over 18 weeks.

Colorectal and Upper GI – The number of routine patients waiting for treatment remains above plan. Clinical priority is given to the more urgent pathways and loss of elective capacity from on-going winter pressures on beds has resulted in additional cancelled operations. **ACTION:** The clinical team has a plan developed for an additional consultant to support both the emergency and elective capacity to achieve RTT trajectory.

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

3.2.3 Clostridium Difficile (c-diff)

RAG RATING: GREEN

The 2016/17 National objective for the number of C.diff cases is 18 cases. For Monitor compliance reporting the target in 2016/17 is 18 cases measured as the number of cases agreed with commissioners being due to a "lapse in care".

In May, there are 5 new cases of c-diff recorded with four confirmed as No lapse in care and one still to be assessed. The cumulative lapse in care for 2016/17 is one case.

The dashboard details the number of cases and the split between community and acute settings.

3.2.4 Cancer standards

RAG RATING: AMBER

Provisional data for the 31 days for subsequent Surgery standard is reported as not being achieved in May. This is prior to final validation and submission in national returns which is due in early July. From the total patients treated in May of 47 there were 3 patients who were not treated within 31 days, of these 2 patients choose to wait. These are provisional figures and are likely to improve once validation is complete. The forecast for Q1 is for all cancer targets to be achieved.

3.3 Summary Finance Report

RAG RATING: AMBER

The Trust submitted an Annual Plan to NHS I for the financial year 2016/17, based on a Payment By Results (PbR) contract arrangement. However, as reported at the last Board meeting, agreement has been secured to reinstate a Risk Share Agreement that underpinned the business case for the creation of the Integrated Care Organisation. A revised plan has been prepared, reflecting this agreement, with the Trust picking up a share of the system risk in 2016/17, and resulting in a predicted deficit of £5.1m in line with risk share for deficit greater that £1.9m. Following discussion with our NHS I Regional Director, the Director of Finance has written to NHS I requesting a formal amendment to the Trust's control total in this regard.

Key financial headlines for month 2 to draw to the Board's attention are as follows:

- **EBITDA:** for the period to 31 May 2016 EBITDA is £0.15m. This is broadly in line with plan, both as submitted and revised. When compared to the current PbR based plan it represents a £0.09m adverse variance. Should the revised plan based on the Risk Share arrangement be accepted by NHS I, this would result in an adverse EBITDA variance plan of £0.23m.

- **Income & Expenditure:** the year to date income and expenditure position is a £2.5m deficit; again broadly in line with both original and revised plan. This level of performance represents a £0.23m favourable against the PBR plan, and £0.10m favourable against the RSA plan.The Trust has a £1.34m deficit in May after risk share income has been applied.

- **CIP Programme** - delivery remains challenging, with £1.33m delivered to date. Whilst supporting revenue performance is in line with plan, we need to secure the remainder of the CIP Programme as a matter of urgency. The level of savings planned increases significantly from Quarter 2 forward, so it is imperative that we secure better traction in the programme. With that in mind, detailed action plans have been developed in support of the vast majority of schemes, and progress will be reported at scheme level to the Finance and Performance Committee.

- **Risk Rating**: The Trust has delivered a Financial Sustainability Risk Rating of 2, which is as planned.

- **Cash Position**: balances are lower than plan (PBR plan by £10.14m, RSA plan by £8.67m) mainly due to debtors, offset by lower than planned capital spend.

- **Capital:** capital expenditure is £2.69m behind plan at month 2.

- **Agency Spend:** Agency Registered Nursing spend to date is running at 11% in month, 10% year to date, against a cap of 4%. AS a result NHS I has written to the Trust to confirm they are re-profiling our expenditure threshold across the year.

Further details are included in the attached financial schedules and narrative

4 Contract Framework

The CCG contract for 2016/17 is now agreed, heads of terms for the contract have been signed and the detailed contract documentation is being reviewed and processed.

4.1 Service Transformation Fund (STF) performance trajectories

The trajectories below have been agreed and submitted to the CCG and NHS I. These will contribute to the Trusts ability to secure the STF:

STF trajectories and performance

	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
4 hour standard	82.5%	84.8%	86.8%	89.9%	90.5%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Performance against plan / standard	89.4%	87.4%										
RTT - incomplete pathways	90.9%	91.2%	91.3%	92.02%	92.6%	92.9%	93.1%	93.2%	93.2%	93.1%	93.3%	93.3%
Performance against plan / standard	92.1%	92.5%										
Diagnostics < 6 weeks wait	98.91%	98.98%	98.96%	99.01%	99.0%	99.0%	99.2%	99.2%	99.2%	99.2%	99.2%	99.1%
Performance against plan / standard	88.50%	99.10%										
Cancer 62 day	96.0%	92.5%	85.9%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.0%	86.4%	85.2%
Performance against plan / standard	87.6%	90.0%										

1. A+E / MIU (type 1 and 2) waiting times < 4 hours (Target trajectory 92%) - Planned trajectory of improvement to achieve 92% by September 2016 to be maintained for remainder of 16/17
2. RTT % patients waiting under 18 weeks (Target 92%) - Planned delivery July 2016
3. Diagnostic waiting times < 6 weeks (Target 99%) - Planned delivery from July 2016
4. Cancer 62 day referral to treatment (Target 85%) - Target delivered from April 2016.

4.2 Commissioning for Quality and Innovation (CQUIN)

The CQUIN Schemes for 2016/17 are under review by both the CCG and the Trust and are due to be signed by the long stop date (30th June) in the contract.

4.3 Diagnostic tests waiting over 6 week
RAG RATING: GREEN

In May the standard for diagnostic waits has been achieved with 0.9% of patients waiting at the end of month over 6 weeks. There continue to be service pressures in particular for CT scanning. Further actions to reduce the overall number of patients waiting and provide resilience to fluctuations in demand are being implemented.

4.4 12 hour Trolley waits
RAG RATING: GREEN

In May there were no 12 hour trolley waits recorded

4.5 Cancelled operations
RAG RATING: RED

Operations cancelled on the day of admission by the hospital remain above the national standard. In addition in May 9 patients were not re-admitted within 28 days of cancellation. The number of patients cancelled and not re-admitted within 28 days has increased steadily since February.

5. Community and Social Care Framework

5.1 CAMHS
RAG RATING: RED

The percentage of patients seen within 18 weeks has improved in May to 80% from 59% in April although this remains below the target of 92%. At the end of May the longest wait for treatment experienced by our patients was 27 weeks from referral.

5.2 Community Service Delivery Unit Harm Free care

The CSDU harm free rate was exceptionally low this month at 85.8% (previous month 92.5%) – Pressure Ulcer Harms reported on the day of ST audit was the main contributory factor and these were as follows:

- PU Harms CSDU 10.87% (previous month 6.7%)
- 'Old'/Transferred in PU harms = 9.27% (previous month 6.5%)
- 'New' PU harms 2.43% (previous month 2.22%)

5.3 Delayed Discharges

RAG RATING: GREEN (May) Red (year to date)

There has been a significant improvement in the number of community bed days lost. May saw the lowest level over the last 13 months with 166 bed days lost, previously the best performing month was October 2015 when 211 bed days were lost. The improvement in delays for reasons solely attributable to Social Care are as follow; Apr: 223 days lost; May: 141 days lost. The Hospital that showed the greatest improvement was Newton Abbot Templar Ward (Apr: 166 Bed Days Lost to delays; May: 62).

The reasons recorded for delays and the improvement between months is analysed as follows;

- Patient / Family Choice (Apr: 76 days; May 24 days)
- Residential Home Placement (Apr: 87 days; May: 32)
- Nursing Home Placement (Apr: 35 days; May: 0)

SAFER patient flow management principles, which include daily MDT review of all patients have been implemented in Ashburton Hospital and Templar Ward during May 2016 with a strong focus on discharge planning. This initiative advocates full engagement with patients and families on the choices available to them and their expected date of discharge. Whilst it is too early to statistically attribute this work to the improvements in the reduction in community delays outlined above, there is no doubt that discharge improvements have been seen. In addition a dedicated discharge co-ordinator has been allocated to Newton Abbot Hospital to support discharge processes and additional support to Totnes Hospital is planned. However, it should also be noted that during May there have been short periods of bed closures due to infection across the community Hospitals which have impacted on bed capacity.

A system-wide piece of work to review complex discharge planning is underway, supported by the Trusts' Quality Improvement Team building on from the success of a Discharge Coordination Site which enables tracking of patients across the Acute and Community bed-based system. On-going monitoring will track how these

6 Supporting documents to this integrated performance report

1. Month 2 Quality, Performance and Finance Dashboard
2. Month 2 Quality and Performance Databook
3. Month 2 Financial schedules and narrative

				May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Year to date 2016/17
1	Safety Thermometer - % New Harm Free	9 (full year)															
1	Reported Incidents - Major + Catastrophic *																
1	Avoidable New Pressure Ulcers - Category 3 + 4 *																
1	Never Events																0
1	Written Complaints - Number Received *																77
1	VTE - Risk assessment on admission - (Acute)																94.8%
1	VTE - Risk assessment on admission - (Community)																92.7%
1	Medication errors - (Acute) *																78
1	Medication errors - (Community) *																45
1	Hospital standardised mortality rate (HSMR) - 3 months in arrears YTD = last 12 months cumulative																96.7%
1	Infection Control - Bed Closures - (Acute) *																292
1	Fracture Neck Of Femur - Time to Theatre <36 hours																77.9%
1	Stroke patients spending 90% of time on a stroke ward																72.3%
1	Dementia - Find - monthly report																36.5%
1	Follow ups past to be seen date																6073

Corporate Objective Key	
1	Safe, Quality Care and Best Experience
2	Improved wellbeing through partnership
3	Valuing our workforce
4	Well led

NOTES

* For cumulative year to date indicators, RAG rating is based on the monthly average

[STF] denotes standards included within the criteria for achieving the Sustainability and Transformation Fund

Corporative Objective		Target 2016/2017	13 month trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Year to date 2016/17
MONITOR COMPLIANCE GOVERNANCE																	
1	Overall Quarterly Monitor Governance Score and rating	N/A			2			1			2			2	2	1	
1	A&E - patients seen within 4 hours [STF]	>95%		89.9%	91.2%	82.4%	80.2%	90.2%	91.4%	87.9%	85.3%	81.8%	82.0%	84.9%	89.4%	87.4%	88.3%
	A&E - trajectory [STF]	>92%		82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	84.8%	84.8%
1	Referral to treatment - % Incomplete pathways <18 wks [STF]	>92%		91.7%	91.4%	92.4%	92.2%	92.1%	91.5%	91.2%	90.8%	91.2%	91.4%	91.8%	92.1%	92.5%	92.5%
	RTT Trajectory [STF]			90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	91.2%	91.2%
1	Number of Clostridium Difficile cases - Lapse of care - (ICO) *	<18 (year)		1	3	2	1	2	0	1	0	0	0	0	1	0	1
1	Cancer - Two week wait from referral to date 1st seen	>93%		94.0%	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.3%	96.4%	96.3%
1	Cancer - Two week wait from referral to date 1st seen - symptomatic breast patients	>93%		94.4%	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	99.0%	98.4%
1	Cancer - 31-day wait from decision to treat to first treatment	>96%		98.7%	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.4%	98.0%	97.2%
1	Cancer - 31-day wait for second or subsequent treatment - Drug	>98%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
1	Cancer - 31-day wait for second or subsequent treatment - Radiotherapy	>94%		95.7%	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%	87.9%	96.5%	100.0%	93.5%	98.3%	96.2%
1	Cancer - 31-day wait for second or subsequent treatment - Surgery	>94%		93.8%	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.6%	96.1%
1	Cancer - 62-day wait for first treatment - 2ww referral [STF]	>85%		92.5%	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	87.6%	90.0%	88.9%
1	Cancer - 62-day wait for first treatment - screening	>90%		100.0%	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.5%	93.3%	91.7%
MONITOR COMPLIANCE FINANCIAL SUSTAINABILITY																	
4	Capital Service Cover	2			1			1			1			1	1	1	1
	Capital Service Cover - Plan														1	1	1
4	Liquidity	3			3			2			4			4	4	4	4
	Liquidity - Plan														4	4	4
4	I&E Margin	4			0			2			1			1	1	1	1
	I&E Margin - Plan														1	1	1
4	I&E Margin Variance From Plan	3			0			4			4			3	3	3	3
	I&E Margin Variance From Plan - Plan														3	3	3
4	Overall Financial Sustainability Risk Rating	3			2			2			2			2	2	2	2
	Overall Financial Sustainability Risk Rating - Plan														2	2	2

The Governance rating score is assessed against the number of failed indicators in accordance with the Risk Assurance framework. A score of 4 or over will trigger a RED rating. Any individual indicator failed for 3 consecutive months can trigger a status of governance concern leading to potential investigation and enforcement action.

Corporative Objective		Target 2016/2017	13 month trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Year to date 2016/17
CONTRACTUAL FRAMEWORK																	
1	Diagnostic tests longer than the 6 week standard [STF]	<1%		2.5%	1.2%	1.1%	2.6%	2.7%	0.4%	0.8%	1.1%	2.8%	1.0%	1.6%	1.5%	0.9%	1.2%
	Diagnostic trajectory [STF]			1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.09%	1.02%	
1	RTT 52 week wait incomplete pathway	0		0	0	0	1	1	1	1	2	3	5	4	4	6	
1	Mixed sex accomodation breaches of standard	0		0	0	0	0	3	1	0	0	0	0	1	0	0	
1	On the day cancellations for elective operations	<0.8%		1.3%	1.0%	0.7%	0.8%	0.8%	1.0%	1.0%	1.4%	1.3%	1.4%	0.9%	1.5%	1.4%	
1	Cancelled patients not treated within 28 days of cancellation *	0		2	4	3	2	0	0	2	3	2	9	10			13
1	Ambulance handover delays > 30 minutes [STF] *	0		27	18	68	87	86									251
	Handovers > 30 minutes trajectory *			50	50												90
1	Ambulance handover delays > 60 minutes [STF] *	0															38
1	A&E - patients seen within 4 hours DGH only	>95%															82.8%
1	A&E - patients seen within 4 hours community MIU	>95%															100.0%
1	Trolley waits in A+E > 12 hours from decision to admit	0		0	0	0	0	0	0								2
1	Number of Clostridium Difficile cases - (Acute) *	<3															5
1	Number of Clostridium Difficile cases - (Community)	0		0				0	0	0			0	0	0		1
1	Care Planning Summaries % completed within 24 hours of discharge - Weekday	>77%		55.6%	60.0%	61.0%	61.7%	61.5%	62.4%	61.8%	55.0%	58.5%	58.5%	54.0%	63.6%	56.2%	59.6%
1	Care Planning Summaries % completed within 24 hours of discharge - Weekend	>60%		27.3%	32.8%	37.4%	28.1%	24.3%	26.7%	30.2%	23.8%	35.3%	22.0%	24.6%	25.0%	22.4%	23.7%
1	Clinic letters timeliness - % specialties within 4 working days	>80%		72.7%	86.4%	77.3%	72.7%	59.1%	59.1%	72.7%	77.3%	72.7%	77.3%	86.4%	81.8%	72.7%	77.3%

NOTE

* For cumulative year to date indicators, RAG rating is based on the monthly average

Corporative Objective		Target 2016/2017	13 month trend	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Year to date 2016/17
COMMUNITY & SOCIAL CARE FRAMEWORK																	
1	Number of Delayed Discharges *	2216 (full year)		508	401	320	403	317	211	467	327	325	415	338	351	166	517
1	Timeliness of Adult Social Care Assessment assessed within 28 days of referral	>70%		71.3%	70.6%	71.0%	70.3%	69.6%	69.9%	71.0%	67.0%	68.8%	68.8%	68.9%	86.0%	78.7%	78.7%
3	Clients receiving Self Directed Care	>90%		92.2%	92.4%	93.3%	93.4%	93.1%	92.8%	92.5%	92.7%	92.1%	92.9%	93.6%	92.5%	91.6%	91.6%
2	Carers Assessments Completed year to date	40%		11.3%	18.5%	18.4%	24.2%	27.4%	32.1%	35.9%	38.2%	41.2%	42.8%	43.3%	5.9%		11.9%
3	Number of Permanent Care Home Placements	617		652	652	646	645	639	645	630	636	637	640	635	628	624	624
1	Children with a Child Protection Plan (one month in arrears)	NONE SET		157	156	161	190	199	216	216	212	174	147	139	131		131
3	4 Week Smoking Quitters (reported quarterly in arrears)	NONE SET			126			231			303						
3	% OCU in Effective Drug Treatment (reported quarterly in arrears)	NONE SET			7.2%			6.3%			6.4%						
1	Safeguarding Adults - % of high risk concerns where immediate action was taken to safeguard the individual [NEW]	100%													100.0%	100.0%	
1	Bed Occupancy	80% - 90%		90.7%	92.1%	90.6%	92.3%	89.9%	90.3%	92.7%	92.4%	94.8%	92.5%	91.9%	92.8%	89.8%	
1	CAMHS - % of referrals seen within 18 weeks	>92%		73.9%	77.8%	33.3%	45.5%	71.4%	90.0%	72.0%	50.0%	83.3%	53.6%	76.5%	59.3%		
CHANGE FRAMEWORK																	
3	Number of Emergency Admissions - (Acute)			2546	2631	2732	2580	2694	2776	2760	2708	2609	2740	2945	2797	2975	5772
3	Average Length of Stay - Emergency Admissions - (Acute)			3.4	3.5	3.2	3.2	3.2	3.2	3.4	3.5	3.5	3.3	3.4	3.7	3.3	3.5
3	Hospital Stays > 30 Days - (Acute)			23	33	27	21	28	17	18	21	21	28	29	35	34	69
CORPORATE MANAGEMENT FRAMEWORK																	
2	Staff Vacancy Rate (excl temp workforce and additional hours)	<5%		7.00%	5.80%	6.50%	4.50%	6.40%	6.60%	6.80%	7.50%	6.80%	7.00%	7.45%	7.92%	7.99%	7.99%
2	Staff sickness / Absence 1 month arrears	<3.5%		4.30%	4.20%	4.20%	4.20%	4.10%	4.10%	4.00%	4.00%	4.00%	4.00%	4.05%	4.11%		4.11%
2	Appraisal Completeness	>90%		84.00%	86.00%	86.00%	86.00%	84.00%	80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%	82.00%
2	Mandatory Training Compliance	>85%		87.00%	87.00%	88.00%	88.00%	87.00%	89.00%	89.00%	90.00%	90.00%	89.00%	88.10%	87.85%	88.00%	88.00%

Performance & Quality Databook

Month 2 May 2016

Contents

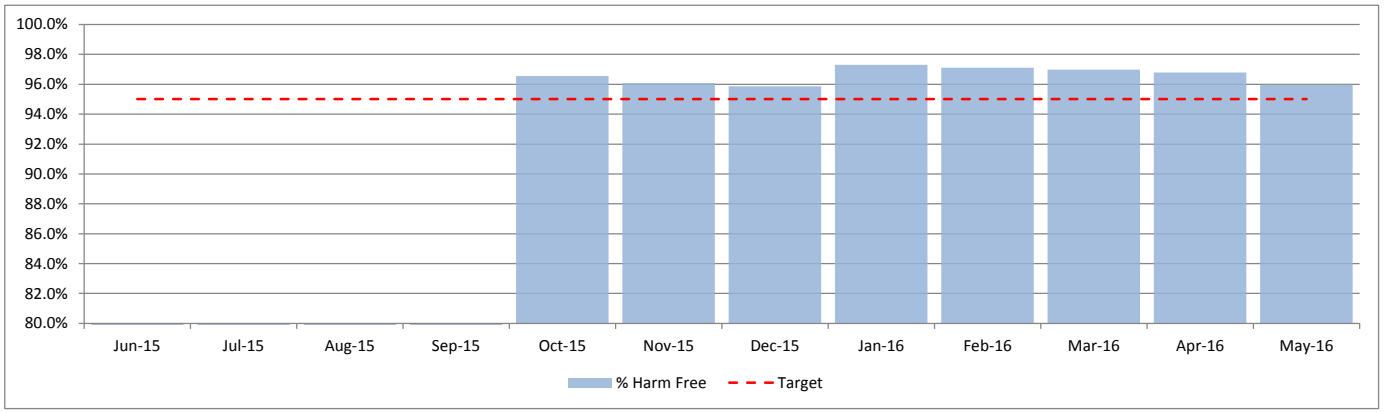
QUALITY FRAMEWORK

Month 2 May 2016

QUALITY FRAMEWORK

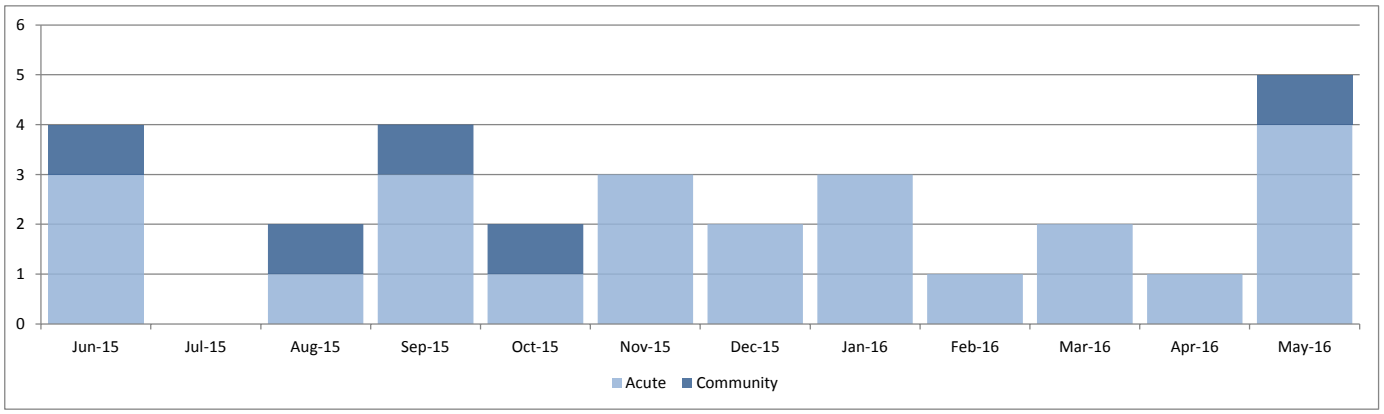
Harm Free - Trust Total

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients					985	1044	994	1109	1075	1057	1027	1044
Harm Free					951	1003	953	1079	1044	1025	994	1002
% Harm Free	n/a	n/a	n/a	n/a	96.5%	96.1%	95.9%	97.3%	97.1%	97.0%	96.8%	96.0%
Target	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



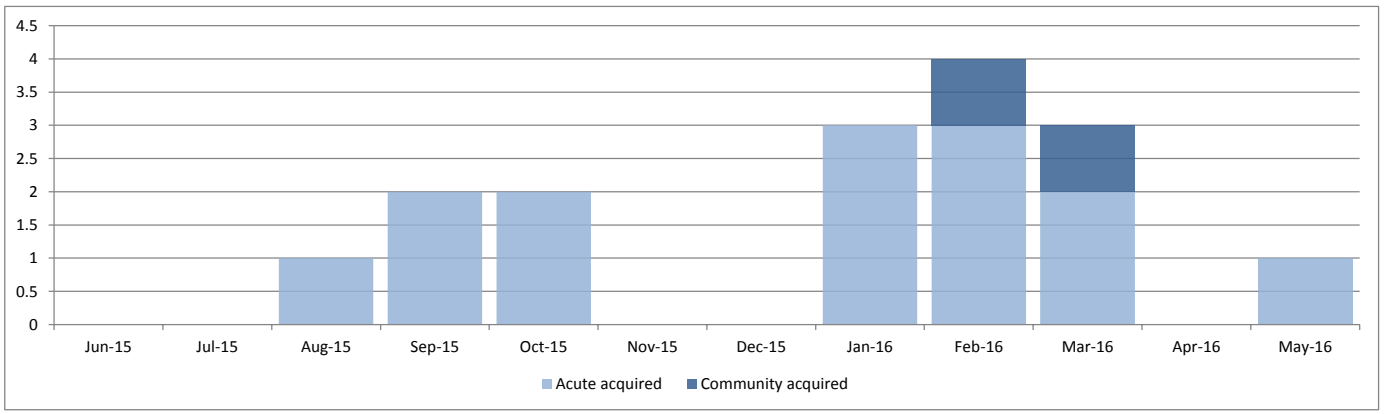
Reported Incidents - Major and Catastrophic

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	3	0	1	3	1	3	2	3	1	2	1	4
Community	1	0	1	1	1	0	0	0	0	0	0	1



New Pressure Ulcers - Categories 3 and 4 (avoidable)

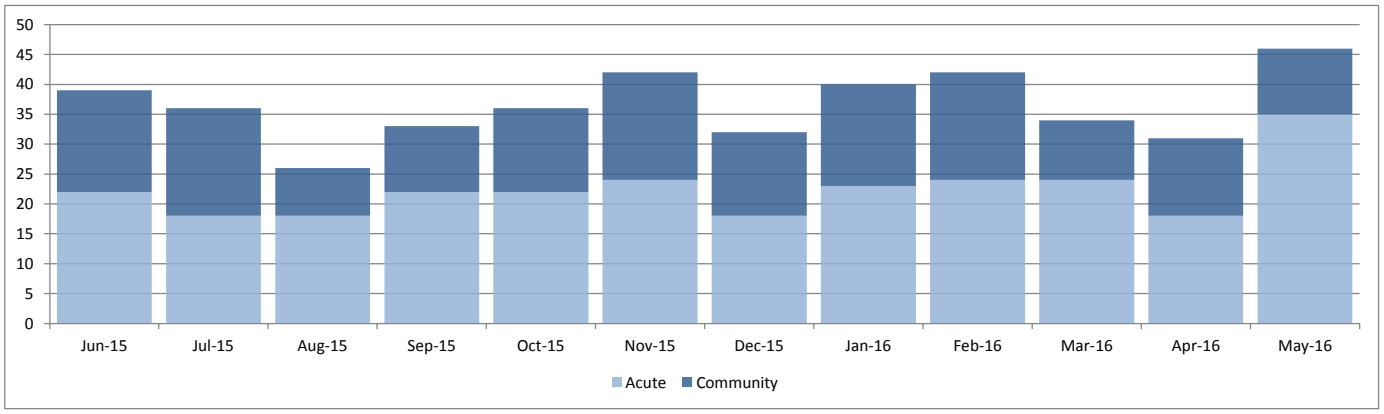
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute acquired	0	0	1	2	2	0	0	3	3	2	0	1
Community acquired	0	0	0	0	0	0	0	0	1	1	0	0



QUALITY FRAMEWORK

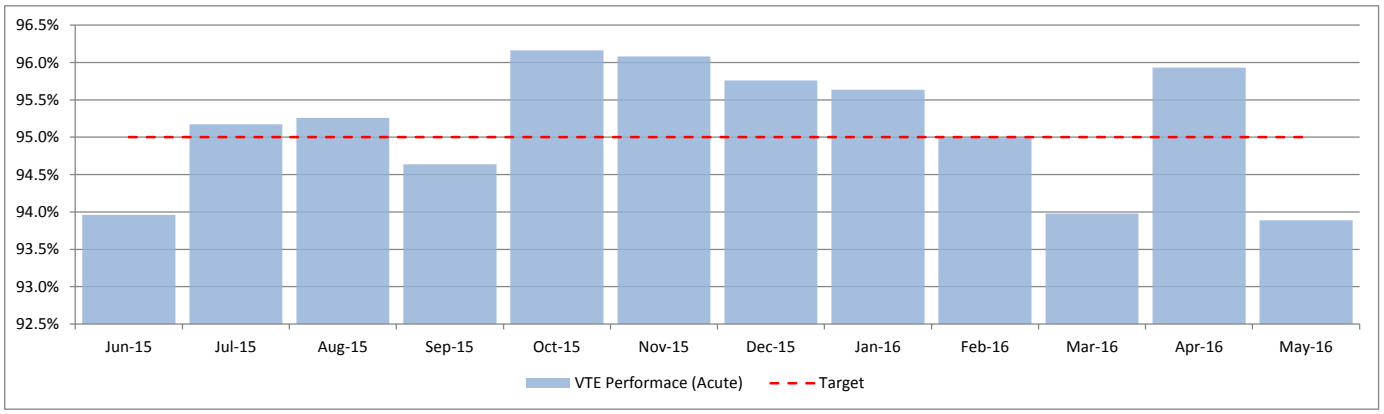
Written complaints

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	22	18	18	22	22	24	18	23	24	24	18	35
Community	17	18	8	11	14	18	14	17	18	10	13	11



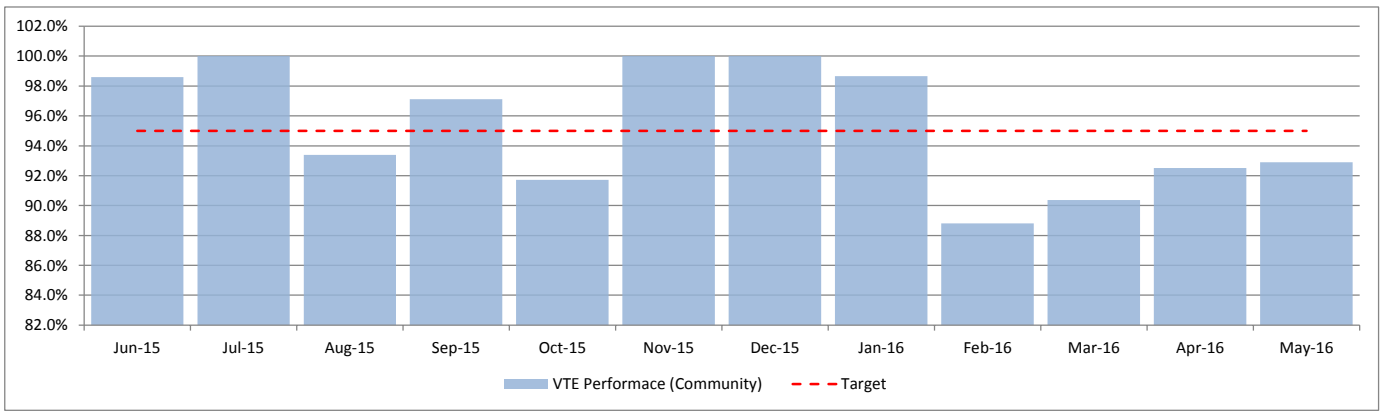
VTE Risk assessment on admission - (Acute)

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
VTE Numerator	5709	5955	5528	5930	5738	5593	5352	5653	5424	5573	5261	6098
VTE Denominator	6076	6257	5803	6266	5967	5821	5589	5911	5710	5930	5484	6495
VTE Performace (Acute)	94.0%	95.2%	95.3%	94.6%	96.2%	96.1%	95.8%	95.6%	95.0%	94.0%	95.9%	93.9%
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%



VTE Risk assessment on admission - (Community)

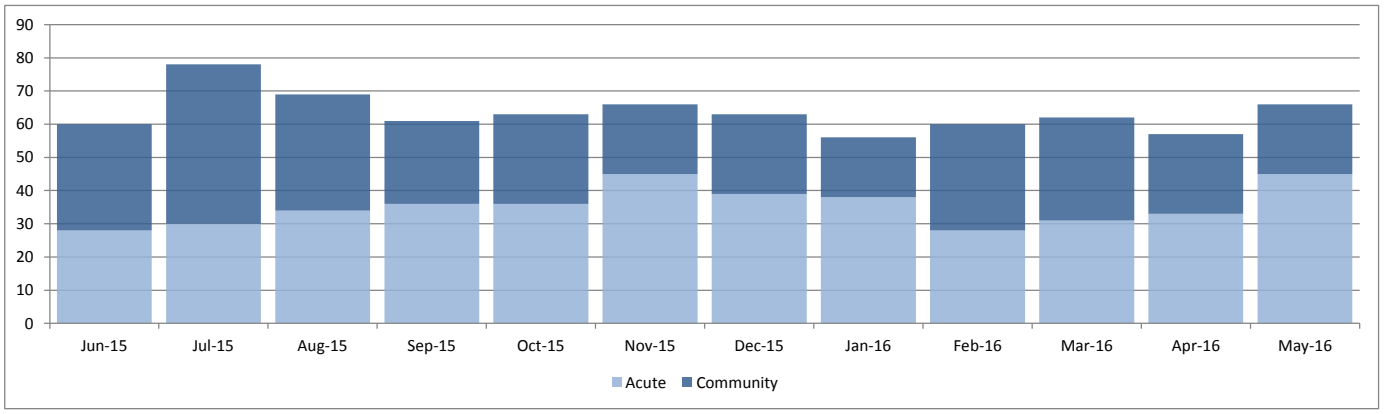
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
VTE Numerator	140	130	127	135	133	135	137	148	135	122	136	131
VTE Denominator	142	130	136	139	145	135	137	150	152	135	147	141
VTE Performace (Community)	98.6%	100.0%	93.4%	97.1%	91.7%	100.0%	100.0%	98.7%	88.8%	90.4%	92.5%	92.9%
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%



QUALITY FRAMEWORK

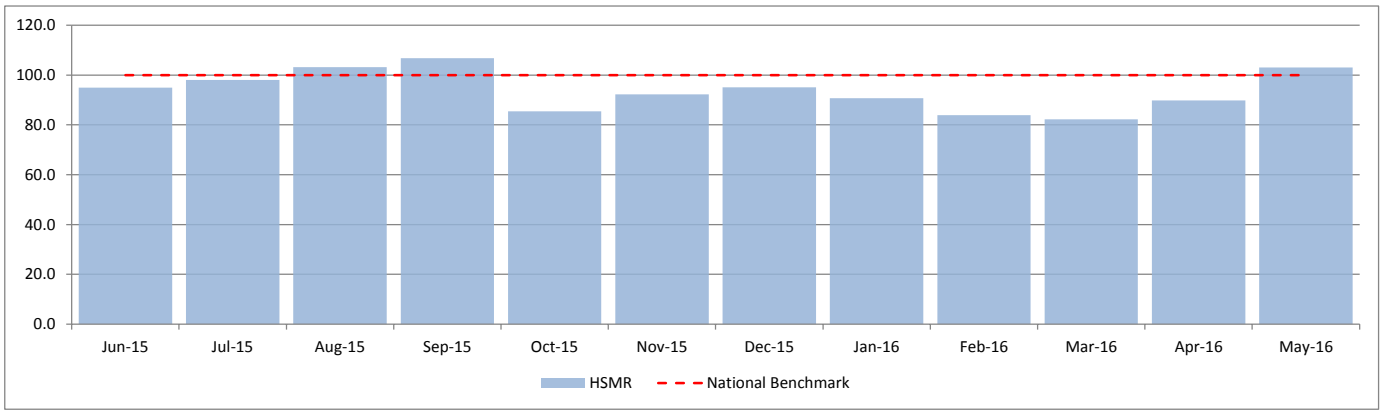
Medication Errors

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	28	30	34	36	36	45	39	38	28	31	33	45
Community	32	48	35	25	27	21	24	18	32	31	24	21



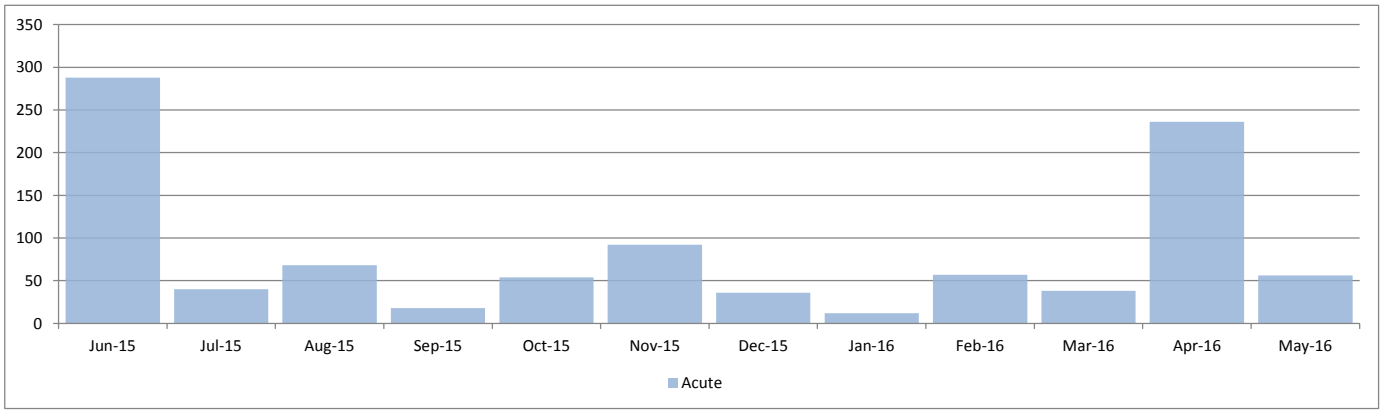
Hospital Standardised Mortality Rate (HSMR) national benchmark = 100

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
HSMR	95.0	98.0	103.2	106.8	85.4	92.2	95.1	90.7	83.9	82.2	89.8	103.0
National Benchmark	100	100	100	100	100	100	100	100	100	100	100	100



Infection Control - Bed Closures (acute)

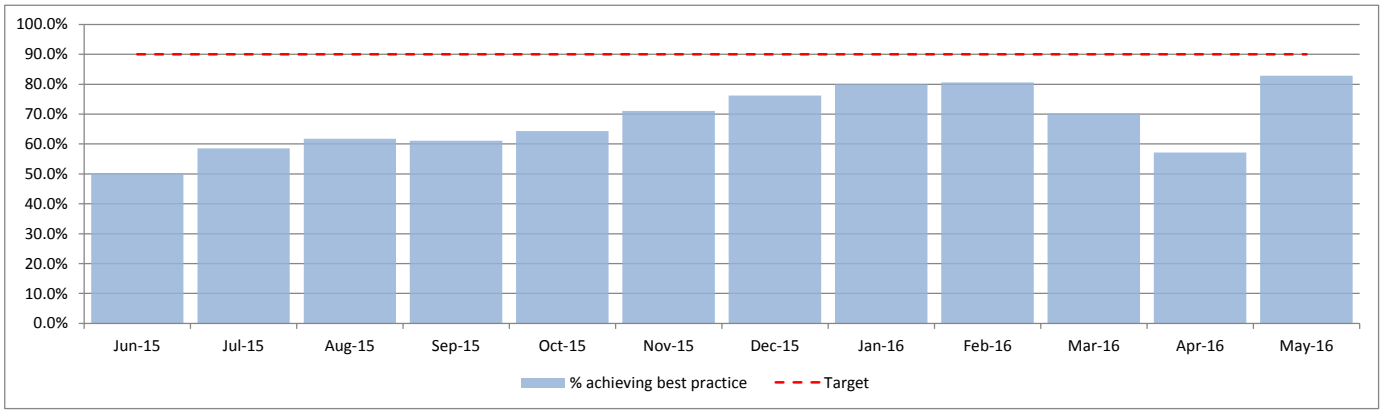
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	288	40	68	18	54	92	36	12	57	38	236	56



QUALITY FRAMEWORK

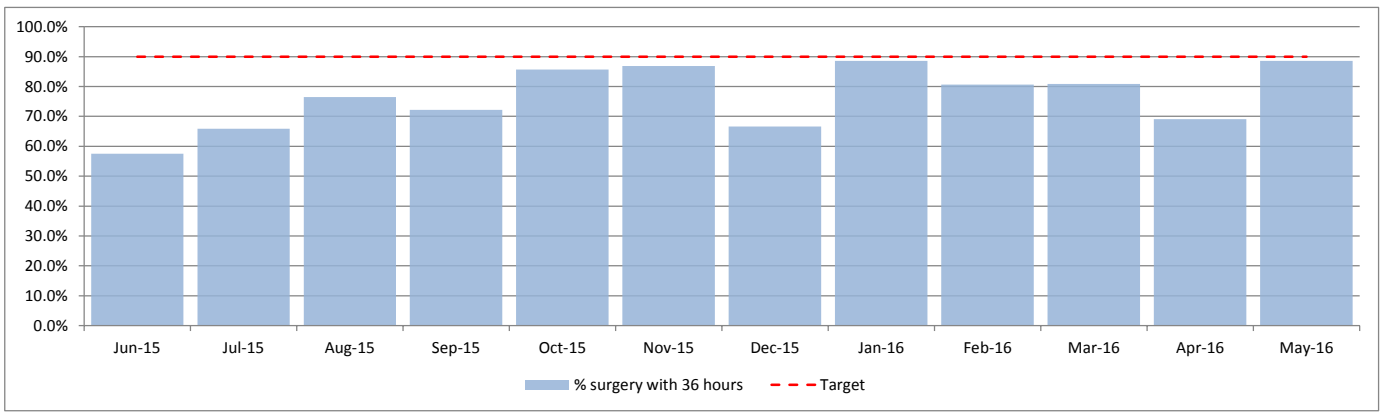
Fracture Neck of Femur - Best tariff assessment

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients	40	41	34	36	28	38	42	35	31	47	42	35
Achieving best practice	20	24	21	22	18	27	32	28	25	33	24	29
% achieving best practice	50.0%	58.5%	61.8%	61.1%	64.3%	71.1%	76.2%	80.0%	80.6%	70.2%	57.1%	82.9%
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%



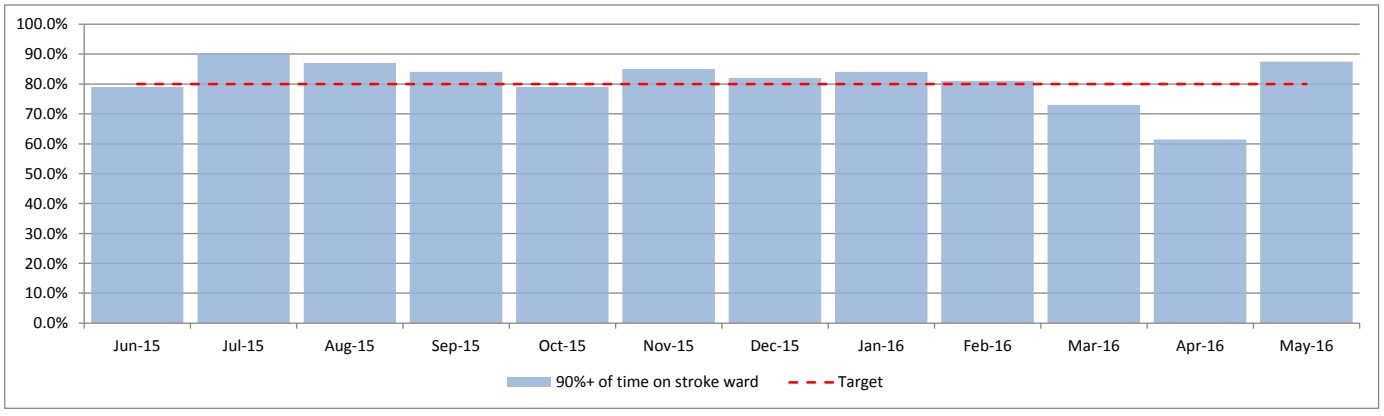
Fracture Neck of Femur - Time to theatre within 36 hours

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients	40	41	34	36	28	38	42	35	31	47	42	35
Surgery with 36 hours	23	27	26	26	24	33	28	31	25	38	29	31
% surgery with 36 hours	57.5%	65.9%	76.5%	72.2%	85.7%	86.8%	66.7%	88.6%	80.6%	80.9%	69.0%	88.6%
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%



Stroke

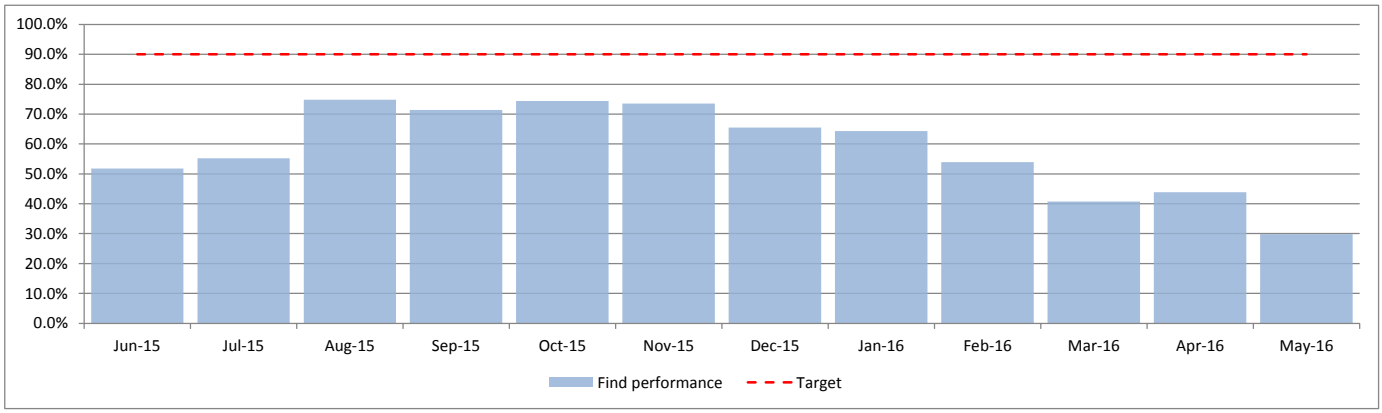
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
90%+ of time on stroke ward	79.0%	90.0%	87.0%	84.0%	79.0%	85.0%	82.0%	84.0%	81.0%	73.0%	61.4%	87.5%
Target	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



QUALITY FRAMEWORK

Dementia - Find

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Numerator	362	401	457	423	472	461	484	402	360	350	366	133
Denominator	491	531	543	532	581	556	630	558	545	584	607	446
Find performance	51.8%	55.2%	74.8%	71.4%	74.4%	73.5%	65.5%	64.3%	54.0%	40.7%	43.9%	29.8%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



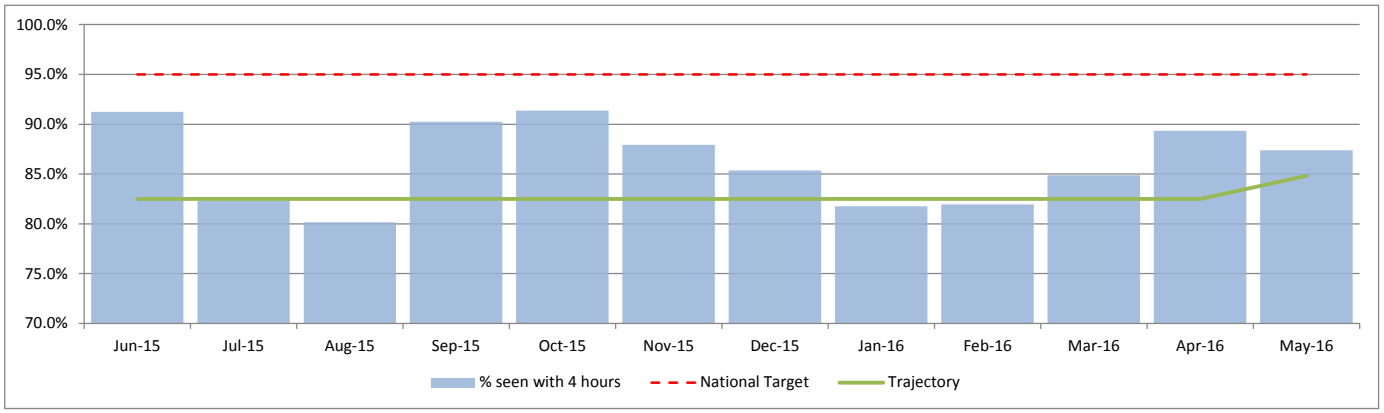
MONITOR COMPLIANCE FRAMEWORK

Month 2 May 2016

MONITOR COMPLIANCE

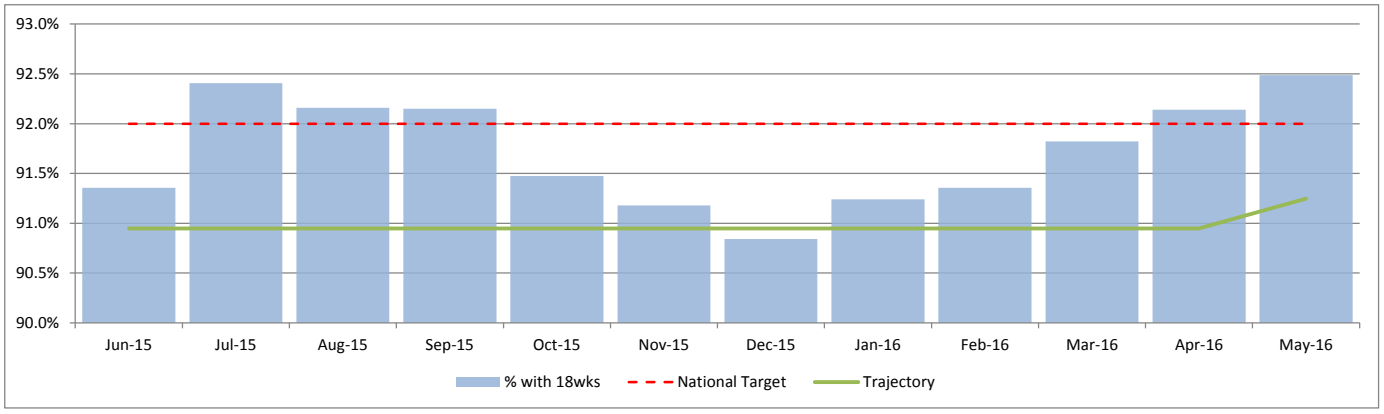
A&E and MIU patients seen within 4 hours

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
	6518	6755	6209	6087	8712	8451	8135	8223	8084	9298	8627	9741
4 hour breaches	571	1192	1232	594	753	1020	1192	1500	1459	1406	918	1229
% seen with 4 hours	**91.2%**	**82.4%**	**80.2%**	**90.2%**	**91.4%**	**87.9%**	**85.3%**	**81.8%**	**82.0%**	**84.9%**	**89.4%**	**87.4%**
	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	82.5%	84.8%



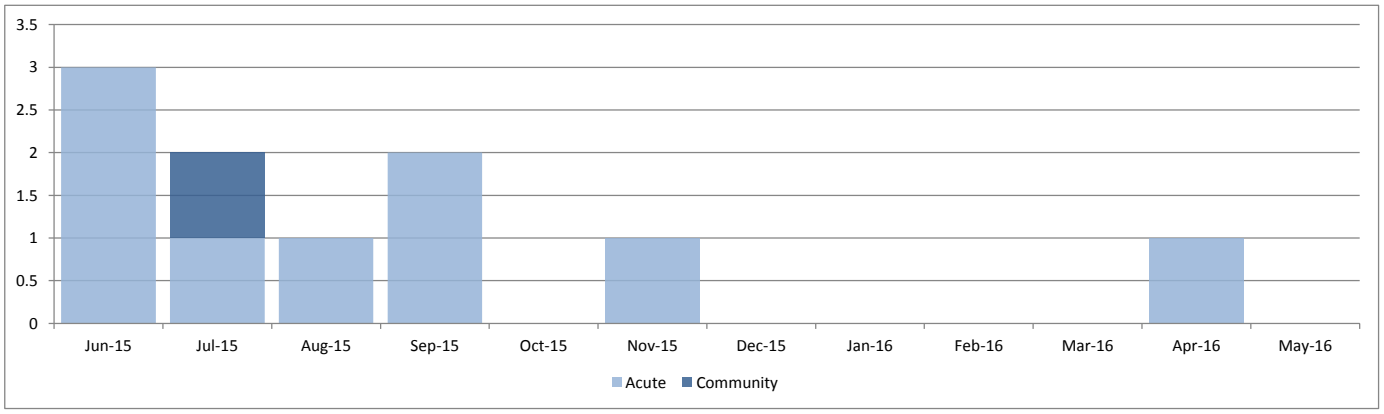
Referral to Treatment - Incomplete pathways

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Incomplete <18wks	14226	16101	15763	14849	14140	14100	14503	14292	14566	14518	14771	15194
Incomplete >18wks	1346	1323	1341	1265	1318	1364	1462	1372	1378	1293	1260	1234
% with 18wks	**91.4%**	**92.4%**	**92.2%**	**92.1%**	**91.5%**	**91.2%**	**90.8%**	**91.2%**	**91.4%**	**91.8%**	**92.1%**	**92.5%**
National Target	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Trajectory	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	90.9%	91.2%



C Diff. Lapse in Care

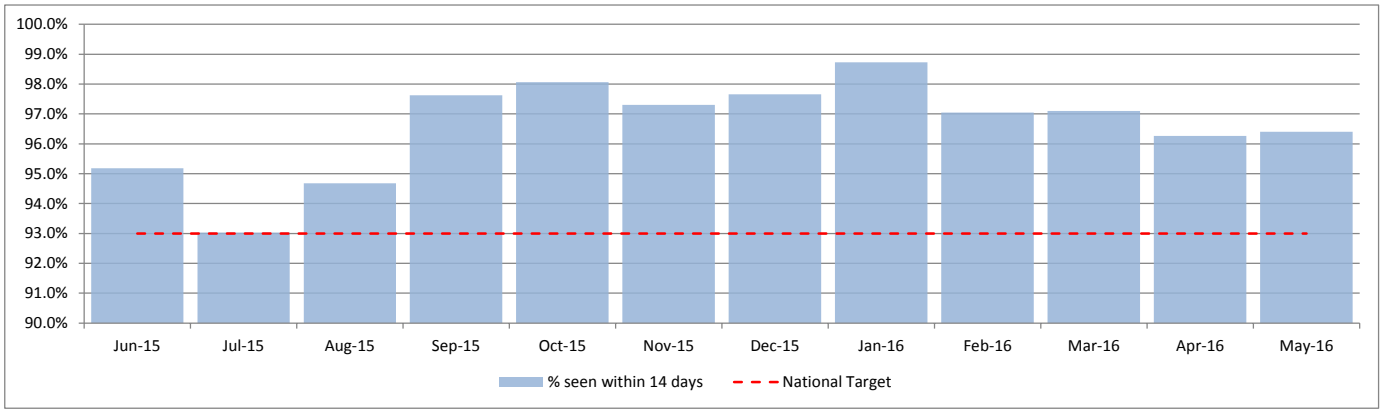
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	3	1	1	2	0	1	0	0	0	0	1	0
Community	0	1	0	0	0	0	0	0	0	0	0	0



MONITOR COMPLIANCE

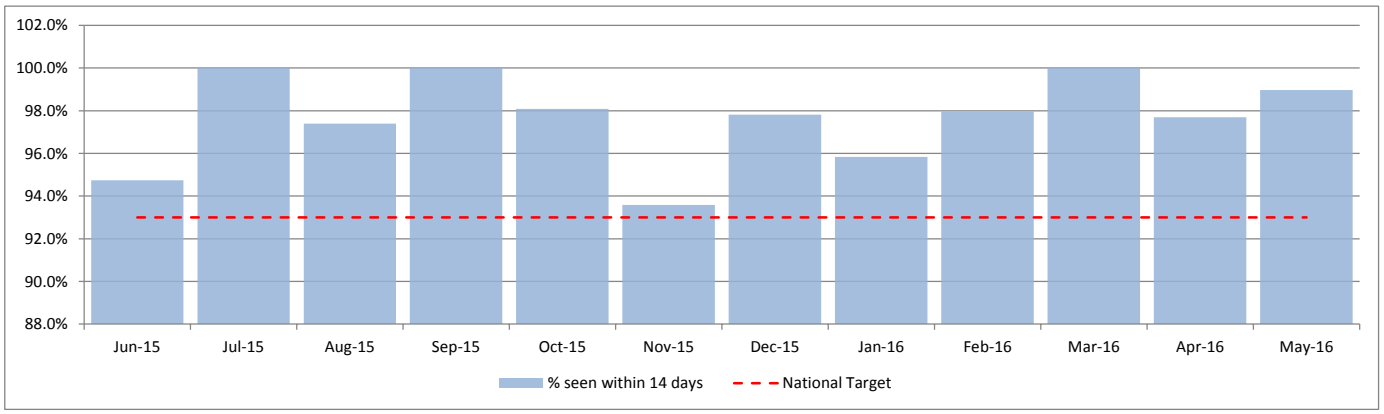
Cancer - Two Week Wait Referrals

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
2ww Referrals	913	903	826	884	879	889	897	705	846	965	884	1001
Seen within 14 days	869	840	782	863	862	865	876	696	821	937	851	965
% seen within 14 days	95.2%	93.0%	94.7%	97.6%	98.1%	97.3%	97.7%	98.7%	97.0%	97.1%	96.3%	96.4%
National 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%



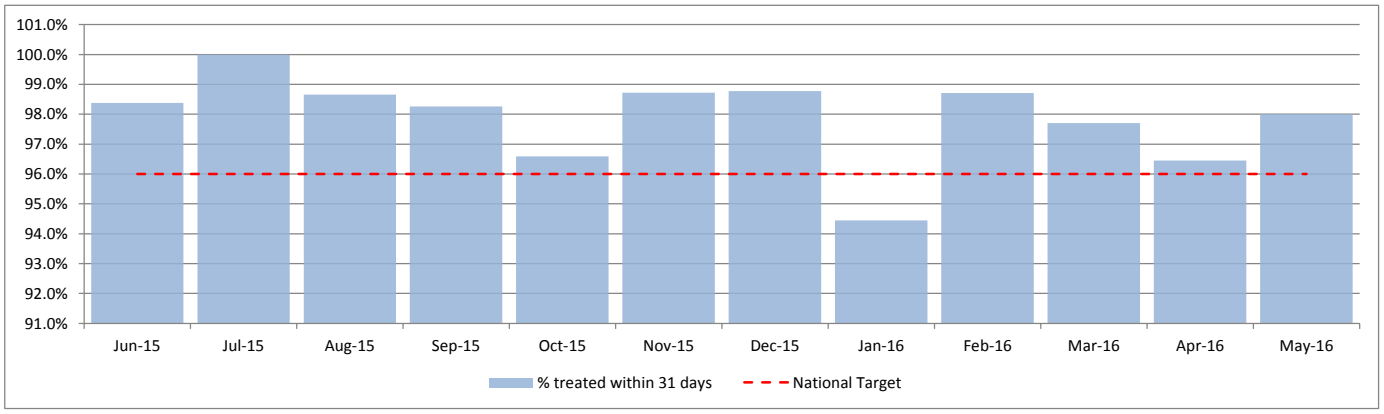
Cancer - Breast Symptomatic Referrals

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Breast symptomatic referrals	114	112	115	90	104	109	137	96	98	130	87	97
Seen within 14 days	108	112	112	90	102	102	134	92	96	130	85	96
% seen within 14 days	94.7%	100.0%	97.4%	100.0%	98.1%	93.6%	97.8%	95.8%	98.0%	100.0%	97.7%	99.0%
National 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%



Cancer - 31 day wait from decision to treat to first treatment

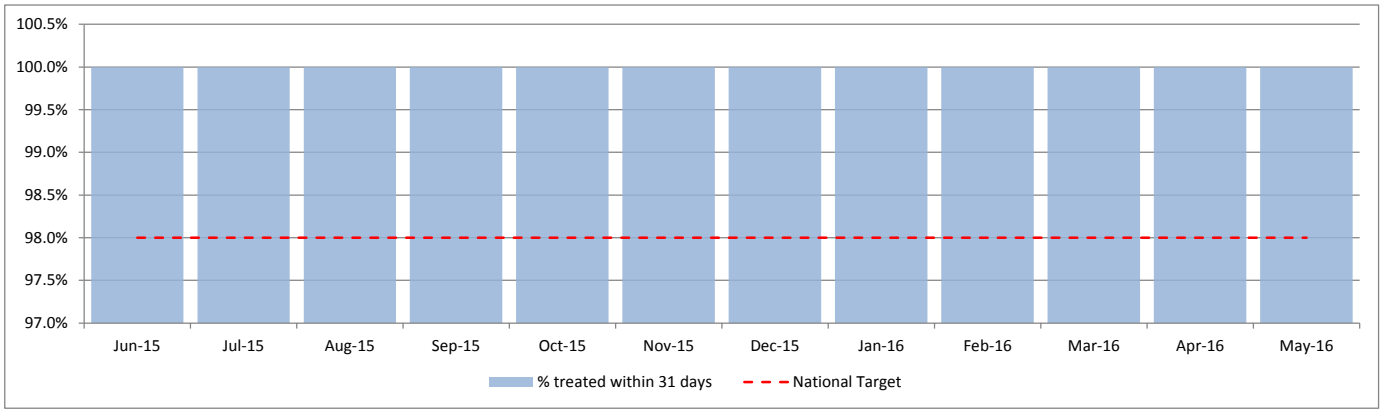
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
1st treatments	185	169	149	172	176	156	163	162	155	174	197	200
Breaches of 31 day target	3	0	2	3	6	2	2	9	2	4	7	4
% treated within 31 days	98.4%	100.0%	98.7%	98.3%	96.6%	98.7%	98.8%	94.4%	98.7%	97.7%	96.4%	98.0%
National 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%



MONITOR COMPLIANCE

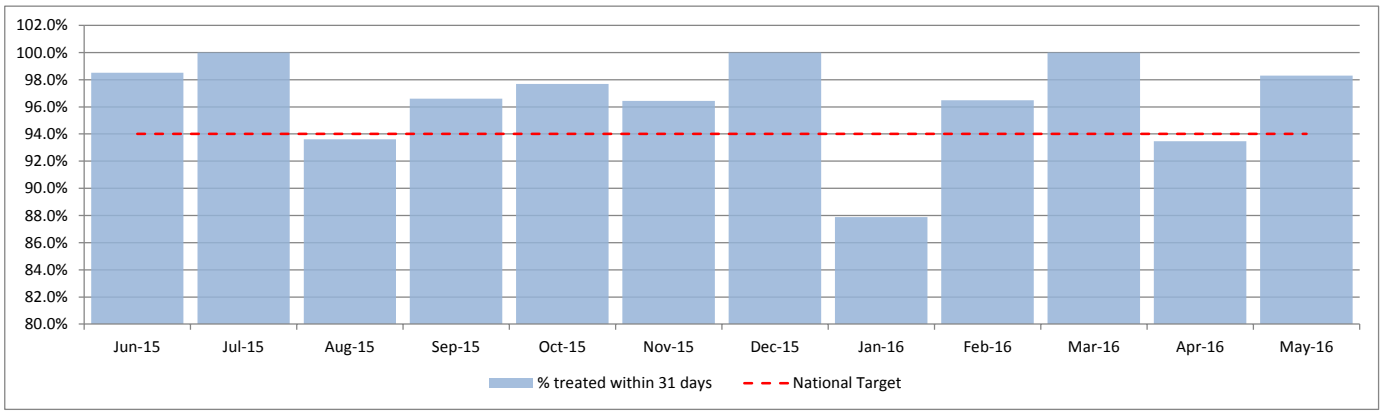
Cancer - 31 day wait for second or subsequent treatment - Drug

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Subsequent Drug treatments	57	48	38	55	52	49	47	59	52	62	71	66
Breaches of 31 day target	0	0	0	0	0	0	0	0	0	0	0	0
% treated within 31 days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
National 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%



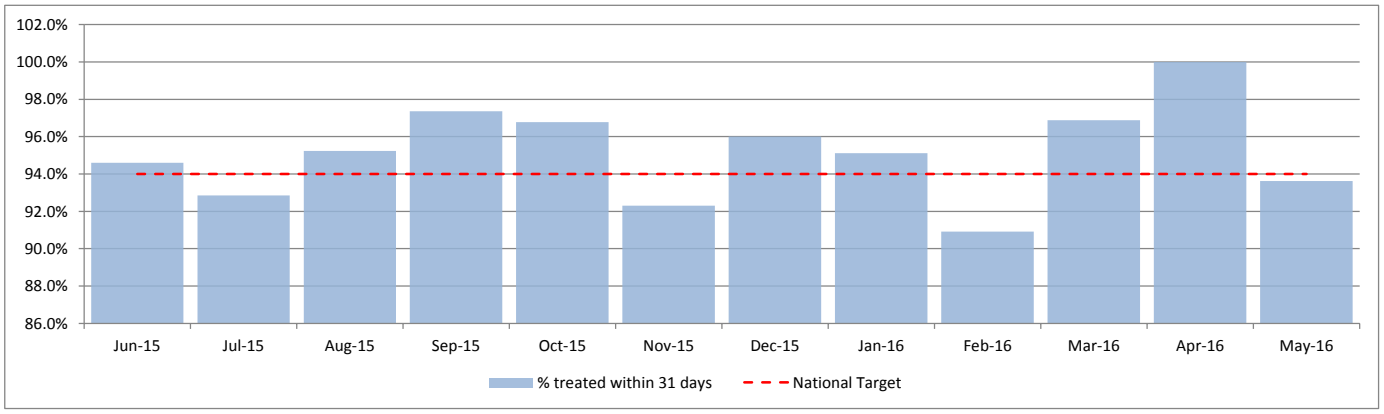
Cancer - 31 day wait for second or subsequent treatment - Radiotherapy

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Sub radiotherapy treatments	67	46	47	59	43	56	42	66	57	64	46	59
Breaches of 31 day target	1	0	3	2	1	2	0	8	2	0	3	1
% treated within 31 days	98.5%	100.0%	93.6%	96.6%	97.7%	96.4%	100.0%	87.9%	96.5%	100.0%	93.5%	98.3%
National 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%



Cancer - 31 day wait for second or subsequent treatment - Surgery

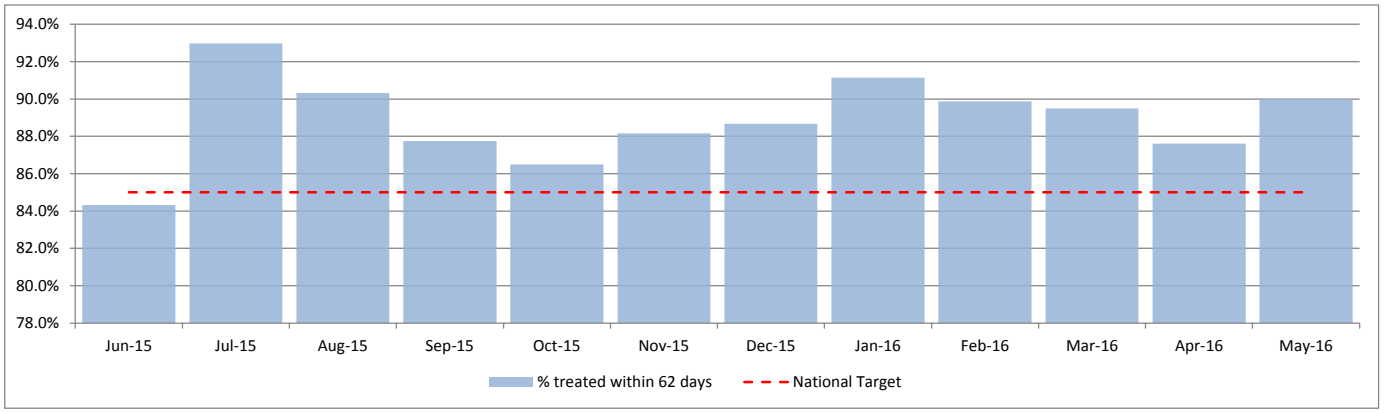
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Subsequent surgery treatments	37	28	21	38	31	39	25	41	44	32	30	47
Breaches of 31 day target	2	2	1	1	1	3	1	2	4	1	0	3
% treated within 31 days	94.6%	92.9%	95.2%	97.4%	96.8%	92.3%	96.0%	95.1%	90.9%	96.9%	100.0%	93.6%
National 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%



MONITOR COMPLIANCE

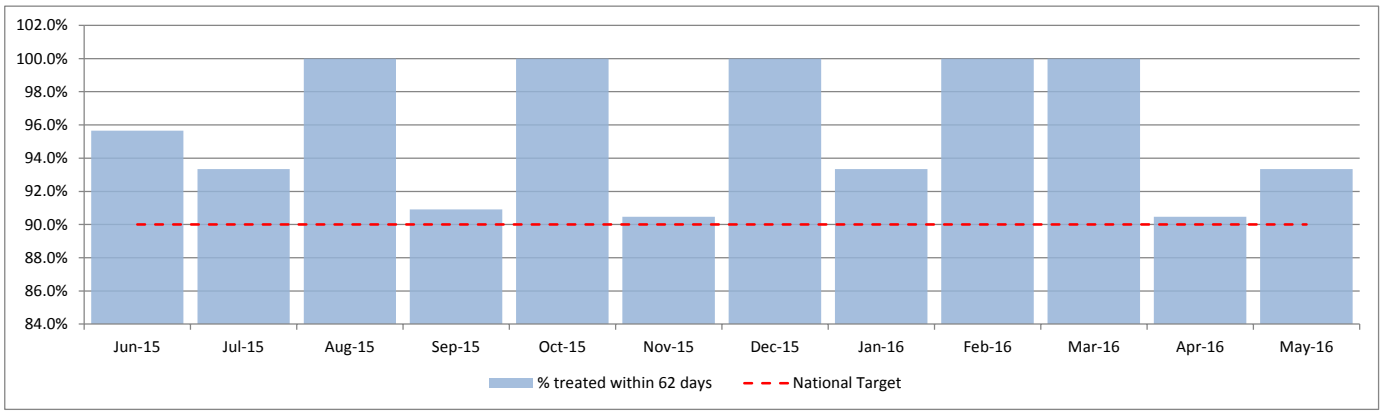
Cancer - 62 day wait for 1st treatment from 2ww referral

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
1st treatments (from 2ww)	92.5	85.5	77.5	98	100	76	75	79	79	90.5	105	115
Breaches of 62 day target	14.5	6	7.5	12	13.5	9	8.5	7	8	9.5	13	11.5
% treated within 62 days	84.3%	93.0%	90.3%	87.8%	86.5%	88.2%	88.7%	91.1%	89.9%	89.5%	87.6%	90.0%
National 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%



Cancer - 62 day wait for 1st treatment from screening referral

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
1st treatments (from screening)	11.5	7.5	8	11	11	10.5	15.5	15	7	13.5	21	15
Breaches of 62 day target	0.5	0.5	0	1	0	1	0	1	0	0	2	1
% treated within 62 days	95.7%	93.3%	100.0%	90.9%	100.0%	90.5%	100.0%	93.3%	100.0%	100.0%	90.5%	93.3%
National 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%



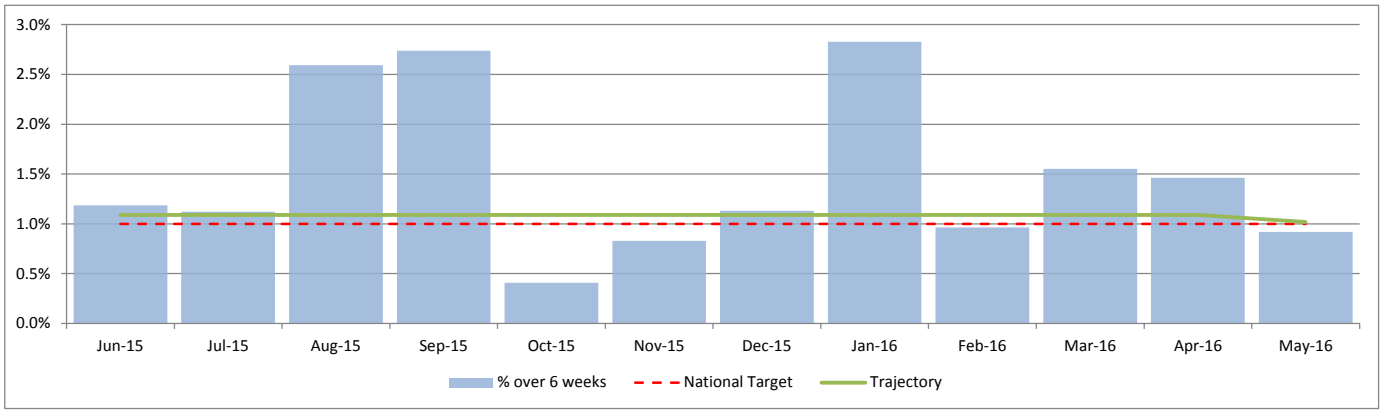
CONTRACTUAL FRAMEWORK

Month 2 May 2016

CONTRACTUAL FRAMEWORK

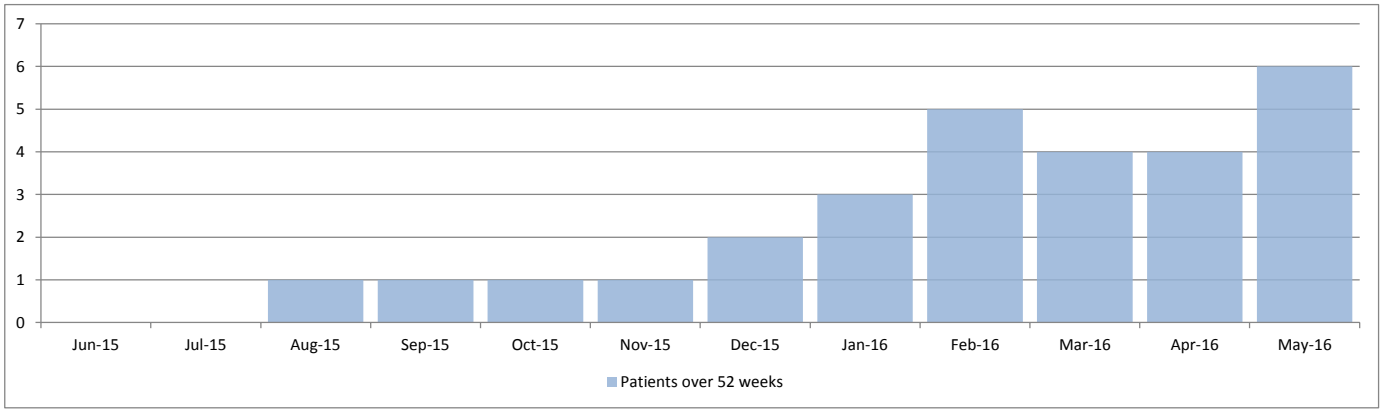
Diagnostic Tests Longer than the 6 week standard

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients	3455	3834	3470	3688	3667	3382	3800	3750	3637	3543	3693	3377
Waiting longer than 6 weeks	41	43	90	101	15	28	43	106	35	55	54	31
% over 6 weeks	**1.2%**	**1.1%**	**2.6%**	**2.7%**	**0.4%**	**0.8%**	**1.1%**	**2.8%**	**1.0%**	**1.6%**	**1.5%**	**0.9%**
National Target	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Trajectory	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%



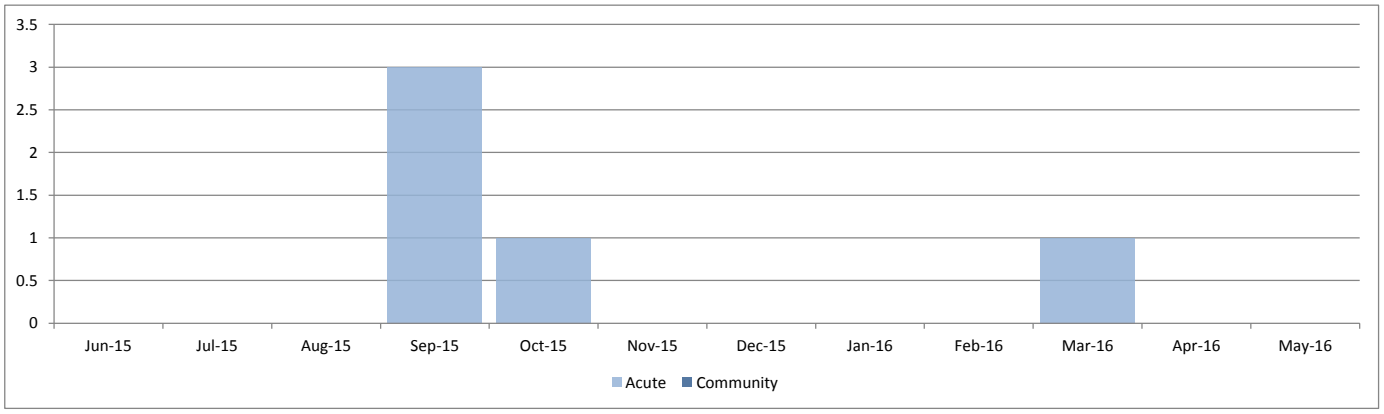
Referral to Treatment over 52 week incomplete pathways

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients over 52 weeks	0	0	1	1	1	1	2	3	5	4	4	6



Mixed sex accomodation breaches of Standard

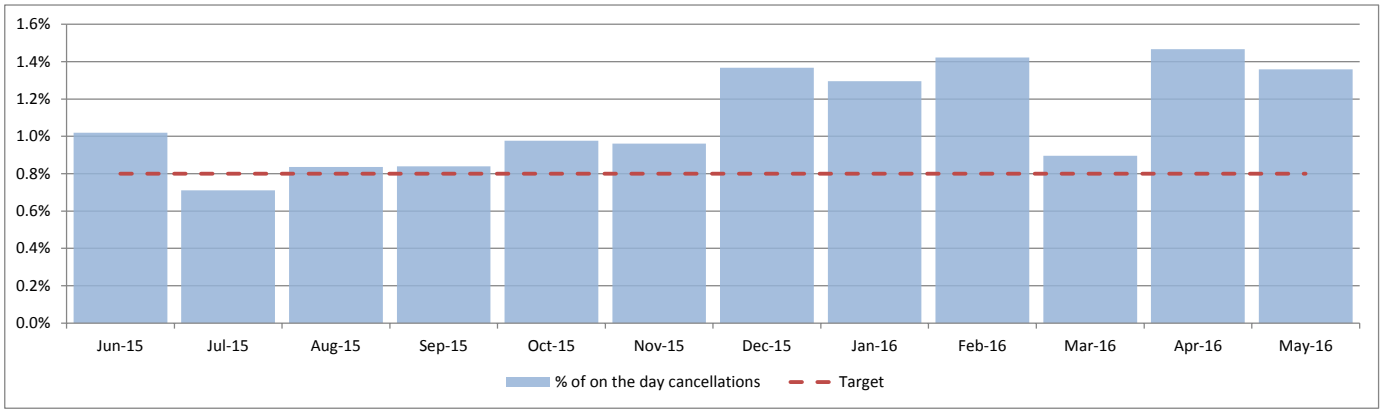
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	0	0	0	3	1	0	0	0	0	1	0	0
Community	0	0	0	0	0	0	0	0	0	0	0	0



CONTRACTUAL FRAMEWORK

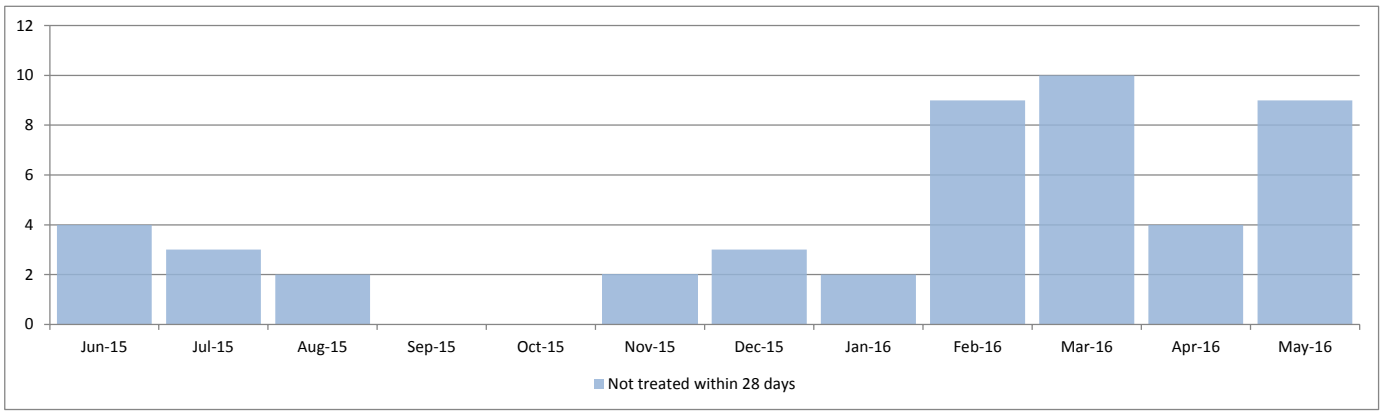
On the day cancellations for elective operations

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Cancellations	36	26	27	30	32	30	41	40	45	29	47	46
Elective spells	3534	3662	3229	3576	3275	3123	2998	3089	3164	3236	3205	3387
% of on the day cancellations	1.0%	0.7%	0.8%	0.8%	1.0%	1.0%	1.4%	1.3%	1.4%	0.9%	1.5%	1.4%
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%



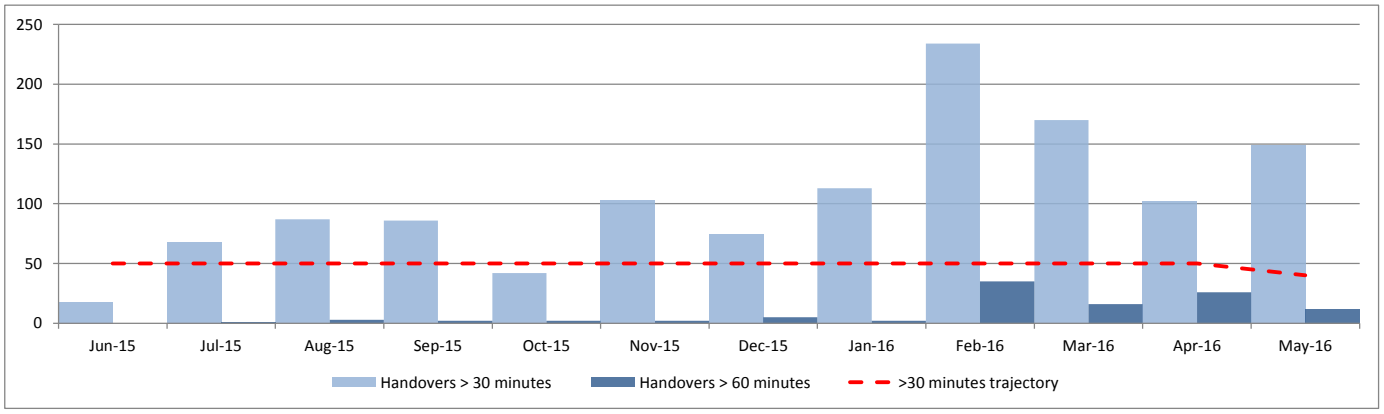
Cancelled patients not treated within 28 days of cancellation

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Not treated within 28 days	4	3	2	0	0	2	3	2	9	10	4	9



Ambulance handovers

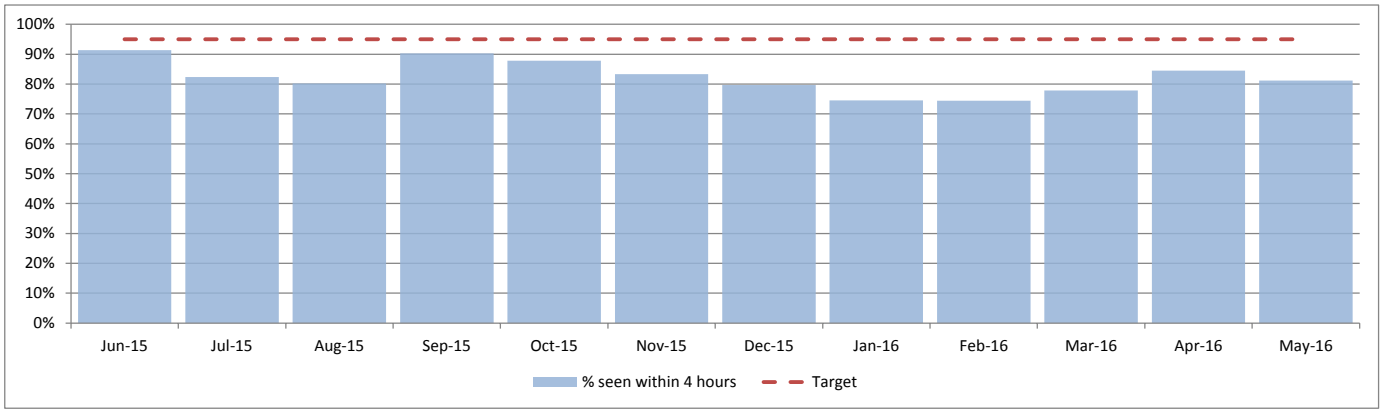
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Handovers > 30 minutes	18	68	87	86	42	103	75	113	234	170	102	149
Handovers > 60 minutes	0	1	3	2	2	2	5	2	35	16	26	12
>30 minutes trajectory	50	50	50	50	50	50	50	50	50	50	50	40



CONTRACTUAL FRAMEWORK

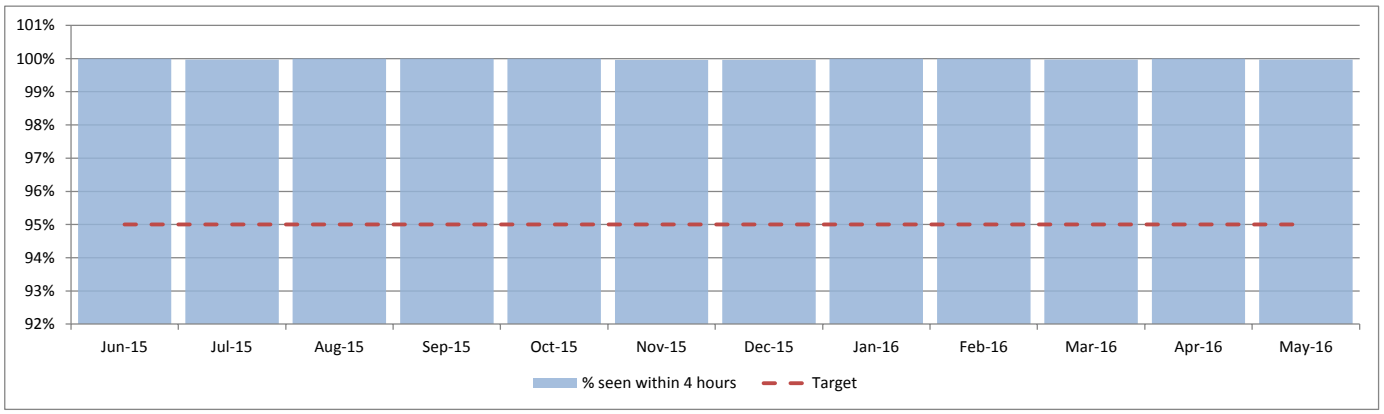
A&E patients seen within 4 hours (DGH only)

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients seen	6518	6755	6209	6087	6192	6090	5874	5896	5693	6334	5924	6534
4 hour breaches	566	1192	1232	594	753	1019	1191	1500	1459	1405	918	1228
% seen within 4 hours	91%	82%	80%	90%	88%	83%	80%	75%	74%	78%	85%	81%
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%



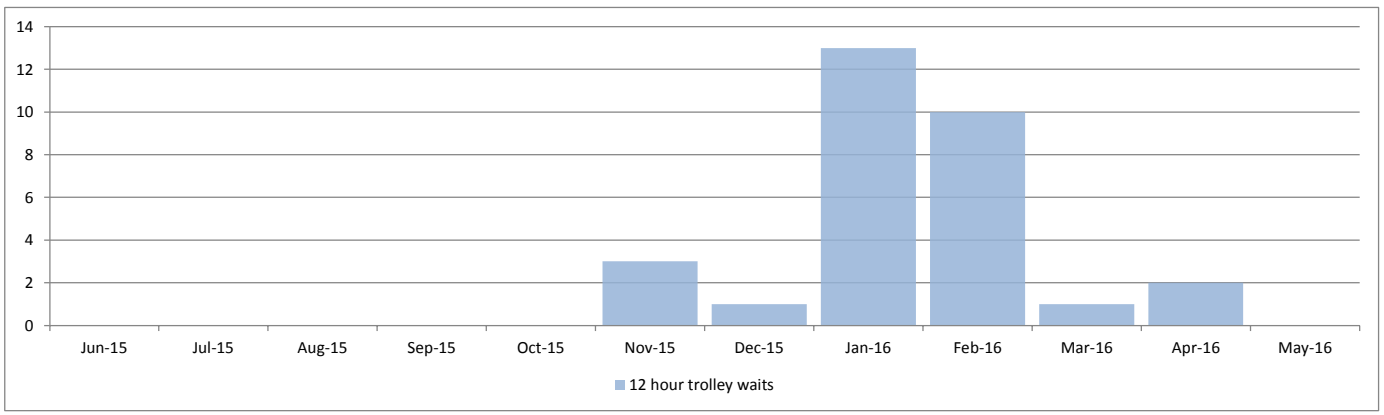
A&E patients seen within 4 hours (community MIU)

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Patients seen	3308	3477	3159	2788	2520	2361	2261	2327	2391	2964	2703	3207
4 hour breaches	0	1	0	0	0	1	1	0	0	1	0	1
% seen within 4 hours	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
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%



A&E Trolley Waits over 12 hours from decision to admit

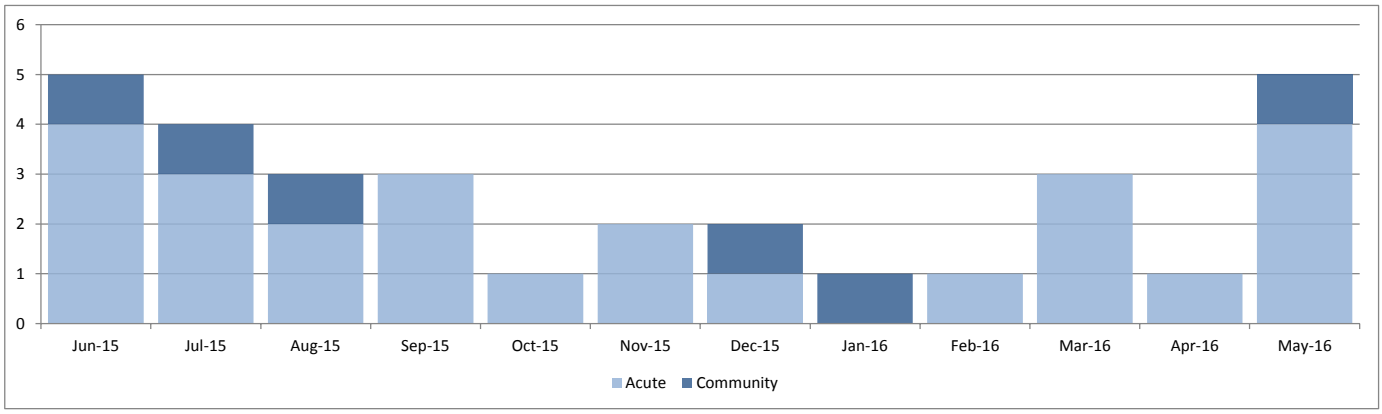
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
12 hour trolley waits	0	0	0	0	0	3	1	13	10	1	2	0



CONTRACTUAL FRAMEWORK

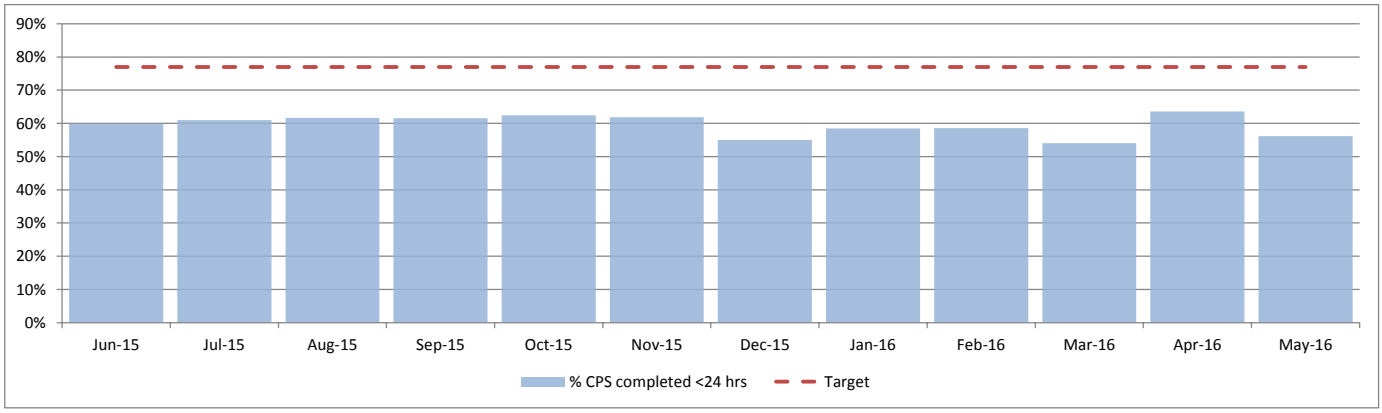
Number of Clostridium Difficile cases

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Acute	4	3	2	3	1	2	1	0	1	3	1	4
Community	1	1	1	0	0	0	1	1	0	0	0	1



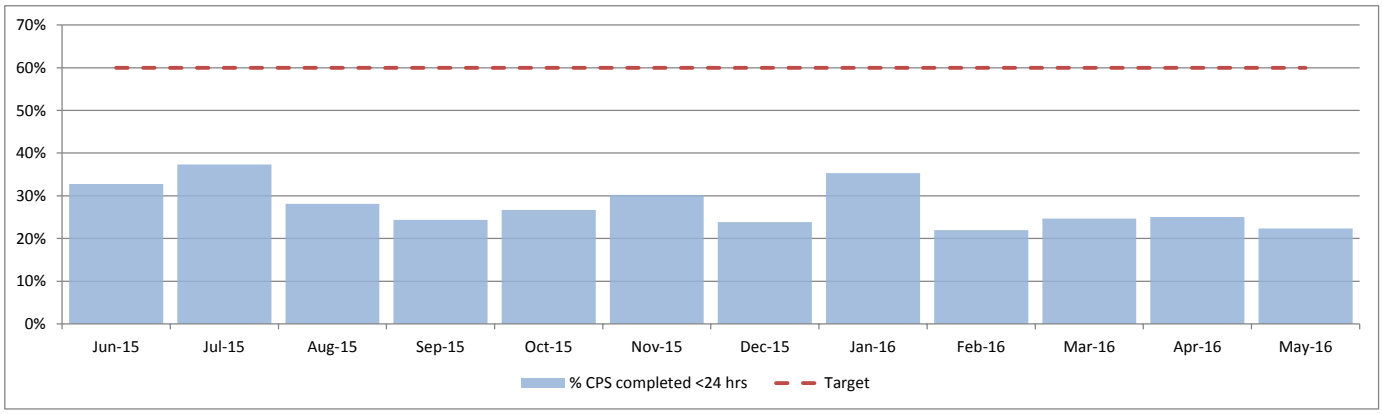
Care Plan Summaries completed with 24 hours of discharge - Weekday

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Discharges	1099	1167	1032	1165	1148	1132	1025	997	1089	1085	1105	1109
CPS completed within 24 hours	1833	1913	1673	1893	1840	1831	1863	1705	1860	2008	1737	1975
% CPS completed <24 hrs	60%	61%	62%	62%	62%	62%	55%	58%	59%	54%	64%	56%
Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%



Care Plan Summaries completed with 24 hours of discharge - Weekend

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Discharges	137	158	159	108	132	134	93	166	91	100	132	119
CPS completed within 24 hours	418	423	565	444	495	444	390	470	414	406	528	532
% CPS completed <24 hrs	33%	37%	28%	24%	27%	30%	24%	35%	22%	25%	25%	22%
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%



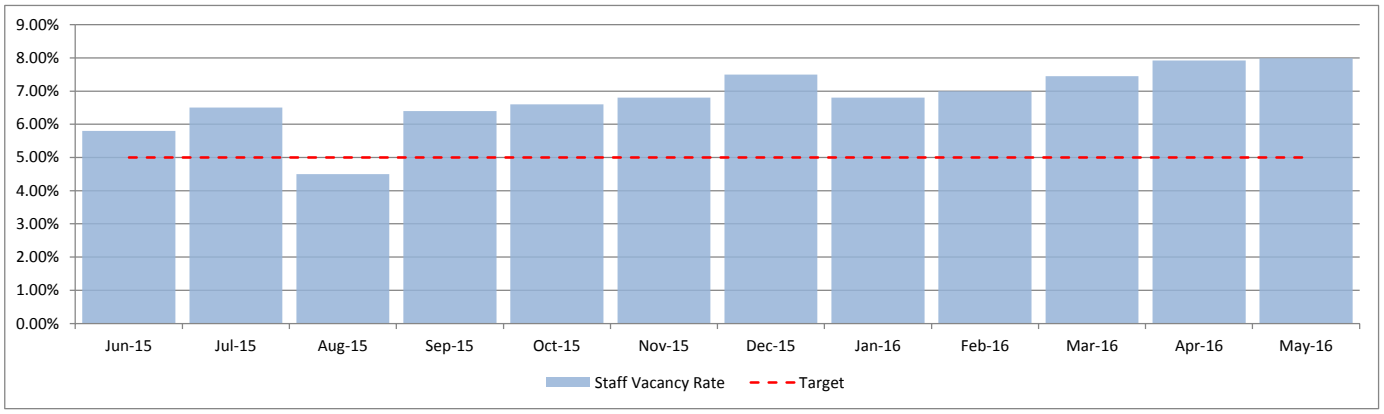
CORPORATE MANAGEMENT FRAMEWORK

Month 2 May 2016

CORPORATE MANAGEMENT FRAMEWORK

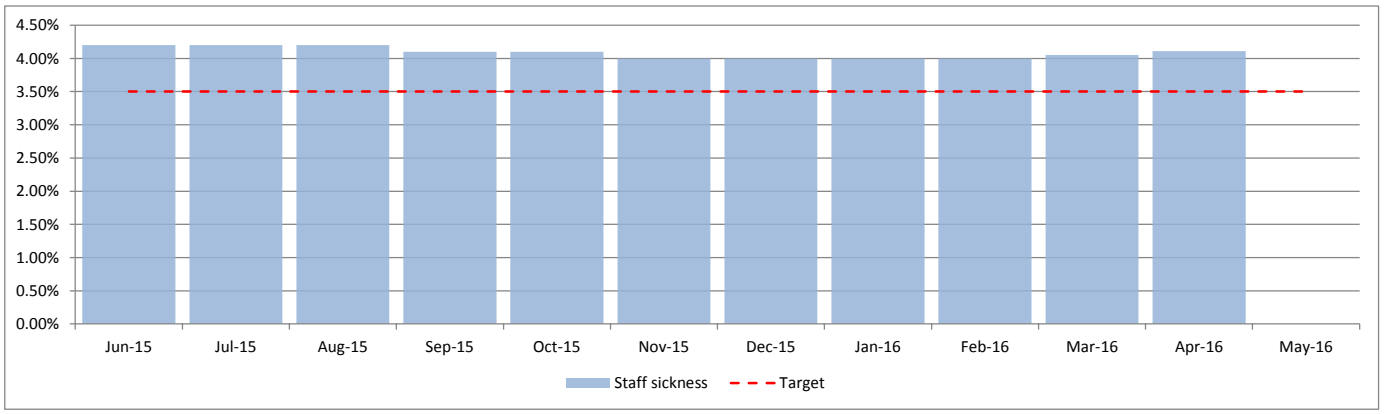
Staff Vacancy Rate (excluding temp workforce and additional hours)

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Staff Vacancy Rate	5.80%	6.50%	4.50%	6.40%	6.60%	6.80%	7.50%	6.80%	7.00%	7.45%	7.92%	7.99%
Target	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%



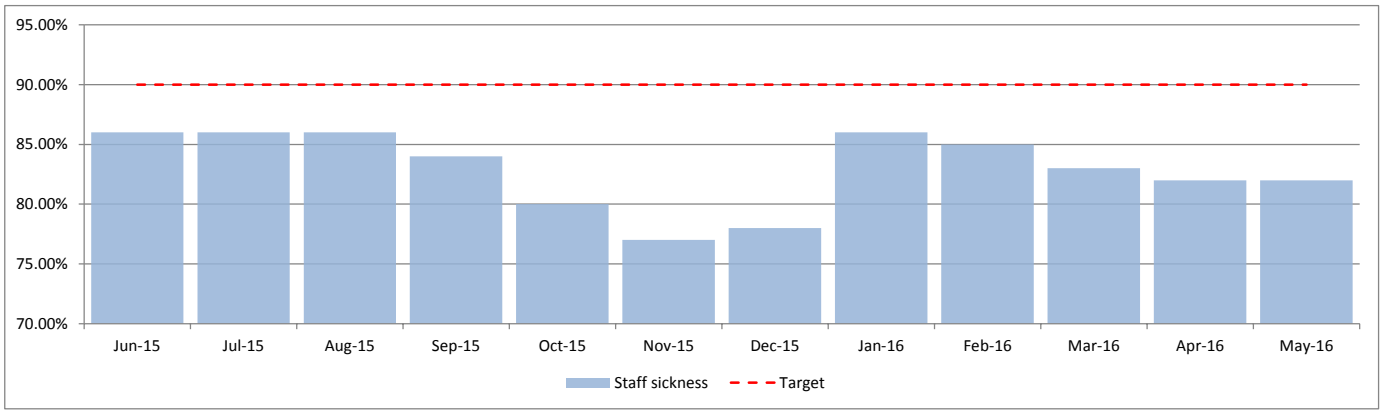
Staff sickness

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Staff sickness	4.20%	4.20%	4.20%	4.10%	4.10%	4.00%	4.00%	4.00%	4.00%	4.05%	4.11%	n/a
Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%



Appraisal Completeness

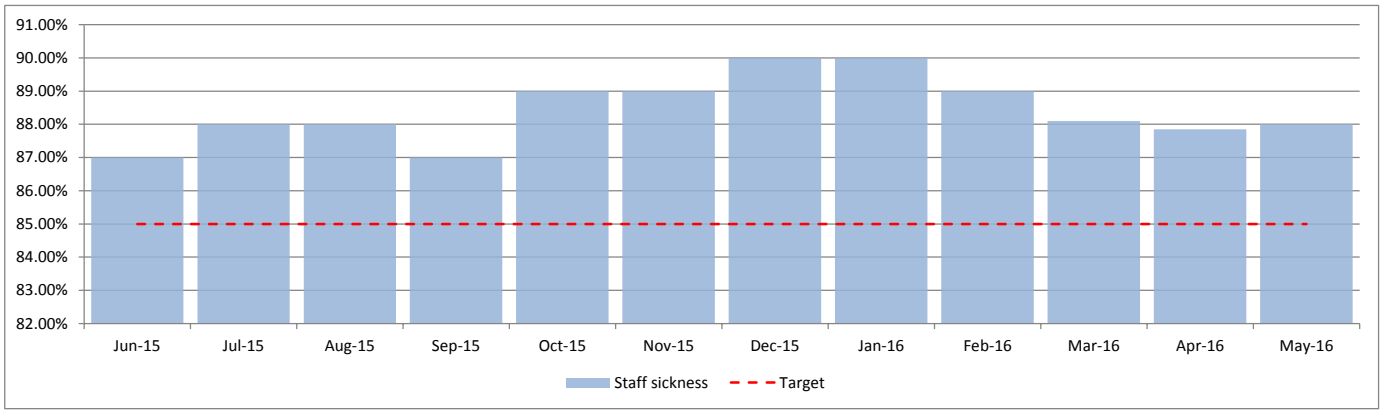
	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Staff sickness	86.00%	86.00%	86.00%	84.00%	80.00%	77.00%	78.00%	86.00%	85.00%	83.00%	82.00%	82.00%
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



CORPORATE MANAGEMENT FRAMEWORK

Mandatory Training Completeness

	Jun 15	Jul 15	Aug 15	Sep 15	Oct-15	Nov-15	Dec 15	Jan 16	Feb 16	Mar-16	Apr-16	May-16
Staff sickness	87.00%	88.00%	88.00%	87.00%	89.00%	89.00%	90.00%	90.00%	89.00%	88.10%	87.85%	88.00%
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%



Summary of Financial Performance

	Year to Date - Month 02			Plan Changes		Previous Month YTD	
	PbR Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Income & Expenditure							
Income	64.83	66.18	1.35	1.82	(0.47)	0.44	↓
Operating expenses	(64.89)	(66.33)	(1.43)	(1.68)	0.24	0.04	↑
EBITDA	**(0.06)**	**(0.15)**	**(0.09)**	**0.14**	**(0.23)**	**0.48**	↓
Non-operating revenue	0.03	0.32	0.29	0.00	0.29	(0.00)	↑
Non-operating expenses	(2.68)	(2.65)	0.03	0.00	0.03	(0.00)	↑
Surplus / (Deficit)	**(2.71)**	**(2.47)**	**0.24**	**0.14**	**0.10**	**0.48**	↓
Cash & Balance Sheet							
Cash Balance	23.29	13.15	(10.14)	(1.47)	(8.67)	(5.72)	↓
Capital Expenditure	4.17	1.48	(2.69)	0.00	(2.69)	(1.19)	↓
Loans & leases Drawn down	1.31	0.00	(1.31)	0.00	(1.31)	(0.24)	↓
Key Metrics							
EBITDA Margin	(0.1%)	(0.2%)	(0.1%)			(0.7%)	↑
I&E Surplus Margin	(4.2%)	(3.7%)	0.4%			(0.7%)	↑
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	3	3	0			(2)	↑
Overall Financial Sustainability Risk Rating	**2**	**2**	**0**			0	↔

The Trust submitted an Annual Plan to Monitor for financial year 2016/17 showing EBITDA of £19.1m and an overall surplus of £1.7m, based on a Payment By Results contract arrangement.

The Board have been briefed on the overall financial challenge to the Health and Care System in 2016/17 and the difficulties in agreeing contract arrangements, that initially resulted in the movement away from the planned Risk Share Agreement (RSA) for the original plan. Encouraged by both Regulators - NHS England and NHS Improvement - negotiations to reinstate the RSA have continued and have reached conclusion. This report is presented on the basis that the RSA has been maintained, with the Trust picking up a share of the system risk in 2016/17. The main change from the PbR arrangements is that income expectations will be set under a block contract arrangement, with the corresponding removal of QIPP saving targets and inflationary pressures from Adult Social Care and Placed People are within the RSA. This results in a revised EBITDA of £11.2m surplus and an overall deficit of £7.7m after estimated risk share income has been applied. In order to show a meaningful position the movement between this two plans can be seen in the "Changes to PbR and RSA plan" column.

The Trust has briefed NHS Improvement regularly on the expected impact on the Trust's plan and is attempting to negotiate permission to submit a revised plan on the basis of final contract settlement. This would avoid the adverse FSRR scoring associated with the 'I&E margin variance' and better secure the Sustainability and Transformation Fund.

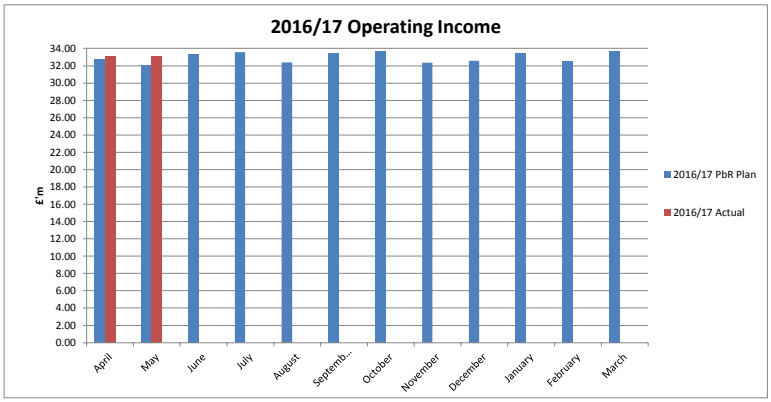
At EBITDA level, performance for month 2 based on the PbR plan is £0.09m adverse. Should the plan be agreed based on the Risk Share arrangement this would result in an EBITDA position of £0.23m adverse.

Within this position, income is ahead of plan by £1.35m based on PbR, and £0.47m behind plan based on risk share agreement. Under the terms of the proposed risk share agreement an additional £2.1m has been accrued to reflect the contribution expected from commissioning organisations . This is based on the month two position versus the fixed target risk share position.

4.2 Statement of Comprehensive Income

4.2.1 Operating Income

	Year to Date - Month 02			Plan Changes		Previous Month	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance to RSA Plan £m	Change
Income by Category							
Healthcare (Acute and Community)	47.68	50.40	2.72	3.48	(0.76)	0.41	↓
Social Care	9.25	9.08	(0.17)	(0.21)	0.03	0.00	↑
Other Income	7.90	6.69	(1.20)	(1.46)	0.25	0.02	↑
Total	**64.83**	**66.18**	**1.35**	**1.82**	**(0.47)**	**0.44**	↓



- Income is ahead of PBR plan by £2.72m. Within this value, Acute income based on PbR is actually £0.45m behind plan at M2. Of this, based on PbR, c£0.4m relates to NHS E and this is mainly NonElective and chemo therapy income being behind plan. It is too early in the year to take any views on this variance . Using the RSA, the Trust is £0.42m behind plan, with the variances being broadly the same as above.
- £2.1m income has been accrued to reflect the risk share contribution expected from commissioners based on the month 2 position agains the risk share phased target.
- Other income is £1.2m adverse against the PbR plan, and £0.26m favourable against a Risk Share plan. This mainly relates to the Sustainability and Transformation funding income (£6.7m under the Pbr arrangements ,full year effect and set at £3.35m in the reforecast). Final rules for achievement of this funding are yet to be published. Whilst we have assumed 50% achievement in the reforecast, there has not been any income accrued against this in month 2.

Healthcare Income - Commissioner Analysis							
South Devon & Torbay Clinical Commissioning Group	26.22	26.95	0.72	0.74	(0.01)	(0.00)	↔
North, East & West Devon Clinical Commissioning Group	0.89	0.90	0.01	(0.00)	0.01	0.01	↔
NHS England - Area Team	1.24	1.22	(0.02)	0.00	(0.02)	(0.01)	↔
NHS England - Specialist Commissioning	4.78	4.40	(0.38)	(0.04)	(0.34)	(0.25)	↓
Other Commissioners	1.34	1.22	(0.12)	(0.05)	(0.06)	(0.02)	↓
Sub-Total Acute	**34.47**	**34.69**	**0.22**	**0.64**	**(0.42)**		↓
South Devon & Torbay Clinical Commissioning Group (Placed People and Community Health)	12.80	13.15	0.35	0.35	(0.00)	0.00	↔
Other Commissioners	0.41	0.39	(0.02)	(0.01)	(0.00)	0.00	↔
Total Acute and Community	**47.68**	**48.23**	**0.55**	**0.97**	**(0.43)**	(0.28)	↓
Healthcare Income - By Business Unit							
Medical Services	14.73	16.01	1.29	0.49	0.79	0.51	↑
Surgical Services	10.96	11.90	0.93	0.42	0.50	0.56	↓
Women's, Childrens & Diagnostic Services	7.23	7.17	- 0.06	(0.03)	(0.03)	(0.28)	↑
Community Services	13.21	13.54	0.33	0.33	0.00	0.00	↔
Non-Clinical Services / Central Contract Income	1.55	- 0.39	- 1.95	(0.25)	(1.70)	(1.07)	↓
Total	**47.68**	**48.22**	**0.55**	**0.97**	**(0.43)**	(0.28)	↓

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 02			Plan Changes		Previous Month	
	Plan £m	Actual £m	Variance £m	Changes PbR to RSA Plan £m	Variance to RSA Plan £m	Variance £m	Change
Healthcare Activity - By Setting							
	Activity	Activity	Activity			Activity	
Elective In-Patient Admissions	714	719	5	83	(78)	(94)	↑
Elective Day Case Admission	5,119	5,572	453	179	274	(121)	↑
Urgent & Emergency Admissions	19,303	19,117	(186)	91	(277)	(546)	↑
Out-Patients	69,172	75,343	6,171	1,204	4,967	2,196	↑
Community Services							
Total	**94,308**	**100,751**	**6,443**	**1,557**	**4,886**	**1,435**	↑
Social Care Income							
Torbay Council - ASC Contract income	6.78	6.52	(0.26)	(0.26)	(0.00)	0.00	↔
Torbay Council - Public Health Income	0.83	0.83	(0.00)	(0.00)	0.00	0.00	↔
Torbay Council - Client Income	1.65	1.74	0.09	0.06	0.03	(0.00)	↑
Total	**9.25**	**9.08**	**(0.17)**	**(0.20)**	**0.03**	**0.00**	↑
Other Income							
Non Mandatory/Non protected clinical revenue	0.25	0.25	0.00	(0.90)	0.90	(0.01)	↑
R&D / Education & training revenue	1.45	1.52	0.07	0.00	0.07	0.02	↑
Site Services	0.39	0.37	(0.02)	0.00	(0.02)	(0.00)	↓
Revenue from non-patient services to other bodies	0.91	0.99	0.08	0.00	0.08	0.01	↑
Misc. other operating revenue	4.90	3.56	(1.33)	(0.56)	(0.78)	(0.01)	↓
Total	**7.90**	**6.69**	**(1.20)**	**(1.46)**	**0.25**	**0.02**	↑

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 20 July 2016

Agenda Item:	9
Report Title:	Secretary's Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Topical areas of interest presented by the Company Secretary following the last Council of Governors meeting on 20 April 2016.

2. Main Report

2.1 **Volunteers event (27 May):** Several of the Governors were able to attend the engagement event which was arranged, in partnership between the Trust, the Community Development Trust (CDT) in Torbay and Community Voluntary Services (CVS) in South Devon, on Friday 27 May2016. The Chair and Chief Executive acknowledged the vital role which voluntary organisations can play in the development of the care model, and confirmation of the investments which have been agreed in services provided by local voluntary organisations.

Nearly 70 people attended the event coming together from across the voluntary sector and our own services. It was a vibrant event which was well received by participants, with a high level of energy and enthusiasm. The key messages from the event divide into two broad areas:

i) Issues which can only be addressed by paying attention to the way that we work with our partners from all sectors in the future. For example by treating each other as equal partners and improving communication by hearing as opposed to just listening to feedback.

ii) Ideas which require tangible action to be taken in partnership with colleagues from voluntary and community organisations. These include consideration of issues such as community transport, low level mental health services, and some issues associated with housing.

The Trust is now working with colleagues from voluntary organisations, primarily CDT in Torbay and CVS in South Devon, to plan how these issues and ideas can be addressed and taken forward. The Trust's Strategy and Improvement directorate has been leading this work and would be happy to attend a future governors meeting to present a more detailed report if the governors would find that helpful.

2.2 **Joint meeting between Council of Governors and Board of Directors:** The next Board-to-Council meetings will be as follows:

- 17 August 2016, 3pm in the Anna Dart Lecture Theatre, Horizon Centre.
- 19 October 2016, 3pm in the Anna Dart Lecture Theatre, Horizon Centre.

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 20 July 2016

Agenda Item:	11
Report Title:	Quality and Compliance Committee Report
Report By:	Wendy Marshfield
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Update report of the Quality and Compliance Committee (Q&CC) following their most recent meeting on **24 June 2016**.

1.2 It was agreed to circulate the notes of the meeting to all governors therefore rather than produce a main report below, the details can be found as at attachment one.

1.3 The terms of reference for this Committee were updated post integration and subsequently reviewed with new members on 24 June 2016. As per section four of the notes, the Company Secretary was asked to bring the terms of reference to this meeting for approval.

2. Recommendations

2.1 Council of Governors receives the draft notes as at attachment one and supports the current work of the Quality and Compliance Committee.

2.2 Council of Governors approves the terms of reference as at attachment two.

3. Decisions Needed to be Taken

3.1 Note and comment on the information attached.

4. Attached to this report

Attachment one - Draft notes of the June Q&CC meeting.
Attachment two - Terms of Reference

Torbay and South Devon NHS
NHS Foundation Trust

Council of Governors

Wednesday 20 July 2016

Agenda Item:	12
Report Title:	Membership Development Report
Report By:	Company Secretary
Open or Closed:	Open under the Freedom of Information Act

1. Summary of Report

1.1 Current update on the work of the Mutual Development Group.

2. Background Information

Mutual Development Group (MDG)

2.1 The MDG now meets on a quarterly basis (February, May, July and November) to consider and take forward the requirements placed on it by the Council of Governors.

2.2 Attachment one refers to the draft notes of July's meeting for your reference and information.

2.3 At the Quality and Compliance Committee on 24 June 2016, the chair (Wendy Marshfield) asked for the diagram below to be taken to this meeting. The nine examples are taken from the NHS Providers Governance Survey 2016 which was published in May 2016 under the heading 'Approaches to Membership Engagement that achieved the most valuable outcomes'.

Questions on Notice
Wednesday 20 July 2016
Council of Governors

No.	Governor Questions	Constituency	Executive Lead	Trust Response
1.	Please could the Trust respond to the following statement; some governors concerned that the Trust had not kept them informed of the specific emergency department red rated issues as highlighted in the Care Quality Commission's (CQC's) report i.e. aware of the four-hour target during 2015/16, but not the underlying CQC issues.	Torbay	Jane Viner	
2.	Can you assure governors that the work required to meet the actions required following the CQC inspection are achievable and what the impact on the financial status of the Trust will be	Torbay	Jane Viner	
3.	The successful implementation of the care model and more efficient working within the Integrated Care Organisation (ICO) is dependent on ensuring the delivery of shared health and social records. What assurance can be given to the governors that there is clarity about the plan to deliver shared records for health and social care professionals in 2016/17 , 2017/18 onwards, that it is on target and meeting the needs of the care model as it is now being currently rolled out and CQC recommendations.	Torbay	Rob Dyer	